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HEARING DATE(s):	18 – 20 January 2006
FINDING OF:	Mr Greg Cavanagh SM

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Death in Custody, Federal Agencies and their duty of care to detainees.

REPRESENTATION:

Counsel:

Assisting:	Mr Colin McDonald QC
Aust. Fisheries Management Authority (AFMA):	Ms D Mortimer SC & Ms Doyle
Dept. of Immigration, Multicultural & Indigenous Affairs (DIMIA):	Mr Michael Grant

Solicitors:

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0072/2005

In the matter of an Inquest into the death of

MUHAMMAD HERI
ON 28 APRIL 2005
IN DARWIN HARBOUR

FINDINGS

(Delivered 3 March 2006)

Mr Greg Cavanagh SM

1. Muhammad Heri ("the deceased") died at about 2.30pm in Darwin Harbour on 28 April 2005; his death was that of someone being held in lawful custody. The death was reported to the Territory Coroner pursuant to Section 12 of the *Coroners Act* ("*the Act*") which defines a "reportable death" to include, inter alia, a death of a person that,

> "(a) is detained anywhere in the Territory by a person authorised to do so under any Act or law in force in the Territory, including a law of the Commonwealth: or
>
> (a) Is in the process of escaping from detention referred to in paragraph (a)." (Section 12 (1A)).

2. For the reasons that appear in the body of these findings, the death fell within the ambit of that definition and a coronial investigation was mandatory. The holding of this Inquest additional to that investigation is also mandatory because the death was a "death in custody" as defined in the Act.

3. Section 34(1) of *the Act* details the matters that an investigation Coroner is required to find during the course of an Inquest into a death. That section provides:

"(1) A coroner investigation –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) cause of death;

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

(v) any relevant circumstances concerning the death."

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

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

5. The duties and discretions set out in subsection 34(1) and (2) are enlarged by section 35 of *the Act*, which provided as follows:

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner."

6. Furthermore, section 26 requires in relation to "Deaths in Custody":

> "26. Report on additional matters by coroner
>
> (1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –
>
> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant."

7. The public Inquest in this matter was heard at Darwin Magistrates Court between 18 and 20 January 2006 (inclusive). Counsel assisting me was Mr Colin McDonald QC. Ms D Mortimer SC with Ms Doyle representing the Australian Fisheries Management Authority (AFMA), and Mr Michael Grant representing the Department of Immigration, Multicultural & Indigenous Affairs (DIMIA) also sought leave to appear and I granted them leave pursuant to section 40(3) of *the Act*.

FORMAL FINDINGS

8. In accordance with the statutory requirements under *the Act*, the following are my formal findings arising from this Inquest:

(a) The identity of the deceased was Muhammad Heri, a male Indonesian national; he was from a village called Probolinggo. I am unable to ascertain his exact date of birth however, I understand from the evidence that he was about 37 years of age.

(b) The place of death was at a place in Darwin Harbour, Darwin, Northern Territory of Australia at about 2.30pm on 28 April 2005.

(c) The cause of death was Coronary Atherosclerosis.

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

1. The deceased was a male.

2. The deceased was an Indonesian national.

3. The death was reported to the Coroner.

4. A post mortem examination was carried out on 29 May 2005.

5. The pathologist viewed the body after death, and the pathologist was Dr Terence John Sinton of the Royal Darwin Hospital.

6. I was informed by a member of the Indonesian Consulate at the Inquest (Transcript P140) and accept that the father and mother of the deceased are unknown.

7. The deceased resided on board the fishing vessel “Gunung Mas Baru” at the time of his death.

8. The deceased was employed as a fisherman at the time of his death.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING COMMENTS, REPORTS AND RECOMMENDATIONS

9. At the time of his death, the deceased was being detained as an illegal fisherman under the provisions of the *Fisheries Management Act*. The deceased was detained in Darwin Harbour on board the Indonesian fishing vessel “Gurung Mas Baru”. The vessel was intercepted by HMAS Bunbury earlier on 19 April 2005 and was boarded by a party including Australian Navy personnel and an authorised Fisheries officer, Mr Darren Heal, at about 7.00 am that morning. There followed an exchange between Lieutenant Wyles of the Australian Navy and the deceased in Bahasa Indonesia assisted by the use of standardized cards in the Indonesian language. The deceased identified himself as the master of the vessel and this was recorded in Mr Heal's notebook.

10. The position of the vessel at the time of apprehension on 19 April 2005 was plotted by the navigator of the HMAS Bunbury as 10 degrees 10.7 seconds south and 136 degrees 18 seconds east, or about 40 kilometres inside the

Australian Fishing Zone off the Australian coast. Through the use of the cards and the interpreter it was ascertained that the vessel had sailed from Apona in the Maluku Islands of Indonesia. The deceased was recorded as saying the vessel had left Apona on 16 April 2005, and the vessel had been in the position it was found in the Australian Fishing Zone since the previous evening, and that the purpose of the voyage was to fish.

11. The vessel was equipped with a long line and fishing gear. The vessel had a generator which enabled the catch to be frozen and, accordingly, the vessel fell into the category referred to as a Type III “Ice boat”. The deceased was recorded by Mr Heal as stating that he knew the vessel was in Australian waters and that he did not have a licence 'to fish here'.

12. At about 10:46 am on 19 April 2005, using standard card number 40, Mr Heal advised the deceased that the vessel was going to be taken under tow. Mr Heal then issued a notice pursuant to s 84(1)(k) of the *Fisheries Management Act 1991* directing the vessel “Gurung Mas Baru” to Darwin. HMAS Bunbury at first towed the vessel but then allowed it to steam back to Darwin, with the boarding party on board. The vessel arrived in Darwin Harbour on Thursday 21 April 2005. On Friday 22 April 2005, officers from the Australian Fisheries Management Authority (“AFMA”) boarded the vessel and searched it.

13. As the subsequent coronial investigation of Detective Sergeant Brayshaw and members of the Major and Organised Crime Unit Northern Territory Police revealed, the vessel was taken to a quarantine area situated 1.5 nautical miles from the Stokes Hill wharf and within the harbour. There are two areas where Indonesian fisherman are detained on their boats. One is near Stokes Hill wharf and with which I am familiar (Inquest into the death of Mansur), the other and the relevant one for this inquiry is 1.5 nautical miles from the Stokes Hill wharf.

14. The vessel was held at the quarantine area until 28 April 2005, which is the material date in question. On board the vessel was the deceased and nine other crew members. The vessel was approximately 20 metres in length and 4 metres wide and room to move on board was very limited and living conditions were basic. After the AFMA search of the vessel on 22 April 2005, the deceased and the crew members remained on board the vessel. The vessel was moored at the quarantine area. Pursuant to contractual arrangement with AFMA, the vessel and other detained Indonesian fishing vessels were secured and supervised by personnel employed by Currawong Pty Ltd which trades as Barefoot Marine. Food, basic supplies and water were provided daily to Indonesian fishermen detained at the quarantine area.

15. Prior to 28 April 2005, arrangements were being made for the repatriation to Indonesia of the crew members (this did not include the deceased who was going to be kept for the purposes of being charged with relevant offences). Repatriation was anticipated to be by aircraft from Darwin. In order for the crew members to be able to fly they had to undergo a medical examination in order to ascertain whether they were fit to fly and indeed the examination was colloquially called a 'Fit to Fly' examination. The examinations were to take place on or about 29 April and the deceased, the master of the vessel, had not had any medical examination from the time of his initial detention to the time of his death on 28 April 2005.

16. After lunch on 28 April 2005, the deceased started complaining of a sore back and he started vomiting. According to crew members, there had been no previous observed illness on the part of their master, nor was there any history of previous fights on board or altercations which might have led to injury. After the deceased complained to other crew members that his back was sore, he appears to have been given a massage by one of the crew. The massage involved the use of a coin. The crew member later interviewed, Hindi, gave the time the deceased started to feel sick as around 1.00 pm and

that it is contained in an audio tape transcript that was subsequently taken by Sergeant Brayshaw as part of his investigation.

17. The deceased then collapsed and the crew then sought to draw attention to the situation by sounding a claxon which the vessel had been provided with. Another member of the crew waved a towel. This activity drew the attention of Barefoot Marine employees, Mr Neale Henderson and Mr Christopher Carson who were attending another Indonesian vessel at the time the crew members sounded the alarm. Barefoot Marine maintained a 24 hour presence in the quarantine area by way of two employees being present on a motorized 7 metre boat at all times. The operation of Barefoot Marine at the quarantine area required a log to be made of significant events each day. That log was collected by Detective Sergeant Brayshaw as part of the investigation and was tendered as evidence during the Inquest.

18. Mr Henderson and Mr Carson proceeded immediately to the "Gurung Mas Baru" in their 7 metre boat. The deceased was transferred to the 7 metre boat with the assistance of Indonesian crew members. Mr Henderson and Mr Carson were both trained in first aid. The deceased was checked for vital signs and a faint pulse was found. They could not determine whether the deceased was still breathing and that was because of the nature of the sea conditions at the time. The crew member Hindi told Detective John Worrall on the evening of 28 April 2005 that the deceased could not talk when he was put on the Barefoot Marine boat but was awake. However, both Mr Henderson and Mr Carson recall the deceased was unconscious when they first observed him on their arrival at the "Gurung Mas Baru".

19. The sea was choppy and there was some difficulty in getting the deceased on board the Barefoot Marine vessel. Mr Henderson took several Indonesian crew members to assist. The journey to the pontoon area took about 10 to 15 minutes. On the way Mr Henderson telephoned the owner, Mrs Jenny Scullion, and the operations manager of Barefoot Marine, Mr Darryl Rolfe,

that he had an emergency and for them to call an ambulance. Mr Henderson arrived at the pontoon area at Stokes Hill Wharf and again with the assistance of Mr Carson and the Indonesian crew members, the deceased was lifted onto the pontoon area and laid down. He was certainly unconscious at this stage and unresponsive.

20. A St Johns Ambulance was dispatched at 1435 hours, 2.35 pm. On board were ambulance officers and paramedics, Lisa Trevaskis and Sophie Ploughman. The ambulance arrived at 1442 hours and the officers took another two minutes to get down to the pontoon area. On arrival at the paramedics undertook an examination of Muhammad Heri. It is apparent that Muhammad died before the ambulance officers arrived.

21. At page 2 of Sophie Ploughman's transcribed interview, at folio 28 of the investigation brief, her observations were recorded by detectives as follows:

> "The patient was obviously appeared unconscious. My partner was attending. We both checked for response, we found not - he had no response, no vital signs, no active pulse, his eyes were dilated, fixed and dilated at about 5. They were glassy, and dried over. And after attending that he had no vital - no life signs at all and appeared that he'd been like that for some time, the crew said they might have felt a pulse when they picked him up 20 minutes earlier but they weren't sure. As they said, they might have heard a breath when they put him down on the concrete, but apart from that, they had no signs of life."

22. The ambulance officers could not do anything to resuscitate the deceased and the deceased was pronounced dead. This was translated to the crew members present by Mr Henderson who had conversational fluency in Bahasa Indonesia.

23. The Coroner's Office was notified of the death at 2.45 pm. The noted reason for the notification was unexpected death. Mrs Jenny Scullion, one of the owners of Barefoot Marine operation, had also notified the Northern Territory Police promptly. At 3.50 pm, Detective Senior Sergeant Proctor of

the Major and Organised Crime Unit instructed Detective Sergeant Wayne Brayshaw to head up and conduct an investigation into the death of the deceased on behalf of the Coroner.

24. Sergeant Brayshaw inspected the body and noted that there were no obvious signs of injury or trauma. Senior Constable Herrmann photographed the body in its supine position on the pontoon. The body was moved to allow Senior Constable Herrmann to photograph the deceased's back, arms and feet. Soon thereafter Members Brayshaw, Worrall, Evans, Herrmann and Hamilton, in the police launch "Finnis" were escorted out to the "Gurung Mas Baru" by Mr Henderson. This occurred at around 4.57 pm. It took about 15 to 20 minutes to get out to the quarantine area. The detectives made an investigation of the vessel, Senior Constable Herrmann took photographs, nothing significant was located, there were no signs of disturbance or signs that looked out of the ordinary. Medication was seized by Ms Ruth Herrmann which proved subsequently to be Panadol and had no bearing on the investigation. The police party returned to shore. The detectives then went to room 7 of the Peninsular Apartments on Smith Street, Darwin where the Indonesian crew members were being held by Barefoot Marine personnel.

25. Sergeant Brayshaw then explained through an interpreter why the police were present and why they were conducting an investigation because it was a death in custody. The crew members indicated their understanding and assent to the process of interviews through the interpreter. Taped statements were obtained from all nine crew members, the two Barefoot Marine staff, Mr Henderson and Mr Carson and from Mrs Jenny Scullion. All interviewees were cooperative. The taped material was then taken to the Peter McAulay Centre and later transcribed and verified by the interviewing officers. Therefore all immediately relevant observers were interviewed on audio tape by midnight on 28 April 2005.

26. On 29 April 2005, Sergeant Brayshaw tasked Detective Worrall to attend the autopsy to be conducted by Dr Terence Sinton at the Royal Darwin Hospital. The body of the deceased had arrived at the mortuary at 1715 hours on 28 April 2005. The cause of death was readily ascertainable by Dr Sinton who conveyed his conclusions to Detective Worrall. The cause of death was coronary atherosclerosis. There were no signs of foul play. Dr Sinton's autopsy report concluded:

> "COMMENTS
>
> 1. The deceased was reportedly a foreign fisherman being held in detention in Darwin Harbour. After a period of some hours during which he complained of feeling unwell, he apparently collapsed suddenly and unexpectedly, and could not be revived.
>
> 2. At autopsy, the significant findings included the following:
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> (i) clinically significant coronary artery disease (coronary atherosclerosis).
>
> (ii) an area of clinically significant stenosis in one of the major brain arteries.
>
> (iii) extensive black carbon pigmentation both lungs, consistent with a history of heavy smoking.
>
> (iv) fluid accumulation in the lungs, consistent with acute heart failure.
>
> 3. Samples of blood, liver and stomach contents were taken at autopsy for toxicological analysis. No alcohol, amphetamines, opiates, benzodiazepines, or cannabis metabolites were detected in the blood.
>
> 4. The skull and remaining bony skeleton were intact with no evidence of any recent trauma. Similarly, there was no evidence of any recent soft tissue injury.
>
> 5. Given the history and autopsy findings, it was likely that he died in acute heart failure as a consequence of longstanding coronary artery disease.

CAUSE OF DEATH

Condition leading directly to death: 1(a) Coronary Atherosclerosis"

27. Sergeant Brayshaw questioned officers from DIMIA, AFMA and the Australian Quarantine Service. They were all co-operative. At the conclusion of his investigation, Sergeant Brayshaw recommended that, in the future, all masters and crew of foreign fishing vessels detained should be medically examined within 24 hours. Apparently, in the then existing DIMIA guidelines, there was a stipulation that all crew be medically examined preferably within 24 hours. In this case that stipulation clearly was not adhered to. The deceased had been in Darwin Harbour for seven days without medical examination before his unfortunate death. Sergeant Brayshaw also raised in his brief that consideration be given to making the 24 hour period prescriptive by nature and not preferable as set out in the DIMIA guidelines. He provided the main reason for this stipulation as being that of public health and safety.

28. Evidence at the Inquest established that detainees are going to be held at a land-based facility in Darwin in the near future. The facility is due to be in operation in about June this year. The standards of this facility are of course most important in relation to Australia's discharge of its duty of care to detained foreign fishermen and to ensure their safety. I was shown the facility; apparently millions of dollars are being spent by the Federal Government at the site adjacent to the Stuart Highway at Berrimah, in order to house detainees in acceptable and appropriate conditions.

29. The evidence indicates there have been significant and beneficial changes in detention standards and procedures since the death of the Indonesian fisherman named Mansur. It appears that AFMA has taken the experience of the Mansur death and my Inquest recommendations seriously and have adopted a positive approach in seeking to implement those recommendations. I think their response has been commendable.

30. Given the sensitivities and the importance of burial to members of the Islamic faith, the initiative taken by Mr John Anderson from AFMA, documented in the running sheet annexed to Mr Wilson's statement and the AFMA officers generally in seeing to the repatriation of the body of the deceased, is to be commended.

31. The evidence established that the responsibility for the apprehension and detention of those Indonesian fishermen who are taken to Darwin, changed rapidly late last year as a result of a Federal Cabinet decision. I was told that Australian Customs Service and DIMIA are now responsible for the apprehension and detention of such foreign fishermen. AFMA still has a prosecutorial role and is the authority which has the responsibility for deciding whether a vessel is brought into Darwin Harbour. I note that Mr McDonald QC was concerned that this multi-agency approach to the apprehension and detention of fishermen may result in blurred lines of responsibility and confusion. I have no comment to make about this matter at the present time.

32. Pursuant to s 26(1)(a) of the Act which refers to my obligation to report on the care, supervision and treatment of the person while held in custody, I find that there is no evidence to support a finding that the care, supervision and treatment of the deceased, that he received during apprehension and detention, caused or contributed to his death.

33. On all of the evidence, I find that the deceased's underlying heart condition would most probably not have been detected during the course of a general medical examination. However, it remains speculative as to whether a competent medical examination might have elicited or found indications, complaints or symptoms of ill health requiring further investigation. However, it is to be noted that all of the crew members interviewed indicated that the deceased had not previously manifested any signs of illness or made any complaint at all.

34. In conclusion, and on the basis that all detained fishermen (those to be repatriated as well as those to be charged) will be detained at the land based facility that I viewed in Darwin, I recommend that such fishermen be thoroughly medically examined by a medical practitioner within 24 hours of reception into the facility.

35. I make this recommendation for two reasons;

(a) The Federal Government has a fundamental duty of care to Indonesian fisherman apprehended and detained by its agencies. Without a thorough and timely medical examination of the fisherman, I do not believe that this duty of care can be properly exercised or performed.

(b) Public health and safety concerns also mandate such a medical examination given the range of diseases that can be brought into Australia from Indonesia.

Dated this 3rd day of March 2006

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GREG CAVANAGH
TERRITORY CORONER