QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Calvin Wayne Bee**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Normanton
FILE NO:	COR/03 1451
DELIVERED ON:	09 August 2006
DELIVERED AT:	Normanton
HEARING DATE(s):	21 July 2006 & 07-08 August 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**Coroners inquest, death in custody, riders concerning incarceration of alcoholic persons, sudden unexplained death in epilepsy**

REPRESENTATION:

Counsel Assisting:	Mr Mark Plunkett
Senior Constable Bradley Bowser, Constable Nicole Mitchell & Constable Matthew Mithchell:	Mr Adrian Braithwaite
Queensland Police Service Commissioner:	Mr Wayne Kelly

Findings of the Inquest into the death of Calvin Wayne Bee

Table of Contents

Introduction 2
The Coroner's jurisdiction 2
The basis of the jurisdiction 2
The scope of the Coroner's inquiry and findings 3
The admissibility of evidence and the standard of proof 3
The investigation 4
The inquest 5
Directions hearing 5
The inquest 6
The Evidence 6
Background 6
Alcoholism, injury and trouble with the police 6
Domestic violence leading to incarceration 7
Sentenced by the Court and taken into custody 8
Sudden fitting in the morning 10
Immediate first aid 11
Attempts at resuscitation 12
Calvin Bee is pronounced dead 13
The autopsy and the medical opinion 13
Findings required by s. 43 – particulars of deaths 14
The identity of the deceased: 14
Place of death 14
Date of death 14
Cause of death 14
The Committal Question 14
Manslaughter by failing to provide necessities of life 15
Recommendations – Riders 17
Introduction 17
Video surveillance of prisoners 17
Recording watch house inspections 18
Assessment of alcohol withdrawal risk 18
Recommendation 1. – *A review of the assessment and treatment of alcohol withdrawal risk among watch house detainees* 19
Alcohol abuse among Indigenous Australians 19

The Coroners Act 1958 provides in s. 43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death Calvin Wayne Bee.

Introduction

On 18 August 2003, Mr Bee, a 42 year old Aborigine, was sentenced by the Magistrates Court at Normanton to six months imprisonment for three breaches of domestic violence orders. He was taken into custody and held at the watch house at Normanton. At that time he appeared to be in good health and did not appear to be affected by liquor. He did not complain to police of any illness or injury, nor was any apparent.

The next morning at about 7.00am, Mr Bee was lying on a bench in a communal cell when he was seen to convulse, fall to the ground, continue to fit, and lapse into unconsciousness.

Despite attempts by an ambulance officer who soon arrived, Mr Bee was unable to be resuscitated.

These findings explain how the death occurred and determine whether any person should be charged with a criminal offence in connection with the death. They also consider whether changes to police procedures could reduce the likelihood of deaths occurring in similar circumstances in future.

The Coroner's jurisdiction

In England, coroners have investigated sudden and violent deaths for eight hundred years and they have done the same in this country since European occupation. However, many people still have a limited understanding of the role and function of coroners and inquests. A potential for further confusion arises in this case as a result of the passing of the *Coroners Act 2003* in the period intervening since the death and this inquest. It is therefore appropriate that before I turn to an examination of the evidence in this case, I say something about those issues, to put what comes after in some context.

The basis of the jurisdiction

Although this inquest was concluded in 2006, as the death being investigated occurred before 1 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s. 100 of that Act and the provisions of the *Coroners Act 1958* (the Act) are therefore preserved in relation to it.

Because the death occurred while the deceased was detained in a watch house, the police were obliged by s.12(1) of the Act to report it to a coroner. Section 7(1)(a) (i) and (iii) confer jurisdiction on a coroner to investigate such a death and s.7B authorizes the holding of an inquest into it.

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death.

The Act, in s. 24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-

- the fact that a person has died,
- the identity of the deceased,
- when, where and how the death occurred, and
- whether anyone should be charged with a criminal offence alleging
- he/she caused the death.

After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

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.[1]

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 authorizes a coroner to make preventive recommendations,[2] referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[3]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s.34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

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.[4]

---

[1] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[2] s.43(5)
[3] s.43(6)
[4] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625

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.[5] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, 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.[6]

Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted in a criminal trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[7] 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*[8] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organization.

The investigation

As can be readily appreciated whenever a death is connected with police action it is essential that the matter be thoroughly investigated to allay any suspicions that inappropriate action by the officers may have contributed to the death. It is also desirable that the general public be fully apprised of the circumstances of the death so that they can be assured that the actions of the officers have been appropriately scrutinised. The police officers involved also have a right to have an independent assessment made of their actions so that there can in future be no suggestion that there has been any "*cover up*."

At 8:00 am on 19 August 2003 after arriving to commence duty at Normanton Detective Senior Constable Michael Anderson of the Criminal Investigation Branch was informed of the death of the deceased. He spoke to the Regional Crime co-ordinator and was directed to commence an investigation by taking statements from the prisoners who were incarcerated with Mr Bee. He attended at the watch house, secured the scene and took photographs of it.

At 8:30 am on 19 August 2003 the Mt Isa coroner was advised of the death. Also on the morning of 19 August, Detective Senior Sergeant Ian Anderson the officer in charge of the Mount Isa CIB was directed to travel to Normanton. He arrived early in the afternoon. Fortuitously, Inspector Loxton of the Ethical Standards Command (the ESC) was in Townville involved in another matter and was able to be re-deployed with minimal delay. He therefore arrived in

[5] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[6] *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[7] *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
[8] (1990) 65 ALJR 167 at 168

Normanton soon after Senior Sergeant Anderson and they took control of the investigation and commenced taking statements from relevant witnesses and interviewing the officers involved. Their investigation was thorough and competently carried out. I am satisfied that it rigorously examined all of the relevant issues.

The Royal Commission into Aboriginal Deaths in Custody observed of a police investigation into custodial death that: '*It is a question of establishing and maintaining a system which will evoke trust. It is not only a question of justice but of justice being seen to be done'.*[9]

To this end it was recommended by the Royal Commission that all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and **in every respect should be as independent as possible** from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.[10]

The circumstances of the initial investigation of this death graphically illustrates the practical difficulties of attaining these high standards, particularly remote regions. Obviously, it would not have been appropriate for no investigative steps to be taken until an officer from the Brisbane based ESC arrived. On the other hand, detailing a local officer to commence the inquiry, led to the undesirable outcome whereby the initial investigator later participated in the interviews of the subject officers as their support person. Such dual roles are not compatible. I hasten to add however that I do not believe that this unusual arrangement compromised the integrity of the investigation on this occasion.

.

The inquest

Directions hearing

On 21 July 2006, I opened the inquest with a directions hearing at which Mr Mark Plunkett of Counsel was appointed to assist me. The Commissioner of the Queensland Police Service and the officers involved in the detention of Mr

[9] RCIADIC National Report, v 3 p 120 [4.2.22].
[10] RCIADIC Recommendation 33; see also 32; 34; 35 and *State Coroner's Guideline* 7.5 providing that deaths in custody warrant particular attention because of the responsibility of the state to protect and care for people it incarcerates, the vulnerability of people deprived of the ability to care for themselves, the need to ensure the natural suspicion of the deceased's family is allayed and public confidence in state institutions is maintained. Further, a thorough and impartial investigation is also in the best interests of the custodial officers; Also *State Coroners Guidelines*, 7.3 that investigations 'must commence from the premise that they are potential homicide cases.' OPM 1.17 providing that deaths in custody 'are to be conducted expeditiously and impartially'; OPM 1.17; OPM 16.24.3.

Bee were granted leave to appear. The family of Mr Bee were advised of the hearing as was the Aboriginal and Torres Strait Islander Legal Service. Counsel Assisting outlined the issues to be examined at the inquest and the witnesses it was proposed to call to give oral evidence.

The inquest

The inquest commenced on 7 August 2006 and evidence was given over the next two days. Fifteen witnesses were called to give oral evidence and 59 exhibits were tendered. The family of Mr Bee were not separately represented but they conferred frequently with Mr Plunkett and I trust the issues that were of concern to them were adequately ventilated.

The Evidence

I turn now to the evidence. Of course I cannot 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

The deceased was an Aboriginal man, born on 21 May 1961 at Normanton in the Gulf of Carpentaria. He grew up and had lived all of his life in the Normanton area. He was an active hunter and fisher and engaged in these activities with his younger siblings and extended family.

He was 42 years of age at the time of his death. By general Australian standards this is a young age to die. However a death at this age, brought about by poor health, is endemic for Aboriginal people in Australia.

Alcoholism, injury and trouble with the police

By all accounts, and plainly supported by medical and police records, the deceased had a long history of alcohol abuse, particularly over the last 12 years of his life.

He was first arrested for drunkenness when he was 16 years of age and dealt with by way of admonishment and discharge by the Children's Court at Normanton.

In 1991 and 2000 he was reported to be drinking three to four casks of wine a day. These anecdotal accounts are corroborated by pathology tests in 1991 and 2002 which showed liver damage consistent with chronic alcohol abuse. The autopsy found chronic damage to the brain and the liver of the deceased caused by alcohol consumption.

It is unsurprising therefore, that the deceased had a long criminal history for public drunkenness, obscene language, disorderly conduct, wilful damage, dangerous operation of a motor vehicle and assault. The deceased had 11

breaches of domestic violence orders, the first recorded when he was 30 years of age. He was frequently involved in violent fights.

He had been married but was separated from his wife. Since 1989, Mr Bee lived in a domestic relationship with Ms Bettina Gregory. She said that in his latter years they regularly drank a cask of wine a day and not necessarily every day, although she also said in evidence that Mr Bee drank most days.

She stated that each fortnight they would receive a combined welfare payment of $670.00. They used much of this to buy what the locals call "fruity"- white wine sold in four litre casks.

His partner also stated that after long drinking bouts Mr Bee would suffer delirium tremens, or the 'horrors', during which he would shake, hear voices and see images of dead people coming towards him. Again, this was not a condition for which the deceased had sought medical help although the records of the local hospital record that in January 2003 he was given sedatives to ameliorate these symptoms.

His younger brother, Hendrick Bee knew the deceased to be a heavy drinker, but was unable to say whether the deceased had ever suffered a fit and as far as he knew no one in his family was ever known to have taken a fit.

There were no medical or police records of the deceased indicating that the deceased had ever suffered from convulsions or that he had been diagnosed with epilepsy, or that he was any taking medication for the health ravages inevitably wrought by his excessive alcohol intake.

Domestic violence leading to incarceration

Sadly, it is common for alcoholics to engage in violence against intimates. The deceased did this to the extent that on 26 July 2002 the Magistrates Court at Kowanyama issued a domestic violence order against Mr Bee as a result of his violence towards Ms Gregory. The court file suggests that on 12 September 2002 the order was served on the deceased and explained to him. The evidence of his partner and various police officers indicates that this order proved to be ineffective to protect Ms Gregory from Mr Bee's violent outbursts.

On 23 March 2003 his partner made a complaint to the police alleging that Mr Bee had, on 21 March 2003, dragged her from her bed, pinned her to the bed room wall by holding her at the throat and threatened to kill her. When he released her, she ran from the house and sought shelter with a neighbour, after which the police took her to stay with family and friends.

At about 6:00 pm on 9 April 2003 at Normanton it seems Mr Bee assaulted Ms Gregory by pushing her to the ground, and punching her about the face. He left the scene before the police arrived. At about 11:00 pm that evening at another address the deceased approached his partner with a knife demanding that she go home with him. The police were again called. According to the police who responded, both Mr Bee and Ms Gregory were very intoxicated

and by the time they arrived Ms Gregory had disarmed Mr Bee and she declined to be taken to another location.

At 11.10 am on 11 April 2003 Mr Bee was seen by police to be arguing with Ms Gregory on the veranda of the Purple Pub at Normanton. They moved on after being told to do so by police. But as they walked down the middle of Landsborough Street Mr Bee was observed to be yelling and swearing loudly at Ms Gregory and then at the police, when they asked him to desist. Mr Bee resisted arrested and was charged with behaving in a disorderly manner, obstructing police and assaulting police and he was taken into custody.

While in custody for these matters, the deceased was charged with three breaches of the domestic violence orders arising out assaults upon Ms Gregory. He was released on his own undertaking to appear before the Magistrates Court at Normanton on 18 August 2003.

Sentenced by the Court and taken into custody

That morning, before attending court, the deceased and his wife drank one cask of "fruity" between them although it seems possible that they may have shared it with friends. When giving evidence at the inquest Ms Gregory seemed to want to minimise the amount that Mr Bee drank on this day insisting that he only had two glasses and that they did not finish the cask. They then walked to the court house and waited for Mr Bee's case to come on for hearing. Ms Gregory said Mr Bee knew it was likely that he would be sent to prison but he was not particularly distressed at this prospect.

The charges were not dealt with by lunch time and so they went home and ate lunch. Mr Bee also had another glass of "fruity".

After lunch a field officer from the Aboriginal Legal Service picked him up and drove him back to the court house.

Mr Bee contested the DVO breaches but he was convicted and sentenced to six months imprisonment on two of the offences and one month's imprisonment for the third, with all sentences to be served concurrently. He was fined in relation to the public order offences with default periods meaning the fines would be "cut out" while the main sentence was served.

The charging officer, Senior Constable Bowser, was present for the sentencing and took the deceased to the police watch house to be held there until he could be delivered into the custody of a Department of Corrective Services to serve his sentence. It was intended that Mr Bee stay in the Normanton watch house over night and be transferred to Mt Isa the next day and then onto the Townsville Correctional Centre.

The watch house is part of the Normanton police station which is located next door to the court house. At about 7:05 pm the deceased was taken into the station day room where he was given into the custody of Constable Nicole Mitchell.

Also present in the day room at the time was Nicole's husband, Constable Matthew Mitchell and Senior Constable Bowser. Constable Nicole Mitchell processed the deceased by entering his details into the watch house register. In accordance with proper procedure, she also asked Mr Bee a number of medical questions that are printed on each page of the register. According to all three officers, the deceased answered each of these questions in turn clearly and quickly and appeared to be in good health. All also say that Mr Bee did not appear to be affected by liquor. Relevantly, those questions included "*Do you suffer from any of the following: (a) Epilepsy?"* And *"Do you drink more than 6 alcoholic drinks a day?"* Mr Bee answered both in the negative.

Senior Constable Bowser then searched Mr Bee, removed his belt and shoe laces before Constable Nicole Mitchell placed the deceased into the male bulk cell, that is a large cell that is used to house multiple prisoners, particularly Aborigines, in the belief that the company lowers the risk of suicide.

There were two other prisoners in there; Vernon Roberts and Garth Moses. A female prisoner, Erica Roslyn Wilson, was in a separate female section of the cells.

Prisoner Moses, who had known the deceased since boyhood, greeted the deceased. They talked and discussed their respective sentences. Mr Bee told them that he'd been drinking that day and the day before. In view of the frequency with which he did this it might be concluded that the drinking was excessive if it was noteworthy.

The other prisoner, Mr Roberts, gave evidence at the inquest that Mr Bee looked unwell and coughed a bit when he was brought to the cell. He didn't eat his evening meal when it was served.

Also on duty at this time was Police Liaison Officer Katherine Roberta Snow. She knew the deceased as he was related to her. She knew that the deceased had a serious drinking problem.

Shortly after 7:00 pm Ms Snow saw the deceased and the other prisoners receiving their evening meals. Later she observed the deceased on the television monitor sleeping soundly. From her observations Ms Snow had no reason to think that that the deceased was ill.

After dinner Constable Nicole Mitchell collected the plates and utensils and said all prisoners appeared to be in good spirits.

At about 8:30 pm Constable Nicole Mitchell again went to the cells to have Mr Bee sign the property receipt form. Again, according to her, the deceased appeared to be well.

Some time later Constable Nicole Mitchell distributed blankets and turned out the main lights. Thereafter during the evening the light from the hallway is sufficient to see into the cell and enough for the video monitor to work properly.

Mr Moses says he heard the deceased snoring during the night. Mr Roberts remembers that Mr Bee appeared to sleep soundly and he did not hear him make any unusual noises during the night.

Throughout the remainder of her shift Constable Nicole Mitchell conducted periodic checks from the door way of the cell. She was able to maintain a near constant view of the prisoners on the closed circuit monitor in the control room as she attended to other paper work. She did not however, record these cell inspections in the register kept for this purpose: she says she was too busy to do so.

Constable Nicole Mitchell did not use the video recorder to record what it was showing because she considered there was no reason to do so. In any event she had not been shown how to use of the video system in the five or 6 months she had been there. It was clearly not the practice to do this at the Normanton watch house.

At about 11:30 pm on the night of 18 August 2003 Constable Matthew Mitchell came on duty. He noticed that his wife had not completed the cell inspection register and claims to have discussed with her the times when she had made those inspections and then wrote up the book.

He then took over responsibility for the prisoners and noticed the deceased and the two other male prisoners were asleep in the bulk cell. He also checked on the female prisoner in the female cell.

His wife and PLO Snow went off duty soon after Constable Matthew Mitchell came on and they left the station. Senior Constable Bowser, who was only relieving in Normanton and who was scheduled to leave the next day, was asleep in a spare room at the station.

Throughout the remainder of the shift Constable Matthew Mitchell conducted checks on the prisoners all of whom appeared to be sleeping well. He also monitored the prisoners via the closed circuit television monitor in the control room.

At no time that day or evening did the deceased complain to his de facto or the police that he had been feeling ill. Indeed, apart from the remark to prisoner Moses, which was not brought to the attention of the police, there was nothing by way of complaint, appearance, or conduct of the deceased which gave rise to any inkling of what was to occur the next morning.

Sudden fitting in the morning

The next morning at about 6.30am, Sergeant John McArthur, the officer in charge of the station, arrived for work and met with Constable Matthew Mitchell and had coffee. Sergeant McArthur then left to pick up the police prosecutor from a local motel.

After coffee Constable Matthew Mitchell went to the cells, woke the prisoners and directed them to have showers. He told them the prisoner transfers would

be leaving in an hour and so they had to ready themselves. He left some toast that he had made for them. He says at this time he saw Mr Bee was awake but still lying down. Constable Mitchell then went back into the station.

Mr Roberts says that after he was woken he showered and came back to the bulk cell and ate his breakfast. Mr Moses stated that he saw the deceased go and sit on the toilet in the cell and later saw him again lying on the bench. Mr Bee did not eat any of his breakfast.

Prisoner Roberts was standing near the door of the cell, drinking a cup of tea and talking to Mr Moses when he saw Mr Bee begin to convulse. As he did so, Mr Bee began slipping off the bench and on to the floor. Mr Roberts sprang towards him to catch Mr Bee's head before it hit the floor. He turned Mr Bee onto his side and began rubbing his back and calling to him. He then ran to the cell door and alerted the police by yelling out "*Emergency!*"

Mr Moses also says he saw the deceased have a fit. He says Mr Bee was shaking and coughing while lying on his back. He says Mr Bee rolled off the bench onto the floor and continued to shake while on the ground. The prisoners tried to hold him still by his shoulders, patted him asking if he was alright. Mr Moses agrees that Mr Roberts put the deceased on to his left side facing the bench and started to rub his back and he says this was when the deceased vomited up some water. Both men also say there was a little blood in the regurgitant.

Immediate first aid

When Constable Matthew Mitchell was walking to the main area of the police station after delivering the prisoners meals to the cells, he heard shouts coming from the cells; *"Sergeant…Boss"*. He ran back into the cells and saw Mr Bee lying on the floor on his back with his head nearest the toilet. He saw one of the other prisoners trying to assist the deceased who was not moving. The prisoner said that the deceased had been convulsing. Constable Matthew Mitchell told the two prisoners to move to one side of the cell. He examined the deceased and placed him on his side in the recovery position. He says he could detect a pulse and could see that there was no obstruction in Mr Bee's throat. He says that he put his cheek near Mr Bee's cheek and was able to hear him breathing and see his chest rise and fall.

Constable Mitchell ran back into the police station and dialled triple zero which caused him to be connected to the Mt Isa police communications centre. He told the officer he spoke to there that he required an ambulance at the Normanton police station urgently. When he hung up the phone Constable Mitchell yelled for Senior Constable Bowser who he knew to be somewhere in the station. Constable Mitchell then ran back to the cells.

Senior Constable Bowser came out of the bathroom and ran to the watch house. He saw the bulk cell door was open. Inside he saw Constable Matthew Mitchell leaning over the deceased who was on his left hand side in the recovery position with his head towards the cell toilet with his feet angled away towards the door. Senior Constable Bowser says he could hear the

deceased moaning a little bit. The other prisoners were at the other end of the cell. Constable Matthew Mitchell told his colleague he did not know what was wrong but that he could find a pulse and that the ambulance had been called. One of the prisoners told Senior Constable Bowser that the deceased was alright until he began fitting and fell from the bench. Both officers confirm that there was a small amount of blood on the floor near the deceased's mouth. Neither could see any obvious injuries to the deceased. Constable Matthew Mitchell then left the deceased with Senior Constable Bowser to go and give the ambulance access to the watch house.

While waiting for the ambulance Senior Constable Bowser says he kept checking on the condition of Mr Bee who, he says, had a pulse and was breathing.

Attempts at resuscitation

At 7:06 am the officer in charge of the Normanton Ambulance Station, Wayne Fagg, received a call from the Mount Isa police communications advising an ambulance was needed urgently at the Normanton watch house. At 7:12 am the ambulance arrived at the watch house. On arrival in the cells Mr Fagg saw the man he now knows was Mr Bee unconscious on the floor lying on his left side. He was told that the deceased had taken a fit and hit his head. He saw a small amount of blood on the left hand side of the Mr Bee's head.

He found Mr Bee was non-responsive - that is he was not breathing and he had no pulse. When giving evidence, Mr Fagg at first volunteered that one of the officers present may have told him that there had been no pulse or breathing for some time but when cross-examined about this he seemed unsure.

A cardiac monitor recorded very low electrical activity from Mr Bee's heart. In an attempt to revive Mr Bee he activated the manual mode of the cardiac defibrillator and applied three cardiac shocks. Ventricular fibrillation was observed and ambulance officer Fagg commenced cardiac pulmonary resuscitation.

Around this time, Sergeant McArthur arrived and saw the attempts to resuscitate the deceased. He heard Ambulance officer Fagg say: *"Not looking too good.*" He moved the two male prisoners into the smaller cell.

Senior Constable Bowser helped the ambulance officer with monitors and shock equipment. The stretcher was retrieved from the ambulance and deceased was helped into the ambulance by the police officers. Ambulance officer Fagg advised Constable Matthew Mitchell to notify the Normanton Hospital of their pending arrival with a cardiac arrest patient.

Sergeant McArthur drove the ambulance to the hospital while the ambulance officer continued to try to resuscitate Mr Bee in the back. Upon arrival at the hospital no pulse or respiration was detected.

Calvin Bee is pronounced dead

At about 7:30 am the Medical Superintendent of the Normanton Medical Centre and the Kurumbah Health Clinic, Dr Christopher Paul Gilford was at his home adjacent to the hospital when received a call from the nurse on duty advising that a patient had arrived following a respiratory or cardiac arrest. He attended the emergency department where he observed the deceased, whom he knew, lying on a trolley. He found no signs of life. The pupils of the deceased were fixed and dilated. His electro cardia graph (ECG) showed no activity. A pulse was not detected and there was no respiratory effort. He was told that he had not had any pulse for about fifteen minutes.

At 7.45 am Dr Gilford pronounced life extinct and issued a Life Extinct Certificate. Dr Gilford states that the deceased's alcohol consumption would predispose him to having a fit after he had stopped drinking also giving him an increased risk of heart attack. Dr Gilford did not believe that there were any suspicious circumstances surrounding the death.

The autopsy and the medical opinion

The next day Mr Bee's body was flown to the John Tonge Centre at Brisbane, where on 21 August an autopsy was conducted by Dr Beng Ong, an experienced forensic pathologist.

Examination of Mr Bee's brain and liver showed evidence of chronic alcohol abuse. There were also changes to part of his brain that suggested an earlier trauma that left permanent damage of a type likely to lead to epilepsy. These, coupled with neuronal necrosis – death of brain cells - in other parts of the brain, led Dr Ong to conclude that Mr Bee may have had an epileptic seizure that resulted in his sudden death. Although he found a fresh bruise on Mr Bee's left temple, Dr Ong considered that this could have been caused by mild trauma such as would be expected if he hit his head while suffering a seizure. He found *"(T)here is no evidence of recent significant trauma in the deceased."* Toxicological analysis showed *t*here was no alcohol in Mr Bee's blood at the time of death.

Another possible explanation for the seizure that led to Mr Bee's death is the withdrawal of alcohol he experienced when he was at court on the afternoon before his death and then in the watch house over night. Dr Robert Hoskins, the Director of the Clinical Forensic Medicine Unit, gave evidence that it is well recognised that alcoholics and some other drug abusers will suffer seizures when they are deprived of their drug of choice but that this is unusual within the first 24 hours of abstinence. The local medical superintendent, Dr Gilford, however, said he was aware of such seizures being experienced within shorter periods of time than that quoted by Dr Hoskins.

The difficulty in identifying the cause of the fatal seizure in Mr Bee's case is that it doesn't fit easily within any of the more recognised patterns, in that he had not previously suffered a seizure and he had only been abstinent for about 18 hours. On the other hand there was found at autopsy, pathological evidence that could explain a seizure of this type.

This difficulty is compounded by the limited understanding neurologists still have of the mechanism of death in such cases. Indeed, so limited is the current knowledge that a category of death called sudden unexplained death in epilepsy has been fashioned. It is an exclusionary diagnosis with which a death may be labelled if it has the appropriate characteristics and there is no other more likely cause of death.

Findings required by s. 43 – particulars of deaths

I am required to find, so far as has been proved, who the deceased was and when, where and how he came by his 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.

The identity of the deceased: the dead man was Calvin Wayne Bee

Place of death: Mr Bee died in the watch house in Normanton, near the gulf of Carpentaria, Queensland

Date of death: He died on 19 August 2003

Cause of death: Mr Bee's death should be classified as Sudden Unexpected Death in Epilepsy (SUDEP).

The Committal Question

Insofar as it is relevant to this case, the Coroners Act provides in s24, s41(1) and s43 that if a coroner holding an inquest into a death, considers that the evidence is sufficient to put a person on trial for murder or manslaughter, the coroner may order that the person be committed for trial.

It is not my role as Coroner to decide whether any person is guilty of an offence in connection with the death of the deceased who died in the Normanton Watch house or indeed, even whether the prosecutorial discretion should be exercised in favor of presenting an indictment and bringing the matter before a jury.

Rather, I only have jurisdiction to determine whether anyone should be committed for trial. That requires I consider whether a properly instructed jury *could,* on all of the evidence presented at the inquest reasonably convict any person of any of the offences that are raised by the evidence.[11]

There is no evidence indicating at any stage after Mr Bee was taken into custody that any person did any act intending to cause him any harm. Nor is there any evidence that any willed act caused his death. There are no

[11] see *Short v Davey* [1980]Qd R 412

suspicious circumstances in the death of the deceased. There is nothing to suggest that the deceased died by anything other than natural causes. In those circumstances, neither the offence of murder nor what is referred to as voluntary manslaughter arises for consideration.

Manslaughter by failing to provide necessities of life

Therefore that only leaves for my consideration the Code provisions that deal with the common law offence of involuntary manslaughter that impose special duties of care on people, the breach of which can provide the causal link between the death and the persons on whom the duty is cast if criminal negligence can be established.

The provision with possible application to this case is Section 285. Insofar as it may be relevant to this case, it provides that:-

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

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

- the police had the deceased under their charge or control;
- he was unable to withdraw himself from their control;
- they failed to provide to deceased the necessaries of life; and
- as a result of that failure Mr Bee died.

There is no doubt about the first two elements – the deceased was in secure custody. In relation to the third and fourth, the Crown would need to persuade a jury that the necessaries of life which were not supplied were medication to prevent fitting or the application of appropriate resuscitation measures once his need for them became apparent and that those failures caused the death of Mr Bee. I believe a jury could be so satisfied.

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

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

All of the officers who were involved in the control of Mr Bee while he was in custody on the day before and the day of his death have given evidence that

they believed he was reasonably healthy and well and, up until the time that he began convulsing, suffering from no illness that would require them to seek medical attention for him. It would now seem clear that in this regard they were mistaken. However, s24 provides that a person who omits to do an act under an honest and reasonable but mistaken belief in the existence of a state of things is not criminally responsible for the omission to any greater extent than if things were as they believed.

In this case, I do not believe that the Crown could prove to the criminal standard that the officers' beliefs concerning the health of Mr Bee were either unreasonable or not honestly held. In those circumstances they could not be held liable for their failure to get him prophylactic medication.

The other aspect of the conduct of the officers which needs to be scrutinized from this perspective is their provision of first aid once Mr Bee's convulsing became known to them. When it was discovered that the deceased had taken a fit, the police acted swiftly and properly by checking for a pulse, clear airways and by placing Mr Bee in the recovery position. There was a police officer with the deceased at all time checking on Mr Bee while waiting for an ambulance to arrive. Both officers say that they did not commence cardiopulmonary resuscitation because Mr Bee was still breathing and had a pulse. There must be some doubt as to the accuracy of these claims in view of the evidence of the ambulance officer, Mr Fagg, that when he arrived he could detect no signs of life in Mr Bee. On one view of the evidence it seems likely that Mr Bee's pulse and breathing stopped some time before the ambulance arrived. If a jury were persuaded that the officers had omitted to respond with sufficient promptitude to Mr Bee's resuscitation needs it could be argued that these omissions brought their conduct within the provision of s285.

However, in my view the evidence would not enable the Crown to prove that the failure to provide more timely resuscitation caused Mr Bee's death. Further, even if that could be proven, I am not satisfied that such an omission would be so far below the standard of what could reasonably be expected as to amount to criminal negligence having regard to the very short time for which it apparently continued.

The courts have consistently, and understandably, held that to be criminally liable the prosecution needs to prove a more blameworthy departure from the expected standards than is required by a plaintiff seeking civil redress. The classic judicial articulation of this difference is found in *R v Bateman*[12] where Hewart LCJ said:-

In explaining to juries the test which they should apply to determine whether the negligence in the particular case amounted or did not amount to a crime, judges have used many epithets, such as "culpable", "criminal", "gross", "wicked", "clear", "complete". But, whatever epithet be used, and whether an epithet be used or not, in order to establish criminal liability the facts must be

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

such that, in the opinion of the jury, the negligence of the accused went beyond a mere matter of compensation between subjects and ***showed such disregard for the life and safety of others as to amount to a crime against the State*** *and conduct deserving punishment ... It is desirable that, as far as possible, the explanation of criminal negligence to a jury should not be a mere question of epithets. It is in a sense a question of degree and it is for the jury to draw the line, but there is a difference in kind between the negligence which gives a right to compensation and the negligence which is a crime. (emphasis added)*

I do not consider that in this case any negligence that may be able to be proven against the officers would have the qualities identified by His Honor. Accordingly, for all of these reasons I find that no person should be committed for trial in connection with Mr Bee's death.

In this section dealing with the committal issue I have of necessity taken the view of the evidence most critical of the officers as I am required to do when determining whether a jury could convict them. Having disposed of that issue, I am inclined to observe that a more charitable view of their actions is probably also more reasonable. I believe that all those involved with Mr Bee during the period in question did all that could reasonably be expected of them and that none of their actions contributed to his death.

Recommendations – riders

Introduction

In addition to establishing the details of a particular death, an inquest is also an opportunity to identify practices or procedures that could contribute to other deaths in future. Pursuant to s.43(5) of the Act I am authorized to make riders or recommendations designed to reduce the likelihood of similar deaths to that investigated by this inquest.

In this case there were a number of issues that raised concern from this perspective, namely:-

- the inadequacy of surveillance of prisoners in the Normanton watch house;
- the practice in relation to recording the results of cell inspections, and
- the limited approach to the assessment of and response to alcohol withdrawal risk;

Video surveillance of prisoners

In the 6 months between their arrival at Normanton and this death, neither of the Constables Mitchell had received any instruction in the operation of the video-system at Normanton police station nor training as to when the cells should be video recorded rather than just monitored.

The standard operating procedures for the Normanton police station in force at the time of this death deal with the video equipment on the basis that "*the best way of understanding the workings of these devices is by experiment, and by asking questions of experienced staff."* They did not make any mention of when the equipment was to be used or when the cells were to be recorded. These deficiencies were not detected during routine station inspections.

The investigating officer sensibly recommended that these shortcomings be addressed by an amendment to the standard operating pocedures that made the officer in charge of the station responsible for training all officers, mandated a register of video tapes be maintained and stipulated that the recording equipment be used on every occasion that a person is placed in custody.

Those recommendations were accepted but surprisingly, it seems that as recently as July this year they had still not been implemented.[13] The District Officer has issued a written instruction directing that this happen forthwith. In view of that action no further comment should be needed from me in this regard.

Recording watch house inspections

Constable Nicole Mitchell did not complete the prisoner inspection register after each inspection of the prisoners but rather said she believed that it was acceptable to do this at anytime before the completion of her shift. The potential for inaccuracy to result from such a practice is obvious. Accordingly the investigating officer recommended that the relevant section in the O.P.M. be amended. This has happened and there is therefore no need for further comment from me.

Assessment of alcohol withdrawal risk

As discussed earlier in these findings, one of the possible causes of the seizure that led to Mr Bee's death was alcohol withdrawal. The evidence of Dr Hoskins is that people who are at risk of developing a seizure from this cause usually display easily identifiable symptoms and that once identified this risk is readily ameliorated by the administration Diazepam, a cheap and relatively benign sedative.

I am also aware of other expert evidence that suggests that such seizures can occur with very little warning. The Royal Commission into Aboriginal Deaths in Custody Report into the death of John Raymond Pilot, concerned a man who died in a similar way to the deceased in this inquest. In that case, Commissioner Wyvill QC quoted from the evidence he had received from a relevantly experienced psychiatrist, a Dr Price, who said:-

> *'... the form of convulsive movements which would come on really without any warning whatsoever, that one minute the*

[13] see exhibit 2.5

patient or the person might appear to be relatively normal and the next minute they might actually be in an epileptic seizure or in alcoholic withdrawal seizure [which] would be indistinguishable from an epileptic fit.'"[14]

The police service is aware that alcohol dependency can lead to numerous health complications and so seeks to identify those who might be at risk by asking questions of all detainees when they are admitted to a watch house. The effectiveness of this method of identifying those who might be at risk of withdrawal seizures is limited by the widespread habit among alcoholics of under reporting the extent of their alcohol abuse. Mr Bee exhibited this tendency on his last incarceration.

Dr Hoskins also gave evidence that there are relatively simple instruments that can be administered that will assess a person's withdrawal risk more effectively than the current bald, closed question relating to six drinks per day.

Once a person is identified as being at risk, it is then necessary to take some preventative or prophylactic action such as the administration of Diazepam. The challenge is to implement a system that does not over-burden the para-medical or clinical services available to the police service, while still ensuring those who are in need of preventive medicine receive it quickly. I do not believe that I have sufficient data to say how that challenge should be addressed.

Recommendation 1. – *A review of the assessment and treatment of alcohol withdrawal risk among watch house detainees*

Accordingly, I recommend that the QPS, liaise with the Director of Queensland Health's Clinical Forensic Medicine Unit to review the most effective way to identify and respond to alcohol withdrawal risk among watch house detainees with particular attention to the special needs of remote watch houses.

Alcohol abuse among Indigenous Australians

An inquiry into Aboriginal health and alcoholism is beyond the scope of the inquest. However, to make no reference in these findings to alcohol abuse, intra-family violence and unemployment among the Aborigines of Normanton would be to fail to avert to a seminal contributing factor to the death of Calvin Bee. The extent to which the condition of the deceased is common among Aboriginal people in this region and the State generally is sadly notorious. [15]

In my findings on the death of a Death of a Hope Vale Man in an Aboriginal

[14] Chapter 9

[15] see Justice T Fitzgerald QC (Chair), *Cape York Justice Study* (CYJS), November 2001 (further, as regards alcohol abuse and policing on Aboriginal communities); Queensland Government (DATSIP), *Making Choices About Community Governance*, Green Paper, *Review of Indigenous Community Governance*, March 2003 at 10-15; Queensland Government (DLGPSR), *Community Governance Improvement Strategy*, December 2004;

Community Police Van delivered in 7 August 2005[16], I referred to the reports of the Royal Commission into Aboriginal Deaths in Custody which found that "*heavy reliance upon alcohol can be understood in terms of the lifestyle of many residents who have to contend with a wide range of stresses resulting from discrimination, unemployment, poor living conditions and a general lack of prospects."*[17] Those comments are equally apposite to this case but they offer no solution to the problem. Unhappily, neither can I.

I close the inquest.

Michael Barnes
State Coroner
Normanton
9 August 2006

[16] at page 12
[17] Individual Reports on Perry Daniel Noble, Richard Frank (Charlie) Hyde & David Mark Koowootha Part 7, Chapter 22 - Underlying And Other Issues