CITATION: *Inquest into the death of Mark Corbett* [2003] NTMC 044

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Tennant Creek
FILE NO(s):	A0060/2002
DELIVERED ON:	5 September 2003
DELIVERED AT:	Tennant Creek
HEARING DATE(s):	2, 3, 4, 5 June 2003
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

CORONERS: Inquest, death in custody, protective custody, detention in Watchhouse, sobering up shelters.

REPRESENTATION:

Counsel:

Assisting:	Mr Tom Berkley
For Commissioner of Police:	Mr John Stirk
Family:	Mr Stewart O'Connell

Judgment category classification:	A
Judgement ID number:	NTMC 044
Number of paragraphs:	80
Number of pages:	30

IN THE CORONERS COURT
AT TENNANT CREEK IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0060/2002

In the matter of an Inquest into the death of

MARK CORBETT
ON 11 JULY 2002
AT TENNANT CREEK HOSPITAL

FINDINGS

(Delivered 5 September 2003)

Mr GREG CAVANAGH SM:

1. Mark Corbett ("the deceased") was an Aboriginal male who was born at Elkedra Station in the Northern Territory during 1954. The deceased died in Tennant Creek Hospital in the Northern Territory at 0242 hours on 11 July, 2002. He was 48 years old; the evidence disclosed that he was very much loved and liked by his family and others who knew him. He was a happy and easy going man.

2. In my view, and as explained to the many members of his family present at Tennant Creek Court at the commencement of the Inquest, the nature of the hearing is as follows (Transcript P3):

> "This is an inquest into the death of Mark Corbett. My job as the Coroner is to find out what happened, how it happened, is to find out the truth of how this man died so that people who love him and who knew him, and the rest of the community, can know about that man and how he died; to learn about it and those who loved him can grieve about it properly knowing everything that happened.
>
> That's what the Government have appointed me to do. That's what the law says I must do. This is not like an ordinary court case where the judge stays up here and shuts up and lets the lawyers run the case. I run this. It's my investigation, to find out what happened to that man and why. I hope and trust that Mr O'Connell has explained that to you. I don't know. He's appeared in coronial cases before,

but they're very much different to the ordinary criminal cases he appears in."

3. The death occurred after police and others noticed the deceased to be in discomfort in the police station cells at Tennant Creek. He had been apprehended twice on 10 July, 2002 and on the second apprehension was placed in protective custody in those police station cells. An ambulance was called to the cells and the deceased taken to Tennant Creek Hospital, where he died. The death was properly categorised as a "Death in Custody".

4. Accordingly the death is reportable to the Coroner pursuant to Section 12(1) of the *Coroner's Act* ("the Act"). Section 15(1)(a) requires that a public inquest be held into a "Death in Custody".

The Inquest

5. I conducted the inquest at Tennant Creek Court House over 4 days from 2-5 June 2003 inclusive. At the inquest Mr. Berkley appeared as Counsel assisting the Coroner. Mr. Stirk appeared for the Commissioner of Police and Mr. O'Connell appeared for the family of the deceased.

6. The death of the deceased was comprehensively investigated by Senior Sergeant Nixon, whose two volume reported was tendered (Exhibit A) as the first of fourteen physical exhibits. That report was compiled in accordance with Northern Territory Police General Order D2, a copy of which was tendered at Exhibit H. In addition to various important official records the investigation report contained statements taken in written or audio form from thirty-nine witnesses. A fortieth statement, from Dr. Spain, a specialist anaesthetist, was obtained to provide expert commentary on the potential harmful effects of the ingestion of Gastrogel and Xylocaine viscous (Exhibit L).

7. I commend the efforts of Senior Sergeant Nixon and thank him for the thoroughness of his investigation. I note the comments of Counsel for the family in final submissions (Transcript P191):

> "MR O'CONNELL: Yes, sir. Sir, just a brief introduction before I get into those submissions and that is to thank this court on behalf of the family for holding the case here in Tennant Creek. The family have asked me to thank you, also thank the investigation that was conducted which was very thorough. It has been a hard week for them, Your Worship. You have already noted the number of people that have attended."

8. Sixteen witnesses were called to give oral evidence to the inquest. The first was Senior Sergeant Nixon, the police officer in charge of the investigation of the circumstances surrounding the death of the deceased. Other police witnesses were Constable Russell, who was involved in both apprehensions of the deceased for protective custody on 10 July, 2002; Senior Constable Muir and Constable Norris who were responsible for organising the second apprehension of the deceased for protective custody; Constable Paragreen, who noticed the deceased's discomfort in the police cells and who called an ambulance to attend on the deceased; ACPO Goddard, who attended the police cells with Constable Paragreen and Acting Sergeant Mader to assess the medical condition of the deceased; and Sergeant Kerr who gave evidence of the orders and instructions relating to the supervision of persons in the police cells.

9. Anthony Newcastle and Gordon Nappa were in the cells with the deceased and gave evidence of their observations of the deceased's condition and their attempts to raise an alarm over the deceased's health. Each spoke to Constable Paragreen, and observed the arrival and departure of the ambulance officers called to treat the deceased.

10. Ms Kinraid, the Director of the Barkly Region Alcohol and Drug Abuse Advisory Group ("BRADAAG") provided the Inquest with a Funding Schedule and Service Plan for the Sobering Up Shelter in Tennant Creek

(Exhibit J), the job description for shelter workers, and the BRADAAG protocol on the Management of Intoxicated and Disruptive People (Exhibit K). As well, the then shelter manager Mr. Canete was also called to give evidence of his recollection of and dealings with the deceased during the deceased's admission to the sobering up shelter on 10 July, 2002.

11. One of the ambulance officers who attended on the deceased in the police cells, Marcel Clark, gave evidence of her attendance and the treatment given to the deceased at the police cells and the hospital. In addition, Craig Garraway, the Deputy Operations Manager, St Johns Southern Region, was called to give evidence of the procedure for calling an ambulance after hours in Tennant Creek and commented on the response time of the ambulance team called to assist the deceased.

12. Darren Trindall, a qualified enrolled nurse, was the Senior Aboriginal Health Worker on duty at the Tennant Creek Hospital on the night of 10/11 July, 2002. He gave evidence of the reception of the deceased into the hospital, the administration to the deceased of a Gastrogel and Xylocaine mixture, and the treatment of the deceased in hospital, including the attempts to resuscitate the deceased. Dr.Pearson is the Medical Superintendent of the Tennant Creek Hospital. He was called by Trindall to attend the deceased after the deceased lost consciousness. He gave evidence of his treatment of the deceased, attempts as resuscitation and the administration of the Gastrogel and Xylocaine mixture. He pronounced the deceased to be dead at 0242 hours on 11 July, 2002.

13. Dr Sinton, the Pathologist who performed the autopsy on the deceased at 0900 hours on 12 July, 2002 at Alice Springs Hospital, gave evidence of his opinion as to the cause of death of the deceased.

14. Included in the exhibits were video tapes taken by surveillance cameras of the police cells and the watch-house desk which show, amongst other things, the processing of the deceased into protective custody, the activities of the

deceased and others in the cells, the attendance of police in the cells to assess the deceased and the arrival and departure of the St. Johns ambulance team (Exhibits D & E).

15. Also in evidence were the medical records of the deceased (Exhibits B & C) including the critical ambulance and Tennant Creek Hospital Records concerning the treatment of the deceased on the night of 10/11 July, 2002.

CORONER'S FORMAL FINDINGS

16. 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 Mark Corbett a male Aborigine who was born at Elkedra Station in the Northern Territory on an unknown date in 1954.

(b) The time and place of death was 0242 hours on 11 July, 2002 at the Tennant Creek Hospital, Tennant Creek in the Northern Territory.

(c) The cause of death was an Acute Cardiac Dysrhythmia of an unknown cause.

(d) Particulars required to register the death are:

(i) the deceased was a male;

(ii) the deceased was Mark Corbett;

(iii) the deceased was an Australian resident of Aboriginal origin;

(iv) the death was reported to the Coroner;

(v) the cause of death was an Acute Cardiac Dysrhythmia.

(vi) the Pathologist was Dr Terry Sinton, the Director of Forensic Pathology at the Royal Darwin Hospital, and he viewed the body after death;

(vii) the deceased's mother was Katie Corbett;

(viii) the deceased's father was Quart Pot Corbett;

(ix) the deceased usually lived at Speedway Camp, Tennant Creek in the Northern Territory;

(x) the deceased had no usual occupation;

(xi) the deceased was at one time married according to Aboriginal tradition but the name of his traditional wife is not known.

(xii) the deceased was aged 48 years, having been born on an unknown date in 1954. If a notional date of birth of 1 July, 1954 is given, the deceased was 48 years of age at the time of his death.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

17. The relevant factual circumstances surrounding the death of the deceased can be divided into three distinct periods over the afternoon and night of 10 July, 2002 and the early morning of 11 July, 2002.

18. The first period concerns the activities of the deceased on 10 July, 2002 up to and including his being taken into protective custody and then him leaving the sobering-up-shelter of his own will at 2105 hours that evening.

19. The second period commences with the second apprehension of the deceased for protective custody from about 2130 hours on 10 July, 2002 until the arrival of the St Johns Ambulance team at the police station cells at approximately 0043 hours on the morning of 11 July, 2002.

20. The third period concerns the medical treatment given to the deceased by ambulance officers and at the Tennant Creek Hospital from 0043 hours until his death at 0242 hours on 11 July, 2002.

The First Period

21. The deceased was apprehended and taken into protective custody shortly before 1720 hours on Wednesday 10 July, 2002 at Peko Park, Paterson Street, Tennant Creek. He was apprehended by Constables Russell and Zio, who formed the opinion that the deceased was seriously affected by alcohol.

22. Section 128 of the *Police Administration Act* empowers members of the Northern Territory Police to apprehend persons who are intoxicated in public places and take them into custody. This is the procedure commonly known as protective custody. This law only allows detention for protective custody if the person concerned is seriously intoxicated either by alcohol or by some other drug. The police are also able, for sensible and humane reasons, to divert persons who would otherwise be detained by them in protective custody to the care of others who are equipped to deal with intoxicated persons. In Tennant Creek it is the sobering up shelter run by BRADAAG. According to the anecdotal evidence of the witnesses Canete and Hodges the deceased was a regular visitor to the sobering up shelter in Tennant Creek, although his actual record of attendances was not adduced.

23. Constable Russell said that at the time of his apprehension the deceased was in the company of Victor Dobbs, George Philomac, the deceased's sister Lorna Corbett, and Noelene O'Keefe. Each of these persons gave an audio taped interview to police, which was transcribed and are part of Exhibit A. The accused was described by these persons as being drunk, and fell over when called over to the police vehicle. This fall probably explains the small graze on the deceased's right hand at the time of autopsy. I note that in his statement Dobbs said that the deceased was able to get into the back of the

police van without assistance, after he was helped to his feet by his drinking companions.

24. Lorna Corbett says in her statement that the deceased was drinking port with her and at least one other, probably George Philomac, during the daylight hours of 10 July, 2002. A total of eight bottles of port were consumed between a drinking group that consisted of three or four persons, counting the deceased. Both Lorna Corbett and Philomac noticed that the deceased was coughing a lot during the day. Lorna Corbett described the deceased as liking to sing along when he was drunk, and she said that he did not get into any fights on that day. I note that the deceased had a post-morbid blood alcohol content of 0.13. Accordingly, and working back from that figure, it is clear that the deceased, at the time of his apprehension shortly before 1720 hours, could have had a blood alcohol reading as high as .31.

25. In my opinion the deceased was seriously intoxicated by alcohol at the time of his apprehension in Paterson Street, Tennant Creek, and the police acted responsibly in apprehending him.

26. The deceased was taken to the sobering up shelter, the records of which indicate that the deceased was received at 1720 hours. On duty were Marnie Sutton and Gynys Hodges. Virgilio Canete came on duty at 2000 hours. After his reception the deceased removed his shirt and went to bed. He arose once during his stay to go to the toilet and then went back to bed. His shirt was being washed for him, so the deceased was dressed only in his jeans. I pause to recommend to staff at the sobering up shelter that when they go to the trouble of washing clients' clothes, they provide some substitute clothing during the process; this would appear to have contributed to the deceased complaints during the evening of feeling cold. He arose again at about 2100 hours. He was loudly complaining that he was cold. Unsuccessful attempts were made to settle the deceased by Canete, and the deceased left the shelter of his own accord at 2105 hours on 10 July, 2002.

He was dressed only in his jeans. I was told that the overnight temperature in Tennant Creek that night was 14.3 degrees Celsius.

The Second Period

27. The exact movements of the deceased immediately after he left the sobering up shelter are unknown, however, Senior Constable Muir noticed the deceased outside Muir's private residence at 19 Hollis Street, Tennant Creek at approximately 2130 hours. Senior Constable Muir gave evidence that:

    (1) he approached the deceased, who gave his name as Mark;

    (2) the deceased said that he was cold, and was crossing his arms across his body;

    (3) Muir telephoned the Tennant Creek Police and asked for a police van to come and pick up Mark as Mark was cold;

    (4) The deceased was only wearing jeans.

28. Constables Rankine and Dunn attended at 19 Hollis Street with Constable Russell also in the police van. Constable Russell was being given a lift home and identified the deceased to Rankine and Dunn as a person Russell had taken into protective custody earlier that day. The deceased was again apprehended for protective custody. Both Rankine and Dunn thought that the deceased was intoxicated at this time. Rankine gave evidence that the deceased replied "….I'm alright..." in response to a question from Rankine about how the deceased felt. The deceased was able to get himself aboard the police van again without assistance. At this time Rankine and Dunn received a radio call to attend the Goldfields Hotel in Tennant Creek to assist Constables Gibson and Garland in the apprehension of Gavin Hogan,

who was known to be violent. After Hogan was apprehended he too was placed in the back of the police van with the deceased.

29. Constable Russell was then dropped home and the police van made its way to the Tennant Creek Police Station. The deceased was processed in the watch-house at approximately 2145 hours. He had been in police custody for about 15 minutes. The deceased was taken to the watch-house because Russell had earlier told other police that he thought the sobering up shelter was full. The shelter had a capacity of 14 beds on 10 July, 2002. An examination of the shelter records tendered in Exhibit A indicate that there were twenty people through the shelter that day. At the time of the deceased's second apprehension, only twelve beds were occupied. Russell could not remember when giving evidence how he came by the information that the shelter was full. I consider that Russell's belief that the shelter was full was a genuine belief, as his oral evidence at the inquest was that police would rather transport a person in protective custody to a sobering up shelter, as opposed to taking the time to process such a person at the watch-house, and then take responsibility for that person.

30. The Control Card filled out upon the deceased's reception into the watch-house shows the name Francis Corbett. This was not satisfactorily explained at the inquest. The tapes at Exhibit E show the reception of the deceased. The deceased was dressed only in jeans, and placed both hands on the watch-house counter, apparently for support, whilst he was being processed. His belt was removed from him. The deceased appeared to be compliant with Police requests. Two officers can be seen placing blankets around the deceased and leading him quietly to the cells.

31. ACPO Goddard was in the watch-house at the time of the deceased's reception. She left there to go on patrol with Acting Sergeant Mader, just prior to the first signs on the surveillance cameras of the deceased becoming uncomfortable. This left the Tennant Creek Police Station being manned by

Constable Paragreen, who at the time was known as Probationary Constable Malloy. Constable Paragreen made a statement to the investigating officer and gave oral evidence. Standing Orders at Tennant Creek at the time required a physical check of the occupants of the cells every fifteen minutes. Constable Paragreen made her first check at 0022 hours on 11 July, 2002, according to the timing on the surveillance video. In her statement given to the investigating officer (Enclosure 24 to Exhibit A) she said of her first observation of the deceased (at page 9 of 64):

> "He had a blanket over him and there was actually another couple of blankets actually lying around but um like I'll be honest I just walked over and had a quick glance at him but I could see he was breathing he actually was breathing quite quickly. I don't know if he moved but I, whatever he did I didn't, he wasn't a concern anyhow he had his blanket over his head, he was um he didn't look to be in any sort of um having any problems breathing or anything. He looked fine he just looked like he was sleeping."

32. Later in her statement (page 11 of 64) and confirmed in her oral evidence she said:

> "There was nothing that concerned me at all with that particular cell check."

33. It is worth mentioning at this stage that the deceased was sleeping on a mattress between two other persons, Anthony Newcastle and Gordon Nappa, and also that the cell containing these men, and three other inmates, was equipped with a duress alarm accessible by the inmates of the cell.

34. Both Newcastle and Nappa gave oral evidence at the Inquest. Both witnesses deposed that they became concerned after the deceased's moaning had woken them up. The deceased was saying words to the effect of:

> "Something is eating my stomach".

35. Newcastle pressed the duress alarm at least twice, a fact corroborated by the surveillance video. He thought that he spoke to a police officer on one of

those occasions through the intercom, which forms part of the alarm. Paragreen, in her written statement (and confirmed in oral evidence) said:

> "There was no alarm, no buzzer, nothing."

36. Yet she also gave evidence that at about the time that Newcastle can be seen on the surveillance tapes pressing the duress alarm she thought that she heard some moaning, but thought that it was coming from the alarm's control panel. She later even thought that the television monitor had speakers on it and she thought that the sounds she heard must have came from those speakers.

37. Senior Sergeant Nixon gave evidence in relation to the duress alarm as follows (Transcript P19/20):

> "So the most likely scenario is that the mute button had been activated?---Yeah, you're correct, it probably was, yes.
>
> And once that mute button is activated, it remains mute until someone presses another button to bring it back on line?---To reset it, yes, that's my understanding.
>
> It could've been put on mute that morning and remained mute all day? Possibly?---The possibility is there, yes.
>
> Now it also came out from your investigation, didn't it, that Constable Malloy had no idea how the whole duress alarm system worked?---At the time of the incident she was aware, but when she first got to the station, which wasn't too long before, she wasn't. When the alarm did sound she didn't know what it was and she rang Alice Springs Police and asked what it was.
>
> So there was no formal training in relation to the use of the duress alarm?---I think there was training of sorts but it was haphazard; it wasn't a consistent thing.
>
> And there was no procedure at the time when you came on shift to make sure that the mute button wasn't on?---Certainly there's a handover of shift coming on. They talk to each other, how many prisoners you've got and so forth, and do a checklist, but the actual muting part I don't think there was, no.

> And do you consider that that's fairly important, a thing that should be passed on, give that the alarm is there for the obvious reason of emergencies when something happens in one of the cells?---Well the change of each shift, the oncoming shift should be aware if those things are working."

38. The next cell check was not due until 0037 hours, but Constable Paragreen in fact did her next cell check at 0031 hours, some nine minutes after her first check at 0022 hours. The only people awake at this time other than the deceased were Paragreen, Newcastle and Nappa. It is at this point that there is a great deal of correlation between their versions of events, and the surveillance tapes tendered in evidence.

39. Both Nappa and Newcastle deposed that they told Paragreen to get help for the deceased. Paragreen, in her evidence, said that she had ascertained from the deceased his true name and some unspecified complaints of pain. She was unsure of what to do after speaking to Newcastle and Nappa, who were dominating the conversation with her, and just wanted Acting Sergeant Mader to return to the Police Station and assess the condition of the deceased. She said in her statement (page 84 of 96):

> "Anthony and Gordon just kept yelling at me so I went back and I believe the phone rang then and I took a job, something to do with rock throwing and I then got back onto the radio and spoke to Sergeant Mader and ACPO Goddard and as I was speaking to them I said like…basically I think someone needs to come 'round and look at him, he's getting worse. He's got tummy pain or something but I wasn't sure and as I was speaking to them on the radio they actually pulled in and they came in and made assessments and they did all they had to do and from that Sergeant Mader directed me to get in contact with an ambulance to come down."

40. Mader's statement corroborates Paragreen's evidence. He recalls telling Paragreen to ring an ambulance and to "keep an eye" on the situation. He and ACPO Goddard then went out on the rock throwing job that Paragreen had logged earlier.

41. Although there was twelve minutes time difference between the settings on the cell surveillance cameras and the reception area cameras I am satisfied after a comparison of the videos that the time differences are consistent between the videos, and arose merely because one or both systems were initially set-up on the wrong time. This is born out by the similarity of the evidence of Nappa, Newcastle and Paragreen from this point on.

42. I am satisfied that within nine minutes of Newcastle pushing the duress alarm, and in any event within the fifteen minutes at which the next cell check was set, Paragreen attended the cells and spoke to both Newcastle and Nappa regarding the physical condition of the deceased.

43. I am satisfied that within minutes Mader and Goddard also attended the watch-house and visited the cells with Paragreen to assess the deceased's physical condition. It was then that the ambulance attendance was authorised.

44. Whatever the time calibration difference between the various surveillance systems and telephone systems in use at the time, I am satisfied that at 0027 hours (according to Alice Springs Police Communications time calibration) Constable Paragreen rang Alice Springs Police and requested an ambulance attend at the Tennant Creek Police Station. I am satisfied that six minutes later (notionally at 0033 hours) St Johns Ambulance in Tennant Creek were given that task at that they arrived at the Tennant Creek Police Station 10 minutes after that (notionally at 0433 hours). As ambulance officer Garrwaway noted in evidence, this was a quicker than normal response as the crew of Clark and Bigwood had just returned from another job and were all kitted up to respond to the next call. Both Nappa and Newcastle gave oral evidence of their recollections of the ambulance arriving within ten minutes of being called by Police.

45. The surveillance tapes show the arrival of the ambulance officers Clark and Bigwood. Constable Paragreen was concerned that the deceased should be

removed from the cell for treatment, so she entered the cell and dragged the mattress upon which the deceased was lying into the floor area outside of the cell.

46. In relation to her not taking the distressed deceased out of the cells earlier and prior to the arrival of the ambulance officers, she told me and I accept (Transcript P60):

> "THE CORONER: Anyway, you got the ambulance as soon as you could for medical reasons?---Yep.
>
> MR O'CONNELL: Was there any reason why, prior to the ambulance coming, you didn't take the person out of the cell?---Gordon Nappa and Anthony Newcastle, they were becoming quite agitated. I was there by myself and it would've been no benefit for me to go in and them to become violent. I couldn't have assisted him at all. And also his condition wasn't changing. He – he didn't require any treatment that I could provide to him so it was best that he was left there, for my safety."

47. Often modesty, pride, position and sex are not considered in an emergency, and I am satisfied after hearing Constable Paragreen give evidence that she did not intend to shame the deceased by dragging him on his mattress out of the cell. Rather, I am satisfied that she was only concerned to assist the deceased by getting him to a place where she thought the ambulance officers could safely treat the deceased by the fastest means. She acted quickly, efficiently and decisively in removing the deceased from the cell. Her actions seemed to concern Nappa, who gave evidence that he thought Paragreen's actions shamed the deceased, especially when he was offering to help her carry the deceased from the cell. In assessing Nappa's evidence I note that by his own admission he was in custody for being severely intoxicated, and in any event I would have thought it more prudent for Paragreen to act the way that she did rather than to rely on assistance from an intoxicated person to carry the obviously ill deceased from the cell.

The Third Period

48. All of the evidence before me suggests that the ambulance officers acted quickly and appropriately in tending to the deceased and taking him to hospital, where they arrived at approximately 0110 hours on 12 July, 2002, having left the watch-house at 0105 hours. This was three hours and twenty minutes after his initial reception into the police cells. At the hospital the deceased was initially triaged (assessed) by Senior Aboriginal Health Worker Darren Trindall. Trindall gave oral evidence to the inquest that upon his arrival the deceased was awake and abusive and uncooperative. Trindall had commenced triage at about 0115 hours. The deceased seemed intoxicated to Trindall. The deceased complained of pain in the stomach and Trindall administered what is known as a "pink lady", which is a mixture of Gastrogel and Xylocaine at about 0120 hours.

49. The deceased was sitting up on a bed at this time. Some minutes later Trindall approached the deceased to give him another drink of water when the deceased fell straight back on the bed, in cardiac arrest. Trindall asked the ambulance officers to assist him with the deceased and to get the other ward staff. At about 0150 hours a Dr Tonga and the Medical Superintendent, Dr Pearson were telephoned and requested to attend urgently. Dr Pearson, assisted by Dr Tonga, tried various means of resuscitation of the deceased. As well as ordering tests to determine the condition of the deceased, Dr Pearson also administered adrenalin to the deceased in an attempt to "kick-start" the deceased's heart. The deceased was intubated and CPR, which included the manual inflation of the deceased's lungs, was continued until 0242 hours, when Dr Pearson noted the deceased's death on the hospital records. This was almost five hours after the deceased's reception into the police cells.

50. I am satisfied after hearing the evidence of Trindall and Dr Pearson that there was nothing remarkable about the medical treatment of the deceased

up until the time of his death. The deceased did not present as a pressing emergency upon his arrival at Tennant Creek hospital. I am satisfied from hearing the evidence of Dr. Pearson, the Medical Superintendent, that the treatment given to the deceased from his reception at the hospital until his death was timely and appropriate.

51. The administration of the "pink lady" did, however, cause the first of two important questions to arise for determination by the Inquest, that is, whether the administration of the drug lignocaine contributed to the deceased's death.

52. The autopsy conducted by Dr Sinton on 12 July, 2002 raised the second, and most important question for determination by the Inquest, that is, the actual cause of death of the deceased where the Pathologist could not come to a finding.

The Role of Lignocaine

53. In his autopsy report Dr. Sinton noted the presence of lignocaine, which is a local anaesthetic administered to the deceased under the brand name Xylocaine Viscous. Dr Sinton noted in his report:

> "Lignocaine is a drug which is sometimes used in the acute treatment of cardiac dysrhythmias. However, infrequently, it may, of itself, produce acute severe side effects, including cardiac arrest."

54. The question that arose for consideration by me was whether the administration of lignocaine to the deceased just prior to his death contributed in any way to his death. A specialist report was obtained from Dr Spain regarding the effects of lignocaine in the dosage given.

55. Dr Spain explained in his report:

> "Xylocaine Viscous is a 2% preparation of Lignocaine which means it would contain 20mg/ml. The patient was given 10ml which amounts to a total of 200mg. The drug is poorly absorbed into the blood, with only 35% absorption normally. Notes from the Drug

> Information service at Royal Darwin Hospital state that does of 250mg-500mg in adults result in subtherapeutic plasma concentrations.
>
> In the presence of hypotension, liver blood flow and lignocaine clearance are decreased significantly, based upon the degree of hypotension. Thus in a hypotensive patient, it is possible that the plasma level would have been higher than normally expected from this dose, however it is extremely unlikely that it would have got to a toxic level.
>
> Toxic levels of lignocaine or its metabolites after oral ingestion would be expected to cause Nervous System toxicity long before adverse cardiac effects. Thus one would have expected the patient to have a convulsion before any arrhythmia of the heart would occur."

56. Dr Sinton concurred with the expert commentary of Dr Spain and conceded that, having read that report, the chances of lignocaine having played a part in the death of the deceased were reduced to a mere possibility, and unlikely, as opposed to any probability of contribution.

57. On the basis of the expert evidence before me I cannot find that the administration of lignocaine contributed to the death of the deceased. I am satisfied that the preparation of Gastrogel and Xylocaine Viscous, known as a "pink lady", was administered to the deceased in an attempt to treat the stomach pain, of which the deceased was complaining. It was given in a measured dose that Trindall had been taught to prepare. Even though the Medical Superintendent would not have administered a "pink lady" to the deceased, his oral evidence was that it was commonly administered in Tennant Creek Hospital, and that its administration was unremarkable in this case.

The Cause of Death

58. Lorna Corbett, in her statement given to police, said that she suffered from a family illness she described as being "…tight in the stomach". She said "And my brother when he passed away he had stomach tight."

59. Both Drs Sinton and Pearson agreed in oral evidence that this tightness of the stomach was indicative of cramps associated with colic. Dr Pearson, after reviewing the treatment of the deceased upon his reception at Tennant Creek Hospital, concluded that the logical course of inquiry from the presentation of the victim was to look for some internal bleeding to explain the stomach pain felt by the deceased. The cardiac arrest of the deceased was, therefore, unexpected.

60. Dr Sinton, with the benefit of hindsight, is sure that at the time of his admission to Tennant Creek Hospital the deceased was in a state of cardiogenic shock. Dr Pearson did not readily accept that proposition, but both doctors did agree that before his death the deceased had entered into a state of acute cardiac dysrhythmia. This is a condition where the heart does not maintain its normal rhythm, and this lack of rhythmic beating can lead to the heart stopping altogether, which is called arrhythmia.

61. Dr Sinton could not find any reason for the deceased's death during his examination of the deceased. There were no signs of violence or injury to the deceased, nor of any organic disease. Dr Sinton reported:

> "At the time of this report, and following macroscopic, microscopic and toxicological examinations, no clear pathophysiological cause for his death could be determined."

62. Dr Sinton gave evidence (Transcript P132):

> "Right. Now, doctor, did you look for bruising, any sign of injury that the deceased may have suffered prior to his death?---I looked at that two ways, firstly with an external examination of the body literally from the soles of the feet to the top of the head and then subsequently on further examination being able to look directly at some of the tissues under the skin, notably on the trunk, over the face and head and on the arms. There was no evidence of any damage to those tissues.
>
> Right, thank you, doctor.

> THE CORONER: Did you find any evidence of anything that was of a suspicious nature?---No, sir, I didn't.
>
> MR BERKLEY: Right, thank you. I suppose in short the deceased's heart stopped and that heart stopped due to this dysrhythmia the lack of proper rhythm and that's what caused this death?---In my opinion, yes."

63. In his oral evidence to the Inquest, Dr Sinton said that he always thought the cause of the deceased's heart stopping was the dysrhythmia. Dr Sinton said that science is simply not advanced enough at the present to find the cause of the dysrhythmia which was unaccompanied by any significant pathology. That is why he placed "undetermined" next to the cause of death in the post mortem examination report. What is certain is that the deceased's heart stopped after a period of dysrhythmia, a period identified by both Drs Sinton and Pearson as being present at least shortly before the deceased collapsed in the Tennant Creek Hospital. The hospital and ambulance records were not available to Dr Sinton at the time that he completed the report on the post mortem examination of the deceased. When appraised of the contents of those records during oral evidence Dr Sinton was able to confidently assert that the deceased's heart was in a state of dysrhythmia before his death, a state that lead to the heart stopping. After weighing all of the evidence I am satisfied that the cause of the deceased's death was acute cardiac dysrhythmia. I am also satisfied that acute alcohol toxicity, identified in the post mortem report, was a significant condition contributing to the deceased's death.

Behaviour of Police

64. The video tape of the deceased's reception into the watch-house cells shows the police then present acting courteously to the deceased. It was in fact the police officers who draped the deceased in blankets because he did not respond to the offer of blankets from the police. Notwithstanding their kindness, the investigation by Senior Sergeant Nixon uncovered a number of

procedural errors committed by police in the performance of their tasks associated with the apprehension of the deceased.

65. The evidence of Constable Steven Norris was interesting and relevant to the reasons behind the procedural errors in and around the reception of the deceased into the watch-house, and I quote (Transcript P63):

> "Right. Now you were present ultimately when the deceased was brought in?---Yep.
>
> And during the investigation by Detective Nixon you agreed that there was no real assessment made by anyone when he was brought in?---This is at page 39?---Yeah. What was happening was, because of the amount of people we had in, there was a lot of people who were extremely aggressive, we were fighting to try and get them in there. And I was on the computer, there was another one next to me on the cards asking them and talking to them and that. To be honest, because we're short-staffed, as they were coming through you tried to get them as quick as possible to get out to other jobs because we were very busy. We had another person go off with a bottle down one of the camps and I was trying to get them processed as quickly as possibly – as possible.
>
> And as a result of that no assessment was done?---Well, as they'd come in we'd talk to – you know, ask their names and – 'cause quite often we know who they are and we'll say 'This is whoever'. You ask them their date of birth. A lot of them don't know their date of birth. They won't tell or too drunk to tell you. It's hard to get information from a lot of them.
>
> But with this particular person there was never any inquiry made as to how he was feeling, whether he had any illness, whether he was taking medication?---I can't remember, to be honest.
>
> Well, isn't that what you told Detective Nixon?---This is page 39?---Yeah.
>
> Nixon says: 'No assessments are made by anyone?---Yeah, when I look back at it. I mean, because, as I said, there was five of us there and two of us, one putting it on computer and another one talking to him and there's sort of 4 or 5-way conversation with people talking. As I said, I suppose because we were rushed for time, we were trying to get it done quickly to get back out."

And (Transcript P64):

> "What changes have there been since this incident?---Well, the way it's affected me is I will only do one at a time because – I mean, once again, it's a problem – with short-staffing and things like that – that we have to stop and process one person at a time and you don't let them go until the whole thing is done as thoroughly. But the problem is you'll get a call and there'll be something going on out there and it's a hard balance sometimes. I mean, you've got someone here you want to try and do the right thing by but it takes time and you could have someone with a weapon going off at a camp or in the main street. It's – it's a problem.
>
> The watchhouse still isn't permanently staffed?---No, no.
>
> And the staffing situation on an average night shift how many people do you have on?---Two, I mean, if you've got someone in custody you've got a third member out, but that third member, I mean the phone rings, the radio goes, people come to the front door. You're trying to do the two jobs at once and it's – it can get out of hand."
>
> And is it regularly busy in Tennant Creek at night?---Yeah."

66. These errors are set out fully in the investigation report. I am satisfied that none of those procedural errors contributed in any way to the deceased's death. The report of Senior Sergeant Nixon has been referred to the highest levels of the Northern Territory Police and I am satisfied that action has been taken by the command structure within the Police Force to address those procedural errors. I consider that there is no reason to criticise the care, supervision and treatment of the deceased by the Police.

67. I note the evidence of Senior Sergeant Nixon in this regard and accept same (Transcript P15):

> "Would you agree, detective, that a lot of those persons who are taken into custody are chronic drinkers of alcohol?---Yes, certainly.
>
> And a lot of them, as a result of that, and their living conditions, are of poor health?---Yes, definitely.
>
> And for those reasons you would agree that there was a commission into deaths in custody?---Yes. Yes, I am.

> And that the outcome of that was that Aboriginal persons in custody require a very high degree of care, a duty of high care to be provided by the police to those persons?---That is correct.
>
> Would you agree, detective, that the situation in Tennant Creek as far as care provided to those persons at the time of the death was less than satisfactory?---The care, on my view, was still there. Just procedurally it could've been better."

68. The Aboriginal Community Police Officer Denis Goddard also told me (Transcript P115):

> "MR O'CONNELL: Yes, sir. Ms Goddard, so you were saying because of all the things that you had to do it was very difficult to keep up the 15 minute cells checks that night?---That is correct yep.
>
> And that wasn't a particularly busy night so on a busy night it would be almost impossible to keep?---That's why they started to put 2 people on, one in the watchhouse and one in the muster room.
>
> But that wasn't the practice back when this happened?---Nope.
>
> Is it the case now that there's someone permanently in the watchhouse?---The – like on Friday nights and Wednesday nights which are the busy nights, you have one in the watchhouse. Like ones watchhouse keeper and the other ones the muster room but otherwise no you just have one in the muster and watchhouse."

69. Counsel for the family of the deceased made detailed submissions regarding three areas of concern of the family. It was firstly submitted that better communication between Police and Night Patrol should exist in Tennant Creek, and that the level of communication seems to be personality dependent. I agree with those submissions.

70. Indeed the Officer in Charge of Tennant Creek Police Station (Sergeant Darrell Kerr) was very frank with the court in saying (Transcript P25/26):

> "All right. Sir, just in your statement you also had on 1 August 2002 a meeting with Leanne Riley, Patrick Ah Kitt and Debbie Hampton from the Anyinginyi Congress Aboriginal Corporation Alcohol After-Care to reproduce a cell visitors scheme. Can you tell us about that briefly, sir?---It was basically to introduce a scheme where

Aboriginal persons could visit the cells at different times to check on the welfare of prisoners; also to work as a calming influence. When sometimes there's an Aboriginal person locked up, it's helpful to have a person, Aboriginal person, attend the cells.

Now you were also aware that as part of Senior Sergeant Nixon's investigation into the circumstances surrounding the death of the deceased, a number of procedural deficiencies were identified in this investigation?---That's correct.

You also in enclosure 27 have – I'm sorry. At enclosure 27 is an internal memorandum by you to all members of the Tennant Creek Base Police Station dated 17 July 2002?---That's correct.

You tell us: how was that raised? Why did you raise that document?---That was raised – there was some inconsistencies with entries being entered on the watchhouse log, insufficient details, so I raised the issue to make sure that all members were aware of the requirements under PROMIS and IJIS in recording details in offender journals and offender logs.

All right. Was that part of a general review by you or did the death of the deceased inspire the raising of that document?---The death of the deceased inspired it.

All right. And from time to time is it your experience that members new to stations or just by virtue of the posting cycle needed to be reminded of the duties in policing generally in the Northern Territory at different stations by a senior member issuing internal memorandums to keep them up to speed?---That's correct.

All right. Sir, where do you work now?---Katherine Police Station.

When did you leave Tennant Creek?---Approximately two months ago.

Since then have you noticed any change in the standard of the application of standard operating procedures at Tennant Creek Police Station, particularly in relation to the reception of prisoners in the cells?---Since the – the instruction was issued?

Yes?---Yes, just that the IJIS entries are more detailed, more timely, more accurate.

What about cell checks, are you satisfied as to the frequency of those being conducted in accordance with SOPs?---Yes, the cell checks are still conducted every 15 minutes in accordance with our SOPs."

71. And in relation to lack of staff he told me (Transcript P27/28):

"And another matter for concern was that when the deceased was taken into custody there was no inquiries conducted as to his state of health. Is that another matter that's been addressed in some detail?---Yes, all – like I was saying before, all IJIS entries have been reinforced, the need to have more detail, to ask the appropriate questions as to any health problems, etcetera. That's been reinforced and certainly all new members attending the station for day induction there's a heavy focus on watchhouse procedures.

And is that a vast improvement from the situation before the death?---I – I think everyone needed a reminder of the procedures and that's certainly been reinforced. So the – the standard of the IJIS entries and recording is certainly a lot better.

And is it the case – I know you don't work here any more, but in that time after the death is it the case that an officer was permanently based in the watchhouse?---No. Staffing level at the police station meant that an officer wasn't permanently based in the watchhouse and the - - -

THE CORONER: That's the same at Katherine, isn't it? I did a death in custody there, a fellow who died in the cells a couple of years ago, and even though it's a whole new police station, the watchhouse cells are right out the back, aren't they?---They are.

And the bloke who looks after them is at the reception at the front?---That – that's so.

That's how it was?---At the moment they've increased the staffing at Katherine so they have an auxiliary who's permanently in the watchhouse and one who's permanently at the front counter, so that alleviates the problem there, but in Tennant Creek normally it's the one auxiliary on an evening shift who has to handle front counter and also watchhouse.

MR O'CONNELL: In your opinion should there be a staffing increase so that there is at least one auxiliary permanently in the watchhouse?---It would – it would certainly help. The standard operating procedures – I forget what section it is – states that the person handling the watchhouse-keeper duties are not perform other

duties that would detract them from the duties they're doing, which means if it got busy they would contact the OIC to arrange for someone to be called in on overtime, so they could be able to look after their prisoners without being disturbed all the time.

And the clear intent of those procedures is that the person who's on the watchhouse, their main focus, should be on the care of the prisoners?---That's correct.

So the situation in Tennant Creek is still not satisfactory in that regard?---It – it would b ideal if there was a permanent watchhouse-keeper and a front counter member, as they do in Katherine. There is a provision that with the watchhouse-keeper if it gets busy to call the OIC to get an extra member in."

72. The second area of concern for the family related to the treatment of persons in protective custody. It was submitted that a formalised system of communication between the watch-house and the sobering up shelter be instituted so that the available bed space can be determined at any time that the shelter is open. It was also submitted that the assessment of Aboriginal persons in protective custody should be fuller, with family contact details being obtained, and done in a culturally sensitive way. This leads on to the third area of concern, which related to the treatment of persons who appear to be ill. The family submitted through counsel that, particularly in relation to Aboriginal persons in protective custody, that the family be notified of the apparent illness immediately that it becomes apparent. Similarly, the family would like to see a stronger protocol in place regarding the decision of when a doctor is to be called for a sick inmate, rather than what appears to be a totally discretionary system now in place. Once again, I agree with all of those submissions. Other submissions were made, however I think the submissions noted here represent the principle concerns of the family. I must say that I agree with all of their concerns.

RECOMMENDATIONS AND CONCLUDING COMMENTS

73. Once again a formal inquest has been held into the death in custody of an Aboriginal male in the Northern Territory. The deceased only came to be in

custody because he drank an excessive amount of alcohol and got himself drunk in public. The Police, on their various patrols, notice persons who are drunk in public and, if they assess that such a person is seriously intoxicated, Police as a matter of course exercise their powers under the *Police Administration Act* to apprehend persons and place them in protective custody. I have addressed those powers in formal findings on a number of previous occasions, and there is no need to address them again here, as on any view of the facts of this case the powers were properly and appropriately exercised.

74. In this particular case the deceased, having been picked up and detained by the police for his own protection, was not taken directly to a sobering up shelter or the Watchhouse. The police attended another incident at one of the local hotels with the deceased being kept in the back of the paddy wagon (a metal cage), and also went back to the Watchhouse with the deceased via the home address of a police officer in order to drop that police officer off. In keeping with the rationale that operated to have the deceased in the metal cage in the first place, and having regard to precepts of human dignity, I do not think that this is good policy, and I think it should be discouraged and I so recommend. I understand that staffing shortages on the night in question at the police station resulted in this state of affairs.

75. It was reported to me during the Inquest that there is an increasing alcohol problem in Tennant Creek. Apparently one of the reasons is the large increase in the sale and consumption of fortified wine. I was told that the number of persons taken into protective custody in Tennant Creek rivals the numbers in Katherine, a much larger centre that possesses a sobering up shelter three times larger than the one in Tennant Creek. This is a serious problem Ms Kinraid gave evidence of an increase in funding of $40,000.00, which allowed the employment of one additional staff member and an alteration to the shelter to increase its capacity by two beds. This sort of

funding increase is somewhat tokenistic when compared to the problems caused by public drunkenness in Tennant Creek.

76. I was impressed with the evidence of Ms Kinraid, who amongst other things, told me (Transcript P102):

> "THE CORONER: You agree don't you – that I think everyone in this courtroom would agree – that if the government are going to allow policeman to pick up people who need caring for because they're too drunk, then they ought to be cared for in places other than cells with bars on them that are made for criminals – would you agree with that?---Whole heartedly.
>
> Yes?---Your Honour.
>
> And so you've got beds made up for people, showers and all that there?---We have beds and showers but the only difference to other sobering-up shelters in the Northern Territory is that we do not proceed – provide food.
>
> Okay and you're not a 24-hour service?---We're not a 24-hour service.
>
> MR BERKLEY: And you're not open on the weekend are you?---Not open on the weekend.

And (Transcript P107):

> And His Worship asked you a number of questions along the lines of whether – well I guess the question I'd like to ask you is; do you in your opinion believe that you're sufficiently funded to cater for the level of alcohol abuse in Tennant Creek?---Definitely not.
>
> In your opinion and you're probably one of the best people to give this opinion, is the alcohol a problem amongst Aboriginal people getting worse?---Definitely."

And (Transcript P108):

> "THE CORONER: We've just got to get – we've got to get these people out of police cells.
>
> MR O'CONNELL: Yes.

> THE CORONER: It's just you know – its ridiculous it's still happening after 20 years since the royal commission. People sleeping on concrete floors in little cells made for criminals."

And (Transcript P110):

> "Would question be – the service I think you said is shut Saturday night and Sunday night?---That's correct.
>
> And is that purely funding driven?---Um - - -
>
> Or the lack of funding is the reason for the - - -?---The lack of funding yep.
>
> SO what two nights?---Pardon?
>
> MR O'CONNELL: Saturday and Sunday.
>
> THE WITNESS: Saturday and Sunday the weekends – we're not open weekends.
>
> THE CORONER: So Saturday nights – they've got to be taken to the cells – there's no option?---That's correct."

77. It was recognised over twenty years ago in the Royal Commission into Aboriginal Deaths in Custody that persons who drink too much are not criminals by that act alone. They should not be in police cells, but in facilities such as the sobering up shelters found in larger population centres. I, too, have repeatedly commented on the need to avoid placing inebriated people in police cells during my time as the Northern Territory Coroner. This is, of course, predicated on the availability of a suitable alternative to the police cells.

78. The organisation known as BRADAAG is to be commended for its attempts to provide and run a sobering up shelter in Tennant Creek. However, it is clear that the shelter is undersized, under-funded and undermanned. There will certainly be many more persons locked up in police cells in the Northern Territory simply for being drunk. Some of those persons will be in a poor state of general health, and most if not all will have been

apprehended because at the time of their apprehension they had drunk to levels dangerous to their health. I once again remind the government, as I reminded it in the Inquest into the Death of Rita Dandy (190/2001) of recommendation 80 of the Royal Commission into Aboriginal Deaths in Custody:

> "That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons."

79. The need for adequately sized, manned and funded sobering up shelters in the Northern Territory is increasing with the alcohol problem, particularly as it is manifested in Aboriginal community groups around Darwin and regional centres. It is for responsible government to provide these adequate sobering up shelters, and without delay and I so recommend.

80. Finally, this Inquest has revealed that the Tennant Creek Watchhouse at the time of the death was inadequately staffed by police officers (and I refer to their own evidence in this regard). So long as the police have the care of drunken people held in their Watchhouses, so they have to resource the Watchhouse to ensure proper care. It appears in relation to this death that some of the Commissioners own guidelines and procedures were not complied with because of inadequate staffing levels. Accordingly, I recommend that staffing be monitored and set at appropriate levels.

Dated this 5th day of September, 2003.

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GREG CAVANAGH
TERRITORY CORONER