OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael John EDDY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 496/04(9)
DELIVERED ON:	12 February 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	12 – 15 December 2005 & 12 October 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, positional asphyxia, amphetamine use, autopsy reports, registration of causes of death.

REPRESENTATION:

Counsel Assisting:	Mr Mark Johnson
Ms Wendy Capner, Next of Kin:	Mr Peter Callaghan, SC (I/B Caxton legal Service)

Plain Clothes Senior Constable Brendan Jorgenson, Plain Clothes Senior Constable Madonna Norrish, Detective Sergeant George Bruce, Detective Sergeant Todd Reid, Sergeant Franco Lanaro, Senior Constable Anthony Chiverall & Senior

Constable Neil Smith:	Mr Paul Brown (I/B Gilshenan & Luton Lawyers)
Queensland Police Service Commissioner:	Mr Richard Taylor (I/B QLD Police Service Solicitor)

Findings of the inquest into the death of Michael John EDDY

Table of contents

Findings of the inquest into the death of Michael John EDDY 2
Table of contents 2
Introduction 3
The Coroner's jurisdiction 3
The basis of the jurisdiction 3
The scope of a Coroner's inquiry and findings 3
The admissibility of evidence and the standard of proof 4
The investigation 5
The inquest 6
The evidence 8
Background 8
Mr Eddy comes to the attention of police 9
Police attend the unit 11
Mr Eddy is arrested 13
Mr Eddy is restrained 16
Medical attention is provided 17
The initial response 18
Expert evidence concerning the cause of death 19
Amphetamine toxicity 20
Asphyxia 21
Excited delirium 22
Oleoresin capsicum spray 23
Conclusion as to cause of death 23
Findings required by s45 25
Identity of the deceased 25
Place of death 25
Date of death 25
Cause of death 25
Referral to DPP pursuant to s48 25
Concerns, comments and recommendations 27
The initial interception 28
Follow up action 28
The degree of force used against Mr Eddy 28
Recommendation 1 - Use of force training 29
Cause of death when opinion is dependent upon factual circumstances ... 29
Recommendation 2 - Extraneous information relied upon for autopsy reports 31
Recommendation 3 – Amendment of the *Births Deaths and Marriages Act 2003* 31

The *Coroners Act 2003* provides in s45 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 specified officials with responsibility for the justice system. These are my finding in relation to the death of Michael John Eddy. 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 the morning on 20 February 2004, four police officers went to a home unit in a three story block owned by the Department of Housing in Dutton Park, Brisbane. They were looking for Michael Eddy, believing him to be the person who had fled from a traffic interception earlier in the evening.

They were let into the unit but were told that Mr Eddy was not there. They didn't believe this and demanded entry to a closed bedroom in the unit. When they forced the door, they were confronted by Mr Eddy who resisted their attempts to arrest him. A violent struggle ensued. After Mr Eddy was restrained it was noticed that he was suffering some sort of medical emergency and an ambulance was called and first aid administered. He was not able to be revived and was pronounced dead at the scene.

These findings seek to explain how that happened and make recommendations aimed at reducing the likelihood of death happening in similar circumstances in future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because Mr Eddy was, when he died, attempting to avoid being taken into police custody, his death was a "*death in custody*"[1] within the terms of the Act and so it was required to be reported to the State Coroner for investigation and inquest.[2]

The scope of a Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and

[1] See s10(1)(c)
[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody

- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as that issue was not contentious in this case I need not seek to examine those authorities here. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence,

[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J

the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

As soon as police at the unit became aware that Mr Eddy had died, the unit and immediate surrounds were treated as a crime scene in that it was secured and movements in and out of it were recorded.

The death was reported up the chain of the QPS command and the officer in charge of the Homicide Investigation Group was instructed that his officers were to be the lead investigators. The officer detailed to lead the investigation and the officer in charge of the group attended the scene a few hours after the death, as did officers from the QPS Ethical Standard Command and the Crime and Misconduct Commission.

Some effort was made to separate the officers directly involved in the death but they were together for some time after the death at the unit complex. In evidence they acknowledged that they had discussed the incident before they were told not to. I have no evidence to suggest that they conspired to undermine the integrity of the investigation but such poor practice allows to arise suspicions to that effect.

The unit was examined by a scenes of crime officer who took samples of fluids he found on the walls of the unit and swabs from Mr Eddy's body. Some implied criticism was made of the failure of this officer to attempt to analyse the mucus that was thought to have flowed from Mr Eddy onto the carpet in the unit. In my view analysis of this substance would not have revealed anything that was not able to be examined during the autopsy.

Photographs were taken of the unit and Mr Eddy's body.

No attempt was made to examine Constable Jorgenson's police issue firearm for fingerprints even though the officer alleged that the dead man had handled it. For reasons that will become obvious when I discuss the evidence, I consider this to be a regrettable oversight but not one that has any bearing on the outcome of these proceedings.

---

[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[10] (1990) 65 ALJR 167 at 168

Later in the morning of the death, the four officers who had been directly involved in the incident that led to the death were interviewed at length and required to participate in another interview at the scene of the death. That “walk through” was video taped. It was not a complete re-enactment, in that no one took the part of the deceased man or the others present at the time of the incident. Rather, the officers being interviewed simply showed where they had been at various times and pointed out where other participants had been. For this reason it was of substantially less value that it would have been a proper re-enactment. The officer participated I the interviews after being given a direction to do so pursuant to the *Police Service Administration Act 1990*. As a result the answers they gave are able to be relied upon by me to make the findings required by s45(2) of the Act but could not be used against the interviewee in criminal proceedings.

The two civilians who were present at the unit at the material time were also interviewed later on the same morning. The investigating officers were impliedly criticised by counsel for the family for not re-interviewing these witnesses after they were more rested and, in one case, sober. I expect those witnesses may have been able to give amore coherent account if their interviews had been postponed but I can also understand why the investigators would want to get a detailed version from those witnesses as soon as possible. In this case I don’t consider any evidence was lost nor any harm done by the timing of these interviews. Nor do I consider anything of substance would have been gained by re-interviewing them subsequently.

After the scene was examined, Mr Eddy’s body was transported to the John Tonge Centre where, on 21 February 2004, a full external and internal examination was undertaken by a forensic pathologist Dr Alex Olumbe in the presence of Dr Anthony Ansford a senior forensic pathologist from the same centre. On 23 February, as a result of a request from solicitors then acting for Mr Eddy’s mother I ordered that a second autopsy be performed in the presence of a private forensic pathologist retained by the family.

Despite the reservations mentioned above, I am satisfied the investigation was reasonably thorough and that it was competently undertaken.

The inquest

A directions hearing was convened on 15 August 2005 at which Mr Johnson was appointed counsel assisting and leave to appear was granted to Mr Eddy’s mother, the officers involved in attempting to arrest him and the Commissioner of the Queensland Police Service. An issues list was distributed and a tentative list of witnesses discussed. The matter was then adjourned for hearing on 12 December when it proceeded for four days. The hearing was then adjourned to enable more expert evidence to be obtained: another forensic pathologist was briefed to provide a report. The hearing resumed on 12 October 2006. One hundred and forty-three exhibits were tendered and 18 witnesses gave evidence.

When they gave evidence, the three officers directly involved in restraining Mr Eddy claimed that some of their answers might incriminate them. I accepted

that objection and pursuant to s39 of the Act directed that they answer the questions as I considered it was in the public interest that they gave a complete account of their involvement in the death. As a result the answers they gave are able to be relied upon by me to make the findings required by s45(2) of the Act but could not be used against the witness in criminal proceedings.

At the conclusion of the hearing I sought and received submissions on whether s45(5) of the Act prevented me from making comments on the lawfulness of the forced entry by police to the bedroom occupied by Mr Eddy and the appropriateness of the force used to restrain him. As a result of considering those submissions I concluded that I could not comment on the lawfulness of the entry but I could comment on the degree of force used so long as such comments did not suggest the officers involved may have committed a criminal offence as a result of that use of force.

Another legal issue that arose as a result of some residual uncertainty surrounding the interpretation of provisions of the relatively new *Coroners Act 2003* concerned the mechanism by which coroners now respond to evidence of possible criminal offences. No longer do coroners have the power to commit a person for trial in connection with a death investigated at inquest. Instead, pursuant to s48, if, as result of the information obtained while investigating a death, a coroner reasonably suspects someone has committed an offence, the coroner must give that information to the appropriate prosecuting authority.

It seems clear that if a coroner chooses to make such a referral, he/she should not include that fact in his/her findings or comments as that would offend against the prohibition in s45(5) or s46(3) of including a statement that a person may be guilty of an offence. However, that does not necessarily conclude the issue of whether any of those granted leave to appear at the inquest, including the person who might be the subject of such a referral, have a right to be heard in relation to that decision.

As a matter of general principle, a person whose rights may be adversely affected by an administrative or judicial decision has a right to be heard before such a decision is made. As mentioned earlier, this has been held to apply to a coroners findings and it might be thought to entitle also the subject of a possible referral under s48 to be given an opportunity to be heard on that point.

Indeed, s36 of the Act which authorises "*a person who the Coroners Court considers has sufficient interest in the inquest*" to "*appear, examine witnesses and make submissions at the inquest*" may be thought to extend the right to make submissions on the s48 issue to all those who have been granted leave to appear at the inquest.

Arguments against this approach are articulated in the Tasmanian decision of *R v Tennent; ex parte Jager*.[11] In that case, which dealt with similar provisions of the Tasmanian legislation, the Court divined an intention in the legislation to protect the reputation of those who might be the subject of public submissions urging a coroner to refer matters to the prosecuting authorities. It addressed the concern I expressed earlier about being required to give those adversely affected a right to be heard by holding that a referral to prosecuting authorities did not affect a person's rights or reputation and was of no legal consequence: a person who suspected that he/she may have been the subject of such a referral could make a submission directly to the decision maker, namely, the prosecuting authority. However, somewhat confusingly, the court went on to observe that even if the rights of the subject of a referral were so adversely affected as to give him/her a right to be heard, that didn't mean that others granted leave to appear at the inquest could also insist on being heard on that question.

As a result of having considered the *Tennent* decision and the submissions received from the parties in relation to this issue I have come to the view that the right to make submissions, conferred by s36 on those granted leave to appear at the inquest, should be limited to the findings or comments that can be made at the inquest under s45 and s46 respectively and not extend to whether I make a referral under s48, a process that occurs separately and discretely from the inquest.

The parties also made written submissions on the factual matters and possible preventative recommendations. I found them to be of great assistance.

The evidence

I turn now to the evidence. Of course I can not even summarise all of the information contained in the exhibits and transcript but I consider it appropriate to record in these reasons the evidence I believe is necessary to understand the findings I have made.

Background

At the time of his death Michael Eddy was 26 years of age. He had a significant criminal history for a person of his age and had served time in prison. He had an extensive drug habit having used amphetamines and other "*hard drugs*" for most of his adult life.

In the period shortly before his death, Mr Eddy had not been convicted of any serious criminal offences for some years but he was on bail in relation to traffic and drug charges that had been preferred four days prior to his death.

It seems that for some time Mr Eddy had been extensively involved in selling amphetamines. Indeed on the day before his death he spent the day with his girlfriend, Bernadette Smith, visiting associates for this purpose.

[11] (2000) 9 Tas R 111

His movements in the latter part of 19 February 2004 have not been established with certainty. It seems that in the late afternoon he went with Ms Smith to visit his mother, Wendy Capner, at her home in Loganholme and told her that he, Ms Smith and her 14 month old baby would stay at Ms Capner's house that night so that they could have some peace and quiet away from Ms Smith's noisy and drunk brother, Dion Windus, with whom she had been staying. Ms Capner says the couple and the baby returned to her house at about 7.00pm and were still there when she returned from dinner at about 9.00pm.

Shortly after this, Ms Smith and Mr Eddy quarrelled and he dropped her back to her brother's unit on Gladstone Road Highgate Hill. It seems that he must have then returned to his mother's house as she says that soon after she went to bed between 10.30 and 10.50 she heard and saw his car come back to the property. She then went to sleep and could not give any evidence about Mr Eddy's movements from then on.

Mr Eddy comes to the attention of police

If this chronology is correct, Mr Eddy can not have stayed there for very long, as his car came to the attention of police on the South East Freeway shortly after 11.00 pm. At that time, Plain Clothes Constable Jorgenson and Detective Sergeant Bruce were driving an unmarked police car in-bound on the Southeast Freeway in the Mt Gravatt / Tarragindi area.

Both were in plain clothes. Constable Jorgenson was driving. He noticed a car behind them driving in a manner he thought suspicious in that although there was little traffic on the freeway, it was very close behind the police car and when Constable Jorgenson moved into the left lane to allow the vehicle to pass it instead followed him into the left lane again remaining close behind the police car. This prompted Constable Jorgenson to wonder whether the vehicle was following them. To test this theory, he exited the freeway with little warning and noticed that the vehicle followed them off the freeway.

The police vehicle slowed behind another vehicle that had also exited the freeway and the vehicle we now know was being driven by Mr Eddy passed them in the left-hand lane. It turned left up Juliet Street, Greenslopes. The police vehicle soon caught up with it in Juliet St and the officers activated a blue flashing light that they had taken from inside their vehicle and placed on its roof. Mr Eddy's vehicle stopped. Constable Jorgenson got out of the police car and went to approach Mr Eddy's car when it suddenly sped off. The police gave chase and followed Mr Eddy's car through Fairfield and Dutton Park to Highgate Hill where they lost sight of it when it turned down a side street.

Both officers say that during this chase the car driven by Mr Eddy reached a speed of approximately 100 km/hr and that it went through three red traffic lights. They say that they considered it posed a danger to the other vehicles that were on the road at the time. The police were not able to find Mr Eddy's car after it turned off Gladstone Road as they had fallen some distance behind it during the chase.

This version of the chase has obviously been provided only by the police officers who were involved in it. However aspects of it are corroborated by the evidence of Ms Smith who says that when Mr Eddy rang her soon after he had eluded police, Mr Eddy told her that he had been chased by police and that it involved him "*running some red lights*". I am therefore satisfied that from that point on police were legitimately investigating an offence of "dangerous driving."

After driving around the area where they had last seen the car they had been chasing, the police officers went to the Dutton Park Police Station and made checks on the police computer system by inputting the registration number of the vehicle that they had been trying to intercept. These checks were made between 11.31 and 11.47pm. They revealed two names for the person we now know was Mr Eddy. The checks also gave an address in Loganholme and a telephone number that, when called, was answered by Ms Capner, Mr Eddy's mother. She told Constable Jorgenson that her son was not home. He told her of his earlier unsuccessful attempt to intercept her son's car and asked her to request her son to call him.

The recall of both parties as to the contents of that call is generally consistent; they differ however as to the time of the call. Constable Jorgenson says he made the call when he was conducting the computer checks referred to above. Ms Capner says she received the call at about 3.00am after she had been asleep for some time. I am of the view that she must be mistaken about this aspect of the matter and that her confusion is explicable by her having been asleep just before she received the call. There was no reason for Constable Jorgenson to make the call after he knew Mr Eddy was dead; it is far more likely that he made it when he was seeking to establish Mr Eddy's whereabouts.

One of the computer searches revealed an address on Gladstone Road, Highgate Hill that Mr Eddy had given when granted bail only three days before. The searches also provided police with a photograph of Mr Eddy and a record of his criminal convictions that gave them reason to suspect he might resort to violence if confronted.

The officers resolved to go to the Gladstone Road address to investigate the offences of dangerous driving and disqualified driving they believed Mr Eddy had committed earlier when they had pursued him.

Before they could go there, Sergeant Bruce received a call from an officer he and Constable Jorgenson had earlier agreed to assist with an inquiry at East Brisbane. As a result, Sergeant Bruce and Constable Jorgenson went to that job where they took up with Detective Senior Constable Todd Reid and his work partner Plain Clothes Senior Constable Madonna Norrish. That job was quickly resolved and the four officers then arranged to go to the Gladstone Road address.

In the meantime, shortly before 12 o'clock, Mr Eddy telephoned Ms Smith and told her he had been in a police chase. He said he was coming to the unit and

asked her to wait outside, which she did. Mr Eddy arrived shortly after, on foot. Ms Smith said he appeared terrified and was sweating profusely.

They went up into the unit and although Mr Winduss denied in evidence that he knew Mr Eddy was in the unit when police arrived soon after, Ms Smith says the two men acknowledged each other before she and Mr Eddy went into her bedroom.

Police attend the unit

The four police officers arrived at the Gladstone Road unit block in two vehicles at about 12.20 am; three male officers and one female, all in plain clothes. The unit of interest was on the second floor of a block at the back of the property. Constable Jorgenson was the first to reach the unit. He says the solid front door was open but a screen door was closed. He knocked on it and a man now known to be Dion Winduss, Ms Smith's brother, came to the door.

Constable Jorgenson says he introduced himself and told Mr Winduss that they was looking for Michael Eddy while showing him the photograph the officer had downloaded from the QPS computer system. He says Mr Winduss said that no one else was in the unit and denied knowing Mr Eddy but, according to Constable Jorgenson and the other officers who had by this time also arrived at the door of the unit, Mr Winduss did not object when Constable Jorgenson asked to come in to check whether the person they were looking for was there. In an interview with police the next day Mr Winduss agreed that he consented to the officers entering the unit. In evidence at the inquest he retracted this version. Having regard to the numerous other inconsistencies in the versions given by him, I do not consider I could prefer the evidence of Mr Winduss to that of the officers where there is no other independent evidence bearing on the question.

All of the officers then entered the unit. The passage-way from the front door led past a kitchen and a bathroom to the right and opened into a living/lounge area. Directly at the end of that passage way, in line with the front door was a bedroom. Its door was closed.

The officers say they continued trying to elicit information from Mr Winduss but he was non responsive and inconsistent. A water pipe, commonly used for smoking marihuana was seen to be in the living room which was very untidy. Mr Winduss had an obvious recent injury to his hand which he explained by pointing out a broken glass pane in a door in the bathroom. When the officers questioned him about who was in the closed bedroom he gave inconsistent answers but at some stage mentioned that his baby nephew and his sister were in there alone.

The officers understandably suspected that Mr Eddy might be in the room and repeatedly banged on it and called for him to open the door which was locked from the inside. No response was forth-coming. Ms Smith conceded that she and Mr Eddy knew that police were at the door looking for him and that they didn't respond because they didn't want Mr Eddy to be taken into custody.

The officers decided that they would force their way into the room and Sergeant Bruce went back to one of the vehicles to get a pair of handcuffs and a canister of capsicum spray. Constable Jorgenson says that he was not necessarily anticipating violence and had not decided how he would proceed if Mr Eddy was located in the room. I have difficulty accepting this. In my view the evidence suggests the officers had decided that they were going to take Mr Eddy into custody and anticipated he might resist. In view of his criminal history, his actions earlier in the night when he had shown scant regard for his safety or that of other road users and his refusal to open the door that assessment would not seem unreasonable.

Senior Constable Reid kicked the door twice before it came open. In the ensuing 10 to 15 minutes, a fracas ensued that was described by all of the experienced police officers present as the most violent they had ever witnessed.

I am persuaded that the struggle was fierce, dynamic, volatile, terrifying, distressing, exhausting, confronting and confusing. In those circumstances it is highly unlikely that anyone could accurately describe all of what occurred and even the most truthful and attentive witnesses could be expected to give differing accounts. It might be thought that the police officers present could be motivated to deliberately downplay the level of force they deployed and to exaggerate the resistance they met. Equally, one might suspect that the civilians present might seek to exaggerate the force used by police and understate the defiance of Mr Eddy. With one exception, I am satisfied that this did not happen to any great degree and that a surprisingly consistent account emerged from the various versions given by the numerous witnesses who gave evidence. The one exception is Mr Winduss. It seems he did not know even vaguely the time of day, who was in the unit or what, when and how much he had been drinking. His sworn evidence was so inconsistent with his earlier interview and so divergent from the accounts of the other witnesses on so many issues that I consider no reliance can be placed on anything he said unless it is corroborated by other witnesses.

I shall attempt to synthesize an account from the evidence of all of the other witnesses, noting where appropriate, significant disagreement.

When the officers entered the bedroom they found Mr Eddy and Ms Smith lying on a mattress on the floor. They say both immediately jumped to their feet and began abusing the officers and demanding they leave the premises. All of the officers also say that Mr Eddy grabbed Ms Smith and held her in front of him as if using her as a shield to keep the officers away from him.

The officers all says that they identified themselves and tried, unsuccessfully to calm Mr Eddy. All except Senior Constable Norrish say they did not notice Ms Smith's baby in a cot in the corner of the room. They say that they told him why they were there and that he had to come with them. He denied driving the car earlier in the evening as they alleged.

Ms Smith says that she jumped to her feet and placed herself between Mr Eddy and the police. She agrees that she moved back and forth on a couple of occasion to block efforts by police to grab Mr Eddy but disagrees with the assertion by the officers that Mr Eddy was using her in the manner they describe. She conceded however, that Mr Eddy at one stage had his hand on her shoulder and in the circumstances I consider an observer could easily have concluded that Mr Eddy was attempting to keep the woman between himself and the police in an endeavour to stop them grabbing him.

One of the officers managed to grab Ms Smith from Mr Eddy's grasp and she was bundled out of the room. Senior Constable Norrish initially took charge of supervising her and Mr Winduss in the living area of the unit.

Mr Eddy is arrested

Meanwhile, the male officers who were still in the bedroom claim that Mr Eddy adopted a fighting stance and made it clear he was not going to co-operate with their inquiries. Constable Jorgenson gave evidence that Mr Eddy punched him in the chest and continued to "*shape up*" to the officers as they tried to gain control of the situation. Constable Jorgenson says he told Mr Eddy that he was under arrest. No other officer recalls hearing this. He said in evidence the arrest was for the dangerous driving he had seen Mr Eddy engage in earlier in the evening. The officers all say that Mr Eddy was warned that unless he co-operated oleoresin capsicum spray (O.C. spray) would be used against him. They say that he continued to act in a very aggressive and threatening manner and the spray was deployed. The officers say that it had minimal impact on Mr Eddy: he fell back momentarily, appeared to wipe the spray from his eyes and then again attacked them. The O.C. spray was again deployed but again had minimal effect on deterring Mr Eddy from his resistance to their attempts to subdue him.

During the course of the investigation the O.C spray can was examined and found to be empty. Inspector Turner gave evidence that a can would normally contain sufficient gas for six to eight applications and so it seems that considerably more spray was used on this occasion than is usual.

Constable Jorgenson says that after the spray was deployed he and the others two officers attempted to grab Mr Eddy to restrain him. Mr Jorgensen also admits to striking Mr Eddy on the thigh with his heavy steel torch in an unsuccessful attempt to disable him. Senior Constable Reid says he also saw Constable Jorgenson kick Mr Eddy in the stomach to "*get some distance between them*". In evidence at the inquest Constable Jorgenson denied doing this. Senior Constable Reid acknowledges punching Mr Eddy and kneeing him in the thigh in an attempt to overcome his resistance.

Ms Smith does not significantly disagree with this account except she contends that Mr Eddy did not attack the police and their violence towards him was therefore disproportionate to his resistance. He was arguing with them about why he had to go with them but she says she didn't see him assault the officers until after he had been sprayed at which time he was just defending himself.

Ms Smith also contends that Mr Eddy never rose fully to his feet but was crouching on the bed when the officers set upon him. She says she saw them all pile on top of him; kicking and punching him. It is difficult to accept that Mr Eddy would not have stood to challenge the police and if he had his hand on Ms Smith's shoulder as she described, Mr Eddy was obviously elevated to a significant degree. Also, when she was in the bedroom Mr Eddy was behind her and she may not have been in the best position to view him. When she was removed from that room, it seems likely that she was not at all times in a position to observe everything that was occurring in the bedroom.

The submissions on behalf of the family seek to rely on the O.C. spray residue being found on the wall 1350mm above the floor to support the suggestion that Mr Eddy never rose from his knees before being sprayed and set upon by police. I do not accept that. No one suggests that Mr Eddy stood up straight and tall; the police contend that he adopted a fighting stance. If that were the case, the difference between his head height and the position on the wall where the spray was found might well be slight. In any event the submission ignores the evidence that Mr Eddy was seen to wipe spray from his face. He could easily have transferred it to the wall with his hand or arm. Nor does it seems likely that police would have struck his thigh unless Mr Eddy was standing.

The only other significant difference between the versions of Ms Smith and the police officers is that she seemed fairly certain that Mr Eddy was handcuffed in the bedroom. All of the officers say he was not handcuffed until later in the struggle when he was in the living room. I am inclined to accept this on the basis that it is more likely that had the officers piled on top of him and handcuffed Mr Eddy in the bedroom, the officers would have been able to gain control of him sooner. I am further re-enforced in this view by its concurrence with the version given by Sergeant Bruce when he first discussed the matter with an officer who attended the scene before Mr Eddy was known to have died. In my view it is most unlikely that Sergeant Bruce would have given a false account of this aspect of the incident at this stage when he apparently did not even realise he was being recorded.

I consider that it is more likely than not that Mr Eddy did violently resist the police taking him into custody. I do not consider that I can find with precision exactly what happened at every stage of the ensuing struggle. It is apparent from the versions of the officers and the injuries that were found at autopsy that police responded to Mr Eddy's resistance with a significant degree of force. The evidence does not enable me to find that force was disproportionate to the resistance.

The officers contend that Mr Eddy then attempted to rush past them out of the bedroom and up the passage way towards the front door. They say he succeeded in getting midway between the bathroom and the kitchen before Constable Jorgenson was able to halt his progress and the others joined in trying to wrestle Mr Eddy to the ground. That was very difficult to do in the narrow confines of the hallway. All officers say they were very surprised at the

strength and tenacity of Mr Eddy's resistance to their efforts. Constable Jorgenson says he has never dealt with such a strong person, nor had such difficulty trying to contain someone.

There was some disagreement concerning the order in which the combatants exited the bedroom but in view of the circumstances in which that occurred that would be expected. I am not persuaded by the accounts that suggest that Mr Eddy broke free of the officers and was recaptured; that seems most unlikely and is not supported by Senior Constable Norrish who says the four men came out of the bedroom in "*like just a huddle.*"

All of the officers say the three male officers struggled with Mr Eddy in the hallway. Ms Smith says they never went down the hallway but crashed around in the living room. She acknowledges however, that around the relevant time she went back into the bedroom to retrieve her child. She says she was in that room for a minute or so and she would have had her back to the doorway when taking the child from its cot. Further, the polilight examination of the unit undertaken after the death revealed on the walls of the hallway, traces of a liquid I am satisfied was O.C spray that appears to have been wiped from someone's body. This is consistent with Mr Eddy coming into contact with both walls of the hallway between the bathroom and the bathroom as he struggled with the officers.

During this struggle Constable Jorgensen says that on two separate occasions he felt Mr Eddy trying to remove his service revolver from the holster on his belt. Constable Jorgenson says that on both occasions he responded to this by alerting the other officers that this was happening and by punching at Mr Eddy's hand and arm. Sergeant Bruce and Senior Constable Reid give some support for this allegation although both of them say that it only happened once. Senior Constable Norrish says she heard no mention of a gun. Ms Smith denies this happened. It is also significant that when he first gave an account of the incident to a senior officer who attended the scene very soon after Mr Eddy's death, Sergeant Bruce made no mention of this aspect of the matter. I note that the autopsy examination found no injury consistent with Mr Eddy's hands or arms being punched as described by Constable Jorgenson. I am unable to resolve this inconsistency, and have doubts as to whether it occurred. However little turns on it. The officers do not seek to justify any escalation of the force they used as a result of the incident.

The struggle continued, although by this time the officers seem to have exerted some control in that they were able to move Mr Eddy back down the hallway and into the living room, where they all crashed against the wall and some furniture before falling to the floor. Mr Eddy continued to struggle and tried to regain his feet. Senior Constable Reid then took hold of Mr Eddy's legs to keep him down. Constable Jorgenson was around Mr Eddy's torso and managed to wrestle handcuffs on, after which he lay against Mr Eddy while keeping control of his arms by holding onto the handcuffs. Sergeant Bruce was around Mr Eddy's neck and shoulders.

Mr Eddy is restrained

It is acknowledged that during the struggle Sergeant Bruce sought to apply a vascular neck restraint on a number of occasions and although unable to do so effectively it is clear that at times he had his arm around Mr Eddy's neck.

Mr Smith alleges that when the four men fell to the ground, Constable Jorgenson had his knee on Mr Eddy's chest and despite Mr Eddy asking him to get off, Constable Jorgenson failed to do so. All of the officers denied this happened.

Sergeant Bruce says he maintained his hold around Mr Eddy's neck and shoulders. He denies that he was obstructing Mr Eddy's airway and instead maintains that Mr Eddy was lying with his neck in the crook of the officer's arm while Sergeant Bruce's other arm was around Mr Eddy's shoulders. Even if his description of the placement of his limbs is accepted it is more likely than not in my view that Sergeant Bruce was, while in this position, compromising Mr Eddy's airway and/or cerebral blood supply. I consider it likely that he would have used both arms to try and restrain Mr Eddy and this must have resulted in pressure being applied to Mr Eddy's neck.

Constable Jorgenson was lying against Mr Eddy in the region of his torso. He had hold of the handcuffs and was pushing them out past Mr Eddy's head so that Mr Eddy's arms were outstretched in that position. He sought to restrain Mr Eddy by lying across his rib section with his upper body. Sergeant Bruce described him as being on top of Mr Eddy. When he gave evidence Mr Jorgenson said he weighed 125 kilograms. I find that it likely that he too significantly impeded Mr Eddy's capacity to breath.

The officers say that after he was handcuffed, Mr Eddy continued to struggle for a minute or so and then his resistance ceased. The officers continued to restrain him, concerned that he might be gathering his strength for another effort until they noticed him making snorting or hawking sounds. They also noticed that his breathing changed suddenly, he seemed to be puffing, and that copious quantities of clear or pinkish brown mucus issued from his nose and mouth. Mr Eddy had ceased struggling by this stage and it was then apparent that Mr Eddy was unconscious. From the timing of phone calls made by Senior Constable Norrish, who was first seeking more police assistance and then calling for an ambulance, it seems that approximately eight minutes elapsed from when the officers and Mr Eddy fell to the floor until he lost consciousness. During much of that time Mr Eddy was being restrained as described above.

All present say that when it became apparent that Mr Eddy was unconscious he was raised into a sitting position with his back against the front of a chair and his hands cuffed in front of him. More mucus like fluid came from his nose and mouth. Senior Constable Norrish who was speaking to the QAS operator over the telephone advised the operator that the patient was not breathing. Constable Jorgenson says that he could not find a pulse. Senior Constable Reid says that he could feel a pulse at this stage but this is inconsistent with the evidence of Sergeant Bruce who says that it was the inability of Senior

Constable Reid to find a pulse that cuased him to check. Sergeant Bruce says that when he did so he found none.

At about this time a number of dog squad and general duties officers who had responded to the radio broadcast call for assistance began arriving at the unit. In view of the O.C. spray still in the unit it was decided to move Mr Eddy outside. The officers involved in the struggle initially tried to do so but it seems they were too fatigued from the struggle and so the dog squad and general duties officers took over. Ms Smith raised some concern about how this was done, suggesting that Mr Eddy was unnecessarily dragged along the concrete floor. I don't accept there is any basis for this criticism. Mr Eddy was not a small man who was undoubtedly difficult to carry on account of his being unconscious and made slippery by sweat and O.C spray.

One of those officers, Senior Constable Chiverall says that when Mr Eddy was laid on the concrete walkway outside the unit he checked his pulse and breathing and is sure both were strong and regular. He says that initially they put Mr Eddy in the recovery position but then, in accordance with instructions from the QAS relayed by Senior Constable Norrish, they placed Mr Eddy in a supine position. It seems this was a mistake because when the officers again confirmed that Mr Eddy was breathing and had a pulse they were instructed to put him into the recovery position which they did. Other unidentified officers are reported to have commented that they could see that Mr Eddy was breathing.

Medical attention is provided

The ambulance officers arrived soon after. They say that when they arrived they were told that Mr Eddy recently been checked and found to have a pulse, but when they examined him they found him to be unconscious, not breathing and with no detectable heart rhythm. He had fixed and very dilated pupils. A copious amount of fluid was in his airway. He was observed to be cyanosed and cold to the touch. The paramedics applied all appropriate resuscitations methods to no avail. They advised the police officers in attendance that Mr Eddy was dead.

The evidence of the ambulance officers casts doubt over the reliability of Senior Constable Chiverall's evidence. It seem unlikely that a person who had a strong pulse would be cyanosed when examined only two or three minutes later and the copious amounts of fluid the para-medics found in Mr Eddy's airway would have made breathing very difficult. Further, the dispatch message given to the paramedics told them that they were to attend an *"Unconscious not breathing patient"*

Ms Smith says that when Mr Eddy was taken out of the unit and placed on the walkway she saw one of the police officers performing what looked to her like heart massage on him. All of the officers who gave evidence denied doing this or seeing anyone other than the ambulance officers doing it. Heart massage would only be undertaken if Mr Eddy had no pulse. I am of the view that Ms Smith is mistaken. I don't accept that the dog squad officers who were involved in removing Mr Eddy from the unit would all lie about detecting a

pulse and improperly put him in a recovery position if they knew his heart had stopped and CPR was needed and then falsely deny administering CPR. I think it far more likely that in the very distressing circumstances that she found herself in Ms Smith has seen an ambulance officer tending to Mr Eddy and wrongly remembered that as being done by a policeman.

On arrival their initial arrival at unit block, the four officers involved in the fatal incident "*booked off the air*" at 12.14 am. The ambulance was called at 12.44 by which time it seems Mr Eddy had been restrained for some minutes. The unit block is quite large and the unit in question was at the back and up two flights of stairs. Allowing three minutes for the officers to find the unit and another three for them to gain entry and argue with Mr Winduss about the identity of the occupants of the bedroom, after which Sergeant Bruce went back to the police car and returned with the restraint accoutrements, it can be estimated that the struggle commenced at about 12.24 to 12.28. If these estimates are correct it can be seen that the whole incident continued for between 16 and 20 minutes.

The initial response

One of the officers who responded to the call for assistance was the Sergeant Thorne, the District Supervisor. He immediately declared the area a crime scene and secured it. He contacted the Regional Duty Officer who attended and advised the Ethical Standards Command of the QPS and the Crime and Misconduct Commission of the death.

The District Supervisor also directed that the officers involved in the incident be provided with assistance to counter the after affects of the O.C. spray and that they remain in a secluded part of the unit complex. Sergeant Thorne also directed that Ms Smith, her baby and Mr Winduss also be taken care of. In evidence he said that he assumed that the officer to whom he gave this direction would have provided them with water to wash off any residual O.C. spray and food for the baby. Ms Smith denies that either of these things was done.

As already mentioned, insufficient effort was devoted to ensuring that the officers involved in the incident could not undermine the integrity of the investigation by colluding. This would not have happened had four civilians been involved in a violent struggle that resulted in a death and it is disappointing that it was allowed to occur in this case.

It was suggested on a number of occasions during the inquest that the four officers who attended at the unit colluded to give a consistent account of the incident. I don't believe that there is evidence of that. Indeed in a number of instances the versions of the officers are not consistent. Not all of them say they heard Mr Eddy being arrested and not all of them say they heard Constable Jorgenson mentioning that Mr Eddy was attempting to seize his revolver; two aspects of the matter one might have expected unanimity on had there been collusion. On the other hand, not all of the officers were fulsomely frank. In neither his interview nor his "walk through" did Constable Jorgensen mention that Mr Eddy punched him in the chest before he was sprayed with

the O.C., nor did he mention that he struck Mr Eddy with his torch and kicked him in the stomach. Many of the applications of force were only conceded in response to direct and leading questions. However, by the conclusion of the forensic process the officers had admitted to punching, kicking, striking with a torch and attempting to apply neck restraint holds. It is not hard to conceive of motives all of the people involved in the incident might have for giving a less than fully truthful account. However, it is also easy to accept that participants in such a violent and volatile encounter would have trouble accurately remembering exactly what transpired. Numerous studies have highlighted the limited reliability of memory in such circumstances. As I said earlier I am satisfied that the accounts summarised above reasonably describe what happened with sufficient detail to enable me to reliably make the findings the Act requires.

Expert evidence concerning the cause of death

I now turn to the application of expert opinion to the eye witness evidence.

On the day after the death, an autopsy was performed on Mr Eddy's body by two experienced forensic pathologists, Dr Olumbe and Dr Ansford. Six days later, a second autopsy was performed at the request of the family of Mr Eddy. This autopsy was witnessed by Dr Collins an independent pathologist retained by the family.

Reports were also obtained by the Court from Professor Olaf Drummer, a forensic toxicologist and Associate Professor Lindsay Brown, a pharmacologist.

In March 2006, after the eye witnesses and the pathologists who had undertaken the original autopsy had given evidence, the material was reviewed by Professor Stephen Cordner, the director of the Victorian Institute of Forensic Medicine, and he provided a report and gave evidence.

I have been greatly assisted by the evidence of those experts.

In their report, Drs Olumbe and Ansford noted numerous injuries of varying severity over many aspects of Mr Eddy's body that are consistent with his having been involved in a violent struggle. They opined that none of the injuries is likely to have cuased the death and neither of the other doctors disagree with that. However, I believe that some of the injuries may assist me in understanding what transpired during the struggle.

In my view the most significant injuries from this perspective are:-

- petechial haemorrhages in the left eye;
- two parallel lineal bruises in the right inguinal region;
- a 9 x 6 cm triangular bruise to the left loin;
- subcutaneous bruises to two points on the sternocleidomastoid muscle in the neck measuring 5 x 3 cm and 7 x 2 cm respectively;
- bruising and haemorrhage in the soft tissue around the horn of the thyroid cartilage; and

- subcutaneous haemorrhage over an area of 34 x 14 cms on the lower left back.

In their report, Drs Olumbe and Ansford suggest that, in their view, the most likely cause of death is amphetamine toxicity but they also countenance another two other possibilities, namely asphyxia and excited delirium.

Dr Collins provided a report in which he indicated an unwillingness to stipulate a cause of death pending the factual matrix in which the incident occurred being made clearer by oral evidence. He countenanced a number of possible contributors however, namely, excited delirium, methamphetamine toxicity, restraint asphyxia, capsicum spray and heart disease.

Professor Cordner, on the other hand, settled on "*Probable respiratory embarrassment occurring in a setting of restraint and unconsciousness in an obese man*[12] *with evidence of methamphetamine use.*"

I shall now deal with the evidence relevant to each of those possibilities.

Amphetamine toxicity

When writing his autopsy report, Dr Olumbe settled on amphetamine intoxication as the most likely cause of death because a complete examination of the body failed to reveal any disease or injury that could account for the death and as a result of the toxicology analysis finding that Mr Eddy had levels of methylamphetamine and amphetamine in his blood that were above those which have in other cases been associated with fatalities.

There is no doubt that Mr Eddy was a heavy amphetamine user and although Ms Smith gave evidence that they were seeking to address their addiction the toxicology tests show that her belief that Mr Eddy had not used drugs on the day of his death is obviously wrong. His high levels are also consistent with his excessive, hyperactive and violent response when confronted by the police.

However, although high, the level of methylamphetamine in Mr Eddy's blood is commonly found in users who suffer no significant negative effect. Indeed Professor Drummer, in his report to the court said that methylamphetamine rarely causes death by itself. While Mr Eddy was clearly showing signs of intoxication at the time the police arrived, as it must have been some hours since he ingested the drug and as he was not exhibiting signs of a toxic reaction, it is unlikely that an overdose of the drug killed him.

Professor Brown, in his report to the court highlights the difficulties in establishing the cause of death in cases such as this. He pointed out that while the blood level of methylamphetamine found in Mr Eddy was 2.5 times higher than the median concentrations reported in studies of amphetamine fatalities, concentrations of 6 times higher have also been found. This means that people can survive with levels much higher than that found in Mr Eddy.

[12] When giving evidence he altered this to refer to a person with a BMI of over 32

Asphyxia

Drs Ansford and Olumbe gave evidence about the various mechanisms of death by asphyxia and Dr Olumbe attached to his autopsy report a number of articles touching on the issue.

Positional asphyxia can occur when because of a person's position there is interference with their ventilatory efforts. It was concerns about this that led law enforcement agencies in the U.S. to abandon "*hog tying*" prisoners. In that situation it is the person's own weight or their position that restricts the person's capacity to adequately ventilate. It may also apply to those situations where another person puts pressure on the chest of the deceased and restricts the capacity of the person to breath. The usual pathological findings at autopsy are intense congestion with widespread formation of petechiae.

Restraint asphyxia refers to an interruption to the oxygen supply to the brain either as a result of an interference with the respiratory function, a constriction of the blood supply to the brain or the cessation of the heart as a result of over stimulation of the vagus nerves as a result of efforts to restrain the deceased person.

Asphyxia of this type may flow from a number of mechanisms.

- **Occlusion of the windpipe** occurs if an arm or other object is placed across the front of the neck for some minutes. Petechial haemorrhages and pulmonary oedema are likely to be evident at autopsy. It is likely to require pressure of moderate force sustained for a number of minutes to result in death from this mechanism.

- **Obstruction of the venous return** by an arm or an object produces anoxia in the brain and is evidenced by suffusion of the face and petechial haemorrhages. Because death occurs as result of stagnation of the blood, this is a gradual process that requires the obstruction to be maintained for some minutes

- **Interruption of the blood supply to the brain by pressure on the carotid arteries** requires considerable force and will usually be evidenced by bruising to the strap muscles of the neck. A loss of consciousness occurs in a small number of seconds and death will follow quite quickly, within a minute or two if the blood supply is not restored.

- **Vagal inhibition of the heart** can result from pressure to the vagus nerve. Death is almost instantaneous and unless the laryngeal cartilage is fractured, this mechanism of death will not be easily established at autopsy.

Drs Ansford and Olumbe were in agreement that whatever the mechanism of the asphyxia, if the position causing the restriction was changed or the obstruction or vagus stimulation was removed prior to death the victim would almost always recover, albeit with some hypoxic brain injury the extent of

which will depend upon the length of time for which the brain was deprived of oxygen. Professor Cordner on the other hand expressed the view that once the person lost consciousness as a result of interruption of the blood flow and/or constriction of his breathing, death could still result even if at that stage the mechanism(s) causing the interference was removed.

Excited delirium

Excited delirium is a term used to describe the symptoms witnessed in a person who, because of drug ingestion or mental illness, exhibits irrational behaviour accompanied by hyperactivity and violence. A description of the condition contained in an annexure to Dr Olumbe's autopsy report bears some similarities to some of what was seen in this case.

> *They are confused irrational hyperactive and usually violent. In an attempt to restrain them from injuring themselves or others, a violent struggle ensues. Immediately after the struggle ends, the individual abruptly becomes unresponsive, develops cardiopulmonary arrest, and does not respond to cardiopulmonary resuscitation. In cases involving the police, the individuals usually become unresponsive after being handcuffed and placed or wrestled to the ground…(T)oxicology testing will usually reveals drugs such as cocaine or methamphetamine.*[13]

Other references refer to those experiencing excited delirium *"performing feats of apparently superhuman strength"*[14] *and* cite examples of four wardsmen being needed to restrain a 12 year old female.[15]

The mechanism of death is thought to be arrhythmia brought on by the interaction between the blood levels of catecholamines and potassium. In cases where amphetamines are present, their stimulatory effects on the heart can exacerbate this risk.

At the inquest it was explained by Drs Olumbe and Ansford this way. During high intensity exertion there is a release of catecholamines and potassium into the blood stream. When both are present in high levels they neutralise the cardiac arrhythmogenic effects that extremes of either can cause if present alone. However, when the exertion ceases, there is an immediate and rapid drop in blood potassium concentrations while catecholamines levels do not peak for a few minutes. It is this period following the cessation of exertion when blood catecholamines continue to rise that the text quoted above refers to as the "*time of post exercise peril."*

If a stimulant like amphetamine is also present it can exacerbate the problem in two ways; the psycho - stimulant effect contributes to the person engaging in irrational and violent behaviour and gives him/her extreme strength to

---

[13] DiMaio V and DiMaio D, *Forensic Pathology*, 2nd edn, CRC Press, Washington, p500
[14] Pollananen M, Chiasson D, Cairns J, & Young J, *Unexpected death related to restraint for excited delirium,* 1998, Canadian Medical Association Journal p1603 at 1605
[15] Di Maio, op cit, p503

prolong the struggle. It also places an increased demand for oxygen on the heart at the time when the high levels of catecholamines are contributing to coronary artery constriction. Even without artificial psycho-stimulants victims can be very difficult to control.

Oleoresin capsicum spray

Since 2000, QPS officers have been authorised to use O.C. spray. A review of its use by those officers was recently undertaken by the Crime and Misconduct Commission which involved an assessment of all complaints concerning the use of O.C. spray and survey responses from officers. The report of that review was tendered in evidence as was a report by a pharmacologist, Associate Professor Lindsay Brown, who was also retained by the CMC as part of their review. To assist Dr Brown assess whether O.C. spray may have contributed to Mr Eddy's death he was briefed with a copy of the investigation report and the autopsy report.

Both reports conclude that there is no evidence that the spray causes serious harm. While deaths have occurred following the deployment of the spray, in all cases there were other factors that seemed more likely to have caused those deaths. Dr Brown advised that "*my review of the peer reviewed literature on adverse effects of oleoresin capsicum spray suggests there are very few, if any, deaths that can be convincingly shown to have been caused by the spray*"[16]

Conclusion as to cause of death

The evidence indicates that Mr Eddy had a long standing addiction to methylamphetamine and in the days before his death he had regularly taken very substantial amounts of the drug without fatal effect. It is clear that he had a high tolerance to the drug. It is also clear that he was not displaying signs of an overdose before the police arrived at his unit. I am convinced that the drugs found in his blood stream had been ingested some hours before Mr Eddy's death. Were they sufficient to cause his death he would have been displaying symptoms of a toxic reaction when he arrived back at the unit. The amphetamines in his blood suggest that Mr Eddy's body was effectively metabolising the methamphetamine.

It is significant in my view that Drs Olumbe and Ansford arrived at their conclusion after excluding asphyxia as a possible cause when they had only a version of events that did not contain as full an explanation of the circumstances in which the death occurred as became available during this inquest. It is with caution that I reject the opinion of such experienced pathologists but I note the observation of Professor Cordner that "*forensic pathology can only function effectively with information about the circumstances in which the death occurred.*"[17]

I do not consider the death can be adequately explained by amphetamine intoxication.

[16] Exhibit 2.6 p3
[17] Exhibit 2.19, p1

This does not mean however that the drugs played no part in his death. I shall return to this aspect of the matter shortly.

As mentioned earlier the description of the condition referred to as excited delirium bears a resemblance to some of Mr Eddy's symptoms. However on closer examination I am not convinced this adequately explains the death. Mr Eddy was clearly not delirious prior to the arrival of police. He argued with them about whether he had been driving the vehicle earlier as they alleged. He then sought to avoid apprehension by hiding behind Ms smith and adopting a fighting stance. He punched one of the officers in the chest. Thereafter, although his resistance to the efforts to arrest him was extreme, the evidence of the officers is that it was in response to violent behaviour on their part. The officers admit that they then emptied a can of O.C. spray into his face, struck him about the thigh with a heavy metal torch (the autopsy evidence suggests this occurred twice and involved blows to the groin), and kicked him forcibly in the stomach. The officers deny holding him down in the room and punching and kicking him as alleged by his girlfriend but extensive bruising to Mr Eddy's back is not explained by the officer versions of events. In those circumstances, a violent reaction from a methamphetamine intoxicated person can be explained with out characterising the behaviour as delirious. While Mr Eddy's behaviour may have been unreasonable or excessive, it was not irrational, in my view. I do not therefore consider that this death occurred as result of excited delirium.

The exhaustive examinations of Mr Eddy's body undertaken during two autopsies revealed numerous injuries. The three pathologists who participated in those examinations agreed that none of the injuries was serious and none was sufficient either alone or in conjunction with others to cause death but some are relevant to an understanding of what transpired and how the death may have occurred.

A number of witnesses gave evidence that Sergeant Bruce attempted to apply a carotid neck restraint when the combatants were struggling in the hallway and the living area. I accept the evidence that he did not at that stage successfully apply the hold. However, when the three officers and Mr Eddy crashed to the floor, Sergeant Bruce described Mr Eddy's neck as being cradled in the crook of his right arm. It is apparent that all three officers were at that stage fully engaged in trying to restrain Mr Eddy and it is reasonable to assume that Sergeant Bruce therefore had hold of Mr Eddy around the upper body, and quite possibly, his neck. He was struggling and trying to regain his feet. The injuries to his neck described earlier indicate that considerable force was applied to this region of Mr Eddy's body. The evidence of the officers does not provide a sufficient explanation for those injuries.

Constable Jorgenson says when they were on the floor he was leaning his considerable bulk against Mr Eddy's torso in a manner that is likely to have restricted his ability to breath.

Both of these holds had the potential to restrict Mr Eddy's breathing; the pressure around his neck could well have interfere with the supply of blood to his brain. This situation was maintained for several minutes. While in this situation Mr Eddy lost consciousness and never regained it.

Drs Olumbe and Ansford contend that if Mr Eddy was breathing when the officers got off him and sat him up, asphyxia was not the cause of death because he was at that stage breathing freely when no obstruction to his respiration was occurring. Professor Cordner on the other hand says that asphyxia could only be excluded if after the obstruction to his respiration was removed, Mr Eddy was conscious.

I am satisfied that Mr Eddy did not regain consciousness after the restraints to his breathing and circulation were removed: I am less sure of whether he was still breathing at this stage. Some of the autopsy findings are consistent with asphyxia being the cause of death while others that might be expected are absent. However, the circumstances in which the death occurred persuade me that these absences are not conclusive. Accordingly, I find that the restraint applied to Mr Eddy did play a part in the death.

It is also likely that the bio-chemical effects on his heart of high level amphetamine use and the sudden cessation of extreme exertion contributed to the fatal outcome. I accept Professor Cordner's view that it is not possible to apportion the extent to which each of these factors contributed to the death.

Findings required by s45

I am required to find, as far as possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last aspect of the matter, the manner or circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Michael John Eddy

Place of death – He died at 228 Gladstone Road, Highgate Hill, Queensland

Date of death – Mr Eddy died on 20 February 2004

Cause of death – He died from restraint asphyxia compounded by the effects of amphetamine abuse and extreme exertion.

Referral to DPP pursuant to s48

The Coroners Act by s48 requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence*" to give the information to the appropriate prosecuting

authority. However, when determining whether that such a referral is to be made, a coroner is not to have regard to evidence given after a witness has claimed that an answer to a question may incriminate the witness and has been directed by the coroner to nevertheless provide that answer.[18]

I take "*committed an offence*" to mean that there is admissible evidence that could prove the necessary elements to the criminal standard.

The use of the term "*reasonable suspicion*" is redolent of the test applied when a search warrant is sought. In that context it has been held that a suspicion is a state of mind less certain than a belief and to be reasonable it must be based on some evidence, but not necessarily well founded or factually correct and be a suspicion that a reasonable person acting without passion or prejudice might hold.[19]

However a search warrant is frequently sought when very little might be known about the circumstances of the suspected offence. In that context it is applied when there has been inadequate opportunity to allow the suspicion to gestate into a belief and authority is sought to take the steps that might enable that to occur. As a result, a relatively low level of certainty is needed to satisfy the test. It would seem incongruous that a similar approach be taken when there has been an extensive investigation and public inquiry in which all relevant witnesses have given evidence under oath and have been cross examined and world renowned experts have provided reports and also given oral evidence. In those circumstances there is little room for uncertainty and reliance on speculation or conjecture would seem unnecessary. The removal of doubt by the forensic process means that for a suspicion to be reasonable it must be well founded.[20]

I consider this potential anomaly can be overcome by construing the subsection as requiring a referral to the DPP only when the coroner considers that the Crown could prove all of the elements of an offence.

I have found that the restraint imposed on Mr Eddy by Sergeant Bruce and Constable Jorgensen was a contributing factor in the death, but that finding was based on evidence that would not be admissible in a criminal trial and was made to the lower standard of proof than such proceedings would require.

Further, in view of the uncertainty as to the extend to which the other factors beyond the control of the officers contributed to the death, I do not consider that the Crown could prove to the criminal standard that they cuased the death in the sense that word is used in s293 of the Criminal Code.

---

[18] s48(1)
[19] For a discussion of the authorities see Tonc K., Crawford C., & Smith D., *"Search and Seizure in Australia and New Zealand",* LBC, Sydney, 1996 at p68
[20] An analogy: if a detective is told by a usually reliable informant that there is a gun in the glove box of a car, he might have a reasonable suspicion that is the case. However if he searches the glove box and finds none a suspicion to that effect would no longer be reasonable.

There is no evidence that the officers intended to kill Mr Eddy or do him grievous bodily harm. I accept that they were lawfully seeking to arrest him and inadvertently contributed to his death. In these circumstances, the Crown would have to rebut the defence set out in s23 of the Criminal Code which provides that a person is not criminally responsible for an event which occurs by accident. The authorities establish that in that context, "*event*" refers to the consequences of a willed act[21] and "*accident*" refers to unlikely consequences that an ordinary person would not reasonably have foreseen.[22] I don't believe the evidence in this case would enable the Crown to prove that an ordinary person in the position of the officers would have reasonably foreseen that restraining Mr Eddy as they did was likely to result in his death.

Nor do I consider that a prosecution based on criminal negligence would have any prospects of even getting to a jury. The Crown could not show that the officers had such disregard for the safety and welfare of Mr Eddy as to amount to such a great falling short of the standard of care which a reasonable person would have exercised as to merit criminal punishment.[23]

For these reasons I do not intend to refer this matter for the consideration of the DPP.

Concerns, comments and recommendations

Section 46, in so far as is relevant to this matter, 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 death was preventable to the extent that had police not attempted to arrest Mr Eddy in all probability he would not have died. That is not to suggest that police were wrong to seek to arrest him and indeed had Mr Eddy not violently resisted their attempts it is also likely that no harm would have come to him. However, as it is far more likely that the actions of police can be modified by having regard to research and reason than can the actions of the illicit drug abusers, it makes sense to focus on how the police responses to these situations may be made less dangerous.

Amphetamine abuse is rapidly increasing and so it is likely that police will need to respond to an increasing number of similar incidents in future. The association between drug induced psychosis and/or intoxication and physical restraint resulting in death must be recognized. It is pointless to suggest that people should avoid taking illicit drugs - that is not going to happen and I doubt that many people would accept that those who do take such drugs should be placed at added risk of death as a result of police action. It is therefore incumbent on the QPS to train its officers to recognise this condition and to know how to appropriately respond to it. I shall deal with the response

[21] *Kapronowski v R* (1973) 133 CLR 209
[22] *R v Van Dem Bemd* (12994) 179 CLR 137
[23] See *Nydam v R* [1977] VR 430 at 445

of the police officers to the challenges presented by Mr Eddy in the order in which they occurred.

The initial interception

In their written submissions, the lawyers representing Mr Eddy's family suggest that the decision by police to intercept Mr Eddy soon after he exited the South-east Freeway was over zealous and a waste of police resources. I do not accept that. Mr Eddy's behaviour attracted police attention. Their response of a license check was relatively low level and non intrusive. As Mr Eddy's response demonstrated, their "*hunch*" was well founded.

Follow up action

Once the officers had seen Mr Eddy drive in a dangerous fashion while trying to evade them and having done checks that disclosed that he had been bailed on for serious drug offences only a few days earlier and was disqualified from driving, they were duty bound to attempt to locate him. I therefore consider that it was appropriate for the officers to go to the Dutton Park unit.

The degree of force used against Mr Eddy

As I have indicated earlier, I do not accept Ms Smith's claim that Mr Eddy did not resist police in the bedroom of the unit. Had he, as she claims, adopted a foetal position after being sprayed it is difficult to conceive of how the officers would not have succeeded in restraining him in that room.

I find it more likely that Mr Eddy adopted a fighting stance and engaged in a violent exchange with the officers that involved them using all of the contents of a can of O. C spray and kicks, punches and strikes with a torch in an attempt to subdue him. Their failure to apprehend him at that point suggests a lack of skill on their part and a high degree of resistance on the part of Mr Eddy. The use of a whole can of O.C. spray was pointless and dangerous in such a confined space shared by a baby. It is more difficult to conclude that the other force used by the officers in the bedroom was excessive in view of Mr Eddy's continued resistance and the lack of any serious injury caused by it.

When dissecting the actions of the officers on the night in question from the safety and comfort of a courtroom, it is important to reflect on the very difficult and challenging situation the officers suddenly found themselves in. Something that they anticipated to be quite routine quickly turned into something very different.

I have carefully considered whether the officers should have withdrawn and developed some other strategy to take Mr Eddy into custody and concluded that this was not a case where that would have been appropriate for two reasons. First, there was Mr Eddy's continued offending behaviour. Although the officers did not have all of the information now known to us concerning Mr Eddy's ongoing drug dealing, they were sufficiently aware of his breach of bail and disregard for the safety of others as evidenced by his dangerous driving to make his apprehension imperative. Second, they had no way of knowing that he would resist to the extent that he did. The officers expected to be able

to fairly easily affect an arrest once Mr Eddy was located in the bedroom. From the time they engaged with him until the fatal conclusion there was little opportunity for them to withdraw while maintaining control of the situation.

And finally, in relation to use of force, it is readily apparent that the use of restraints that constricted Mr Eddy's breathing and/or the blood flow to his brain was inappropriate, even if unintentional.

Inspector Turner a senior officer involved in police training told the inquest that officers are instructed to use only one or two bursts of O.C. spray and that they are warned of the risks of restraint asphyxia. That training was apparently insufficient to adequately regulate the conduct of the officers involved in this case. It is important that officers be reminded of the fatal consequences that can so easily flow from their actions.

Recommendation 1 - Use of force training

I recommend that the QPS review the training provided to officers concerning the use of O.C. spray and the dangers of restraint asphyxia to ensure that the risk of fatalities are appropriately emphasised.

Cause of death when opinion is dependent upon factual circumstances

The circumstances of this case focussed attention on an issue of general importance to the coronial system, namely, the sources of information a forensic pathologist should consider when giving an opinion as to a cause of death after he/she has undertaken an autopsy. Should a pathologist have regard only to information revealed by the examination or is it appropriate to integrate that clinical information with evidence provided by others involved in the investigation?

The issue arose in this case because it is contended by the legal representatives of the family of Mr Eddy that the form 1 contained inaccurate information which may have caused the pathologists who undertook the autopsy to inappropriately exclude restraint asphyxia as a likely cause of death. According to two learned authors, the danger of relying on information from such sources is, that "*the pathologist has no way of validating the information provided by others.*"[24]

If a pathologist offers opinions based only on what is discovered at autopsy, leaving it for the coroner to mediate that opinion with reference to evidence the coroner obtains from other sources, the danger of inaccurate or untested evidence influencing the pathologist's opinion and/or the coroner's findings is reduced. However, that approach could also result in productive lines of inquiry not being pursued as pathologists who are unaware of the factual context in which a death is thought to have occurred may have no impetus to alert investigators to the significance of aspects of those circumstances.

---

[24] Freckelton I. & Ranson D., *Death Investigation and the Coroner's Inquest, Oxford University Press*, Melbourne, 2006. p477

Further, that approach would also delay the making of a finding of a cause of death in many uncontroversial cases. Under the current practice in Queensland, a pathologist considers the information contained in the initial police report of the death along with the information gleaned at autopsy and provides the Registrar of Births Deaths and Marriages with an autopsy certificate that stipulates a cause or causes of death if the pathologist considers the evidence available from those sources enables that to be determined with sufficient certainty.[25] This allows the death to be registered, insurance policies to be claimed against and other legal steps finalised at an early stage. If a coroner later comes to a different conclusion, his or her findings are referred to the Registrar and an amended cause of death certificate can be issued.[26]

During the course of this inquest I raised these issues with the chief forensic pathologist, Dr Charles Naylor. He very helpfully canvassed a number of options and pointed out the shortcomings of my suggestion that pending the surrounding facts being established, pathologists refrain from formulating a cause of death in cases where there were a number were possible based on the autopsy results. Dr Naylor pointed out that when treating live patients or seeking to establish a cause of death, doctors are reliant on data from three sources: history, examination and test results. He opined that *"(D)eficiencies in any of the data are likely to affect the reliability of the diagnosis"* and that requiring autopsying doctors to exclude from their deliberations information provided by police or other investigators would result in a high proportion of autopsy certificates showing the doctor's opinion as to cause of death as "*undetermined*" with the deleterious consequences referred to earlier.[27] This would obviously be undesirable as, although the death could be registered, a cause would not be available which could unnecessarily add to the distress of the family and delay insurance payouts in some cases for many months.

I am of the view that it would be preferable to ensure that pathologists and other doctors undertaking autopsies state fully in their reports the external information they have relied upon when arriving at their opinion as to the cause of death and detail other possibilities if the facts are not as they have assumed them to be. This is what Drs Olumbe and Ansford did in this case to an extent, although they were not able to say whether they received any significant other oral information from the police investigators who attended the autopsy. Further, as they were not given the versions of the civilian witnesses present at the unit during the struggle they did not know that much of the versions that they had been given would be contested.

---

[25] An eminent pathologist has referred to the attribution of cause in forensic pathology as "*one particular area, amongst many, of confusion at the dynamic interface of law and medicine"* that he attributes to different conceptions those two professions have of the term – Cordner S.M., "*Cause in forensic pathology*: *the Cause and Manner of Death*." In: Freckelton I, Mendelson, D, editors. *Causation in Law and Medicine*. Aldershot, Ashgate, 2000. pp.289-308.

[26] Paradoxically, this does not happen automatically but is a matter for the discretion of the Registrar – s42(2)(d) *Births Deaths and Marriages Registration Act 2003*

[27] Exhibit 2.21

However, the doctors mentioned the external material they had relied upon and stipulated that their examination had disclosed no anatomical cause of death. They recited that they could not "*absolutely exclude*" other possible causes of death but then offered an opinion as to what they considered was the most likely cause of death, in their view.

As this was a death in custody, an inquest was mandatory and it was inevitable that the factual context in which the death occurred would be exhaustively examined.

In my view the only responses needed to reduce the risks of faulty findings highlighted by this aspect of this case are:-

- an instruction to all doctors that they should list in their autopsy reports the sources of information that they have relied upon and a summary of the factual circumstances that are material to the opinions they have expressed, and
- a mandatory requirement that the Registrar of Births Deaths and Marriages amend the register to reflect a coroners findings if they differ from the information entered on it in reliance on an autopsy certificate.

Recommendation 2 - Extraneous information relied upon for autopsy reports

The form mandated for autopsy reports will be amended to include a requirement that the doctor who undertakes the autopsy list the sources of information other than the examination of the body. I recommend that the chief forensic pathologist and the director of the clinical forensic medicine unit encourage forensic pathologists and government medical officers undertaking autopsies to include in their reports a discussion of the contextual information that is critical to their opinions as to the cause of death.

Recommendation 3 – Amendment of the *Births Deaths and Marriages Act 2003*

I recommend that the Births Deaths and Marriages Act 2003 be amended to require that upon receipt of a coroner's findings the Registrar if necessary amend the details of death entered in the register so that they accord with those findings.

Michael Barnes
State Coroner
Brisbane
12 February 2007