CITATION: *Inquest into the death of Hector Martin* [2006] NTMC 075

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0039/2005
DELIVERED ON:	8 September 2006
DELIVERED AT:	Darwin
HEARING DATE(s):	28, 29 30 March 2006
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Death in Custody, natural cause death, prison supervision of ill inmates.

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Correctional Services:	Mr Johnson
Corrections Medical Service:	Mr Ford
North Australian Aboriginal Justice Agency (NAAJA):	Mr Chris Howse
Family of deceased (instructed by NAAJA):	Mr Wiley

Judgment category classification:	B
Judgement ID number:	[2006] NTMC 075
Number of paragraphs:	37
Number of pages:	19

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

No. D0039/2005

In the matter of an Inquest into the death of

HECTOR MARTIN
ON 13 MARCH 2005
AT DARWIN PRISON

FINDINGS

(Delivered 8 September 2006)

Mr Greg Cavanagh SM:

1. Hector Martin ("deceased") died at the Royal Darwin Hospital on 13 March 2005. At the time of his death he was a person held in custody within the meaning of s. 12 of the *Coroners Act* as he was at that time serving a sentence at Darwin Prison, Berrimah. Pursuant to s. 12 of the *Coroners Act*, his death must be reported to me and it was so reported on Sunday 13 March 2005 and investigated on my behalf by members of the Northern Territory Police.

2. Pursuant to s. 15 of the *Coroners Act* an Inquest is mandatory, because the deceased was a person in custody at the time of his death. I must, if possible, make findings as to the matters set out in s. 34 of the *Coroners Act*. A Coroner hearing an Inquest into a death in custody has further duties and powers which are set out in s. 26 of the *Coroners Act*. That section provides that I shall "investigate and report on the care, supervision and treatment of a person being held in custody" and that I shall make recommendations with the respect to the prevention of future deaths in similar circumstances as I consider relevant.

3. I have before me a number of exhibits, including in particular a brief of evidence comprising two volumes prepared by the investigating police

officer. I heard oral evidence from a number of witnesses. On the basis of that oral evidence and the documentary evidence tendered before me, I am able to make the findings set out herein.

4. Counsel Assisting me at this Inquest was Ms Helen Roberts. I granted leave to Mr Johnson of Counsel, instructed by Mr Smyth, to appear on behalf of Correctional Services. I granted leave to Mr Ford to appear on behalf of Corrections Medical Services. I granted leave to Mr Wylie of Counsel who was instructed by Ms Jones of the Katherine office of North Australian Aboriginal Justice Agency ("NAAJA"), on behalf of the family. Members of the deceased's family were here throughout the Inquest listening to the evidence and the submissions. I granted limited leave to Mr Howse, also of NAAJA, to make submissions at the conclusion of the evidence on behalf of "the Aboriginal public".

5. The coronial investigation carried out by officers of the Northern Territory Police Force, was, I am sorry to say, not of a high quality as is ordinarily the case. Deaths of persons held in custody are mandated by the Commissioners of Police in every State and Territory (in Police General Orders) to be investigated as if the death was a homicide. That is to say, a high level of resourcing, skill, effort and work is required.

6. In this case, statements from some key witnesses were not taken until months after the death, and interrogation of key witnesses was not of a vigorous or searching nature. Furthermore, my office had to prompt the completion of the investigation in circumstances where proper supervision of the matter by senior officers should have obviated that need. Fortunately, this has not caused me any concerns about my finding as to the cause of death, however, my findings as to the circumstances have been affected (viz. the matter of how long the deceased laid in his own vomit before the doctor arrived at his cell).

7. I am pleased to note that the Commissioner has accepted my criticism and I quote part of his letter dated 1 June 2006:

> "The Major Crime Section provides an extremely high standard of investigation into Deaths in Custody, and it is unfortunate this investigation has blemished this record, and tarnished the reputation of investigators in this section. A number of systemic issues were identified by the time the completed Hector Martin investigation file was submitted. As a result, stringent measures were put in place within the Major Crime Section, and across this organisation to ensure the concerns you highlighted do not occur again."

FORMAL FINDINGS

8. Pursuant to s. 34 of the Act, I find, as a result of evidence adduced at the public Inquest as follows:

(i) The identity of the deceased person was Hector Martin (also known as Hector Jabanardi), born on 14 June 1968 at Yuendumu in the Northern Territory of Australia.

(ii) The time and place of death was at the Intensive Care Unit ("ICU") of the Royal Darwin Hospital at 10.30am on 13 March 2005.

(iii) The cause of death was cerebrovascular accident (i.e. stroke).

(iv) Particulars required to register death:

1. The deceased was a male.

2. The deceased's name was Hector Martin.

3. The deceased was an Aboriginal Australian.

4. The cause of death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was cerebrovascular accident (i.e. stroke).

6. The pathologist was Dr Terence John Sinton of Royal Darwin Hospital.

7. The deceased's mother was Lorna Nabarula and his father's name was Pompey Jabanunga.

8. The deceased was an inmate of Darwin Prison.

9. The deceased was unemployed at the time of death.

10. The deceased was born on 14 June 1968.

CIRCUMSTANCES LEADING UPTO THE DEATH

9. On the 3 March 2005, the deceased was sentenced to five months imprisonment in the Katherine Court of Summary Jurisdiction. He had a history of serious chronic illness related to alcoholism, and he had served a number of periods in custody for offences, some of which were also related to alcoholism. He was transferred to the Darwin Police Watchhouse on the evening of 3 March 2005 and onto the Darwin Prison on Friday 4 March 2005. On his reception at Darwin Prison, Prison Officer Mills completed a risk assessment form consistent with the usual procedure. Nothing of particular note arose. The deceased was then seen for his "medical reception" by Registered Nurse Miller of Corrections Medical Services. The deceased apparently reported that he was suffering from alcohol withdrawal. He was given what is known as the "grog pack" including valium and Vitamin B. An appointment was made for consultation with the prison doctor on 7 March 2005.

10. On Monday 7 March 2005, Dr Robyn Walker saw the deceased. She prescribed Vitamin B1 and Iron and she ordered some blood tests. She made an appointment for the deceased to see the optometrist and she made a note to see him again in one week's time. She was aware he was a chronic alcoholic from what he told her and from his previous medical notes. His

appearance was consistent with reasonably late alcohol withdrawal. Dr Walker gave evidence that she would expect ordinary physical symptoms of alcohol withdrawal to start two to three days after the last drink and last for about five days, at which time she would expect them to start to abate.

11. On Wednesday 9 March 2005 the prisoner, or somebody else on his behalf, requested medical assistance because he had been vomiting. He was brought to the medical centre and seen again by Dr Walker. She noted there was no blood in his vomit, his pulse and blood pressure were fine and his skin was warm and dry. Despite this, he looked quite unwell. At that point, she made an assessment that he was still in alcohol withdrawal despite the fact that she would have expected the symptoms to be abating by this stage.

12. He did not complain of anything else other than vomiting, although the doctor observed that he was not very talkative and he "looked wretched". She made a decision to put him on what was called "medical observations" or "medically at risk" (transcript p22):

> "So the decision to put him on medical observations, what was that based on?---There was two things I as concerned about at that point, was he going to vomit again, and if so, was he going to vomit blood? It has been reported to me that he had been vomiting blood, but this was third hand information.
>
> Yes?---And also a severe side effect of alcohol withdrawal can be a seizure, similar to an epileptic seizure, so they were two things I was concerned about, so that is why I elected to put him on medical observations."

13. I heard evidence that the system for placing a prisoner "medically at risk" involved the completion of a form by the doctor. In this case, Dr Walker said that she signed the form but she did not actually complete it. The reason given on the form for this deceased's status was: "coughing up blood, severe sweats". Dr Walker agreed, in examination, that severe sweats was not actually a symptom that she had observed on the deceased and it was possible that someone else had written that. Her major concerns were

vomiting blood and seizure. She went on to say, however, that she would expect that a seizure was a serious problem which could obviously be observed, and ought to cause some concern whether or not it was written on the form.

14. The system of medical observations was such that the prisoner was placed in a cell on his own with a camera and the camera screen looked at by a prison officer from the communications room every fifteen minutes of the screen. The prison officer was required to record observations about what he or she saw every fifteen minutes. Those written observation sheets were tendered before me as part of Exhibit 4. Dr Walker said that the system of medical observations involving prison officers watching the prisoner to check for any deterioration in condition was used regularly, on average, three times a week. She expected that if the prisoner vomited blood or had a seizure that she would be contacted. In those circumstances, she would have directed that he be taken straight to hospital.

15. There was no contact made with Dr Walker during the night of 9-10 March, 2005. She next saw the prisoner when she was called to his cell urgently at about 10.00am on 10 March when it was discovered that he was non-responsive. When she arrived at the cell, she observed the prisoner lying on his stomach with his feet pointing towards the cell door and his head turned to one side. She noted he had been incontinent of urine and there was vomit in the cell and she heard the "snoring" sound of a partially blocked airway. He was not responsive to any testing and an ambulance was called. She said it was apparent to her immediately that he was very unwell but it may not have been apparent to a person with no medical training quite how unwell he was. The evidence is that he had been in the position in which Dr Walker found him for at least several hours prior to 10.00am. She was asked the following (transcript p26):

> "In the circumstances in which the prisoner was in that position, the position in which you found him for several hours prior to you being

called to the cell, would you have expected in that situation that the sister would have been contacted?---I did, when I found him and I checked the log, I requested to see the log, I was very surprised and upset that he had been in that position for so long and no one had been contacted.

THE CORONER: Did you say anything at the time, had a go at anyone?---I remember that I was in the cell calling out to people, 'When was the last time he was seen awake, when was the last time he was seen awake'. No one was able to tell me."

16. The deceased was taken to hospital by ambulance and admitted to the Intensive Care Unit immediately. A scan revealed an extremely large bleed within his brain. There was nothing that could be done for him, and he died after palliative care only. The autopsy was performed by Dr Sinton. Dr Sinton gave evidence that the deceased died from a large and recent intra-cranial haemorrhage, being in layman's terms a "massive stroke". The type and size of stroke suffered by this man was something that Dr Sinton described as one of the largest bleeds he had seen in all of his experience as a Forensic Pathologist. Further, his prospects of survival once the bleed commenced were extremely small to none. The objective signs that one might expect to see as part of the onset of the stroke would include relatively non-specific things like a stumbling gait, inability to grasp, and some visual or auditory changes. The person suffering the stroke would have a pain in the head, which could be very painful.

17. The medical evidence is to the effect that the external signs exhibited by the deceased during the day and evening of 9 March were consistent with the onset of a stroke. However, Dr Sinton also made the point that the symptoms and signs eg dizziness, headache, vomiting were also consistent with a number of other possible illnesses or causes. In Dr Sinton's opinion, at the time that the deceased saw Dr Walker as a patient his symptoms, at that time, were not such as to place stroke high on a list of possible diagnoses.

18. After consideration of all of the evidence and submissions, I am satisfied that the deceased was appropriately treated at all times by medical practitioners. I accept Dr Walker's evidence that the symptoms the deceased was exhibiting in the afternoon of 9 March 2005 would not have resulted in his admission to Royal Darwin Hospital for observation. Her only other option, at that time, was to arrange for him to be observed by camera by a prison officer in the way I have described. The facts of this case illustrate the shortcomings of that system.

19. On the afternoon of 9 March, the deceased was taken from the medical centre to observation cell B6 in a wheelchair. Prison Officer Hicks was working a 4.00pm to midnight shift in the communications room. Her duties included answering the telephone or radio, the intercoms and alarm systems, and observing the TV monitors for viewing in the cells or blocks. The evidence was there are eight monitor screens in the communications room, with two monitors showing the observation cells. The pictures were continuous, displaying seven different cells, pausing for only a few seconds at each. However, the communications officer had the facility to pause on any particular cell or to move the picture to a bigger and clearer monitor, to look more closely. Prison Officer Hicks first saw the "medically at risk" file for the deceased at about 5.40pm. She had a look at the file to see how often she had to make observations, and what the problem was for the particular prisoner. Based on what she read in the file, and her conversations with Senior Prison Officer Aberdeen-White, her view was that the prisoner was suffering from alcohol withdrawal. She was asked what she was looking for in her fifteen minutely observations and she answered (transcript p53):

> "So after you'd read that information what was in your mind as to what you were going to be looking for at your 15 minutely observations of the prisoner?---Just that – just make sure that he doesn't have a fit or just sort of make sure he relaxes and, you know, there's not much you can do for them. They might get the shakes or

> something like that with alcohol withdrawal. It's very hard to see on a monitor.
>
> And I'm going to show that in a moment. Now you mentioned a fit, why would a fit be something that you might be looking for?---No particular reason just you'd try and look for anything that's out of the normal in somebody that's in a cell, I suppose, you know, yeah.
>
> What about vomiting, is that something you consider abnormal or you considered abnormal or normal with respect to your observations of this prisoner?---Well if somebody is throwing up I suppose they must be sick with something, anybody can throw up, I mean you don't have to be really sick to be throwing up, I suppose. Again that's another thing that's very hard to tell on the monitor, it's very hard to tell whether a person is actually throwing up because you can't see colour or anything else really."

20. She saw the prisoner apparently throwing up on several occasions. Her recollection was confirmed by my viewing of the video taped cell footage, which showed the prisoner apparently throwing up in the toilet on a number of occasions. During the early part of Prison Officer Hicks' evening shift, the deceased was seen to walk around his cell, pick paint off the walls or the window sill, get up and down from the bed and speak to Prison Officer Hicks on the intercom several times, including telling her that there was nothing wrong and he wanted to go to a group dormitory, and later that he wanted a cigarette. Her impression was that he was bored and looking for something to do. At about 7.15pm he pressed the intercom and he asked to speak to a doctor. He was told by Prison Officer Hicks that the doctor had already gone home and it was not possible for him to see the doctor until the following morning. Upon my listening to the tape, the deceased was reasonably insistent that he wanted to see a doctor. Prison Officer Hicks in evidence said that she did not take this particularly seriously because "he'd just been seen by medical not long before and ….it was just the way he had been saying that he wanted to get out, he wanted to go to the dorm, he wanted to be with his brothers sort of thing and he just didn't want to be there".

21. At about 9.00pm, Prisoner Officer Hicks contacted her senior officer because the prisoner was leaning over the sink and from her perspective she could not really see what he was doing. She spoke to him through the intercom and asked him what he was doing and he did not answer her. Her primary concerns were: "I didn't know whether he was trying to hurt himself, I didn't know whether he had something that he could cut himself with or whatever else because the way he was acting and hanging over the sink, trying to hide from the camera". When she contacted Senior Prison Officer Aberdeen-White, she conveyed her concern that he may have been trying to hurt himself. She could not remember whether she told her supervisor that he had been vomiting a lot.

22. It appeared to me that Senior Prison Officer Hicks was attempting to give honest evidence in the witness box. She was aware that it was her role to observe the prisoner and make notes or observations and she did that. It was apparent from her evidence, as with a number of the other prison officers, that her major understanding of her role was that she was to prevent the prisoner from harming himself. As soon as she saw some potential for this, she immediately contacted her senior officer. By contrast, she observed repeated vomiting and the prisoner asking to see a doctor, and neither of these caused her any particular concern in a context where she expected that the prisoner was suffering from alcohol withdrawal. She said in answer to one question that "When you take it as part of throwing up is part of withdrawals it is something, I suppose, you go through".

23. After Prison Officer Hicks contacted her supervisor, three prison officers went to the cell. Senior Prison Officer Aberdeen-White has close to twelve years experience, the majority at Darwin Prison. On the night in question she was the senior prison officer on the evening shift. She was told on the afternoon of 9 March by another prison officer that the deceased was being placed "medically at risk" due to alcohol withdrawals. She said, in evidence, that she had "lots" of experience with prisoners suffering from

alcohol withdrawals symptoms and expected things like shakes, sweats and lack of coordination and difficulty speaking clearly. She received a phone call about 9.15pm from communications and Officer Hicks told her that prisoner in B6 was "leaning over the sink, he's got his back to the camera and I can't see what he is doing". Her concerns were that he might be trying to self harm.

24. She first of all tried to speak to the prisoner through the hatch but he would not respond to her requests to move away from the sink so the officers opened the door. The officers had a conversation with the prisoner and Officer Saunders gave him a cigarette and lit it for him. Because Prison Officer Hicks had depressed the button for the intercom at the same time, the conversation was recorded and was able to be replayed in court. In court the conversation was listened to several times. The deceased has a very quiet voice and he is difficult to hear. Nevertheless, he could be heard saying something about dizziness and something about pain in his head. He was being questioned by the much louder and clearer voice of Prison Officer Saunders. In the witness box, Prison Officer Aberdeen-White said she could not hear any of the conversation because she was standing at the door of the cell at the time. She said that she did see the prisoner slide down the wall from his position at the sink to a sitting position on the ground just as the officers entered the cell. She said the following (transcript p112):

> MS ROBERTS: You say he sort of slid down against the wall in your interview. So you saw him do that?---He moved, yes.
>
> And you saw him do it on the screen?---Yes.
>
> Did the manner in which he did that cause you any concern?---No.
>
> Did the fact that he told you he was sick cause you any concern?---No.
>
> Why not?---Because that's why he was there.

> Well I just want to explore that a bit more. What's your understanding of why he was in that cell?---He was coming down off alcohol. He was placed medically at risk because he was having alcohol withdrawals.
>
> Yes but at risk of what though?---Medically at risk.
>
> Yes but what does that mean?---He was put in there under observation because he had the sweats and the uncoordinated movement and we were just keeping a watch on him.
>
> THE CORONER: Madam. Surely it means he's at risk of getting sicker don't you think?---Yes.
>
> Right. So he was in there being observed because he was at risk of getting sicker than he already was?---Yes.
>
> Right, thanks.
>
> MS ROBERTS: And if you observed him getting sicker than he already was – if you did – what were you then going to do?---Well what we normally do is that we'd ring up medical."

25. Senior Prison Officer Aberdeen-White's evidence was consistent with the general tenor of the evidence of the other prison officers. That is, they were concerned about suicide risk and they knew what to look for in that regard, however in my view, their role with respect to physical illness was unclear to them.

26. Prison Officer Alan Kelly had nine years experience as Prison Officer at Darwin Correctional Centre. He was on duty on the night shift, being midnight till 8.00am on 10 March 2005. He said that he observed the prisoner on the screen or monitor every fifteen minutes, as he was required to do, between midnight and 8.00am. Contrary to what Officer Hicks said, Officer Kelly said that the screen or monitor in the communications room was very clear, clearer than the one he was watching in the court room for the replay of the video. Prison Officer Hicks said "at all times when I monitored prisoner Martin I noticed that his stomach was moving in and out, in and out and that he was breathing even though during the night to my

knowledge when I was observing him he never moved from the position he was in during the time of the shift." The deceased was on the floor of his cell face down and on the segments of the video that I saw, he did not move positions in any significant way. Officer Kelly insisted that he could actually see the prisoner's stomach moving to assure him that he was breathing. He assumed that he was in a deep sleep. This is what Officer Kelly said about his understanding of his role in observing a prisoner who had been placed under "medical observations" (transcript p171):

> "So what was your understanding of – just describe in your own words what you were to look for in that period of observation between 12 midnight and 8 am?---Anything that would concern me of a prisoner at risk medically"
>
> THE CORONER: Like what?---Like if he started bashing his head against a brick wall.
>
> Well that's someone at risk of self-harm isn't it?---Not necessarily. He could have been put at risk and then we've had it a couple of times, they've been put at risk for medical reasons and they've just gone silly and started – but you know, throwing themselves against the wall.
>
> What about not going silly, just getting sicker?---Well, you can't tell they're getting sicker if I assume he's asleep and even if he was awake how would I know that he's getting sicker? I'm not a doctor, I'm not trained in any medical practices and unless he actually physically pushes the intercom button to let me know that he's feeling sick I wouldn't know."

27. Prisoner Officer Saunders was with Senior Prison Officer Aberdeen-White when she went to the cell to check on the deceased at about 9.00 or 9.30pm on 9 March. Prison Officer Saunders was somewhat defensive when giving evidence before me, however it also eventually became clear that he was similarly concerned with the prisoners mental health rather than his physical health. On the portion of the recorded conversation during which the deceased speaks of dizziness and a pain in the head, Officer Saunders is heard asking the deceased about whether he is having any trouble or

something from back home in his community. He explained this to me (transcript p151):

> "MS ROBERTS: Is that your voice?---I recall speaking to him about business going on with him from back home at the community, yes.
>
> THE CORONER: And what did you mean by 'business'?---Any type of Aboriginal cultural business, whether it be some kind of black magic or if he's been sung or had any belief along that line, that something was wrong with him because he had been sung or in trouble with his community that way."

28. Prisoner Officer Saunders refused at any time to concede that the prisoner had complained to him of any physical problems (transcript p152):

> "MS ROBERTS: And did you hear earlier in that conversation the person who apparently you asked him a question about dizziness and then where?---I don't recall that part of the conversation with him. What I recall asking him was whether any business was going on with him from back home from his community.
>
> You recall asking him 'Where did you slip'?---Possibly could have. I just don't recall the full conversation.
>
> What was it that he said that gave you the impression that his complaint was with respect to something that was happening back at his community?---May not have been something he said, it's a common thing within the prison system in the Territory. We see quite a few blokes you know who have had some experience with cultural business.
>
> Yes, but what was it about – if it wasn't something he said – was it something that he did that indicated to you that he had problems?---Not particularly, no.
>
> Well what led you to ask him those questions?---It's common within the Northern Territory prison system with the Aboriginal inmates.
>
> Why would you think this prisoner at that time that you were speaking to him possibly had some sort of as you've put it cultural problems?---Just because of his situation where he was. With any one of them it's common.
>
> Did you think there was something the matter with him?---Well the doctor had placed him at risk so there must have been.

And do I understand you to be saying that your view is that the most likely explanation for what was wrong with him was a cultural problem?---No.

Well can you try then to tell me why it was that you assumed that he may have had a cultural problem?---Because its common within the Northern Territory. I mean I've seen that much of it over the years in the prison system.

All right, let me put it this way; what was it that made you assume he had a problem at all?---Because the doctor placed him at risk.

So - - - ?---Obviously there was a problem, she wouldn't have done it for nothing."

29. Dr Walker's evidence was that the deceased's symptoms over the course of the evening and following morning were such that she would have expected medical assistance to have been sought by the Prison Officers (transcript p25):

"MS ROBERTS: If you, well I was going to ask about ordinary vomiting, repeated ordinary vomiting of the point of say eight times attempted or actually vomiting over a period of a couple of hours, would that be something of medical concern?---I would expect the sister to be contacted, yes.

Even in a case of a prisoner who was perhaps colloquially understood to have been going through alcohol withdrawals?---Yes.

What about prisoner telling the prison officer that he felt sick and had severe - he wouldn't have used the word severe, I'm sorry - got sick and had a headache at the time that he's saying these things, he's sitting on the ground and declining to get up, is that something of concern?---I image it would be yes, it would depend on how he looked and the individual prison officer, I imagine, I would consider it of concern, yes.

Is there any - and I'm going to ask the prisoners officers this as well, but was there any culture whereby medical staff would be annoyed if they were unnecessarily called out by a prisoner officer, if it turned out that the prisoner was fine in the end?---No, Doctor Wake and the nurses and myself consistently use to say, 'if there's any concerns call us.' And from my understanding I would be extremely surprised if

the sisters became annoyed, because - we want to know basically, yes."

30. By contrast, the prison officers were reasonably consistent on one point, and that was that they did not understand what it was that they were looking for in terms of physical deterioration. They appeared much more confident with the concept of observing the prisoner for signs of suicidal ideation or other mental health deterioration, to the extent that seeing any form of movement was considered acceptable.

31. In my view, such observation procedures, while perhaps appropriate for "prisoners at risk of self harm" are not appropriate for medically unwell prisoners. The appropriate observers ought be medically trained persons such as nurses. There may be a myriad of changes, symptoms and signs relevant to an illness (some subtle, some unsubtle) that would only be noticed by such medically trained observers rather than a prison worker.

32. This Aboriginal man was in custody on this occasion for offences of drink driving and disqualified driving. He was ill from alcoholism. Under the system that applied at the time in the prison, he was ill enough to be watched but not ill enough to be admitted to hospital. He had presented on the afternoon of 9 March 2005 with non-specific symptoms. The arrangement was to place him in a cell alone with a camera. A small screen was to be looked at every three or four seconds every fifteen minutes by a single officer working in the communications room. That system was apparently designed to assess the prisoners' physical health. He had suffered a bleed in the brain which presents with equivocal signs to an observer, in particular to a non-medically trained observer. I find that there was no chance of his successful recovery from that bleed. However, he lay alone dying on the floor of a concrete cell for several hours. As regarding the manner of death, it is relevant to quote Dr Sinton's autopsy report (page 8):

"CAUSE OF DEATH

Condition leading directly to death:	1(a) Cerebrovascular Accident (Stroke)
Morbid conditions giving rise to the above cause:	1(b) Cirrhosis of the Liver 1(c) Chronic Alcohol Toxicity

The normal liver is responsible for the production of some of the clotting factors needed to make the blood clot when an injury occurs. Cirrhosis, ie destruction of normal liver tissue from chronic alcohol toxicity, may therefore lead to an increased propensity to bleed following relatively minor trauma. It is also recognised that seemingly spontaneous haemorrhage may occur inside the skull, where detection of the haemorrhage may be delayed, and therapeutic access may be difficult. The end result is a cerebrovascular accident (CVA) or stroke, with a high mortality rate commensurate with severity of the haemorrhage. This man suffered a very severe haemorrhage, with consequently a very severe stroke which caused his death."

33. There is one further factual issue in relation to this death. When Dr Walker attended the cell on the morning of 10 March 2005, she was clear that there was vomit on the floor of the cell near the head of the deceased. I accept that evidence.

34. In the morning, the prisoner officers had been into the cell twice. Once at 9.00am when they could not rouse the deceased, and again about an hour or more later. The officers are insistent that when they went in at 9.00am there was no vomit and that to their observations the deceased was sleeping comfortably. Somewhat curiously the officers that went in at 10.00am continue to insist that there was no vomit at the time that the doctor arrived. The officers were tested on their evidence and insisted that there was definitely no vomit. In my view, their evidence in this regard is wrong and I reject it (as I have stated, I prefer the evidence of Dr Walker). There is no evidence that any vomit made any medical difference to the deceased or was in any way causative of death. However, it would be understandably distressing for the family to think that he was lying in vomit for any longer

than a few moments, and in particular for the long time that I find occurred. It was simply not dignifying or respectful of the deceased.

35. In my view, there is no question that the system of having Prison Officers make medical observations on a video screen is an unsatisfactory system which did not assist the deceased on this occasion. However, it is no longer the system that is in place at Darwin Correctional Centre. The system was changed shortly after the deceased's death. Counsel for Correctional Services made the submission himself that the camera surveillance system was limited, partly due to the nature of the camera setup and partly due to the fact that the Prison Officer making the observations was not medically trained and was not provided with sufficient information about the medical problems. The system has now changed and any prisoner that is placed on "medical observation" is observed in the clinic by a nurse. The procedure was implemented in December 2005. That would appear to me to be far more appropriate than what occurred in this case.

36. It was raised with me by Mr Howse, specifically, that the new regime of nurses observing "at risk" prisoners has not been extended to prisoners who are "at risk" due to their mental health status. One of the concerns, or complaints, raised by some of the Prison Officers in these proceedings and indeed not resolved by Mr Johnson in submissions, was that they were given insufficient information about the nature of the prisoners' illness or what to expect. In an earlier Inquest finding of mine into the death of Mr Marika (2000) NT47, I was concerned with the issue of information sharing about prisoners who may be suffering mental health problems. I heard in that Inquest that Prison Officers were not told about psychiatric problems of individual prisoners due to confidentiality. In these proceedings, Ms Julie Jenkins, who has overall responsibility for the contract between Corrections and Corrections Medical Services, gave evidence about these matters. Ms Jenkins said that she had read my findings and recommendations in the death of Mr Marika the day before she came to give oral evidence in these

proceedings. When I asked some questions about the issue of confidentiality and communication, she said that to the extent of her involvement in meetings between the various stakeholders, this issue had not arisen.

37. It is interesting that my recommendations in Marika's case were made prior to the *Coroners Act* requirement that the Government consider and respond formally to all of my recommendations in this area. Given what was said by Ms Jenkins in evidence, and by Counsel for Correctional Services, I do not feel it necessary to make a further formal recommendation in this matter on this subject, as I have been assured that earlier Inquests into deaths in custody and recommendations therein will be carefully considered by the department.

Dated this 8th day of September 2006.

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GREG CAVANAGH
TERRITORY CORONER