QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Neil Richard Banjo**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Normanton
FILE NO(s):	2017/293
DELIVERED ON:	2 October 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 May 2018, 25-27 June 2018, written submissions received February to March 2019.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in police operations, remote community, public nuisance offences, use of force, violent confrontation, open hand tactics.

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper (Coroners Court)
Ms C Logan:	Mr Tim Carberry (ATSILS, Mt Isa)
Commissioner of Police:	Ms Elizabeth Kennedy (QPS Legal Group)

Constables Lynch and Salau:	Mr Stephen Zillman (instructed by Gilshenan and Luton)

Contents

Introduction

1. Mr Neil Banjo was an Aboriginal man who was 53 years of age when he died at the Mercy Place Nursing Home in Cairns on 18 January 2017.

2. Mr Banjo had suffered a serious head injury following a confrontation with Queensland Police Service (QPS) officers on the street outside his home at Normanton on the night of 25 February 2016. A birthday celebration was underway for Mr Banjo's daughter, Heather. Police officers from the Normanton Station were called to Mr Banjo's home to respond to allegations that another daughter, Zoelene, aged 18 years, was "running amok".

3. As QPS officers attempted to arrest Zoelene for public nuisance, Mr Banjo and others from the party intervened and expressed concern that she was being "rough handled" as police were taking her to the police vehicle. During that confrontation Mr Banjo was pushed backwards by a police officer and he fell, striking his head on the road surface. The entire incident took less than a minute.

4. After receiving emergency treatment at the scene, and at the Normanton Hospital, Mr Banjo was transferred to the Townville Hospital on 26 February 2016, where he remained until May 2016. He was then transferred to the Cairns Hospital but he remained bed bound and unable to communicate. Mr Banjo was discharged to nursing home care on 17 January 2017, but died the following day.

5. These findings consider the appropriateness of the use of force applied to Mr Banjo by police officers on the night of 25 February 2016, together with the findings required by s 45(2) of the *Coroners Act 2003*; namely the identity of the deceased, when, where and how he died and what caused his death.

The investigation

6. As the original cause of Mr Banjo's head injuries was related to his interaction with QPS officers, his death was investigated as death as a result of police operations under s 8(3)(h) of the *Coroners Act 2003*. I was satisfied that the circumstances of the death required the holding of an inquest.

7. Detective Senior Sergeant Michelle Clark of the Mount Isa Child Protection Investigation Unit initially investigated the circumstances in which Mr Banjo sustained his injuries. Her investigation was overseen by Detective Inspector Robert Hytch of the QPS Ethical Standards Command.

8. Following Mr Banjo's death, Detective Inspector Hytch completed an Overview Report in which he concluded that the action of police officers who interacted with Mr Banjo did not breach QPS legislation, policy or procedures.

9. A post mortem examination was conducted on Mr Banjo's body at the Cairns mortuary on 19 January 2017. Blood and urine samples were obtained and subject to further toxicological testing.

10. As Mr Banjo's death occurred the day after he was discharged from the Cairns Hospital, and almost 12 months after he suffered the injuries in Normanton, an independent medical report was obtained after I heard the oral evidence at the inquest. A report was obtained from Dr Mark Little in relation to the medical care provided to Mr Banjo from the time his head injury was sustained until he was transferred to Mercy Place. Dr Little is a Consultant Clinical Toxicologist and Emergency Physician, who is currently employed as a Senior Staff Specialist at the Cairns Hospital.

The inquest

11. The inquest opened with a pre-inquest conference on 16 May 2018. Miss Cooper was appointed as counsel assisting and leave was granted under s 36 of the *Coroners Act 2003* to Mr Banjo's partner, the Commissioner of Police and Constables Lynch and Salau.

12. Evidence was heard from 11 witnesses at Normanton and Mount Isa on 25 and 27 June 2018. All the statements, records of interview, medical records, photographs, body worn camera footage and materials gathered during the investigation were tendered at the inquest. Written submissions were received from the represented parties following the conclusion of the evidence and the receipt of Dr Little's report.

13. Constable Salau claimed privilege under s 39 of the *Coroners Act 2003* and was directed by me to give evidence. The evidence which he gave at the inquest cannot be used against him in any other proceeding, except for a proceeding for perjury.

14. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

15. The *Coroners Act 2003* makes it clear that the purpose of an inquest is not to determine questions of civil or criminal liability, or to apportion blame. An inquest provides an opportunity to set out all the relevant facts associated with a death to enable the coroner to find the cause of death, and when, where and how the deceased person came by his death. A coroner can also consider whether any recommendations might be made to prevent similar deaths occurring, or to otherwise improve public health and safety and the administration of justice

The evidence

16. On the evening of 25 February 2016, Constables Timothy Salau and Ross Lynch, both stationed at Normanton Police Station, were called to attend 44 Sutherland Street, Normanton, in response to a disturbance.

17. In addition to Zoelene Beasley and Cheryl Logan, I heard from a number of other relatives and friends who witnessed the events that evening, including Heather Beasley[1], Carla McGilvary[2], James McGilvary[3] and Harold Sambo.[4]

18. Before the QPS arrived the family and friends had been celebrating Heather Beasley's birthday together at 44 Sutherland Street. Mr Banjo had been drinking beer and rum and was intoxicated.[5]

19. Mr Banjo's partner, Cheryl Logan, had called 000 for police to attend at Sutherland Street, as their daughter, Zoelene Beasley, had been arguing with her father, Mr Banjo. Ms Logan said that she had told Zoelene to go outside and calm down.

20. Ms Logan said that she and Mr Banjo had been partners for 35 years. She said that Mr Banjo worked for the council as part of the Community Development Program. He was a man who was "happy all the time" and had very good relationships with this children and grandchildren. I extend to her and Mr Banjo's family my condolences.

21. Zoelene Beasley told the inquest that she was sitting on the footpath when police arrived at the address. She was upset following the argument with her father.[6] She recalled that she had consumed two six packs of lemon vodka cruisers.[7] The police asked her for her name and date of birth, but she refused to tell them either.[8]

22. I heard evidence from both officers about what happened after they arrived at 44 Sutherland Street. Constable Lynch activated his body worn camera at the scene, and Constable Salau activated a digital audio recorder. The following day, a re-enactment of the events was conducted with Constable Salau and Detective Senior Sergeant Clark which was recorded on video. Each of these recordings was tendered and referred to during the inquest.[9] It was difficult to make out specifically what happened from the body worn camera recording alone as it was approximately 7:30pm when the events occurred and the lighting was

[1] T1, 25 from line 33.
[2] T1, 39 from line 35.
[3] T1, 60 from line 28.
[4] T1, 48 from line 39.
[5] T1, 6 from line 42; 32 from line 27.
[6] T1, 14, from line 2.
[7] T1, 14, from line 19.
[8] T1, 15, from line 8.
[9] Exhibits E8.1 & 8.2; E12.1; E16.

poor. Notwithstanding, Constable Lynch recalled that he had no trouble seeing at the time, as there was still a reasonable amount of light.[10]

23. I am satisfied that when the officers arrived, Zoelene Beasley was sitting on the footpath close to 44 Sutherland Street, with a vodka cruiser bottle in her hand, and a vodka cruiser carton next to her.[11] Consistent with the evidence given by Zoelene, both recordings capture her swearing at the police officers and refusing to provide any of the details they requested.[12]

24. Zoelene Beasley then threw the vodka cruiser bottle which landed on the bitumen road and smashed. Her evidence was that she did not intend to hit either police officer with the bottle.[13] Although he was not hit by the bottle, Constable Lynch thought that it was thrown in his general direction.[14] It was accepted by Constable Lynch at the inquest that it was possible the bottle was not thrown in any particular direction, but was simply an act of aggression on Zoelene's part.[15]

25. The officers perceived that the bottle was directed at Constable Lynch and this resulted in them proceeding to arrest Zoelene. Zoelene was initially placed in a 'come-along' hold by the officers, which was described by Constable Salau as controlling the arm and, therefore, the rest of the body by placing one hand just above the elbow and another hand on the wrist.

26. Constable Salau said that Zoelene Beasley was half on the ground and had tried to make herself "dead weight" by lifting her feet off the ground. He said he then transitioned to a hammer lock position, "*which is where her arm's behind her back, and then we assisted in walking her towards the police vehicle*".[16]

27. The officers had planned to secure Zoelene Beasley in the police vehicle.[17] I heard evidence from a number of witnesses about the way Zoelene was escorted to the police vehicle.[18] Consistent with the evidence of both police officers and Carla McGilvary, and from what can be seen on the body worn camera footage, I am satisfied that she was not dragged to the police vehicle.

[10] T2, 33, from line 29.
[11] T1, 20, from line 6.
[12] Exhibits E8.1 and B10 (BWC); Exhibit E12.1 (Digital recording).
[13] T1, 22, from line 10.
[14] T2, 36, from line 28.
[15] T2, 37, from line 1.
[16] T2, 59, from line 7.
[17] T2, 37, from line 21.
[18] T1, 29, from line 43; 42 from line 39.

28. As Zoelene was being escorted to the police vehicle, a number of other persons approached the police, including Mr Banjo. Constable Lynch recalled that Mr Banjo was becoming increasingly upset. His evidence on this point was as follows:

> ---He – I – I was only periodically looking but he – he was following – following us across the road and obviously didn't like that we were arresting – I believe it's his – his daughter – and he was – he was starting to escalate his behaviour. His – his voice was obviously getting louder and more aggressive. He was – I – I think he may have been concerned that we were being a bit rough on her and we were – as we were walking, more – more Constable Salau than myself, he's providing him as much information as he can about, you know, what we're doing and why we're doing it to try and help the situation. Normally, people – people get upset with what we're doing and we – we – we explain to them and so it makes more sense, so they can understand.[19]

29. The audio recording captured the following conversations taking place at this point. During this time Zoelene is audibly distressed, repeatedly yelling 'Leave me alone' and 'don't hurt me'.

> 01:35- Neil BANJO states, "Hey young officer, don't rough handle her".
> 01:37- Neil BANJO stating, "Don't hurt her, don't hurt her."
> 01:40 Zoelene BEASLEY crying, "Leave me alone. Leave me"
> 01:41- Neil BANJO states, "Don't rough handle her."
> 01:42- Constable SALAU states, "We won't hurt her."
> 01:43- Neil BANJO states, "Whoa, whoa, whoa don't push me."
> 01:43- Constable SALAU states, "I will push you and you'll end up getting arrested for obstruct as well. Give us some space and we will treat her accordingly OK.
> 01:50-Neil BANJO states, "Well don't rough handle her."
> 01:51- Constable SALAU states, "We are not rough handling her."
> 01:52- Another female voice continues screaming loudly at this time.
> 01:53- Constable SALAU states, "You'll end up under arrest as well."
> 01:56- Female voice "I'm not under arrest. I'm just telling youse, you got no right to rough fucken handle her."
> 01:59- Constable SALAU states, "We are not rough handling, we're taking her into custody.
> 02:02- Multiple persons heard screaming with Constable SALAU stating, "She threw a bottle at this officer."[20]

[19] T2, 37, from line 46.
[20] Exhibit E12.1; Exhibit A4, 16.

30. Constable Lynch described in his evidence how Mr Banjo became more aggressive:

> ---He was to my right and behind, so on – as you can kind of see there, I'm sort of in line with the rear of the vehicle. I suppose we're on a bit of an angle as – as we're trying to get to that door. So that's myself and Zoelene, Constable Salau, and then, I think, Mr Banjo was sort of on – on Tim's right shoulder. So, as I said, he's – he's been following us across the road the whole time and he's gradually building in his – his response to us and - - -
>
> When you say "gradually building", what do you mean?---His – his – his voice is getting louder. His demeanour is getting much more – much more aggressive. He's not – he's not really taking anything on board unfortunately. The – the advice that we're giving him. I think there was a number of times there where we – we ask him to stand back because he's kind of get – getting to that point where we start to become concerned about our personal safety, when someone's right up in our – in our face or in very close proximity to us.[21]

31. The evidence about what happened in the lead up to Mr Banjo falling backwards onto the roadway was derived from various sources.[22] Heather Beasley accepted during her evidence that her father was speaking to the officers in an aggressive manner.[23]

32. It was apparent from the evidence that there was initial contact between Constable Salau and Mr Banjo before the final push by Constable Salau that led to Mr Banjo's fall. Constable Lynch said that he saw Mr Banjo place his hand on Constable Salau. Constable Salau responded by placing his hand on Mr Banjo's chest,[24]or pushing him away.[25] Constable Salau's evidence was that his initial push took place after Mr Banjo placed his hand on his chest. The body worn camera footage depicts Mr Banjo at one stage shouting *"Whoa, whoa, whoa don't push me"*, consistent with the digital recording, and Constable Lynch stating repeatedly *"step back"* and *"back away, back away."*[26]

33. The digital recording then captured the followed conversations taking place:

> 02:04- Neil BANJO is heard yelling, "I seen the cunt."
> 02:07- Movement sounds followed by screaming
> 02:07- Constable SALAU stating, "Give us some space"
> 02:08- Constable SALAU states, "Get away."

[21] T2, 38, from line 26.
[22] T2, 39, from line 10 (Officer Lynch);
[23] T1, 31, from line 26.
[24] T2, 61, from line 26.
[25] T1, 16, from line 43.
[26] Exhibit B13, 3-4.

02:10- Constable SALAU states, "Put her in the back of the car we'll get QAS on this guy."[27]

34. With respect to the above extract of the digital recording at the timestamp 02:04, Constable Salau's evidence at the inquest, was that he heard Mr Banjo state *"I saw you, cunt."*[28] It was possible that Mr Banjo was referring to his perception that his daughter was being *"rough handled"* by the police when he made that remark. However, I consider that it is equally plausible that he was referring to the bottle that was thrown by Zoelene when he said "*I seen the cunt*" in response to Constable Salau. While standing on the footpath earlier, he told officers that he had purchased the carton of vodka by stating "*I bought the cunt, why should I put it down*".

35. Constable Salau's evidence was that at the time Mr Banjo said *"I seen the cunt"*, there was *"a distinct, simultaneous rise in voice and in [Mr Banjo's] posture with his fist rising and getting into a position"*[29].

36. The only evidence of Mr Banjo's hand forming a fist was from Constable Salau.[30] Heather Beasley described in her evidence that he *"only pointed"*[31], and other witnesses described how he was in fact waving his hands at the police with open palms.[32]

37. Constable Salau demonstrated in his re-enactment how Mr Banjo held his right fist up by his right ear.[33] He rejected the possibility that Mr Banjo in fact had both hands in the air, or that his hands were open.[34] He described in his evidence how Mr Banjo was *"just closer than my full arm's extension."*[35] Mr Banjo might have been saying something, but to Constable Salau it sounded like a growl.[36]

38. Constable Salau said he consequently decided to perform the *"crouch dive technique"* on Mr Banjo in order to *"gain time and space".*[37] Constable Salau perceived that if he did not use this technique, *"the inevitable result would be that I'd be punched in the face."*[38] The evidence of neighbour, James McGilvary, corroborated this to some extent, as he told the inquest *"…I could understand, like, if the police officer did feel threatened."*[39]

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[27] Exhibit E12.1; Exhibit A4, 16.
[28] T2, 62, from line 8.
[29] T2, 62, from line 38.
[30] Ibid.
[31] T1, 36, from line 24.
[32] T1, 44, from line 38; 64 from line 36; 68 from line 24.
[33] Exhibit E16; T2, 62, from line 6.
[34] T2, 63, from line 9.
[35] T2, 62, from line 45.
[36] T2, 63, at line 16.
[37] T2, 63, from line 3.
[38] T2, 63, from line 6.
[39] T1, 65, from line 14.

39. I consider that Constable Salau was a credible witness. However, I am not able to conclude that Mr Banjo had drawn his right hand back into a fist. I do accept that he was presenting in an agitated manner in very close proximity to Constable Salau, with his hands moving erratically. The body worn camera footage shows him moving towards Constable Salau just prior to the push. I accept that these factors were perceived by Constable Salau to constitute a threat to his personal safety.

40. I was taken to Constable Salau's re-enactment of the crouch dive technique during his evidence.[40] He said that he put his full bodyweight into it.[41] After seeing Constable Salau perform the crouch dive that night, Constable Lynch's evidence was *"it was certainly a solid – solid push."*[42]

41. The crouch dive caused Mr Banjo to fall backwards to the ground. His head struck the bitumen with force. Constable Salau's evidence was that he was looking down as he executed the crouch dive. He looked up in time to see Mr Banjo's torso strike the ground before his head.[43] James McGilvary's evidence was that the fall caused Mr Banjo's legs to raise in the air in a somersault fashion.[44] Constable Salau could not recall if Mr Banjo's legs raised in the air at any stage, [45] and no other witness gave any evidence of this.

42. Constable Salau elaborated during his evidence on the threat assessment he conducted from when he arrived at Sutherland Street. His evidence in this respect was as follows:

> ---So my initial assessment on the way was that it would be – it would be a fairly benign sort of occurrence. On getting to the job, I reasoned that I saw a person who was intoxicated and emotional. So I thought there may have been an offence, or at least some requirement to start recording at that point, because we'd have to take further action. I then reacted instantaneously, when the bottle was thrown. I then conducted another risk assessment once we actually had Zoelene physically in our grips, but were walking over to the police vehicle, in that I was aware there was people behind us and wanted to make sure that we didn't place Zoelene on the ground, because it would likely cause an incident, which we'd be outnumbered by. And then I recall, when we actually got to the back of the vehicle, and looking at the deceased, who was larger than me, and the fact that there was other people there as well; I recall two to three others. Obviously, they were quite aggressive, and I was – to be honest, I was scared.

[40] Exhibit E16; T2, 63 from line 1.
[41] T2, 63 from line 24.
[42] T2, 40, from line 10.
[43] T2, 63, from line 30.
[44] T1, 68, from line 3.
[45] T2, 63, from line 41.

> What were you scared about?---That there was someone who is struggling with one hand, and I was having trouble holding on to her, while simultaneously, I had someone who was bigger than me demanding I release her, and two to three other people who were also aggressive, as well as the people at Sutherland Street, at the actual residence, who were coming to the gate to watch. I'd attended incidents before, and knew that it was – it would quite likely get out of hand.[46]

43. Constable Salau was asked in his evidence whether he considered using any options apart from physical force. He recalled going through the process of considering his accoutrements. He briefly considered capsicum spray, and thought that was not suitable to use given the group of persons present, and would also have exposed he and Zoelene to secondary exposure. He said that Taser was not appropriate and he did not like to use closed-hand techniques unless he had no other option. He said that the crouch dive technique was in the first three things taught about officer safety in the police academy. It was something he remembered specifically for the purpose of gaining space and time, while he considered other options.[47]

44. I heard evidence from witnesses about the quality of lighting on the street; where the police car was situated; where the bottle thrown by Zoelene Beasley landed; whether or not Zoelene Beasley had consumed any of the vodka cruiser; the movement of Mr Banjo once he was pushed; and the response of officers Salau and Lynch after Mr Banjo fell to the ground. It is not necessary for me to arrive at a conclusion in relation to each of those matters. I accept Miss Cooper's submission that those were peripheral issues and that the primary issue was the appropriateness of the use of force applied to Mr Banjo which caused him to fall to the ground.

45. The police officers called the Queensland Ambulance Service (QAS) at 7:35pm, and the ambulance arrived at 7:41pm.[48] It was noted by paramedics that Mr Banjo had a Glasgow Coma Score of 8/15, sluggish pupils, and was unresponsive to painful stimuli. However, he made some movement of his hand when asked to squeeze.[49]

46. Mr Banjo was initially taken to the Normanton Hospital, and was then transferred via the Royal Flying Doctor Service (RFDS) to the Townsville Hospital (TTH) Intensive Care Unit. While at Normanton Hospital, Mr Banjo was intubated after 4-5 hours. The discharge summary from Normanton Hospital to TTH on 26 February 2016 notes the principal diagnosis as severe traumatic brain injury.[50] A CT scan conducted on 29

[46] T2, 65, from line 2.
[47] T2, 65, from line 28.
[48] Exhibit F1.
[49] Ibid.
[50] Exhibit F2, from 16.

April 2016 showed a stable subdural haemorrhage, and no new concerns were noted.[51]

47. Mr Banjo remained at TTH until 9 May 2016, when he was transferred to Cairns Hospital. The discharge summary for the transfer to Cairns noted that he was clinically stable. It also noted that he was bed bound without any option of rehabilitation, he was not able to communicate, and needed full nursing care.[52] He was awaiting appropriate placement at a nursing home.

48. A bed became available at the Mercy Place Nursing Home at Woree, and Mr Banjo was transferred there on the afternoon of 17 January 2017. I received statements from those persons involved in Mr Banjo's care and these were tendered at the inquest.[53] Mr Banjo had been transferred to the nursing home in a medically stable condition.[54] There were no concerns about his presentation.[55] Arrangements were made for him to see a General Practitioner the following morning, as was the usual practice with new admissions.

49. On the morning of 18 January 2017, registered nurse Amanda Rastall was rostered to care for Mr Banjo. She recalled that she received a handover from registered nurse Lynn Dunn.[56] She read the discharge summary from Cairns Hospital, and commenced her medications round as Mr Banjo still had about an hour before his PEG feeding finished. After completing the medication round, at about 9:00am, she attended Mr Banjo's room and saw two nurses present, who were about to wash him. The nurses informed RN Rastall that Mr Banjo was *"breathing funny"*, and asked if she would assess him.[57]

50. RN Rastall observed that Mr Banjo was flushed and slightly yellow in colour. He was febrile, and there was no apical or radial pulse for more than 30 seconds. His pupils were dilated and fixed and non-reactive to light. RN Rastall noticed that Mr Banjo had stopped breathing, and was unresponsive to painful stimuli. RN Rastall subsequently declared Mr Banjo deceased.[58]

[51] Exhibit F3, 128.
[52] Exhibit F2.1.
[53] Exhibits G1 – G4.
[54] Exhibit G1, paragraph 15.
[55] Exhibit G1, paragraph 21; Exhibit G2, paragraphs 21-22; Exhibit G3, paragraphs 21-24.
[56] Exhibit G5, paragraph 6.
[57] Exhibit G5, paragraph 11.
[58] Exhibit G5, paragraph 12.

Autopsy results

51. A full internal autopsy examination, with associated toxicology testing, was conducted by experienced forensic pathologist, Dr Paull Botterill, on 19 January 2017. Dr Botterill's report was tendered at the inquest,[59] and he gave oral evidence.

52. Internal examination showed:

- changes in keeping with severe past head injury;
- an excess of fluid in the lungs with probable infection involving the lungs;
- discolouration of the kidneys suggestive of kidney infection;
- enlargement of the prostate and bladder;
- severe hardening and narrowing of the arteries of the heart and rest of the body;
- honeycomb-like scarring within the lung tissues; and
- gallstones.

53. Dr Botterill's evidence was that at the time of performing the autopsy, the cause of death was not completely clear. The possibilities considered included overwhelming infection complicating kidney and/or lung disease, a functional compromise of the tracheostomy airway, a seizure disorder, a cardiac arrhythmia complicating coronary artery disease or mixed drug toxicity. Given the possibilities, further investigations were performed by way of microscopic examination.

54. Microscopic examination showed heart muscle scarring, lung congestion and infection, some liver inflammation and scarring as well as changes in the kidneys suggestive of diabetes. Microscopic examination of the brain confirmed changes in keeping with old traumatic injury.

55. Toxicology testing showed the presence of an anticonvulsant and medication to lower blood pressure. The anticonvulsant was detected at a level below at least one reported therapeutic range, and thus raised the possibility of an associated seizure as the mechanism of death.

56. Dr Botterill's evidence was that despite the microscopic testing, the cause of death remained difficult to clarify. He remained confident that it was most likely that the death was the consequence of the past brain injury. However, the mechanism of death could have been either a seizure, consequences of sepsis (following aspiration), or an arrhythmia complicating coronary artery disease.

[59] Exhibit A2.

57. His evidence was that it was not always easy to identify an unequivocal cause of death. In this instance, there were at least two conditions which had the potential to result in death. The first was the consequences of a traumatic brain injury, and those consequences were related to the possibility of seizures or convulsions or developing infections. The other reasonable possibility was an irregularity of the heart rhythm associated with hardening and narrowing of the arteries - coronary artery atheroma.[60]

58. Dr Botterill's evidence was that it was possible that the arrhythmia complicating coronary artery disease could have occurred without the presence of the past brain injury. He said that if there were no brain injury or changes related to that present, he would not have hesitated to give that as the cause of death. However, there was evidence of infection within the lung, infection within the windpipe branches, and previous placement of a feeding tube, which is associated with an increased risk of aspiration. Those changes raised the likelihood that the underlying brain injury was the more likely cause of death. However, Dr Botterill was not able to say with certainty that the death could not have been from an arrhythmia from the coronary artery disease.[61]

59. Although Dr Botterill's post-mortem report determined the formal cause of death to be as a direct result of the traumatic brain injury, with coronary atheroma listed as a significant condition contributing to the death, it was clear that he could not exclude that it was a reasonable possibility that the coronary atheroma occurred independent of the brain injury.

Investigation findings

60. As previously noted, the circumstances leading to Mr Banjo's head injury being sustained were initially investigated by the QPS Child Protection Investigation Unit at Mount Isa. This investigation was led by Detective Senior Sergeant Michelle Clark who provided a report detailing the findings of the investigation.[62] Detective Senior Sergeant Clark also gave evidence at the inquest.[63] Detective Inspector Hytch's overview report did not alter or add to any of the conclusions reached by Detective Senior Sergeant Clark.[64]

61. The police investigation was informed by recorded interviews with persons who were in attendance at 44 Sutherland Street Normanton in the lead up to Mr Banjo sustaining his head injury. Interviews were also conducted with other police officers who were involved in the aftermath of the incident. The various recordings of the incident, as already referred to in these findings, were seized. A statement was obtained from the receiving doctor at Townsville Hospital about the nature of the injuries sustained.[65]

[60] T2, 68 from line 45.
[61] T2, 69 from line 16.
[62] Exhibit A4.
[63] T2, 2 from line 13.
[64] Exhibit A5.
[65] Exhibit B11.

62. Disciplinary interviews were conducted with Constables Salau and Lynch.[66] Both officers were directed to answer questions pursuant to section 4.9 of the *Police Service Administration Act (PSAA) 1990*. This direction abrogates the privilege against self-incrimination and a re-enactment was conducted with Constable Salau which was video recorded.[67]

63. Detective Senior Sergeant Clark gave evidence of the contributing factors, as she saw them, which resulted in Mr Banjo sustaining his head injury. Her evidence was that Normanton was an isolated community which only had one police crew comprised of two junior constables on duty at the relevant time. She said that when the officers attended at 44 Sutherland Street, there were around 20 persons at that address. There was a significant amount of alcohol consumed during the afternoon and into the evening.

64. Detective Senior Sergeant Clark said that Zoelene Beasley's reaction to the police attendance, which saw a bottle being smashed on the roadway, had escalated the incident. She said that this was an incident that would initially be assessed as "unknown" risk. When the bottle was thrown near a police officer, it escalated to a high risk situation.[68]

65. Detective Senior Sergeant Clark ultimately concluded that the actions of Constable Salau were appropriate in all of the circumstances. She considered that the option of tactical withdrawal was limited for the officers, given their position on the road and the number of persons starting to enclose them in that situation.[69]

66. Detective Senior Sergeant Clark explained the factors she took into account in concluding that the police actions on the night were appropriate. She said that her investigation was required to determine whether the actions of the officers were lawful from both a criminal and disciplinary perspective. The situational use of force model requires police to consider a number of options. The options are not escalating and the assessment is continuing and fluid. The minimal uses of force are presence and communication. The level increases to open hand tactics, closed hand tactics and then other accoutrements such as capsicum spray, Tasers and the firearm.

67. Detective Senior Sergeant Clark said Constables Salau and Lynch were endeavouring to arrest Zoelene Beasley. They had a tense situation and people were screaming at them to "*Stop rough handling her*." The officers told those present to step back, but that communication was not assisting the situation. She said that Constable Salau found himself in a situation where a person was coming towards him and he used *"the least amount of force, as far as the dive crouch technique, which is an open handed*

[66] Exhibit E8 (Salau); Exhibit E12 (Lynch).
[67] Exhibit E16.
[68] T2, 11 from line 9.
[69] T2, 12 from line 11.

push, in that situation". She concluded, after looking at the elements, that Constable Salau had to try and defend himself, and that his actions were appropriate.[70]

APPROPRIATENESS OF THE USE OF FORCE APPLIED

68. At the inquest I heard evidence on this issue from Senior Sergeant Damien Hayden, Officer in Charge of the QPS Operational Skills Training Unit (OSTU). As part of the investigation conducted by the ESC, Senior Sergeant Hayden conducted a review of the body-worn camera footage, the re-enactment video involving Constable Salau, and the digital recording of Constable Salau, and provided an opinion in the form of a statement as to the appropriateness of the use of force applied on the night of 25 February 2016.

69. During his evidence at the inquest, Senior Sergeant Hayden explained how police officers are trained in use of force techniques and the conduct of threat assessments. He said that officers are instructed that situations they encounter are high risk or unknown risk. Officers are given a decision-making tool, which is known as the "POP" process. Officers make an assessment of the person they are dealing with; any object or anything that can be used as a weapon; and their environment. The threat assessment should guide officers in making decisions that are both tactically sound to resolve the incident as well as organisationally sound.

70. Senior Sergeant Hayden confirmed that the conduct of threat assessments is a subjective process, based on an officer's perception of the situation at the time. He explained that the QPS does not mandate any particular response to a particular situation. Ultimately use of force is a decision that every officer is accountable for on an individual basis.

71. The technique used by Constable Salau was described by him to the ESC, and in his evidence to the inquest, as the *"crouch dive technique"*. Senior Sergeant Hayden provided a description of this particular technique during his evidence, as an open hand tactic that is contained in the situational use of force policy. He said that it was a technique used to create space. It can be delivered with a degree of force, where it is almost like an open hand strike.

72. Senior Sergeant Hayden explained that the technique is usually applied in close quarters and high risk situations where officers may be at risk of being assaulted. It is a technique applied dynamically and with the forceful application of body weight.

[70] T2, 11 from line 27.

73. When asked what consideration is given to the characteristics of the person the force is being applied to, particularly whether the person might be affected by alcohol or drugs, Senior Sergeant Hayden's evidence was that in the general risk assessment officers perform, if someone is alcohol affected, they may be more unsteady on their feet, and may be more prone to falling over. Officers are instructed to assess risk on a case-by-case basis and *"obviously, that may not be the appropriate technique or tactic to apply for that person"*. Senior Sergeant Hayden accepted the proposition that while the issue of alcohol is relevant to the selection of any use of force, it is also relevant to the actual threat assessment being made by the officer. He also accepted as a general proposition, that it was often the case that persons affected by alcohol are more prone to commit acts of violence, than if they were not affected by alcohol.

74. Senior Sergeant Hayden's evidence was that the initial decision made by Constable Salau to apply force to Mr Banjo was justified. The application of force to Mr Banjo was a reasonable and proportionate response to his actions of obstructing Constable Salau and pushing his chest. Further, the tactic used by Constable Salau was delivered in accordance with QPS training doctrine, in circumstances where the only option was to forcefully move Mr Banjo away from the rear of the vehicle, and to make space.

75. Senior Sergeant Hayden had reviewed the video evidence and considered that Mr Banjo unnecessarily inserted himself into the arrest and was obstructing the officers, and at one stage laid hands on Constable Salau. He considered the actions of Constable Salau in the dynamic nature of the circumstances in attempting to place a resisting or a difficult person in the back of the van. He said that it was a reasonable action on his part to attempt *"to make space and to free himself from Mr Banjo's interference".* He did not see anything on the video that was excessive. Constable Salau applied the technique in accordance with the QPS instructions.

76. Senior Sergeant Hayden said that if the QPS did not want officers to use that type of technique or thought that the technique was excessively risky and produced systemic injuries, it would not continue to instruct that as an organisation. He thought that the technique was applied appropriately and the circumstances were sound. He thought it was the correct technique or tactic at that time.

77. Senior Sergeant Hayden's evidence was that the officers had made a very reasonable, genuine attempt to try and calm the situation down, or at least that intention was communicated to the persons involved. He considered all of the other use of force options available to the police officers that were not used due to their inherent risks to the persons involved (i.e. Taser, OC spray, baton, other physical tactics).

78. Overall, Senior Sergeant Hayden considered there was no breach of QPS policy by either of the officers. He described the incident as "*a very difficult policing situation to be involved in, with multiple persons, operating in low light and not having immediate back-up and other police to assist. It was a very challenging situation to be involved in.*"

79. Senior Sergeant Hayden's evidence was of considerable assistance to the inquest. His conclusions were consistent with those put forward by Detective Senior Sergeant Clark. After having regard to the opinions of Senior Sergeant Hayden and Detective Senior Sergeant Clark, I accept that the use of force applied to Mr Banjo on the night of 25 February 2016 was appropriate and in accordance with QPS policy.

80. In reaching this conclusion I have also had regard to the fact that Mr Banjo was much larger man than Constable Salau and was affected by alcohol. He was upset at the level of force that he perceived was being used in the arrest of his daughter. The QPS officers were attempting to take Zoelene into custody by placing her in the rear of the police vehicle. Mr Banjo and others approached the police vehicle with raised voices and yelling. Mr Banjo moved into a position where Constable Salau was within arm's length and failed to move away despite a number of requests.

INDEPENDENT MEDICAL REVIEW

81. I was assisted by court-appointed expert, Dr Mark Little who is a employed as a Senior Staff Specialist at the Cairns Hospital. He was briefed after the oral evidence, to provide an expert opinion on the following matters:

- With respect to the emergency response – whether it was appropriate that it took 4-5 hours for Mr Banjo to be intubated and if he had been intubated earlier, whether that might have made a difference to the end diagnosis;
- With respect to the note in the clinical records which essentially indicates that it took multiple attempts to contact the neurosurgical registrar, all of which were unsuccessful, whether earlier intervention would have made a difference in the case given the nature of the injury sustained; and
- With respect to the events ongoing from the Cairns Base Hospital, whether there was any issue in terms of the adequacy of the placement of Mr Banjo at Mercy Place, and further whether Mercy Place were caring for Mr Banjo in accordance with the allied health care plan that was in place.

82. Dr Little confirmed that Mr Banjo arrived at the Normanton Hospital by QAS at 8:05pm on the night of the incident. The on call medical officer was called three minutes later. In Dr Little's opinion, appropriate nursing care and observations were performed during this stage, with regular nursing observations conducted throughout Mr Banjo's stay in Normanton Hospital.

83. While at Normanton Hospital, Mr Banjo was found to have a reduced level of consciousness (Glasgow Coma Score (GCS) of 8/15), and he was intermittently combative with an 8cm contusion on the back of his head. He was moving all limbs.

84. Dr Little concluded that appropriate treatment and investigations were commenced. While awaiting the arrival of the RFDS, Mr Banjo was reassessed by Dr Amy Neilson, and regular observations performed by the nursing staff. By 8:10pm, the RFDS Aeromedical Transfer Record showed the RFDS had been contacted and activated to fly to Normanton and transfer Mr Banjo to TTH.

85. The RFDS team arrived at 12:30am on 26 February 2016. In discussion with the Clinical Coordinator at Retrieval Services Queensland, Mr Banjo was intubated at approximately 1:30am. Following intubation, Mr Banjo's ECG showed wide spread ST depression. Dr Little noted that while this is usually seen with myocardial ischaemia, these changes are also seen in head injuries and that was the cause in Mr Banjo's case.

86. Mr Banjo arrived at TTH Emergency Department at 4:45am on 26 February 2016. A CT scan of Mr Banjo's brain and subsequent neurosurgery revealed a severe brain injury. The CT findings, as summarised in the ICU notes dated 26 February 2016, showed "terrible injuries", as follows:

    a) Extensive intra and extra axial haemorrhage throughout both cerebral hemispheres.
    b) Haemorrhagic contusions at the junction of the grey and white matter in the left frontal gyri raise the suspicion of diffuse axonal injury.
    c) Subfalcine herniation with 9mm of midline shift from left to right and left downward transtentorial herniation.
    d) Minimally displaced longitudinal fracture involving the parietal and left frontal bones.

87. Dr Little's evidence was that while in a major trauma centre or major emergency department the standard of care would be to intubate a patient with Mr Banjo's presentation earlier, he was not critical of the delay in the Normanton Hospital. He explained in his evidence that Normanton is a *"remote small hospital, with limited staff and possibly a limited mix of skill and back up."* In the circumstances, Dr Little's opinion was that it was reasonable to observe Mr Banjo closely, with early activation of the RFDS, which is what occurred here.

88. Due to the severe nature of the injuries, Dr Little's opinion was he did not believe the delay in intubating Mr Banjo significantly affected the overall outcome. He thought that Mr Banjo was appropriately managed and observed in a very remote small rural hospital with limited resources.

89. With respect to the attempts to contact the neurosurgical registrar on the night of the incident, Dr Little found these references in the Emergency Department and Intensive Care Unit notes of TTH. In Dr Little's opinion, any delays in contacting the consultant neurosurgeon did not make a difference to the overall outcome, given the nature of the injuries Mr Banjo had sustained.

90. With respect to the events following Mr Banjo's admission to Cairns Hospital, Dr Little confirmed that Mr Banjo was transferred to Cairns Hospital via RFDS on 9 May 2016. At this stage he had a GCS between 6-9/15, had a PEG tube inserted in his stomach to feed him, and had a tracheostomy tube in place to assist with his breathing.

91. By 18 May 2016, Mr Banjo had been assessed as not suitable for rehabilitation and requiring placement at a high-level care facility. He was unable to communicate, feed himself, move himself or complete activities of daily living. In Dr Little's opinion, it was appropriate for Mr Banjo to be placed at Mercy Place. He was transferred there on 17 January 2017 at approximately 4:15pm.

92. On review of each of the relevant records and the statements provided by Mercy Place staff, Dr Little concluded that Mr Banjo suffered a sudden event that resulted in his death. He noted that Mr Banjo's observations prior to leaving Cairns Hospital for Mercy Place did not suggest he had a significant chest infection.

93. While Dr Little agreed with the differential diagnosis provided by Dr Botterill, he suspected Mr Banjo suffered a sudden cardiac event and wondered whether there was an element of pulmonary oedema, as explained by Dr Botterill's findings in the autopsy report. He did not believe that staff at Mercy Place could have done anything to prevent the death. He considered that if Mr Banjo had still been at Cairns Hospital, the outcome would have been the same.

94. I accept the expert medical evidence from Dr Little that the medical care provided to Mr Banjo from the time his head injury was sustained to the his transfer to Mercy Place, was adequate and appropriate in all of the circumstances. Based on the severity of Mr Banjo's pre-existing injuries, his death could not have reasonably been prevented by the staff at Mercy Place.

Findings required by s. 45

95. 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 – Neil Richard Banjo

How he died - On 25 February 2016, police officers were called to a disturbance at 44 Sutherland Street, Normanton, involving Mr Banjo's daughter, Zoelene Beasley. Mr Banjo was intoxicated when police arrived. Ms Beasley was sitting on the footpath. She was agitated and refused to answer questions asked by police. She subsequently threw a vodka cruiser bottle which smashed on the road surface. This action was perceived by the police officers to be an act of aggression towards them, and they subsequently arrested Ms Beasley for public nuisance. After the police officers moved to arrest Ms Beasley and were attempting to place her in the police vehicle, Mr Banjo approached the officers on the road. Mr Banjo was presenting in a manner Constable Salau perceived as aggressive in terms of his physical and verbal behaviour. This caused Constable Salau to be concerned for his personal safety. In order to gain time and space, Constable Salau performed a "crouch dive" in which he forcefully pushed both of his hands forward onto Mr Banjo's chest. As a result of being pushed, Mr Banjo fell to the ground and struck his head, sustaining a traumatic brain injury. Mr Banjo was transferred to the Normanton Hospital and then the Townville Hospital for treatment. He was subsequently transferred to the Cairns Hospital in May 2016. He was discharged to nursing home care on 17 January 2017, and died the following day.

Place of death – Woree in Queensland.

Date of death – 18 January 2017.

Cause of death – The most likely cause of Mr Banjo's death was traumatic brain injury. It is also possible that he

died from coronary artery atheroma unrelated to the brain injury.

SECTION 48 (2) REFERRAL

96. Section 48(2) of the Act provides that if, from information obtained while investigating a death, a Coroner reasonably suspects a person has committed an indictable offence the Coroner must give the information to the Director of Public Prosecutions (DPP). A reference to information in s 48 does not include information that would tend to incriminate a witness that is compelled under s 39(2). In this matter that was the evidence of Constable Salau.

97. As the evidence during the course of the inquest supported the conclusion that the use of force applied by Constable Salau was appropriate and justified in all of the circumstances, there will not be a referral to the DPP in this matter.

COMMENTS AND RECOMMENDATIONS

98. Section 46 of the *Coroners Act 2003* empowers a coroner to comment on matters connected with a death relating to:

    (a) public health and safety;
    (b) the administration of justice; or
    (c) ways to prevent deaths from happening in similar circumstances in the future.

99. I consider that Mr Banjo's level of intoxication affected his ability to protect himself by breaking his fall when he was suddenly pushed over. Senior Sergeant Hayden's evidence was that specific vulnerabilities of the person subject to police use of force should form part of the general risk assessment performed by an officer. I accept that the crouch dive manoeuvre is an effective technique to create space and time, and that it lies towards the lower end of the range of use of force options available to police. I also accept that police officers are required to make rapid decisions about use of force options. However, officers should be required to have regard to the specific risk of significant head injury to someone who is intoxicated and suddenly knocked off their feet on a hard surface.

100. This inquest did not consider wider evidence about policing in remote communities. However, as Detective Senior Sergeant Clark's report noted this incident involved two junior constables, with less than 3 years service. The constables were working in a remote community where 61% of the population identify as Indigenous.[71]

101. The constables were called by a family member to attend an alleged nuisance incident involving a very young woman which arose at a private

[71] https://statistics.qgso.qld.gov.au/datsip/profiles

birthday gathering, where a large number of persons were affected by alcohol.

102. With the benefit of hindsight, it is possible that Mr Banjo's death could have been avoided if the attending constables had considered options apart from arresting Zoelene Beasley on 25 February 2016. When they arrived she was sitting alone on the footpath, as directed by her mother, but with a quantity of alcohol. While it was not clear that she was drinking in a public place, she was drunk, swore at the police and threw a bottle in their general direction. The officers then arrested Zoelene[72] for public nuisance and the situation escalated rapidly as family members tried to intervene, alleging that she was being *"rough handled"*.[73]

103. While I did not hear any evidence on the diversionary options available to police in Normanton it is possible that a Community Justice Group member, or an Indigenous police liaison officer, might have assisted the officers in the resolution of the original complaint, which was essentially a dispute between family members.

104. It is also possible that the situation might not have escalated if officers elected to discontinue the arrest of Zoelene when it became apparent that they were being confronted by angry family members concerned for her wellbeing. A notice to appear or an on the spot fine might have been issued as alternatives to arrest.

105. In 1991, the Report of the Royal Commission into Aboriginal Deaths in Custody identified that Indigenous Australians are grossly over-represented in custody. In the 28 years since 1991, many reports have been written, strategies developed and Justice Agreements entered into in an effort to address the issues relating to the overrepresentation of Indigenous people in custody.[74] Despite these efforts, the rate of overrepresentation has increased. The rate of imprisonment for Indigenous Queenslanders is 11.6 times higher than for non-Indigenous people.[75]

106. Relevant to the circumstances of Mr Banjo's death, the Queensland Productivity Commission's Report on its Inquiry into Imprisonment and Recidivism presents the Government with another opportunity to consider the drivers of Indigenous overrepresentation, including issues associated with the exercise of police discretion, diversionary options for minor offences and whether public nuisance offences should be redefined.

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[72] T2, 78, line 1 Constable Salau said "The offence for which I arrested her was public nuisance and in my mind she was disorderly in a public place."
[73] On 20 June 2016, Ms Beasley was fined over $900 for the offences of contravening a police direction, obstruct police and public nuisance.
[74] For example, *Pathways to Justice—Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2017)
[75] Queensland Productivity Commission, Draft Report, *Inquiry into Imprisonment and Recidivism,* p 32

107. The Commission's draft report noted the key to addressing these issues in remote Indigenous communities is to enable communities to develop solutions for themselves.

Recommendation

I recommend that the Queensland Police Service include the circumstances of Mr Banjo's death in its use of force and cultural competency training materials and amend relevant operational policies to:

- *Ensure officers have specific awareness of the risk of significant head injury to vulnerable persons who are pushed and fall as a result of the "crouch dive manoeuvre"; and*
- *Encourage greater use of police discretion and alternatives to arrest in responding to public nuisance and other low level offences.*

108. I close the inquest.

Terry Ryan
State Coroner
2 October 2019