QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert Noel TURPIN**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2015/3241
DELIVERED ON:	4 May 2017
DELIVERED AT:	Cairns
HEARING DATE(s):	18 January 2017; 2 – 3 May 2017
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in the course of a police operation; suicide; domestic violence; dissemination and interpretation of information to first response police

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Commissioner of Police:	Ms Belinda Wadley
Constable Kai Waller; Constable Kane Hildebrand; Senior Constable Tracy Brown; Sergeant Matthew Duncan:	Mr Troy Schmidt i/b Gilshenan & Luton

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Introduction

1. Robert Turpin was a 23 year old Aboriginal man who was found unresponsive at his mother's residence in Atherton on 12 August 2015. He was found hanged by police in the bathroom. His partner, Tonee Goltz, had called 000 just after 7:30am, alleging that Mr Turpin had assaulted her and her younger sister. At around the same time, Mr Turpin had taken a belt into the bathroom and locked the door. The first responding police crew were on scene by 7:40am.

2. Police were able to force entry into the bathroom, where they located Mr Turpin. The Queensland Ambulance Service (QAS) was called and arrived at the scene at 7:57am. Police managed to initiate and continue CPR while the QAS were en route. When the QAS arrived a pulse was able to be found. Mr Turpin was taken to the Atherton Hospital, but was later flown by CareFlight helicopter to the Cairns Base Hospital Intensive Care Unit. He died 8 days later, on 20 August 2015.

3. These findings:

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

    - consider whether any third party contributed to his death;

    - consider the adequacy and appropriateness of the police response to the information conveyed during the 000 call relating to Mr Turpin which may have suggested he had formed an intention to commit suicide; and

    - consider the adequacy and appropriateness of the current methods by which first response crews are provided information, and updates of information, pertaining to jobs they attend.

The investigation

4. The investigation into the circumstances leading to Mr Turpin's death was led by Detective A/Senior Sergeant Jillian McCarthy from the Queensland Police Service Ethical Standards Command Internal Investigations Group (IIG). She was assisted by two other officers from the IIG.

5. The ESC was not notified of Mr Turpin's death until 18-19 September 2015 as the death was not initially identified as a death that happened in the course of police operations. Before that date officers from the Tablelands CIB were leading the investigation. The ESC investigation was informed by statements and recorded interviews with:

    - police officers involved;

    - attending QAS staff;

- persons who were inside the residence in the lead up to the death (to the extent that they could be located); and

- Mr Turpin's next of kin.

6. Body worn camera footage from the attending police officers was examined, as was relevant CAD data and call logs. Forensic analysis was conducted and photographs of the residence were taken. All of the police investigation material was tendered at the inquest.

7. An external autopsy examination with associated testing was conducted by Forensic Pathologist, Dr Paull Botterill. Further evidence was provided by Dr Botterill regarding hypoxic damage to the brain and when this might have become irreversible.

8. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

9. An inquest was held in Cairns on 2 – 3 May 2017. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. I accepted the submission from counsel assisting at the pre-inquest conference, Miss Cooper, that all evidence be tendered and that oral evidence be heard from the following witnesses:

    - Detective A/Senior Sergeant Jillian McCarthy;
    - Tonee Goltz;
    - Mr Turpin's younger brother;
    - Constable Kai Waller;
    - Senior Constable Tracy Brown;
    - Constable Kane Hildebrand;
    - Sergeant Matthew Duncan; and
    - Dr Paull Botterill.

10. I consider that the evidence tendered in addition to the oral evidence from these witnesses was sufficient for me to make the requisite findings.

The evidence

Personal circumstances

11. Mr Turpin was born in Atherton on 10 December 1991. He is survived by his mother, Vanessa, a younger brother, three sisters and his extended family.

12. Mr Turpin had commenced a relationship with Tonee Goltz in September 2011. They were living together at various addresses, before residing with Mr Turpin's mother for about a year up to the time of his death. In her

evidence to the inquest, Ms Goltz confirmed that things between her and Mr Turpin were 'pretty good' at the start of the relationship. She described Mr Turpin as a 'clown'; nice, gentle, caring and generous.[1] She said that he would sometimes get a bit jealous when other males were around and would show his anger by becoming more quiet than usual. Ms Goltz recalled that Mr Turpin had been physically violent towards her on two occasions, and that these incidents had prompted police attendance.

13. Ms Goltz said that Mr Turpin drank alcohol a lot and smoked marijuana almost every day. In the couple of months before his death, he had also used ice; however, Ms Goltz did not know how often he used it.[2] She had seen him smoking ice on two occasions, and recalled that when he used ice it made him more aggressive, snappy, quiet and moody.

14. Mr Turpin appears to have stayed in and around the Atherton area for all of his life. He lived with his mother and other family members at a unit at Armstrong Street. The medical records obtained and tendered at the inquest demonstrate that Mr Turpin did not have a mental health history for which he was receiving treatment.[3]

15. The police investigation revealed that Mr Turpin was a user of drugs and also consumed alcohol on an almost daily basis. His criminal history was relatively minor, and included street offences such as trespass and contravening directions of police. These offences were most probably committed in the context of his alcohol and drug use.

16. I extend my condolences to Ms Goltz and to Mr Turpin's mother, siblings and extended family.

Events leading to death

17. I heard evidence from Ms Goltz at the inquest. She confirmed that in the days before the incident, she and Mr Turpin had been drinking a lot of alcohol, including wine and bourbon. Mr Turpin was also smoking cannabis during this time. The reported use of cannabis was confirmed by toxicology results.[4]

18. The use of alcohol by Mr Turpin and others in the unit on the night before the incident (11 August 2015) was also confirmed by others who were there, including his brother and Yasmin Bong. Mr Turpin was described by Ms Goltz as unusually anti-social on that day. She noted that he was watching television with headphones on.

19. Ms Goltz recalled that Mr Turpin was angry at her on11-12 August 2015. He was jealous because his cousin, Richard Congo, had come to the unit a couple of days before the incident and provided alcohol to Ms Goltz. It appears from Ms Goltz's evidence that she and Mr Turpin had been

[1] Exhibit B6, page 4 from line 101.
[2] Exhibit B6, page 9 from line 280.
[3] Exhibit C16.
[4] Exhibit A6.

arguing about this for several days, and were still arguing about it in the lead up to the time he hanged himself. Ms Goltz's evidence at the inquest was that Mr Turpin told her he thought that she was going to leave him.

20. Ms Goltz said that on the morning of 12 August 2015 she went to have a shower. She said that Mr Turpin joined her in the shower, and told her he wanted to commit suicide because no one loved or cared about him. She did not consider he was being serious. He had also expressed an intent to kill himself twice during the previous night. She said that she responded to Mr Turpin by saying words to the effect that while he was loved and cared for, "*it's just the silly things you do*" that caused her concern.[5]

21. Ms Goltz went to lie down on the bed after the shower. Mr Turpin lay beside her and was 'being rough' by pulling Ms Goltz towards him. Ms Goltz's evidence was that she just wanted to be on her own because she was still angry with Mr Turpin and his actions were unnecessarily rough. Ms Goltz jumped up, and as she walked outside she said words to the effect that she needed to 'get away' to have a break.

22. Ms Goltz's evidence was that Mr Turpin must have thought she meant that she needed a break from him, because he pulled Ms Goltz back inside the unit and she subsequently fell onto the floor. This action that woke up Ms Goltz's sister, who then became involved to help her older sister. In doing so, Mr Turpin pushed her sister who she also fell to the floor.

23. Ms Goltz told Mr Turpin that she was going to call the police, and she described him at this point to be "*jumping around, like jumping up in the air trying to snap his neck*."[6] Mr Turpin's brother also saw him doing this.[7] Ms Goltz said that she then saw Mr Turpin walk off to the bathroom and she thought he was just going to the toilet. His brother recalled seeing Mr Turpin grab a belt and walk silently to the bathroom.[8] Ms Bong recalled Mr Turpin saying "*that's it then*" before heading to the bathroom.[9]

24. Ms Goltz's evidence at the inquest was that she had called 000 some 5-10 minutes after Mr Turpin headed into the bathroom. However, in her interview with the QPS in September 2015 she said that he had gone to the bathroom while she was on the phone to 000. I consider that the latter is more likely to be the case. The time of that call was 7:36am. The audio recording of the 000 call was tendered at the inquest.[10] The call lasted 3 minutes 30 seconds. Ms Goltz said to the operator, "*He just pushed me and my little sister on the ground because he's still drunk and he hasn't slept yet*", followed by "*He just fuckin' smashed her on the ground man and she's crying. She's not even used to this shit*", followed by "*Yeah, I want him fuckin' gone before I go. It's actually his family's house but (wd) go somewhere else*".[11]

[5] Exhibit B6, page 11 from line 345.
[6] Exhibit B6, page 15 from line 489.
[7] Exhibit B10, page 17 from line 535.
[8] Exhibit B10, page 12 from line 386.
[9] Exhibit B2, page 9 from line 280.
[10] Exhibit D1.
[11] Exhibit B6.1.

25. Two minutes into the 000 call, Ms Goltz was asked by the operator where the offender was (a reference to Mr Turpin). The conversation is extracted as follows:

> *"Operator* *And where's the offender at the moment?*
> *Tonee:* *He's in the bathroom trying to hang himself or some shit. I don't know.*
> *Operator:* *Can you be a bit more clearer of that?*
> *Tonee:* *I have no idea where he is. He's.. I'm outside. I waited for him when he was in the bathroom trying to kill himself*
> *Operator:* *He's stated he's trying to kill himself.*
> *Tonee:* *Yeah*
> *Operator:* *Is that what he said to you?*
> *Tonee:* *No he grabbed a belt. But I know what he's doing cause he was tryin' to do it earlier today, like 3 times.*
> *Operator:* *Ok. So he's gone into the bathroom.*
> *Tonee:* *Um, I think so. I'm not really sure.*
> *Operator:* *He's attempted suicide previously today?*
> *Tonee:* *Yeah, like 3 times in one night. He's only pushed me and my sister that's it and she fell on the ground. He hasn't like punched us handed or anything he just pushed both of us.*"[12]

26. Ms Goltz told police that after her call to 000 ended she went to the bathroom door and tried to speak to Mr Turpin. He did not respond but she could hear that he "coughing or spitting or something like that".

27. A copy of all audio Computer Aided Dispatch (CAD) recordings was obtained during the police investigation, and a précis of the recordings prepared. These were tendered at the inquest.[13] A copy of the Incident Log was also tendered at the inquest.[14] This Incident Log references job code 312 as being for Domestic Violence and job code 503 for Attempting/Threatening Suicide.

28. At 07:37:42 The Cairns communications room placed a radio call to call signs Atherton 250 or 351. This call was answered by Atherton 351, which was Senior Constable Tracy Brown and Constable Kai Waller, who were both at the Atherton Police Station at the time. The operator advised there was a Code 2 for a domestic at Armstrong Street. The officers confirmed their availability to attend. The job was relayed as "*Job Number 342, Priority 2, Job Code 312 / 503 at 7:38am*".[15] The job address was nominated as 2/14 Armstrong Street, Atherton.

29. Senior Constable Brown and Constable Waller are confirmed as being assigned to the job at 7:39:01am.[16] It is clear from the call recording that the operator relayed the following information to the crew of Atherton 351:

[12] Exhibit B6.1.
[13] Exhibits D1.1; C7.
[14] Exhibit C6.
[15] Exhibit C6.
[16] Exhibit C6.

> *Robert Turpin has assaulted the informant, who is Tonee Goltz and the informant and her sister. I say again. Has assaulted the informant and her sister. QAS not required. The informant stated that TURPIN has now gone to the bathroom and taken a belt. The informant stated that TURPIN has attempted suicide 3 times in the past 12 hours.*"[17]

30. A second crew consisting of Constable Kane Hildebrand and Sergeant Matthew Duncan, with the call sign Atherton 250, were also assigned to the job very shortly after at 7:39:39am. They also proceeded on Code 2 urgency.

31. At 07:40:01, the Cairns communications room provided further advice to both crews, as follows:

> *Robert Noel Turpin (Date of birth: 10.12.1991) has a current Domestic Violence ("DV") order with him nominated as the respondent. The current aggrieved is Tonee Goltz. The DV Order has mandatory plus 1. Also flagged for drug usage. Female Tonee Goltz is being supervised by Department of Correctional Services.*[18]

32. I heard evidence from each of the attending police officers at the inquest. What was apparent in the evidence about these events is that none of the attending officers heard the specific information pertaining to Mr Turpin's apparent suicide attempts over the previous 12 hours, or the fact that he had reportedly proceeded to the bathroom with a belt. Only Senior Constable Brown acknowledged that he was aware before attending at the scene that the job entailed both domestic violence and possible self-harm.

33. Constable Waller's evidence at the inquest was that he heard the initial job called over his portable radio at the station. As soon as he was aware that it was a Code 2 he grabbed his bag and went to the car. He had no recollection of a reference to a belt or suicide in the initial job allocation. He said there was a considerable amount of background noise and his focus was on getting to the job. As a relatively junior officer he had not attended many Code 2 jobs.

34. At the inquest I was assisted by body worn camera footage, produced by Officers Duncan and Brown, which showed the initial attendance at the unit, followed by the attempts to gain access to the bathroom.[19]

35. Senior Constable Brown and Constable Waller arrived at the address at around 7:40am, some four minutes after Ms Goltz had placed the call to 000. Ms Goltz was outside the residence when they arrived, and Constable Waller proceeded to talk to her. Before arriving at the address,

[17] Exhibit D1.1, call 073742; C6.
[18] Exhibit D1.1, call 074001; Exhibit C7.
[19] Exhibits D10-10.1; D11.

it had been agreed between the officers that as Constable Waller was the junior officer, he would take the lead in discussions with Ms Goltz.

36. Constable Waller's evidence was that Ms Goltz was reluctant to allow police to enter the property. She was not forthcoming with any information about the events that led to her calling 000. She asked why the QPS were there and told them they could not enter without a warrant.

37. Ms Goltz initially told Constable Waller that Mr Turpin had left the premises. It was not until about five minutes after the QPS arrived that she told him that Mr Turpin was in the bathroom, and she had earlier heard crying and choking sounds. She had told Constable Waller this just before entry was forced to the bathroom. Constable Waller said at the inquest that if he was aware of the suicide threats he would have focused on trying to locate Mr Turpin before speaking with Ms Goltz.

38. While Constable Waller spoke with Ms Goltz, Senior Constable Brown went inside the address and attempted to speak with a number of occupants, primarily Mr Turpin's brother and Ms Goltz's sister (both were minors). The actions and conversations of Senior Constable Brown are caught entirely on his body worn camera. It is clear from that footage that neither of those occupants of the unit were forthcoming with information, and were generally being unhelpful to the police.

39. Mr Turpin's brother was speaking very softly and another occupant had a persistent and loud cough. His brother can be heard saying at around 7:45:40 on the footage that Mr Turpin was "*in the bathroom with a belt*" and he later said "*I hope he hasn't done something stupid*".

40. While Senior Constable Brown was speaking with Ms Goltz's sister and Mr Turpin's brother, Sergeant Duncan and Constable Hildebrand arrived. They had initially mistakenly gone to 13 Armstrong St, and had spent a short time speaking with the occupant of that address about his knowledge of the disturbance at 12 Armstrong St.

41. Sergeant Duncan asked Senior Constable Brown words to the effect of "where's the offender". Senior Constable Brown directed him to the bathroom. There was still no mention of Mr Turpin having a belt.

42. Sergeant Duncan and Constable Hildebrand proceeded straight to the bathroom, which was locked. The officers repeatedly knocked on the door, and called out to Mr Turpin, but there was no response. Sergeant Duncan attempted unsuccessfully to use a set of police keys to release the door lock. He could not see anything from the crack between the bottom of the door and the floor. By this time, Senior Constable Brown had gone around to the exterior of the residence to try and gain access to the bathroom window, also to no avail.

43. At this point Mr Turpin's brother came over to the bathroom door. Sergeant Duncan asked him if he was sure Mr Turpin was in the

bathroom. Mr Turpin's brother then told Sergeant Duncan that his brother had taken a belt with him into the bathroom. The evidence at the inquest was that this was the first time the attending police became aware from anyone who was at the unit that Mr Turpin had a belt with him in the bathroom.

44. Sergeant Duncan and Constable Hildebrand proceeded to force entry into the bathroom by kicking open the door. The body worn camera footage from Sergeant Duncan confirms that from the time of the first kick, to the time when the door opened, just over 1 minute had elapsed. Police located Mr Turpin with the belt around his neck. One end of the belt was tied to the towel rack, and the buckle end was tied around his throat. He was described as being in a seated position, with his legs out in front of him. His bottom was slightly raised off the ground, according to Constable Hildebrand. His tongue was protruding from his mouth, his eyes were open, and he had no pulse. He was generally unresponsive, though his body was still warm.

45. Sergeant Duncan untied the belt, and proceeded to perform CPR on Mr Turpin. He saw evidence of a ligature mark around the neck. A pulse was obtained. The QAS arrived on scene at 7:57am.[20] Mr Turpin was taken firstly to the Atherton Hospital[21], but was then flown by CareFlight helicopter to the Cairns Base Hospital Intensive Care Unit.[22] His prognosis was deemed futile, and he died 8 days later, on 20 August 2015.

Autopsy results

46. An external autopsy examination was conducted by Senior Staff Specialist Forensic Pathologist, Dr Paull Botterill.[23]

47. The limited nature of the examination revealed a healed laceration over the scalp, old scars over the limbs and possible areas of bruising on the neck. Dr Botterill explained that it was difficult to confirm a residual ligature mark. Despite this, he was satisfied that the findings were consistent with the hypoxic consequences of an attempted ligature hanging. Dr Botterill could not find any other obvious causes of death.

48. Dr Botterill's concluded in the autopsy report that the cause of death was probably hanging, but it was not possible to exclude the presence of non-suicidal bruising deep to the skin of the neck, or damage to the structures of the voice box. At the time of performing the autopsy, Dr Botterill also could not exclude the possible contribution of alcohol and/or other drug toxicity to the death. Accordingly, further investigations were performed.

[20] Exhibit C13.
[21] Exhibit C16.
[22] Exhibit C15.
[23] Exhibit A7.

49. Toxicology results subsequently showed the presence of cannabis and alcohol at a BAC of 0.087. Other drugs detected were consistent with Mr Turpin's time in the Cairns Base Hospital ICU.

50. After receiving the toxicology results Dr Botterill was satisfied that the BAC, while sufficiently high to result in a degree of impairment of rapid and extremely complex motor skills, was not sufficiently high to cause death in and of itself. The BAC would not have impeded Mr Turpin's ability to create and/or place a knot in the belt. However, Dr Botterill could not rule out that the BAC and cannabis had resulted in some behavioural changes, which may have impacted on the circumstances leading up to the death.

51. Dr Botterill determined the formal cause of death to be 'consistent with hanging'. Alcohol and cannabis intoxication were listed as other significant conditions.

52. After providing his autopsy report, Dr Botterill was asked to provide an opinion as to whether earlier police arrival and attendance upon Mr Turpin might have realistically made a difference to the level of hypoxic damage suffered.[24] Dr Botterill explained that, in a general setting, it would be correct to say that any reduction of the period of lack of effective blood flow, and thus provision of oxygen to the brain cells, would decrease the chances of irreversible brain damage. However, Dr Botterill gave evidence that it would be impossible to accurately state in Mr Turpin's case a specific time, beyond which such irreversible brain damage would have occurred.

53. Dr Botterill explained that while most cells of the body can tolerate periods of a lack of oxygen and still regain normal function, the brain cells require a continuous supply of oxygen and nutrients for normal function. He gave evidence of a generalised proposition that irreversible brain damage will occur if there has been interruption of oxygen supply to the brain cells for in excess of four minutes.

54. A the inquest, Dr Botterill reiterated that this was a generalised statement, and he was unable to say with any degree of specificity the point at which Mr Turpin's brain damage would have been irreversible. However, the effect of his evidence was that it was extremely unlikely that anything police could have reasonably done after locating Mr Turpin would have saved his life.

Investigation findings

55. The ESC investigation relevantly addressed and analysed the various times that police received the job details, arrived at the address, and further when the bathroom door was eventually forced open. It was confirmed, from the timings on his body worn camera, that Senior Constable Brown had the following response times:

[24] Exhibit A7.1.

- *Response time of 2 minutes 39 seconds from the time of police arrival at front door of address until first knock on bathroom door to gain entry;*

- *Response time of 4 minutes 26 seconds from the time of the first knock on the bathroom door until forced entry of the bathroom was gained;*

- *Total time from police arrival at the job address to locating deceased in bathroom was 7 minutes 5 seconds; and*

- *Total time from first response police requesting urgent QAS attendance to QAS until arrival of ambulance to street of job address was 7 minutes 44 seconds*.[25]

56. During the course of the investigation, investigators liaised with Cairns Police Communications regarding any differences in the timings on the body worn camera footage, and the timings on the CAD documentation. It was found that that most accurate timings were those provided on the CAD voice recordings. This was deemed to be the case as those timings were computer generated and thus not subject to any operator input or human error.

57. Detective A/Senior Sergeant McCarthy conducted an analysis and comparison of the timings as they appeared on the body worn camera recordings of Senior Constable Brown. She ultimately found that the footage was displaying times 2 minutes and 2 seconds ahead of the CAD audio recordings.

58. A similar comparison was conducted on the timings as they appeared on the body worn camera recording of Sergeant Duncan. Detective A/Senior Sergeant McCarthy ultimately found that footage was displaying times 4 minutes and 12 seconds ahead of the CAD audio recording.

59. The ESC investigation found that the address and its occupants were well known to officers from Atherton Police Station, particularly for domestic violence and other related disturbances. At the time of their attendance on 12 August 2015, all officers believed they were entering a volatile domestic violence incident with unknown variables and unknown risks to themselves and other occupants of the residence. All officers considered their own safety to be paramount in the circumstances.

60. Detective A/Senior Sergeant McCarthy undertook a review of all available CAD and body camera footage to inform her investigation findings. She was satisfied that the primary evidence clearly articulated that all responding officers were actively engaged in attempting to ascertain the location of Mr Turpin and investigate the occurrence of domestic violence.

61. All officers identified that they could smell cannabis at the address and all identified a lack of cooperation by the occupants with the police attending

[25] Exhibit A10, page 7.

at the address. In addition, none of the occupants displayed any overarching concern or urgency regarding Mr Turpin's welfare.

62. The ESC investigation found the responding officers attended the incident in a timely manner upon receipt of the job details. It was concluded that there was no misconduct displayed by any of the officers involved and further concluded that no disciplinary proceedings were required. I accept the conclusions of Detective A/Senior Sergeant McCarthy.

63. I appreciate that Mr Turpin's death did not occur for some eight days after he was found in the bathroom, and that police were hopeful over that time that he might make a full recovery.

64. The attending police officers did not provide sworn statements until after the death in late August 2015, and were not subjected to disciplinary interviews until mid-September 2015. While this is not the usual course for an investigation into a death in police operations, in the circumstances and with the assistance of the body worn camera footage, I am satisfied with the integrity of the evidence of the officers involved.

65. The inquest examined the adequacy and appropriateness of the current methods by which first response crews are provided information, and updates of information pertaining to jobs they attend. This was because the specific information relating to Mr Turpin's attempted suicide, and his possession of a belt in the bathroom, was broadcast from the Cairns communications room to the officers via police radio. However, these details were not in fact heard, or taken in, by the officers.

66. It is clear that the job was allocated to the first response officers as a "*Job Code 312 / 503".* The second broadcast from the Cairns communications room provides the DV Order particular to the job address and that Ms Goltz and Mr Turpin were the known respondent and aggrieved. It does not repeat any of the known information related to the attempted suicide or the respondent being in possession of a belt.

67. Constable Waller confirmed in his evidence that he did not hear the information relating to the attempted suicide or belt, and he believed he was responding to a Code 2 domestic violence incident.

68. Constable Hildebrand confirmed that he was in the station attending to correspondence when he heard the call for a Code 2 domestic violence incident and a person threatening suicide. He did not recall any information being relayed about a belt. Constable Hildebrand relayed the job details, as he recalled them, to Sergeant Duncan who was in the Sergeants' dayroom inside the station. Sergeant Duncan did not actually hear the radio call himself. The speaker in his office was not turned up as he was meeting with another officer at the relevant time.

69. Sergeant Duncan confirmed in his evidence that he believed he was proceeding Code 2 as a back-up crew to a domestic violence incident at the address. He did not hear the communications broadcast, had no knowledge of the attempted suicide, and was acting solely upon the information relayed to him by Constable Hildebrand. Senior Constable Brown has no independent recollection of the job being allocated from the Cairns communications room as anything other than a domestic violence incident.

70. Senior Constable Brown acknowledged in his evidence that, after reviewing his body camera footage, his questioning of occupants at the unit about self-harm indicated he must have, at some point, received information to that effect that Mr Turpin may have been causing self-harm.

71. Essentially, all of the first response officers had limited or no recollection of the job details provided by the Cairns Communication room being related to an attempted suicide or of a reference to Mr Turpin being in possession of a belt. Apart from Senior Constable Brown, the officers accepted, with the benefit of hindsight, that if they had known this specific information, they would have proceeded immediately to the bathroom of the residence and forced entry without attempting to speak with any of the occupants of the address. Senior Constable Brown said that he was influenced by the demeanour of the other occupants, which did not give rise to any sense of urgency.

72. This raised similar issues to those examined during the recent police shootings inquest which examined the deaths of five men during 2013 - 2014. At the recommendations phase of that inquest in October 2016, I received evidence from A/Superintendent David Nevin, in addition to a written statement tendered by Superintendent Glenn Horton. The statements from Officers Horton and Nevin were tendered, once again, at this inquest given their direct relevance to Mr Turpin's circumstances.[26]

73. In terms of the ways in which job information could be better disseminated to general duties crews, one method raised for examination was for the officers to have access to the information over the radio and to also have access to that information in some sort of written form. In this respect, the implementation of the 'QLite program' was examined.

74. The QLite program allows general duties officers not only to hear the job information over the radio and clarify details with the radio operator and the COMCO. Officers can also check the information for themselves on a QPS issued I-Pad, or similar tablet device, with access to QPRIME. A/Superintendent Nevin's statement provided important information about the QLite program for the purpose of this inquest.

[26] Exhibits B15 – B16.

75. A/Superintendent Nevin explained that the QLite device is basically an I-Pad that supervising and frontline officers can access. On the device, the officers have access to QPRIME which is a QPS database which stores records; checks on persons, vehicles and places; and displays safety flags which identify particularly important information (e.g. if a person is known to be violent, or possess weapons).

76. The capacity for frontline staff to have access to the device means those officers have access to QPRIME in real-time and can check any information as required. In practical terms, this means that the officers have the ability to start researching details of occupants and any relevant background information on the way to a job.

77. During his evidence to the recommendations phase of the police shootings inquest, A/Superintendent Nevin was asked about potential problems with using the devices, such as in places that might not have adequate internet coverage. His evidence was that, in areas in the west of the State, the devices usually work using satellite communication. He was unable to provide any further information about that aspect or capability of the device.

78. The A/Superintendent also gave evidence of a project then underway with the objective to add information available via QCAD (the Computer Aided Dispatch System) to the QLite devices so that officers, remote from their station computers, are also able to receive job details directly via the QLite tablet.

79. At this inquest I heard that police officers are now able to see the job details on the screen in front of them, just as the COMCO would, and have access to other information over and above that available on QPRIME.

80. As for the status of the QLite program, A/Superintendent Nevin gave evidence that there were just over 5000 QLite devices distributed to police across the State. The A/Superintendent was not able to give further evidence about any plans for the distribution of further devices. The Project sits under the Mobility Services Project Team, and the A/Superintendent was aware that this Team constantly reviews the Project and were responsible for making any submissions in that regard.

81. In terms of how the current number of devices are distributed, the A/Superintendent gave evidence that a proportion of devices were allocated to various regions and districts based on the number of frontline operational police. The further distribution of these devices is managed by the individual police districts and regions.

82. A/Superintendent Nevin gave evidence that there are currently 12,000 police in the QPS. With just over 5000 QLite devices currently issued, he agreed with the proposition that around 50% of the need was being met, though he was unable to provide an exact figure.

83. In their evidence at the inquest, each of the officers were asked about their knowledge of the QLite program, and whether they had seen the I-Pads in action in their current roles. Three of the officers have been issued with a QLite device. They spoke very positively about the benefits of real time access to both QPRIME and to the job card as details are entered and updated by the Communications Room.

84. While my recommendations for the police shootings inquest remain under consideration, I note that Counsel Assisting made a submission in that inquest as follows:

> *In our submission, the QLite program is an integral part of the future of effectively disseminating significant information to frontline police. The evidence heard by A/Superintendent Nevin, in terms of how the QLite devices should work in conjunction with the radio dispatch, has clearly pointed to the benefits of frontline officers having access to these devices. It is clear from A/Superintendent Nevin's evidence that just over 5000 devices are currently in the field. However, these are not necessarily all distributed to frontline police, of which there are upwards of 7000.*[27]
>
> *Ultimately, it is a matter for the QPS to continue making submissions for further funding as it deems appropriate. In that regard, in our submission, it would be prudent for Your Honour to make comment as to the remarkable benefit of the QLite devices to frontline police in ensuring that they have effective access to significant information about a job, in real-time.*
>
> *In that light, Your Honour might consider recommending that the Minister for Police continue to submit for appropriate funding for further QLite devices to be distributed. Further to that, Your Honour might consider recommending that Queensland Treasury approve such requests made by the Minister for Police.*[28]

85. Given its application to the circumstances of Mr Turpin's case, Counsel Assisting reiterated this previous submission in her closing remarks.

Domestic violence history

86. At the time of Mr Turpin's death, a Domestic and Family Violence Protection Order (DFVPO) was in place between him (the respondent) and Ms Goltz (the aggrieved). It had been in place since 11 November 2014 and was to expire on 10 November 2016. A copy of the DFVPO and its supporting documents were tendered at the inquest.[29] There is no evidence that Ms Goltz was getting assistance from any domestic violence service, or had attempted to get help in that regard. The domestic homicide audit attached to Detective A/Senior Sergeant McCarthy's

[27] Police Shootings, Recommendations phase transcript of proceedings, day 1, page 79 from line 4.
[28] Section 46 Submissions by Counsel Assisting the Coroner – Police Shootings Inquest
[29] Exhibits C17 – C20.

investigation report set out the level of police attendance at the address in the years before the death and also highlighted what issues arose and what difficulties police came across in responding to calls for help.[30]

87. One of the conditions of the DFVPO was that Mr Turpin not reside with Ms Goltz, a condition which was ultimately being breached at the time of his death. This factor became relevant to my consideration of Mr Turpin's death, as it was possible that if Ms Goltz had not been staying with Mr Turpin, the conflict and the escalation in the violence towards Ms Goltz which preceded Mr Turpin's suicide might not have occurred over 11-12 August 2015.

88. Ms Goltz confirmed in her evidence to the inquest that she and Mr Turpin remained in contact despite the no contact condition. Ms Goltz said that they both had "*nowhere else to go*"[31] and she was trying to "*go back to court to take it off"*[32]; which was a reference to the residential condition. Her evidence at the inquest was that she was happy living with Mr Turpin and, although they fought, she wanted to stay with him. In those circumstances I accept that it was appropriate for the QPS not to have commenced breach proceedings against Mr Turpin.

89. The Queensland Government has committed to the implementation of all 140 recommendations from the 'Not now, not ever' report by the Special Taskforce into domestic violence. This inquest provided an opportunity to consider Recommendation 86, which relates to the ability for tailored and flexible responses to be provided by service providers to individuals to assist in aggrieved persons staying safe in their homes:

> *86. The Taskforce recommends that the Queensland Government:*
>
> *a. Provides flexibility to service providers to offer the necessary crisis accommodation required for the situation, whether that be access to a domestic and family violence refuge or brokerage funding for the perpetrator to stay in short term accommodation*
>
> *b. Ensures the Queensland Police Service's current operational procedures strongly support women and children staying in the home, where safe, in line with the principles of the Act*
>
> *c. Expands safety upgrade programs to give more victims the option to stay safely in their own homes.*[33]

90. In this regard, I have been made aware of the 'Keeping Women Safe in their Home' research project. In September 2015, the Australian Government announced a $100 million package of measures to provide a safety net for women and children at high risk of experiencing violence. This national package seeks to address DFV across the nation through a

[30] Exhibit A10 from page 9.
[31] Exhibit B6, page 7 from line 213.
[32] Exhibit B6, page 7 from line 215.
[33] *Not Now Not Ever: Putting an End to Domestic and Family Violence in Queensland,* 2015

Women's Safety Package, with investment to improve frontline support and services, leverage innovative technologies to keep women safe and provide education resources to help change community attitudes to violence and abuse.[34]

91. One of the Queensland elements funded under the Women's Safety Package is the purchase of services of a consultant or professional research body with the specific research skills, knowledge or expertise, to explore, consult and report recommendations/strategies for culturally suitable 'safe at home' security options or solutions. These solutions will expressly benefit Aboriginal and Torres Strait Islander persons, specifically Indigenous women at risk of or affected by domestic and family violence, living in remote areas of the State.

92. I was also assisted in these matters by Inspector Regan Carr, Manager of the DFV and Vulnerable Persons Unit within the QPS. Inspector Carr provided a statement which was tendered at the inquest setting out the current measures being undertaken by the QPS to address Recommendation 86 of the 'Not Now, Not Ever' report, commonly referred to as Recommendation 86B.[35] Inspector Carr explained that the recommendation is generally considered in conjunction with the QPS led Recommendation 134, which requires the QPS to adopt a proactive investigation and protection policy which requires the consideration of safety of the victim as paramount when deciding a course of action.

93. Inspector Carr confirmed that the following body of work was commenced by the QPS, under the First Action Plan (2015-2016), relevant to Recommendations 134 and 86B:

- *A state-wide consultation process which sought the views of a range of QPS stakeholders (vertical slice) on how improvements could be made in line with the recommendations which resulted in a series of options papers, including a review and proposal relating the current Police Protection Notice (PPN) system. The proposal attempted to achieve greater accountability for perpetrators, increased protection for victims, while ensuring police action was more effective and efficient. In addition, the options proposed to rebalance the burdens and risks from the aggrieved to the respondent in a reasonable and fair manner and address the gaps that have previously existed in the protection afforded to victims of domestic and family violence. The preferred Queensland Police Service position regarding PPNs was articulated in the Service's submission in response to the review of the D&FVP Act.*

- *A continual review and improvements in the Operational Procedures Manual (OPM).*

- *The development of a specific DFV training intervention. Under the broad umbrella of ' vulnerable persons', the QPS developed a combined DFV and mental health legislation training program to frontline police officers*

[34] https://www.malcolmturnbull.com.au/media/release-womens-safety-package-to-stoptheviolence
[35] Exhibit B14.

and civilians working in a community contact role to be delivered in early 2017. This program involved a face to face one day intervention predominantly about DFV dynamics (with emphasise on the critical role police play in terms of investigating DFV, in particular how important it is for investigating officers to act in the best interests of victims to ensure quality outcomes and to prevent repeat victimisation), including an outline of the legislation and some cultural awareness and sensitivity content in a DFV context.

- *Commencement of a review of the QPS Protective Assessment Framework (PAF) - applied by officers at all incidents or reports of domestic violence where a relevant relationship is established. The QPS began a process of engaging with tertiary institutions to evaluate the PAF with the view to enhancing and aligning it more with an actuarial tool in order to better determine the risks posed to the victim.*

- *A proactive approach to obtaining referrals for respondents and aggrieveds. Since the commencement of the new Police Referrals service in December 2015, the number of DFV referrals made in Jan-Jul 2016 have increased between 49 - 89% per month compared with the previous system referrals for the same time periods*.[36]

94. Inspector Carr clarified that many of the matters listed above are longitudinal in nature, and/or require a process of continual review and improvement. The majority of the matters listed have continued into the Second Action Plan (2016 – 2019). Over the next three years, the QPS will implement and finalise a number of matters commenced under the First Action Plan, as follows:

    - *Implementation activities in support of the proclamation of the Domestic and Family Violence Protection and Other Legislation Amendment Act 2016. This will include the necessary training intervention for all sworn officers, but also the necessary changes to the OPMs and associated support documents. The key legislation change relevant to the QPS is the expansion of the allowable PPN conditions and the ability to provide immediate protection to victims as well as enable 'ouster' conditions on respondents so that victims and children can remain in the home until the matter is heard before a Magistrate.*

    - *The commencement and completion of the Vulnerable Persons Training Package intervention which is heavily focused on a cultural change message which prompts police to review their current knowledge of causes and effects of DFV. A series of videos targeting operational police have been developed as part of this training package which asks police officers if they have done all that they can to prevent future episodes of DFV.*

    - *The review of the PAF is due for completion by the end of 2017. This work will tie in with the Common Assessment Framework being developed by Department of Communities, Child Safety and Disability Services when triaging high-risk DFV relationships to ensure that victims and families do not fall between the cracks*.[37]

[36] Exhibit B14, paragraph 9.
[37] Exhibit B14, paragraph 11.

Conclusions

95. I conclude that Mr Turpin died as a result of his own actions after he hanged himself. I find that none of the police officers or other occupants at his address at Atherton caused or contributed to his death in any way.

96. I am satisfied that the actions and decisions made by the attending police officers in the immediate lead up to Mr Turpin's death, based on the information which was available to them at the time, were appropriate and timely.

97. I am satisfied from the evidence that it is more likely than not that by the time police arrived at the incident address, Mr Turpin had already been locked in the bathroom with the ligature in place for at least five minutes. I am unable to determine exactly when Mr Turpin became unconscious as a result of the effects of the ligature. However, I take into account the evidence of Dr Botterill that the general timeframe that the brain can be deprived of oxygen before damage is irreversible is some four minutes.

98. Officers had arrived at the unit approximately six minutes after the 000 call started. The level of risk was unknown. I consider that it was appropriate for officers to take time to conduct an initial assessment of the situation in order to ensure their safety and that of the occupants of the unit. They located Mr Turpin in an unresponsive state within a further seven minutes after having to force entry to the bathroom. I am satisfied on the balance of probabilities that Mr Turpin's death could not have reasonably been prevented by the attending officers. I am unable to conclude that the earlier arrival of the officers at the unit or their earlier entry to the bathroom would have made any difference to the outcome.

99. I am satisfied that the investigation conducted into Mr Turpin's death by the Ethical Standards Command was appropriate, thorough, and covered all relevant areas of investigation. I am satisfied that the protocols established to investigate deaths in the course of police operations in accordance with the *Coroners Act 2003*, and Queensland Police Operational Procedures Manual were complied with.

Findings required by s. 45

100. 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 evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Robert Noel Turpin.

How he died - Mr Turpin died as a result of his own actions after he hanged himself from a towel rack.

Place of death – He died at the Cairns Base Hospital, Cairns in the State of Queensland.

Date of death – He died on 20 August 2015.

Cause of death – Mr Turpin died as a result of hanging.

Comments and recommendations

101. Section 46 of the *Coroners Act*, insofar as it 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.

102. In this case I have found that there are no grounds for criticism of the police officers involved. They responded professionally and in accordance with their training in a stressful situation involving uncooperative witnesses. It was clear that Ms Goltz did not want officers to enter the residence, and she initially told them that Mr Turpin was no longer present. Other occupants conveyed no sense of urgency when officers entered the residence.

103. Mr Turpin had locked himself in a bathroom with a belt while his partner was calling the QPS. She had told the 000 call taker that he had attempted suicide 3 times in the last 12 hours. While these particulars were not known to attending police at the time, they are matters which they should have been aware of, as they were clearly contained in the initial tasking from the communications room. However, I accept that in the context of preparation for urgent attendance at a Code 2 job, factors such as the officers' heightened state of arousal, the configuration of the radio at the station and extraneous noise as they moved around the station, led to their not comprehending the particulars relayed in the tasking over the police radio.

104. I consider that it is likely that the officers would have been aware of this information had they had access to the job card before leaving the station or on a QLite device in August 2015. In turn, they would have been focussed on locating Mr Turpin upon arrival at the incident address.

105. With respect to the QLite program, I accept the submission of Counsel Assisting that information relating to jobs needs to be provided to first response officers in a way which is more reliable than over the police radio. I accept that Counsel Assisting has made a similar submission in the recent police shootings inquest, in which I am currently considering recommendations.

106. In that regard, I am satisfied of the significant benefit of the QLite devices to frontline police in ensuring that they have effective access to significant information about a job, in real-time.

107. I recommend that the QPS continues to prioritise the distribution of QLite devices to front line officers, and that the Queensland Government provides the QPS with the necessary resources to enable the rollout of these devices.

108. With respect to the information provided by Inspector Carr regarding recommendations 134 and 86B of the 'Not Now, Not Ever' report, I consider that there are no further recommendations I could reasonably make at this time to prevent a similar death from occurring in the future.

109. I close the inquest.

Terry Ryan
State Coroner
Cairns
4 May 2017