Coroners Act, 1996
[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION INTO DEATH

Ref No: 32/ 15

I, Barry Paul King, Coroner, having investigated the death of ***Michael Joeseph Bottomley*** *with an inquest held at* ***Perth Coroner's Court, Court 51, CLC Building, 501 Hay Street, Perth,*** *on* ***8 September 2015*** *find that the identity of the deceased person was* ***Michael Joeseph Bottomley*** *and that death occurred on* ***4 May 2012*** *at* ***Plaza Arcade Laneway in Perth*** *from* ***multiple injuries*** *in the following circumstances:*

Counsel Appearing:

Ms K E Ellson assisted the Coroner
Mr A B Burnett (Squire Patton Boggs) appeared on behalf of the City of Perth

Table of Contents

INTRODUCTION

1. Just before midnight on 3 May 2012 Michael Joseph Bottomley (the deceased) was lying in a laneway off Murray Street Mall in the Perth CBD (the laneway), when a waste removal truck operated by City of Perth employees backed up the laneway and ran over him, causing him fatal injuries.

2. Earlier that evening the deceased had been warned by police officers not to sleep in the laneway because of the danger of being run over by a truck.

3. On 8 September 2015 I held an inquest into the deceased's death.

4. As there was no suggestion of criminality in the manner of death, the issues of how death occurred and the manner of death were clear and uncontentious.

5. While the circumstances of the deceased's death were foreseeable to some extent, there was no evidence before me to indicate that anyone had died in a similar way in a Perth laneway.

6. The focus of the evidence was therefore limited to the conduct, training and procedural framework of the police officers who came into contact with the deceased on the day of his death and to procedural changes implemented by the City of Perth in relation to waste and recycling removal in laneways.

7. The documentary evidence adduced at the inquest was a brief of evidence containing reports by investigators of the Western Australia Police Major Crash Investigation Section and the Internal Affairs Unit, as well as documents provided by the City of Perth and others in response to requests from this Court.[1]

[1] Exhibit 1, Volumes 1 and 2

8. Oral evidence was provided by Senior Constable Damian Eyon-Williams and Constable Diane Murray of the Western Australia Police and Mr Douglas Forster, Interim Director of Construction and Maintenance with the City of Perth.

9. Following the taking of oral evidence I did not seek submissions from counsel and I informed counsel that I did not intend to make adverse findings against any person or entity. Not surprisingly, no submissions were offered.

THE DECEASED

10. The deceased was born in Scotland on 21 November 1958, making him 53 years old at the time of his death. He was adopted at birth and moved to Australia in 1969 with his adoptive parents to settle in the Lesmurdie/Kalamunda area. He continued to reside in a house in Lesmurdie as his primary home until his death.

11. The deceased went to a Catholic primary school and secondary college in Gooseberry Hill and Lesmurdie before attending Kalamunda Senior High School. He continued to be religious as an adult.[2]

12. The deceased was well-read and was known to have a sharp intellect and a flair for creative writing, including poetry, though it seems that he was not particularly interested in study.[3] He had been diagnosed with attention deficit hyperactivity disorder and had been prescribed dexamphetamine.[4]

13. The deceased later showed an interest in nursing and for some time he was a nurse at the Kalgoorlie Hospital.[5] At around the time of his death he sometimes also worked

[2] Exhibit 1, Volume 1, Tab 9
[3] Exhibit 1, Volume 1, Tab 35
[4] Exhibit 1, Volume 1, Tab 28
[5] Exhibit 1, Volume 1, Tab 8

with a friend rubbing down cars prior to them being spray painted.[6]

14. From the time that the deceased was approximately 32 years old the deceased abused and was dependent on alcohol, possibly as a result of trauma experienced as a nurse in Kalgoorlie.[7] He also suffered from depression for which he was prescribed an antidepressant.[8]

15. The deceased also suffered from a number of medical conditions, including insulin-dependent diabetes mellitus, oesophagitis and hiatus hernia, alcohol-related liver disease, hepatitis C and asthma. His general health was poor and his diabetes was poorly controlled as a result of his alcohol dependency.

16. The deceased had 18 admissions to the inpatient withdrawal unit at Royal Perth Hospital. After an admission in February 2006 he abstained from consuming alcohol for three years. The deceased's last admission was from 17 April 2012 to 24 April 2012. During that admission he participated well in the whole of the program, including group activities. On discharge his mood was improved and he felt hopeful.[9]

17. For the 14 years before his death, the deceased had an on-off relationship with Jodie Allison Pierce, who in 2012 lived in a unit on Claisebrook Road in East Perth.

18. The deceased and Ms Pierce had a child together in 1999. The child was adopted out at birth and neither of them had further contact with him. This issue unsettled the deceased and he often raised it with Ms Pierce.

19. The deceased's habits were unreliable and erratic. He would often spend several days a week with Ms Pierce at her unit but would not always return after he went out during the day. He would drink heavily and would sometimes end up staying at Bridge House, a men's hostel

[6] Exhibit 1, Volume 1, Tab 9
[7] Exhibit 1, Volume 1, Tabs 9 and 28
[8] Exhibit 1, Volume 1, Tab 28
[9] Exhibit 1, Volume 1, Tab 28

in Highgate with a sobering up unit. Ms Pierce would leave her door open for him in case he returned without his keys.[10]

3 MAY 2012

20. On the morning of 3 May 2012 the deceased argued with Ms Pierce about his alternating wish to have and not to have children. He left her unit at about 8.30 am to go into the central business district. Ms Pierce left the door open as she expected him to return that night.[11]

21. There is no evidence to establish the deceased's whereabouts during that day, though Ms Pierce told police that he would often go to the library in the city.[12]

22. At about 7.30 pm on 3 May 2012 two police officers, Constable Damian Eyon-Williams and Constable James Thorne were driving through the Murray Street Mall towards Barrack Street when they noticed the deceased lying beside, and partly in, a flower box in front of a coffee shop near the entrance to the laneway. He appeared to be asleep. On the other side of the flower box from the deceased were his bicycle and backpack.[13]

23. The police officers stopped and approached the deceased on foot to check on his welfare. They had not met him before then. The deceased was wearing dark trousers and a patterned jumper. His feet were bare. He had a 'bum bag' which he wore on the front. With his backpack was a bottle containing wine. He smelled of alcohol.[14] When the police officers approached the deceased, he sat up against a pole to speak with them.[15]

24. Constable Eyon-Williams poured out the wine and put the bottle in a nearby rubbish bin. After inspecting the deceased's identification, he checked on the computer in

[10] Exhibit 1, Volume 1, Tab 9
[11] Exhibit 1, Volume 1, Tab 9
[12] Exhibit 1, Volume 1, Tab 9
[13] Exhibit 1, Volume 1, Tab 34
[14] Exhibit 1, Volume 1, Tab 13
[15] Exhibit 1, Volume 1, Tab 34; ts 16 per Eyon-Williams, D

the police vehicle to see if there were any alerts associated with him. There were none.[16]

25. Constable Thorne chatted with the deceased, who told him about his partner and his farm. The deceased appeared to have been drinking but not to be drunk. He was coherent and, according to Constable Thorne, was not slurring his words.[17]

26. Constable Thorne said that the deceased told the police officers that he did not want any police or medical attention and just wanted to be left alone.[18] They had no welfare concerns for him, so left him where he was.[19]

27. Constable Eyon-Williams asked the deceased if he was all right or if he wanted an ambulance, to which the deceased replied, 'No. I'm just drunk. Leave me alone. I'm not going anywhere.'[20]

28. Constable Eyon-Williams testified that the deceased was rude and unhelpful in explaining why he was lying there. The deceased had an abrasion on his forehead but did not appear to need medical attention. He appeared to Constable Eyon-Williams mildly intoxicated and was slurring his words slightly.[21]

29. Constable Eyon-Williams asked the deceased if he had a place to go. The deceased said that he lived on Claisebrook Road. He said that he had argued with his partner but would try to sort it out with her later when he was sober. Constable Eyon-Williams told the deceased to sit where he was and to sober up before going home. [22]

30. Constable Eyon-Williams did not consider that the deceased needed protective custody or that he could be

[16] Exhibit 1, Volume 1, Tab 13
[17] Exhibit 1, Volume 1, Tab 12, pp. 12-14
[18] Exhibit 1, Volume 1, Tab 12, pp. 6, 17
[19] Exhibit 1, Volume 1, Tab 12, p. 16
[20] Exhibit 1, Volume 1, Tab 13
[21] ts 9 per Eyon-Williams, D; but see: Exhibit 1, Volume 1, Tab 13
[22] Exhibit 1, Volume 1, Tab 13

issued a move-on notice. The deceased did not appear to have a mental health issue or to be a danger to himself.[23]

31. The two police officers then continued their patrol.

32. At about 10.30 pm on 3 May 2012 three other police officers, Constable Diane Murray, Constable Alex Michailidis and Constable James Byrne were on foot patrol together in Murray Street Mall. They were approached by an unidentified man who told them that someone was lying down in the laneway and that it was unsafe to do so because trucks made deliveries in the laneway.

33. The three officers walked up the laneway using their torches. One of the lights on the wall of the laneway was not working.[24] The laneway narrows about halfway and begins an upward incline. It was so dark that they did not see anyone until they had walked in about 50 metres and were up close to the deceased, who was on the ground with his back against a wall and his legs in the laneway. He was on the narrow, inclined portion of the laneway. On the ground beside him was his backpack. He was partially hidden by a drain-pipe on the wall and appeared to be asleep.[25]

34. Constable Murray tapped the deceased's foot with her foot and the deceased immediately awoke and asked the time. She told him that it was 11.45 pm and that he could not sleep there because he could get run over by a truck. The deceased replied that he did not want to be run over. He then stood up. [26]

35. Constable Murray asked the deceased for identification. The deceased pulled out his wallet and went through his pockets, putting the wallet on the ground. The wallet opened up on the ground and displayed the deceased's Centrelink card.[27]

---

[23] ts 10-11 per Eyon-Williams, D
[24] ts 34 per Forster, D M
[25] Exhibit 1, Volume 1, Tab 15, p. 13
[26] Exhibit 1, Volume 1, Tab 15, p. 3
[27] Exhibit 1, Volume 1, Tab 15, p.11

36. Constable Murray asked the deceased to pick up the wallet and to give her the Centrelink card. The deceased bent over without any difficulties, picked up his wallet and passed her the card. Constable Murray then radioed the police station to ask for a name check on the deceased while the other police officers spoke to him.[28]

37. Constable Byrne asked the deceased if he had anywhere to stay, and the deceased replied that he did in Lesmurdie. He told Constable Murray that he had come to Perth to visit his girlfriend.[29] He said that he was an alcoholic and that he had just fallen asleep in the laneway. He said that he knew that he could not stay there. He said that he would be able to find somewhere and that he would be all right.[30]

38. After Constable Murray had completed the name check and informed the other police officers that there was nothing outstanding on the police system relating to the deceased, Constable Michailidis asked the deceased if he was going to leave the laneway. The deceased replied, 'Yeah, I'm on my way, guys.' The deceased picked up his bag and appeared ready to go.[31]

39. The police officers then left the deceased in the laneway and went back to the mall to resume their patrol. They did not see the deceased leave the laneway, but were satisfied that he was going to leave.[32]

40. The impression of each of the police officers was that the deceased was not intoxicated at all and that he did not need their help. He appeared lucid and coherent and his actions were co-ordinated.[33]

41. The police officers indicated that, if they had considered that the deceased was in danger or needed help, they

[28] Exhibit 1, Volume 1, Tab 15, pp. 4, 12
[29] Exhibit 1, Volume 1, Tab 15, p. 13
[30] Exhibit 1, Volume 1, Tab 16, p. 10
[31] Exhibit 1, Volume 1, Tab 14, p. 25
[32] Exhibit 1, Volume 1, Tab 14, pp. 20, 27; Exhibit 1, Volume 1, Tab 15, pp. 15, 22; Exhibit 1, Volume 1, Tab 16, pp. 16-17
[33] Exhibit 1, Volume 1, Tab 14, pp. 20, 27; Exhibit 1, Volume 1, Tab 15, pp. 15, 22; Exhibit 1, Volume 1, Tab 16, pp. 16-17

would have taken appropriate action, which may have meant taking him to Bridge House or the hospital. They would not have left him in the laneway. There was no basis to issue him with a move on notice or to take him into protective custody.[34]

EVENTS LEADING UP TO DEATH

42. At about 11.55 pm on 3 May 2012, City of Perth employees Kevin Fretwell and Peter Cullen approached the Plaza Arcade laneway in a 13 cubic metre rubbish truck (the truck). Mr Fretwell was the driver and Mr Cullen was his assistant, or 'swamper'. Their task was to back the truck into the laneway and to remove recycling material that had been placed into the laneway by adjacent businesses.[35]

43. The truck was equipped with a rotating amber light on the roof, rear and side reversing lights and a loud reversing warning beeper. There were also lights above the rear compactor area which illuminated that area for workers to deposit waste or recycling into the compactor. There was a rear camera that displayed the compactor area as a video image on a screen on the dashboard of the truck.[36] The purpose of that camera was mainly to indicate to the driver what was happening with the swamper around the rear of the truck.[37]

44. Mr Fretwell stopped the truck in the Murray Street Mall with the driver's side facing the laneway so that he could look into it. He could see white bollards near the end of it. He could not see anything else of note in the laneway.[38]

45. At that time, the City of Perth had a policy restricting employees from entering laneways on foot at night due to

[34] Exhibit 1, Volume 1, Tab 14, pp. 23, 27; Exhibit 1, Volume 1, Tab 15, pp. 22, 25; Exhibit 1, Volume 1, Tab 16, p. 22-23
[35] Exhibit 1, Volume 1, Tab 10
[36] Exhibit 1, Volume 1, Tab 25
[37] ts 31 per Forster, D
[38] Exhibit 1, Volume 1, Tabs 3 and 10

concerns about potential violence from persons using the laneways for improper purposes.[39]

46. In addition, the recent death of a truck driver who had got out of a rubbish truck in the same laneway and had been crushed against a wall when the truck moved had led to a directive to drivers and passengers in rubbish trucks not to get out of the trucks in laneways where the truck doors could not be opened completely.[40]

47. After looking into the laneway and not seeing anything unusual, Mr Fretwell started to back the truck into the laneway. Mr Cullen remained in the passenger seat in accordance with the City's policy.[41]

48. As Mr Fretwell was reversing the truck he was looking at his mirrors, trying to keep the driver's side as close as possible to the wall.[42] As the truck was going up the inclined part of the laneway, Mr Cullen heard what he thought was a scratching noise as if the truck had hit a milk crate or something on the ground. He and Mr Fretwell then heard a faint sound, like a person calling out.[43]

49. Mr Fretwell stopped the truck and Mr Cullen got out of the truck and squeezed between the truck and the wall to go to the back of the truck. Mr Cullen saw the deceased lying on his side on the ground at the back of the truck, so he told Mr Fretwell to drive the truck forward.[44]

50. Mr Fretwell drove forward to where the laneway was wide enough to open his door, got out of the truck and went to the back to join Mr Cullen.[45] After seeing the deceased, Mr Fretwell called his supervisor, Anthony Walker, to tell him what had happened and to ask him to call for an ambulance.[46]

---

[39] ts 30, 39 per Forster, D
[40] ts 37 per Forster, D
[41] Exhibit 1, Volume 1, Tab 10
[42] Exhibit 1, Volume 1, Tab 3
[43] Exhibit 1, Volume 1, Tab 10
[44] Exhibit 1, Volume 1, Tab 10
[45] Exhibit 1, Volume 1, Tab 10
[46] Exhibit 1, Volume 1, Tab 11

51. Mr Walker called St John's Ambulance Service and drove to the laneway while on the phone. When he arrived, the deceased was still breathing but his breathing soon stopped. Acting on the instructions of the ambulance service operator, he checked the deceased's pulse and, when he could not find one, he administered cardiopulmonary resuscitation.[47]

52. Ambulance officers arrived and took over the resuscitation but were unable to revive the deceased due to his non-survivable injuries.[48]

CAUSE OF DEATH

53. On 7 May 2012 Chief Forensic Pathologist Dr C. T. Cooke conducted a post mortem examination of the deceased.[49]

54. Dr Cooke found severe 'crushing-type' injuries to the chest and abdomen with compound fracturing of the right mid-thigh region. He also found pulmonary emphysema and congestion, coronary and aortic arteriosclerosis, chronic pancreatitis and fatty change to the liver.[50]

55. Toxicological analysis showed a blood alcohol level of 0.352 per cent together with therapeutic levels of mirtazapine (an antidepressant), quinine/quinidine (an antiarrhythmic agent) and desmethyldiazepam (a derivative of 1,4 benzodiazepam and a metabolite of diazepam).[51]

56. Dr Cooke formed the opinion, which I adopt as my finding, that the cause of death was multiple injuries.[52]

[47] Exhibit 1, Volume 1, Tab 11
[48] Exhibit 1, Volume 1, Tab 27
[49] Exhibit 1, Volume 1, Tab 4
[50] Exhibit 1, Volume 1, Tab 4
[51] Exhibit 1, Volume 1, Tab 5
[52] Exhibit 1, Volume 1, Tab 4

COMMENTS ON THE ACTIONS OF POLICE OFFICERS

57. In my view, the actions of both sets of police officers were entirely appropriate.

58. In addition to the available documentary evidence and the oral evidence of Constable Eyon-Williams, a video recording of Constables Eyon-Williams and Thorne makes clear that they treated the deceased with care and respect. They spent a fair amount of time with him to ensure, so far as practical and without infringing his rights, that he did not require assistance.

59. I reach the same conclusion in relation to the evidence relating to Constables Murray, Michailidis and Byrne. After being informed of the deceased's presence in the laneway, they entered the laneway out of concern for his welfare and satisfied themselves that he would not remain there.

60. The transcripts of the interviews of each of these officers undertaken by Internal Affairs Unit officers on the morning of 4 May 2012 consistently show that the officers believed that the deceased was able to look after himself, that he had been made aware of the danger of remaining in the laneway, and that he was going to leave the laneway directly. The procedures adopted with the interviews made collusion between the officers very unlikely.

61. Constable Murray impressed me as a competent officer and a truthful witness with a good memory. She carried on a conversation with the deceased and formed the impression that he was not intoxicated. She noted that he was able to bend down to pick up his wallet without difficulty, had no problem in taking his Centrelink card out of the window section of his wallet, and did not smell of alcohol.[53]

62. I note that, even if the police officers had required the deceased to leave the laneway while they were there, once

[53] ts 25-26 per Murray, D

they had left the area the deceased could have easily returned to it.

63. As to the potential inconsistency between the deceased's extreme post mortem alcohol level and the police officers' evidence, his apparent sobriety, there are reasonable explanations.

64. Evidence received from Dr Rodney Brown, a drug and alcohol specialist, indicated that people such as the deceased who have daily exposure to high levels of alcohol develop compensatory changes in the brain to preserve functioning in response to the depressant effects of alcohol. Such people are able to appear behaviourally unremarkable despite blood alcohol levels that would render the occasional drinker insensible. Dr Brown said that the observations of the three police officers who did not consider the deceased to be obviously intoxicated were entirely consistent with the presence of a high level alcohol tolerance.[54]

65. In addition, when the three police officers saw the deceased at about 11.45 pm, he had probably been sleeping for some time, perhaps since about the time Constables Thorne and Eyon-Williams had left him some four hours earlier. That period of sleep may have had a positive effect on the deceased's ability to appear less intoxicated than his blood alcohol level would otherwise indicate.

COMMENT ON THE ACTIONS OF THE CITY OF PERTH EMPLOYEES

66. It might be argued that Mr Fretwell should have ensured that no-one was lying in the laneway before he backed the truck into it.

67. Mr Fretwell visually checked the laneway so far as he was able from the truck before backing into the laneway. In accordance with City of Perth procedures at the time,

[54] Exhibit 1, Volume 1, Tab 30

neither he nor Mr Cullen got out of the truck to inspect the laneway.

68. The truck had warning lights and a reversing beeper, which could reasonably have been expected to have reduced the likelihood that anyone would remain in the laneway as they moved into it.

69. While the truck had a reversing camera, the screen in the cab of the truck appears to have provided a poor image of what was immediately behind the truck[55] and, in any event, Mr Fretwell was obliged to watch his mirror because of the narrowness of the laneway.

70. In my view it is not open to criticise Mr Fretwell for complying with the instructions of his employer as to how to carry out his tasks. Out of completeness, I note that an investigator from the Major Crash Investigation Section concluded that evidence gathered in the investigation suggested no fault by Mr Fretwell in the death of the deceased.[56]

HOW DEATH OCCURRED

71. Given the foregoing circumstances, I find that death occurred by way of accident.

CHANGES TO CITY OF PERTH PROCEDURES

72. Following the death of the deceased, the City of Perth implemented a procedure requiring swampers to get out of trucks and to walk behind them as they back into laneways.[57]

73. The City of Perth also introduced a procedure requiring the owners of laneways to ensure that lighting in the laneways was properly maintained. The procedure involved notifying the relevant owner if a light was not

[55] Exhibit 1, Volume 1, Tab 34.A; Exhibit 1, Volume 2, Tab 40.1.7
[56] Exhibit 1, Volume 1, Tab 2
[57] ts 34 per Forster, D M; Exhibit 1, Volume 2, Tab 40.5.1

working and then, if the light was not fixed within a reasonable period, refusing to use the laneway to remove waste or recycling material until the light was fixed.[58]

74. In addition, the City of Perth changed its organisation of tasks. Prior to the deceased's death, crews were entitled to go home once a task was finished. This arrangement led to the potential for employees to rush their jobs and thereby create hazards. The current procedure is to have crews work a slightly shorter shift and to have educational programs to manage fatigue. [59]

75. I am satisfied that these changes to procedures are likely to reduce considerably the likelihood that another person using a laneway in Perth to sleep will be run over by a City of Perth truck.

CONCLUSION

76. While the deceased was not homeless, at the time of the hearing of the inquest into the death of the deceased, the pitiable sight of apparently homeless people spending nights sleeping on the ground in doorways and similar refuges in the City of Perth has become only too commonplace. It is easy to imagine dangers inherent with that practice.

77. As a result of the deceased's death, one such danger has been removed or reduced, hopefully providing the deceased's family with some consolation for his death.

B P King
Coroner
6 October 2015

[58] ts 34 per Forster, D M; Exhibit 1, Volume 2, Tab 40.4.6
[59] ts 33 per Forster, D M