CITATION: *Inquest into the death of Matthew Winsloe Hinton* [2009] NTMC 061	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0247/2008
DELIVERED ON:	2 December 2009
DELIVERED AT:	Darwin
HEARING DATE(s):	27 – 29 October 2009
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Unexpected death, recreational drug overdose, police response, ambulance response, medical response.

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
St John Ambulance:	Alistair Wyvill SC
Department of Health & Family Services:	Tom Anderson
Karen Joyner:	Ian Rowbottam

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

No. D0247/2009

In the matter of an Inquest into the death of

MATTHEW WINSLOE HINTON
ON 24 NOVEMBER 2008
AT THE INTENSIVE CARE UNIT -
ROYAL DARWIN HOSPITAL

FINDINGS

2 December 2009

Introduction

1. Matthew Winsloe Hinton ("the deceased") was a Caucasian male born on 21 November 1980 at the Gold Coast Hospital in Southport, Queensland. The deceased was admitted to the Gove District Hospital ("GDH") at 7.01am on Sunday 23 November 2008 after being transported there by St Johns Ambulance ("SJA") for a "suspected drug overdose".

2. Earlier that morning, police had been called to the units known locally in Nhulunbuy as the "Family Flats" in Eugenia Avenue, Nhulunbuy. This death was reportable to me because it was unexpected. However, as a result of the police involvement in the lead-up to this death, it was also investigated as a death in custody.

3. It is clear from the evidence led before me, both orally and in written form, that this death did not occur at a time when the deceased was "in custody", according to the provisions of the Coroner's Act ("the Act"). An inquest into his death was therefore not mandatory, however I have exercised my discretion pursuant to section 15(2) of the Act to hold an inquest because of concerns in relation to various delays in the provision of medical assistance to the deceased, the failure for an ambulance to be dispatched, the

subsequent cancellation of that ambulance and the unexpected nature of his death.

Nature and Scope of the Inquest

4. Pursuant to section 34 of the *Act*, I am required to make the following findings:

> (1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*;

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

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

6. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> (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.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner.

7. Ms Jodi Truman appeared as Counsel assisting me. Mr Alistair Wyvill SC was granted leave to appear as Counsel for St John Ambulance Australia (NT) Incorporated. Mr Ian Rowbottam was granted leave to appear as Counsel for Ms Karen Joyner, an employee of SJA. Mr Tom Anderson was also initially granted leave to appear for the Department of Health and Family Services ("the Department"), however I note that eventually a "joint position" of SJA and the Department was tendered in evidence before me (exhibit 11) and Mr Anderson took no significant role in the proceedings.

8. I thank each Counsel for their extremely helpful assistance in this matter. I also note that the deceased's parents, his sister, and a number of other family members were in attendance at this inquest. I am aware that they had travelled many thousands of kilometres to attend and I thank them for their assistance and respect that they have shown to this court.

The Conduct of the Inquest

9. Twelve (12) witnesses were called to give evidence at this inquest. Those persons were:

   a. Detective Senior Constable Matthew Akers, the Officer in Charge of the Coronial Investigation;

   b. Mark Hinton, the father of the deceased;

   c. Paige Mackenzie, the girlfriend of the deceased at the time of his death;

   d. Senior Constable Roger D'Souza, Police Officer of the Nhulunbuy Police Station;

   e. Constable Jason Machacek, Police Officer of the Nhulunbuy Police Station;

f. Dr Brian Spain, Intensive Care Specialist at the Royal Darwin Hospital;

g. Mr Wayne Bevan, Paramedic employed by SJA;

h. Mr Peter Monks, Deputy Operations Manager of SJA;

i. Ms Renee Caldwell, employed at the time of this death as an Emergency Medical Dispatcher ("EMD") of SJA;

j. Mr Michael McKay, Director of Operations of SJA;

k. Ms Karen Joyner, employed at the time of this death as an EMD of St John Ambulance; and

l. Dr Michael Kennedy, Consultant Physician and Clinical Pharmacologist and Cardiologist.

10. A brief of evidence containing 22 civilian and 7 police statements, together with numerous other reports, SJA and Police documentation, was tendered at the inquest (exhibit 1). I thank Detective Senior Constable Matthew Akers for the efforts he made in relation to his investigation concerning this death. Public confidence in coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that involve police, they do so to the highest of standards. I consider that Detective Senior Constable Akers has done so and I thank him.

Formal Findings

11. Pursuant to section 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 Matthew Winsloe Hinton, who was born on 21 November 1980 at the Gold Coast, Queensland in Australia.

ii. The time and place of death was at the Intensive Care Unit ("ICU") at the Royal Darwin Hospital ("RDH") at 4.54am on 24 November 2008.

iii. The cause of death was acute multiple drug toxicity.

iv. Particulars required to register the death:

a. The deceased was male.

b. The deceased's name was Matthew Winsloe Hinton.

c. The deceased was of Caucasian descent.

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

e. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton.

f. The deceased lived at Unit 12/10 Bottlebrush Avenue, Nhulunbuy in the Northern Territory.

g. The deceased was an unemployed plasterer.

h. The deceased's parents were Mark Winsloe Hinton and Debra Lee Hinton.

Background of the late Matthew Winsloe Hinton

12. The deceased had turned 18 years of age only 3 days prior to his death. He was born in Queensland and was raised and educated there. I received in evidence a transcript of a recorded conversation conducted by police with the deceased's father, namely Mr Mark Hinton ("the father"). That conversation detailed that the deceased had completed his high school education at Benowa State High School on the Gold Coast. The father described the deceased as "always a good kid, very conscientious". Unfortunately it is clear that after leaving school the deceased became involved in the "drug scene". He had been employed as a plasterer through

the family business and it appears that a great deal of his earnings was spent on recreational drug use, and subsequently for much greater and more frequent usage.

13. The father states in his recorded conversation with the police that he could not really recall when the family first realised that the deceased was using drugs. He openly and honestly suggested that it was probably over a period of years. The father described occasions where he and his wife would attempt to confront the deceased about what was going on, which would lead to arguments between them. The father stated that he and his wife made it quite clear to the deceased that they would not tolerate drugs in the house and that the deceased would be banned from the family home if he brought drugs to the house.

14. Unfortunately it appears that these warnings had little effect. Approximately 10 months prior to his death (ie. in or about January 2008) the father discovered a syringe at the family home. The father described a large argument occurring with the deceased at which point he left the family home. After being unable to gain employment on the Gold Coast the deceased decided to move to Nhulunbuy to attempt to find work at the Alcan Refinery in the mining industry.

15. It is clear on the evidence that it was never the case that the deceased was simply abandoned by his family because of his drug usage. The father detailed weekly telephone calls with his son. The father also described the deceased as having returned to the Gold Coast "every couple of months" for a "few days or so", during which time he would see his family. It is clear that the deceased was very much loved by his family.

16. The father described that the second last time that the deceased had returned to Queensland he had looked "really good, he had a job, he was looking really good, straight, clean". Unfortunately it appears that some time thereafter the deceased then lost that job and "he just went downhill from

there". The father described that he suspected the deceased began taking heavier drugs, but whenever his family questioned him about it "he would just deny it".

Circumstances surrounded the death

17. As stated previously it appears from the evidence that the deceased had been indulging in drug use in Queensland prior to his death. Due to his refusal to admit his usage to his family, it is unclear precisely what he was using in Queensland, although it is noted that his father found a syringe.

18. In terms of his drug usage upon relocating to Nhulunbuy in the Northern Territory, I received into evidence a number of statements from persons who knew of, or associated with, the deceased. Those statements make clear that the deceased was indulging in a number of drugs but in particular methamphetamine. I note that it was never the subject of any substantial dispute during these proceedings that the deceased was using this drug.

19. Ms Paige Mackenzie was the girlfriend of the deceased prior to his passing. She gave evidence before me in the witness box. Ms Mackenzie had also undertaken a recorded conversation with the police. A transcript of that conversation also formed part of exhibit 1. Ms Mackenzie gave evidence that she and the deceased had commenced a relationship a number of months prior to his passing. Ms Mackenzie stated that initially the relationship was very good and the deceased treated her very well. Unfortunately things changed and Ms Mackenzie began to note behavioural changes in the deceased.

20. Ms Mackenzie stated that in the 3 weeks prior to his death, the deceased had been staying with her, at her residence, whilst her father was away. Ms Mackenzie stated that during the time that the deceased was living with her, the deceased's drug usage became more extensive and he became paranoid. One of the examples that Ms Mackenzie gave of the deceased's paranoia was

when he put a lock on her bedroom. She also stated that the deceased would continually watch the windows and began scratching and picking at his skin. I heard evidence from Detective Senior Constable Akers that such behaviour (constantly scratching and picking at one's skin) is typical behaviour for someone who has been using methamphetamine heavily and is known colloquially as "speed sores".

21. Ms Mackenzie also described the deceased becoming very antisocial, locking himself in her room and avoiding any interaction with people who visited her residence. Ms Mackenzie described the deceased as smoking from his "pipe" for 2 to 3 hours per day. She stated that during that time the deceased would pay no attention to anything but his pipe. Ms Mackenzie stated in evidence that she knew what the deceased was smoking was "speed".

22. The father stated that he had spoken to the deceased for the last time on Friday 21 November 2008. The call was to wish his son a happy birthday. The father told me that during that telephone call there were no indications from the deceased that he was depressed or suicidal and in fact he told his father that he was looking forward to having a "big night" for his birthday on the Saturday with his girlfriend. The father also recalled a conversation just prior to the deceased's death when the deceased told him that he was aware that the police were looking for him. When he enquired as to why they were looking for him, the deceased stated, "I think it is to do with drugs". The father encouraged his son to go and speak with the police, but he stated that he didn't want to see them on his birthday so he would go and see them "on Monday". As is clear from the evidence that day never came for the deceased.

23. Ms Mackenzie also gave evidence before me in relation to the weekend of the deceased's birthday. She states that the couple met at the Walkabout Hotel ("the hotel") in Nhulunbuy on the afternoon of Saturday 22 November

2009 and they checked into the hotel. Ms Mackenzie stated that upon checking into the hotel, she went to sleep. Ms Mackenzie stated that when she awoke, the pipe that the deceased would smoke drugs from was present. As a result, she assumed that he must have been smoking drugs whilst she was asleep. Ms Mackenzie gave evidence that she later saw the deceased take 9 "trips", or LSD, and she was unhappy about him taking that many. She stated they spoke about this, but the deceased was determined to take them that night, describing that he wished to "celebrate big".

24. Ms Mackenzie set out in her statement that the deceased took the trips at about 10.30 or 10.45pm and that within about 20 minutes he started to feel the effects. Ms Mackenzie recalls the deceased vomiting a couple of times and she assumed that this was his body trying to reject the drugs. After vomiting a few times, Ms Mackenzie stated that the deceased was fine and lay down on the bed. A short time thereafter Ms Mackenzie noticed that the deceased appeared very confused "in his head", stating he would be fine one minute but not the next.

25. Ms Mackenzie also recalled that the deceased was continuously looking for his dog. Because of the deceased's behaviour, Ms Mackenzie placed the deceased into the shower to try and see if that would wake him up a little, because she was concerned that he was "tripping out" too much from the drugs. After a while, Ms Mackenzie stated that she became concerned about the deceased; it appeared that as time wore on the confusion and hallucinations appeared to be more intense. Ms Mackenzie therefore encouraged the deceased to leave the hotel and to travel home with her. Ms Mackenzie gave evidence that the deceased was very reluctant about leaving the room, but because of her encouragement he finally agreed. I heard evidence from Detective Senior Constable Akers that if a direct route were travelled, the distance between the Walkabout Hotel and Ms Mackenzie's residence at Unit 12/10 Eugenia Avenue is less than 300 meters.

26. Ms Mackenzie could not recall precisely when the couple left the hotel but on the way the deceased's disorientation became more intense and he was becoming very confused. On the way the deceased began complaining about being "really hot" and during the journey they would have to sit down whilst Ms Mackenzie felt his temperature. Once the couple had reached the family flats, Ms Mackenzie stated that she became quite emotional because of the deceased's behaviour and she did not know what to do. As a result she telephoned one of her friends, namely Jessica Tabone.

27. Ms Tabone also participated in a recorded conversation with the police. A transcript of that recorded conversation formed part of exhibit 1. Ms Tabone recalled Ms Mackenzie calling her at about 4.45am on Sunday 23 November 2008. Ms Tabone recalls Ms Mackenzie sounding as if she was crying and asking for help. As a result, Ms Tabone walked downstairs and found Ms Mackenzie "balling her eyes out" and sitting on the ground. Ms Tabone stated that she saw the deceased and he was "just freaking out".

28. Ms Tabone described numerous attempts of Ms Mackenzie to get the deceased upstairs but he would not come. As a result, Ms Tabone considered there was nothing that they could do to help the deceased. The girls therefore decided to leave the deceased and go back to the flat.

29. Ms Mackenzie stated in her evidence that when she left the deceased he was naked and she believed that there was nothing more that she could do. She was asked why she didn't contact an ambulance or seek any medical assistance and Ms Mackenzie stated that she "didn't know that it was that serious". Ms Mackenzie gave evidence that she thought that what would happen is that the deceased would finish his trip like he did the last time she saw him take LSD and that he would be fine the next day.

Involvement of the Northern Territory Police and St Johns Ambulance

30. Tendered before me in evidence were a number of transcripts of recorded conversations conducted with various civilians who lived in and around the Family Flats in Nhulunbuy. Mr Julius Janco and his friend Mr James Te-Au recalled returning to the flats at approximately 3.30am and seeing the deceased in the car park with Paige Mackenzie. Both men described the deceased as "tripping out". When they first saw the deceased he was clothed and had Ms Mackenzie with him. Both men stated that they watched events for a period of time and Mr Janco stated that at one stage he could hear Ms Mackenzie becoming either annoyed or distressed. As a result he went down to the wash bay area of the flats where he saw Ms Mackenzie with the deceased. He believed that this was at approximately 4.30 or 5:00am. Ms Mackenzie appeared fine and he left the area.

31. Various witnesses described the deceased as acting like "a dog on all fours, barking and scratching" in the grass and making noises that could not be understood. Mr Te-Au described the deceased as like a "fish out of water flopping about on the ground".

32. Steve and Janine Honner both undertook recorded conversations with the police. The couple resided at flat 2, block 8 of the Family Flats. Mrs Honner was in fact the first person to call 000 and request an ambulance. Mrs Honner stated that she woke at about 5:00am when her husband's alarm went off for him to get ready for work. When she awoke she thought she could hear approximately 2 or 3 people out the front of their flat, laughing and making noises. It was at that stage that she thought that the group sounded as if they were very close to their bedroom window. As a result Mrs Honner got up and pulled the louvers apart to see what was happening outside. Although it was dark, Mrs Honner stated that she could see a person lying in the garden bed, just under her bedroom window.

33. After discovering the man outside, Mrs Honner went out to her husband, Steve, and told him that there was a man outside that was very drunk lying in their garden bed. Mr Honner stated that he had heard the noise but told his wife to leave the man alone. Mrs Honner returned to the bedroom, but because the noises were strange she once again looked outside. On this occasion she noted that the man was naked, except for a sock, and was rolling around on the ground making "babbling noises". Mrs Honner described those noises in her recorded conversation with the police as "sort of like half screaming and was going from what sounded like laughing hysterically to sort of whimpery". As a result of those noises Mrs Honner stated that she became scared and went back out to her husband and told him that she thought the man was in a bad way and she was going to ring the police. Initially Mr Honner attempted to discourage his wife but because of her concerns she rang the police on the local Nhulunbuy number of 8987 1333.

The Police

34. Mrs Honner approximated the first call to police as occurring at about 5.10 or 5.15am. In this regard I also heard evidence from the police officer that received the call, namely Senior Constable Roger D'Souza. Senior Constable D'Souza gave evidence before me and also undertook a recorded conversation with the police. Senior Constable D'Souza confirmed that he was on duty, working overtime, as Acting Watch Commander in the early hours of the morning of Sunday 23 November 2008.

35. Senior Constable D'Souza recalled receiving a call from Mrs Honner with whom he knew previously. He noted she was distressed and stated that she wanted police there in a hurry. Senior Constable D'Souza stated that the telephone call was short and it occurred around the time of the approximate recollections by Mrs Honner.

36. Mrs Honner set out in her statement that when she called police on this first occasion she told them what was happening with the man and that the police officer said they would get someone around there straight away. Senior Constable D'Souza gave evidence that after being provided with some initial details about the man and being asked to get police there in a hurry, he told the caller that they would be there soon and he immediately made contact with the "on-call" members, namely Constable Jason Machacek and Constable Patrick Carson.

37. Whilst telephoning the on-call members, and making arrangements for them, he received a further call from Mrs Honner seeking police assistance. Again this call was made on the local Nhulunbuy police number. Mrs Honner stated in her recorded conversation that her second call to police occurred approximately 5 or 10 minutes after her first call. The reason she made the second call was because the man was throwing himself "around quite radically" and was against the lattice in the outside area, right underneath the lounge room window. Mrs Honner stated that she could hear his body "hitting the concrete quite heavily" and that the man was "still with this hysterical sort of like laughing and whimpering". It really scared her and as a result she telephoned the police again.

38. Senior Constable D'Souza gave evidence that during this second call he recalled Mrs Honner stating that it might be a good idea to call the ambulance. He asked her why an ambulance was needed, and she stated that the man was rolling around in the dirt and bashing himself on the logs. Constable D'Souza stated in evidence that he suggested Mrs Honner call the ambulance because she was a person he previously knew and therefore trusted she would call the ambulance. He stated unless he had known Mrs Honner he would have called the ambulance himself and this was the first time in his 21 years as a police officer that he had ever felt confident enough to suggest to a civilian that they call the ambulance whilst he organised the police.

Ambulance

39. Mrs Honner duly made contact with the ambulance. A transcript of that initial 000 call was tendered, and played, in evidence before me. The SJA operator on duty that morning, who spoke to Mrs Honner during that first telephone call, was Renee Caldwell. During that call it is clear that Mrs Honner is extremely concerned about the welfare of the man outside her residence. She describes him screaming and rolling around and being "absolutely out of his tree". In addition Mrs Honner tells Ms Caldwell that the man is "hurting himself". It is clear from that conversation that Ms Caldwell advises Mrs Honner that she will "get somebody there as soon as possible".

40. Tendered in evidence before me as part of exhibit 1 was the Intergraph Computer Aided Dispatch ("ICAD") record for this event prepared by SJA. I heard evidence that this was the document initiated by Renee Caldwell following Mrs Honner's 000 call. The first recording for this event on the CAD is the entry made by Ms Caldwell. That entry is recorded at 5.25am. Within that first CAD record is a notation, "male is hurting himself".

41. Mrs Honner set out in her statement that after that first phone call with the ambulance she realised her husband had gone outside. She went out and saw the man raising his legs up and slapping them down onto the ground. She describes the man as "sort of scuttling along on all fours…..on his knees and hands, scuttling along sideways and just really uncontrollable". Mrs Honner also noted that the man wasn't speaking but it sounded as if he was really scared of what was happening and then he would be laughing.

42. It appears that during this time, Constables Machacek and Carson came into the police station, got there police gear and then jumped in a police vehicle to travel to the scene. Constable D'Souza states that he provided brief details to both officers as to the location and that the man was Caucasian,

naked and "just going off". Constables Machacek and Carson then left the station.

43. Mrs Honner stated that whilst outside she noted that there were other people at the Family Flats who had been drawn to what was going on outside. Also tendered in evidence before me were a number of transcripts of recorded conversations with other residents at the units. I have previously described some of their recollections earlier in this decision. Of particular note is the recorded conversation with Ms Deborah Hepple who resided at unit 6, block 8 of the Family Flats.

44. Ms Hepple states that it was about 5.20am that she got up to see what the noise was that was going on outside. When she goes outside, she sees a naked man in the neighbours yard. As a result she calls 000 and is connected through to the police. Whilst she is speaking to police on that 000 call she is advised that someone has already called an ambulance. A copy of this conversation was also played in evidence before me. It records her stating that she has been told that an ambulance has already been called. She then ends the conversation. This conversation will become more relevant later in these reasons.

Police Arrival

45. As stated earlier, the officers to arrive at the scene are Constable Patrick Carson and Jason Machacek. As a result of the playing of the re-enactment conducted with Constable Machacek, only he gave evidence before me. Constable Machacek recalled the particulars of the job that he received from Senior Constable D'Souza indicated to him that the man involved was either on drugs or under the influence of alcohol and was causing injury to himself.

46. Constable Machacek recalled that when they attended at the scene they could see from the car park a man naked in the garden area with his arms

flailing about and appearing quite agitated. He recalled that the man was thrashing his head around wildly and he could hear thumps that he believed were the man hitting his head against one of the logs. Both officers approached the man cautiously and tried to establish some communication with him, telling him that they were there to help him and trying to calm him. Unfortunately their attempts to communicate with the man garnered no response whatsoever and the deceased continued to behave erratically and violently.

47. As a result, the officers discussed the situation and decided that because of the failure to interact with him verbally, the best thing for both his safety and theirs was to place handcuffs upon the man and remove his ability to move his upper body and cause any further injury to himself. Constable Machacek stated that he also noted during this time that the man's eyes were rolling into the back of his head and he appeared at times to be laughing. Constable Machacek described he and Carson taking position on each side of the man and asking him to try and settle down. It is clear from the evidence of both officers that they continued to attempt to interact with the deceased verbally throughout. Despite these attempts, Constable Machacek gave evidence that the man continued to violently shake his head and thump it into the ground and he also noted that the men's legs were also out of control. Constable Machacek stated that he considered the location to be dangerous. As a result the police handcuffed the man.

48. Constable Machacek gave evidence that in the initial moments after the handcuffs were put in place the man continued to violently throw his head onto the ground. As a result he and Constable Carson placed the man onto his back. When they did this, the man then began kicking his legs into the air and as a result Constable Machacek took hold of the mans legs and Constable Carson took hold of his head.

49. Constable Machacek stated that because of the deceased's behaviour he got on to the radio to Senior Constable D'Souza and requested an update as to the estimated time of arrival for the ambulance. Constable Machacek indicated that they needed an ambulance urgently, it was "a serious thing and it did require immediate ambulance".

50. Constable Machacek stated that after the placement of the handcuffs upon the man he was aware of, and concerned about, the man suffering from positional asphyxia. I had tendered in evidence before me an extract from the NT Police "Defensive Tactics Manual" related to "Positional Asphyxia" (exhibit 7). I note that this is a phenomenon that has arisen in recent years indicating a correlation between restraint positions and the sudden, unexpected death of persons in custody. It was noted that positional asphyxia is likely to involve a person who is either obese, affected by psychosis, illness or fatigue and usually involves multiple police or the use of incapacitant sprays.

51. The extract also notes that physical restraints should only be used when the situation clearly justifies it and when there is no other way to prevent physical harm to the person or to others. I pause to note here that as a result of the evidence that I received, I consider that the two police officers followed this guideline in terms of their interaction with the deceased. Unfortunately however it appears from the situation that they faced, that there was simply no other alternative but to place some physical restraint upon the deceased so as to prevent him causing harm, not just to himself, but also potentially to any other person in the area.

52. It is further stated in the manual that there are various prevention strategies that then can be put in place once restraint has been utilised. One of those prevention strategies is to constantly monitor the person. In this regard I note that throughout his evidence Constable Machacek described numerous occasions where they moved the deceased through various positions. It is

also noteworthy that during this period the officers moved the deceased from the garden bed area to an area closer to the car park. I heard evidence that they did this so that the deceased was closer to where the ambulance would arrive.

53. Constable Machacek also noted that at one stage they considered taking the deceased in their police vehicle to the hospital because the ambulance appeared to be taking so long. Unfortunately the deceased became agitated again and because of difficulties that they were having in attempting to try and control him, they decided that if they placed him into the rear of the police vehicle it was more likely than not that this would result in further injury.

54. As a result Constable Machacek made contact with Senior Constable D'Souza again asking for an estimated time of arrival for the ambulance. Constable Machacek recalled Constable D'Souza telling him that he had been attempting to make radio contact with the ambulance to try and get some answers, but there was no response. Constable D'Souza said that he would continue to make these attempts.

55. Constable D'Souza gave evidence that because of his inability to be able to communicate with the ambulance by local radio, he made a decision to telephone police communications (COMMS) direct. He spoke with the officer in charge on his direct number and asked if they had sent an ambulance from dispatch. Constable D'Souza stated that he could hear the officer in charge have a conversation and he got the distinct impression that an ambulance had not been dispatched. After he spoke with the officer in charge at COMMS, Constable D'Souza communicated with Constable Machacek and told them that for some reason an ambulance had not been dispatched, but there was one on its way now.

Ambulance Arrival

56. I heard evidence that the ambulance arrived at the scene at 6.19am. This was some 54 minutes after the first call by Janine Honner to 000 seeking an ambulance. It was clear from the evidence before me that the dispatch of the ambulance to the scene that morning did not occur in accordance with SJA policy and procedures. Both Ms Caldwell and Ms Joyner undertook a recorded conversation with police in addition to giving evidence before me.

57. On Saturday 22 November 2008 Ms Caldwell commenced an evening shift that started at 7:00pm and was scheduled to finish at 7:00am on Sunday 23 November 2008. Ms Caldwell stated that her duties that evening were as an emergency medical dispatcher ("EMD"). Her partner on the shift was Karen Joyner and they had split their duties down the middle so that Ms Caldwell would take the calls that night and Ms Joyner would dispatch the ambulance. Ms Caldwell gave evidence that part of a dispatchers role on occasion was to keep an eye on the job and to ensure that contact was made with the police to confirm that it was safe to dispatch an ambulance crew into the area. Ms Caldwell stated that she had been employed with SJA for approximately 7 years at the time of this incident, initially in a causal or part time manner, and then full time for the 18 months prior to the death of the deceased. Her employment has always been as an EMD.

58. Ms Joyner also gave evidence. She stated that she had been with SJA by the time of this incident for approximately 8.5 years. Ms Joyner agreed that her role that morning was as dispatcher and entailed her paging or ringing an ambulance crew and dispatching them to a scene and providing them details of the job. Ms Joyner gave evidence that the role undertaken by Renee Caldwell that morning was as call taker which meant that she took the 000 calls, obtained the relevant information, coded the job and then put the information onto the ICAD system. Ms Joyner then accessed this information in her role as dispatcher.

59. Ms Caldwell's recollection was that the caller on the 000 call she received was quite distressed. Ms Caldwell stated that during the conversation she could hear the man hitting the door and she could hear him screaming. Ms Caldwell stated that she considered that it sounded like a situation that ambulance could not attend until the police attended. It is clear however that Ms Caldwell ended the call with Ms Honner advising her that SJA would "be there as soon as we can".

60. Ms Caldwell gave evidence that because of the nature of what she heard, and the complaints being made to her by the caller, she initially put the job into the system as a "threatened suicide". Ms Caldwell stated that the reason she did this is because she did not really think that she had a code that would fit other than a threatened suicide. In addition she believed that if the job were coded in such a fashion then that would also get the police attending to the job as well. She made clear that at no stage did she actually think this was a threatened suicide.

61. Also tendered in evidence before me was the SJA "Communications Procedures Manual" as at October 2008. I heard evidence that this was the manual in operation at the time of this incident and sets out the procedures to be followed by EMD's during the course of their duties. Both Ms Caldwell and Ms Joyner stated that they understood that this manual was applicable to the carrying out of their duties on this day.

62. Ms Caldwell gave evidence that after ending the initial call seeking an ambulance, both she and Ms Joyner sat and waited until they heard from the police. Ms Caldwell stated that she recalled it was not a very busy night that night. In accordance with the delineation of their jobs between one another that morning, Ms Caldwell stated that she understood that it was Ms Joyner who would have dispatched the ambulance. Ms Caldwell also stated in her recorded conversation with police that she did not consider there was

really any procedure to be followed when an ambulance was waiting to hear whether it was safe to be dispatched to the scene.

63. In this regard I note that Part 2, Division 3 of the SJA Communications Procedures Manual sets out information related to ambulance bookings and calls. At Item 3.1.6 it states as follows:

> "In ALL instances where a call for an ambulance has been received an ambulance crew will be dispatched, if the location of the incident can be determined. If danger to the crew is suspected dispatch will still take place, however, this will be coordinated so as to attend in company with the police. Such dispatch will occur unless POSITIVE information is received from police VIA CAD entry, or other reliable source at the scene such as off duty AMBULANCE personnel. This information WILL be entered in full in the daily OPS report and the case chronology"

64. Neither Ms Caldwell nor Ms Joyner made any reference to this provision operating on their minds at the time that this incident was occurring. Each admitted that it applied to them however when carrying out their duties at the time.

65. Ms Joyner gave evidence that she recalled overhearing the telephone call received by Ms Caldwell in relation to the Family Flats at Nhulunbuy. Ms Joyner stated that she also recalled hearing that someone in the Joint Emergency Services Communications Centre ("JESCC") confirming that Nhulunbuy Police already had a job in place in relation to this incident. Ms Joyner gave evidence before me about accessing information related to that other police job during the course of her deciding what to do in relation to this job. I intend to say more about this aspect of her evidence later in these reasons.

66. Constable D'Souza gave evidence that he recalled receiving a phone call from communications in Darwin giving him a job for the Nhulunbuy flats. Constable D'Souza stated that he advised that they already had a job. He provided them with his officers' details. As a result of that contact from

JESCC this further reinforced his initial belief that an ambulance was on its way.

67. Ms Joyner gave evidence that after holding the job on the system she subsequently cancelled the job for an ambulance. The ICAD log records that cancellation as occurring at 5.51am. Ms Joyner stated that she did this as she "hadn't heard anything further" from the police; she knew they already had the job, and she considered it was more a police job than an ambulance job because police had recorded it as a general disturbance rather than a threatened suicide. Ms Caldwell gave evidence that she became aware of the cancellation of the job after it had occurred and that this was a decision made by Ms Joyner and was not discussed between the two of them. I will also return to this part of the evidence later in these reasons.

68. As stated previously, eventually Senior Constable D'Souza, clearly in sheer frustration and confused as to what was happening, rang communications in Darwin direct and spoke to the officer in charge. Ms Joyner gave evidence that she recalled Sergeant Neil McDonald asking her for an estimated time of arrival for the ambulance for Gove Police. Ms Joyner stated that it was upon receipt of that information that she re-opened the job and finally dispatched an ambulance. The ICAD log records this as occurring at 6.05am. Ms Joyner stated at this point in time she contacted the officer in charge of SJA in Nhulunbuy, namely Robert Bevan.

69. Mr Bevan gave evidence before me, and he undertook a recorded conversation with police, which was tendered in evidence as part of exhibit 1. Mr Bevan is a trained paramedic and had held the role as officer in charge of SJA in Nhulunbuy for 3.5 years as at the date of this incident. Mr Bevan stated he was "on call" on the day and was at his residence when he received a call at 6.06am from the communications centre in Darwin. Mr Bevan stated that he was given no real information at that stage and there

were no further details forthcoming except that he was dispatched as a code 2.

70. I heard evidence that a code 2 is a classification given for immediate dispatch, but when there is no urgent threat to life established. The SJA Communications Manual sets out the coding of calls as at Part 4, Division 3. It notes that a code 2 may be where the patient is in considerable discomfort due to pain or illness, but does not warrant the crew taking traffic exemption liberties and it is not justified for there to be red flashing lights/siren. It does note however at 3.2.1 that:

> "A crew dispatched on a code 2 will respond immediately with no delay and drive to the accident/incident by the most direct route. No diversion will be allowed unless specifically instructed by the EMD"

71. Mr Bevan gave evidence that upon receiving the call he got out of bed, got dressed and telephoned the volunteer officer about the job. The volunteer officer on that day was Mr Klayton Robb. Mr Robb undertook a recorded conversation with police and this also forms part of exhibit 1. Mr Bevan gave evidence that he and Mr Robb agreed to meet at a nominated location for Mr Bevan to collect Mr Robb on the way to the incident. It subsequently occurred that Senior Constable D'Souza took Mr Robb to the scene. Unfortunately it appears that there was some confusion as to what information was then passed on to Mr Bevan. For the purpose of this inquest I consider these matters have little or no bearing as Mr Bevan was only waiting for approximately 3 minutes when he was advised that Mr Robb was already at the scene. I consider the delay to be insignificant in all the circumstances.

72. Also tendered in evidence before me, as part of exhibit 1 was the SJA Case Card for this incident. Mr Bevan gave evidence that this is a form that is required to be completed by ambulance officers whenever they attend to a job. That case card records Mr Bevan arrived at the scene at 6.19am and was with the patient at 6.22am. Ambulance arrival at the scene therefore

occurred almost an hour after the initial call from Mrs Honner to 000 seeking an ambulance.

73. Mr Bevan gave evidence that upon his arrival he saw a man lying down on the ground with 2 police officers on each side, who were securing him. He stated that his initial treatment was to assess the man's breathing and check for a pulse. He stated that the deceased's pulse was very fast. He provided oxygen for the deceased and administered Midazolam. I heard evidence that this was an injection provided to calm the deceased due to his agitated state, so as to be able to treat him. Mr Bevan gave evidence that this appeared to have a quick effect and the deceased visibly calmed down.

74. Mr Bevan gave evidence that as a result of the observations he made, he formed an opinion that the man appeared to be drug affected. He recalled hearing some reference to ICE, but was advised that it could have been a mixture of things. Due to this possibility, Mr Bevan gave evidence that he made a decision to provide an injection of Naloxone (also known as Narcan). Mr Bevan gave evidence that this was an injection provided to reverse the effects of any narcotics that the deceased may have taken. Unfortunately this appeared to have no effect and Mr Bevan gave evidence that this was more than likely due to the fact that whatever drug had been taken, it was not a narcotic.

75. Mr Bevan gave evidence that after a period of time they were eventually able to place the deceased onto a stretcher and move him to the ambulance. Once the deceased was in the ambulance, a cardiac monitor was used to check his oxygen saturation levels. Mr Bevan gave evidence that he remained in the rear of the ambulance with the deceased and also had Constable Machacek with him in case the man became agitated once again. Mr Robb then drove the ambulance.

76. Mr Bevan recorded in the SJA case card leaving the scene at 6.56am. Mr Bevan gave evidence that they arrived at the hospital at 7.01am and had

travelled there under a code 1. Again I heard evidence that a code 1 is a medical emergency where the flashing lights and sirens are used. It is used in life threatening situations. It is clear from the evidence that at this stage all person's considered the deceased's medical condition was extremely serious and/or life threatening. Mr Bevan gave evidence that upon his arrival at GDH he handed over the care of the deceased to staff.

77. Also tendered in evidence before me was the statutory declaration of Dr Tamsin Cockayne. Dr Cockayne was the district medical officer on call for the GDH on Sunday 23 November 2008. Dr Cockayne recorded in her statement the presentation of the deceased at the hospital and the seriousness of his condition. Dr Cockayne stated that the deceased's presentation was consistent with a possible amphetamine overdose. As a result a management and treatment plan was put in place to provide support and resuscitation. This plan was also confirmed with the emergency physician in Darwin.

78. Dr Cockayne stated that initially the deceased's condition improved very slightly and he became more alert however unfortunately at approximately 9.15am his condition began to deteriorate. Because of his worsening condition, arrangements were made to transfer the deceased to the ICU at RDH. This plan was discussed with Dr Brian Spain, the ICU Specialist at RDH. Dr Cockayne sets out in her statutory declaration the signs of widespread multi organ failure exhibited in the deceased. As a result, his family were advised to travel to Darwin. At 2.30pm the deceased was stabilised sufficiently to transfer him via the NT Aeromedical Service to RDH.

79. I heard evidence from Dr Brian Spain, who is the Director of Anaesthesia at RDH. Dr Spain also provided a statutory declaration to the police, which was tendered in evidence before me as exhibit 8. Dr Spain stated that he recalled communications with GDH about the deceased in the morning of 23

November 2008. At that time Dr Spain was performing the role of Intensive Care Specialist. Dr Spain gave evidence that he considered that the treatment being undertaken by the doctors at GDH at the time was appropriate, however despite this treatment the deceased's condition continued to deteriorate and shortly after his arrival at RDH he went into cardiac arrest.

80. Dr Spain gave evidence that despite the extraordinary attempts by the ICU doctors and staff to keep the deceased alive they were unable to maintain an adequate blood pressure and he passed away at 4.54am on Monday 24 November 2008 in the presence of his parents and sibling. Dr Spain gave evidence that the deceased's chances of survival were extremely low however all reasonable attempts were made to try and save his life.

81. I heard evidence from Dr Michael Kennedy, Consultant Physician and Clinical Pharmacologist and Cardiologist of New South Wales. Dr Kennedy prepared two reports in relation to this death. They were tendered in evidence before me as exhibit 6. Dr Kennedy described the amount of drugs found in the deceased's system and the impact those drugs had upon his body. In particular Dr Kennedy provided evidence related to the impact of the delay of the ambulance attending upon the deceased. The thrust of Dr Kennedy's evidence was to the effect that he considered there might have been a very small chance of survival for the deceased, however that chance would have required him to be admitted to an acute tertiary facility immediately from the car park where he was taken from the ambulance. In basic terms, the deceased was dying when he was admitted to GDH at 7.01am. As stated during his evidence, any chances of survival for the deceased were unfortunately by that time just "pure speculation".

Findings

82. At the commencement of this inquest Counsel Assisting indicated to me in her opening statement that one of the main issues for consideration was the decision not to send an ambulance when one had been requested by Mrs Honner during her initial 000 call. The secondary issue was also consideration of the actions taken by police in relation to the circumstances that they faced on this day. I also intend to consider the actions taken by the medical staff on this day.

Decision not to send an ambulance

83. During the course of these proceedings I had tendered in evidence before me materials related to an inquest conducted by me into the death of Mr Steven Power on 5 September 2003 at Palmerston. Those materials formed exhibit 5. I handed down my findings in the *Inquest into the death of Stephen Power* on 5 August 2004. I considered that material particularly relevant in relation to this inquest as the inquest into the death of Mr Power also related to a refusal to send an ambulance. Also relevant was the fact that one of the emergency medical dispatch officers involved in that matter was Ms Karen Joyner. Ms Joyner did not dispatch an ambulance following a 000 call.

84. I found in the earlier Inquest that Ms Joyner's decision on that occasion not to send an ambulance was wrong and ill considered and that she had been dismissive of the caller and the caller's legitimate requests for an ambulance. On that occasion Mr Trevor Sellick, who was then the Operations Manager of the Northern Region of SJA also gave evidence, and quite properly conceded that the SJA response to the calls for assistance were not acceptable. Mr Sellick told me that SJA had reacted to what had occurred quickly and made changes to their system by implementing a policy that EMD's were not to fail to dispatch an ambulance except in the clearest of circumstances. This was highlighted during the course of those proceedings as having eliminated much of the discretion, or judgement, of

the dispatcher. Of note is that during the course of the proceedings in the matter of *Power* Ms Joyner was specifically asked whether since these events, occurring back in September 2003, there had been any change in the way in which EMD's were instructed to deal with calls, particularly in relation to the exercise of discretion and judgement. In answer to this question, Ms Joyner stated at page 41 that in relation to the changes:

"We're not allowed to not send an ambulance anymore"

85. Despite receiving this assurance during the course of Ms Joyner's evidence and what appeared to me at that time to be an understanding by Ms Joyner that there had been changes to deal precisely with this sort of situation and to remove any random discretion of the EMD officer, Ms Joyner has clearly once again made a determination not to dispatch an ambulance. This is a worry.

86. In relation to the relevant changes to the Communications Manual, I note in particular that items 3.1.6 to 3.1.8 under Part 2, Division 3 of the manual are changes implemented since 2004. In my opinion it is quite clear that item 3.1.6 requires that an ambulance should be sent in <u>all</u> instances where the location of the incident can be determined. SJA themselves chose to highlight the word "all" in their manual, making it absolutely clear in my view what is required of the EMD in such circumstances. I do not consider there is anything ambiguous in the wording of that clause or in what is required.

87. Following the terms of that clause, there was absolutely no issue here that the location of the incident was "determined", and in fact was determined on the <u>first</u> call at 5.25am. I accept that there was some concern about the risk of danger to the crew. That concern was valid given what could be heard in the background during the 000 call from Mrs Honner. However, I also note that item 3.1.6 does provide that if danger to the crew is suspected, dispatch is still to take place but it is to be coordinated so as to attend in company

with the police. There was simply no compliance whatsoever with this provision. Given the assurance provided to me by Ms Joyner in her evidence in the matter of *Power,* there is no doubt in my mind that Ms Joyner was aware of this provision. As a result, she should have ensured that an ambulance was dispatched and, if necessary, was dispatched in coordination with the police.

88. Ms Joyner attempted in her evidence to provide some explanation for her failure. Mr Rowbottam, stated in his final submissions on behalf of his client that the two basic reasons were the information Ms Joyner received from Ms Caldwell and the information she received from the ICAD log. In this regard, I do not accept Ms Joyner's explanation. Ms Joyner had a clear and absolute obligation upon her on the morning of Sunday 23 November 2008 to send an ambulance. It was not for her to make a "decision" about whether one should be sent or not. The policies and procedures operating upon her on that morning had been changed 5 years ago to remove her discretion in this regard; they had been changed as a result of the very actions of Ms Joyner. Mr Rowbottam described Ms Joyner's decision as one borne about by "flawed logic"; I do not agree, she thought she knew better than what was prescribed. The manual made it clear for an ambulance to be sent.

89. I note that earlier in these findings I referred to some evidence of Ms Joyner in alleging a conversation between herself and Ms Caldwell about the cancelling of the ambulance. I do not accept this evidence at all. I consider this was an attempt by Ms Joyner to shift blame for the cancellation and her failure to dispatch an ambulance. Ms Caldwell has stated all along that she and Ms Joyner did not discuss the cancellation of the ambulance. It was never suggested in cross-examination of Ms Caldwell that this was not true.

90. Ms Joyner was represented by experienced counsel who carefully cross-examined Ms Caldwell according to his instructions. He did not suggest

that Ms Caldwell was mistaken about this issue. I find that Ms Joyner created this excuse whilst she was in the witness box and I do not believe her evidence in this regard. In addition, Ms Joyner after initially stating that she could actually recall speaking with Ms Caldwell about cancelling the ambulance, later in her evidence, conceded that it was not a matter of recalling the conversation but a matter of assuming that she had spoken to Ms Caldwell. She stated that this was because it was something that they would always talk about. In this regard, I should hope not, because if this were true it would mean that the cancellation of ambulances is discussed on a regular basis (when SJA policy prescribes that it should not be occurring). Ms Joyner clearly did not fulfil her duties as a dispatch officer on this occasion.

91. Obviously Ms Renee Caldwell was also responsible on this day to ensure compliance with the procedures of SJA. However it was clear from the evidence of both Ms Caldwell and Ms Joyner that the role undertaken by Ms Caldwell on this date was to be the call taker and the role of Ms Joyner was to be the dispatcher. Therefore the obligations of dispatching the ambulance rested on the shoulders of Ms Joyner and she should have complied in all of the circumstances.

Action taken by police

92. This was clearly an extremely difficult matter for the police to deal with. They were placed in a situation of not knowing, due to the behaviour of the deceased, as to what action he was going to take next. There were no persons in the vicinity to tell them what he had taken, as Ms Mackenzie had left the area with her friend and left the deceased to his own devices. In my view Officers Carson and Machacek did all that they possibly could in the very difficult circumstances in which they found themselves. It is clear from the evidence that at all times they were concerned for the safety of the deceased and were aware of the possibility of a negative impact upon him by

virtue of their actions and they attempted to reduce the risk of any danger to him as best they could.

93. I make no criticism whatsoever of the police on this occasion. I consider that they acted at all times in the best interests of the deceased, both in terms of his medical health and in terms of taking the necessary action to investigate what had happened to him.

Actions taken by medical staff

94. In terms of the staff at both the GDH and the RDH, likewise I make no criticism whatsoever. It is clear that they were faced with a critically ill patient, who I find was dying by the time he reached hospital. I consider extraordinary efforts were made to assist the deceased but the damage to his organs from the drugs that he had ingested had already occurred. It was an extremely difficult situation for them.

95. In relation to the actions taken by paramedic Wayne Bevan, I note that there was an internal case review conducted by Mr Peter Monks into the circumstances pertaining to the response by SJA officers. I note that during the course of the investigation there were a number of issues raised in relation to the actions taken by Mr Bevan. I note the outcome of that investigation. I do find however that Mr Bevan was an impressive witness during these proceedings and I consider he did all that he could upon reaching the deceased.

Conclusion

96. Counsel for SJA, Mr Wyvill SC, provided a written outline of the "position" taken by SJA in relation to this death. Within that statement was acceptance that there was an avoidable delay caused by the failure to send an ambulance when called upon to do so. This was an appropriate concession to be made. In addition it was noted that SJA had undertaken its own investigation and acted upon the findings of that investigation in reviewing its systems and

manuals and retraining and disciplining its staff. I accept this has occurred and do not consider that any recommendations I make would further assist.

97. I note the submissions that SJA has also indicated that the delay in the dispatching of the ambulance was not causative in any way of the death of the deceased. I accept this.

98. I have no recommendations to make arising from this inquest.

Dated this 2nd day of December 2009.

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GREG CAVANAGH
TERRITORY CORONER