Scott & Anor v Northern Territory of Australia & Ors [2005] NTSC 29

PARTIES:	SCOTT, LETTY MARIE AND: SCOTT, NATHAN WILLIAM v NORTHERN TERRITORY OF AUSTRALIA AND: MEDLEY, BARRY AND: ROBERTSON, HAROLD AND: LAWSON, MICHAEL
TITLE OF COURT:	SUPREME COURT OF THE NORTHERN TERRITORY
JURISDICTION:	SUPREME COURT OF THE TERRITORY EXERCISING TERRITORY JURISDICTION
FILE NO:	No. 47 OF 2003 (20304424)
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JUDGMENT OF:	ANGEL J

REPRESENTATION:

Counsel:

Plaintiffs:	(by leave) Mr D Taylor (law student)
Defendants:	Mr M Grant

Solicitors:

Plaintiffs:	–
Defendants:	Solicitor for the Northern Territory

Judgment category classification:	C
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IN THE SUPREME COURT
OF THE NORTHERN TERRITORY
OF AUSTRALIA
AT DARWIN

Scott & Anor v Northern Territory of Australia & Ors [2005] NTSC 29
No. 47 of 2003 (20304424)

BETWEEN:

LETTY MARIE SCOTT
First Plaintiff

AND:

NATHAN WILLIAM SCOTT
Second Plaintiff

AND:

NORTHERN TERRITORY OF AUSTRALIA
First Defendant

AND:

BARRY MEDLEY
Second Defendant

HAROLD ROBERTSON
Third Defendant

AND:

MICHAEL LAWSON
Fourth Defendant

CORAM: ANGEL J

REASONS FOR JUDGMENT

(Delivered 16 June 2005)

PRELIMINARY

[1] On 5 July 1985 Douglas Bruce Scott died whilst in custody within Cell 8 of C Block in the Remand Section of Berrimah Prison near Darwin. An autopsy on the body of the deceased was performed on 5 July 1985 by the then Government Pathologist, Dr Kevin Lee, Forensic Pathologist, who produced a Post Mortem Report (see Exhibits D123, D124 and D125). It is common ground that the death of the deceased was later the subject of an inquest pursuant to the then Coroners Act (NT) and also the subject of an inquiry in 1989 by the Royal Commission into Aboriginal Deaths in Custody. Both the Coroner and the Royal Commissioner, The Honourable Elliott Johnston QC, concluded that the deceased had taken his own life. Apparently neither the Coroner nor the Royal Commission received submissions or heard evidence to the contrary.

THE PLAINTIFFS' CLAIM

[2] The present plaintiffs, the widow and the son of the deceased, have for many years contested the conclusion that the deceased took his own life. They bring the present action pursuant to s 13(1) Compensation (Fatal Injuries) Act (NT). They allege Prison Officers, the defendants Medley, Robertson and Lawson together with former Senior Prison Officer William Henry Bowden, now deceased, murdered the deceased in his cell. They sue the Northern Territory of Australia as vicariously liable for that murder. They allege the prison officers hanged the deceased within his cell "to simulate the suicidal hanging, as a result of which, if the deceased was not already

dead when hanged by the defendants, he was finally killed by this action". (para 36 Further Further Amended Statement of Claim).

[3] The plaintiffs further say the defendant prison officers and others concealed the murder of the deceased. They say the deceased was initially hanged by the neck from a grate in the ceiling of his cell and that his feet were "high above the floor" (para 38 Further Further Amended Statement of Claim). They allege he was photographed in that position twice by Chief Prison Officer Birbeck and subsequently "re–hanged" in the position depicted in the two photographs comprising Exhibits P2 and P3. They say the defendant prison officers, Senior Prison Officer Bowden, Dr Kevin Lee and Detective Sergeant Michael Alfred Stevens conspired to conceal the murder (para 42 Further Further Amended Statement of Claim).

[4] The defendants deny the plaintiffs' allegations and plead "the deceased died by self inflicted hanging".

RELATED PROCEEDINGS

[5] Following the first inquest the remains of the deceased were interred in a public cemetery in Townsville in Queensland. In related Court proceedings the plaintiffs obtained an Order of this Court for exhumation of those remains. Pursuant to that Order the remains were exhumed on 2 April 2005. A second autopsy examination was conducted the following morning by Professor Vanrell, a forensic pathologist nominated by the plaintiffs, Professor A J Ansford, a forensic pathologist nominated by the defendants,

and Professor Williams, a forensic pathologist representing the State of Queensland. The results of that exhumation and second autopsy examination and any conclusions that might be drawn therefrom are the subject of contested evidence before me. See Exhibits P37 and P48 (Professor Vanrell), D112, (Professor Ansford) and D100 (Professor Williams).

THE ISSUE

[6] Evidence was led as to the deceased's status within the prison at the time of his death. He was incarcerated in the remand section of the gaol. The plaintiffs allege he was not in lawful custody. The defendants say he was in lawful custody. There is no evidence as to the deceased's state of knowledge or belief regarding the lawfulness or otherwise of his custody. Following discussion it was agreed at the bar table that it was unnecessary for me to try that issue which has no relevance to liability. No evidence was lead or arguments adduced with respect to the plaintiffs' claims in negligence nor with respect to the matters averred in paragraph 94 and following of the Further Further Amended Statement of Claim.

[7] The issue between the parties then is a narrow one, whether the deceased's death was self–inflicted or whether, as the plaintiffs say, he met his death as a consequence of an assault by prison officers in his cell. More particularly the issue for decision is whether the plaintiffs have established to the degree of satisfaction required that the defendant prison officers murdered the

deceased in his cell. In the course of the trial it was agreed that the issue of compensation be deferred and that I decide the issue of liability only (t 327–8).

[8] The plaintiffs having brought this claim, the onus of proof is upon them. Having regard to the very serious nature of their allegations they bear a particularly heavy onus of proof, albeit not beyond reasonable doubt: *Briginshaw v Briginshaw* (1938) 60 CLR 336, especially at 361–3, per Dixon J.

[9] In dealing with the evidence it is to be borne steadily in mind that the deceased died in 1985. Experience tells us that hindsight is a wonderful thing, that the passage of time can play many tricks, that the most honest of witnesses can – quite unwittingly – assume or build up false reminiscences and tenaciously hold false opinions and assert as facts matters that are simply not so. It is also to be borne in mind that much has changed since 1985, that procedures, both prison and medical, have improved, that we know more, that photography is more sophisticated now and its use in medical and Police investigations more widespread now and better understood. In so saying I do remind myself that no social or racial group or period in history has a monopoly on virtue or vice and that nothing is good or bad because it is old or new.

THE WITNESSES

[10] There was a substantial body of oral and written testimony and Exhibits. The plaintiffs called two ex–prisoners, the witnesses Percy and Bindai. The relevant Exhibits to the witness Percy are Exhibits P19, D46 and D47 and in relation to the witness Bindai, Exhibits P20, P21, D44, D45, P49, P52 and P53. Percy and Bindai were prisoners on remand in C Block, which is comprised of a quadrangle with two parallel rows of cells on opposite sides of a grassed area. Their cells were opposite Cell 8. Exhibit P28 includes Royal Commission photos taken within C Block. The evidence of Percy and Bindai was that they saw four prison officers in or about the deceased's cell in the early hours of 5 July 1985, that they heard cries for help, that an assault took place, that they cleaned blood from within Cell 8 the following morning after removal of the body of the deceased.

[11] The first plaintiff gave evidence. She said the deceased was not suicidal. She denied being separated from the deceased at the time of his death.

[12] I heard evidence from various prison personnel who gave general evidence concerning gaol layout, routines regarding lockup and release of prisoners, body counts and the circumstances surrounding the discovery of the deceased hanging in his cell and the first raising of alarm at 6.22 am.

[13] I heard evidence from attending Police, in particular the Police witnesses Wernham and Stevens (Exhibit D94). I heard evidence from Mr Barbaro, counsel assisting Royal Commissioner Johnston QC.

[14] There was a substantial body of hospital and medical documentary evidence relating to the deceased's medical background and evidence from gaol records of the deceased's incarceration and medical treatment whilst incarcerated.

[15] I heard a substantial body of expert evidence. The plaintiffs called the following expert witnesses:

(a) Dr Cyril Wecht MD.JD. Coroner for Allegheny County, of Pittsburgh Pennsylvania USA, Clinical Professor of Pathology at the University of Pittsburgh and Distinguished Professor Carlow College, Pennsylvania, USA.

(b) Professor Tohru Ohshima MD PhD of Forensic and Social Environmental Medicine, Graduate School of Medicine, Kanazawa University, Kanazawa, Japan.

(c) Professor Dr Jorge Paulete Vanrell, Professor of Forensic Medicine, Graduation Course of Laws, Paulista University, Sao Paulo, Forensic Medicine Expert in Districts of Sao Paulo Court of Justice, Sao Paulo, Brazil.

(d) Dr Manoj Kumar Moharty, Assistant Professor of Forensic Pathology, Department of Forensic Medicine, Kasturba Medical College, Manipal, Karnataka, India.

(e) Professor Jorgen Thomsen, Professor of Forensic Medicine, University of Southern Denmark, Odense University, Odense, Denmark.

(f) Dr Michael Freeman PhD Dc MPH Forensic Trauma Epidemiologist, Clinical Assistant Professor Department of Health & Preventive Medicine, Oregon Health & Science university, School of Medicine, Salem, Oregon USA.

(g) Dr Timothy Palmbach JD MS (Forensic Science), Commanding Officer Division of Scientific Services, Meriden, Connecticut

USA, Adjunct Instructor and Distinguished Lecturer, University of New Haven, West Haven, Connecticut, USA.

[16] The defendants called the following expert witnesses:

(a) Professor A J Ansford, Senior Pathologist, Forensic Pathology, Scientific Services, Queensland Health, Locum Senior Forensic Pathologist, Royal Newcastle Hospital, Hunter Health Services, New South Wales and Royal Darwin Hospital, Casuarina, Northern Territory of Australia.

(b) Professor Stephen Cordner, Director of the Victorian Institute of Forensic Medicine, Professor of Medicine at Monash University, Melbourne, Victoria, Australia.

(c) Professor David John Williams, Consultant Forensic & Anatomical Pathologist, Associate Clinical Professor of Pathology, University of Queensland, Clinical Professor of Pathology James Cook University, Director of Anatomical Pathology at Townsville General Hospital, Queensland, Australia.

(d) Gale Edward Spring, Associate Professor of Scientific Photography and Program Leader of Scientific Photography in the RMIT portfolio of Science, Engineering and Technology, School of Applied Science, Melbourne, Victoria, Australia.

(e) Dr Kevin Lee, Senior Specialist Forensic Pathologist with the Department of Forensic Medicine based at the Royal Newcastle Hospital, Newcastle, New South Wales, Australia. As at 5 July 1985 Dr Lee held the position of Forensic Pathologist for the Northern Territory of Australia.

[17] Photographic expert Professor Spring's photos (Exhibit D121) were commented upon and interpreted by him and various other experts, as were many other photographs in evidence of the deceased's body hanging in

Cell 8, of the deceased's body prone on the bed in the cell and of the deceased's body in the morgue following its removal from gaol.

[18] The hearing of oral evidence concluded on 19 May 2005. The plaintiffs filed 85 page written submissions on 23 May 2005. The defendants filed 98 page written submissions on 6 June 2005. The plaintiffs' final written submissions in reply were filed on 10 June 2005.

THE POLAROID PHOTOGRAPHS

[19] Chief Prison Officer Ian Birbeck was alerted to the body of the deceased hanging by the neck from a sheet tied to a grill in the centre of the ceiling of Cell 8. Having rapidly satisfied himself that the deceased was obviously beyond resuscitation he obtained a camera and took two Polaroid photographs of the deceased hanging in Cell 8. It was the plaintiffs' case – see paragraphs 37 and following of the Further Further Amended Statement of Claim – that Birbeck photographed the deceased with his feet well clear of the floor and hanging by a noose resembling a hangman's noose, that is, with coils as Mrs Scott depicted in Exhibit P56. In particular the plaintiffs say that the deceased as photographed by Mr Birbeck did not appear as depicted in Exhibits P2 and P3.

[20] Mrs Scott gave evidence that she saw two Polaroid photographs at the Royal Commission which were coloured, not black and white, and square, not oblong. These photographs, she said, were shown to her by Mr Barbaro, counsel assisting the Royal Commission.

[21] She said they depicted the deceased suspended by a coiled noose (Exhibit P56) with his feet high off the floor. Both Chief Prison Officer Birbeck and Mr Barbaro gave evidence that the Polaroid photographs taken by Mr Birbeck depicted the scene as it appears in Exhibits P2 and P3, that is, Exhibits P2 and P3 are but photographs of the original, now lost, Polaroid photographs.

[22] Much expert evidence before me addressed the question whether the feet of the deceased as they appear in Exhibit P2 were clear of the floor of the cell. This question related to the issue as to whether the deceased was fully or only partially suspended, an issue, which in turn related to the significance, if any, of the fracture of the deceased's right thyroid cartilage. A body of expert evidence was led by the plaintiffs to the effect that a broad soft ligature partial hanging as was said to be the present case of a person under 30 years of age would be highly unlikely to result in a fracture of the thyroid cartilage. Such a fracture was far more likely to occur in the case of manual strangulation or hanging or strangling by a narrow ligature or by incapacitation by means of a carotid sleeper hold whereby the Adam's apple area of a victim's throat is squeezed in the crook of the arm. The thyroid cartilage fracture sustained by the deceased was said to be inconsistent with suicidal hanging in the manner depicted in Exhibits P2 and P3.

[23] In my opinion Mrs Scott is honestly mistaken as to what she saw in the lost Polaroid pictures. She only saw them briefly and in a state of high emotion. Interestingly Mr Barbaro made the same error. At one time he considered

the Polaroid pictures depicted the feet well off the ground: see his interview with the lawyer Mr Rodney Lewis (Exhibit P106) and subsequent correction of his mistake (t 716–718). I accept the evidence of both Mr Barbaro and Mr Birbeck that Exhibits P2 and P3 are photographs of Mr Birbeck's original Polaroid photographs. See Exhibit D 103 paras 5–12. The evidence is former police photographer Neiman (deceased) photographed the Polaroid photographs of Mr Birbeck, (see Exhibit D92 and Exhibit D104 Annexures A and B and the copy Polaroids accompanying Exhibit D107) and Nieman's photographs of the Polaroid photographs were distributed among the parties to the Royal Commission (t 685). I accept Mr Birbeck's evidence that Exhibits P2 and P3 depict what he saw and photographed when he first entered Cell 8. The plaintiffs' case that the deceased was hanged twice is not proven.

PARTIAL OR COMPLETE SUSPENSION

[24] As I have said a body of expert evidence was called as to whether the deceased's feet as depicted in Exhibit P2 were in contact with the floor of the cell. In this regard I should mention that Senior Prison Officer Bowden's statement (Exhibits D88 and D129 Annexure A) asserts that the deceased's feet were off the floor when he was hanging in the cell. Similarly Prison Officer Robertson says that the deceased's feet were off the floor at the time (Exhibit D84). Prison Officer Lawson also said he saw the deceased fully suspended. See Annexure ML4 to Exhibit D77.

[25] The forensic experts agree that the photograph in question (Exhibit P2) is of poor quality. Professor Gail Spring gave evidence concerning what he said was shadow around particularly the heel of the deceased's right foot and the left extremity of the deceased's left foot. He said the feet were clear of the floor. Of all the evidence on this issue I was most impressed with that of Dr Michael Freeman (Exhibit P 54) who noted that in Exhibit P2 each foot of the deceased generally appears to be at right angles with each lower leg at a time well before rigor mortis set in. Exhibits P4 and P9, photographs of the deceased's lower legs and feet prone on the cell bed, depict the feet at an oblique rather than right angle to the lower legs. Were the deceased's feet to be well clear of the floor whilst he was suspended one would expect his feet to be hanging at an oblique angle to the lower leg. This reasoning convinces me it is unsafe to rely upon eye witness accounts which simply must be mistaken. There is no reason to think they took particular notice or appreciated the significance of the issue as to whether the deceased's feet were clear of the floor.

[26] I conclude that the front of the feet of the deceased were in contact with the floor at the time Mr Birbeck took his Polaroid photographs and that to the extent that it is relevant it was a partial rather than a complete suspension. I agree with the evidence and reasoning of Dr Freeman in paragraph 5 of his affidavit of 16 May 2005, Exhibit P138, for his conclusion that Exhibit P2 depicts the front of the feet of the deceased touching the floor of Cell 8. In so concluding I note that Dr Freeman (t 291) and the defendants' experts

Professor Cordner (t 916) and Professor Ansford (Exhibit D112 page 7) all agree that this hanging, if partial, was as close to complete as could be; there was virtually complete suspension. I accept this evidence.

WAS SUICIDE POSSIBLE?

[27] As the plaintiffs' expert Dr Freeman said, in an investigation as to whether a person has committed suicide the first question is whether they were able to commit suicide. Exhibit D105 comprises the Royal Commission's view notes tendered by consent before the Royal Commission. The Royal Commissioner noted that the deceased was well able to commit suicide within Cell 8 by hanging himself by a sheet from the grill in the centre of the ceiling of the cell. The dimensions of Cell 8 are set out in Exhibit P70. Also relevant are Exhibits D92 and P96. The cell contained fixed furniture comprising the concrete bed slab on which was situate a thin mattress, an inbuilt desk and shelf and a concrete vertical slab partitioning off the toilet. The Court went on a view and inspected Cell 8. Exhibit 131 comprises the view notes and agreed measurements taken on the view. The shortest distance between the desk top and the grill was 200 centimetres. The grill could thus readily be reached by the 183 centimetre tall deceased if standing on the desk. I conclude the deceased was well able to commit suicide within Cell 8 by hanging himself from the ceiling grill without the use of the stool depicted in Exhibits P3 and P12.

MECHANISMS OF DEATH BY HANGING

[28] The mechanisms of death by hanging are conveniently set out in the Reconstruction Report comprising part of Exhibit P 33.

[29] Death can occur by obstruction of the air ways, commonly due to the tongue being raised and forced against the back of the pallet and pharynx and occlusion of the veins carrying blood back from the head to the heart. These two mechanisms, often in combination, will produce physical signs including petechial haemorrhages into the face and eyes through capillary bleeding and obvious signs of congestion and discolouring resulting from venous engorgement. In the present case there was no evidence of petechial haemorrhaging and although the witness Lawson said the face of the deceased was swollen (t 471, 478) that evidence is inconsistent with that of other witnesses and the Police photographs which do not show swelling of the face.

[30] An alternative mechanism of death due to hanging is pressure causing blockage of the arteries. Death this way may occur sooner than by obstruction of the air–ways because pressure on the carotid arteries is more likely to cause death as a result of reflex cardiac arrest due to distension of the carotid sinus. The rapidity of this mechanism which can occur in both manual strangulation and hanging commonly results in death with a pale face and no petechial haemorrhages or signs of congestion.

[31] Sudden death without asphyxial signs is a well recognised occurrence in hanging resulting from reflex cardiac arrest particularly if there is more of a drop or free swinging, that is, full as opposed to a partial suspension which is more likely to cause sudden pressure or traction on the carotid arteries. It is also well recognised to occur as a likely consequence of manual strangulations or throttling because fingers can easily inflict deeper and more direct pressure on the carotid sinus than can be achieved by a broad ligature.

[32] The expert evidence in this case is largely agreed that the body of the deceased showed a lack of asphyxial changes and that death occurred as a consequence of pressure to the vegal nerve area due to sudden constriction of the neck. Professor Cordner's evidence concerning the mechanisms of death by hanging is in Exhibit D117 paragraphs 31–36. He describes death by interference with respiration on the one hand and death by interference with the flow of blood on the other. Having described pressure on the vagus nerve stimulating it "to exert its fatal slowing effects on the heart", he concludes that "in any particular case it is usually not possible to say which one or combination of the above factors was/were the mechanisms by which the pressure on the neck caused the death. Inferences can be drawn".

THE CAROTID SLEEPER HOLD

[33] Prison Officer Wood gave evidence that during the 1980's arm locks and pressure point techniques were learned as part of his training to restrain

prisoners. (t 776). The pressure points used were on the arms, elbow and legs together with the pressure point at the base of the jaw. The pressure points were used when necessary to control prisoners. The use of a finger or thumb or baton on the pressure point at the corner of the jaw became disused. (t 777). It was part of general training to use the pressure point under the jaw (t 778). While a strangle hold was never part of general procedure the carotid sleeper hold was also part of their training where the crook of the elbow was applied to the front of the neck (t 779).

[34] The carotid sleeper hold was, I find, a neck restraint technique in use at the time of the deceased's incarceration by prison staff and the application of which was part of their general training. As is evident from Exhibits P126 and P135 the carotid sleeper hold whilst once a widely used method of restraining persons is no longer in use.

[35] The hold is applied to the carotid arteries located on both sides of the neck. A subject is approached from the rear and an arm placed around the subject's neck with the elbow in line with the subject's sternum forming a "V" with the point of the "V" in front of the subject's chin. The other arm is placed behind the subject's head to prevent the head turning or twisting. Pressure is applied on each side of the neck by the forearm and bicep causing a substantial reduction in the supply of oxygenated blood to the brain through the carotid arteries. Although blood supply to the brain is reduced by as much as 40% proper application of the hold does not stop the flow of blood to the brain. The reduced blood flow to the brain causes loss

of consciousness within a matter of seconds. A proper application of the carotid sleeper hold does not compress the air ways or otherwise interfere with the passage of air to the lungs.

[36] The hold is not to be confused with a head lock or a choke hold, the latter of which cuts off the supply of air to the lungs by compression of the wind pipe. The subject of a choke hold will feel suffocated and will seek to defend himself or herself. Experience showed that a carotid sleeper hold is potentially lethal because of the varying physiological characteristics of subjects. In addition, faulty application of the hold could result in accidental crushing of the wind pipe with fatal consequences. The hold even applied correctly and effectively has on occasions resulted in the death of the subject. It fell into disuse because of the dangers associated with its use.

HYPOTHESES

[37] The following are possible hypotheses:

1. The deceased hanged himself using the sheet as a ligature.
2. The deceased was manually strangled (by hand) and thereafter hanged by a sheet.
3. The deceased was strangled with a narrow ligature and thereafter hanged by a sheet.

4. The deceased was incapacitated by the application of force to the pressure point in the neck at the corner of the jaw and thereafter hanged by a sheet.

5. The deceased was incapacitated by a carotid sleeper hold and thereafter hanged by a sheet.

THE FORENSIC EVIDENCE

[38] Each of the forensic pathologists who gave evidence in this case was, and was accepted to be, well qualified to give the expert evidence he gave. The plaintiffs, as I have said, allege that Dr Kevin Lee and Detective Sergeant Stevens were conspirators in a cover–up of murder. I unhesitatingly reject this allegation. Plainly neither is or was corrupt. Dr Lee was patently an honest and competent expert witness whose conduct of the first autopsy was said by Professor Cordner to satisfy the 1985 professional standards of conducting autopsies. I accept Dr Lee as a truthful and reliable witness.

[39] Professor Cordner gave evidence (Exhibit D116) about other cases dealt with by the Royal Commission into Aboriginal Deaths in Custody. That evidence highlights the adequacy of Dr Kevin Lee's autopsy on the remains of the deceased. In 41 of the 99 deaths in custody, the autopsy was not performed by a Forensic Pathologist but by a General Practitioner. In 12 of the 99 cases there was no inquest at all. Of the 20 cases that Professor Cordner was involved in reviewing, in eight cases the deceased was removed from the scene, that is, there was no body in situ, and in only four of the

twelve cases where there was a body in situ, the person who later conducted the autopsy attended the scene. In addition, in only seven cases were photographs taken of the body in situ. Photographs were taken in only five of 20 autopsies.

[40] It was Professor Cordner's conclusion that even when compared to standards introduced after the experience of the Royal Commission into Aboriginal Deaths in Custody the autopsy performed by Dr Lee was of a good standard. In terms of the standards that applied at the time of the autopsy in 1985 it was of comparatively high quality. Both Professor Ansford and Dr Williams gave evidence that the examination of the remains of the deceased at the second autopsy disclosed that Dr Lee's post–mortem examination had been thorough and extensive.

[41] Dr Lee gave evidence as follows: He attended the prison where he saw the body of the deceased on the bed within Cell 8. There was a sheet loose around the neck which had obviously been loosened prior to his arrival. He said there were no obvious signs of damage to the neck or significant ligature marks. The body was warm to touch. There was a vague area of impression around the neck most prominent in the area of the larynx. The impression was 4.5 centimetres wide at the front and 6 centimetres at the sides. It peeked upwards to the back and was quite consistent with having been caused by the sheet as depicted in Exhibits P2 and P3. There were no other signs of external injury on the body of the deceased. There was no evidence of facial trauma apart from a single area of light bruising which

was identified with a cross marked on Exhibit D 124. He said there was certainly no evidence of bruising in the area of the deceased's pressure point in the neck at the corner of the jaw, an area he dissected during the first autopsy. There was no bruising of the vegal nerves, jugular veins or carotid arteries, the likely consequence of a drop hanging.

[42] Dr Lee gave evidence that hangings not involving a drop would not normally cause bruising in that area although bruising in that area may well occur in the case of manual strangulation. He also gave evidence that an expertly applied carotid sleeper hold would not normally be expected to produce injury of any description. He gave evidence that there was no evidence of trauma in the pelvic region or in the knuckles, forearms, elbows or wrists. There was certainly no fracture of the left jaw. He expressed the opinion (t 1027) that the deceased's injuries were consistent with a self–inflicted hanging and also consistent with a deceased having been incapacitated by a carotid sleeper hold and thereafter immediately hanged.

[43] Both the plaintiffs' expert Professor Wecht (t 179–181) and the defendants' expert Professor Cordner (t 877) said that the fracture of the deceased's thyroid cartilage did not militate against a finding of self–inflicted hanging.

[44] The forensic experts appear to agree that with a full drop hanging ordinarily there would be damage to the neck vertebrae, ie. bone damage. The deceased sustained no bone damage to the neck vertebrae. This was confirmed at the second autopsy. See Professor Vanrell's affidavit of

4 April 2005 para 41, Exhibit P37. The experts were agreed that there was no evidence of manual strangulation, that is, strangulation by use of the hands, which would inevitably leave telltale bruising. See eg. Professor Wecht (t 174) and Professor Vanrell (t 247–8). The forensic experts also appear largely to agree that in the event of manual strangulation with the hands there would be not only telltale signs of bruising to the neck but in addition soft tissue or other injury to the limbs caused by defensive measures taken by the deceased. It also appeared to be common ground amongst the experts that severe blunt trauma such as to cause skull damage would necessarily be attended with brain damage of which there was no evidence at the first autopsy.

[45] As regards the hypotheses referred to previously a complete drop hanging is, according to Dr Freeman, complete speculation (t 303) and in any event unlikely given the lack of bone damage to the deceased. Professor Vanrell gave evidence that the possibility of a drop hanging can be excluded in the present case (t 245). I agree. Hypotheses that the deceased was incapacitated either by manual strangulation or by strangulation using a narrow ligature and thereafter hanged are also in my view improbable given Dr Lee's evidence, which I accept, that apart from the vague area of impression he referred to there were no obvious signs of damage to the neck or significant ligature marks and that there were no other signs of external injury apart from that shown on Exhibit D 124. The lack of evidence of bruising at the deceased's pressure point at the corner of his jaw and the

lack of evidence of bruising of the vegal nerves, jugular veins and carotid arteries support this conclusion as does the lack of any injuries on the limbs consistent with defensive measures taken by the deceased. This conclusion is also supported by Professor Cordner's evidence (t 879) that hyoid bone fractures are more common than thyroid cartilage fractures in cases of manual strangulation. He gave evidence of the significance of lack of injuries to the deceased's arms (t 883–4) and said (t 885) that when people are incapacitated as a result of injury the overwhelming circumstance is that there is observable injury.

[46] Reference was made in the evidence to an apparent fingernail mark on the lower left side of the deceased's neck. It is to be seen equidistant between a mole and the collar of the deceased's t–shirt in Exhibit P8, a Police photograph of the deceased taken at the morgue. The nail mark was not noted by Dr Kevin Lee at the post–mortem examination. Professor Cordner gave evidence, which I accept, that it is consistent with the mark of a finger checking for the pulse at the neck and that it is not a finger mark indicative of manual strangulation (t 883). This was also the view of Professor Ansford (t 849).

[47] The remaining hypotheses are that the deceased died as a consequence of self–inflicted hanging or that he was killed or incapacitated by the application of a carotid sleeper hold and thereafter immediately hanged by a sheet at the hands of prison personnel.

[48] The expert evidence appears to be largely agreed that a person can be incapacitated by a carotid sleeper hold causing no observable injury, that is, without telltale signs. See Professor Cordner (t 906) and Dr Lee (t 1024). Compare the evidence of Professor Ohshima as to whether there could be bruising: "sometimes yes, sometimes no" (t 316) and that of Professor Wecht that the deceased could have been rendered unconscious and lifted up and suspended without leaving marks (t 182). Professor Vanrell, contra, says a carotid sleeper hold would result in injury to the vegal nerves, jugular veins and carotid arteries and should be discarded as an hypothesis because of no evidence of such bruising (t 246). Professor Ansford (t 831) says that the evidence is consistent with the deceased having been rendered unconscious via the pressure point in the corner of the jaw and then suspended whilst unconscious, although he also says (t 848) one would usually get internal bruising of soft tissue in the relevant area. Professor Ansford's conclusion (t 830) is that the cause of death in the present case is by hanging and that the mechanism of death was probably a combination, as in most hangings, of reflex vegal nerve activity (the nerve end at the corner of the jaw) compression of the main arteries of the neck, the carotid arteries and possibly a degree of asphyxia, the cardiac mechanism probably being predominant. He added that it is difficult to say.

[49] On the balance of probabilities I am not persuaded that the deceased could have been incapacitated either by manual strangulation or the use of some narrow ligature. In reaching that conclusion I remain unpersuaded that the

mark to the rear lower right of the deceased's neck as depicted in Exhibits P1, P24, P27 photo 19, D121 photo 6, and referred to in the evidence and discussed extensively by the expert witnesses, is the mark of a narrow ligature altogether independent of the sheet by which the deceased was found hanging. I have reached that conclusion on the whole of the evidence including that of Dr Lee that no such mark was noted upon his initial physical examination of the body or at the first autopsy, the evidence of Professor Ansford that the mark is not in a location such as to be evident of an incapacitating activity (t 829), and the evidence of Professors Williams, Ansford and Cordner, particularly the latter, who following his examination of Professor Spring's photograph of the deceased's right neck area, said that no *injury* is evident in that photo, Exhibit D121 photo 6. See, also Dr Lee (t 1030). Professor Vanrell agreed (t 244) that only the pathologist conducting the initial autopsy could say with any certainty whether or not what is depicted in P1 is an injury or artefact. Dr Lee said there was no such injury. I accept that evidence in light of all the other evidence. This conclusion is also supported by the circumstance that the Reconstruction Committee of which Professor Wecht was a member when first viewing Exhibit P1 in 1999 considered the photograph unremarkable apart from some areas with slight discolouration.

[50] Professor Vanrell participated in the re–autopsy of the body of the deceased and presented a forensic report of his findings (Exhibit P37). In that report he noted what he said was an irregular outline of the left side of the cranium

(face), fractures of the pelvis, separation of the occipito/temporal sutures of the skull, a complete fracture of the left styloid process, a complete fracture of the left side of the jaw and an increase of the distance ulna–carpo, bilaterally, all of which lesions he asserted were pre–mortem and not inflicted by the deceased himself. The dehiscence of the sutures of the base of the skull he described as "lethal" and the fracture of the styloid process as "potentially lethal". Fractures of the pelvis he said were consistent with the deceased having been tortured in the genital region and the fracture of the jaw was consistent with a facial blow. It was suggested these injuries to the deceased indicated he had suffered a prolonged and severe assault. This was said to be supported by the evidence of the witnesses Bindai and Percy that there was extensive blood in the cell on the morning of 5 July and expert evidence to the effect that the photograph Exhibit P2 showed cotton wool or some block in the left ear of the deceased such as would be used to stop bleeding from the ear consequent upon a severe head injury. Professor Vanrell's findings from the second autopsy were dismissed by Professor Williams as "complete nonsense" (t 639–640) and by Professor Cordner as "outside acceptable forensic pathology opinion" (t 890).

[51] I reject any notion that the deceased sustained a prolonged severe assault or that he sustained the injuries Professor Vanrell alleges in Exhibit P37. I do so for the following reasons:

- There is no evidence of severe external injuries in the Police photos taken within the cell or at the morgue during the first autopsy.
- Dr Lee made no observations of internal or external injuries consistent with a prolonged severe assault. See his evidence at t 1020–1025.
- Trauma sufficient to cause a fractured skull such as asserted by Professor Vanrell would undoubtedly have associated brain damage of which there was no evidence.
- A prolonged severe assault would have caused an uproar within the prison and there is no evidence of this.
- The account by the two purported eye witnesses, Percy and Bindai, was of a short assault.
- No signs of violence on the body of the deceased were observed by either Sergeant Stevens (t 545) or Watch Commander Wernham (t 785).
- Two or more prison officers could quite readily and quickly have overwhelmed the deceased in his cell, particularly if he was caught unawares.
- Anyone who entered the deceased's cell with murderous intent would in all likelihood have overwhelmed the deceased as quickly and stealthily as possible to effect

their purpose. A prolonged assault would attract unwanted attention.

Professor Vanrell's conclusions from the second autopsy must be rejected.

[52] I accept the evidence of both Professor Williams and Professor Ansford that no evidence of foul play was evident from the second autopsy. I accept the evidence of Professor Ansford in Exhibit D112 that an objective examination of the remains of the deceased at the second autopsy disclosed nothing as to whether any damage to the remains occurred before or after death and that there was no scientific or other basis for saying any observable bone damage occurred before death. I accept the evidence of both Professor Ansford and Professor Williams that the changes observed were nothing other than part of the 20 year long decomposition process.

[53] From the forensic evidence I conclude that only two hypotheses are open: either the deceased committed suicide by hanging using a sheet as a ligature or alternatively he was killed or incapacitated by the application of a carotid sleeper hold following which he was immediately hanged by means of the sheet.

THE DECEASED'S MARRIAGE AND RELATIONSHIP WITH HIS WIFE THE FIRST PLAINTIFF

[54] The aboriginal deceased was born on 16 June 1959 in Townsville, Queensland. The aboriginal first plaintiff was born at Raggetts Well, Glen Helen in the Northern Territory on 26 April 1953. They met and later married in Townsville, Queensland on 9 July 1983. Their Marriage

Certificate is Exhibit P74. At the time of their marriage the first plaintiff had two daughters by a previous relationship. Following their marriage they moved to Alice Springs for several months and in September 1983 went to New Zealand (t 336). They returned to Australia in December that year.

[55] The first plaintiff said the deceased worried about "trying to feed us" (t 338). The deceased used to hit the first plaintiff and they used to fight (t 341). The deceased returned alone to his family in Townsville and the first plaintiff followed later. She found the deceased to be abusing alcohol there (t 343–44). The plaintiff gave evidence which I accept that the deceased was stressed by the fact that he was married to an older woman with two children by another man. At times he was very jealous of the plaintiff. Whilst in Queensland he assaulted a taxi driver, apparently falsely accusing him of impropriety with his wife (t 345–46). The deceased was arrested for that assault. The first plaintiff borrowed $1,000.00 to bail the deceased out of custody. Following that, the plaintiff returned to the Northern Territory alone (t 350–51). At the end of January 1984 the deceased returned to Darwin and from then until May 1985 when he went to gaol at Berrimah the deceased travelled between Townsville and Darwin looking for work.

[56] The deceased was at times abusive and violent towards Mrs Scott and her daughters; "But I don't blame Douglas when I look at what he had to put up with. Michelle, she was a real little bitch" (t 354–55). "... he got on with me – but it just didn't work out with the kids" (t 368). On an unspecified

date and at a time when the first plaintiff was pregnant with the second plaintiff the deceased moved into the Salvation Army hostel in Darwin. The plaintiff went to Adelaide where the second plaintiff was born on 2 September 1984. Whilst in Adelaide the first plaintiff and the deceased often spoke on the phone. She returned to Darwin in December 1984 (t 368). The first plaintiff said the deceased "did not want to be married to someone with kids" (t 374).

[57] On 22 February 1985 the deceased assaulted the first plaintiff in a bar at the Hotel Darwin (t 375). The first plaintiff did not want the deceased charged with assault but apparently he was (t 376). The plaintiff said: "Douglas was leaving me so he was not going to kill himself in prison" (t 378).

[58] I have no doubt that the first plaintiff loved the deceased despite the many difficulties they had. She wrote a letter (Exhibit D65) addressed to the Magistrate dealing with her husband's case which amply demonstrates her concern and support for her husband despite his ill–treatment of her (t 390). Also demonstrative of her genuine concern for her husband is the fact that when Police went to Bagot Community at 1.00 am on 26 May 1985 to arrest the deceased the plaintiff was already there trying to persuade him to come home (t 401).

[59] On 30 May 1985 whilst he was incarcerated the deceased informed prison officers that his wife was distressed and there was a need for him to speak to her urgently, Exhibit D68, (t 407). According to Exhibit D68, a Darwin

Prison document comprising part of Berrimah Gaol records, Mrs Scott was phoned but did not want to speak to the deceased and the deceased was so informed. She visited him in prison following this. The first plaintiff visited the deceased in prison on 29 May and 14 June 1985. The first plaintiff denied these were her only visits. (t 410). She gave evidence that she visited Superintendent Natt on 14 June and told him that the deceased was mentally ill and in need of help. In July she travelled to Broome with her sister Dixie. She gave evidence that she saw the deceased on 2 July, the Wednesday prior to the Friday he died (t 412). She strongly denied telling Sergeant Stevens that her marriage was finished (t 414) when he phoned her, following the death of the deceased.

[60] Exhibit P58 is a phonogram from the first plaintiff to the deceased in Darwin prison dated 7 June 1985 which says "We will always love you – Love Letty and your baby son Nathan". Exhibit P75 is a photograph of the deceased happily holding his baby son Nathan, the second plaintiff.

[61] Exhibit P22 are two undated handwritten letters from the deceased to his mother. One of those letters was apparently written whilst he was on remand. In that letter the deceased enquired of the well–being of relatives in Queensland. He said he would have to write to a person called Walter "soon" and continued: "or if I get to go back down to Townsville I can go and see him... I want to come back down to Townsville and to be with you and Dad ... I'm fine and still thinking of comming (sic) home. One thing is whatever Letty says to any of yous (sic) down there, disregard it. I'll be

going to see the doctors on the 26th July but as far as anything else goes I'm well. ... I can't wait to have a feed of chillie again, you can't get bird's eye chillies up here. Well, Mum I will have to write again to let you know how I am getting on with the Court case. I'm on remand till next month July ... I love you and realy (sic) miss you."

[62] It is clear that at the time of writing that letter the deceased was contemplating the outcome of his Court appearance on 25 July 1985, seeing "the doctors on the 26th July", and looking forward to future contact with his family members in Townsville. It gives no hint of suicide.

[63] An entry in the C Block journal of 29 May 1985 states the deceased "Received a 'Dear John' from wife – returned to the block crying – to be kept under supervision at all times. Deputy Superintendent Natt." I note that incident was earlier than the first plaintiff's phonogram, Exhibit P58.

[64] Exhibit D107 is a composite copy of extracts from Royal Darwin Hospital files, the Darwin Prison medical file, a file of Dr P E James, a Townsville Community Health Centre file, and a Townsville General Hospital file all relating to the deceased.

[65] On 7 August 1984 the Psychiatric Registrar of the Townsville General Hospital prepared a summary of the deceased's contact with the Psychiatric Unit. Following psychiatric and psychological testing of the deceased the Registrar reported: "I do not feel it would be fair to make any diagnoses at this point in time except to say he was admitted here for re–socialization and

this failed." That appears in Exhibit D107E folios 20–21. As appears at folio 24, a letter dated 1 February 1985 from the Senior Specialist Psychiatrist, Northern Territory Department of Health to Dr Drysdale of the Psychiatric Unite of the Townsville General Hospital: "The deceased was an inpatient of the Royal Darwin Hospital from 20 December 1984 to 18 January 1985 on account of depression, personality disorder, border line intelligence." That letter also states, amongst other things, that the deceased's mood was depressed, and, relevantly: "no suicidal ideation noted". On that same day, 1 February 1985, the deceased filled out a document headed "Checklist Life Events" for the Townsville General Hospital Psychiatric Unit in which he recorded both "marital separation" and "marital reconciliation" as of personal significance. That document appears at folio 25 of Exhibit D197E.

[66] It is clear from the records, consistently with the first plaintiff's evidence before me, that the marriage came under strain because the deceased had difficulties with the first plaintiff's daughters: see Exhibit D107A. The Darwin Hospital file entry at folio 71 is the deceased's account given on 9 January 1985: "Things started to go wrong early in the marriage when he started trying to discipline his step–children aged 14 and 11 years. Said that he and his wife had discussed divorce but now he is not sure. Seemed very enthusiastic when suggestion made that they should have some joint counselling". Another entry the same day records that the deceased and the first plaintiff "had talked it over in the evening and had come to the decision

that it was best they part". The following day there is an entry "Doug was farewelled at the lift by his wife who screamed at him that she hated him, hated his family, he was sick in the head and she never wanted to see him again". Exhibit D107, folio 7 is an undated entry in the records of the Townsville Community Health Centre file which records amongst other things: "married at 24 years – last year, met March 1983 – married in June, two kids from wife's previous marriage, didn't realise what I was getting into. Moved with wife ? Mount Isa ? Alice Springs ? Mount Isa ? Alice Springs ? New Zealand (alone) wife followed ? now split with wife in Darwin". The same entry records "use to lack confidence, frightened of things: wife brings him out of it." Further entry records "hard for kids to accept him – jealous of wife's attention". A further entry records: "most beautiful wife I could have. I want to be with wife but she's frightened of me – will have him back if I see about my problem".

[67] When the first plaintiff returned to Darwin just before Christmas 1984 she found that the deceased had admitted himself to the psychiatric ward of the Royal Darwin Hospital. He was there until his discharge on 26 January 1985. It was during that time that the first plaintiff found a letter of confession from the deceased to the Jehovah Witnesses relating to certain past experiences that deeply disturbed him. It was following his release from the Royal Darwin Hospital that he assaulted the first plaintiff in the Hotel Darwin.

[68] The deceased was arrested again in May 1985 for smashing a plate glass window in commercial premises in Cavenagh Street and for stealing. Following his release on bail he went with the first plaintiff to see Dr Taylor at the Mental Health Unit at the Royal Darwin Hospital. That attendance was on 21 May 1985 and is recorded in the Out–Patient Clinical Progress Sheet in Exhibit D67. In the course of that attendance the first plaintiff made various complaints to Dr Taylor in relation to the deceased's sexual conduct, in part in relation to matters in the letters of confession to the Jehovah Witnesses. The deceased was both clearly upset and in receipt of psychiatric treatment in relation to these issues (t 388–89). It was five days later on 26 May 1985 the deceased was arrested at Bagot Community.

[69] There are many other notes and entries, but I have cited sufficient to demonstrate that the relationship was a volatile and troubled one and that the deceased had many bouts of depression though he was never diagnosed as having a psychiatric illness or being suicidal. It is also clear that despite their many differences of opinion, their ups and downs and angry eruptions, that the first plaintiff genuinely cared for her husband.

[70] The evidence is also clear that the first plaintiff considered her husband had a psychiatric problem. See, for example, the entry of 21 May 1985 in the Out Patients Hospital notes, Exhibit D67. I do not overlook Exhibit D107A folio 40, a Royal Darwin Hospital file note of 20 December 1984 that records that the deceased "attempted suicide once in the past three years

ago" whilst at the same time expressing the view that the deceased was "not suicidal".

THE RELATIONSHIP BETWEEN THE DECEASED AND PRISON OFFICERS

[71] Each of the defendant prison officers denied any knowledge of the deceased prior to his death. I have already noted that Superintendent Natt noted in the C Block journal that the deceased was "to be kept under supervision at all times" on account of the "Dear John" letter. See Exhibit D109, "C" Block entry 29 May 1985.

[72] Exhibit D127A is a statement of Senior Prison Officer Thomas of 13 March 1988. He refers to an incident of 31 May 1985 when the deceased injured his eye. He also makes reference to the deceased "salaaming" on the ground on 20 June 1985. Thomas says it was the first he had seen or heard of such an incident although it is apparent from other evidence, including, from the witnesses Bindai and Percy, that the deceased did this from time to time during his incarceration. The actions of the deceased in kneeling and putting his forehead on the ground is corroborated by the statement of former prisoner, Rene Charles Dooling, Exhibit P23, who describes the deceased doing that not only in the dining room on an occasion when he was told by prison officers to get up or he would be locked up but four or five other times and doing it in the exercise yard once or twice. Dooling also states that the deceased on the evening before he died was yelling and

screaming in the television room and that he was placed in his cell by prison officers early. It is apparent that the deceased came to the attention of a number of prison officers because of his eye injury and unusual behaviour, which, it appears, was well known to fellow prisoners. Senior Prison Officer Thomas recommended that psychiatric treatment be sought for the deceased as a consequence of the incident of 20 June 1985.

[73] Senior Prison Officer Thomas' knowledge of the deceased is in stark contrast to a lack of knowledge of the deceased of the defendant prison officers. It seems odd, to say the least, that the deceased's somewhat bizarre behaviour did not come to the attention of *any* of the defendant prison officers, if not directly, at least by way of report or via paperwork, eg. the C Block Journal. See also Exhibit D57 – that the deceased was a very troubled individual can not be doubted having regard to his alleged past as reported to the authorities. See particularly Exhibits D66, D67 and D93. See also Exhibits D61 and D62.

WITNESSES BINDAI AND PERCY

[74] Each of these witnesses was a prisoner in the Remand Section in the cells opposite Cell 8. There are many difficulties with their evidence. There were substantial language and communication difficulties. Each had signed prior statements inconsistent with their affidavit evidence and oral evidence in Court. Percy appeared to suffer from the effects of long term alcohol abuse. The length of time since the occurrences of which they spoke added

to the difficulties. Each at times appeared not to understand questions and yet answer them. Each at times was subject to the affliction of gratuitous concurrence, a well known difficulty with many Aboriginal witnesses. In each case there was the added problem that in giving evidence in this Court, their account was hampered by difficulties encountered with interpreters. The circumstances of them signing documents was not fully explored. Justices of the Peace and others before whom they had sworn or declared statements were not called to give evidence. The difficulties were further compounded by the witness Percy being unable to read through failing eye sight. Neither witness was able to give a fair account of himself in examination in chief or be appropriately and fairly tested by cross–examination. The plaintiffs' lack of legal representation added to these problems. Overall the evidence of Bindai and Percy was most unsatisfactory.

[75] Each gave evidence of having cleaned up blood in Cell 8 after the Police, Dr Lee, the pathologist, and Ambulance people had left the gaol. If, as the plaintiffs allege, there was a cover–up, surely the cell would have been cleaned prior to the Police and pathologist attending the gaol, not afterwards. The Police photographs, including Exhibit D46 which was marked by the witness Bindai indicating where he said there was blood, show no blood, even though the photographs, on these witnesses' account, were taken before the clean up. Another added difficulty is that the witness Bindai gave an account of the Senior Prison Officer involved in an assault

having an eagle tattooed on his arm. None of the prison officer defendants had such a tattoo, nor did Senior Prison Officer Bowden. See Exhibits D81 and D128.

[76] Exhibit P19 is an affidavit of the witness Laurie Percy. On its face it was sworn and signed without the aid of an interpreter. It is of sufficient importance that I deem it necessary to set its terms out in full. It is in the following terms:

> "I, Laurie Percy, of (NFA – longgrass') sworn, make oath and say as follows:
>
> 1. On the day before Douglas Scott died, I was playing cards in C Block (Remand) with Douglas Scott, John Dargie and Jeffrey Bindai – (from Turkey Creek WA) – then later we were put in cells (single).
> 2. I saw guards go into Douglas' cell after prisoners were put in cells.
> 3. I then heard Douglas call for "Help" almost straight away.
> 4. Douglas' voice was then muffled – but I could still hear.
> 5. I saw one guard looking out small glass in door, keeping watch.
> 6. One or more prisoners yelled out to guards.
> 7. Maybe hour or two, then ambulance come and also photographer.
> 8. I saw stretcher with body covered in white sheet being removed from Douglas' cell.
> 9. Two guards got Jeffrey Bindai and me out of cells in morning to clean Douglas' cell. I saw blood–stained plastic gloves on the cell floor. (Douglas' cell).

10. I saw blood on walls – floor– sheet – pillow–slip. 'Heaps' – blood on walls and floor was 'thick'.

11. We used mop and bucket – sponges –– to clean blood from cell. No guards in cell at time.

12. I think he died because guards bash him up.

13. Normally siren wake prisoners up – but that morning siren was late and so was breakfast.

14. No–one interviewed me in prison.

15. After release – 'long time' – I was interviewed by some plain–clothes men (2) (Normal clothes – not suits) who showed me photos, "big mob" – they were Black and White photos.

16. The two men were from down South – And they found me by talking to Jeffrey Moreen who took them to where I was staying. Jeffrey Moreen was present during this interview.

17. One showed photos – One took notes in notebook.

18. They told me they were driving back to Turkey Creek, drive all night, to talk to Jeffrey Bindai again. They had a Commodore, 'flash one'.

19. They said that Jeffrey Bindai said 'hello'.

Sworn at Darwin
By Laurie Percy this 15th day of September 2004.

Before me:	)	
	)	(sgd)
	)	....
	)	Deponent: Laurie Percy
Justice of the Peace	)	
	)	
(sgd)	)	
....	)	
Name of JP	)	Fiona Gallacher Justice of the Peace Northern Territory Ph: (0) 8999 6224".

[77] Exhibit P20 is an affidavit of the witness Jeffrey Bindai sworn on 27 May 2004 annexing a Statutory Declaration of his declared on 27 September 1996 which he says is true and correct. Each document appears to have been executed without the aid of an interpreter. The Statutory Declaration which was declared before a barrister, Daniel Bezniak, at Halls Creek in Western Australia is in the follows terms:

> "Geoffrey Bindai of Turkey Creek Western Australia solemnly and sincerely declare as follows:
>
> 1. I was a prisoner in Berrimah Gaol near Darwin in July 1985 when about that time another prisoner whose cell was opposite from mine was found hanging.
>
> 2. I remember the night before that prisoner was found hanging I was lying in my bunk asleep when I heard a click. It was late at night maybe around midnight and I got up from my bed to see what was going on.
>
> 3. I looked at between the louvres into the courtyard and I saw four men going into the cell over there. One of them had a long black stick.
>
> 4. I heard a man calling 'help, help me' and some of the other boys starting shouting.
>
> 5. A man then came over to my cell and he said to me 'If you don't be quiet you will be next'. I was not shouting because I was too frightened. I noticed that the man who spoke to me had an eagle tattooed on his arm.
>
> 6. The next day that same officer came up to me and said 'Are you alright Geoffrey?' and I said 'Yeah, I'm alright'.
>
> 7. I could hear the sounds of the man being hit in his cell. I then went to sleep. I was frightened.
>
> 8. The next morning I looked out from my cell and I saw a man hanging in his cell. I saw a sheet but not a face.
>
> 9. –