CITATION: *Inquest into the death of Owen King* [2003] NTMC 061

TITLE OF COURT:	Coroner's Court
JURISDICTION:	ALICE SPRINGS
FILE NO(s):	A0055/2002
DELIVERED ON:	3 December 2003
DELIVERED AT:	Alice Springs
HEARING DATE(s):	29 and 30 JULY 2003
FINDING OF:	GREG CAVANAGH SM

CATCHWORDS:

REPRESENTATION:

Counsel:

Assisting:	Mrs Lyn McDade

Solicitors:

For the Commissioner of Police:	Mr John Stirk
For the Family:	Mr Kim Kilvington

Judgment category classification:	A
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0055/2002

In the matter of an Inquest into the death of

OWEN KING
ON 24 JUNE 2002
AT ALICE SPRINGS HOSPITAL

FINDINGS

(Delivered 3 December 2003)

Mr GREG CAVANAGH SM:

THE NATURE AND SCOPE OF THE INQUEST

1. Owen King ("the deceased") died at about 12:10pm on 24 June 2002 at Alice Springs Hospital from natural causes, namely lobar pneumonia.

2. The death occurred after the deceased had been released from protective custody at Alice Springs Police Station. The deceased had been apprehended pursuant to S128 of the *Police Administration Act* on two occasions on 23 June 2002. He was initially taken into protective custody at 4.53am on 23 June 2002 when he was found outside the Alice Springs Post Office in Hartley Street. He was taken to the Watch House and placed in protective custody until his release at 9.42am. He was apprehended again at 4.29pm near Adelaide House.

3. Shortly after his arrival at the Watch House on the second occasion it became apparent that he was unwell and in urgent need of medical attention. He was immediately conveyed to Alice Springs Hospital where despite intensive and aggressive medical intervention he died on 24 June 2002.

4. Accordingly the death is one which is reportable to the Coroner pursuant to section 12(1) of the *Coroner's Act* ("the Act") on two bases. Firstly the death was unexpected and secondly immediately before his death the deceased was in the custody of a member of the Northern Territory Police Service.

5. The question of immediacy in terms of police custody is relevant to whether or not the death is a "death in custody" pursuant to the expanded definition of such deaths found in the Act. In my view, I should not take a narrow or restrictive view of the wording having regard to the aims and policy behind the legislation. Furthermore the care and attention the deceased received while in actual custody are all matters that were canvassed during the Inquest. I note that Counsel for the police conceded that this death was a "death in custody" and that the death was at my direction investigated by the police as a "death in custody" in accordance with extant Standing Orders.

6. I find that the death was a "death in custody", pursuant to the definition of that term in the *Act*. As a result of the operation of S15(1) of the *Act* it is mandatory that a public Inquest be held into the death of the deceased.

7. This Inquest took place in Alice Springs on 29 and 30 July 2003. Mrs McDade appeared as Counsel Assisting the Coroner. Mr John Stirk appeared on behalf of the Commissioner of Police and Mr Kim Kilvington appeared on behalf of the senior next of kin and family of the deceased.

8. Eight witnesses were called to give evidence during the Inquest. These witnesses were Detective Sergeant John Nixon; the police officer in charge of the investigation of the circumstances surrounding the death of the deceased, Constable Fiona Williams; Police Auxiliary Robert Norris; Police Auxiliary Kevin Ward; Sergeant Michael Potts; Constable Hamilton; Dr Terry Sinton and Assistant Commissioner of Police Doug Smith. In addition to their evidence, statements from a number of other witnesses

were admitted into evidence. These statements are to be found in the police report tendered as Exhibit 2. Medical records relating to the deceased were also tendered and admitted into evidence.

CORONER'S FORMAL FINDINGS

9. Pursuant to section 34 of the Act, I find, as a result of the evidence adduced at the public Inquest the following:

(a) The deceased was Owen King (also known as Colin Barnes) an Aboriginal male who was born at Claremont in Queensland on 8 March 1969.

(b) The deceased died at 12.10pm on 24 June 2002 at the Alice Springs Hospital.

(c) The deceased died from natural causes namely lobar pneumonia.

(d) Particulars required to register the death are;

(1) The deceased was a male.

(2) The deceased was Owen King.

(3) The deceased was an Australian resident of Aboriginal origin.

(4) The death was reported to the Coroner.

(5) The cause of death was lobar pneumonia. The cause of death was confirmed by post mortem examination.

(6) The pathologist was Dr Terry Sinton of Royal Darwin Hospital and he viewed the body after death.

(7) The deceased's mother was Olivia Punch.

(8) The deceased's father was Duck King.

(9) The deceased had no fixed place of abode in the Northern Territory.

(10) The deceased's occupation is unknown.

(11) The deceased's marital status is unknown.

(12) The deceased was 33 years of age.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

The investigation of the death

10. The investigation as a "death in custody" was thorough, objective and professional.

The protective custody provision of the Police Administration Act (PAA).

11. Section 128 of the *Police Administration Act* empowers members of the Northern Territory Police Service to apprehend persons who are intoxicated in public places and take them into custody. This is the procedure commonly known as protective custody. The law only allows detention for protective custody if the person considered is seriously intoxicated either by alcohol or some other drug.

12. As I have commented in previous Inquests, the police are also able to divert persons who would otherwise be detained in Watch Houses for protective custody to "Sobering Up Shelters". I remain firmly of the view that these facilities are so much more appropriate to care for intoxicated persons than police Watch Houses which after all are built and intended to be used to detain alleged criminals. I note that the police who apprehended the deceased on both occasions intended to take him to "DASA", the

"Sobering Up Shelter", in Alice Springs, rather than the Watch House. However, the shelter was not open on Sundays. The police had no alternative but to take the deceased to the Watch House.

13. Division 4 of Part VII of the *Police Administration Act* deals with the circumstances in which a person can initially be detained for protective custody. Detention is justified only if the person concerned is "seriously affected apparently by alcohol or a drug" vide Section 127A of the *Police Administration Act.*

14. It is appropriate that I should cite the protective custody provisions of the *Police Administration Act* as it was at the time of the deceased's death in full:

> ***Division 4 – Apprehension without Arrest***
>
> **127A. Definition**
>
> In this Division "intoxicated" means seriously affected apparently by alcohol or a drug.
>
> **128. Circumstances in which a person may be apprehended**
>
> (1) Where a member has reasonable grounds for believing that a person is intoxicated with alcohol or a drug and that that person is in a public place or trespassing on private property the member may, without warrant, apprehend and take that person into custody.
>
> (2) For the purposes of carrying out his duties under subsection (1), a member may, without warrant, enter upon private property.
>
> (3) A member of the Police Force who takes a person into custody under subsection (1) may –
>
> (a) search or cause to be searched that person; and
>
> (b) remove or cause to be removed from that person for safe keeping, until the person is released from custody, any money or valuables that are found on

or about that person and any item on or about that person that is likely to cause harm to that person or any other person or that could be used by that person or any other person to cause harm to himself or another.

(4) For the purposes of subsection (3), the person of a woman shall not be searched except by a woman.

(5) All money or valuables taken from a person under subsection (3) shall be recorded in a register kept for that purpose and shall be returned to that person on receipt of a signature or other mark made by that person in the register.

129. Period of apprehension

(1) Subject to this Division, a person who has been apprehended and taken into custody under section 128 shall be held in the custody of a member of the Police Force, but only for so long as it reasonably appears to the member of the Police Force in whose custody he is held that the person remains intoxicated.

(2) Subject to this Division, where it reasonably appears to a member of the Police Force in whose custody a person is held at the time under this section that the person is no longer intoxicated, the member shall, without any further or other authority than this subsection, release that person or cause him to be released from custody without his entering into any recognizance or bail.

(3) A person who has been taken into custody under this section and who is in custody after midnight and before half past 7 o'clock in the morning on that day, may be held in custody until half past 7 o'clock in the morning on that day, notwithstanding that the person is no longer intoxicated.

130. Protection of apprehended person

(1) A person in custody after apprehension under section 128-

(a) shall not be charged with an offence;

(b) shall not be questioned by a member in relation to an offence; and

(c) shall not be photographed or have his fingerprints taken.

(2) Where a person is questioned in contravention of subsection (1)(b) any answers which he may give to any such question shall be inadmissible in evidence against him in any proceedings.

131. Release

(1) The member of the Police Force in whose custody a person is held under this Division may, at any time, without any further or other authority than this subsection, release that person or cause him to be released without his entering into a recognizance or bail, into the care of a person who the member reasonably believes is a person capable of taking adequate care of that person.

(2) A person in custody shall not be released under subsection (1) into the care of another person if the person in custody objects to being released into the care of that person.

132. Continued detention

(1) If, after a period of 6 hours after a person has been taken into custody under section 128, it reasonably appears to the member in whose custody he is held that that person is still intoxicated with alcohol or a drug, the member shall bring the person, as soon as practicable, unless sooner released under this Division, before a justice.

(2) Where a person is brought before a justice under subsection (1), the justice shall, if it appears to him that the grounds for continuing the person's detention under subsection (1) –

(a) no longer exist – order the release of the person from custody; or

(b) continue to exist – give such directions as he thinks fit to a member for the safety and welfare of the person including, if he thinks fit, keeping him in the custody of a member (but only for so long as it reasonably appears to the member in whose custody he is held at the time that those grounds continue) or releasing him from custody.

133. Application to member for release

(1) A person apprehended under section 128 may, at any time after such apprehension, request a member to take him before a justice in order that the person may make an application to the justice for his release.

(2) Where a request is made of a member under subsection (1) he shall, if it is reasonably practicable for the person to be brought before a justice forthwith, bring the person, or cause the person to be brought, before the justice forthwith unless sooner released."

The deceased's first apprehension for protective custody on 23 June 2002

15. The evidence adduced at the Inquest establishes that the deceased was found by Constable Doyle and Williams asleep on the footpath outside the Alice Springs Post Office. At the time (4.53am) it was –2 degrees in Alice Springs. Doyle roused the deceased and made the following observations:

> "…I observed that he was showing signs of intoxication, he smelt heavily of liquor. Um he was unsteady on his feet and his speech was slurred."

And later in his interview:

> "…Um you've got to take all things into consideration being the, the time, the weather, his intoxication and he was sleeping on the side of the pavement. We had a lot of problem juveniles that evening um but the primary conclusion was the fact that he was intoxicated and he wasn't able to look after himself properly."

16. Constable Williams in her evidence before me said that the deceased appeared intoxicated and told her and Doyle that he had been "drinking all day". She also noted that he appeared confused and unsteady on his feet.

17. As I indicated earlier, Doyle and Williams wanted to take the deceased to "DASA", however it was not open. The deceased did not live in Alice Springs and was unable to provide police with the name/s and addresses of any person who might be able to look after him.

18. The police officers had reasonable grounds for believing the deceased was seriously affected by alcohol given their observations of his demeanour and smell and his volunteered information that he had been "drinking all day". Neither police officer observed anything about the deceased to suggest to them that he was not seriously unwell nor did the deceased confide in the officers that he was unwell.

The deceased's first episode in custody at the Watch House.

19. He was taken to the Watch House and placed in custody after being assessed by the Watch House Keeper, Auxiliary First Class Robert Norris. The Police Custody Manual mandates that a pre-custody assessment be conducted prior to placing persons in the cells. The result of that assessment is required to be recorded in the Watch House Journal or the Integrated Justice Information System (IJIS). Norris in his oral evidence and in his statements to the investigating officer stated that he always conversed with detainees and completed the necessary assessment. The detention assessment is made up of eight criteria as follows:

(1) Suicide signs or health problems.

(2) Obvious pain or injury.

(3) Obvious signs of infection.

(4) Under influence of alcohol.

(5) Signs of alcohol/drug withdrawal.

(6) Appearance of despondency.

(7) Irrational or mentally disturbed.

(8) Carrying medication.

20. In the case of the deceased, he was of the view after speaking with the deceased and going through the assessment that:

> "He seemed fine, he seemed to be affected by alcohol and that was his only problem."

21. Norris accordingly marked Y (yes) for intoxication and N (no) for the remaining criteria. He frankly conceded that he could not recall the actual conversation he had with the deceased, however, he believed he would have assessed him as he did all others and had he become aware of a problem or believed that the deceased was not intoxicated he would have taken whatever action was appropriate, be that referring the matter to his superior or obtaining medical treatment for the deceased.

22. The deceased was then placed in cell 17. Regular cell checks were conducted as prescribed by the Custody manual between 5.00am and 7.00am when Norris handed over to Auxiliary Ward.

23. Although Norris cannot recall doing so, I find that he did inform Auxiliary Ward that the deceased was breathing unusually. Ward recalls being informed, however, neither made a note of this irregularity in the custody log as they should have. Sergeant Potts came on duty as the Watch Commander at 7.00am and shortly thereafter he conducted a cell check. He observed that the deceased was breathing heavily and determined to enter the cell to check on him. Potts did enter the cell and woke the deceased. He spoke with the deceased and believed that his breathing although 'heavy' was not a cause for concern and that the deceased did not need medical attention. It was after he had entered the cell that Ward informed him that Norris had noticed the deceased's breathing also. Again no notation was made in the log about the deceased's breathing.

24. Constable Barry who was on duty with Ward and Potts conducted the next two cell checks and found the deceased asleep on the first check and awake on the second. Ward conducted a cell check at 8.30am and 8.45am. On

both occasions the deceased was asleep. Constable Barry then conducted another cell check and found the deceased awake. He then entered the following observation in the custody log …'Lang appears sober …'. It is clear that Barry meant to enter, 'King appears sober' and that he was referring to the deceased when he made the entry. Shortly after at 9.42am the deceased was released from protective custody.

25. This decision was made by Ward who formed the view that the deceased was sober. Potts observed the deceased before he left the Watch House and he was of the view that the deceased was 'normal', albeit there was still 'liquor on his breath'.

26. It is clear that the deceased did not at any time inform the police that he was unwell and experiencing breathing difficulties.

27. The deceased left the Watch House alone.

The deceased's second custody episode

28. The deceased was found by police at about 4.29pm on 23 June 2002 near Adelaide House asleep on the concrete in the gutter.

29. Constable Pethick and Constable Kluske were of the opinion that the deceased was intoxicated. Although they found him to be coherent, he was very cold, unsteady on his feet and smelt of liquor. The police conveyed the deceased to "DASA", the sobering up shelter, but found it closed. The deceased was taken to the Watch House. Constable Hamilton was at the Watch House and met Pethick and Kluske when they arrived with the deceased. She had agreed to process the deceased because Pethick and Kluske had been called to a house fire.

30. Hamilton escorted the deceased into the Watch House reception area and sat next to him to ascertain his details. Whilst sitting with the deceased she noticed the following and I quote from her evidence:

> "…and he's talking gibberish, he's incoherent, wasn't making much sense he's breathing rapidly and slowly. I raised this concern about his medical condition with Gary Wilson the Watch House Commander and said that I would take him as an 8 zero 6 to the hospital and have him assessed or treated or whatever he needed…"

and

> "…that smell wasn't grog, like you can smell grog on people. It was acidic like apple cider kind of smell…".

31. The deceased was taken by police vehicle to Alice Springs Hospital by Constable Hamilton and her partner Constable Bailee. An ambulance was not called because it was quicker to take the deceased in a police vehicle. He was handed over to staff at the emergency section.

32. At this time the deceased was effectively unable to communicate and very unwell. On all of the medical evidence I find that, in fact, the deceased was not severely intoxicated on this second occasion of detention but very ill. The signs of illness and severe intoxication are similar and I do not criticise the police for this mistake. Indeed neither counsel for the family nor any other counsel suggested I do so criticise. The police are to be commended for picking up the fact of the deceased's illness as soon as they did. I quote counsel for the family (transcript p.65):

> "MR KILVINGTON: Your Worship, may I indicate that I won't be, on behalf of the family, I'm not justified, I don't feel, on any of the evidence, to make any allegations of wrong-doing against the policemen. I won't be making any allegations at any officer or witness who has given evidence so far, who has done anything other than their best."

And (transcript p.95)

> "Now with respect to the second apprehension, again no criticism is made of the police because even more so than in the morning, because his illness was more advanced, even more so, in all probability, he would have been demonstrating indicia of illness, which is equally consistent with the indicia of intoxication.

> With respect to his treatment upon reception at the watch-house to be assessed, no criticism could possibly be made of Officer Hamilton. Indeed I'd ask Your Worship to consider commending her responsible response to this situation. She acted immediately. Made an assessment. Was responsible enough to seek a second opinion. Asserted herself and acted quickly."

The deceased's medical treatment

33. The deceased was provided with aggressive and appropriate medical care by staff at the hospital. At the time of his admission he was "in extremis" or put another way very near death. The medical report provided by Dr Campbell which I set out here in full, adequately and appropriately summarises the medical treatment provided to the deceased.

> "I have made this statement with the aid of contemporary notes made at the time by the triage nurse, by the staff of the Intensive Care unit and Medical team and by Dr Afilika who was employed as a Registrar or Resident Medical Officer within the emergency department. The copy of the patients chart which I have been sent contains no notes in my writing apart from some drug orders, but I do recall that I was involved in the care of this patient in the emergency department.
>
> He was transported to the emergency department by the police on the afternoon of the 23rd of June, 2002 and arrived at 1715. According the triage nurse he had been found in a confused state in some church gardens and brought to the Emergency Department. There was no record of him having been at the Alice Springs Hospital before. The triage nurse noted he had a respiratory rate of over 60 (normal is about 12, anything over 20 is abnormal) and was "almost collapsing". He stated he had vomited some blood. The nurse triaged him as an emergency (ie, category 2, must be seen within 10 minutes.)
>
> After initial observations by a nurse was seen by Dr Afilaka who recorded 1730 as the time seen. Dr Afilika examined him and found him very short of breath. For that reason, we could not get much information from Mr King.
>
> Pulse 130, BP 92/54. When he listened to the patient's chest he found decreased air entry and suspected pneumonia, so Mr King was sent for an Xray. This confirmed pneumonia in both lungs.

Blood tests showed significantly fewer white blood cells than normal, and respiratory failure. That is, the oxygen in his blood was half normal. In addition he was developing acidosis. That is, his blood was becoming slightly acid because his oxygenation and circulation was not enough to allow normal metabolism.

Dr Afilika told me about the patient. I noted he was looking exhausted, dry, and was labouring to breathe. I wrote an order for his initial antibiotics (penicillin and gentamicin) at 1745 so I would have seen him within a few minutes of that time. He was moved to the resuscitation area of the emergency department and given large amounts of intravenous fluids, antibiotics, and high flow oxygen. I called the intensive care/anaesthetic consultant who attended shortly thereafter and made arrangements for Mr King to go to the Intensive Care Unit following his initial resuscitation.

Mr King appeared able to understand what was happening to him, although he was breathing too quickly and too exhausted to respond in sentences; he could manage "yes" or "no". I do recall noting that although this patient was critically ill there was nothing to suggest previous poor health; he was well-nourished and muscular.

Mr King responded poorly to resuscitative measures. He was given 8 litres of intravenous fluid but continued to have low blood pressure, and in spite of giving as near to 100% oxygen as we could manage we could not raise his oxygen to near normal limits.

The Intensive Care consultant decided Mr King would need to be intubated, that is, go onto a ventilator or "life support machine" which could give 100% oxygen and take over the work of breathing for him. It was clear that Mr King was exhausted. Mr King, I believe, understood the explanation that was made to him at the time and agreed to this plan.

The Intensive Care consultant next arranged to put in a central venous line. (This is a cannula, put in near the neck or shoulder; that goes to the vena cava which returns blood to the heart; measuring pressures here helps with fluid management). Such a cannula also allows inotropes to be given; these are drugs which stimulate the heart and help to maintain blood pressure. Mr King's blood pressure was poor and there was a danger that it would drop further when he was on the ventilator.

> Further, a cardiograph now showed that as well as having a fast heart rate, there was some non-specific changes which made us worry about heart damage or stress. This can happen from some of the toxins caused by the pneumonia.
>
> Mr King suddenly deteriorated further while was he was being prepared ventilation. His heart slowed, almost certainly because of the lack of oxygen. He stopped breathing and lost consciousness. When that happened, the contents of his stomach – a large amount of green fluid – regurgitated and some of that went into his lungs. He was promptly intubated – ie within a minute of so – and some of this fluid was suctioned from the tube in his airway.
>
> He was given further antibiotics, sedated and put on a ventilator. He was then transferred to the Intensive Care Unit and I did not see him again. Within a short time of arriving in Intensive Care a bronchoscopy was performed. That is a way of removing material, including gastric contents, sputum, or pus, from the lungs. Some fluid was removed but no particulate matter.
>
> He was given maximum ventilatory and respiratory support but died the next day. Blood cultures grew Streptococcus pneumonia. This was the cause of his pneumonia, it was the anticipated cause and he was given appropriate antibiotics.
>
> Mr King had a poor prognosis on presentation. He had a severe pneumonia, he had septic shock, he had a low white cell count and did not respond promptly to initial measures – that is, fluid and oxygen."

34. I also had the benefit of evidence from Dr Terry Sinton who informed me about the deceased's condition and cause of death, and importantly how his illness would have caused him to display all the classic indicia of intoxication. Toxicological tests conducted on the deceased's admission blood found no alcohol.

Conclusions and Recommendations

35. It is clear from the evidence that the deceased was extremely unwell on 23 June 2002 and had probably been unwell for some days before. It is also clear that the deceased had been drinking alcohol despite his illness during

the day/night of 22 June and probably into the morning of 23 June 2002. I am of the view that when he was firstly apprehended on the morning of 23 June the deceased was intoxicated, notwithstanding the toxicological results. Even if he was not at that time he would have appeared to the police to be intoxicated to such a degree as to warrant his apprehension pursuant to S128. I also make no criticism of the second apprehension although I find that it is highly unlikely that the deceased was intoxicated at the time. Again he would have been displaying all the indicia of intoxication and the apprehending police in my view acted appropriately.

36. Police officers albeit the holders of First Aid certificates are not medical personnel and it would be very difficult for even an experienced police officer to be able to discern between an unwell person and intoxicated person in the circumstances police found the deceased.

37. Constable Hamilton is to be commended for her accurate assessment that the deceased was unwell, and for her prompt action in taking him straight to hospital, and I so recommend.

38. As I indicated earlier in these findings I should comment on the role of Sobering Up Shelters. I note the following evidence and comments that flowed at the Inquest (transcript p.7) of Ms McDade's summary of Police inability's to access the sobering up shelter.

> "As I previously indicated the deceased was initially apprehended by police and taken into custody, pursuant to section 128 of the Police Administration Act at 4:53am on 23 June. He was apprehended by Constables Doyle and Williams. They found him asleep on the footpath outside the Alice Springs Post Office. They roused him and ascertained who he was.
>
> Doyle, in his interview with Senior Sergeant Nixon, says, amongst other things, 'I observed that he was showing some signs of intoxication. He smelt heavily of liquor. He was unsteady on his feet and his speech was slurred.' Doyle also

observed that the deceased was very cold and at the time the temperature was about 2 degrees.

It was Doyle's intention to take the deceased to the sobering up shelter but it was Sunday and the sobering up shelter was closed."

And (transcript p.11)

"At 9:42 the deceased left the watch-house alone. At about 4:29 on the 23rd he was found by police near Adelaide House, asleep on the concrete.

Constable Pethick, who apprehended him on this occasion, with Constable Kluske, was of the opinion that at this time Owen King was intoxicated. He will give evidence that he believed King was coherent but very cold and unsteady on his feet. And again it was his intention to take the deceased to DASA. And again he was informed that DASA was not open, hence he again conveyed the deceased to the watch-house."

39. I also note the evidence of Assistant Commissioner, Doug Smith (transcript p.70):

QUESTION: The police force already devotes, particularly in Alice Springs, a large proportion of its resources to administering section 128, doesn't it? --- Look, it would have to be well beyond 50 if not 70% of the work of the police at Alice Springs. The whole chain of custody from the taking people into custody on the street right through to the management of the people, it is very, very resource intensive. It is the highest risk thing that the police officer does regularly. And I've got to emphasise that because we're dealing with the management of a particular risk. Now it's all very well – and numerically we say that the number of very serious custody incidents as a percentage of actual taking of people into custody is very low. However, any custody incident, particularly one that results in serious injury or death, is one of those things where it's a low frequency but an incredibly high risk because it really does impact on everyone that's involved. Every police officer who has anything to do with a custody that results in a death in custody is significantly marked by the incident because it is a reflection on them. I personally know that when you dealt with people and interview people they're very concerned. I mean they think about their career and, you

know, what this is going to mean for their future. So it has a huge impact on - - -"

And (transcript p.73)

"THE CORONER: But you'd rather see them go to a 24 hour sobering up shelters, wouldn't you, than the police cells? --- I would, together with proper medical assessments."

And (transcript p.80)

"You've heard a bit about DASA, are you aware of how many beds DASA has in Alice Springs? --- DASA has 30 beds. I don't know what the mix is for male and female but it's got 30 beds.

And what's your view about the adequacy of that number of beds for the population of Alice Springs? --- Well simple maths, there's not enough because if there were enough there wouldn't be protective custody's that should be at DASA that are in the watch-house.

Have you – I think – reviewed the figures between summer and winter in terms of people that end up in the watch-house because DASA is unable or full? --- There's two issues there. The first is that some people should not be in the care of DASA so obviously we have to keep those in our custody. I can't give you a breakdown on that. But over the last 18 months our records indicate that there were 5192 people taken into police protective custody at the watch-house. 5226 for other reasons of custody, whether it be offences, assaults, remands or whatever. That's 10,418 people. That's an average of 19 custody events for a 24 hour period at Alice Springs. The figures do differ from summer to winter. I am advised by members of the watch-house here at Alice Springs, Your Worship, that between 40 – 60 people can be regularly taken into custody on a 24 hour period in the summer months, and this is around 10 to 20 during winter months. But it is not unusual when DASA is closed, for example, on a Sunday and Monday, even in winter, to have up to 40 people in the watch-house. We have taken a snapshot from the records on IJIS for a 24 hour period. Now on a Thursday on 16 January this year, a summer day, 58 people were taken into police custody; 30 of those were under the provisions of section 128. On a Sunday, on 6 July, a winter day and the day that DASA was closed, 23

people were taken into custody and 10 of those were under section 128.

The bottom line is DASA needs to be open 7 days a week? --- Look, it's my view that it the resources are available it should be open 7 days a week and they probably need at least another 15 beds to take the pressure off the watch-house."

40. I also quote Mr John Stirk (counsel for the Commission for Police) (transcript p.98):

"In terms of DASA funding, we obviously join with the often quoted statement that it is not the job of a policemen to be looking after people in protective custody, and obviously Assistant Commission Smith has give you some indications again as in Corbett that the number of beds need to be increased.

The liquor restrictions in Alice Springs led to the sobering up shelter being open after 2 o'clock on Monday, In the old days it wasn't open again until 2 o'clock on Tuesday. One really doesn't understand the rocket science by which we accept that it needs to be open an extra day but somehow leave this 38 hour gap between midnight on Sunday and 2pm on Monday. I think all counts have indicated to Your Worship that that is an issue that ought to be put to the relevant authorities as a recommendation that it be open 7 days a week.

In terms of the location of medical staff, obviously, on behalf of the Commissioner, the view is that if the primary and ideal port of call is for people to go through DASA, then obviously DASA ought to be funded to have – whether it's a doctor, an aboriginal health worker or nurse, as part of their regime."

41. I also quote Mr Kim Kilvington (counsel for the family) (transcript p.96):

"MR KILVINGTON: I think that would be highly desirable and particularly, Your Worship, given the evidence – I wasn't aware of the extent to which police had to deal with the administration of this particular section of the Police Administration Act, but I can't imagine that the public would be very happy to find out that their police force is engaged to the extent of perhaps 70% of their resources - - -

> THE CORONER: Well I don't think so either and I don't think the police commissioner is either. You spend 6 months training a police constable to be a crime fighter and then you find that the majority of what they do the years that they're in Alice Springs is picking up drunks."

42. I remind Government again that police Watch Houses are not designed to accommodate drunken people but rather to incarcerate criminals. More resources are required to ensure that the Alice Springs Sobering Up Shelter is open every day to take care of drunken people and staffed with, inter alia Health Professionals, and I so recommend. In making this recommendation I remind the responsible Minister (who I understand is the Minister for Health and Community Services) of my comments and recommendations in recent coronial findings including those of Gaykamangu (deceased) handed down on 10 April 2003 (paragraph 31 p.18):

> "I have no recommendations to make pursuant to the Act, except to reiterate those contained in my findings regarding Rita Dandy (D190/2001). This case (once again) exemplifies the need for 24 hour well resourced "sobering-up" shelters staffed by trained and qualified paramedics.

And Corbett (deceased) handed down on 5 September 2003 (paragraphs 77 - 80 inclusive p.29-30):

> "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.
>
> 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."

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.

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."

43. At the time of the hearing of this Inquest I did not have the benefit of the report prepared pursuant to section 46B(3) of the Act in relation to the recommendations flowing from the Inquest into the death of Rita Dandy. One recommendation was that Sobering Up Shelters be funded to enable them to operate 24 hours a day.

44. I quote from the response dated 13 August 2003 the Chief Executive Officer of the Department of Health and Community Services;

> "Increasing the hours of operation of the Darwin Sobering-Up Shelter to 24 hours per day is not considered best practice and therefore would not be a priority for increased funding. Whilst the Sobering-Up Shelter does provide the first "port of call" for

> police officers, a 24 hour service would not necessarily provide for greater safety for the individual because clients are voluntary and can walk out of the shelter at any point of the sobering-up process. The guidelines provide procedures for this scenario where a client who has been admitted under "protective custody" has their details entered in the "refusal journal" and police are then notified immediately. Careworkers have no powers of apprehension and therefore can only use powers of persuasion to convince the client to remain in care. The benefit of the shelter is that it requires no legislative direction for a client to remain in care for longer periods."

45. It is difficult to understand the logic that allows sobering up shelters open some days of the week and/or some part of a day but not others. That is to say, if it is good enough to have a sobering up shelter open on Saturday then why not a Sunday, especially when there is little change in drinking habits. The proposition that it is "not best practice" to operative a sobering up shelter 24 hours per day (especially in Alice Springs) is questionable in my view.

46. Given the information from the Department it would appear that intoxicated people in need of care and safety, once again fall between available services. Police cells are not designed for the containment of intoxicated persons and "it is not the job of a policeman to be looking after people in protective custody", yet existing sobering up shelters do not have the power (apart from persuasion) to make an intoxicated person remain in their safe environment.

47. This highlights the incredibly difficult and complex nature of the problem for our community of dealing with the results of widespread alcohol abuse. The Department of Health has advised that "over the next 3-5 years the Department is proposing to refocus and expand its alcohol and other drugs services, and is currently developing a comprehensive Alcohol and Other Drugs Program Service System Strategy." Significant funding has also been allocated in the 2203/2004 budget for the Itinerant's Strategy.

48. I can only hope that these strategies reduce the number of people found to be in need of the kind of care that is afforded by “protective custody”.

Dated this 3rd day of December 2003.

Greg Cavanagh

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GREG CAVANAGH
TERRITORY CORONER