CITATION: *Inquest into the death of Adam Chandler* [2010] NTMC 054

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coroners
FILE NO(s):	D0139/2009
DELIVERED ON:	10 September 2010
DELIVERED AT:	Darwin
HEARING DATE(s):	30 June – 2 July & 19 July 2010
FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Unexpected death, alcohol related deaths in Darwin CBD, Police Watchhouse procedures.

REPRESENTATION:

Counsel:

Assisting:	Anthony Young
Commissioner of Police:	Kelvin Currie
Dept. of Health:	Jodi Truman
David Parrington:	Glen Dooley
Damien Mick:	Helena Blundell

Judgment category classification:	B
Judgement ID number:	[2010] NTMC 054
Number of paragraphs:	67
Number of pages:	19

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

No. D0139/2009

In the matter of an Inquest into the death of

ADAM CHANDLER
ON 13 AUGUST 2010
AT ROYAL DARWIN HOSPITAL

FINDINGS

(10 September 2010)

Mr Greg Cavanagh SM:

INTRODUCTION

1. Adam Chandler died at Royal Darwin Hospital at about 8.02 pm on 13 August 2009 from blood loss caused by severe internal injuries. He was 20 years old. At the time of his death he was in the third year of a science degree at Charles Darwin University. He wanted to be a teacher.

2. He had been injured at about 4.30 am that morning after a session of heavy drinking at the Victoria Hotel with companions. During rough, drunken play one of those companions, David Parrington, picked up a palm from a planter box in the street outside Shenannigans Pub in Mitchell Street and dropped or threw it onto Adam's abdomen as Adam lay on his back on the footpath.

3. The plant, with roots and dirt, probably weighed about 20 kg. The force of the impact caused severe internal injuries. The most serious appears to have been a rupture or ruptures of the inferior vena cava, the main vein transporting blood from the lower body. However, there appear to have been multiple points of blood loss.

4. Over the next 15 ½ hours Adam bled to death. The fact of his injury was not noticed by anyone until about 4 pm on that day when his mother came home to find him desperately ill.

5. The death of Adam Chandler was a reportable death on a number of different grounds under section 12 of the *Coroners Act*. It was unexpected, unnatural or violent and it resulted, directly or indirectly, from an injury. It was also reportable because the death occurred during an anaesthetic (although not as the result of an anaesthetic), that is, during surgery. It may also have been reportable on the ground that the deceased was held in custody "immediately before his death", although I did not find it necessary to determine if the circumstances of the death, that is some ten hours after his release from custody, satisfied this criterion. The death was, in any event, investigated as if it was a death in custody. The investigation was led by Sgt Karl Day of the Major Crime Unit. All witnesses were interviewed by experienced investigators and interviews recorded and transcripts of the interviews made.

6. The holding of a public inquest is not mandatory but was held as a matter of my discretion pursuant to section 15 of that *Act*.

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

> "(1) A corner 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*;

8. 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."

9. 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."

10. Evidence in the inquest was heard on 30 June and 1, 2 July 2010 at Darwin and submissions made. The matter was then adjourned for me to consider my findings.

11. On 22 June 2007 counsel assisting had written to Reviction Pty Ltd, the licensee of the Victoria Hotel, advising that it may have an interest in the hearing and inviting it to seek leave to be legally represented. A letter was also hand delivered to the Victoria Hotel on 23 June 2010. Reviction Pty Ltd did not seek leave to appear at the commencement of the hearing but subsequently complained about late notice. Accordingly, and prior to findings being delivered, I relisted the matter on 19 July 2010 to allow the company to appear, make submissions and indeed, call evidence if desired. The only matter of interest to Reviction Pty Ltd is whether the provision of alcohol to Adam Chandler and his companions may have contributed to his death. Despite adequate notice of the relisting, the company did not appear on 19 July 2010.

12. Mr Tony Young appeared as counsel assisting, Mr Glen Dooley as counsel for Mr David Parrington, Ms Helena Blundell as counsel for Mr Damien

Mick, Mr Kelvin Currie for the Commissioner of Police and Ms Jodie Truman as counsel for the Royal Darwin Hospital.

13. I heard evidence from Sgt Karl Day, coronial investigating officer, Snr Constable Stephen Downie, Constable Adam Threlfo, police auxiliary officers Hayley Masters, Robert Armitage, Brendan Shervill and Helen Herron, paramedic Nicholas Bigwood, Dr Oscar Aldridge, Dr Didier Palmer, Dr Colin Summerhays, Dr Terence Sinton, a pathologist, and civilian witnesses Jerome Lacco, Benjamin Brayshaw, Owen Griffiths, Jon Walton, Damien Mick and David Parrington.

14. I also have a brief of evidence before me consisting of, among other things, statements of witnesses not called to give oral evidence.

FORMAL FINDINGS

15. Pursuant to section 34 of the *Coroner's Act* ("the Act"), I find, as a result of evidence adduced at the public inquest, as follows:

    (i) The identity of the deceased was Adam Chandler born on 26 April 1989.

    (ii) The deceased died at Royal Darwin Hospital, Darwin, on 13 August 2009.

    (iii) The cause of death was acute haemorrhage and blunt abdominal trauma.

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

    1. the deceased was male;

    2. the deceased was not an Aboriginal Australian;

3. a post-mortem examination was carried out and the cause of death was as detailed above;

4. the pathologist viewed the body after death;

5. the pathologist was Dr Terence Sinton;

6. the deceased's mother is Debbie Louise Chandler and his father is Brian Lindsay Chandler;

7. the deceased lived at 6 Bristow Court, Bakewell, Northern Territory of Australia;

8. the deceased was a student.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

16. On the evening of 12 August 2009 Adam Chandler and his companions; Jon Walton, Keegan Smith, Jerome Lacco, Damien Mick and David Parrington, arranged to go out for a drinking session at the Victoria Hotel. All were between 18 and 20 years of age. They were all friends, some from school, and were on good terms with each other. David Parrington was something of a newcomer to the group and he was primarily a friend and workmate of Jerome Lacco. He did not know the others particularly well and had not known them long.

17. The young men met up at Adam's home at 6 Bristow Court, Bakewell at around 9.30 pm. They brought some beers and Jon Walton brought some cans of pre-mixed rum and coke. Although it is impossible to say now how much each drank it was probably at least 2 or 3 stubbies of beer each with the exception of Jon Walton who drank rum and cokes.

18. Shortly before midnight they left for the Victoria Hotel driving in Jerome Lacco's car. It is unclear who drove because there were inconsistent recollections by the witnesses but it was probably Jerome Lacco or David

Parrington. The six young men arrived at the Victoria Hotel about midnight or shortly after. Jon Walton worked for a security company employed by the Victoria Hotel and was known to the staff of the hotel. This enabled him to obtain cheap or free drinks from the bar staff. He and his companions obtained wrist bands which, when displayed, meant the bar staff would give them cheap drinks. This evidently was a reason for choosing to go the Victoria Hotel that evening. According to the evidence of Jon Walton, Damien Mick and David Parrington each of them drank 6 or 7 "Jaeger bombs" (a mixture of a liquer and Red Bull) and 7 or 8 beers while at the Victoria Hotel. Some of them also drank "Cowboys", a schnapps based mixed drink. Each of Jon Walton, Damien Mick and David Parrington said they were intoxicated by closing time, each assessing their level of intoxication at 7 or 8 on a scale of 10. Each of the young men was probably intoxicated before closing and heavily intoxicated by closing time at 4 am. The young men then left. They were intending to go to a take away food outlet. Keegan Smith and Jon Walton went to a bank auto-teller and became separated from the others.

19. At about 4.30 am on 13 August 2009 Adam and his three companions; Jerome Lacco, Damien Mick and David Parrington, walked in northerly direction in Mitchell Street. A cctv camera at the secure taxi rank in Mitchell Street recorded their progress. The film shows them engaging in rough play on the footpath outside Shenannigans Pub. They appeared to rugby tackle one another. Adam was wrestled or knocked to the ground and lay on his back. The film shows Damien Mick raising his foot as if to stamp on Adam in the abdominal area as he lay on his back. While the film shows he stamped down in the direction of Adam's abdomen it is unclear from the film whether he made any contact with Adam and, in any event, the blow did not appear to have been delivered with much force. A second or two later, David Parrington is seen to take a plant from its planter box and, from about shoulder height, drop or throw it onto Adam's abdomen. The plant is seen to

hit Adam with obvious force. Adam was unable to get up initially but then he slowly got to his feet. He walked with difficulty and moved to a fence beside the footpath where he is seen to lean over it with his head down as if trying to catch his breath. He then walked a little further and sat down on the edge of the road. A little later he is seen to lie down on his side. The cctv footage shows Adam in obvious discomfort. In retrospect it is easy enough to see that he was injured.

20. Senior Constable Stephen Downie and Constable Adam Threlfo observed the tail end of this rough play from a patrolling police vehicle, although not the throwing or dropping of the pot plant, and stopped their vehicle in the street. They noticed a plant or plants lying on the footpath. Senior Constable Downie said in his record of interview that he first saw Adam Chandler sitting on the footpath. The cctv film does not clearly show Adam's position as the police vehicle stopped. However, at some point he must have stood up because the film shows all four walking to the cage at the back of the vehicle. Adam, walking unaided and with no obvious sign of injury and was the last to be placed in the vehicle. He is seen to climb into the cage without assistance. One of the officers then picked up a plant and placed it back in the planter box.

21. The police vehicle then drove about 100 metres to the Darwin watch-house. All four were received into the watch-house at about 4.45 am. Watch-house cctv cameras recorded almost all of the next 5 hours that Adam spent in police custody. The cctv equipment at the reception counter also recorded sound.

22. The watch-house Custody Manual for Darwin Police Station requires that persons being received into the watch-house be screened for ill-health or injury. Section 12 states:

> "The receiving officer is to ensure a screening form is completed describing the present state of mind, sobriety and health of the person accepted into custody".

23. Section 12.3 adds the warning that:

> "…members should be aware that intoxicated persons are often unable to offer an informed opinion and, under these circumstances, it is advisable to err on the side of caution".

24. Adam Chandler was accepted into custody at 4.57 am. The police auxiliary logging the details in the police record keeping system, IJIS, logged the following entry: "Chandler received from members Threlfo and Downey (sic) for section 128, appears intox, had nil meds, nil apparent injury, was searched and placed into cell M5 for sleep, sus' was closed".

25. Senior Constable Downie and Constable Threlfo, the detaining police officers, and each of the police auxiliaries gave evidence that they had not noticed any injury to Adam Chandler. I have no reason to doubt that evidence.

26. However, the visual and sound record of the cctv film from the watch-house shows the following events which, in retrospect, may be seen as significant.

27. At the reception counter, while Adam was being received into the watch-house and his details logged, Senior Constable Downie asked him whether he had any excuse for acting in a "disorderly manner". Adam replied that he had been hit with a pot plant and went on to say, twice, that he had been "hit in the side of the guts". He said he had been unable to get up and had been unable to walk properly. Senior Constable Downie then asked "What's that got to do with acting in a disorderly manner?" To be fair to Senior Constable Downie, in context it appears that Adam may have been denying that he was acting in a disorderly manner rather than complaining of injury. In any event, none of the persons present thought to follow up his remarks or ask Adam if he had any injury.

28. Adam was then asked by Police Senior Auxiliary Robert Armitage, who was present while Adam was at the reception counter, if he had "any health problems". He did not verbally reply to this but appears to have shaken his head. Mr Armitage then walked towards the cells followed by Adam and Senior Constable Downie. According to the sound recording, as he walked Adam then said, clearly as an afterthought to his negative headshaking, "I'm winded. Does that count". An officer, probably Armitage or Downie, can be heard to reply "Nuh". Nothing more is heard to pass between Adam and any of the officers. At the time Adam was able to walk although not freely, as will be seen below, and to talk.

29. Senior Auxiliary Armitage stated in his record of interview that:

> "… from there [the reception counter] we walked him to the cell, on his way to the cell he told the members to just slow down a bit because he had the wind knocked out of him, he was hit in the stomach with a pot plant or pot or thereabouts – um – I asked him if he was okay and he said yeah he's fine just had the wind knocked out of him, from there he went into the cell and he just sat down quietly in the corner at the front glass panel of the cell M5".

30. The conversation reported by Mr Armitage is not recorded on the cctv sound record. This is possibly because there appears to be an area where vision and possibly sound is not recorded between the areas filmed by the reception counter camera and the camera in cell M5. However, I am not sure that Mr Armitage's recollection is anymore than a general recollection at best. Adam would not need to repeat that he had been hit by a plant. He had already said this to Senior Constable Downie, within Mr Armitage's earshot, a short time earlier. He had also said a short time earlier that he had been "winded". He would hardly need to repeat that to Mr Armitage seconds later. Significantly, Mr Armitage did not mention in his record of interview the words that are recorded: Adam's question "I'm winded, does that count?" and the reply "Nuh".

31. While I think it is likely that Adam asked Mr Armitage to slow down on the walk to the cell, I am not satisfied that Mr Armitage responded by asking Adam if he was “okay” and that Adam replied that he was “fine” and he “just had the wind knocked out of him”.

32. Adam was placed in a cell with his companions. None of them noticed any injury. He did not directly complain of injury and I am satisfied that his injury was not obviously apparent to a lay person.

33. At about 8.55 am the cctv film shows him go to an intercom in the wall of the cell and press it on two occasions. If he called he did not appear to be answered because he returned to his seat without speaking.

34. During the hearing I asked Sgt Day, the senior investigating officer, to go the watch-house and check if the intercom in cell M5 was working. He reported that it was not and that it was apparently out of order.

35. David Parrington, in his record of interview, said that Adam pressed the intercom and he was trying to get the attention of the watch-house officers but that it did not work. The officer conducting the interview, Sgt Day, asked David what he thought Adam wanted to say over the intercom. According to the transcript of the interview David replied “Um – (inaudible) just gotta tell ‘em something (inaudible)”. It appears that Sgt Day thought David was unable to add anything because he responded “I guess its hard to look into the future and predict what someone’s gonna say”. They then moved to another topic.

36. In his oral evidence-in-chief David Parrington said that Adam wanted to complain of his injury when he attempted to use the intercom. Counsel assisting cross-examined him about that evidence and pointed out that he did not appear to have said that in his interview with Sgt Day. David conceded that he might have been reconstructing. I am unable to say whether Adam’s intention in attempting to use the intercom was to complain of injury,

although it is certainly possible and it is possible he wished to complain of feeling unwell. However, he did not complain to any officer once released from the cell and made no direct complaint of injury to his friends in the time, which must have been more than one hour, from his release to being delivered home. Whatever Adam's intention, I am satisfied that the intercom did not work when he attempted to use it.

37. At 9.46 am Adam and his companions were released from custody. In retrospect it is apparent from the watch-house cctv footage that Adam was, at least, in discomfort at the time of his release. He is heard breathing heavily and he holds his side from time to time. However, the cctv film also shows that he still walked and talked without any obvious signs of injury. The cctv footage shows him walking without obvious difficulty in the street away from the watch-house, apparently talking to his companions. I am satisfied that there was nothing obvious about his physical appearance at the time of his release to alert the watch-house officers to his injury.

38. Once released from the watch-house Adam and his companions waited in Mitchell Street while Jon Walton was called to come and collect them. Jon Walton gave evidence that after he arrived Adam complained that he had a very sore chest and back and explained to Jon that he had been hit and "winded" with a pot plant by David Parrington. He did not directly say he was injured. Nevertheless, Adam said he felt sick and in fact he vomited. Jon Walton said he vomited too. He said they both laughed then, putting it down to having drunk too much alcohol in the preceding hours.

39. An aspect of Jon Walton's evidence should be noted. He said that he and Keegan Smith went to the watch-house during the morning to see if their companions were there, probably not long after they were detained. Once they confirmed that they were there Jon asked his mother to ring the watch-house and ask if the young men could be released into her custody. The Custody Manual provides that in appropriate circumstances an intoxicated

person may be released into the custody of a responsible person. Jon’s mother rang but the watch-house officers apparently refused to release them into her custody. The reason for this was unclear and the matter was not explored further in evidence.

40. Adam and his companions then drove to Jerome Lacco’s house at Tiwi to collect a spare car key and then returned to Jerome’s car in the city. Jon Walton said that during the journey to Tiwi they all laughed about the experience because it was their first time in the police cells. Jon said that Adam mentioned again that he was sore but nothing more was said about that. Jon thought everyone was still a little intoxicated.

41. After returning to the city Adam got in Jerome Lacco’s car and was driven home to Bakewell. He then went to bed and remained there until his mother, Debbie Chandler, came home from work at about 4 pm. He was very ill by that time but still conscious. She called an ambulance at 4.40 pm (1640 hrs) and he was taken to the Royal Darwin Hospital, arriving at about 5.40 pm (1740 hrs).

42. At 1650 hrs the ambulance officers observed a pulse of 140 and blood pressure of 80 on 50. They took a history that he had been hit with a 5kg pot plant while lying on the ground. He complained of lower left abdominal pain and general kidney pain on both sides. He was given intravenous saline and oxygen. At 1740, just before arrival at the Hospital, his pulse was 110 and blood pressure 90 on 50.

43. On arrival at the Hospital he was noted by the triage nurse to be “BIBA [brought in by ambulance], 10 kg pot fell onto the patient last pm while intoxicated. Today nausea and vomiting coffee colour, initially hypotensive and tachy[cardic]. BP improved post intravenous therapy, pale plus GCS15”.

44. These observations are indicative of shock likely (and in fact) due to blood loss. Adam was made a triage Category 3 (to be seen in 30 minutes). He was

later upgraded to a Category 2 (to be seen in 10 minutes) and then a Category 1. Initially no bed was available because car accident victims came in the hospital while he was there. These were in fact less serious cases than Adam. In the result, Adam waited 45 minutes in the care of the ambulance officers while less serious cases were given priority.

45. Dr Didier Palmer, the Director of the Emergency Department at Royal Darwin Hospital, was called by the Hospital to explain the operation of the triage system at the Emergency Department. He explained that a triage system categorizes patients according to urgency of treatment rather than time of arrival. Triage occurs before complete medical examination and necessarily involves less than complete information about a patient's condition.

46. Dr Palmer said the Hospital uses the Australian Triage Scale which is a scientifically validated system proven to be as safe or safer than any other system. It involves 5 categories. Category 5 is least urgent and Category 1 is most urgent. Adam's condition was initially categorized as Category 3, that is, "potentially life-threatening or important time-critical treatment or severe pain". Category 2, for example, is "imminently life-threatening". Dr Palmer explained that the triage decision is based on physiological predictors, risk factors and level of pain.

47. Dr Palmer explained that Adam's circulation and blood pressure at time of admission was properly characterized, according to the Australian Triage Scale, as "mild haemodynamic compromise", his breathing as "mild respiratory distress" and his Glasgow Coma Scale score as greater than 12 or, in lay terms, he was conscious and speaking. His pain was "moderately severe".

48. Risk factors are also taken into account. For example, a patient who has been involved in a high speed motor car accident may receive a higher Australian Triage Score based on that fact. This in fact happened and a

number of motor car accident victims admitted into the Emergency Department were the subjects of a "Trauma Alert" and given priority over Adam despite, after later medical examination, being found to be less seriously injured than Adam.

49. Dr Palmer also explained that if Adam had been given a higher priority, a Category 2, on admission he would probably not have received treatment sooner than he did because the beds were full. His condition on arrival would not have merited categorization as Category 1. Forty five minutes after admission, once Adam's condition deteriorated, he was re-categorised as a Category 1 and seen by a doctor immediately. Surgery began very soon after.

50. I accept Dr Palmer's evidence. I accept that Adam's condition on arrival was properly categorized according to the accepted criteria of the Australian Triage Scale.

51. Dr Summerhays, one of the two very experienced surgeons who operated on Adam, was asked whether Adam's 45 minute wait in the Emergency Department made any difference to the outcome. He said it did not. I accept his evidence.

52. Dr Summerhays was also asked whether he thought Adam might have survived had he been seen earlier in the day, say in the period soon after he was injured. Dr Summerhays said it was difficult to say with any confidence. In general terms, he said, if Adam's condition had been better when his abdomen was explored in surgery he probably would have had a better chance of surviving longer. However, he could not say that Adam's life could or could not have been saved if he had been seen earlier in the day. It was going to be difficult to save him in any event because of the severity of his injury. I accept this evidence.

53. Adam Chandler was a young man with much to look forward to in life. He was looking forward to becoming a teacher. I have no doubt that he would have become a valuable and contributing member of our community. He was a loved son, brother and friend. His death was a loss to those who loved him and to the community. His death is to be deplored.

54. In my view, the death was accidental and happened as a result of "rough play" between happy and extremely drunk friends. I do not believe that a crime was committed by any of these friends in connection with the death.

55. The level of intoxication of Adam and his companions was a contributing factor to Adam's death. They were so drunk they were unable to take care of themselves and each other. They were drinking at the Victoria Hotel for 4 hours, apparently drinking a mixture of drinks, including liquers, spirits and beer. They were provided with the drinks for free or cheaply because one of the young men worked there as a bouncer. They left at 4 am. They were heavily intoxicated when taken into protective custody at about 4.30 am.

56. It is an offence to sell liquor to an intoxicated person under section 102 of the *Liquor Act*. I am precluded by section 34(3) of the *Coroners Act* from naming a person that has or may have committed an offence. Nevertheless, the community has a strong interest in the proper regulation of the sale of alcohol. The death of Adam Chandler is an example of the consequences of the too ready availability of alcohol in our community. I do not forget the role of individual responsibility of the patron but the licensees and staff of liquor outlets are also charged with a responsibility under the *Liquor Act* to ensure the safe use of alcohol.

57. I am not satisfied that responsibility was discharged in this case. I can see no justification for the "discounting" the price of alcohol or giving it away as appears to have happened here. Price is a significant factor in minimizing alcohol related harm. I RECOMMEND that the Attorney-General and the relevant Minister consider what steps can be taken, either through the

tightening of license conditions or the creation of an offence, to ensure this practice is stopped.

58. Whether the conduct the police was satisfactory is a question of some difficulty. A young man remained in police custody for about 5 hours without the fact of his serious injury being noticed. To be fair to the officers involved, it must be said that his injury was not obvious to a lay person. It was genuinely not noticed. His friends did not notice it either. I accept the evidence of Senior Constable Downie that he wishes Adam Chandler had made a direct complaint of his injury. If he had events may have unfolded differently.

59. Nevetheless, troubling elements remain. Adam told the detaining officers and the receiving officers at the watch-house counter that he had been hit with a pot plant in the "side of the guts" (and the detaining officers had seen the plant or plants on the footpath), that he had been unable to get up and that he had been unable to walk properly. In response to the question from Mr Armitage about whether he had any health problems he initially shook his head but then said "Does being winded count?" and was answered "Nuh". Mr Armitage said that Adam complained that he could not keep up on the walk to the cells. I think it is significant that Adam was not asked the simple question "Do you have any injury?" This should be a standard question of persons taken into custody.

60. On balance I conclude that there was enough to put the officers on inquiry that there may have been a problem with Adam Chandler's health or that he may have been injured. It was not enough that they simply accepted Adam's own terribly mistaken view that he was "winded" or that they concluded that his answer did not "count". The Custody Manual, which is not simply a guide but constitutes orders as to the officers' treatment of persons in custody, instructs officers to be aware that that intoxicated persons are often unable to offer an informed opinion and to err on the side of caution. In this

case the officers did not err on the side of caution. At best they were unobservant. Undoubtedly there is a certain routine in detaining drunks, and routine dulls responses and the sharpness of observations. However, once a person is taken into custody the custodian, which ultimately is the Northern Territory, takes responsibility for the care of that person. In this case I find that responsibility was not satisfactorily discharged.

61. It is not possible to say that the outcome for Adam would have been different if he had received medical treatment earlier on the day of his death and, accordingly, I cannot say that the deficiencies in his care in the watch-house contributed to his death.

62. The Royal Commission into Aboriginal Deaths in Custody made a number of recommendations about custodial health and safety that have a direct bearing on this matter, particularly Recommendations 123 to 127a, 133d and 140. Recommendation 123 refers to the necessity for clear policies and procedures that are enforceable and enforced. Recommendations 124 and 125 refer to the need for de-briefing following incidents of importance such as deaths with a view to assessing the effectiveness of procedures and forms. Recommendation 126 refers to the need for the person who undertakes the screening of detainees to be properly trained and designated and for the screening to be undertaken with care and thoroughness. Recommendation 133d refers to the need for persons whose work is dedicated wholly or substantially to cell guard duties to receive more intensive and specialized training than other officers.

RECOMMENDATIONS

63. I repeat my words in terms of recommendations in paragraph 56 herein.

64. It is apparent that the procedures at the Darwin watch-house incorporate most if not all of these recommendations. However, this case emphasizes that complacency is dangerous. A recommendation that merits particular

notice is that about de-briefing after important incidents. I recommend to the Commissioner of Police that a de-briefing of the officers involved be undertaken with a view to assessing the effectiveness of forms and procedures.

65. I recommend that the Commissioner of Police give consideration to additional or "refresher" training for all watch-house officers on the high standards required of them in relation to the screening of the health of prisoners. I also recommend that the health screening and the form used include the question "Do you have any injury?"

66. Counsel for the Commissioner of Police submitted that I should make a recommendation that a nurse or nurses be employed in the two largest watch-houses, Darwin and Alice Springs. These watch-houses receive thousands of intoxicated persons each year who are detained under section 128 of the Police Administration Act. Mr Dooley pointed out that large numbers of detainees are received at the Katherine watch-house too. Detainees are often in poor health. They will sometimes have serious injuries. Adam Chandler's injury was very serious but not obvious to an untrained person. Police officers and police auxiliary officers have limited first aid training (even if more intensive and specialized training is desirable for watch-house officers). They are not paramedics or nurses and cannot be expected to have that level of expertise. The responsibility for screening the health of detainees is an important one but difficult for police and auxiliary officers to discharge effectively. Recommendation 127a of the Royal Commission into Aboriginal Deaths in Custody was that there should be "a regular medical or nursing presence in all principal watch-houses in capital cities and in such other major centres as have substantial numbers detained..". I recommend that the Commissioner of Police and the Northern Territory Government consider this matter again.

67. There is one more matter that deserves mention. Another of the recommendations of the Royal Commission into Aboriginal Deaths in Custody was that there be direct means of communication between detainees in cells and their custodians (Recommendation 140). The Darwin watch-house was built, at very considerable expense, to take into account many of the recommendations of that Royal Commission. It is unacceptable that the intercom in Adam's cell was inoperative. If, as appears possible, the intercom in cell M5 has remained inoperative from 13 August 2009 until the hearing of this inquest in June and July 2010 that is a lamentable disgrace. I recommend that the Commissioner of Police give instructions in relation to this immediately. I would be grateful to hear what measures he has taken.

Dated this 10th day of September 2010.

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GREG CAVANAGH
TERRITORY CORONER