

CITATION: *Inquest into the death of Bryan G aka Abel Dallos* [2001] NTMC 67.

TITLE OF COURT: Coroner's Court

JURISDICTION: Alice Springs

FILE NO(s): A0077/2000

DELIVERED ON: 15 October 2001

DELIVERED AT: Alice Springs

HEARING DATE(s): 5 & 6 September 2001

FINDING OF: Mr Greg Cavanagh SM

**CATCHWORDS:**

CORONERS – INQUEST  
Airport Security  
Mental Health  
Involuntary Patient  
Aviation Investigation

**REPRESENTATION:**

*Counsel:*

Assisting: Mr Stewart Brown

*Solicitors:*

Alice Springs Airport: Mr John McBride

Territory Health Services: Mr Terry Riley

Judgment category classification: B

Judgement ID number: [2001] NTMC 67

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IN THE CORONERS COURT  
AT ALICE SPRINGS IN THE NORTHERN  
TERRITORY OF AUSTRALIA

No. A0077/2000

In the matter of an Inquest into the death of

**BRYAN G ALSO KNOW AS ABEL DALLOS  
ON 16 DECEMBER 2000  
AT A POSITION APPROXIMATELY TWO  
KILOMETRES EAST OF THE ALICE  
SPRINGS AIRPORT, ALICE SPRINGS IN  
THE NORTHERN TERRITORY**

**FINDINGS**

(Delivered 15 October 2001)

Mr GREG CAVANAGH:

1. Bryan G who was also known as Abel Dallos (“the deceased”) died at around 5.00 am on the 16<sup>th</sup> of December 2000 at a position approximately two kilometres east of the main runway of the Alice Springs Airport in the vicinity of the Santa Teresa Road. The cause of his death was from multiple injuries that he sustained in an aircraft crash.
2. Section 12(1) of the *Coroners Act* (“the Act”) defines a “reportable death” to mean a death that:

“appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury”.
3. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to section 15(2) of the Act.
4. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

“(1) A coroner investigating –

(a) death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*;

(v) any relevant circumstances concerning the death.”

5. Section 34(2) of the Act operates to extend my function as follows:

“A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated.”

6. The public inquest in this matter was held at Alice Springs Magistrates Court on the 5<sup>th</sup> and 6<sup>th</sup> of September 2001. Counsel assisting me was Deputy Coroner Mr Stewart Brown. Mr John McBride sought leave to appear on behalf of the Alice Springs Airport Pty Ltd. Mr Terry Riley sought leave to appear on behalf of Territory Health Services. I granted leave to both of them pursuant to section 40(3) of the Act.

7. The senior next of kin of the deceased is his mother, Mrs Delores Dallos. She lives in Thornlie, a suburb of Perth. She was aware of the Inquest but unfortunately was unable to attend in person.

8. Four witnesses were called to give evidence during the Inquest. These witnesses comprised Detective Sergeant Scott Pollock, the police officer in charge of the investigation of the circumstances surrounding the death of the deceased; Mr Brian Leslie Griggs, the Chief Flying Instructor and General Manager of the Alice Springs Aero Club; Mr Brian Pepper, an air traffic

controller employed at the Alice Springs Airport and Mr Malcolm McCallum, the Operations and Technical Manager of the Alice Springs Airport Pty Ltd.

9. In addition to their evidence some eleven statements from other witnesses were admitted into evidence. These statements included an expert report compiled by Mr Warren Stewart, a qualified commercial pilot and aircraft engineer who examined the wreckage of the aircraft in which the deceased met his death.
10. There was also tendered into evidence a number of records relating to the health and personal antecedents of the deceased. These records included his medical records at the Alice Springs Hospital, the Royal Darwin Hospital and the Tamarind Centre, a mental health facility operated by Territory Health Services in Darwin.

## **CORONER'S FORMAL FINDINGS**

11. Pursuant to section 34 of the Act I find as a result of the evidence adduced at the Public Inquest the following:
  - (a) The identity of the deceased was Bryan G, a male who was formerly known as Abel Dallos but who was born as Abel Blanco at Subiaco in Western Australia on the 6<sup>th</sup> of March 1975.
  - (b) The time and place of his death was at a point approximately two kilometres to the East of the main runway of the Alice Springs Airport in the vicinity of the Santa Road at around 5.00 am on the 16<sup>th</sup> of December 2000.
  - (c) The cause of his death was from multiple injuries which he sustained when the aeroplane he was in collided with the ground.

(d) The particulars required to register the death are:

1. The deceased was a male;
2. The deceased was caucasian;
3. The cause of death the was reported to the Coroner was plane crash;  
A post mortem examination was carried out and the cause of death was multiple injuries sustained in an aircraft accident;
4. The pathologist viewed the body after death;
5. The pathologist was Dr Michael Zillman of the Royal Darwin Hospital;
6. The father of the deceased was Angelo Blanco;
6. The mother of the deceased was Delores Abel;
7. The deceased had no formal place of abode;
8. The deceased was not employed in any occupation at the time of his death.

#### **RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH**

12. At sometime prior to dawn on the morning of Saturday the 16<sup>th</sup> of December 2000, most probably at around 4.30 am the deceased illegally entered the General Aviation area at the Alice Springs Airport. To enter the Airport it was necessary for him to either climb a security fence or for him to manipulate a coded keypad that controlled a gate in the fence. The fence was 2.4 metres high and topped with three strands of barbed wire. Once in

the General Aviation area the deceased was able to enter the cabin of a single engine Piper Warrior aeroplane, registered call sign VH – CLT. The aeroplane was owned by the Alice Springs Aero Club. The cabin of the aeroplane was not locked and the aeroplane itself was in a hanger occupied by the Alice Springs Aero Club. At the time the door of the hanger was open.

13. It is apparent that the deceased was able to start the engine of the aeroplane with a key that he had in his possession. The lock on the ignition of the aeroplane was not of a sophisticated manufacture and a person with some skill in manipulating locks would be able to defeat the lock with the right kind of substitute key. There is evidence to which I will refer later on in these findings that indicates that the deceased did have such skill with keys and locks. In this regard the letter from Dr Carolyn Graham, Psychiatrist in Charge of Graylands Hospital dated 24<sup>th</sup> March 2000, which was tendered in evidence is relevant.
14. The deceased had never held a pilot's licence. He had never, to the knowledge of those that had been previously involved with him, ever had formal flying lessons. Nevertheless the deceased was able to manoeuvre the aircraft on to the main runway of the Alice Springs Airport. The Airport was not in use at the time however the landing lights are kept on at all times of darkness in case of emergencies. The deceased was able to follow these lights and take off.
15. The deceased was able to manipulate the throttle of the aircraft to full thrust and thereafter the lift generated by the aeroplane's wings would have been sufficient to get the aeroplane airborne without any further input from the deceased at the controls.
16. Once airborne the deceased would have experienced visual disorientation in the pre-dawn darkness, as he had no visual cues from the ground to guide him. He would not have known where the horizon was and as a result he

would not have known if he was going up or down. The aircraft when operating under full engine power, which was necessary to get it into the air, is subject to a torque effect that pulls it to the left and downwards. An experience pilot knows how to compensate for this effect and can compensate for it by some input at the controls. The deceased did not. It seems that after take off and after reaching a height of approximately 350 feet above the ground the aircraft assumed a downward flight path of approximately 5 degrees and banked steeply to the left. It was therefore inevitable that the aircraft would collide with the ground. The collision occurred approximately 1-2 kilometres after the aircraft left the runway. Most likely in the darkness the deceased would not have been aware that he was going to crash. At impact the speed of the aircraft has been estimated be between 110- 120 knots.

17. The aircraft's left wingtip struck a large tree and was eventually separated from the fuselage. The propeller struck another tree and was destroyed. The aircraft continued for another twelve metres and impacted with the ground in a nose downward position. The force of this collision ejected the deceased from the cabin. He was thrown about 500 metres from the main wreckage of the aircraft. The aircraft subsequently caught fire as a result of sparks from damaged live wires igniting petrol vapour. Police who investigated the accident found a key in the aeroplane's ignition. It was not the authorised key used to start the ignition to the aeroplane.
18. The deceased suffered multiple injuries particularly to his neck and head and would have died instantly on impact.

## **THE BACKGROUND OF THE DECEASED**

19. The deceased was born in Subiaco Western Australia on the 6<sup>th</sup> of March 1975. His parents separated shortly after his birth and his mother re-

married. As a result on the 11<sup>th</sup> of September 1978 he assumed his mother's married name of Dallos. He grew up primarily in Perth. He completed Year 11 at Lynwood Senior High School in Perth in 1990/91. On the 18<sup>th</sup> of June 1999 the deceased changed his name to Bryan G.

20. The deceased had a long history of serious mental illness. In April of 1995 he was admitted to the Graylands Psychiatric Hospital in Perth and was diagnosed as suffering from chronic schizophrenia. Thereafter he was admitted to mental health facilities in Perth, Melbourne and Sydney. His illness was characterised by treatment resistance, absconding from care, non-compliance and violence. He was delusional and exhibited bizarre behaviour centred on religious, grandiose and persecutory themes.

21. He was admitted to Graylands Psychiatric Hospital on several occasions. On each occasion he was diagnosed as suffering from paranoid schizophrenia and polysubstance drug abuse. His stay at Graylands was problematic. In March of 2000 Dr Graham wrote as follows in respect of him:

“There have been two assaults on Graylands staff in the context of them detaining him. Mr Dallos absconded at least twice from our medium secure civil ward and we never worked out how he did it! (? picking locks)... His record is almost 100% in absconding from each hospital admission!”

22. His last prolonged admission was from 26<sup>th</sup> November 1998 to 9<sup>th</sup> July 1999 at the Graylands Psychiatric Hospital in Perth. He absconded from Graylands on the 18<sup>th</sup> of June 1999 and was absent until the date of his formal discharge on the 9<sup>th</sup> of July 1999.

23. At sometime after this he came to the Northern Territory. On 23<sup>rd</sup> of March 2000 he was admitted to the psychiatric ward at the Alice Springs Hospital as a voluntary patient after having been brought in by police following bizarre behaviour at the Salvation Army Hostel in Alice Springs. He discharged himself from the ward the next day.

24. Thereafter it seems that the deceased camped out around Alice Springs and at the Salvation Army Hostel. He also went to Yulara where he again came to the notice of the police.
25. It seems that around this time the deceased began to become increasingly more and more fixated with aeroplanes and the delusion that once in an aeroplane that he would be able to fly in it to God.
26. The first evidence of this delusion occurred in March of 2000 and is provided from the evidence of Brian Griggs. Mr Griggs is the chief flying instructor of the Alice Springs Aero Club. The club offers to members of the public the opportunity to take part in what is known as a Trial Instruction Flight. This is a short flight in which a participant can see if he or she wishes to take flying lessons and is able to take an aeroplane through some basic flying manoeuvres under close supervision.
27. On the 31<sup>st</sup> of March 2000 the deceased took part in one of these flights with Mr Griggs. The flight was in the same Piper Warrior aircraft in which he was ultimately to meet his death.
28. He took another such flight on the 11<sup>th</sup> of May 2000 with one of Mr Grigg's colleagues, Ms Rodgers. Again the flight was in the same Piper Warrior aircraft. Ms Rodgers described the deceased as acting strangely during the flight.
29. At sometime during the evening of the 15<sup>th</sup> of May 2000 the deceased unlawfully entered the Royal Flying Doctor Hangar at Alice Springs Airport. He broke a window to gain entry to an office. The senior pilot found him hiding under a desk. When challenged he said: "You know me, I was waiting for a doctor in the patients' waiting room."
30. Police arrested him and charged with unlawful entry, criminal damage and assaulting the pilot who discovered him. He was refused bail and brought before the Alice Springs Court of Summary Jurisdiction.

31. It became apparent to the police who had arrested him and the magistrate concerned that the deceased was not mentally well. As a result the presiding magistrate ordered that he be psychiatrically examined. Dr Tabart, a psychiatrist saw him on the 17<sup>th</sup> of May. Dr Tabart believed that the deceased was “acutely psychotic”. He recommended that the deceased be transferred in custody to the secure unit at the Joan Ridley Unit at the Royal Darwin Hospital.
32. This did in fact occur and on the 20<sup>th</sup> of May the deceased was transferred by road to the Joan Ridley Unit. He was remanded in custody and was under prison guard when he was at the Unit. The criminal charges were adjourned until 8<sup>th</sup> of June.
33. The Mental Health Unit of Territory Health Services were charged with the care and medical treatment of the deceased whilst he was remanded in custody at the Joan Ridley Unit.
34. As a result the Mental Health Team made an application to the Mental Health Review Tribunal in respect of what on-going treatment the deceased should receive whilst he was at the Joan Ridley Unit.
35. This application was made pursuant to the Northern Territory *Mental Health and Related Services Act* on the 7<sup>th</sup> of June 2000. On that date the Tribunal determined that the deceased was suffering from a mental illness and required treatment as a result of his illness but lacked sufficient insight to consent to the necessary treatment. Accordingly an order was made under section 123 of the *Mental Health and Related Services Act* that he be involuntarily detained for a period of three months. The order was to be reviewed on the 5<sup>th</sup> of July 2000.
36. The next day, the 8<sup>th</sup> of June, the Court of Summary Jurisdiction at Darwin further adjourned the criminal charges against the deceased to the 29<sup>th</sup> of June. However no further orders were made in respect of remanding the

deceased in custody at the Joan Ridley Unit and as a result he was at large without bail. Accordingly he was transferred from the secure unit at the Joan Ridley Unit to the Cowdy Ward at Royal Darwin Hospital.

37. Negotiations then ensued between the solicitors for the Mental Health Team and the Police Prosecutions Unit and the deceased's legal advisers with a view to having the charges against the deceased either withdrawn or for an application to be made to the Court pursuant to section 78 of the *Mental Health and Related Services Act* – that is that the charges be dismissed because of the deceased mental state at the time of the commission of the offences. It seems that all agreed that the deceased was suffering a serious mental illness at that time.
38. The deceased was a management problem at the Cowdy Ward. He absconded on a number of occasions. The most notable of these occurred on the 15<sup>th</sup> of June 2000 when he was discovered by police in an aircraft owned by Anindilyakwa Air at the Darwin Airport. He had illegally entered the aircraft and had started one of its two engines before his apprehension. The police returned him to the ward. In the circumstances it was decided that no charges should be laid against him.
39. The deceased's fixations with aircraft continued. He spoke of flying away to heaven to be with God; of borrowing \$50,000.00 to buy a space shuttle to fly home to God. These references are taken from his medical notes.
40. As a result I have absolutely no doubt that the deceased's delusional obsession with aeroplanes was well known to staff at Territory Mental Health Services. A close examination of the deceased's medical notes makes this abundantly clear. Further the incident at Anindilyakwa Air made it apparent that the deceased was more than capable of putting his delusions into effect. After that incident it was known or should have been known to Mental Health Services that the deceased was potentially a danger to himself and to others.

41. The doctors on the Mental Health Team formed the view that the best facility for the treatment of the deceased was at the Graylands Psychiatric Hospital in Perth, which would be close to his family. Their solicitors wrote to the police prosecutor along these lines:

“We note that on 29 June 2000 the charges against Mr Dallos were adjourned by the Registrar for 3 weeks to allow you to obtain instructions on whether the complainant will apply to the Court to have the charges dismissed pursuant to section 78 of the Mental Health and Related Services Act 1998.

We advise that our client, Mental Health Services, would appreciate it if such a decision and application could be made earlier than 3 weeks, to allow Mr Dallos to be transferred to the specialised forensic ward at the Graylands Psychiatric Hospital in Perth as soon as practicable.”

42. As a result in part of these representations the charges against the deceased were in fact withdrawn in the Court of Summary of Jurisdiction on the 7<sup>th</sup> of July. The police prosecutor noting in a memo:

“From our viewpoint, Mr Dallos is now free to be conveyed to the Graylands Psychiatric Hospital in Perth, as advised.”

43. However the deceased was never transferred back to Graylands. In fact it seems doubtful that there was any fixed commitment from Graylands for him to go back there. For on 11<sup>th</sup> July the authorities at Graylands indicated to the Mental Health Team that they did not wish to re-admit the deceased. The deceased remained in Darwin.
44. The deceased failed to make good progress at Cowdy Ward. On the 10<sup>th</sup> of August, whilst on a walk with a nurse in the grounds of the Royal Darwin Hospital he absconded. Thereafter he never returned to the Cowdy Ward. The further hearing that had been scheduled to take place on the 6<sup>th</sup> of September 2000 before the Mental Health Tribunal never took place.

## THE RESPONSE OF MENTAL HEALTH SERVICES TO THE ABSONDING OF THE DECEASED FROM COWDY WARD

45. At the time the deceased absconded from the Cowdy Ward he was subject to an order made pursuant to the *Mental Health and Related Services Act* that he be involuntarily detained in hospital. At no time until his death was the deceased returned to hospital. The order made in respect of his involuntary detention lapsed on or about the 6<sup>th</sup> of September 2000. No further orders were made or attempted to be in respect of the deceased.
46. The deceased's medical records indicate that at the time of his unauthorised discharge from the Cowdy Ward at Royal Darwin Hospital the deceased had been prescribed 300 mg of *haloperidol* per fortnight. *Haloperidol* is a powerful antipsychotic drug.
47. As I have already indicated the deceased's potentially dangerous fixation with aeroplanes was well known to the Mental Health Team. As a result a plan of sorts was formulated to deal with the situation. I have been able to glean details of the plan and the concerns of the Mental Health Team from the deceased's medical records.
48. A discharge summary was placed on the deceased's file. This summary was dated the 10<sup>th</sup> of August 2000. It indicated that the diagnosis of Mental Health Services at the time of the deceased's admission was paranoid schizophrenia and that the deceased had been non-compliant and treatment resistant during his stay on the ward. It also referred to the incident at the Darwin Airport on the 15<sup>th</sup> of June when the deceased had started a plane to "fly to God but did not know how to land". His mental state on discharged was described as being:

"Still fixed delusions concerning meeting God and being tormented by devils...has persistent obsession about stealing a plane and flying to God. Remained insightless."

49. A note was also made that “Police, Airport, Mother notified Abel had absconded.”
50. Other references to the absconding of the deceased appear in his medical file as follows:
- Nursing note 10/08/00 at 07.50 “Security/Airport Security police and CRC? Notified”
  - Nursing note 10/08/00 at 17.00 “P/C to Darwin Airport informing them that Abel may also try the Katherine, Tennant Creek or Alice Springs airport to obtain an aeroplane. He said he would inform them of this. P/C as requested by Dr Steele”
  - Nursing note 12/08/00 at 11.30 “P/C to Police to inform them that if Abel is found – Could they bring him back to us as he is still under a MHO”
  - Outpatient Clinic Progress Sheet 10/08/00 “ Abel absconded from the ward at approx 0800 hrs. All the relevant people have been informed”
  - Outpatient Clinic Progress Sheet 14/08/00 “Abel called at 1620 hrs. Currently in Alice Springs...encouraged to contact mental health services in Alice Springs or hospital if he feels unwell... advised that both hospital and police had been informed of his whereabouts”
51. The Mental Health Team learnt that the deceased was in Alice Springs around the 14<sup>th</sup> of August 2000. The deceased telephoned Cowdy Ward and told them. As a result of this the Mental Health Ward at the Alice Springs Hospital was informed and advised of the status of the deceased’s involuntary detention but nothing further was done.
52. Further alarming information regarding the deceased was received concerning the deceased on the 19<sup>th</sup> of September 2000. It came about this way. The deceased rang his mother, Mrs Delores Abel in Perth. He told her

that he was in Alice Springs. He did not sound at all well to her and she was concerned. He said that he had plans to start flying lessons in Alice Springs and would soon be able to fly alone. He then planned “to fly to God”. He told his mother that he was not taking any medication, as he did not need it. As a result of her concerns she telephoned Mental Health Services in Darwin.

53. The Mental Health Team met to discuss this news. They too were concerned. They passed the news on to Mental Health Services in Alice Springs.

54. A note was made in the deceased’s file:

“The Team quite concerned about this new information given that we have dealt with Abel for many months prior to his recent absconding. It appears that Abel’s delusions about returning to God have not changed and that he is now making plans to follow this through. Given that he has been removed from a light aircraft at Darwin Airport in the past (attempting to “fly to God”), and he has stated that he is going to take flying lessons in order to do this, the Team decided that action must be taken. Added to this Abel’s admission that he is not currently taking any medication and the risk is high. Discussed issues of confidentiality – the Team decided that the risk of something dangerous happening out way (sic) the need to maintain confidentiality in this instance.”

55. The Mental Health Team formulated a plan. It was decided that they would contact all places in Alice Springs that offered flying lessons and warn them that the deceased might try to enrol. As chance would have it Ms Nikki Roberts, a member of the Team spoke with Mr Griggs at the Alice Springs Aero Club and advised that it would not be advisable to allow the deceased on an aeroplane. She told him to contact the police or Mental Health Services if he had any difficulties with the deceased.

56. The police in Alice Springs were also contacted so that they would be “aware of the potential problem”. A note was made on the deceased’s file

on the 19<sup>th</sup> of September that an un-named shift sergeant at Alice Springs who it was noted was “thankful for the information and will act accordingly and also inform MHS (Mental Health Services) if they pick Abel up”.

57. However the Mental Health Team had no further contact with the deceased after the 19<sup>th</sup> of September 2000 and as a result the deceased was officially discharged from their care.

### **THE BEHAVIOUR OF THE DECEASED IN ALICE SPRINGS AND THE RESPONSE OF THE POLICE**

58. It is clear that after his absconding from the Cowdy Ward at the Royal Darwin Hospital that the deceased went to Alice Springs. He made no secret of this and apparently made no attempt to conceal himself there.
59. At some time after his absconding from Cowdy Ward he again contacted the Alice Springs Aero Club and arranged to take part in a third Trial Instruction Flight (“TIF”). Once again this was in the Piper Warrior aircraft. This third flight was with an instructor who is no longer with the Aero Club. His name is Paul Redford. Mr Redford took the deceased aloft but became concerned at his behaviour in the aircraft. He seemed to Mr Redford to be in a trance-like state and was talking to himself, saying things like he was going to “fly to God.” Mr Redford was concerned enough to terminate the flight early and return to the ground.
60. The deceased had given a false name to take part in the flight. He had given the name Luke Fernando when he had booked the flight. However Mr Griggs saw him after the flight and recognised him from his earlier dealings with him. Mr Griggs think that this third TIF took place on the 5<sup>th</sup> of August 2000 but this cannot be right as the deceased was still in Darwin at this time.

61. A few weeks later the deceased again telephoned the Aero Club and spoke to Mr Griggs and requested yet another flight. Mr Griggs recognised his voice and declined the request.
62. Whilst in Alice Springs the deceased formed a friendship with a man who coincidentally had the name of Gee but who was not related to him. This was Jaesson Gordon Gee. Mr Gee was staying at the Red Shield Hostel in Alice Springs and met the deceased at the Memorial Club at some time around September or October. The deceased at the time was sleeping in a Church courtyard across from the Mobil service station in the centre of Alice Springs.
63. Mr Gee himself held a pilot's licence. The deceased told Mr Gee that he too had an interest in flying, as he believed that this was a means of achieving his mission of getting closer to God. The deceased showed Mr Gee a key to an aircraft, which he kept around his neck. He asked Mr Gee if he would take him flying.
64. The deceased also showed this key to Melinda Dunbar who was the receptionist at the White Gums Holiday Inn. The deceased stayed there for about a month until he was evicted for not paying the rent. He told Ms Dunbar of his plans to fly a plane to God. He said that he had obtained the key from a plane that he had stolen in Darwin.
65. On three occasions the deceased and Mr Gee went out to the Alice Springs Airport. Mr Gee intended to tell the police of any plan to actually steal an aeroplane. On two occasions the two men were distracted and did not get to the Airport. On the third occasion Mr Gee did indeed inform the police of the deceased's plan and on the 9<sup>th</sup> of October 2000 the police met the deceased at the Alice Springs Airport and turned him away.
66. The bizarre nature of the deceased's illness was well known to the Police in Alice Springs who had several dealings with him. The deceased illness and

its association with aircraft were so well known that a Senior Police Officer raised a circular on the 9<sup>th</sup> of October 2000 for distribution to police in Alice Springs which read in part as follows. The deceased was described as: “a person of questionable mental status, he has a history of forced admission into the Joan Ridley Centre, Darwin. He has come to police attention on a number of occasions. On one such occasion Gee was found in a light aircraft, both engines were started and when apprehended he told police that he was “flying to the Lord”. Recent information to hand suggests that it is Gee’s intention to attempt to obtain an aircraft so that he may fly out of Alice Springs.”

67. In early December 2000 the deceased went to Perth to visit his mother. He stayed for about ten days. His mother said that he still seemed to be very sick. He stole his sister’s car. The police were called and Mrs Dallos asked if the deceased could be returned to Graylands for his mental state to be assessed. However this did not occur and he returned to Alice Springs.

#### **THE EVENTS IMMEDIATELY PRIOR TO THE DECEASED’S DEATH**

68. The last documented record of anyone seeing the deceased before his death is from Constable Tottle of the Alice Springs Police. Constable Tottle saw the deceased at the Heavitree Gap Caravan Park during the early evening of the 15<sup>th</sup> of December 2000. The deceased was having an unauthorised shower at the Caravan Park. Constable Tottle saw him ride off on his bicycle in the direction of Alice Springs and away from the airport.
69. At about 5.00 pm that same evening Mr Griggs refuelled the Piper Warrior Aircraft. He was the last person to fly it and he wanted it ready first thing the next morning for flying instruction. The Alice Springs Aero Club had purchased the aircraft new in the United States of America in 1995 for the sum of \$214,000.00.

70. He left the aircraft in a hanger. The aircraft was not locked nor was the hanger. The airport itself is surround by a security fence. Entry through the fence is gained through locked gates, which are controlled by a coded keypad.
71. The Federal Department of Transport and Regional Development, Aviation Security Branch categorise the security measures required at airports within Australia according to the size of aircraft and the number of passengers using the particular airport. Alice Springs Airport is a category 3 airport. This means that its owners, Alice Springs Airport Pty Ltd are required to provide full security for airline passengers and cargo. A security fence must surround the aerodrome with locked gates to the airside. However the requirement that this category of airport have a 24-hour security service was withdrawn some years ago.
72. Mr Griggs left the airport in the early evening. When he left all seemed normal at the Aero Club Hanger. Mr Griggs told investigating police that the only known key to the aircraft's ignition was locked in his office at the time.
73. It is not known exactly how the deceased gained entry to the hanger but he did. Most likely it was some time around 4.30 am on the morning of the 16<sup>th</sup> of December 2000. He could have either scaled the cyclone security fence around the airport or manipulated the keypad to a gate in the fence. The fence itself is approximately 2.4 metres high and is topped with four strands of barbed wire. To a determined person it would not have presented a great challenge. It is also possible that the deceased had ascertained what the code was to the gate from his previous visits to the Alice Springs Aero Club.
74. At any event he was able to get into the unlocked aircraft and once managed to start the engine. At some time shortly before dawn he was able to manoeuvre the aircraft onto the main runway and take off with the disastrous consequences that I have already noted.

75. The deceased had never held a pilot's licence. He had never, to the knowledge of those that have been involved with him, ever had flying lessons. I have no doubt however that the deceased was determined to get into the air.
76. It is extraordinary behaviour for a person unqualified to pilot aircraft to steal an aeroplane during hours of darkness and attempt to fly it. Once airborne a disaster was inevitable. There is no evidence to indicate that the deceased was suicidal in his intent at the time he boarded the aeroplane and took off. It is however clear that he was seriously mentally ill and had been for some time. There can be no doubt that the deceased continued to suffer from paranoid schizophrenia and was delusional. The delusion that he could use an aeroplane to fly to God had been fixed in his mind for some time. As I have already indicated it was a delusion that was well known to both Mental Health Services and the Northern Territory Police.

#### **THE EVENTS FOLLOWING THE CRASH OF THE AIRCRAFT**

77. First light in Alice Springs on the 16<sup>th</sup> of December 2000 was at 5.13 am Australian Central Time. Some Aboriginal people were drinking near the Santa Teresa Road in the vicinity of the Alice Springs Airport in the early morning of the 16<sup>th</sup> of December. They heard a loud bang, which they likened to the sound of two cars running into each other. It was still dark at the time they heard this noise. I have no doubt that this was the sound of the crash of the Piper Warrior.
78. Warren Stewart inspected the wreckage of the aircraft. Mr Stewart is a qualified commercial pilot and aircraft engineer. He formed the view that the aeroplane was in an airworthy condition prior to its theft by the deceased. He is also of the view that the speed of the aeroplane at the time it struck the ground was around 110 – 120 knots. It seems likely that the engine stalled prior to impact.

79. The aircraft was fitted with an Emergency Locator Transmitter (ELT). This is the terminology used for a distress beacon used in an aircraft and is similar to an Emergency Position Indicating Radio Beacon (EPIRB) which is used in a vessel at sea. Distress beacons are constructed to specifications appropriate for the environments in which they are intended to be used. EPIRBs are waterproof and will float. ELT's are usually activated by shock. Such beacons generate signals, which can be detected at either of the frequencies of 121.5 Megahertz (MHz), and 406 MHz. More modern beacons broadcast on the higher frequency and use digital technology that broadcasts an identifying code. The older type of beacon broadcast on 121.5 MHz and uses analogue technology. They broadcast a simple homing signal without any additional information.
80. The signal from ELTs that are broadcast on these frequencies can be detected in a variety of ways. Firstly by a number of low earth orbiting satellites. Secondly by receivers fitting in aeroplanes. Thirdly at ground receivers.
81. The Organisation responsible for responding to all reports in respect of the activation of ELTs in Australia's search and rescue region is the Australian Maritime Safety Authority (AMSA) and in particular its operation section the Australian Search and Rescue Centre known as AusSar. AusSar in term manages the Rescue Coordination Centre (RCC). The RCC receives notifications of distress signals received from satellites, in particular the Cospas and Sarsat group of satellites, which are Russian and American in origin respectively.
82. At 5.00 am Australian Central Time on the 16<sup>th</sup> of December 2000 a satellite detected an alert being broadcast at 121.4975 MHz. This was transmitted to the Rescue Coordination Centre where it was received at 5.05 am. At that time it gave two positions in Australia for the ELT which were approximately 1200 miles apart.

83. A request was subsequently made by RCC to the Flight Information Manager of Airservices Australia's air traffic services centre in Melbourne for aircraft to monitor the 121.5 MHz frequency in the vicinity of these two positions.
84. At 6.47 am Australian Central Time a Singapore Airlines Flight at a height of 37,000 feet in the vicinity of Alice Springs detected an interrupted signal. Because of the height of the aircraft it was apparently not possible to accurately ascertain the position of the beacon. Another report was received from a commercial aircraft flying over Alice Springs at a height of 33,000 feet at about 7.10 am Australian Central Time.
85. Allan Ross Haldane is an airport operations officer at the Alice Springs Airport. On the 16<sup>th</sup> of December he arrived at work at 5.50 am. About five minutes before he arrived at work he saw a small cloud of black smoke in the air to the east of the Airport. Undoubtedly this smoke was from the wreckage of the crashed aircraft. He was near the intersection of the Stuart Highway and Colonel Rose Drive at the time.
86. At 7.10 am Mr Haldane was contacted by RCC and asked to see if he could hear any signals on the 121.5 MHz frequency. Airport Operations was contacted because at that time because RCC did not believe that the Control Tower at the Airport was being manned. At 7.14 am the RCC rang the Alice Springs control tower and spoke to Brian Pepper, who was the air traffic controller on duty at the time and requested that he listen in to the relevant frequency. Mr Pepper came onto duty at 7.00 am. He was unable to locate any transmission from the ELT. This was most probably because ground receivers are not so well placed to receive signals because their receipt of signals is likely to be interrupted by local topographical features or buildings.

87. Thereafter Mr Haldane began to drive around the airport aprons with a hand held radio capable of detecting the relevant signal. He was not able to detect a signal.
88. At sometime after 7.00 am Mr Griggs became aware that the Piper Warrior Aircraft was missing. At 7.15 am he contacted Mr Pepper at the Control Tower. Mr Griggs also contacted the Police around 7.30 am.
89. At 8.05 am Australian Central Time, after another satellite circuit over the relevant portion of the Australian Continent, a further position could be reported to RCC in respect of the ELT. This was approximately six miles East of the Alice Springs Airport.
90. The Operations Manager of the AusSar, John Young has provided an affidavit in respect of the activities of the RCC in respect of this matter on the 16<sup>th</sup> of December 2000 and in particular the monitoring of the signals detected from the ELT fitted in the aircraft concerned. He has indicated the reasons why he believes the various signals, which were received from the ELT, were inconsistent and geographically scattered.
91. In respect of detection by satellite much depends on the trajectory of the passing satellite and often several passes by several satellites are required to give an accurate position in respect of the distress beacon. This explains why the original locations of the source of the ELT were so disparate.
92. As a result of the most recent information provided by RCC Constable Martin John Astridge of Alice Springs Police was able to locate the wreckage of the aircraft. He located the aircraft at 8.21 am Australian Central Time as he was patrolling about 2 kilometres down the Santa Teresa Road. He found the body of the deceased approximately 500 yards from the main body of the wreckage. He was obviously deceased.

93. Although the aircraft itself had been severely damaged by fire police found a key in the aircraft's ignition. I find that this was the key the deceased wore around his neck in the months prior to his death.
94. The effect of Mr Grigg's evidence was that the ignition of the Piper Warrior aircraft was not particularly sophisticated. Certainly it was not designed to defeat the efforts of a person who was determined to start the ignition and who had some experience in picking locks, as the deceased did.
95. The Northern Territory Police have no specialised skill in investigating aviation crashes. As a result police requested that the Australian National Transport Authority send an investigator to view the crash scene. However the Authority declined the request as it considered that the accident was caused by pilot error rather than aircraft design fault or engine failure and as such it was not part of their responsibility to investigate the matter.
96. Accordingly it was necessary for Detective Sergeant Pollock, the officer who was directed to conduct the coronial investigation of this death to enlist the services of the aviation expert, Mr Stewart. The Northern Territory Police bore the not inconsiderable expense in respect of the preparation of Mr Stewart's report.

## **MATTERS FOR COMMENT AND RECOMMENDATIONS**

### **(a) The actions of Police and Mental Health Services**

97. To a certain extent it makes a mockery of an "involuntary order" if the person who is the subject of such an order is able to abscond and nothing is done to return that person to the hospital concerned. This is especially so if the person who has absconded is potentially a source of harm to either himself or others.
98. In the case of the deceased his delusional obsession with aeroplanes was well known to staff at Territory Mental Health Services. An examination of

the deceased's medical notes makes this abundantly clear. It is also clear that on a number of occasions staff at Mental Health Services saw fit to warn others of potential dangers posed by the deceased both to himself and to other members of the public, particularly those connected with the aviation industry.

99. It also became apparent to the Mental Health Authorities well before his death that the deceased was in the Alice Springs area and was non-compliant with his medication. It was clearly known to the Northern Territory Mental Health Authorities that the deceased had fixed and long standing delusions associated with aeroplanes. They had also been given, in the form of the incident at the Darwin Airport involving the Anindilyakwa aircraft, the most compelling piece of evidence imaginable that the deceased was more than capable of putting his delusions into effect.
100. The fact remains that the deceased was not apprehended and returned to a psychiatric facility at any time after his absconding during the currency of the order made under the Mental Health and Related Services Act until the order lapsed on the 9<sup>th</sup> of September 2000. Nor does it seem that any efforts were made to inform the Mental Health Review Tribunal of what had occurred in respect of its order.
101. The bizarre nature of the deceased's illness was also well known to the Police in Alice Springs who had several dealings with him. The police circular of the 9<sup>th</sup> of October gives clear evidence of this. As events ultimately unfolded the circular was ominously prescient. Again the police took no steps to detain the deceased as they could have pursuant to the Mental Health and Related Services Act.
102. However the fact remains that the deceased was potentially a danger to himself and others and to the property of others. Both the police and Mental Health Services recognised this fact. The response to the problem, though well intentioned, proceeded on an ad hoc basis. There was little

coordination between Police and Mental Health Services and little exchange of information between the two services, particularly at a senior level in response to the problem. As a result there was no coordinated plan in respect of the management of the deceased, particularly whether it was appropriate that he be returned to a mental health facility especially at the time he was still subject to the involuntary detention order.

103. It is sad that what all who had professional dealings with him feared might happen, did in fact happen to the deceased. Especially sad that the pleas of his mother were not heeded. It is fortunate that others did not lose their lives through innocently crossing the path of the deceased's ill-fated flight in the early hours of the 16<sup>th</sup> of December 2000.
104. The issue of the treatment of the mentally ill is a sensitive one in this day and age. Any recommendation which are made in this regard must recognise the rights of the mentally ill to have their confidentiality preserved as much as possible and their dignity as human beings respected. In section 10 of the *Mental Health and Related Services Act* are set out a number of principles which relate to the admission and treatment of involuntary patients. These principles include the following:
  - a) "the person should only be admitted after every effort to avoid the person being admitted as an involuntary patient has been taken;
  - b) where the person needs to be taken to an approved treatment facility or into custody for the assessment, the assistance of a member of the Police Force is to be sought only as a last resort and there is no other means of taking the person to the approved treatment facility or into custody;
  - c) involuntary treatment is to be for a brief period, reviewed regularly and is to cease as soon as the person no longer meets the criteria for involuntary admission;"
105. However situations will arise when these principles must be subservient to the need to maintain overall public safety.

106. It is submitted that in appropriate circumstances that the Police should be apprised of the mental status and all relevant concerns regarding mental health patients who have absconded. The Police should be briefed in a formal and systemised way by Mental Health Services in such cases with a view to the two Service jointly formulating a management plan for the recovery of such patients.
107. To this end I recommend that senior officers of the Northern Territory Police meet with the appropriate senior officials within Territory Health Services with a view to creating a joint protocol to deal with the following issues:
- a) the nature of the information that should be exchanged between Police and Mental Health Services regarding absconding patients;
  - b) the level in each organisation at which such information should be exchanged;
  - c) the form in which such information should be exchanged - ie should it be by telephone call or minuted in some more formal way;
  - d) who should be apprised of the absconding of a mental health patient and when;
  - e) in what circumstances should a plan be mandated to ensure the most expedient recovery of an absconding patient;
  - f) should the Mental Health Review Tribunal be advised of the absconding of a patient who is subject to an order of the Tribunal. If so, when.
108. What I envisage is the creation of a formal template that can be followed by both police and mental health professional in the event of a patient absconding and which will necessarily entail some categorisation of the risk involved.

## **SECURITY AT THE ALICE SPRINGS AIRPORT**

109. The evidence of Mr McCallum, Operations and Technical Manager at the Alice Springs Airport was that the level of security at the Alice Springs Airport is currently in excess of that required by Commonwealth Government regulation. The Airport is surrounded by a cyclone fence that is 2.4 metres high and which is topped by four strands of barbed wire. This is considerably higher than that required by Government regulation.
110. In those circumstances I am not prepared to make any criticism of the level of security currently pertaining to the Alice Springs Airport.

## **THE RESPONSE OF AUSSAR TO THE ELT**

111. In the light of the evidence contained in the affidavit of John Young, the operations manager of the Australian Search and Rescue Centre, which is based at 25 Constitution Avenue, Canberra in the Australian Capital Territory I do not believe that any criticism of the Rescue Coordination Centre in respect of its response to the activation of the ELT is warranted. The response of the RCC was appropriate in the circumstances given the level of technology that was available to it at the time.

## **THE RESPONSE OF THE AUSTRALIAN TRANSPORT AUTHORITY TO THE ACCIDENT**

112. The failure of the Australian Transport Authority to respond favourably to the request of the Northern Territory Police for assistance in the investigation of this particular fatal aircraft accident is in my view a proper matter for comment in these findings.
113. At the outset of the matter it may very well have been that the overwhelming likelihood was that the accident was caused by “likely pilot error”. However such a blanket response is of no assistance to the police who assist

me to carry out my statutory obligations under the *Coroners Act*. I am required to examine as exhaustively as possible the exact causes of any particular aviation accident in order that I may fulfil my obligations under the *Coroners Act*. This requires a professional and thorough investigation.

114. Aircraft crashes and fatalities, although mercifully rare in the Northern Territory, are not unknown. Many communities in the Northern Territory rely on the services of small aircraft operators for essential transport and supplies. As a result the provision of air-services is an important matter for the Northern Territory as is the issue of the safety of such services.
115. The Northern Territory Police are not equipped to investigate the technicalities associated with aircraft crash investigation and as such do not have the expertise to establish the causes of such accident to the standard required for coronial investigations. In the absence of the investigators supplied by the Australian National Transport Authority they are reliant on the services provided by private investigators and must bear the associated costs, which are potentially heavy. This represents a shifting of cost in respect of the investigation of air crashes from the Commonwealth Government to the Northern Territory Police.

Dated this 15<sup>th</sup> day of October 2001

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GREG CAVANAGH  
TERRITORY CORONER