QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Peter Alan SUTCLIFFE**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2011/335
DELIVERED ON:	19 November 2013
DELIVERED AT:	Cairns
HEARING DATE(s):	13 October 2013; 18-19 November 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody; siege; hanging

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Various SERT operatives and Senior Sgt Michael Gooiker:	Mr Adrian Braithwaite (Gilshenan & Luton Legal Practice)
Queensland Police Commissioner:	Ms Belinda Wadley

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The *Coroners Act 2003* provides in s. 47 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 Peter Alan Sutcliffe. 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

Shortly after 9pm on 25 January 2011 police arrived at a house in Edmonton, south of Cairns, in response to a call for help. The resident of the house, who had called police, was a former partner of Peter Sutcliffe. She told police that she feared for her safety due to his behaviour. On the arrival of police Mr Sutcliffe took up position in a large semi-enclosed backyard shed and threatened to kill police if they approached.

This prompted the deployment of specialist negotiators and police from the Special Emergency Response Team (SERT). Half an hour of attempted negotiation with Mr Sutcliffe elicited no response. When it was considered sufficiently safe to shine a torch into the shed, Mr Sutcliffe was seen slouched against a post in an upright position but hanging from an internal beam.

These findings:

- confirm the identity of the deceased person, how he died, the time, place and medical cause of his death;
- examine the events which led to the deceased coming in contact with police immediately prior to his death;
- determine whether the police officers involved in these events adhered to the requirements of the Queensland Police Service (QPS) operational procedures manual (OPM);
- consider the adequacy of the investigation into the death conducted by officers from the QPS Ethical Standards Command; and
- consider whether any changes to equipment, policy or procedure may prevent similar deaths in future.

The investigation

The investigation was conducted by officers from the QPS Ethical Standards Command (ESC). A comprehensive coronial report prepared by Inspector Terry Lawrence was tendered at the inquest.

Inspector Lawrence travelled to the incident scene with other ESC investigators on the morning of 26 January 2011. On arrival he arranged to interview each of the SERT officers involved in the events leading to Mr Sutcliffe's death. He also interviewed senior police who had been involved

with the overall management of the QPS approach to Mr Sutcliffe. Walk-through re-enactments were conducted with a number of the officers involved and documents relating to the management of the siege situation were seized. Inspector Lawrence noted that shortly after the incident several SERT officers had been ordered to provide urine samples in order to test for illicit drugs or alcohol.

Scenes of crime and forensic police officers attended the scene and photographs taken shortly after the incident were tendered at the inquest. Video and audio footage taken by some officers at the scene was seized.

Inspector Lawrence oversaw the collation of witness statements from a wide range of civilian witnesses including former partners, his former employer, neighbours and friends. Further statements were taken addressing the movements of Mr Sutcliffe earlier on the day of his death and the possible motivations for his behaviour.

Radio communications and '000' call recordings were obtained as were records of the Queensland Ambulance Service (QAS) response. Inspector Lawrence accessed the call charge records for Mr Sutcliffe's mobile phone. He obtained medical records from Mr Sutcliffe's GP and CCTV footage from a nearby hotel showing Mr Sutcliffe's movements earlier on 25 January 2011.

Set out later in these findings is an account of another siege situation involving Mr Sutcliffe and SERT which occurred at the same address in December 2008. Inspector Lawrence obtained all relevant details and witness statements addressing the progress and outcome of that incident.

I am satisfied all of the relevant information necessary for me to make my findings has been obtained. I find the scene of Mr Sutcliffe's death was adequately preserved, the forensic examination was thorough and there is no indication of collusion between the police officers involved in the incident prior to their being interviewed by ESC officers. I consider the investigation to have been thorough, impartial and professionally conducted. I thank Inspector Lawrence for his efforts.

The Inquest

A pre-inquest conference was held in Brisbane on 10 October 2013. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the QPS Commissioner and various police officers involved in the siege preceding Mr Sutcliffe's death.

A view of the scene was conducted on the morning of 18 November 2013. The inquest commenced later that day and took place over two days. 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

Peter Alan Sutcliffe was born in Sydney on 17 May 1971 and was 39 years of age when he died. After his death his body was formally identified by a former partner, Michelle Williamson.

In 1993 Mr Sutcliffe began a relationship with Ms Williamson that lasted for 13 years and saw the birth of two daughters with whom he maintained intermittent contact.

In 2006 Mr Sutcliffe began a relationship with Belinda Verheeson and they had a son in June 2009. Both relationships were affected, and ultimately ended, due to Mr Sutcliffe's ongoing alcoholism and his inability to control his anger.

Typical of many men who engage in violent and abusive relationships, Mr Sutcliffe's pattern of behaviour suggests that he was unable to accept that his former partners had chosen to end their relationship with him. He sought to continue to exert control over their lives despite their separation from him. This extended to apparent displays of remorse and threats that he would harm himself if he did not get what he wanted.

In December 2008 a series of arguments over a number of days between Mr Sutcliffe and various persons, including Ms Verheeson, and Ms Verheeson's former partner (who had attended to pick up a child), culminated in police being called to Ms Verheeson's residence at 16 Hartill Street, Edmonton.

Mr Sutcliffe refused to engage with police, shutting himself inside the house and later telling them that he had doused the home with petrol and had poured petrol on himself. Police negotiators and SERT officers were called to the property. Mr Sutcliffe told negotiators he would slash the throat of any police officer who attempted to enter the house. After more than seven hours from when police arrived Mr Sutcliffe surrendered peacefully. He was later sentenced to a period of imprisonment equal to that which he had spent in custody on remand, being 106 days. The events prompting this surrender are set out in more detail later in these findings.

In the months leading to his death Mr Sutcliffe was residing periodically at 16 Hartill Street. Mr Sutcliffe would show up at the home unannounced and then refuse to leave. He would also spend some nights in men's shelters and was otherwise homeless. Ms Verheeson told police that Mr Sutcliffe had an intermittent work history as a labourer mainly in the construction industry. His last period of employment was with a local landscaping business although this had ended acrimoniously in December 2010.

Mr Sutcliffe had received treatment for alcohol dependency and depression. However, he reported that he had ceased taking his medication for depression on various occasions and had asked for a different medication in

August 2010. At that time he was prescribed Pristiq (desvenlafaxine). Toxicology results following his death suggest that he was not taking this medication at the time of his death.

Events leading to the siege

Movements earlier on 25 January 2011

Enquiries by Inspector Lawrence established that Mr Sutcliffe had twice attended a pawnbrokers shop in Edmonton on 25 January 2011. The first, at 10am, saw him pawn a games machine for $20. At 11:24am he pawned a hair straightening kit for $60. Both of these items belonged to Ms Verheeson.

Later in the day the proprietor of the pawn shop took a call from Mr Sutcliffe who seemed agitated. He wanted to know whether police had been asking about the pawning of chain saws. The proprietor advised that the only contact relating to chainsaws had come from the proprietor of Pynes Indoor Garden Hire, Mr Sutcliffe's former employer (the significance of which is discussed below).

CCTV footage seized from the Hambledon Hotel in Edmonton shows Mr Sutcliffe attending the bottle shop at 4:50pm and departing with 10 pre-mix cans of scotch and cola.

Contact with former employer

Mr Sutcliffe had worked at Pynes Indoor Garden Hire from 25 August 2010 to 8 December 2010. Inspector Lawrence interviewed his former employer, Julie Falchetti, who said she suspected at an early stage that Mr Sutcliffe had an alcohol problem. Prior to his departure Mr Sutcliffe had used a company vehicle without permission. The vehicle had been involved in a crash which was not reported to police and this had prevented her from claiming insurance for the damage. Notwithstanding this his cessation of work resulted from his failure to turn up from 8 December 2010 onwards rather than being formally dismissed.

During late December 2010 and January 2011 Ms Falchetti noticed various pieces of equipment had gone missing from her business. She was informed by another staff member that Mr Sutcliffe had pawned a chainsaw belonging to the business at a nearby pawnbroker.[1]

On 25 January 2011 Ms Falchetti received a number of calls from Mr Sutcliffe. She did not want to speak to him but the two exchanged a number of increasingly fractious text messages in which accusations of theft were directly put. It is likely that this, among much else, was on Mr Sutcliffe's mind as he sat drinking in the house of Ms Verheeson at 16 Hartill Street.

Ms Verheeson arrives home

After Ms Verheeson arrived home she asked Mr Sutcliffe to leave and locked him out of the house. She says he then removed two light bulbs from the

[1] It appears that Mr Sutcliffe had pawned a chainsaw but that it belonged to Ms Verheeson.

veranda and a spotlight from the side of the house. He became increasingly aggressive and broke the rear door of the residence, gaining access to the house. Ms Verheeson took refuge with her child in a bedroom.

Records of '000' calls show that she initially contacted police at 8:53pm. This initial call was to the effect that Mr Sutcliffe was not causing trouble but was drunk and refusing to leave. The operator was advised that there was a domestic violence order in place between the pair. She sought police assistance to move Mr Sutcliffe on.

A second call at 8:57pm made by Ms Verheeson reveals a significant change had occurred over the preceding four minutes. She is heard to tell the operator that Mr Sutcliffe has '*lost control*', had broken down a door to the residence and could be heard sharpening knives.

A third call was made two minutes later and a fourth at 9:02pm. In each case it is apparent that Ms Verheeson is in fear for her own safety and for that of her child. She tells the operator that she thinks Mr Sutcliffe may have cut power to the property and asks when police were going to arrive. The fourth call continues until the arrival of police at 9:05pm. Ms Verheeson can be heard on the call advising police that she does not know, by that time, where Mr Sutcliffe has gone.

Arrival of police

Constables Martin Shephard, Paul Casey and Michael Whitehead were tasked to attend Hartill Street at 8:59pm. Although Ms Verheeson did not know where Mr Sutcliffe had gone, these police officers received information from Cairns police communications while en route to the property that Mr Sutcliffe had cut power to the property and was in the rear shed. Ms Verheeson, still on the phone, came to the front of the property to open a gate for police. Two other officers, Senior Constable Tony Anderson and Constable Dean Hanrahan arrived moments after the other three officers.

Constables Whitehead and Shephard moved along the eastern boundary of the property into the backyard where, using torch light, they saw Mr Sutcliffe moving into a large backyard shed. Constable Shephard told police he could see a knife in Mr Sutcliffe's hand. Video footage from a camera mounted on Constable Shephard was tendered at the inquest and recorded the subsequent interaction with Mr Sutcliffe (albeit significantly obscured by the low light level and Mr Sutcliffe entering the shed shortly after police contact).

Constable Casey had completed a negotiators course and attempted to engage with Mr Sutcliffe. The evidence from officers at the scene is that Mr Sutcliffe responded aggressively to any attempts to engage telling police to '*fuck off*', telling them he had '*booby-trapped*' the shed area and, on some accounts, referring to possession of a 12 gauge shotgun. There were also fears that Mr Sutcliffe may have doused himself in fuel to the extent that Constable Shephard decided not to use his Taser if he were to engage Mr Sutcliffe. It seems that this concern was based on the threats made in the 2008 siege rather than on this occasion.

The District Duty Officer (DDO), SSgt James Coate, arrived at the scene and instructed the other officers present to form an inner cordon with the intention of preventing Mr Sutcliffe from leaving the premises, though not to approach him. Meanwhile a request for the deployment of SERT was, as necessary, making its way up the QPS chain of command to the Deputy Commissioner. Approval was granted for SERT to attend the incident and they were deployed at 10:38pm. The inquest heard from the Commander of the Cairns based SERT team, Inspector Donni McKay who said the team was deployed with the intention of containing Mr Sutcliffe.

After a period of Mr Sutcliffe failing to respond to Constable Casey, it was decided, in consultation with two senior negotiators who had arrived at the scene, DSgt Michael Gooiker and SSgt Bradley Winks, that 'noise distraction' techniques should be used. In the 2008 incident Mr Sutcliffe had surrendered to police after a period of inactivity was broken by police throwing items against the house in which he had taken refuge. This coincided with Mr Sutcliffe's decision to surrender. On the evening of 25 January 2011 this technique was again used and was followed by Constable Casey offering further encouragement to surrender. Although noise could be heard from within the shed there was no engagement from Mr Sutcliffe.

In accordance with usual practice, on being notified that SERT had been deployed, the negotiators ceased contact with Mr Sutcliffe. The intent of this approach is to allow SERT operatives to position themselves around the inner cordon before further engagement.

The inquest heard that the five person SERT team arrived shortly before 11pm at which time they were briefed by SSgt Coate. During this briefing, loud bangs could be heard coming from the shed at the rear of the property. This prompted Inspector McKay to advise the police forward commander, Inspector Robert Waters, that the five SERT operatives under his command should be deployed immediately. This was done, such that they were in place by 11pm.

During this deployment the senior officers present, Inspectors Waters and McKay and SSgt Winks agreed that further negotiations should be attempted over the following 30 minutes. Constable Casey, with Sgt Gooiker made attempts to engage Mr Sutcliffe by yelling out to Mr Sutcliffe. The evidence from all officers present is that from 11pm once SERT operatives were deployed, no sounds could be heard coming from the shed.

Mr Sutcliffe fails to respond

Although torches illuminated the front part of the shed, there was no other ambient lighting and, as such, almost zero visibility within. It was considered too dangerous to illuminate the large open rear side of the shed as it would immediately reveal the position of police. SERT Operative 53 had taken up position in a neighbouring property allowing him to view the rear eastern side of the shed. This was a largely open section of the shed and, using a night vision scope, Operative 53 could see Mr Sutcliffe. It appeared to him that Mr

Sutcliffe was standing in the middle of the shed leaning up against a post with his hands held in front of his body at waist height. The bottom half of Mr Sutcliffe's body was obscured by, what was ultimately found to be, an air conditioning system. Operative 53 reported back to the other police present that Mr Sutcliffe appeared to be standing but was not moving. Operative 53 had no concerns for Mr Sutcliffe at that time and there was nothing to indicate that, as became evident, Mr Sutcliffe had hanged himself.

At around 11:30pm instruction was given to another SERT operative to throw some items onto the roof of the shed as a noise distraction technique. There had been no response by Mr Sutcliffe to the ongoing attempts to engage with him by this time. When Mr Sutcliffe failed to respond to this loud noise, torches were shone into the shed and it became immediately apparent that Mr Sutcliffe was hanging.

After Mr Sutcliffe initially failed to respond, SERT Operative 67, a senior member of the team, suggested the possible option of sending an operative forward to the shed in order to get a better view of Mr Sutcliffe. Inspector McKay said that this was seriously considered but rejected as being too risky at such an early stage. The initial approach was maintained.

Difference of view between SERT officers

In his interview with ESC, SERT Operative 124 referred to the communication between SERT Operative 67 and the forward command. He referred to this as a request by SERT Operative 67 to have a member of the team move forward which was denied.

At the inquest SERT Operative 124 was less direct in his assessment but indicated that in his view the team had sufficient training to have approached Mr Sutcliffe with minimal risk of detection.

Inspector McKay and SERT Operatives 53 and 67 indicated that in their experience approaching the subject person always contained a level of inherent risk and would very rarely be an approach adopted within the first 30 minutes of SERT taking up position. Operative 67 made it clear to the inquest that he raised the prospect of this occurring merely as a suggestion among a number of suggestions he raised in relation to possible tactics. He had no concerns or criticism that the approach had not been adopted.

Medical treatment

The inquest heard that once it became apparent to police that Mr Sutcliffe was hanging, several SERT officers rushed to him. Inspector McKay indicated that they had in fact responded too quickly in his view given the earlier threats of 'booby-traps'. SERT Operatives cut Mr Sutcliffe from his ligature and commenced CPR.

QAS paramedics arrived a short time later but Mr Sutcliffe could not be revived and he was formally pronounced deceased at the scene at 11:40pm.

Specific Investigation findings

None of the urine samples taken from SERT officers tested positive for the presence of alcohol or illicit drugs.

A blood sample taken from Mr Sutcliffe at autopsy revealed a blood alcohol content of 0.17%. This was higher in the urine and vitreous samples (0.22% and 0.2% respectively). No drugs were detected.

A detailed examination of the scene after Mr Sutcliffe's death revealed two knives within the shed. Mr Sutcliffe's mobile telephone was found at the bottom of the above ground pool and was unsuitable for forensic examination.

Autopsy results

An external autopsy examination was undertaken on Mr Sutcliffe's body by an experienced forensic pathologist, Dr Paul Botterill on 27 January 2011.

CT scans of the body showed an old injury involving the left femur but showed '*…no additional obvious discernable injury*'.

Dr Botterill observed conjunctival petechial haemorrhages and a ligature compression-abrasion furrow around the neck. He considered the high blood alcohol content would have impaired motor skills but not to the point that it would prevent the preparation of the ligature involved.

After considering the summary of events provided by police, the toxicology and CT scan results and his own observations at autopsy, Dr Botterill issued an autopsy report listing the cause of death as:

> *1(a). Consistent with Hanging*

Conclusions

I am satisfied that the deployment of SERT to the situation involving Mr Sutcliffe was an appropriate and proportionate response to his behaviour on 25 January 2011. I conclude that all police officers involved on that evening up until the deployment of SERT officers, acted professionally and did their best to resolve a volatile situation peacefully. The primary question for the inquest was whether those senior police directing the SERT officers acted reasonably when they decided to wait for 30 minutes before either using noise distraction techniques, shining light into the shed or moving an operative into a closer position.

I accept the evidence of Operative 53 that he had no concerns about Mr Sutcliffe while observing him through his night vision scope. The observations of Operative 53 were the primary information relating to Mr Sutcliffe available to those at the forward command post, including Inspector McKay. It had been clear to all those present that, just prior to SERT deployment, Mr Sutcliffe was apparently well enough to be making loud noises in the shed. It was entirely reasonable to allow a significant period for negotiators to attempt contact. I accept that the earlier use of noise distraction techniques, white light at the

rear of the shed or more proximate positioning of a SERT operative involved risks to the safety of police officers and/or to Mr Sutcliffe that could not be justified at such an early stage in the deployment of SERT. Even if I had concluded that it was appropriate to use one of these strategies at an earlier stage, there is still no evidence on which I could conclude that the approach actually adopted by the police commanders was unreasonable.

I find that the overall command and tactical approach of the QPS officers in charge of the siege situation was reasonable and appropriate to the situation.

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 Peter Alan Sutcliffe.

How he died - During a stand off with police and obscured from their view Mr Sutcliffe hanged himself.

Place of death – Mr Sutcliffe died at Edmonton in Queensland.

Date of death – He died on 25 January 2011.

Cause of death – Mr Sutcliffe died from hanging.

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 raises the following issues for consideration from this perspective.

In this case I have considered evidence relating to the night vision equipment available to SERT officers. The lack of depth perception in the night vision scope available to SERT Operative 53 may have contributed to his failure to see that Mr Sutcliffe was hanging, rather than standing, over the final 30 minutes of the stand off. The inquest heard that more modern equipment has since been supplied to SERT teams although it seems that not all operatives have access to it and, in any event, it is not evident it would have made any difference to the outcome of this matter.

There is no suggestion that the apparently very expensive night vision equipment supplied to SERT is inappropriately outdated. It is clear to me from the evidence of the SERT operatives at the inquest that their views with regard to the quality of equipment would readily find their way to senior management within the QPS. In the absence of any evidence showing a

specific piece of equipment would have changed the outcome of this matter, I am not inclined to make any recommendation on this issue.

I do not consider that there are any other matters arising from the circumstances of Mr Sutcliffe's death that prompt the making of a recommendation or comment pursuant to section 46.

I close the Inquest.

Terry Ryan
State Coroner
Cairns
19 November 2013