Part 2:

The Palm Island death in custody

4

BACKGROUND TO THE INITIAL QPS INVESTIGATION: REQUIREMENTS FOR INVESTIGATIONS INTO DEATHS IN CUSTODY

When Mulrunji died in police custody, there were QPS ethical obligations and procedures in place and two sets of external guidelines that could and should have governed the actions of the police officers involved in the investigation:

- the QPS Operational Procedures Manual (OPM)[27] and the QPS Code of Conduct
- the 1991 RCIADIC recommendations which the Queensland Government and QPS said that they had implemented[28] and
- the State Coroner's Guidelines.

In principle, the intention of all is to achieve a thorough and impartial investigation.

We will look first at the external guidelines and then at the provisions of the OPM and the Code of Conduct, with which the officers should have been familiar.

State Coroner's Guidelines

Section 14(1)(b) of the *Coroners Act 2003* provides that the State Coroner must issue guidelines to all coroners about the performance of their functions in relation to investigations generally and, pursuant to section 14(3)(a), the guidelines must deal with the investigation of deaths in custody. Although the guidelines apply strictly to coroners, as the police are obliged to help the coroner, the coroner could in a particular investigation apply any part of those guidelines to a police officer as a reasonable and lawful request or direction under section 794(2) of the *Police Powers and Responsibilities Act 2000*.

QPS procedures for responding to deaths in custody: the OPM

From the time of the discovery of Mulrunji's death, the provisions of the OPM concerning the requirements for a police investigation of a death in custody immediately applied.

In the introduction to the OPM (July 2004) the Police Commissioner stated:

> The Operational Procedures Manual is issued pursuant to the provisions of section 4.9 of the *Police Service Administration Act 1990*. The aim of the manual is to provide guidance and instructions in all aspects of operational policing. *To this end, members are to comply with the contents of the manual so that their duties are discharged lawfully, ethically and efficiently. Failure to comply with the contents of this manual may constitute grounds for disciplinary action.* [emphasis added]

27 The QPS *First Response Handbook* also contains a section on deaths in custody which refers to section 16.24.2 of the OPM. The handbook contains brief details about what to do when an officer finds someone who appears to be deceased in police custody, and what information the responsible officer should obtain. The provisions of the handbook are of little relevance to this matter.

28 In December 1997 the Queensland Government Progress Report on Implementation of the Recommendations of the RCIADIC stated that the QPS Operational Procedures Manual (OPM) provided policy, orders and procedures which addressed the requirements of the RCIADIC recommendations where practicable.

Failure to comply with the OPM is a ground for disciplinary action[29].

RCIADIC recommendations

Recommendation 35 (a) provided:

> That police standing orders or instructions provide specific directions as to the conduct of investigations into the circumstances of a death in custody. As a matter of guidance and without limiting the scope of such directions as may be determined, it is the view of the Commission that such directions should require, inter alia, that:
>
> a. Investigations should be approached on the basis that the death may be a homicide. Suicide should never be presumed.

Changers were made to the OPM, in part, to give effect to the recommendations of the RCIADIC, in particular section 35(a). However, despite the publicly stated adoption of that recommendation on at least three occasions prior to Mulrunji's death[30] there was not at that time an explicit statement in any QPS policy or procedure document, including the OPM, to that effect[31]. Rather the OPM relevant at the time of Mulrunji's death required that:

- Investigating officers should 'not presume suicide or natural death regardless of whether it may appear likely' (section 16.24.3).

The procedures relevant to the investigation of deaths in custody were contained in several sections of the OPM, namely:

- 1.17 Fatalities or serious injuries resulting from incidents involving members (Police related incidents)
- 2.13 Statements
- 2.14 Interviews
- Chapter 6 Special Needs
- Chapter 8 Coronial Matters
- 16.24 Deaths in custody.

29 Section 9(1) (c) of the Police Service (Discipline) Regulations 1990. A ground for disciplinary action is a contravention of, or failure to comply with, an instruction or order given by, or caused to be issued by, the Commissioner.

30 The Queensland Government and the QPS have publicly stated on a number of occasions that they have implemented recommendation 35:

- In June 1995 the Hon. A. M. Warner, Minister for Family Services and Aboriginal and Islander Affairs tabled in the Queensland Parliament the Queensland Government Progress Report on Implementation of the Recommendations of the RCIADIC to December 1994. This second progress report stated that recommendation 35 had been implemented in part (Hansard – Register of Tabled Papers – First Session – Forty-Seventh Parliament, page 262).
- In December 1997 the Queensland Government Progress Report on Implementation of the Recommendations of the RCIADIC October 1997 was tabled in the Queensland Parliament. This report stated that the RCIADIC recommendation 35 had been implemented and included in Chapters 2, 8 and 16 of the OPM (Hansard - Register of Tabled Papers – Second Session – Forty-Eighth Parliament, page 231).
- In January 1999 the Queensland Government Progress Report on Implementation of the Recommendations of the RCIADIC 1996 - 1997 was tabled in the Queensland Parliament. This report stated that the RCIADIC recommendation 35 had been implemented and included in Chapters 2, 8 and 16 of the OPM (Hansard – Legislative Assembly – Papers – 2 March 1999, page 13).

31 The changes to the OPM in April 2009 include the statement in section 16.24.3(ii) that investigating officers should 'treat the death in custody as a homicide until otherwise determined and are not to presume suicide or natural death regardless of whether it may appear likely'.

Officers' obligations under the OPM

The OPM clearly articulated the need for the investigation of a death in custody to be impartial and required the investigation to be thorough. The relevant sections of the OPM in that regard stated that:

- an investigation of a death in custody is to be conducted expeditiously and impartially (section 1.17)
- the regional crime coordinator is directly responsible for the investigation (section 1.17)
- a death in custody is to be investigated by a senior or experienced investigator with sufficient criminal investigation background (section 8.5.19)
- members directly involved in the incident or who are witnesses to the incident should be interviewed separately and as soon as practicable following the incident (section 1.17)
- members directly involved in the incident or who are witnesses to the incident should not discuss the incident amongst themselves prior to being interviewed (section 1.17)
- when investigating a coronial matter, statements should be obtained from all persons having any significant knowledge concerning the cause or circumstances of the death (section 8.4.21)
- statements from witnesses should be as comprehensive as possible and be obtained at the earliest practicable opportunity (section 2.13.1)
- members who may be required to give evidence of conversations, events or occurrences should compile relevant notes at a time during the conversation, event or occurrence, or as soon as practicable thereafter while details are still fresh in their mind (section 2.13.8)
- people of Aboriginal or Torres Strait Islander descent are considered people with special needs and officers intending to interview Aboriginal or Torres Strait Islander people, whether as witnesses or suspects, are to assume a special need exists until the contrary is clearly established using certain criteria (section 6.3.6).

In addition to the above general requirements, the OPM set out specific requirements, in the event of a death in custody, for the following officers:

- the regional crime coordinator
- the commissioned officer responsible for the investigation
- the representative of the Ethical Standards Command (ESC)
- the investigating officer.

Role of the Regional Crime Coordinator

In terms of the Regional Crime Coordinator (RCC), the OPM stated that:

- all deaths in custody be investigated by or under the control of the RCC unless otherwise directed by the ESC or the CMC (section 1.17)
- the RCC should conduct the investigation or appoint an independent senior investigator who:
  - has sufficient criminal investigation background; and
  - is from a police establishment other than where the incident occurred, or where the officers or members directly involved in the incident are stationed (section 1.17)
- the RCC is to be directly responsible for the investigation (section 1.17)
- where the CMC or ESC overviews the investigation, the RCC retains responsibility for the investigation (section 1.17)
- the RCC is to:
  - ensure the integrity of independent versions of members involved in the incident or witness to the incident is preserved as far as practicable
  - ensure members directly involved in the incident or who are witnesses to the incident are interviewed as soon as practicable
  - ensure sections 16.24 to 16.24.5 of the OPM are complied with (section 1.17)

Role of the commissioned officer responsible for the investigation

In terms of the commissioned officer responsible for the investigation, the OPM provided that as part of the investigation, the officer should, among other things:

- not presume suicide or natural death, regardless of whether it may appear likely
- obtain statements from all witnesses as soon as practicable after the incident
- include investigations into the general care, treatment and supervision of the deceased immediately before the death
- inquire fully into the circumstances of the arrest
- immediately arrange for the next of kin to be notified (section 16.24.3).

Role of the representative of the Ethical Standards Command

In terms of the representative of the ESC, the OPM provided that:

- where the CMC or ESC overviews the investigation, the RCC retains responsibility for the investigation (section 1.17)
- the role of the officer representing the ESC is to:
  - liaise with the RCC and CMC
  - immediately assess the incident in conjunction with the RCC and CMC
  - with CMC officers, overview the investigation and provide appropriate advice and assistance to the RCC[32] (section 1.17)
- if the ESC representative is of the opinion proper investigational or procedural matters are not being adhered to, or there are matters which may adversely affect an impartial investigation, the representative should confer with the RCC and CMC to endeavour to resolve the issue (section 1.17)

Role of the Investigating Officer

In terms of the Investigating Officer, the OPM provided that:

- the investigating officer is responsible for, among other things:
  - advising relatives
  - completing a Form 1[33]
  - forwarding a copy of the Form 1 to their respective Officer in Charge so that it is checked (section 8.4.3)
- where additional or relevant information comes to hand that may assist the pathologist in determining the cause of death prior to the autopsy being conducted, investigating officers are to contact the pathologist as a matter of urgency and provide that information on a Supplementary Form 1 (section 8.4.3)
- where an officer has additional information that could not be included on the Form 1 at the time of submission, they should provide this information on a Supplementary Form 1 (section 8.4.8).

Roles not specified under the OPM

The CMC is not aware of any section of the OPM which placed a specific obligation on an Assistant Commissioner, Operations Coordinator (or Chief Superintendent) or District Officer in relation to a death in custody investigation.

32 In this case, the CMC received an Executive Briefing Note outlining background and issues in relation to the investigation dated 22 November 2004 and assumed responsibility for the investigation on 24 November 2004.

33 A Form 1 is a QPS form required by section 8.4.3 of the OPM called: Form 1 QUEENSLAND *Coroners Act 2003* Section 7(3), Police Report of Death to a Coroner.

Code of Conduct

The QPS Code of Conduct[34] in force at the time of Mulrunji's death provided guidance to the members of the initial QPS investigation team about their ethical obligations in discharging their responsibilities.

Specifically, section 2 stated that in the provision of policing services, the public are entitled to expect that members will:

- conduct themselves and discharge their responsibilities with professionalism and integrity
- …
- comply with, and be seen to act within the spirit and letter of the law
- act in the public interest and give priority to official duties and obligations.

Further, at all times members were expected to conduct themselves in a manner that did not discredit the individual member or the reputation of the QPS.

The SELF test

Section 7 of the Code required members assessing the appropriateness of their conduct to apply the SELF test, which includes the questions:

- Would your decision withstand scrutiny by the community or the Service?
- Is your decision fair to the community, your family and colleagues and others?

SELF stands for:

Scrutiny

Ensures compliance

Is **L**awful and

Fair.

Public trust

Other sections of the Code required members to:

- carry out official public sector decisions and policies faithfully and impartially (Respect for the Law and System of Government)[35]
- act responsively in performing official duties (Respect for Persons)[36]
- in recognition that public office involves a public trust … seek to maintain and enhance public confidence in the integrity of public administration and advance the common good of the community the official serves (Integrity)[37]
- exercise proper diligence, care and attention (Diligence)[38]
- act in good faith[39]
- in the performance of official duties[40] …:
  - demonstrate high standards of professional integrity and honesty
  - perform any duties … diligently and to the best of their ability, in a manner that bears the closest public scrutiny and meets all legislative, Government and Service standards.

34 Version 29, August 2003

35 Section 9.1

36 Section 9.2

37 Section 9.3

38 Section 9.4

39 Section 10.1

40 Section 10.15

Conflict of interest

Section 10.6 dealt with Conflict of Interests and required officers to avoid both actual and apparent conflicts of interests and disclose details of any conflict to their supervising executive officer[41].

Failure to comply

Failure to comply with the Code of Conduct is a ground for disciplinary action in section 9(1)(c) of the Police Service (Discipline) Regulations 1990.

41 Section 10.6, Code of Conduct. The term 'supervising executive officer' is not defined in the OPM. 'Executive officer' is defined in the *Police Service Administration Act 1990* as a person who holds a position in the police force as an executive officer.

5

PALM ISLAND, 19–29 NOVEMBER 2004: CHRONOLOGY[42]

This describes the circumstances surrounding the death in custody of Mulrunji on Palm Island on 19 November 2004, by reconstructing the events that took place there from 19 to 29 November 2004.

Friday 19 November 2004

On Friday 19 November 2004 the following police officers were rostered for duty at the Palm Island police station[43]: officers Hurley, Leafe and the Police Liaison Officer (PLO) from 8.00 am until 4.00 pm, and officers Tonges and Steadman from 4.00 pm until midnight. The Senior Constable, although on a rest day, was also present on the Island; two other officers were on rest days from Thursday 18 November until Sunday 21 November 2004, but the available evidence does not disclose whether they were on the Island on this day.

Early in the morning Palm Island resident Gladys Nugent and her two sisters were seriously assaulted by Gladys' partner Roy Bramwell[44], and one sister was taken by medivac to Townsville for treatment.

At about 9.30 am Hurley spoke to Gladys Nugent at the hospital. Ms Nugent and her other sister then went to the police station to make statements. Hurley asked them to return on Saturday to make their statements. Gladys Nugent was concerned for her safety, and asked Hurley to drive her to the Bramwell house so she could collect her medication. The PLO went with Hurley and Gladys Nugent in the police vehicle.

At about 10.15 am, while Gladys Nugent was at the house, Hurley arrested resident Patrick Bramwell, for drunkenness. About five minutes later, just down the road from the Bramwell house, Hurley arrested Mulrunji for public nuisance[45].

When the police vehicle, containing Hurley, the PLO, Patrick Bramwell and Mulrunji, arrived at the station, there were a number of people around the police station, including Alfred Bonner and Penny Sibley. Leafe and Roy Bramwell were also standing outside the police station when the police vehicle arrived, as Leafe had brought Bramwell to the station to be questioned about the earlier assaults.

While Hurley was taking Mulrunji from the police vehicle to the watch-house cell, Mulrunji punched Hurley, the two men struggled and fell through the door way, onto the floor of the police station.

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42 The chronology has been prepared using various sources of material, including the *Palm Island Review* report, various CMC reports, documents from the QPS, CMC files, and material from the Inquest. We are not able to attest to the absolute accuracy of this chronology, however we believe this to be as accurate as possible based on the material available to us.

43 Appendix 2 contains a plan of part of Palm Island Township. It shows the proximity of the Court House and Police Station to the Police residences, Dee Street and the only road from the township to the airport.

44 Readers should note that there are two Bramwells in this narrative: Roy Bramwell, partner of Gladys Nugent, and Patrick Bramwell, also known as Patrick Nugent, who was arrested by Hurley shortly before Mulrunji's arrest and later held in the watch-house.

45 The circumstances of Mulrunji's arrest have been explored in two CMC reports: *Restoring order: crime prevention, policing and local justice in Queensland's Indigenous communities (2009)* and *Policing public order: a review of the public nuisance offence* (2008).

By 10.26 am Mulrunji was in the cell at the Palm Island watch-house. Patrick Bramwell was also placed in the same cell.

Roy Bramwell left the police station some time after Mulrunji had been placed in the cell[46].

At about 10.55 am Hurley entered the cell to do a 'cell check' on Mulrunji and Patrick Bramwell and observed that Mulrunji was 'snoring'. Some twenty minutes later, between 11.15 am and 11.19 am Leafe entered the cell to do another 'cell check'. He was unable to detect that Mulrunji had a pulse rate and immediately told Hurley.

At about 11.19 am Hurley phoned for the Queensland Ambulance Service (QAS) to attend an emergency at the watch-house. Shortly after, at about 11.23 am, Hurley phoned Senior Sergeant Jenkins, officer in charge of the Townsville District Police Communications Centre, and advised that Mulrunji might be deceased.

At about 11.24 am QAS officer Bolton arrived at Palm Island Police Station. When Bolton confirmed that Mulrunji had died Hurley phoned his supervisor in Townsville, Inspector Strohfeldt, at about 11.30 am, and informed him of the death in custody. At about 11.33 am Jenkins also phoned Strohfeldt, confirming the death in custody of Mulrunji and advising him of the circumstances surrounding the arrest and detention of Mulrunji. Jenkins then phoned District Officer Acting Superintendent Neal Wilson and provided him with a similar briefing. At about 11.36 am, ambulance officer Bolton advised QAS Townsville that Mulrunji had died.

Some time after about 11.30 am, while the ambulance was at the police station, Mulrunji's partner, Tracey Twaddle, and her niece approached the police station. The niece asked at the police station who the ambulance was for and was told that it was for Chris Hurley[47].

By about 11.40 am Detective Inspector Webber, Regional Crime Coordinator for the Townsville District, was advised of the death by Strohfeldt. Webber subsequently advised the Acting Assistant Commissioner and the Acting Chief Superintendent of the death.

At about 11.45 am Detective Sergeant Robinson of the Palm Island CIB, who was in Townsville that morning, was phoned by Hurley who told him that Mulrunji had died in custody and that he was the arresting officer. After he concluded his conversation with Hurley, Robinson phoned his supervisor, Detective Senior Sergeant Kitching, at about 11.50 am, and then phoned Webber at about 11.55 am. After that conversation Robinson went to the Townsville CIB office and spoke to Kitching.

By about 11.50 am Webber had appointed Detective Senior Sergeant Kitching of the Townsville CIB as primary investigator (that is, Investigating Officer under the OPM).

At about 12.10 pm, Inspector Kachel, Northern Regional Complaints Manager, was asked to advise the ESC and the CMC of the death. Advice of Mulrunji's death was also forwarded to forensic service officer Senior Sergeant Arthy of the Northern Region.

At about 12.20 pm Webber notified Detective Inspector Aspinall, the Officer in Charge of the Coronial Support Unit in Brisbane of Mulrunji's death and the State Coroner was immediately notified.

After about 1.00 pm Tracey Twaddle and Mulrunji's sisters went to the police station. The front door was locked. On knocking on the back door and asking when Mulrunji was going to get out, she was told by Hurley to come back at 3.00 pm.

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46 Roy Bramwell left the station before the QPS investigation team arrived. This issue will be discussed in Chapter 10.

47 At the Inquest, Tracey Twaddle said 'they' told her the ambulance was for Chris Hurley. It is not clear who 'they' are, and the matter was not pursued with Ms Twaddle.

At 1.04 pm Jenkins sent a Significant Event, Computer Message number 584, on the police computer system to SIGNOR[48], attention ALL, which noted Webber as the 'Investigation Officer' and Strohfeldt as the 'RDO/Commissioned Officer Attending/Responsible'. Under the heading 'Particulars of Incident' it stated that:

> The deceased and Patrick Nugent were arrested in the Palm Island Community, for creating public nuisance and drunk respectively, by Snr. Sgt. Chris Hurley who was assisted by [the PLO], at 1026 hrs. On arrival at the Watch-house the deceased was uncooperative and violent — he punched S/Sgt. Hurley in the jaw as they were being removed from the police vehicle. They were placed in the cells and checked a couple of times before about 1120 hrs, the deceased was noticed to be pale and possibly have a weak pulse. QAS advised and responded whereupon he was found to be life extinct. Palm Island police presently making arrangement for notification of the NOK. Contingency plan being implemented in respect to policing at Palm Island in case there is an increase in public disorder.

At about 2.20 pm Webber, Kitching and Robinson left Townsville by charter aircraft to travel to Palm Island. They were accompanied by Forensic Services Officer Arthy, Scenes of Crime Officer Tibbey, Scientific Section Officer Bartulovich, two Constables and a Human Services Officer.

At about 2.55 pm the investigation team arrived at Palm Island airport. Hurley was there to meet them and he drove Webber and Kitching from the airport to the police station.

By about 3.10 pm forensic officers commenced examination of the cell, including a Polilight[49] examination.

At about 3.10 pm Webber advised Andrea Kyle and Owen Marpoondin of the Aboriginal and Torres Strait Islander Legal Service of the death of Mulrunji. Webber also contacted Kevin Rose, a solicitor for the Townsville Aboriginal Legal Service and informed him of the death.

At 3.40 pm Webber, accompanied by Leafe and Marpoondin, notified Tracey Twaddle of Mulrunji's death and at about 3.55 pm notified Mulrunji's mother and other family members.

Interviews were conducted and audio-tape-recorded at Palm Island Police Station by Kitching and Robinson later that afternoon, evening and night.

- Their first interview was with Hurley, from 4.04 pm to 4.36 pm. It was about the arrest of Mulrunji, the circumstances leading up to his death, and the presence near the police station that day of Penny Sibley and the presence near and in the police station of Roy Bramwell.
- The second was with the PLO from 4.50 pm to 5.10 pm, about the arrest of Mulrunji and the circumstances leading up to his death.
- The next person to be interviewed was Gladys Nugent, from 5.34 pm to 5.45 pm, about what she saw of the arrest of Mulrunji by Hurley that morning.
- The interview of Patrick Bramwell took place between 6.58 pm and 7.07 pm, about what he could remember about what happened that morning.

At 7.25 pm Kitching phoned the on-call Townsville Magistrate, Brian Smith, advised him of Mulrunji's death and obtained permission to arrange for Morley's Funeral Parlour to remove his body from Palm Island.

Kitching, by himself, interviewed Leafe between 7.50 pm to 8.12 pm about the arrest and death of Mulrunji in the watch-house cell.

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48 This was what was in the 'To' field of the email and appears to be an email group. It is not known who actually received the message.

49 A Polilight examination is a forensic process using a light source to detect fingerprints, bodily fluids and other evidence in crime scenes.

At about 8.00 pm the Acting Assistant Commissioner was provided with an update about the matter.

The final interview of the day conducted by Kitching and Robinson was with Palm Island resident Edna Coolburra from 8.22 pm to 8.35 pm about what she saw of the arrest of Mulrunji by Hurley that morning.

By about 9.00 pm Kitching had completed the *Coroners Act 2003* Form 1 — Police report of death to a coroner.

Some time after 10.00 pm that night Hurley, Webber, Kitching and Robinson ate a meal at Hurley's residence which Robinson had prepared at that residence.

Saturday 20 November 2004

The next morning, at about 8.00 am, Kitching and Robinson drove to the Bramwell house in Dee Street to bring Roy Bramwell back to the police station to be interviewed. Kitching told Roy Bramwell that he would like to conduct a quick interview with him in relation to Mulrunji's arrest the day before, that he believed that Bramwell was at the police station about the time Mulrunji was brought into the police station and that he wanted Bramwell to tell them what he saw and what his knowledge was of the matter yesterday. Kitching and Robinson conducted an audio tape-recorded interview with Roy Bramwell at the police station from 8.15 am to 8.27 am. Robinson then prepared a typed statement for Roy Bramwell.

Later that morning Kitching, by himself, conducted an audio-tape-recorded interview with Gerald Kidner from 9.16 am to 9.25 am about Mulrunji drinking on Friday morning and what he saw of the arrest of Mulrunji.

Throughout the morning further interviews were conducted and statements obtained.

Sometime during the morning, Inspector Williams of the ESC arrived on Palm Island to overview the initial QPS investigation. Upon arrival he was briefed by Webber, Kitching and Robinson and he examined the statements and interviews taken to that time.

Subsequently Webber and Williams conducted four audio-tape-recorded re-enactment interviews where the relevant events of 19 November 2004 were described. Tibbey also video recorded the re-enactment interviews and the videos were provided to Kitching for exhibit purposes.

The first of these interviews was with Roy Bramwell from 10.52 am to 11.02 am. He was asked by Webber to re-enact, from his perspective, exactly what he saw and exactly what happened when Hurley came into the police station with Mulrunji the previous morning.

At about 11.20 am, Hurley drove Webber, Williams, Kitching and Tibbey to the scene of Mulrunji's arrest.

The next re-enactment interview was with Hurley from 11.53 am to 12.07 pm. Hurley was told by Williams that what they wanted him to do was to re-enact how he dealt with Mulrunji once they came back to the police station, explain Mulrunji's demeanour, Hurley's actions, what was happening and who Hurley saw around him at the time.

The third re-enactment interview was with the PLO. He was told by Williams that they wanted to do a re-enactment of what happened when Hurley and the PLO arrived back at the police station after arresting Mulrunji and Patrick Bramwell. This interview took place between 12.10 pm and 12.22 pm. During the re-enactment both Webber and Williams questioned the PLO.

The last re-enactment interview was with Leafe from 12.50 pm to 1.12 pm. Williams told Leafe that they were going to get him to do a re-enactment, explain his movements when Hurley arrived in the police paddy wagon, how he dealt with Mulrunji, any conversations Leafe may have had, what happened and where he was.

Kitching and Williams then conducted a further audio-tape-recorded interview with Hurley. Kitching said at the beginning of the interview that they just wanted to cover further issues and ask a few questions. According to this interview it took place between 1.10 pm and 1.22 pm.

Sunday 21 November 2004

Williams and Kitching travelled to Ingham to interview and take a statement from Penny Sibley. Kitching conducted an audio-tape-recorded interview from 7.50 am to 8.05 am at Ingham Police Station with Penny Sibley about what she saw at the police station on Friday morning. After returning to Townsville Kitching briefed Webber in relation to the outcome of his inquiries with Penny Sibley.

Monday 22 November 2004

At the request of Kitching, at about 10.40 am Constable Paul Harvie of the Townsville QPS faxed the Form 1 (which Kitching had completed on Friday 19 November) to the Coroner's Office in Townsville.

Williams returned to Brisbane pending the outcome of the autopsy examination.

At 10.56 am information regarding the death in police custody of Mulrunji, set out in a three-page Executive Briefing Note, was faxed to the CMC by ESC. Later that day at 3.55 pm the CMC faxed a Matters Assessed Report[50] to the ESC noting that the CMC would review the police investigation report.

At Kitching's request, Robinson attended the Palm Island hospital and received a verbal briefing from Dr Clinton Leahy about Mulrunji's medical history. Robinson provided Kitching with this information and advised Kitching of information he received from someone in the community about Mulrunji drinking bleach.

Hurley and the PLO left Palm Island on the afternoon flight.

Tuesday 23 November 2004

Kitching travelled from Townsville to Cairns and met Dr Guy Lampe, forensic pathologist, who performed an autopsy. Dr Lampe then issued an Autopsy Certificate which concluded that the cause of death was intra-abdominal haemorrhage, due to ruptured liver and portal vein.

Kitching took possession of the Autopsy Certificate, called the Acting Assistant Commissioner and Webber and advised them of the results of the autopsy, and then faxed a copy of the certificate to the Acting Assistant Commissioner at the Northern Police Regional Office in Townsville.

Wednesday 24 November 2004

The Commissioner of Police requested the CMC to take over the investigation due to the circumstances surrounding the matter.

Having returned to Townsville in the morning, Kitching received a phone call from Dr Lampe who asked him not to lodge the Autopsy Certificate issued in Cairns as he was to make inquiries with the State Coroner about changing the Autopsy Certificate by having the word 'fall' deleted from section 1(c) of the Autopsy Certificate. Dr Lampe stated his superiors thought that having the word 'fall' on the Autopsy Certificate could result in the pathologist being seen to be assisting police with a cover-up with respect to the death of Mulrunji.

At about 1.00 pm Kitching received another phone call from Dr Lampe who advised him that the State Coroner was happy for the Autopsy Certificate to be changed. Dr Lampe later faxed a copy of the new Autopsy Certificate to Kitching at the Townsville CIB.

50 This is a CMC document by which an agency is advised of the CMC's decision about how to deal with a matter.

Inspector Ken Bemi and Indigenous Complaints Officer Lisa Florence of the CMC and Williams travelled from Brisbane to Townsville and in the afternoon attended a briefing with Webber and Kitching at the Northern Police Regional Office in Townsville. Kitching provided the CMC officers with an outline of the investigation that he had conducted and then handed all the statements, records of interview, documents and exhibits to Bemi.

Thursday 25 November 2004

Williams assisted Bemi with a review of the investigation. Kitching again met with Williams, Bemi and Florence and delivered a copy of the video tapes of the deceased in situ at the Palm Island Police Station and the re-enactments of events by witnesses Bramwell, Hurley, the PLO and Leafe.

Friday 26 November 2004

Bemi, Florence and Williams travelled to Palm Island. Bemi and Williams conducted audio-tape-recorded interviews with Alfred Bonner, Roy Bramwell, Gordon Johnson, Edna Coolburra and Nobie Clay and prepared typed statements as required. However, because of unrest the CMC officers withdrew from Palm Island, departing at about 12.30 pm to travel back to Townsville.

Riots commenced on Palm Island and the police station was burnt down.

Monday 29 November 2004

CMC investigators travelled to Palm Island to resume the investigation there.

6

CRITICISMS OF THE INITIAL QPS INVESTIGATION

Criticisms made by the Acting State Coroner

In her findings, the Acting State Coroner was critical of various aspects of policing on Palm Island and of the initial QPS investigation into the death of Mulrunji.

The Acting State Coroner noted that the starting point for consideration of her comments[51] must be reference to the recommendations of the RCIADIC. At page 28 of her findings, she said:

> It is reprehensible that the detailed recommendations of the Royal Commission into Aboriginal Deaths in Custody should have to be referred to, so many years after the Royal Commission. The evidence is clear however that these recommendations are still apt and still ignored.

The Acting State Coroner's comments are made under the headings:

- Arrest and Policing
- Diversionary Centres and Community Patrols
- Supervision, Monitoring and Care in Custody[52]
- Investigation of Mulrunji's Death.

Fourteen comments (numbers 27–40) appear under the heading 'Investigation of Mulrunji's Death':

27. The involvement in the investigation of Mulrunji's death of officers from Townsville and Palm Island was inappropriate and undermined the integrity of the investigation.
28. In all deaths in custody, officers investigating the death should be selected from a region other than that in which the death occurred. The OPM should be amended to require this.
29. The OPM should be amended to require the appointment of the officer in charge of an investigation into a death in custody by the Chief Commissioner, a Deputy Commissioner or Assistant Commissioner.
30. The OPM should be amended to make explicit the need to consider, when selecting officers for involvement in an investigation of a death in custody, the impartiality and the appearance of impartiality in the conduct of the investigation.
31. The involvement in the investigation of Mulrunji's death of officers who knew Senior Sergeant Hurley personally, or were friends with him, was inappropriate and compromised the integrity of the investigation.
32. The OPM should be amended to explicitly require officers involved in an investigation into a death in custody to disclose any relationship with an officer involved in, or a witness to, that death.
33. The investigation's appearance of impartiality was further undermined by the following conduct:-
    - It was inappropriate for Hurley to meet the investigating officers at the airport upon their arrival;

51 Section 46 of the *Coroners Act 2003* provides that a coroner may, whenever appropriate, comment on anything connected with a death investigated at an inquest that relates to public health or safety, or the administration of justice, or ways to prevent deaths from happening in similar circumstances in the future.

52 The CMC report *Restoring order: crime prevention, policing and local justice in Queensland's Indigenous communities* (November 2009) deals with the section 46 comments that concern 'Arrest and Policing', 'Diversionary Centres and Community Patrols', 'Supervision, Monitoring and Care in Custody'.

- It was inappropriate for Hurley to drive the investigators to the scene of Mulrunji's arrest; and
- It was completely unacceptable for investigators to eat dinner at Hurley's house while the investigation was being conducted.

34. The OPM should be amended to more clearly state the need for officers involved in an investigation to consider the impartiality and the perception of impartiality in the conduct of the investigation at all times.
35. The discussion by Senior Sergeant Hurley of the death of Mulrunji with Sergeant Leafe and (the) Police Liaison Officer prior to being interviewed was inappropriate and contrary to the OPM. It had the potential to undermine the integrity of the investigation and undermine the appearance of integrity of the investigation.
36. The OPM should be amended to require the officer in charge of an investigation of a death in custody to instruct officers involved in, or witness to, the death not to discuss the matter with other witnesses prior to being interviewed.
37. Consideration should be given by the Police Commissioner to the training officers receive to ensure they are aware of their obligations under the OPM if involved in deaths in custody. In particular the Commissioner should ensure that officers strictly comply with section 16.24 (vi) to (viii) of the OPM and **immediately** arrange for the next of kin to be notified where a death in custody occurs.
38. The CMC should be actively involved in all investigations into deaths in custody from the outset. Consideration should be given to having a senior officer of the CMC involved in all investigations into deaths in custody.
39. Difficulties in cross-cultural communication between police and Aboriginal witnesses may have impaired the effectiveness of the investigation of this matter by police. Significant attention should be given by the Police Commissioner to the training of officers, particularly those who are working in or near large Indigenous communities such as Palm Island in relation to communication with Indigenous people and the use of support persons and interpreters. This is a matter that is fundamental to the effective and fair administration of justice in Queensland.
40. The OPM should be amended to include, as an appendix, Chapter 9 of the Supreme Court of Queensland Equal Treatment Benchbook on 'Indigenous Language and Communication'. The OPM should direct officers to follow and apply the contents of that chapter to the greatest extent possible.[53]

Many of these comments, in effect, repeated the recommendations of the RCIADIC.

In addition, in the general course of discussing the evidence the Acting State Coroner also made a number of criticisms of the initial QPS investigation.

Under the heading 'The Investigation', the Acting State Coroner made reference to the *State Coroner's guidelines* which point out that a thorough and impartial investigation of a death in custody is not only necessary to ensure public confidence, but is also in the best interests of the 'custodial officers'[54]. She also referenced a passage from the National Report of the RCIADIC which provides:

> A death in custody is a public matter. Police and prison officers perform their services on behalf of the community. They must be accountable for the proper performance of the duties. Justice requires that both the individual interest of the deceased's family and the general interest of the community be served by the conduct of thorough, competent and impartial investigations into all deaths in custody.

The Acting State Coroner said the 'investigation into Mulrunji's death failed to meet those standards'[55].

53 Finding of Inquest, page 3132

54 State Coroner's Guidelines, section 7.5

55 Finding of Inquest, page 9

Complaints based on the Acting State Coroner's comments received by the CMC

In late May 2007 the CMC received a complaint about the conduct of the initial QPS investigation based on the evidence before the second Inquest and the comments and findings of the Acting State Coroner.

The complaint alleged conduct which could constitute misconduct.

The complainant also asserted that the police officers involved in the investigation should be prosecuted for the criminal offences of conspiring to defeat justice and/or attempting to pervert the course of justice. In that regard the CMC noted that the Acting State Coroner had not formed any reasonable suspicion that any person had committed a criminal offence and that no referral had been made to the Director of Public Prosecutions[56].

As the IRT's investigation was already well under way at that time, the CMC referred the complaint to the QPS to deal with by investigation[57], subject to the CMC's monitoring role by way of a review-before[58].

In the referral the CMC noted the 'allegations' in general terms as involving 'inadequate investigation / lack of impartiality — conducted a deficient investigation into death in custody on Palm Island' and that they were currently the subject of investigation by the IRT. The CMC expected that the IRT would identify and address all the relevant issues arising from the findings and criticisms of the Acting State Coroner.

In a letter dated 20 November 2007, the Commissioner of Police noted that the complaint had been made, that it was based on the criticisms made by the Acting State Coroner and that the IRT had commenced work on the examination of those criticisms.

In late May 2008, the CMC received another complaint also based on the criticisms made by the Acting State Coroner. This complaint was also referred to the QPS to deal with on the same basis as the May 2007 complaint.

The CMC formally requested that the QPS provide a report for the CMC to review prior to finalisation.

During the time that the IRT was conducting its investigation, the CMC provided material to the IRT to assist in their examination of the relevant issues. Meetings were also held on a number of occasions between the members of the IRT and various CMC officers.

Finalisation of complaints

The complaints cannot be finalised until the QPS responds to the CMC's review of the *Palm Island Review* and ultimately makes its final determination about the action, if any, to take in relation to the conduct of the members of the initial QPS investigation team.

Under the *Crime and Misconduct Act 2001*, the QPS is required to provide to the complainants:

- information about the action taken in relation to their complaint
- the reason the action is considered to be appropriate in the circumstances
- any results of the action that are known at the time of the response[59].

The following part of the report deals with the QPS response to the Acting State Coroner's criticisms and comments.

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56 Section 48(2) *Coroners Act 2003* provided: 'If, from information obtained while investigating a death, a coroner reasonably suspects a person has committed an offence, the coroner must give the information to— (a) for an indictable offence—the director of public prosecutions.

57 It is not unusual, as occurred in this case, for an investigation to reveal additional and / or more specific allegations.

58 Section 46(2)(b) CM Act

59 Section 42(7)