QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Michael David LEY
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2011/1894
DELIVERED ON:	12 December 2012
DELIVERED AT:	Townsville
HEARING DATE(s):	23 October 2012, 10 & 11 December 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody; assessment and care of intoxicated prisoners

REPRESENTATION:

Counsel Assisting:	Mr John Aberdeen
Sergeant Wayne Lord:	Mr Martin Burns SC (instructed by Gilshenan & Luton Legal Practice)
Queensland Police Commissioner:	Mr Wayne Kelly (QPS Solicitors Office)
Constable's York, Sabatino, & Faulkner and watch house staff Thompson & Millard:	Mr Andrew McGinness (McGinness & Associates)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Michael David Ley. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

In the early hours of 4 June 2011, Michael Ley was arrested for being drunk in a public place after his former girlfriend evicted him from her flat and called police when he continued to make a ruckus on her front veranda.

It was apparent to the arresting officers that he was very drunk. He appeared to fall asleep almost immediately after being placed in the rear of the police van. At the watch house he was non-responsive when carried to the charge counter. After his details were entered into the custody register he was carried into a cell and placed on one of the beds. During a routine cell check two hours later it was discovered he was not breathing.

Mr Ley was transferred to the Townsville Hospital by the Queensland Ambulance Service (QAS) where he was placed on life support. He died three days later without regaining consciousness. An autopsy established the cause of death to be aspiration pneumonia due to alcohol poisoning. Mr Ley was 30 years old when he died.

These findings:

- confirm the identity of the deceased person, how he died, the time, place and medical cause of his death;

- determine whether the police officers responsible for the deceased's health care while he was in custody adequately discharged their duty; and

- determine whether police otherwise adhered to the requirements set out in the Queensland Police Service (QPS) operational procedures manual (OPM) concerning the assessment and care of prisoners.

The investigation

Even though Mr Ley was still alive when he left the watch house in an ambulance, it was immediately recognised by senior police officers in Townsville that a critical incident had occurred and so the procedures for investigating such matters were activated.

At 5:24am, Inspector Kerry Johnson, the on-call investigator from the Ethical Standards Command (ESC), received a call from Superintendent Col Campbell of Townsville police advising of a likely death in custody.

Later that morning Inspector Johnson briefed other investigators from the ESC to attend Townsville and commence investigations. One of those officers was Inspector Marc Hogan who became the lead investigator and later provided a report to the Office of the State Coroner.

Inspector Johnson consulted with his superiors and it was agreed it was not appropriate for local investigators to interview the subject officers. Having regard to the length of time it would take for ESC officers to arrive in Townsville, it was further agreed it would be unreasonable to require the subject officers to wait at Townsville Police Station until the arrival of the ESC staff. Accordingly, Inspector Johnson contacted the Regional Crime Co-ordinator in Townsville and advised him to send the subject officers home after giving them a direction to not speak about the matter and not to consume alcohol.

Inspector Hogan and other officers from the ESC travelled to Townsville and attended the Townsville police station that afternoon. Inspector Hogan received a briefing and attended the Townsville watch house. After viewing the watch house Inspector Hogan returned to the police station and he, along with the other ESC investigators, commenced interviewing relevant persons over the following days.

The following day an officer from the Crime and Misconduct Commission (CMC) travelled to Townsville and monitored the investigation.

I was advised of the impending demise of Mr Ley and his death was formally reported as a death in custody on 7 June 2011.

Inspector Hogan continued to interview all relevant persons involved with Mr Ley prior to his death and collated all relevant watch house records including CCTV recorded vision from the watch house and other premises Mr Ley had attended before being taken into custody.

Further independent expert reports were commissioned by those assisting me.

I am satisfied the investigation was thorough and professionally undertaken. I commend Inspector Hogan on his endeavours.

The Inquest

A pre-inquest conference was held in Brisbane on 23 October 2012. Mr Aberdeen was appointed as counsel to assist me with the inquest. Leave to appear was granted to the QPS Commissioner, the arresting officer and his partner, the watch house keeper and three members of the watch house staff.

An inquest was held in Townsville on 10, 11 and 12 December 2012 where 12 witnesses gave evidence. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The evidence

Social and medical history

Mr Ley was born on 9 January 1981 at Cairns. When he was quite young Michael was diagnosed with attention deficit hyperactive disorder (ADHD) that compromised his capacity to learn, and subsequently to gain employment.

He was prescribed Ritalin but his Townsville Hospital medical chart records he was poorly compliant with his medication regime.

Michael went to Whitfield primary school and was in the special education unit. He went to Cairns High and was mainly in the special education unit there until he left school at the end of year ten at the age of 16.

Due to Michael's ADHD disorder he was aware of what it was like to be treated differently by his peers and sometimes misunderstood by others.

He had a number of domestic relationships and fathered two children with different women. His daughter, Jaclyn, was aged 10 and his son, Javia, was ten months old at the time of his death. He had little contact with them and was in continuing dispute with Javia's mother.

His close friend Nathan Williams described Mr Ley as a heavy drinker. He said when interviewed; *he just drinks and drinks and drinks…until he's incoherent*.

Mr Ley was in receipt of a disability pension. He played social darts and ten pin bowling. He was an avid Cowboys supporter. He was never in payed employment.

Mr Ley had been friends with Vanessa Hall for about ten years. They met through ten pin bowling. They were engaged in a romantic relationship for about two years, seven or eight years before Mr Ley's death. They broke up because, according to Ms Hall, he became violent when drunk. As a result she obtained a domestic violence order prohibiting Mr Ley from contacting her. About two years prior to his death Ms Hall and Mr Ley again began socialising.

Mr Ley had been before the courts on a number of occasions, usually for public order offences. He had not been prosecuted in the five years preceding his death, although he had come to police attention for public drunkenness only the week before.

At the time of his death Mr Ley was living with his mother in Kirwan, a suburb of Townsville. He is sadly missed by his parents, his brother and his extended family. I offer all my condolences.

Events leading up the arrest

On the afternoon of 3 June 2011, Mr Ley took up with his friend Nathan Williams. The two had been friends for about 16 years and remained in close contact throughout that period. They regularly socialised on alternate Friday afternoons when Mr Ley's pension payments were received.

Mr Williams' partner drove him to Mr Ley's residence at about 5:00pm so they could collect Mr Ley and take him back to their place. Before he left, Mr Ley arranged with his mother that she would come by Mr Williams' house at about 7:00pm so Mr Ley could pay her his rent.

Soon after they got back to Mr Williams' house, he and Mr Ley walked down to the local shops where Mr Ley got money from the ATM. They each had a can of rum and cola. Back at Mr Williams' house they played video games and watched TV until Mr Ley's mother arrived to collect the rent money. She then dropped the two men and Mr Williams' 18 year old son to the Kirwan bowling alley and arranged to pick them up at 9:30pm.

They played a couple of games of ten pin bowling and drank three beers each. At about 9:30pm Mr Ley's mother came. She gave Mr Williams and his son a lift to the bus stop and then she and her son went home.

On the way home Mr Ley began hounding his mother to drop him at the Kirwan Tavern. She repeatedly refused because she was concerned he would drink to excess and get into trouble. Her resistance was to no avail; soon after they reached home he left and walked to the tavern.

CCTV recorded vision shows Mr Ley arriving at the tavern alone at about 10:00pm. He there consumed three or four alcoholic drinks. At about 10:50pm he went to the drive through bottle shop and bought a two litre bottle of Coke and a 750ml bottle of rum. He returned to the public bar and had a bar attendant store the items in the refrigerator until he departed the hotel at about midnight. In the CCTV recorded vision of him leaving the hotel he appears not to be heavily effected by alcohol.

Mr Ley's ex-girlfriend, Vanessa Hall, lived in a first floor unit about 750 metres from the tavern. She said that on the night in question at *around 11:30 to 12 o'clock* Mr Ley arrived at her home. This suggests he walked directly from the tavern to her place.

Ms Hall says that when he arrived she was on the phone to her partner. After opening the door to his knock she simply waved him in while she continued with her conversation. She saw that he was carrying a two litre bottle of Coke and a bottle of Bundaberg rum. She said that neither was opened.

Ms Hall said that after they walked into her lounge room, Mr Ley snatched the phone from her hand and started abusing the person she had been talking to. She says that while he was having this conversation he also requested a cup from her, which she gave him. She claimed he poured himself a drink of rum

and coke which was mixed about half and half. She said that soon after this she demanded the phone back and he threw it on the ground. After the telephone conversation they had an argument about his behaviour. Ms Hall said that after about twenty minutes to half an hour she told him to leave. After some further arguing, he complied and she shut and locked her front door.

She says that a short time later Mr Ley started kicking and banging on her screen door demanding to be let back in.

Ms Hall called the police and complained about the disturbance Mr Ley was causing. Police records show that call was made at 1:32am.

The arrest

Constable David York and Constable Kathleen Sabatino were detailed the job. They were told Michael Ley was at his former girlfriend's house; drunk; has made threats to assault the informant; and kicking at her door trying to get in. They were told there was no DVO current and that Mr Ley had mental health issues suffered from *ADD* and had previously been involved in a drug diversion program.

The officers arrived at Ms Hall's premises at about 1:43am.

The officers heard a man shouting out when they arrived. They walked up the stairs towards Ms Hall's front door and saw the person we now know was Mr Ley, sitting at the top of the stairs. He had a bottle of Coke in his hands which he dropped as the officers approached. When he stood up they noticed a bottle of rum on the veranda floor beside him. Constable York said it was about one quarter full.

The officers asked Mr Ley his name and address. He wouldn't answer their questions. It was obvious to the officers that Mr Ley was very drunk. He was rambling, swearing and dribbling. He was very unsteady. He was demanding to be let into the unit.

They tried to coax him downstairs as they were concerned for everyone's safety standing on the stairway. Constable Sabatino said that Mr Ley resisted these efforts and became aggressive, throwing her hands off his arms as she tried to guide him away from the unit. He was arrested and handcuffed. He was then walked downstairs. Constable York said he resisted this by propping his legs as they descended the stairs.

The officers put him into the pod on the back of their van and lay him on his left side. They said they told him he had been arrested for being drunk in a public place. They said he appeared to fall asleep almost immediately.

Constable Sabatino then went and spoke to Ms Hall to get some details of what had gone on to enable her to consider whether she should apply for a DVO.

When she returned, she got into the driver's seat of the police van and Constable York got into the back seat because the prisoner could not be observed from the front seat when he was lying down in the pod.

Soon after they set off for the watch house, they stopped the vehicle because Constable York was concerned he could not see the prisoner. The officers got out of the car and opened the pod to check on him. They said he was snoring. Constable York moved Mr Ley to a position from which he could be seen from the passenger compartment.

They then again proceeded towards the watch house. Further into the trip they again pulled over and checked that Mr Ley was still breathing. Constable Sabatino said she alighted from the vehicle, opened the pod, looked at Mr Ley and called his name. She said he opened his eyes briefly before appearing to go back to sleep. She considered this meant it was safe to proceed to the watch house and they did so.

QPS records indicate they arrived at the watch house at 2:04am. Both said from the time he was placed in the pod, he did not speak again: the only sound to come from him was snoring.

At the watch house

When the police vehicle arrived at the watch house loading bay at about 2:04am, one of the officers opened the pod. Mr Ley was unable to be roused. A civilian watch house employee, Justin Thompson said he tried to wake him by calling his name and doing a sternum rub but he got no response, other than perhaps, a flicker of the eyes. Another officer working in the watch house, Constable Jamie Faulkner, pinched his ear lobe, again to no effect. Each then took an arm and carried/dragged Mr Ley to the charge counter. The CCTV vision shows his head hanging forward and his lower legs dragging along behind him.

Mr Ley was briefly taken to the charge counter where, in normal circumstances the prisoner would be charged, his particulars would be taken and a series of health questions asked. In this case, because it was obvious the prisoner was unconscious, he was held in front of the charge counter for about 20 seconds before being laid on the floor. There, he was searched and the handcuffs were removed, as were his belt and shoes. Constable Faulkner said he again tried to wake Mr Ley whom he recognised from a previous encounter, but he could not be roused. Mr Thompson did likewise.

As he was being brought in Constable Sabatino asked the watch house keeper, Sergeant Wayne Lord, whether they should take Mr Ley to the hospital. She said he said; *No, its ok, we'll let him sleep here*. Mr Thompson said he also asked Sergeant Lord whether they should accept the prisoner having regard to his condition and was told they would. Sergeant Lord said he doesn't remember these suggestions being made but Constable Sabatino's version is supported by Constable York and Constable Faulkner. The Sergeant admitted the conversations may have occurred. I find that they did.

The officers listed the property they found on him in the appropriate register. Part of the charging procedure required the officers to ask a series of questions about the prisoner's health. Obviously these could not be administered because Mr Ley was unconscious. Nonetheless, Sergeant Lord marked *refused* beside each question even though at the inquest he admitted he had only asked the first few.

The charge of being drunk in a public place was entered in the appropriate record and Mr Thompson was assisted by Constable York to carry Mr Ley to a cell.

When he was first placed in the cell at about 2:10am, Mr Ley was laid on his back, propped up with three square cushions under his head and shoulders. However when Mr Thompson went back to the charge counter and viewed the cell through the CCTV monitors he became concerned about the position of Mr Ley. Accordingly, a few minutes after first placing the prisoner there, he went back to the cell with Constable Faulkner and placed Mr Ley in what is commonly referred to as a recovery position. He said he did that to ensure he had a stable airway due to his level of intoxication. He said he tucked one of Mr Ley's arms underneath his jaw-line to support the airway.

At 2:28am Constable Faulkner conducted general watch house cell checks and the recorded vision on the watch house CCTV shows him making an inspection of the cell in which Mr Ley is housed. This was done by shining a torch from outside the cell door onto the prisoners.

At 2:42am Constable Faulkner again checked on Mr Ley, not as a general watch house check; rather he just went to Mr Ley's cell because his level of intoxication made the officer apprehensive.

At 3:22am Steven Millard, another civilian watch house officer, checked all of the prisoners. Mr Ley was seen to be snoring and his chest rising with respiration.

At 4:03am Mr Thompson was doing a general cell check. When he looked into Mr Ley's cell he couldn't see his chest rising. Nor was he still snoring. Accordingly, Mr Thompson entered the cell and checked for a pulse and respiration. When he found neither he went back to the charge counter and enlisted the assistance of Constable Falkner and returned to Mr Ley's cell and commenced CPR. QAS records indicate they were called at 4:11am by Sergeant Lord. The apparent delay is probably explained by the different settings of the clocks relied upon.

QAS response

At 4:19am the first QAS crew entered the cell responding to the information that a prisoner had suffered an arrest and was not breathing. They found Mr Ley had no recordable pulse, no detectable blood pressure, to be cool to the touch and to have asystole cardiac rhythm. He had vomitus around his mouth

and so suction was undertaken. An airway was established and defibrillation applied which produced a sinus tachycardia rhythm. Adrenalin was given. At 4:35am CPR was terminated when spontaneous circulation and respiration returned. Mr Ley was transported to the Townsville Hospital arriving there at 4:47am.

Hospitalisation

On arrival at hospital, Mr Ley was intubated and tests and scans were quickly undertaken to attempt to isolate the cause of his collapse and coma. His blood was found to contain an alcohol concentration of 0.483%. A CT scan of his brain showed a loss of grey-white matter differentiation in multiple areas. This was said to be consistent with global cerebral ischemia secondary to an evolving hypoxic brain injury. No skull fracture and no cranial bleed were detected. A chest x-ray revealed bilateral diffuse alveolar consistent with aspiration pneumonitis.

Mr Ley's mother, Mrs Simpkins, was advised of the situation at 6:21am. She immediately attended the hospital.

Later, Mr Ley's father, brother and uncle also came to the hospital. They had a number of meetings with the Intensive Care Unit (ICU) consultants and other members of the treating team. They were advised at an early stage that the prognosis was poor.

Over the following days Mr Ley was cared for in the ICU. He remained on mechanical ventilation. His condition did not improve. On 7 June a CT scan indicated brain death. At 3:30pm on that day a life extinct certificate was issued. Although he was still on life support there was no prospect of Mr Ley recovering. Organ donation was discussed with his mother and agreed to.

Mr Ley's father identified his body to police.

Autopsy results

An autopsy was undertaken on Mr Ley's body by an experienced forensic pathologist, Professor David Williams, on 9 June 2011. He found on the top of the head a series of minor abrasions covering an area of two centimetres across. There were however no lacerations or bruises to the scalp. It is clear these injuries could have been caused with a minimal force.

Internal examination revealed no bruising to the strap muscles of the neck and the laryngeal skeleton was intact. This indicated he had not been strangled.

Ribs five to seven were found to be fractured on the left hand side of the chest but this was consistent with attempts at resuscitation.

The lungs showed bilateral bronchopneumonia of an aspiration type. Both lungs also had a degree of emphysema and they had a very solid feel consistent with some established aspiration pneumonitis.

Mr Ley's brain had significant hypoxic ischaemic injury from being without oxygen for some time (probably as a consequence of the aspiration pneumonitis).

Professor Williams came to the conclusion that the cause of death was:
1 (a) aspiration pneumonitis due to,
1 (b) alcohol abuse.

Professor Williams offered the opinion that *trauma played no role in the death of this young man*. *He died entirely due to the consequences of having too much alcohol in his system.*

A report was also obtained from an emergency medicine specialist, Dr Anthony Brown, a senior staff specialist with the Department of Emergency Medicine at the Royal Brisbane and Women Hospital. He had slightly different views as to the mechanism of Mr Ley's death. In Dr Brown's opinion it was likely alcohol poisoning repressed brain function to such an extent that respiration was greatly reduced or stopped altogether. In that state the atonal or flaccid muscles in the stomach and throat allowed stomach content to trickle into the dead man's lungs. If he had not already stopped breathing when this occurred, the aspiration and the continuing effects of the excess alcohol soon caused that to occur. In that state hypoxic ischemic brain injury commenced after a few minutes. By the time Mr Ley was resuscitated that brain damage had become irreversible and led to brain death three days later. In that period, the damage done to Mr Ley's lungs by the aspiration also proliferated.

Neither doctor could categorically rule out the possibility that aspiration occurred much earlier, perhaps even before Mr Ley arrived at the watch house. However, both said this was unlikely because both considered there would have been some manifestation of the event if it was other than very minor. Also, it is likely the period of greatest risk for aspiration to occur was when the blood alcohol in Mr Ley's system was at its highest which would have been around 3:00 to 4:00am. Accordingly, the fact he continued to snore in the same manner from soon after he was put in the pod until he was found at shortly after 4:00am to have suffered a respiratory arrest, strongly suggests it was at about this time that the aspiration occurred.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings.

Identity of the deceased – The deceased person was Michael David Ley

How he died - He died in hospital three days after suffering a respiratory arrest when he was put in a cell

in the Townsville watch house while unconscious due to severe alcohol intoxication.

Place of death – Mr Ley died at the Townsville Hospital in Queensland.

Date of death – He died on 7 June 2011.

Cause of death – Mr Ley died from a global hypoxic ischemic brain injury and the effects of aspiration pneumonitis, both precipitated by severe alcohol intoxication.

Comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. This inquest and another that will be held forthwith, raise for consideration from this perspective the manner in which the health care needs of police prisoners can best be secured.

Mr Ley had a difficult life due in part to a severe psychological disorder with which he continually struggled. His mother did her best to assist him but by the time he was 30 there was little she could do when Mr Ley refused to accept her guidance.

There is no doubt the primary cause of Mr Ley's death was his drinking to excess, which he did frequently. His mother and friends were aware of this tendency and vigorously encouraged Mr Ley to desist, but he was either unwilling or unable to do so. Had he managed to get home on the night he was arrested, it is by no means clear the outcome would have been any different; he may just as likely aspirated in his bed and been found dead there by his mother in the morning.

However, because he was arrested and taken into the custody of the QPS, its officers assumed responsibility for his health care. An alarming proportion of persons arrested are severely intoxicated by alcohol and/or other drugs. It is therefore essential the QPS has policies and procedures to assist officers determine when prisoners need to be examined by paramedics or doctors. And indeed it has.

In this report I will summarise those policies and reflect upon whether they were adhered to. As part of the inquest that will be heard immediately after this case, I will have regard to the evidence from both to consider whether any changes to the policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety.

Review of intoxicated prisoners

The QPS OPM provides in chapter 16.1 the following order:

> *Police officers and watch house officers who have custody of persons are to ensure that persons are treated with dignity and they are provided with the necessaries of life.*

The rest of the chapter sets out various ways this should be safely pursued.

In paragraph *16.6.3 Drunkenness* the following order appears:

> *When a person is arrested for being drunk in a public place and it is more appropriate for the person arrested to be taken to a place of safety, other than a watch house, a police officer at the earliest reasonable opportunity is to take the person to and release them at a place of safety.*

Under the procedure that follows that order it is explained that *a place of safety* is defined to include a place other than a watch house, where the police officer considers the affected person can receive the treatment or care necessary to enable the person to recover safely from the affects of being drunk. Examples of a *place of safety* include:

I. A hospital for a person who needs medical attention.
II. A place other than a hospital that provides care for persons who are drunk (e.g. a diversionary centre).

Section 16.13.1 requires the health care needs of a prisoner to be assessed and re-assessed using a screening tool provided – appendix 16.1.

It provides that if a prisoner appears to be unable to respond or is unconscious QAS should be called.

It provides a list of questions concerning a prisoner's health that should be asked by the charge counter sergeant who is directed to seek medical advice or assessment if the conditions set out in the checklist are met.

A further *Checklist 3: When medical attention or treatment is to be sought (For all prisoners in police custody*) provides*:-*

> *If … the following conditions or symptoms … or signs are observed, medical attention or treatment is to be sought for the person as soon as possible.*
> *Conditions, symptoms, behaviours or signs include:*
> *(i) unconscious or deteriorating conscious state;*
> *(ii) difficulty or impossibility to rouse from apparent sleep;*

The policy stipulates that where an officer is unsure whether medical assistance or an assessment by a medically trained person is necessary, it should be obtained.

In section *16.9 Lodging a prisoner in a watch house* the following appears. *A receiving officer is not to accept into custody a prisoner who is:*

> *I. Unconscious or apparently unconscious; or*
> *II. In need of or apparently in need of urgent or immediate medical treatment.*

Officers are then referred to section 16.13 which is summarised above, to assist in the consideration of whether medical attention should be sought.

Section 48 referral for discipline

The Act in s. 48(4) provides that a coroner may give information about a person's conduct in a trade or profession, obtained while investigating a death, to a disciplinary body if the coroner reasonably believes the information might cause the body to take steps in relation to the conduct.

The arresting officers said that after they had arrested Mr Ley on a charge of public drunkenness they considered him unsuitable for release to a diversionary centre because he had acted in an aggressive manner at the scene and had indicated he wanted to re-enter the flat of Ms Hall. I accept that as a reasonable explanation. Had they taken him to a diversionary centre and he had decamped back to Ms Hall's place and harmed her, the officers would have been criticised.

Their explanation for not ascertaining his address and exploring the possibility of taking him there as required by s. 378 of the PPRA was less persuasive. They had no basis to conclude he was at risk of harming his mother. Had they looked into that possibility she may well have convinced them he would be safe and pose no harm if left in her care. However, I accept that in view of his aggression and his lack of co-operation their failure to do this was not unreasonable in the circumstances.

The options then were to take him to the watch house or take him to hospital. I accept that when the arresting officers were dealing with Mr Ley at the scene of the arrest he was obviously very drunk but not to such an extent that an immediate medical assessment was called for.

He then appeared to go to sleep almost immediately after being put in the pod, which was not unusual for drunk prisoners.

The officers said they stopped twice on the way to the watch house to check on him. They could offer no persuasive explanation as to why they did this, if as they said, he was merely asleep. In any event, Constable Sabatino said that on the second occasion she got out of the police vehicle, opened the pod door and called to Mr Ley. She said that in response he opened his eyes and

then closed them again. She said this reassured her it was safe to continue to the watch house.

I conclude their decision to take him to the watch house rather than call an ambulance or take him to hospital was reasonable in the circumstances.

Once there, watch house staff members quickly became involved in attempting to rouse Mr Ley. It was soon apparent he was not just asleep when he could not be roused even with resort to multiple stimuli. Technically, he was still in the custody of the arresting officers and it was therefore their duty to get him medical attention. However, leaving to one side that legal nicety, I accept the reality of the situation was that they were in the watch house which was under the control of a vastly more experienced officer and they understandably took their lead from him. Constable Sabatino did as much as could be expected by asking Sergeant Lord if they should take Mr Ley to hospital. I don't consider either of the first response officers should be disciplined for not overriding the watch house keeper's assessment.

Sergeant Lord's management of Mr Ley on the night in question is to me inexplicable. He had before him a man who was clearly, deeply unconscious, who could not be roused, who could not answer the questions designed to assist determine whether a medical assessment was needed. Rather than taking the obvious step of calling an ambulance, he subverted that process by falsely recording that Mr Ley had refused to answer all of the questions when only the first few were asked and not answered because the prisoner was incapable of doing so.

Despite it being suggested to him by two junior members that hospital might be a better option, Sergeant Lord was content to watch Mr Ley be carried to a cell.

His actions were completely contrary to the various procedures I have outlined above and that have been repeatedly emphasised in recent years as a result of other deaths in custody.

It was submitted on his behalf that his years of experience in the watch house and repeated warnings from coroners and the commissioner were nullified by a training program he had attended earlier the previous day. However, the session which dealt with sudden death in custody syndrome had little to do with Mr Ley's circumstances: that segment dealt with the after effects of prolonged violent struggles; excited delirium and the like. And it lasted for 10 minutes, according to the OST training handbook tendered into evidence.

It was also submitted Sergeant Lord was led into error by a post arrest risk assessment (PARA) card that was posted prominently on the wall behind the charge counter. That guideline did not stipulate any circumstances in which summoning medical attention was mandatory but rather suggested that when symptoms such as those displayed by Mr Ley were encountered, an officer *should consider appropriate medical attention*. It too dealt with prisoners

brought into custody *after an intense struggle or some other violent physical activity* and indicated that it should *be read in conjunction with … the OPMs and other QPS documents.*

I acknowledge that Sergeant Lord encouraged the watch house staff to *keep an eye* on Mr Ley and they did so. However they were not in a position to monitor his condition as would have occurred in a hospital had Sergeant Lord complied with the relevant policies and procedures.

Accordingly I consider I am obliged to refer the relevant information to the QPS for consideration of disciplinary action.

Section 48 referral for prosecution

If as result of considering information gathered during an inquest, a coroner reasonably suspects a person has committed an indictable offence, s. 48(2) of the Act requires the coroner to refer relevant information to the DPP.

The offence provision with possible application to this case is s. 285 of the Criminal Code. Insofar as it may be relevant to this case, it provides:-

> *It is the duty of every person having charge of another who is unable by reason of …detention… to withdraw himself … from such charge, and who is unable to provide himself… with the necessaries of life …to provide for that other person the necessaries of life; and the person is held to have caused any consequences which result to the life or health of the other person by reason of any omission to perform that duty.*

To succeed, a prosecution under this section would require proof that:-

- Sergeant Lord had Mr Ley under his charge or control;
- Mr Ley was unable to withdraw himself from that control;
- Sergeant Lord failed to provide to Mr Ley the necessaries of life; and
- as a result of that failure Mr Ley died.

There can be no doubt about the first three elements: Mr Ley was in a locked cell as a result of Sergeant Lord's decision that he be held there. The *necessaries of life* include medical attention if that is needed to preserve the prisoner's life. Evidence that the failure to provide that medical attention caused the death was provided by Dr Brown, a senior staff emergency medicine specialist who reviewed the case material.

Dr Brown was of the opinion that had he been taken to the Townsville Hospital soon after he was brought to the watch house at about 2:00am on 4 June 2011, Mr Ley would have been admitted to the emergency department's resuscitation room for critical care, monitoring and treatment. This would have included the monitoring of his vital signs to ensure his airway and circulation were adequately maintained.

Dr Brown considered various tests and scans would have been undertaken in an attempt to identify the cause of Mr Ley's unconsciousness and to exclude causes other than intoxication. In his view, in all likelihood, Mr Ley would have been intubated and his respiration maintained via a mechanical ventilator. He would have been given intravenous glucose if his blood sugar level was low.

In Dr Brown's opinion had these steps been taken *it is highly likely he (Mr Ley) would have survived*. Indeed, at the inquest Dr Brown suggested a likely survival rate of more than 99% had the admission occurred before Mr Ley aspirated. For the reasons detailed earlier, I consider that would have been the case had he been taken to the hospital before he was put in a cell. Dr Brown said that even if Mr Ley had aspirated earlier he had an 80 – 90% chance of survival if he was admitted to hospital before he suffered a respiratory arrest.

These opinions are based on Dr Brown's belief that acute alcohol poisoning is usually successfully managed leading to a full recovery without long term sequelae; the treatments necessary to care for the patient while the body metabolises the alcohol are straightforward and not complex in Dr Brown's view. This led him to conclude *this full recovery is expected providing treatment is given before secondary and potentially irreversible complications occur such as hypoxic brain damage from respiratory depression cardiac arrest or aspiration pneumonia*.

Accordingly, I have at least a reasonable suspicion that the failure to provide the necessary care caused Mr Ley's death.

However, there are two other legal issues which need to be considered.

Section 285 is contained in chapter XXVII of the Code entitled *Duties relating to the preservation of human life.* Unlike some of the other sections in that chapter, the duty it imposes does not seem to be mediated by reference to reasonable care; on the contrary, on its face, section 285 seems to create an offence of strict liability – if, in the circumstances that exist, a person is required to supply necessaries of life, they are responsible for any consequences of a failure to do so.

However the section has to be read in conjunction with chapter 5 *Criminal responsibility* and the general law in relation to criminal negligence.

Section 24 of the Criminal Code provides that a person who omits to do an act under an honest and reasonable but mistaken belief in the existence of a state of things is not criminally responsible for the omission to any greater extent than if things were as the person believed.

In this case, I accept that Sergeant Lord honestly believed there was no need to get medical attention for Mr Ley. He thought he was very drunk, as many watch house prisoners are. He would sleep it off. I'm sure he intended Mr Ley no harm. We know he was mistaken. The question is; was that mistake

reasonable?

For the reasons I have detailed in connection with the disciplinary referral, I don't believe that it was. It is true there was some inconsistency in some of the policy documents, and it is possible Sergeant Lord mistakenly believed the training he had received in relation to sudden death following a violent struggle might apply to all drunken prisoners but I don't accept that is a position a reasonable watch house keeper could come to. In my view, a reasonable person in Sergeant Lord's position who had received the training and guidance provided to all senior QPS watch house keepers would not believe an unconscious prisoner should be put in a cell.

The offence created by s. 285 can be committed by persons deliberately refraining from providing succor or assistance to a person they are obliged by law to save or it can be done unintentionally. In this case there is no suggestion Sergeant Lord intended to cause any harm to Mr Ley and so a prosecution would have to be based on his failure being adjudged criminally negligent.

The courts have consistently, and understandably, held that in such cases the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress. The classic judicial articulation of this difference is found in *R v Bateman*[1] where Hewart LCJ said:-

> *In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and* ***showed such disregard for the life and safety of others as to amount to a crime against the State*** *and conduct deserving punishment ... It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime.* (emphasis added)

That common law test was held to apply in Queensland by our Court of Criminal Appeal (as it then was) in *R v Scarth*[2]*.*

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[1] *R v Bateman* (1925) 94 LJKB 791; [1925] All ER Rep 45; (1925) 19 Cr App R 8

[2] [1945] St R Qd 38

In *Evgeniou v The Queen*[3] the High Court said *recklessness involving grave moral guilt* was needed.

It is important when considering Sergeant Lord's culpability to avoid allowing the terrible outcome to cloud the assessment. Obviously, for Mr Ley and his family a worse outcome is hard to imagine but it is appropriate to acknowledge that when people drink to such gross excess, death can result with little or no fault from any third party.

Applying the higher court observations to this case, I conclude the Crown would either need to prove that Sergeant Lord was conscious of a real and substantial risk that Mr Ley would suffer serious harm if placed in a cell and simply chose to ignore it or that he failed to direct his mind to the possibility at all.

Sergeant Lord struck me as a relatively careful and considered man. A staff member who gave evidence said he was a stickler for the rules. He did not try and deny that others had suggested the prisoner be taken to hospital, but there is nothing before me to indicate any callus disregard for Mr Ley's welfare is likely to have motivated him on the night in question. Rather, I believe he considered the situation and concluded there was little risk of any harm coming to Mr Ley, provided they kept an eye on him. He was just drunk and he would just sleep it off. Sergeant Lord was wrong and I doubt he will ever forget his mistake contributed to a life lost.

I conclude an opportunity to prevent Mr Ley's death may have been lost by Sergeant Lord's failure to adhere to appropriate QPS policies of which he should have been aware. However, his failure to do so does not evidence such gross and reckless disregard for his responsibilities and the welfare of a person in his custody as to amount to criminal negligence, in my view.

Accordingly I do not intend to refer the material to the DPP.

I close the Inquest.

Michael Barnes
State Coroner
Townsville
12 December 2012

[3] (1967) 37 ALJR508