CITATION: *Inquest into the death of Zephaniah Namundja* [2010] NTMC 031

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0183/2008
DELIVERED ON:	22 April 2010
DELIVERED AT:	Darwin
HEARING DATE(s):	19-20 April 2010
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Motor vehicle accident, police pursuit, remote community, liquor restrictions

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Senior Next of Kin	Ms Jodi Truman
Police Commissioner	Mr Kelvin Currie

Solicitors

Senior Next of Kin	Ms Claire Henderson NAAJA

Judgment category classification:	B
Judgement ID number:	[2010] NTMC 031
Number of paragraphs:	32
Number of pages:	13

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0183/2008

In the matter of an Inquest into the death of

ZEPHANIAH NAMUNDJA
ON 14 September 2008
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. Mr Zephaniah Namundja died on 14 September 2008 at Royal Darwin hospital. His cause of death was a severe head injury. He sustained the injury when he fell from the tray of a moving Toyota Hilux twin cab utility on the evening of 4 September 2008 at Oenpelli.

2. The driver of the Hilux, Eric Marrday, pleaded guilty to an offence of dangerous driving causing death and was sentenced in the NT Supreme Court on 26 August 2009. The circumstances surrounding the motor vehicle accident and the deceased's death were investigated by detectives from the Major Crime Unit in Darwin because there had been a short "police pursuit" of Mr Marrday's vehicle prior to the deceased falling and sustaining the injury.

3. The deceased's death was not a "death in custody", even pursuant to the extended definition of "custody" which includes a person fleeing or attempting to flee from police. Brevet Sergeant Smallridge, who was driving the police vehicle, was seeking to apprehend Mr Marrday, the driver, when he activated his lights and sirens and followed the Hilux. Nevertheless I have held this public inquest in order to examine the actions of police and

any other relevant circumstances surrounding the death for the benefit of the deceased's family and the wider community.

4. The passengers in the Hilux, including the deceased, were all drunk and were, to use the term employed by his family, "grog carting" (bringing alcohol purchased elsewhere into a restricted area where its consumption is unlawful). At the request of the deceased's family, and because it appeared to me to be sufficiently connected with the death, this inquest touched upon liquor licensing issues affecting Oenpelli.

JURISDICTION AND FINDINGS

Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act; and
>
> (v) any relevant circumstances concerning the death.

5. Section 34(2) of the Act operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

6. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

7. Counsel assisting me at this Inquest was Ms Helen Roberts. Mr Kelvin Currie was granted leave to appear on behalf of the Commissioner of Police. Ms Jodi Truman, instructed by North Australian Aboriginal Justice Agency ("NAAJA"), appeared on behalf of the deceased's family. Ms Rose Nabbobob, a grandmother for the deceased, prepared a statement on behalf of the family which was read out in Court. She was unable to attend the inquest. The deceased's sister, Sheralee Namundja, did attend and listened to the evidence.

8. The death was investigated by Detective Sergeant Jason Bradbury, who prepared a thorough investigation brief of a high standard (Exhibit 2). I also received in evidence an additional statement from A/Superintendent Rob Farmer (Exhibit 5) and Liquor Licensing Inspector Doug Bell (Exhibit 3). I viewed portions of the "re enactment" interviews conducted with B/Sgt Smallridge and ACPO Martin. I heard oral evidence from Detective Sergeant Bradbury, B/Sergeant Smallridge, Constable Hayden, Sergeant Illet, Dr Hugh Heggie and Doug Bell. On the basis of all of the material before me at the inquest I make the following findings.

Formal Findings

9. Pursuant to section 34 of the *Coroners Act* I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased person is Zephaniah Namundja born 21 April 1986 in Darwin.

(ii) The time and place of death was 5:00am on 17 September 2008.

(iii) The cause of death was blunt head injury occasioned when the deceased fell from a moving vehicle. .

(iv) Particulars required to register the death:

1. The deceased was Zephaniah Namundja.

2. The deceased was of Aboriginal descent.

3. The death was reported to the Coroner.

4. A post mortem examination was carried out by Dr Terence Sinton, who confirmed the cause of death.

5. The deceased's mother was Dorothy Mangayamala Nabobbob and his father was Darryl Miljonjon Namundja.

6. The deceased usually lived at House 350, Gumbalanya Community (Oenpelli).

7. The deceased was unemployed.

CIRCUMSTANCES SURROUNDING THE DEATH

10. The deceased was 22 when he died. He grew up in Gumbalanya, also known as Oenpelli. He had a history of criminal offending since a young age relating to alcohol or other substance abuse. He is missed by his family, including his grandmothers, his two young children, and other extended family, and is remembered by them as a boy who loved to play sport, go camping and hunting.

11. On Thursday 4 September 2008 the Gumbalunya Social Club in Oenpelli where patrons could buy and consume beer on site between certain hours, was closed. It was required by the terms of its licence, as amended by section 13(5) of the *Northern Territory National Emergency Response Act* 2007 to be closed on a Thursday. Prior to 20 November 2007 when the amendments commenced in Oenpelli, the Club had been open for 3 hours each evening, as well as 1 hour at lunchtimes on certain days, and closed all day Sunday. As I understand the evidence, the Thursday closure was imposed upon all similar licensed Clubs in Aboriginal communities on the basis that Thursdays are "pay day" (the day that most recipients of government benefits are paid).

12. On Thursday 4 September 2008 Mr Marrday, the deceased, and 3 other men travelled in Mr Marrday's yellow Hilux to licensed premises on the Arnhem Highway to buy take away alcohol, including beer, wine and spirits. This involved a return trip of several hundred kilometres. At some point on the return journey they collected two other Aboriginal men from the community, who had also bought alcohol, and were looking for a ride home. All of them had been drinking during the day as well.

13. The headlights on the Hilux were not working. There was some discussion about this when it got dark, but they decided to keep driving back to Oenpelli. Mr Marrday, who did not have a licence, was driving. He was drunk. The deceased stood on the flat bed tray of the Hilux holding a Dolphin torch to provide lighting for the driver.

14. At about 9.00 pm B/Sgt Smallridge, the OIC of Oenpelli police station, received a call from Police communications, advising that an anonymous caller had reported that a yellow Hilux was travelling to Oenpelli reportedly with all occupants drunk and alcohol on board. Already that evening, he had apprehended two drunk drivers (one high range, one close to it) and arrested those drivers and their passengers for bringing alcohol into the restricted

area. He had seized several cartons of beer and several bottles of spirits. (Later, when Jabiru police came to assist, they also apprehended a vehicle bringing in beer, located some bottles of spirits in bushland near the crossing, and had to remove a heavily intoxicated man and his companion from the middle of the road).

15. Sgt Smallridge decided to go to Cahill's Crossing with ACPO Hill and ACPO Martin to intercept and apprehend the vehicle. He wanted to prevent a drunk driver driving into and around the Oenpelli community and prevent a potentially large amount of alcohol being brought in with all of the consequences in terms of assaults and other offending that in his experience would follow. He waited for the yellow Hilux by parking the police vehicle a short way down a "goat track" adjacent to the main road which comes across the crossing from the Jabiru side. In this position he could see the crossing, but vehicles on the crossing could not see his vehicle.

16. Sgt Smallridge agreed that this was not the usual position he would place the police vehicle if he was conducting normal traffic duties. In the ordinary course, he would want the police vehicle to be clearly seen to act as a deterrent as well as to apprehend offending drivers. However, on this occasion he said he wanted the driver to get well across before he saw the police vehicle, to prevent him from turning around on the crossing or turning back to the tourist area of Ubirr. My impression from all of his evidence is that Sgt Smallridge took his role in policing illegal grog running seriously. He was quite determined to apprehend the driver of the yellow Hilux if he could possibly do so.

17. He saw the Hilux come across the crossing and heard sounds of drunken revelry. He noticed that the headlights were not on. Once the vehicle had "committed to the crossing", he turned the emergency beacons on his police vehicle and started driving towards the road. His evidence was that the Hilux travelled faster than he expected and so it passed him before he had

reached the position he was intending to be in to stop the vehicle. He saw a man standing on the tray of the ute, as it passed him. He turned in behind the vehicle and followed it with his lights and sirens on for about 100 metres, not reaching a speed greater than 30km/hr. He could not see the vehicle ahead of him because of the large amount of dust. The dust soon changed from red to black. ACPO Martin suggested that the vehicle could have 'rolled' or turned off the road into the bush. Sgt Smallridge immediately stopped his vehicle completely, appreciating the possible dangers in the situation. After waiting for the dust to clear, he drove up and down a straight 1km stretch of road utilising the spotlights to search for the yellow Hilux in the adjacent bush. They did not find it at that time.

18. After about 15 minutes of searching, Sgt Smallridge decided to drive the 14 or so kilometres back into Oenpelli. They continued past the main access road on to the second access road which enters Oenpelli the back way and is more popular with those who wish to avoid scrutiny. Sgt Smallridge observed dust at that track suggesting a vehicle had recently passed by. They turned on to the dirt road and saw a culvert which had apparently been ripped up by an impact and some 40 metres away (having been thrown from the ute tray) lay Mr Namundja, unconscious.

19. Police immediately arranged for emergency medical assistance. The deceased was taken to the clinic where he was assessed as having a Glasgow Coma Score of 3. This did improve over the following hours but he did not regain consciousness at any time. He was evacuated by air to Royal Darwin Hospital at about 4:00 am. Surgery was performed but his head injury was severe, and he eventually died on 17 September in hospital.

20. On the access road where the accident occurred, ACPO Hill waited with the deceased while Sgt Smallridge arranged for the attendance of the ambulance, and drove ACPO Martin back to the station to look after the prisoners whilst he and Constable Hayden returned to the scene. They located the yellow

Hilux (stopped) about 1km from the accident scene, 200 metres off the main track near an outstation. At the approach of the police, occupants ran away. Police arrested Moses Mirrwana, and Aaron Manakgu at that time. Mr Manakgu tried to escape carrying a carton of VB but was too intoxicated to walk. The other occupants of the vehicle, Mr Gumurdul (now deceased), Timothy Nabegeyo and Thomas Balwana were all located later. All nominated Mr Marrday as the driver. Eric Marrday was arrested at his home by Jabiru police between two and three hours after the accident. When interviewed, he admitted that he was driving the vehicle, and that he hit something (the culvert). He claimed that he was not aware that the deceased had fallen from the tray.

21. It was difficult for investigating police to obtain a reliable version of events from the perspective of the occupants of the yellow Hilux, as their observations at the time and their later recollections were all affected to varying degrees by their intoxication. I am satisfied, however, taking into account all of the evidence that Mr Marrday was driving too fast for the conditions, without headlights, whilst intoxicated and attempting to evade the police. In addition it had been decided that the deceased would stand on the tray holding a torch to light the way for the vehicle, a clearly dangerous exercise. These circumstances led to the accident which caused the deceased's head injury.

22. Sgt Smallridge attended to matters of safety and the criminal investigation process in difficult circumstances over the following hours. He made detailed reports to his superiors about the incident, including advising the Duty Superintendent of the circumstances of police contact with the vehicle prior to the accident. Duty Superintendent Farmer said that he did not direct that the matter be investigated immediately pursuant to General Order D2 because he believed the injuries were not as serious as they were. During the hours that the deceased was being treated at the clinic, police enquired as to his progress. It appears that the communication about his Glasgow Coma

Score improvement led to police forming the erroneous impression that his condition was no longer critical. The D2 investigation was commenced on 11 September 2008 when police were advised that the deceased was not expected to survive. It was a high quality investigation.

The Police Pursuit

23. I find it is more likely than not that Mr Marrday saw the police vehicle once he crossed Cahills Crossing, or if he did not, he was alerted to it by the passengers. He was then focused upon evading apprehension because he knew that there would be serious consequences including seizure of the alcohol, seizure of the vehicle, an arrest for drink driving and probable gaol time given his prior history. The police actions therefore did impact upon Mr Marrday's actions to some extent. However, the ultimate accident was separated in time and distance from the original "pursuit". If Mr Marrday drove at a dangerous speed along the access road as a result of seeing the police lights in the distance returning to town, that was his own decision.

24. Sgt Smallridge asserted in answer to some questions put to him that he "did not intend to pursue" the Hilux. My interpretation of this taken in the context of his overall evidence was that he never intended to carry on a lengthy or high speed chase of the vehicle because he knew that in the dark on a dirt road which creates dust, this would be dangerous and/or futile. He did engage in a pursuit, within the meaning of the NT Police UDD and Pursuit Policy, for the period that he followed the vehicle, attempting to have the driver stop. I find that at the time he did not turn his mind precisely to the terms of the Policy and the risk assessment that members must carry out before and while engaging in a pursuit. However, he did carry out a risk assessment, which he explained, when he decided where to wait for the vehicle and how to best apprehend it. He also weighed up the risks of taking action to apprehend a driver who was likely to be drunk and may try and

avoid him, as against the risks of allowing that driver into the Oenpelli community with the alcohol.

25. The deceased's family through their counsel submitted that they understand this was a difficult decision to make and accept that Sgt Smallridge was doing his best to do his job. I find that Sgt Smallridge did turn his mind to the risks, in an effort to carry out his policing duties and ensure the safety of members of the community as best he could in all of the circumstances.

26. Mr Currie, appearing on behalf of the Commissioner of Police, submitted that I should not classify the driving that B/Sgt Smallridge did over the 100 or so metres that he followed the yellow Hilux as a pursuit, because Sgt Smallridge was not driving fast nor "gaining" on the fleeing vehicle but merely "attempting to apprehend" the vehicle. I do not accept this submission. A pursuit may be brief, it may be at a slow speed, it may be justified, it may be entirely futile. None of these features of themselves means that it is not a pursuit within the definition provided by the NT Police UDD and Pursuit Policy. I note that Sgt Smallridge described what he did as a "short pursuit" and that the investigating officer, Detective Sergeant Bradbury, also classified it as a pursuit within the policy. I quote from my comments in the recent Inquest into the deaths of six people at Hermannsburg which address a similar issue (*Inquest into the deaths of Malthouse & Ors* [2009] NTMC 066):

> At the time of the motor vehicle roll over, the vehicle was being pursued by police within the meaning of the NT Police Urgent Duty Driving and Pursuit Policy. The driver of the white sedan … made a decision to accelerate past a police vehicle which was signalling him to stop. The police vehicle … had executed a u-turn and followed the sedan, with its lights on and reaching a speed above the posted speed limit. There was no physical proximity between the two vehicles – in fact neither could see the other – and I find that at the time of the roll over the police vehicle was at least 400 metres behind the white sedan. The two police members did not carry out the risk assessment required by the … Policy. This was due to the fact that the driver in particular did not appreciate that he was engaging in a pursuit. He expressed the view when interviewed … that there is some

material distinction between "following" and "pursuing" a vehicle based either on speed or physical proximity between the vehicles. That this misapprehension exists among junior officers is not surprising given that a similar distinction was drawn by Superintendent Rennie, who held the position of Superintendent, Road Safety Division, for five years. As much as many police may wish it so, there is no such distinction in the policy as it stands. This was properly acknowledged by the other police witnesses, and by Mr Stirk on behalf of the Commissioner.

Liquor Licensing

27. The changes to the Gumbalunya Social Club licence requiring all day closures on Monday and Thursday have been criticised by some as causing an increase in alcohol related problems. It would be unrealistic to suggest that prior to the changes there were "no problems" with grog in Oenpelli. That is contrary to my experience as a Magistrate sitting on circuit courts in Oenpelli. Dr Heggie, a senior general practitioner who lived and worked in Oenpelli for 3 years gave evidence that he saw substantial alcohol related harm. In his opinion, which I accept, alcohol abuse and related harm was caused by alcohol consumed on site at the Club as well as alcohol consumed away from Oenpelli, and/or takeaway alcohol brought back illegally. However, Sgt Smallridge gave evidence, which I also accept, that the change had led to a noticeable increase in "grog running" particularly on a Thursday when community members had money to spend. Constable Hayden, also of Oenpelli police made the same observations. Sgt Smallridge had raised his concerns with the government department responsible for liquor licensing and put his concerns in writing to his superiors in March 2008, some months before this death.

28. Doug Bell, a senior Liquor Licensing Inspector with the Department of Justice (Licensing and Regulation and Alcohol Strategy) gave evidence that the Commonwealth imposed changes to Club licences applied to all Aboriginal Communities in prescribed areas. He agreed that in his experience over 16 years, different communities have quite different problems and needs, and that in terms of liquor regulation, "one size does

not fit all". Whilst Dr Heggie was at Oenpelli he was part of a group working on an Alcohol Management Plan for Oenpelli, however, for one reason or another that process had stalled. One problem he highlighted was that the Plan was to cover both Oenpelli and Jabiru, which had quite different issues to consider. Mr Bell gave evidence that his Department is now in the process of working on more individualised alcohol management plans for communities. In my view, such individualised plans are much more likely to address the differing needs of communities more effectively. The deceased's family has asked me to endorse such plans.

29. I also comment upon one further aspect of alcohol management in prescribed areas which arose in this inquest. The Oenpelli police reported this incident to Mr Bell's Department, who investigated whether there had been any provable breaches of license conditions by either the Bark Hut Inn or the Corroborree Park Tavern, the two premises on the Arnhem Highway where those involved in this incident had purchased alcohol. As part of that investigation they sought access to the "$100 registers" kept by both locations. Section 20 of the *Northern Territory National Emergency Response Act* 2007 (Cth) requires a licensee to record certain details if any person purchases more than $100 worth of takeaway alcohol in one transaction, and creates an offence if the record is not made. Section 20(5) provides:

> The licensee or employee complies with this subsection if, before making the sale, the licensee or employee:
>
> (a) requires the purchaser to produce evidence of the purchaser's identity that is of a kind listed in subsection (6); and
>
> (b) records the purchaser's name and address as specified in that identity document; and

(c) asks the purchaser where it is proposed that the alcohol will be consumed, and records the name or address of that place.

30. I heard that the Registers from both of the licensed premises revealed a record of purchases of more than $100 by Moses Mirrwana and Mr Gumurdul on 4 September 2008. (The other occupants of the yellow Hilux may well have made purchases of less than $100, or multiple such purchases from the same premises). As to ss20(5)(c), the Registers recorded that the alcohol was to be consumed at "Home" (being Oenpelli) in Mr Mirrwana's case, and "Bush" in Mr Gumurdul's case. Mr Bell showed the court similar records for surrounding dates where purchasers had indicated they were intending to consume the alcohol in Ramingining, the Coburg Peninsula, Oenpelli, and other addresses in prescribed areas.

31. The duty placed on the licensee is to record the details only. If the purchaser indicates that he proposes to consume, for example, 4 cartons of beer or 2 bottles of rum in a prescribed area where its consumption would be unlawful, the licensee must simply record the address indicated. It is not an offence to sell the alcohol. There is no duty to advise the police or any other authorities. I find it difficult to see the purpose of this provision, or how it can impact upon the problems of alcohol consumption in Aboriginal communities.

RECOMMENDATIONS

32. I recommend that Alcohol Management Plans are prepared with reference to the specific needs of individual Aboriginal communities in prescribed areas.

Dated this 22nd day of April 2010.

____

GREG CAVANAGH
TERRITORY CORONER