CITATION: *Inquest into the death of Perry Jabanangka Langdon* [2015] NTMC 016

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0075/2015
DELIVERED ON:	14 August 2015
DELIVERED AT:	Darwin
HEARING DATE(s):	11-12 August 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in custody, "paperless arrest scheme"; care and treatment whilst in Darwin Watch House, overrepresentation of Aboriginal people in custody**

REPRESENTATION:

Counsel Assisting:	Peggy Dwyer
Northern Territory Police & Northern Territory Department of Health:	Michael Maurice QC
Family of the Deceased:	Jonathon Hunyor

Judgment category classification:	A
Judgement ID number:	[2015]NTMC016
Number of paragraphs:	93
Number of pages:	34

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

No.

In the matter of an Inquest into the death of Perry (Kumanjayi) Langdon

ON 21 May 2015
AT DARWIN WATCH HOUSE

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. On 21 May 2015, Kumanjayi Langdon died in a Darwin Police watch house cell, on a concrete bench with two strangers he had been housed with that evening. He was a proud Walpiri man. Although I am required to use his birth name once for the formal written findings, I understand and respect that it is culturally appropriate to refer to him after his death as "Kumanjayi"[1], so as to cause the least distress for his surviving relatives, and that is how I will refer to him.

[1] The spelling is 'Kumanjayi' around desert areas in the NT, whereas elsewhere it may be spelt 'Kwementyaye'. See further C Mackinolty and J Gallagher, " A note referring to deceased Aboriginal people – and the use of the term "kumanjayi" and its spelling and linguistic variants", at *http://www.naccho.org.au/download/media-press-releases/Cultural%20Protocols%20mackinolty%20notes%20for%20referring%20to%20deceased%20Aboriginal%20people.pdf*

2. Kumanjayi was 59 years of age when he died and like so many Northern Territory indigenous men he suffered from multiple chronic health complaints, including cardiomyopathy and heart disease. Some time between 7pm and 9pm on the night of 21 May, he died because those conditions caused his heart to stop working.

3. Section 15 of the *Coroner's Act* NT ("the Act") provides that where a person dies in custody an inquest into their death is mandatory. Furthermore, s 26(1) of the Act imposes an obligation on me to "*investigate and report on the care, supervision and treatment of the person while being held in custody*".

4. A broad recommendations power is set out in s 35(2), which provides that:

> *"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".*

5. I must also make such recommendations with respect to the prevention of future deaths in custody, as I consider to be relevant (s.26(2)).

6. Specific obligations on a Coroner dealing with deaths in custody were introduced as a response to the Royal Commission into Aboriginal Deaths in Custody (the Royal Commission), which recommended that Coroners be given this broad mandate to supervise the care and treatment of some of the most vulnerable in our society, and to make recommendations that may prevent further custodial deaths. My

powers are broad enough to encompass that vision and place on me a special and profound responsibility to identify any factors that may have contributed to Kumanjayi's death in the Darwin watch house, and to formulate recommendations that need to be made to prevent a death in similar circumstances.

7. Pursuant to section 34(1) of the Act, I must make findings in relation to:

   (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; and*

   (v) *any relevant circumstances concerning the death.*

8. At the time of his death, Kumanjayi was being detained pursuant to section 133AB of the *Police Administration Act* ("the PAA") - the new so called "paperless arrest" scheme that was introduced by the Northern Territory Government and came into force on 17 December 2014. At around 5.30pm on the afternoon of 21 May this year, he had been seen by Police drinking from a plastic bottle in Spillet Park, an area well known as a place where Aboriginal people like to have a drink. He was arrested pursuant to s.123 of the PAA for the offence of drinking alcohol in a regulated place in a designated area - s101U of the *Liquor Act*. He was not causing any disruption before or during his arrest and at all times he was polite and cooperative. Nevertheless, s.123 affords Police the power to arrest without warrant someone they reasonably believe has committed, is committing or is about to commit an offence.

9. Pursuant to s.133AB, where a member of the Police Force has arrested someone under s.123 for an infringement offence, they may take them into custody and hold them for up to four hours, or, if the prisoner is intoxicated, for as long as they are judged to be no longer intoxicated. At the end of that period, there are four options for the police dealing with the prisoner (set out at paragraph 61 below), including unconditional release or releasing the person and issuing them an infringement notice.

10. The maximum penalty for the minor liquor offence of drinking alcohol in a designated area is a fine of $74 (with a victim's levy of $40) and even before Kumanjayi arrived at the watch house Police had issued the infringement notice (otherwise known as an "on the spot" fine) for that amount. Yet although the offence carried no term of imprisonment, Kumanjayi was handcuffed in public, placed in an iron cage in the back of a police van, transported away from family and friends, presented at the watch house counter with his arms still handcuffed behind his back, searched, deprived of his property, sat down and made to take his shoes and socks off and detained for some hours in a cell built to house criminals.

11. Kumanjayi arrived at the watch house at approximately 6.37pm and he was placed into cell 5 at 6.44pm. He lay down and went to sleep and did not attract the attention of Police again until a cell check at 9.07pm revealed that he had passed away. While the care and supervision of Kumanjayi at the Darwin watch house was adequate in the circumstances, it is clear that there are enormous pressures on Police and Nurses as a result of the paperless arrest scheme and the police initiative known as Operation Ascari II, which encourages the arrest of public drinkers, almost all of whom are indigenous.

12. That increase in the numbers of indigenous people in custody is likely to lead to a proportionate increase in the numbers of Aboriginal people dying in custody. This has led me to recommend that the law should be repealed.

Improvements in Watch house policing and care of prisoners

13. I take this opportunity to note that it is extremely gratifying to witness the enormous improvements that have been made to watch house procedures since the tragic death of Kwementyaye Briscoe in the Alice Springs watch house (see findings delivered on 17 September 2012, at [2012] NTMC 032). I was impressed by the professional and courteous way that Kumanjayi was dealt with by Police who were captured on CCTV, not knowing that the footage would be viewed by this Court. I witnessed significant improvements in watch house etiquette, attention to detail, seniority of staffing and the wearing of obvious arm bands identifying key positions. This is in addition to their cooperation with the custody nurses now employed on busy shifts.

14. I was impressed with the professional, frank way in which Police witnesses gave evidence in these proceedings and the obvious concern they demonstrated for the task of caring for detainees for whom they assume a duty of care.

Coronial investigation

15. I have had the benefit of an excellent brief of evidence that was prepared by Sergeant Isobel Cummins, who was at all times extremely

competent and helpful. In order to fulfil my statutory obligation to make the findings required by s 34(1), including consideration of the broader circumstances surrounding the death, I had tendered in evidence the three volume brief of evidence, including three files of the Police brief, 1 box of medical records, a supplementary brief of evidence, DVD of cells checks and CCTV of custody footage (Exhibit 1); maps of location where Kumanjayi was arrested (Exhibit 2) and a document prepared by NAAJA related to cell checks (Exhibit 3).

16. I heard oral evidence from the following police – Sergeant (Sgt) Isobel Cummins, Senior Constable Michael Deutrom; Sgt Paul Morrissey; Aboriginal Community Police Officer (ACPO) 1st Class Danielle Chisolm and Sgt Paul Jones. I also heard from Registered Nurses Fiona McColl and Christopher Jones, and from family member and Senior Walpiri man, Rex Granites. As always I am grateful for the assistance I received from those witnesses and the time spent by them and other witnesses in participating in records of interview and preparing statutory declarations.

Background

17. Kumanjayi Langdon was a senior Walpiri man and one of 10 children in the Langdon family. He is survived by his wife, Nancy Oldfield, and by their children and an extended Aboriginal family.

18. Kumanjayi was born on 14 September 1955 in Yuendumu and he completed schooling in Yuendumu and Kormilda College. He had previously been employed at the Granites mine, and the school in Yuendumu. He was a man who made a significant contribution to his community and culture. As an artist he contributed to Warlpiri

education through his work writing and illustrating children's books and posters. These are still in classrooms today and will remain important tools in bilingual education programs. I was pleased to be provided with samples of his work and I can see why they are so loved. Kumanjayi completed numerous paintings on key buildings within the community of Yuendumu, including his mural of the local football team, the Yuendumu Magpies, which is still located in the middle of town. For some years he worked as a screen printer and designer at Yurrampi Crafts in Yuendumu. His painting, *Warlukurlangu manu yankirri Jukurrpa (fire country and emu dreaming)* is in the collection of the National Gallery of Victoria

19. During the inquest I heard evidence from Rex Granites, who is the cultural brother of Kumanjayi and who was instructing the North Australian Aboriginal Justice Agency (NAAJA). He spoke about Kumanjayi's talents as an artist and an educator, but also of his character and personality. Mr Granites said that Kumanjayi "was a happy man, a great story teller and made everybody laugh. A lot of people miss him". He took the lead in cultural ceremonies, dancing and singing, and was involved in men's sorry camps to show that he had respect for families on all sides. Mr Granites gave us a picture of Kumanjayi's life back in Yuendumu when he said:

> "In the last years of his life, Kumanjayi didn't work. He was always sitting down with the old people, having a cup of tea and talking to them. He also spent time with the young people. He would sit under the tree and the young people would see him and come and sit down. He talked to them and shared stories that had been told to him. We would call this tree, "the tree of knowledge."

20. Mr Granites told the Court that Kumanjayi and his wife Nancy had a wonderful relationship and were very loving towards each other, Kumanjayi's family was shocked to learn that he had died in the watch house. They had heard different rumours about how he died and they came to the inquest with questions that needed to be answered.

Kumanjayi comes to Darwin

21. Kumanjayi had a history of significant health concerns. At least since 2004 he had been diagnosed with having a markedly enlarged heart as well as issues with his lungs and he received ongoing health treatment in Yuendumu and Alice Springs for his heart condition.

22. On 11 May 2015, Kumanjayi travelled from Yuendumu to Alice Springs on the bush bus and on 13 May he was transported to Darwin so that he could attend an appointment for an angiogram at Royal Darwin Hospital that had been scheduled for the following day. He was booked to stay at Daisy Yamirr Hostel in Tiwi during his time in Darwin, but he visited various family members and was predominately 'long grassing' between 13 and 21 May.

23. Kumanjayi missed his hospital appointment on 14 May and was taken into protective custody by police the following day. Notes from the custody nurse show that she was not happy to keep him in police custody on account of his severe intoxication and he was transported to the Hospital where he spent five hours before being released.

24. On 19 May, just two days before his death, Kumanjayi was again transported by Police to the Emergency Department of the Royal Darwin Hospital due to severe intoxication and an apparent fall in the

Darwin Central Business District (CBD). He was admitted overnight and discharged the following day, that is, the day before his death.

Arrest on 21 May 2015

25. At 5.50pm on 21 May, Kumanjayi was seen by police in the Darwin CBD, in a small park adjacent to Spillett House, located at 65 Smith Street. Senior Constable Michael Deutrom gave evidence that he first saw Kumanjayi drinking from a green plastic bottle when he was about 100 metres away and he continued to observe him at times while Kumanjayi walked down the street and as Senior Constable Deutrom approached him. He gave evidence that he had a reasonable basis for his belief that Kumanjayi had been drinking alcohol because he could see Kumanjayi drinking from a green, plastic soft drink bottle, he thought there was an effort to conceal the bottle from view and Kumanjayi appeared to be intoxicated. As a result, he decided to arrest him for the offence of drinking in a regulated place, contrary to s 101U of the *Liquor Act* NT.

26. I also received evidence that one of the methods used in Operation Ascari is to have an unmarked car with a person in plain clothes who looks for groups of drinkers and conveys that information by radio. Sergeant Shane Shewring was performing that role and he had also identified that there were drinkers in Spillet Park (Paul Morrissey, interview, p 3).

27. When Sergeant Paul Morrisey and Constable Steve Wedding arrived at Spillet Park, Kumanjayi had already been arrested and was seated on a bench in handcuffs. Sergeant Morrissey tipped out some alcohol he found in the park – a cask of wine, a couple of cans of bourbon and

a plastic bottle of wine - into the bushes. There was no evidence that police located the plastic green bottle that Kumanjayi had been drinking from, and it was not with him by the time of his arrest.

28. It is relevant to emphasise that before and during his arrest at this public park Kumanjayi was not violent, was not uttering threats and not swearing or being offensive in any way. He continued to be quiet and cooperative at all times during his dealings with the police officers. That is to say there was nothing to indicate that he was going to cause "social disorder" in the sense that the Attorney General used when he introduced the bill containing the paperless arrest provisions (Second reading speech). I agree with the submission of Counsel for Kumajayi's family that he was an old man minding his own business, enjoying the company of family and friends in an early evening of the dry season. He had been drinking, but had done nothing to bring himself to the attention of police, beyond being with other Aboriginal people in a park in the Darwin CBD. The only possible reason for his arrest was that he had committed the infringement offence of drinking in a public place.

29. Counsel for Kumanjayi's family urged me to make a finding that the arrest had been unlawful, since there was insufficient evidence to justify a reasonable belief that Kumanjayi had in fact been drinking in a public place. However there was some indicia of drinking in a public place, and since Spillet Park was known to be somewhere Aboriginal people like to drink, I find that Senior Constable Deutrom was acting lawfully when he arrested Kumanjayi.

30. Whether the arrest was unreasonable and disproportionate is a separate question. Police General Orders direct Police that arrest

should be an option of last resort (Police General Order 'Arrests', 2.2), in line with a number of recommendations of the Royal Commission, alluded to earlier and set out further below. In this case, arresting Kumanjayi was not the last resort, since other options included:

- Taking Mr Langton to a sobering up shelter;
- Arranging for Night Patrol to come and get him;
- Giving Mr Langton a banning notice and direction to leave the area;
- Telling him to go 'home', for example to a hostel or to stay with family;
- Asking a family member to look after him or take him home (and I note that someone was with him who told Police that Kumajayi was culturally his father);
- Having police take him home to Daisy Yamirr Hostel.
- Leaving him in peace, given that the alcohol had been tipped out and an infringement notice could be issued on the spot.

31. Yet I can hardly be critical of Senior Constable Deutrom, who impressed me as a sincere and conscientious police officer who was trying to achieve the goals promoted by the paperless arrest scheme and Operation Ascari II. The implicit message from the Government and senior police command was that Aboriginal people drinking in designated public places could and should be taken off the streets and detained for up to four hours, or longer if they needed more time to sober up.

32. Still handcuffed, Kumanjayi was placed in the back of the Police van and transported to Darwin Watch House by Sergeant Paul Morrissey and Senior Constable Stephen Wedding. On route, Sergeant Morrissey completed the Watch house reception card, as well as an infringement notice for the liquor offence and a banning notice that prevented Kumanjayi going back in the area of Spillet Park for 48 hours. That

meant that Police had already decided how to deal with the offence before Kumanjayi arrived at the Police station.

33. Before transporting Kumanjayi, arresting Police became aware through IJIS (the Integrated Justice Information System) that he had recently been picked up by Police when he was intoxicated and had been transferred to Royal Darwin Hospital. In fact, ACPO Chisolm told Sergeant Morrissey that she had been involved in detaining Kumanjayi several days earlier and he had been conveyed to Hospital. However there were no health alerts on the IJIS system and nothing about Kumanjayi's appearance or level of intoxication that made Police think he had immediate health concerns.

Arrival and processing in the Watch House

34. Kumanjayi arrived at the Watch House at 6.37pm and was unloaded in the holding cell while he waited to be processed by police. To his credit, Sergeant Morrissey went straight to the reception desk and told the Custody Nurse, Fiona McColl, that Kumanjayi had been taken up to the Hospital the week earlier and he thought she should look up his medical records. Nurse McColl said that she did look up his electronic health records, but she recalled being told that he may have had seizure some days earlier, so that is what she focused on when she did her quick review. I will return to that review of the heath records and her assessment shortly.

35. The health assessment of prisoners now ideally involves three stages – a health questionnaire completed by a police officer in the presence of the custody nurse if they are on shift, a series of basic health tests done by the nurse (heart rate and oxygen), who should then sign the

health questionnaire, and an overview of that process by the Custody Sergeant or Watch House Keeper, who has the ultimate responsibility for deciding whether someone is fit to remain in custody, and if so, whether they are determined to be "at risk". All three persons should sign the health questionnaire and make any comments they consider relevant.

36. That three pronged approach to heath assessment was introduced in the wake of the death of Kwementyaye Briscoe and it has resulted in a momentous improvement in the risk assessment for prisoners. As Kumanjayi Langdon's death shows, it will not enable Police to prevent the deaths of all the chronically ill people that come into their cells, but it offers a much better system than was previously there and it is gratifying to finally see the introduction of experienced nurses into watch houses in line with a recommendation from the Royal Commission. I commend the Government, Northern Territory Police and the Department of Health for their commitment and cooperation on that issue.

37. In Kumanjayi's case, the health questionnaire was completed by Sergeant Paul Morrissey, who I could see from the CCTV footage was professional and courteous. He is an experienced officer, having spent 20 years in the Victorian police before transferring to the Northern Territory five years ago. The most significant questions and answers included that Kumanjayi had been drinking that day, and reportedly around 4 beers; that he sometimes smoked; he did not report any injuries or pain; he did not suffer from epilepsy, fits or seizures and he had no thoughts of self harm or suicide. However, when asked if he had a health condition, Kumanjayi replied "sometimes ..., heart problem". He reported that he took medication for that every morning

and had taken some that day. He answered "no" to the question of whether he had any other health issues or illnesses that they should know about.

38. I was able to watch the relevant CCTV footage and could ascertain that the heath check, including the police questionnaire and Nurse McColl testing heart rate and oxygen, took five minutes, from 6.34pm until 6.39pm. It was clear that Nurse McColl listed carefully to the answers that Kumanjayi gave to Police during that time. Although the audio was difficult to hear in parts, I am satisfied (and Police accept) that towards the end of the assessment Kumanjayi Langdon asked: "where's my doctor", to which Nurse McColl replied "where's your what"? When Kumanjayi repeated "doctor", Nurse McColl brushed that comment off with the reply "The doctor's at the clinic", said as she walked away from the reception towards her office. Kumanjayi was then told by Police to take his shoes off and he said: "I'm tired of being here all day. I'm a bit drained. I need to go to a doctor" and later: "doctor I want her to come".

39. It is evident that neither Nurse McColl nor Police took seriously Kumanjayi's request to see a doctor. From the police perspective, that is understandable when the clinic nurse had just indicated that she had no concerns about his health. For Nurse McColl, who did not have a complete understanding of Kumanjayi's serious health problems, she did not consider that he needed a doctor. Nurse McColl agreed with Counsel Assisting that had she been aware of the medical history, she might have paid more attention to Kumanjayi asking where his doctor was.

40. Had Nurse McColl completed a more thorough check of the e-health

records that she had access to, it would have been immediately obvious that Kumanjayi suffered from a chronic and severe health condition for which he had recently been hospitalised.

41. The following significant conditions were diagnosed and recorded in Mr Langdon's clinical notes:

2004:	cardiomyopathy
2010:	diabetes
October 2014:	pulmonary oedema
February 2015:	congestive cardiac failure and congestive cardiomyopathy
April 2015:	cardiomegaly (enlarged heart)

42. On 31 March 2015 an echo test report revealed severe pulmonary hypertension and dilated cardiomyopathy. There are no cardiologists based in Alice Springs, but there is a periodic cardiac professional rotation with doctors from Darwin and Kumanjayi was seen by cardiologist Dr Ian Agahari. In a letter dated 6 April 2015, he detailed significant health issues related to Kumanjayi's heart – in short that Kumanjayi was showing the symptoms and signs of heart failure. Multiple cardiovascular risk factors included type 2 diabetes, hyperlipidaemia (that is, abnormal levels of lipids – naturally occurring molecules that contain hydrocarbons and make up the building blocks of the structure and function of living cells), hypertension and alcohol abuse.

43. Dr Agahari wrote: "Overall, I think this gentlemen needs a lot of work and there should be a low threshold in admitting this gentleman". The health plan included ongoing counselling to stop

drinking and referral to rehabilitation services. The brief of evidence contains information about the regular medication Kumanjayi was taking, which included drugs related to the cardiac condition.

44. Mr Langdon had been treated in Alice Springs Hospital on 21 April and 12 May 2015 for congestive cardiac failure. He was due to have an angiogram at Darwin Hospital on 14 May but had missed the appointment. I have already mentioned his relatively brief admissions to Darwin Hospital related to his intoxication on 15 and 19 May.

45. Since many prisoners in the watch house will have lengthy medical records that highlight chronic ill health, there is no guarantee that a review of Kumanjayi's records would have resulted in him being transferred to hospital. However, in recent months Kumanjayi had required medical intervention for his serious conditions and Nurse McColl conceded that this would have put her on higher alert to the risks of him being in custody. At a glance, the discharge letter from Royal Darwin Hospital on 20 May 2015 provided information that Kumanjayi Langdon had "severe cardiomyopathy (LVEF 15%), hypertension, diabetes and dyslipidaemia". By the time of Kumanjayi's arrest on 21 May, patient records available on IJIS revealed that he had significant cardiac disease progressing to Cardiac failure (statement of Dr Rod Ormond, par [46]).

46. I received into evidence a statement from Dr Rod Ormond, who is the acting Director of Medical Services for Primary Care in the Top End. He has over 35 years experience in clinical medicine, including five years of remote medicine in the Northern Territory. After reviewing the relevant brief material, including medical notes and CCTV footage, and assessing the policy for clinical assessment, Dr Ormond

was of the opinion that Nurse McColl's assessment and decision to keep Kumanjayi in the cells was appropriate in the circumstances. Kumanjayi was coherent with a normal oxygen saturation level of 97%. Although his pulse rate was elevated at 110, this was equal to the pulse observed when Kumanjayi was assessed by a cardiologist in April 2015 and was not symptomatic of a medical emergency.

47. In all the circumstances, I am satisfied that Nurse McColl's assessment, whilst not thorough, was adequate, and was what might be expected in the context of a very demanding shift. Ideally she would have taken more time to review Kumanjayi's health records, which provide a much more accurate picture of his risks, but it is self evident that the more prisoners police and nurses have to deal with, the less time they have to do a detailed history check. Nurse McColl was doing her best in challenging circumstances.

48. As the Custody Sergeant in charge of the shift, Officer Paul Jones was responsible for oversight of all custodies, including completing a section on the "Custody Health Assessment" form which is designed for oversight of the health check process. A short section on page 2 of the document is headed "DETERMINATION- TO BE COMPLETED BY CUSTODY SERGEANT OR WATCH HOUSE KEEPER". It asks:

- Was the nurse consulted?
- Is the prisoner considered at risk?
- Are you satisfied this person has no immediate health concerns?
- Following consideration of the Custody Awareness factors, does the person appear fit for watch house custody?

There is then room for the senior officer to write comments.

49. Sergeant Jones gave evidence that he understands completing this part of the health assessment is important and that it is ultimately his decision whether someone is fit for custody. Ordinarily he likes to complete the health questionnaire himself, but this night, like many since the introduction of the paperless arrest scheme and Operation Ascari II, was so busy that he did not have time to complete all his tasks.

50. I am convinced that the absence of Sergeant Jones from the health assessment process was not likely to have altered the decision to detain Kumanjayi in police cells, since he regarded Nurse McColl as a very competent clinician and he would have accepted her assessment that Kumanjayi was fit to be in police custody. Nevertheless, the oversight function of the Custody Sergeant or Watch house keeper is a very important one – it provides that a senior officer will take responsibility for ensuring the prisoner is fit.

51. I have no doubt that Sergeant Paul Jones, like each of the officers who gave evidence before me, is a responsible and caring police officer, who takes his custody duties extremely seriously. I accept without hesitation that he was doing his best to get through each of his tasks, but police were "inundated by the usual section 133ABs and protective custodies and were really "under the pump" (Recorded interview, pp 2-3). It is clear from this and other police evidence that the frenetic pace of the shift on 21 May is not unusual since the paperless arrest scheme came into operation. Sergeant Jones gave evidence that in the wake of that scheme, the numbers through the watch house have "dramatically increased", but there has been no corresponding increase in watch house staff (Recorded interview, p

24). Following Operation Ascari II, vans can get banked up around the corner and processing times can blow right out, leaving police to deal with large numbers of prisoners, many of whom are cranky, intoxicated, and chronically unwell.

52. The shortcomings identified in the health check process for Kumanjayi Langdon – the lack of a thorough review of his electronic health record by Nurse McColl and the lack of opportunity for Sergeant Jones to complete his section of the questionnaire - are good examples of why increasing the pressure on police in the watch house may result in the compromise of care for prisoners. In this case, I am confident that those shortcomings did not contribute to Kumanjayi's death. In the future, however, even the best efforts of committed and professional officers and nursing staff may result in care for prisoners being compromised as the watch house strains with increasing numbers of Aboriginal people being brought in for liquor related offences, including public drinking.

Cell 5

53. Kumanjayi was placed into cell 5 at 6.44pm and CCTV footage shows that he lay down and went to sleep. He did not attract the attention of Police at any stage until a cell check at 9.07pm revealed that he had passed away. At no time did he use the call button which was above his head, and no other prisoners sharing his cell alerted Police that he was unwell.

54. The frequency and type of cell checks that Police are required to do is set out in the Northern Territory General Order custody manual. Since Kumanjayi was not marked "at risk", that required Police to "so far as

reasonably practicable", check him every 15 minutes for the first half hour and every 30 minutes thereafter. Watch house footage confirms that cell checks took place at regular intervals, roughly in accordance with General Order. Some cell checks were for longer periods and appeared more thorough than others, but there is not doubt that Police across the shift took their obligations to check on prisoners seriously.

55. During the inquest I commented on the limited efficacy of health checks when Police are dealing with many prisoners who are heavily intoxicated and are asleep. It would be unreasonable to wake prisoners to make sure they are alive and Police are reduced to looking through the Perspex to try and see the rise and fall of the chest. The limitations are revealed in this case - a cell check was done at 9.04pm by a female officer who is shown on CCTV to have looked into the cell for an appropriate period of time, and yet she thought all the prisoners were fine. At 9.07pm, Sergeant Wolfgang Langneck embarked on his cell check and he raised the alarm when he could not see Kumanjayi breathing. When he opened the cell, there were signs that Kumanjayi had been deceased for longer than 5 minutes (he was cold to the touch and his tongue was bluish in colour). No doubt cell checks are important to ensure that there are no obvious warning signs like choking or heavy snoring, and no signs of distress, but it is clearly difficult to make an assessment of a sleeping prisoner.

56. Once Kumanjayi had been discovered, the custody nurse on duty, Christopher Jones, ran immediately to help and all reasonable efforts were made to ascertain if Kumanjayi could be medically assisted. Sadly, he had already passed away.

Cause of death

57. A report from Northern Territory Forensic Pathologist, Dr John Rutherford, confirmed that Kumanjayi died as a result of idiopathic dilated cardiomyopathy (probably alcohol related). That means that he had an inflamed or enlarged heart that was probably related to alcohol consumption, and eventually caused heart failure.

58. Toxicology revealed a blood alcohol level of 0.270%, which is high, but not fatal.

Paperless arrest scheme

59. The "paperless arrest" laws were introduced by the Northern Territory Government and came into effect on 17 December 2014. Section 123 of the *Police Administration Act*, which existed prior to December 2014, states that a member of the Police may, without warrant, "arrest and take into custody any person where he believes on reasonable grounds that the person has committed, is committing or is about to commit an offence".

60. The new section, 133AB of the *Police Administration Act*, gives police a power to detain someone for infringement notice offences, many of which would ordinarily be dealt with by on the spot fines, such as drinking in public, swearing or making too much noise. No penalty of imprisonment applies. A person can be held for up to four hours, or if they are intoxicated, for whatever period is required until they reasonably believe that they are no longer intoxicated.

61. At the end of the period in custody, police must elect whether to:

    a) release person unconditionally

b) release person and issue infringement notice

c) release person on bail

d) bring person to court for the infringement offence or another offence allegedly committed.

62. When introducing the laws, the Northern Territory Government said that police trying to arrest people often get bogged down in paperwork, which is a deterrent to them arresting somebody and taking them to the watch house. NT Attorney-General John Elferink told Parliament that the laws would allow police to "de-escalate social disorder situations or potential situations of public disorder before they escalate into major incidents". (Second reading speech)

63. At the time of Kumanjayi's arrest a police special operation known as Operation Ascari II was running. The mission statement of the Operation is *to reduce the number of alcohol related and anti-social behavior incidents throughout the Darwin and Casuarina regions.* Ascari II was originally scheduled to run from 26 March to 30 June 2015, but has now been extended to 30 Sept 2015.

64. However in operation, the combination of the paperless arrest scheme and Operation Ascari II resulted in Police picking up people drinking in public parks, almost all of whom are indigenous. Sergeant Paul Jones said of the operation police were running on 21 May, they had a number of units out "targeting anti-social behaviour and drinking in public, things like that". Aboriginal Community Police Officer, Danielle Chisolm, acknowledged that Kumanjayi was arrested even though he was not causing any trouble by drinking in the park with

his friends and he was polite and cooperative with police.

65. Although I requested statistical information about the numbers of people detained under the paperless arrest scheme and the percentage of those who are indigenous, I was informed by Counsel for the Police that only limited statistics are available, given the limitations of the old software still utilised. It is simply not possible to determine the numbers of those detained under s.133AB, what they have been detained for and the percentage that are indigenous.

66. From the limited statistics that are available and evidence of hardworking Police officers that are staffing the watch house and are out on patrol, it is indisputable that the vast majority of those detained are indigenous Territorians, as was rightly conceded by Mr Maurice QC on behalf of his client. An affidavit of Deputy Commissioner Mark Payne sets out that between 17 December 2014 and 17 July 2015, the option to release a person from custody and issue them with an infringement offence has been used 1,807 times across the Northern Territory, for 1295 individuals. Of those individuals, Police are able to interrogate the statistical data to confirm that 901 were indigenous or Torres Straight Islander persons (approximately 70%). However for a further 512 offenders who have been released from custody on more than one infringement notice, the programme for collecting statistics is not sophisticated enough to determine how many are indigenous. The evidence from police on the ground allows me to assume that most, if not all of them were indigenous, so that in fact it is more like upwards of 80% of those being released with an infringement notice are Aboriginal.

67. Furthermore, in addition to releasing someone with an infringement

notice, s133AB gives Police three further options of dealing with someone at the expiration of their time in custody. As set out above, Police can also release the person unconditionally, release on bail or bring the person before a justice or court under s.137. Currently Northern Territory Police have no system for calculating what percentage of persons dealt with under those three options are indigenous. It is not acceptable for this new law to be in operation without a tool to evaluate either its effectiveness or its adverse impact. Recommendations 82, 85 and 87 of the Royal Commission were specifically directed to Governments and Police and urged that they monitor the policing of public drinking offences to determine their impact on Aboriginal people.

68. Most telling and helpful to me was the evidence given by police on the street, who are dealing with the impact of the paperless arrest scheme and Operation Ascari day and night. Police gave evidence that the majority of those picked up for drinking in a public place are indigenous and Sergeant Paul Jones agreed with Counsel Assisting when it was put to him that 95% of those detained in police cells for liquor offences are indigenous.

69. The process of arrest and detention necessarily involves being searched by police, handcuffed, having property removed and bagged and being made to take shoes and socks off before being escorted to a cell. I do not doubt that these measures are required in most instances to ensure the safety of police and prisoners, but they are designed for the arrest and detention of criminals and they involve a serious infringement of personal liberties that should only be tolerated where they are absolutely necessary.

70. Furthermore, unlike serious criminals who are afforded the right to legal representation, a bail application, and a court appearance within a confined period of time there are no such protections in place for persons detained under s.133AB.

71. Kumanjayi Langdon, a sick middle aged Aboriginal man, was treated like a criminal and incarcerated like a criminal; he died in a police cell which was built to house criminals. He died in his sleep with strangers in this cold and concrete cell. He died of natural causes and was always likely to die suddenly due to chronic and serious heart disease, but he was entitled to die in peace, in the comfort of family and friends. In my view, he was entitled to die as a free man.

72. Counsel for Mr Langdon's family, Jonathon Hunyor, reminded me of the pertinent quote from his Honour, Deane J, in the case of *Donaldson v Broomby* ((1981) 5 A Crim R 160), where his Honour stated that:

> Arrest is the deprivation of freedom. The ultimate instrument of arrest is force. The customary companions of arrest are ignominy and fear. A police power of arbitrary arrest is a negation of any true right to personal liberty. A police practice of arbitrary arrest is a hallmark of tyranny.

73. His Honour's words are an important reminder of the indignity and shame that can be felt by people being arrested. Sometimes, of course, that is necessary, but a civilised society does not subject its citizens to that mortification unless there are no other reasonable options open.

74. I have already highlighted the significance of officer Morrissey completing the infringement notice by the time they had arrived at the

watch house. Since the decision had been made that Kumanjayi Langdon was ultimately to be released with the infringement notice being issued to him pursuant to s 133AB(3)(b), what could have been the purpose of detaining him?

75. When questioned about why Kumanjayi Langdon was kept in custody from that point, officer Morrissey told me that he was kept in custody for having committed the offence of drinking in a regulated place in a designated area. No court could have locked Kumanjayi up for that offence for any period of time, but under the new laws, the police can exercise their discretion to do so, for a period of up to 4 hours, or longer if Police determined he was still intoxicated.

76. I well understand that Police have a role to play to pick up heavily intoxicated persons to ensure that they are not a danger to themselves, or others. However Police have long had laws in place to take people into protective custody (pursuant to s.28 of the *Police Administration Act*) and to arrest and detain people who commit offences and must be removed from the street to protect public safety (see the offences listed in the *Summary Offences Act* and *Crimes Act*).

77. Counsel for the NT Police and Department of Health conceded that the system of arrests for infringement notices relating to public drinking was being used, in effect, for the purpose of preventative detention. Except in the most extraordinary circumstances, preventative detention cannot be justified. It was submitted by Mr Maurice QC that arrests for public drinking were likely to reduce further, more serious offending. However that is a speculative submission for which there was no evidence, and I reject it as a justification for these retrogressive new laws.

78. Located just one street away from Spillet Park, where Kumanjayi was enjoying a quiet drink with friends, are a host of pubs and bars extending down Mitchell Street in the Darwin CBD. Those establishments, including the Ducks Nuts, the Tap Bar, Shenanigans, Wisdom and Monsoons Bar, have al fresco drinking areas that are popular with the non-indigenous locals and tourists, many of whom imbibe large amounts of alcohol. In his oral evidence, Senior Constable Deutrom assisted me to identify those establishments and he confirmed that they have dress Codes that would have precluded Kumajayi Langdon and other Aboriginal drinkers he had been arresting from entering.

79. The new laws create a system where a large portion of the population drinks freely in pubs and taverns using sections of the public footpath that have been fenced off for outdoor drinking. Just one street away, Aboriginal people (some of whom have come in from remote communities that are under federal fiat banning alcohol, and will choose to live outdoors in the long grass) are being detained for drinking in a designated public place, even if they are enjoying peaceful, quiet time with family and friends. That deprivation of liberty and the differential treatment it results in is unacceptable.

Royal Commission into Aboriginal Deaths in Custody

80. In 1987, the Federal Government established the Royal Commission into Aboriginal Deaths in Custody in response to a growing public concern that deaths in custody of Aboriginal people were too common and poorly explained. Over the next 4 years, the Commission examined all deaths in custody in each State and Territory that

occurred between 1 January 1980 and 31 May 1989, and in April 1991, after one of the longest running and most expensive Royal Commission's in the nation's history, it released its findings.

81. The Royal Commission found that:

> Aboriginal people die in custody at a rate relative to their proportion of the whole population which is totally unacceptable and which would not be tolerated if it occurred in the non-Aboriginal community. But this occurs not because Aboriginal people in custody are more likely to die than others in custody but because the Aboriginal population is grossly over-represented in custody. Too many Aboriginal people are in custody too often (Royal Commission into Aboriginal Deaths in Custody, National Report, [1.3.3] 6).

82. As a result of the staggering findings of overrepresentation at all stages of the criminal justice system, from Police arrest to prison cells, the Commission made 339 recommendations that aimed at reducing the risk of deaths in custody. There were over 40 recommendations specifically targeted to reducing the numbers of those that came into custody in the first place, including:

> Rec 79: That, in jurisdictions where drunkenness has not been decriminalised, governments should legislate to abolish the offence of public drunkenness.
>
> Rec 80: That the abolition of the offence of drunkenness should be accompanied by adequately funded programs to establish and maintain non-custodial facilities for the care and treatment of intoxicated persons
>
> Rec 81: That legislation decriminalising drunkenness should place a statutory duty upon police to consider and utilise alternatives to the detention of intoxicated persons in police cells. Alternatives should include the options of taking the intoxicated person home or to a facility established for the care of intoxicated persons

Rec 82: That governments should closely monitor the effects of dry area declarations and other regulations or laws restricting the consumption of alcohol so as to determine their effect on the rates of custody in particular areas and other consequences

Rec 83: That the Northern Territory Government consider giving a public indication that it will review the two kilometre law at the end of a period of one year in the expectation that all relevant organisations, both Aboriginal and non- Aboriginal, will negotiate as to appropriate local agreements relating to the consumption of alcohol in public that will meet the reasonable expectations of both Aboriginal and non-Aboriginal people associated with particular localities; and

Rec 84: That issues related to public drinking should be the subject of negotiation between police, local government bodies and representative Aboriginal organisations, including Aboriginal Legal Services, with a view to producing a generally acceptable plan

85. That police Services should monitor the effect of legislation which decriminalises drunkenness with a view to ensuring that people detained by police officers are not being detained in police cells when they should more appropriately have been taken to alternative places of care;

The effect of such legislation should be monitored to ensure that persons who would otherwise have been apprehended for drunkenness are not, instead, being arrested and charged with other minor offences. Such monitoring should also assess differences in police practices between urban and rural areas; and

The results of such monitoring of the implementation of the decriminalisation of drunkenness should be made public

87. That all Police Services should adopt and apply the principle of arrest being the sanction of last resort in dealing with offenders.

Police administrators should train and instruct police officers accordingly and should closely check that this principle is carried out in practice.

Rec 92: That governments which have not already done so should legislate to enforce the principle that imprisonment should be utilised only as a sanction of last resort.

83. In her opening address, Counsel Assisting me cited the latest sobering statistics from the annual report of the Australian Bureau of Statistics.

As at 30 June 2014 the number of adult prisoners in Northern Territory prisons was 1,494, an increase of 4% (58 prisoners) from 2013. Aboriginal and Torres Strait Islanders comprised 86% (1,279 prisoners) of the adult prisoner population, and of all states and territories, the Northern Territory had the highest imprisonment rate (829.4 prisoners per 100,000 adult population). The NT had the highest proportion of Aboriginal and Torres Strait Islander prisoners (86% or 1,279 prisoners).

84. This needs to be understood alongside data revealing the shocking statistics of chronic ill health in Aboriginal men and women in the NT. Indigenous Australians still die on average 20 years earlier than non Aboriginal Australians. Cardiovascular disease (CVD) is the major cause of premature death among adult Aboriginal Australians, who are four to seven times more likely to die from cardiovascular disease than the general population.

85. I have significant empathy and respect for front line police in Darwin and around the Northern Territory who are tasked with picking up heavily intoxicated people and putting them in cells, night after night. They already do an extremely difficult job dealing with protective custody laws that require them to detain and care for heavily intoxicated, often chronically unwell men and women. The new paperless arrest scheme imposes a burden that has caused the system to groan under the weight of new arrests.

86. The facts of this matter reveal that some Aboriginal prisoners are being held for reasons of preventative detention; in the case of Kumanjayi Langdon that he might drink again in public. This sick, middle aged Aboriginal man was treated like a criminal, incarcerated

like a criminal, and died in a police cell built for criminals. In my view, it matters not that it was only for a few hours that he was deprived of his liberty.

87. As is outlined in these findings, it is glaringly apparent that the paperless arrest scheme disproportionately impacts on Aboriginal Territorians who make up the vast majority of those detained under the new laws, although they are only around 29% of the Northern Territory population. In my view, laws that impact so disproportionately on one sector of our community are manifestly unfair. Moreover, they are irreconcilable with the recommendations of the Royal Commission, which urged that Police use arrest and detention as an option of last resort. It is no coincidence that just 5 months after the "paperless arrest" laws were introduced, the first person to die being held in custody under s133AB is an Aboriginal man.

88. Ordinarily, it is not appropriate for a judicial officer to criticise laws passed by a democratically elected Government, however I am compelled to do so pursuant to my powers under s.26(2) of the *Coroners Act*. Indeed, the breadth of my recommendations power obliges me to do so where, as here, there is so clear a link between the introduction of that law and an increase in the incarceration of Aboriginal people. Section 133AB of the *Police Administration Act* (the paperless arrest scheme) in my view, perpetuates and entrenches Aboriginal disadvantage. I am going to recommend that the paperless arrest laws that came into operation in December 2014 be repealed, so as to prevent the risk of an increase in the numbers of deaths in circumstances similar to Kumanjayi Langdon.

89. The Royal Commission is a powerful reminder that deaths in custody have impacted disproportionately on Aboriginal Australians for many decades, and those in authority should be ever vigilant to avoid unnecessary deprivation of liberty. Despite the time and expertise spent reporting on deaths in custody, the paperless arrest scheme was introduced without any apparent thought to the impact on the watch house numbers, or the likely increase in deaths in custody.

90. The grief and sadness that a family feels at the death of their loved one is compounded where that death occurs in custody, away from family and friends. Kumanjayi had the right to die as a free man and in the circumstances, he should have done. In my view, unless the paperless arrest laws are struck from the Statute books, more and more disadvantaged Aboriginal people are at risk of dying in custody, and unnecessarily so. That is why I will recommend its repeal.

Formal Findings

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

(i) The identity of the deceased was Perry Jabanangka Langdon born in Yuendumu on 14 September 1955. The deceased resided at Yuendumu, in the Northern Territory of Australia.

(ii) The time and place of death was between 7pm and 9pm on 21 May 2015, at Darwin watch house.

(iii) The cause of death was that as a result of idiopathic dilated cardiomyopathy (probably alcohol related).

(iv) Particulars required to register the death:

1. The Deceased was Perry Jabanangka Langdon.
2. The Deceased was of Aboriginal descent.
3. The Deceased was unemployed.
4. The death was reported to the Coroner by Northern Territory Police.
5. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.
6. The Deceased's mother was Uni Nambijinba and his father was Tim Jabanardi.

Recommendations

To the Northern Territory Government

92. That section 133AB of the *Police Administration Act*, creating the 'paperless arrest' regime, should be repealed.

93. That the Government commission an independent expert inquiry into responses to alcohol misuse in the Northern Territory. This should form the basis for a plan to be developed by government working with stakeholders, including Aboriginal people, communities and organisations, to find solutions.

Dated this 14 day of August 2015. _____

GREG CAVANAGH
NORTHERN TERRITORY CORONER