CITATION: *Inquest into the death of Robert Taylor Daly* [2008] NTMC 055

| | |
|---|---|
| TITLE OF COURT: | Coroner's Court |
| JURISDICTION: | Daly River |
| FILE NO(s): | D0011/2007 |
| DELIVERED ON: | 1 September 2008 |
| DELIVERED AT: | Daly River |
| HEARING DATE(s): | 19 March 2008<br>7 – 9 April 2008<br>10 June 2008 |
| FINDING OF: | Mr Greg Cavanagh SM |

**CATCHWORDS:**

Death in Custody, police responses, Health Worker responses.

**REPRESENTATION:**

*Counsel:*

| | |
|---|---|
| Assisting: | Mr Colin McDonald QC |
| Family: | Mr Phillip Strickland QC |
| Police Fire & Emergency Services: | Mr Tony Young |
| Department of Health: | Mr Kelvin Currie |

| | |
|---|---|
| Judgment category classification: | A |
| Judgement ID number: | [2008] NTMC 055 |
| Number of paragraphs: | 55 |
| Number of pages: | 16 |

IN THE CORONERS COURT
AT DALY RIVER IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0011/2007

In the matter of an Inquest into the death of
**ROBERT TAYLOR DALY**
**ON 26 JANUARY 2007**
**AT NAUIYU HEALTH CLINIC,**
**DALY RIVER**

**FINDINGS**

(1 September 2008)

Mr Greg Cavanagh SM:

1. When this Inquest finished in Darwin on 10 June 2008 I promised that I would come to Daly River and deliver my findings and any comments I considered relevant in the exercise of my jurisdiction under the *Coroners Act*. In accordance with that promise, I have come to Daly River to give my findings.

2. First, I acknowledge the traditional owners of this land and the family members of the deceased man who have attended the coronial hearing and followed the evidence with obvious interest.

3. This is a sad loss of yet another Aboriginal man who died too young. The man who passed away enjoyed a reputation as a good worker and family man. He has died leaving a grieving wife and family.

4. I have heard evidence from witnesses in Daly River and in Darwin. There have been extensive written materials tendered in evidence including a detailed investigation brief prepared by Detective Sergeant Scott Manley, video tapes, tapes of interviews and statements. I have now had time to read the investigation brief and the tendered written statements, diary extracts, medical files and the relevant regional health records. I have also had the

benefit of careful and constructive submissions from counsel assisting me and counsel for the parties. I thank counsel for their efforts and work in helping to define the issues that emerged in this inquiry. I have reflected on these submissions and refreshed my memory of them by reading them from the transcript. These submissions have influenced the manner in which I propose to deal with the evidence in this Inquest.

5. Under section 34 of the *Coroner's Act* I am required to make certain findings if possible and I am able to make comment on matters including safety connected with all death. I propose to make those findings I am required to make if possible and then I propose to make limited comments under section 34(2) of the *Act* on certain matters connected with the death of the dead man which are relevant to public health and safety and the administration of justice.

6. I will first make my findings under subparagraph 34(1)(a) of the *Act*. I make the following findings:

   i. The identity of the deceased was Robert Taylor Daly an Aboriginal male born at Elizabeth Downs, Northern Territory on 13 April, 1968.

   ii. The time of death was 4.05 pm and the place of death was the Naiuyu Health Clinic at Daly River in the Northern Territory.

   iii. The cause of death was coronary atherosclerosis.

   iv. Particulars required to register the death are:

      a. The deceased was a male.

      b. The deceased's name was Robert Taylor Daly.

      c. The deceased was an Australian resident of Aboriginal origin.

      d. The death was reported to the Coroner.

      e. The cause of death was coronary atherosclerosis.

f. The forensic pathologist was Dr Terrance Sinton and he viewed the body after death.

g. The deceased's father was Robert Ilyara Jalriri Wagaman.

h. The deceased's mother was Mary Daly Agala Budjuru Nangala Nangomeri.

i. The deceased resided at Nauiyu Community, Daly River.

j. The occupation of the deceased was a labourer.

k. The deceased was born on 13 April, 1968 and was 38 years of age at the time of death.

7. 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."

8. 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."

9. I will now canvas the evidence briefly and make certain findings relevant to the circumstances leading up to the death of the deceased. At the outset, I am constrained to say that this is yet another death of a young man who had been suffering ill health for a long period of time which was induced at least in large part by a sad and dangerous lifestyle of drinking too much.

## CAUSE OF DEATH

10. Doctor Terence Sinton, the pathologist who conducted the autopsy of the deceased, described the health of the deceased for the week before the deceased died as; *"Awful...He was severely ill, yes. Very ill severely ill."* (See T153.8) Doctor Sinton was of the unchallenged opinion that the deceased died of a condition called coronary atherosclerosis, which is a hardening of the coronary arteries in the heart (T152.7) One of the main arteries to the deceased's heart was 80% blocked: (T153.4) There was evidence that another one of the deceased's major vessels to the heart was completely blocked: (T153.8) The autopsy findings also disclosed greatly abnormal lungs. The deceased had the equivalent of several pints of fluid in each lung: (T154.9-155.1)

11. It is also important for the family to know that there were no signs of recent injury other than therapeutic intervention undertaken a the Daly River Clinic in an effort to save the deceased's life: (T154.3)

## CIRCUMSTANCES LEADING TO THE DECEASED'S DEATH

12. The deceased was a resident of the Daly River Community. He was married to Wendy Longman and the couple had six children, four girls and two boys. They lived in a residence in the Daly River Community. Of relevance to the events leading up to the death, there was a recent *Domestic Violence Act* interim order in existence in respect of the deceased (which had been obtained as a result of a domestic dispute with his wife). Conditions of this order prohibited the deceased from being in the presence of his wife while intoxicated and restrained his behaviour towards her. The deceased was known to be heavy drinker and smoker. The deceased appears to have done most of his drinking in the notorious drinking paddock which is about 300 to 700 metres from the Daly River Pub on the way to the Daly River Community. I visited this drinking paddock when I took a view of certain

places when I sat in Daly River on 3 April 2008. This paddock is an exempt area under section 45D of the *Summary Offences Act*.

13. On Thursday 25 January 2007 the dead man spent most of his time in the company of his wife and family. He was noticed to be coughing badly, a cough which had developed the day before. So bad was the cough that he presented at the Daly River Clinic and was given some cough medicine and Panadol. Although there were no records for this at the clinic, I am satisfied the deceased was given a small vial of a cough mixture called Senagarr. On the evidence I find that he was given a vial of this cough mixture and not the normal 200ml bottle of the suppressant that was tendered in evidence being Exhibit 5 (see T22.1). In making this finding I accept the evidence of Ms Helen Wodak which is recorded at T109-110. I refer also evidence of Wendy Longman at T42.8 when she was shown the exhibit bottle of Senagarr. She said it was a different kind of bottle, "little bottle….smaller".

14. The deceased worked in the morning of this day for a few hours, went to collect his wages around midday on 25 January, 2007 and then sat with his family playing cards for some hours. Again, during this time the deceased was observed to be coughing and expectorating (spitting).

15. During the afternoon of 25 January 2007 the deceased went to the Daly River Pub with his brother Timothy Martin. A quantity of Melbourne Bitter was purchased on behalf of the deceased, but not by him as he was banned from the pub. Timothy Martin and the deceased then walked towards the drinking paddock and drank some beer in an area known as the "cement block". After consuming approximately four cans of beer (it may have been less), the deceased complained of being ill. There were various observations of the deceased at this time recorded later by investigating police.

16. At some stage before sunset, the deceased and Timothy Martin moved location to a group of drinkers sitting near a mango tree inside the drinking paddock. It appears the deceased asked one Dennis Mirrin and his wife to

purchase a carton of Melbourne Bitter cans on his behalf. However, whilst they were away he again felt ill and started to walk back to the community.

17. At around this time the deceased's daughter, Kate Daly noticed her father missing. Kate Daly heard her father coughing in the bush nearby. She and her Uncle Peter Martin found the deceased lying down breathing rapidly. The deceased complained he could not breathe properly and his chest was hurting: (T28.3) The deceased had defecated in his pants.

18. It then appears that the deceased asked for assistance. Kate Daly had her Aunt Pauline Longmirr use her mobile phone: (T28.9) Kate observed that Pauline Longmirr had been drinking in the drinking paddock and was drunk: (T31.6) Wendy Longmirr recalled Pauline say to her that her husband "was lying down, was sick and that he was breathing fast": (T43.8) Wendy Longmirr also recalled Pauline telling her to ring the clinic: (T43.9) Wendy told Pauline to hang up and she then rang the Daly River clinic and spoke to Barak Sambono who was the diver of the clinic ambulance employed at the clinic: (T78.9) and who was on call with Aboriginal health worker Dean Neisner: (T80.2) Wendy Longmirr told Barak Sambono that her husband "was sick at the paddock": (T44.1) Mr Sambono said to Wendy Longmirr that "they would go and pick him up" (T44.2)

19. Mr Sambono then collected the on call Aboriginal health worker, Mr Dean Neisner. Both men went to the Daly River Clinic to collect equipment and they drove to the paddock area to find the deceased.

20. In the meantime, local police officers Senior Constable Ian Kennon, Constable Julie Hollemans and Constable Brendan Berlin were on patrol and they had their attention drawn to the deceased in the drinking paddock. It appears that Peter Martin assisted the deceased to his feet. Senior Constable Kennon smelt alcohol on the deceased, he approached unsteady on his feet and noted that the deceased had defecated as he noticed a strong smell coming from the deceased. By now, it was night time. I find that police

members present considered and believed the deceased was drunk at the time.

21. There is a conflict in the evidence as to whether Pauline Longmirr said to the members present in particular to Senior Constable Kennon the words or words to the effect that: "He's sick. You should take him to the clinic." (See T51.2) In support of this evidence Kate Daly who was in hearing of at least some of the conversation between police members and Pauline Longmirr said she heard Pauline Longmirr say, "My father needs to go to the clinic" (See:T34.2) Police members present deny they heard this request. Senior Constable Kennon denied hearing this. Constable Berlin did not remember any Aboriginal women speaking to him in the paddock: (T143.5) Similarly, Constable Julie Hollemans did not remember "anyone at the paddock" saying to any police officer, including herself, that police members should take the deceased man to the clinic or anything to that effect: (T137.8) I am unable to resolve this conflict of evidence. In doing so, I found all witnesses involved in this aspect of the evidence to have been trying to give their best recollections. I cannot resolve this factual conflict. Nor is it necessary in the circumstances of this inquest that I do so.

22. I accept the submission of Counsel Assisting me, Mr McDonald QC that in light of other reliable evidence it is not necessary for me to make a factual finding on this issue. This is so because, as Mr McDonald QC submitted there is reliable evidence in Constable Hollemans statement dated 26 January, 2007 and tendered as Exhibit 12. In that statement, Constable Hollemans said:

> "DALY stood up and began staggering towards the open cage door, just as he got to the vehicle he stumbled, falling down again, a but as he fell he head butted the cage door, banged his chest on the rear of the cage and fell backwards onto the ground.
>
> S/C 1/C KENNON asked if he was okay and DALY replied, "I'm right, just take me home."

> DALY was assisted again by S/C 1/C KENNON and MARTIN, they picked him up and placed him in the rear of the police cage, I shone my torch on DALY to make sure that he hadn't hurt himself. I did not see any apparent injuries.
>
> At appox 8:30pm DALY was conveyed to the Daly River Watch House. On arrival I observed DALY making noisy quick short breaths. I asked if he was alright to which he replied, "NO, can you take me to the clinic". I asked DALY what was wrong and he replied, "I don't know, I can't breathe properly".
>
> I advised S/C 1/C KENNON of DALY'S complaint, he has then asked DALY what the problem was to which DALY replied, "My heart or something". We then placed him in the fist cell on the right, S/C 1/C KENNON searched him and removed his property. There were no other persons in the cell.
>
> Constable BERLIN and I stayed with DALY while S/C 1/C KENNON called the health clinic to request for someone to attend and assess DALY."

23. It is sufficient for the purposes of my making comment under subsection 34(2) of the *Act*, that I find, as I do, that the police knew at about the time the deceased was placed in the cells the deceased man was complaining of illness of sufficient seriousness that he reported he could not breath and that there may have been a problem with his heart. I will refer to this request later in my reasons.

24. As a result of the observations make by the police officers at the drinking paddock, the deceased was taken into protective custody under the provisions of Section 128 of the *Police Administration Act*. Witnesses attested to the deceased asking to be taken home. Senior Constable Kennon was aware of the domestic violence order and so believing the deceased to be heavily intoxicated, taking the deceased home was not an option. I find that the taking of the deceased into protective custody was reasonable, but tragically mistaken. The physical manifestations of apparent drunkenness mimicked the symptoms of chronic heart disease.

25. When the police arrived, the deceased's daughters left the area because they were under age: (T29.3, 29.7, 31.3) This is understandable yet nevertheless a pity as the police member might have had a more coherent and lucid account of the deceased's health symptoms.

26. The deceased was placed in a police van and conveyed to the Daly River Police Station. The police passed the ambulance containing Mr Sombono and Mr Neisner was seen heading to the drinking paddock. Police records show Senior Constable Kennon putting the deceased into the cells at 20:34 hours for protective custody.

27. Of significance, is the statement and evidence of Constable Hollmans attests, at or around the time the deceased was placed in the cells he was observed to be breathing in short rapid breaths and someone asked the deceased if he took medication for a heart condition and the deceased said he did not and he complained of chest pain. Given the deceased's known lifestyle as a heavy drinker, those physical signs were significant. So too is the fact that Senior Constable Kennon recalls questions from "someone" about heart medication: (see statement of Senior Constable Kennon at p33).

28. It is clear that the deceased's health was a matter for concern to the police. Senior Constable Kennon went to notify the Daly River Clinic contemporaneously Mr Sambono rang the police station inquiring about the deceased from the Daly River Clinic. Mr Sambono complained that he had been called out to attend the deceased. He was told to come and check the deceased in the cells.

29. Barak Sambono and Dean Neisner arrived at the police cells. There was a brief meeting with police members. I accept what Constable Brendan Berlin said that the deceased had complained of being short of breath and with heart trouble. He asked if they "could check him out": See Constable Berlin's statement at pp18-19. Constable Berlin also stated in evidence that

he had seen the deceased being short of breath, moaning and complaining of heart problems: (T148.5)

30. The evidence of the actual check up done on the deceased is not precise or fully clear. However, I accept the evidence of Barak Sambono that he saw Mr Neisner go into the cell where the deceased was alone: (T876) Mr Sambono did not make any notes of the time Mr Neisner was in the cells but in answer to a direct question he roughly guessed the time was 10 and 15 minutes: (T82.8) I cannot find the precise time that Mr Neisner was in the cells, but I accept that it was a short time measured in minutes; because it is clear all persons present were off-put by the stench of the deceased who had defecated himself.

31. I also accept the evidence of Constable Berlin who presented as an honest witness who sought to be helpful and as accurate a witness as he could be. In Constable Berline's statement he said:

> "One male walked in with a stethoscope and did the assessment of Daly. The other guy went in and out. Both of them complained of the smell due to the fact that Daly had defecated himself. The part Aboriginal guy was dry reaching so he came out. The other guy with the stethoscope came and said to me "He's fine."

32. This much I accept of the statement of Constable Berlin. I also accept that the person with the stethoscope was Mr Neisner. I accept that Mr Neisner did an assessment of the deceased, but how thorough that was I cannot find. Mr Neisner considered that the deceased's medical condition was sufficiently good for the deceased to be left in the cells.

33. Barak Sambono was present when Mr Neisner made his observations and assessments. I found him to be a reliable witness. He said in his tendered statement that he did not go into the cell. He asked the deceased how he was and received the reply "he was OK." Mr Sambono (who called the deceased 'Uncle' and who had known the deceased for a long time) said the voice sounded normal. It is apparent that Mr Sambono observed either

directly or was aware that Mr Neisner was making assessments. He noted in his statement to police that Mr Neisner "was in there as well doing normal observation check on him – blood pressure, temperature: see page 20 of his statement. He also said in his statement: "I stood outside with the Constable and the health worker was inside during all the observations. He came out later on and said "He's fine, there's nothing wrong with him" see page 5.9 of the statement: (T83.2) I accept this evidence as reliable. I accept that observations assessments were made in relation to the deceased.

34. After this, the health clinic workers left the police station. The police records disclose the entry that the deceased was "gammon and fake." Constable Berlin said of the health worker without the stethoscope (Mr Sambono) "I think his words were "He's Gammon"" (T148.1) I cannot find on the evidence who said those words or that they were in fact said in respect of the deceased. Mr Sambono denied the use of the word gammon or that there was conversations with Mr Neisner about the deceased being gammon or faking it. What is significant is that the deceased had an opportunity to make his condition known to the health workers and did not do so. In response to Mr Sambono's request, the deceased said words to the effect that he was all right.

35. The word may have been an interpretation of the entirety of events by Constable Berlin who reported this to Senior Constable Kennon who recorded it. This way the conclusion of Detective Sergeant Manley in his coronial report and his officer in charge at page 7. I find this conclusion of Detective Sergeant Manley on this issue the most persuasive assessment of the use of the word 'gammon'.

36. The deceased remained in the cells and was monitored by Aboriginal Community Police Officer, Thomas Matthews. Mr Matthews did regular cell checks throughout the night.

37. The cells were also monitored by video camera with a monitoring station to watch video footage inside the police station. Unfortunately, Thomas Matthews had died by his own hand before this inquest. Thus there is only Mr Matthews tape recorded interview, his statement and evidence of other persons available as evidence as to his discharge of his duties. From his record of interview and the police records it does appear that regular physical cell checks were done and that nothing alerted Mr Matthews that the deceased was ill: (see page 6 of Mr Matthews's interview). It also appears from the taped interview and records that cell checks were carried out about every 15 minutes and that the deceased was not observed to be in distress or showing signs of illness.

38. There were other persons present in the cells who had been apprehended and taken into protective custody. I did not find any of their observations on what they said they heard to be forensically helpful. Their state of intoxication, or in one witnesses case, antipathy towards police made their memory of events somewhat unreliable and, in any event, of little or no relevance to this inquiry. Nevertheless, I accept it was important to call these witnesses for reasons of thoroughness and appropriate accountability to interested observers.

39. Thomas Matthews released the deceased and another apprehended person from their cells at around 6am on 26 January, 2007. In his recorded statement to police, Mr Matthews said the deceased was not complaining of any pain or anything "at this time". Mr Matthews then drove the deceased home. At the time he dropped him off at his house the deceased appeared tired and complained of chest pain: (T619.15) of Mr Matthews's taped interview.

40. After the deceased arrived home, he lay down on a mattress. It seems the deceased later vomited around 10am and asked his wife to get assistance for him. Wendy Longmirr then rang the Daly River Health Clinic and spoke

with Beatrice Parry who organised an ambulance to bring the deceased back the clinic. Beatrice Parry is a senior Aboriginal health worker at the clinic. The deceased was assisted into the ambulance and driven to the clinic when he was immediately admitted and attended to by Beatrice Parry and clinic staff.

41. It was during the examination of the deceased that the deceased complained of chest and stomach pain to Beatrice Parry. Then, he stated vomiting with some blood being seen in the vomitis. He was treated with Maxolon for the vomiting, with Morphine for pain and with fluids. Beatrice Parry rang the District Medical Officer and the local resident nurse, Mark Mullins was called on duty to assist.

42. Dr Van Song Nguyen of the Katherine Hospital was called around 11am on 26 January, 2007 to attend at the clinic. Dr Van Song Nguyen arrived at around 12.30pm and commenced observations, examination and treatment. Dr Song Van Nguyen's opinion at the time was the deceased was suffering from alcoholic gastritis and severe dehydration.

43. An attempt was made to put the deceased on a stretcher for air evacuation but he began to vomit again complaining of severe abdominal pain. The deceased was put back into bed. Unfortunately, soon thereafter he went into cardiac arrest. Resuscitation was commenced and the deceased initially responded. Again unfortunately around 3.45pm the deceased had a second cardiac arrest. Despite further attempts at resuscitation the deceased did not respond and death was pronounced at 4.05pm by Dr Van Song Nguyen at the Daly River Clinic.

44. The Coroners Office was notified of the death by Senior Constable Kennon soon after death was pronounced. An autopsy was carried out at Royal Darwin Hospital on 28 January 2007 by Dr Terence Sinton. Members of the Major Crime Unit attended at Daly River on 27 January 2007 and commenced the investigation into the death of the deceased. Amongst the

investigative steps taken were a video film footage of the cells and taped records of interview.

45. In the course of the investigation, it was discovered that the video recording tapes of the cells at the Daly River Police Station for 25 and 26 January 2007 showed no footage of any activity. Thus, there was no film of the events in the cells on 25 and 26 January 2007. This was flagged as an issue at the commencement of this hearing.

46. I am satisfied on the evidence that the absence of film footage on the video tapes was the result of an unintentional but incorrect installation of the monitoring equipment by Senior Constable Kennon, after equipment had been sent away for service in December 2006.

47. Video surveillance equipment and the tape recordings of police cells serves important purposes: it provides a reliable record of events occurring in cells and acts as a protection for both premises and police. It is vital that this equipment in police cells and watch houses be properly maintained and functioning. It is also vital that police officers using video recording and monitoring equipment are taught how to use and operate the equipment and perform appropriate tasks for replacing video tape. The events surrounding this unfortunate death serves as a reminder of the importance of having properly maintained video recordings that can be accessed and viewed by investigators in the event of a death or other incident in police cell or watch houses.

48. The other factual issue surrounding the circumstances of the deceased's detention that was raised early in this inquest was whether the deceased was hosed down by Senior Constable Kennon while in the cells in protective custody. The issue went to matters of human dignity. Thanks to the video footage taken by Detective Sergeant Henrys and having heard all the evidence, I find that the deceased was not hosed down by Senior Constable

Kennon or any other police officer. I find the deceased took a shower in the course of the time he was in protective custody.

49. Because deaths in custody can give rise to understandable suspicious as to the cause of death, I find there were no suspicious circumstances surrounding the death. I find that the death was from natural causes and a result of the deceased's unhealthy lifestyle.

50. I now propose to make comment within my jurisdiction to a matter of public health and safety. I am inclined to agree to agree with the general thrust of Counsel Assisting me and I also note and accept the balanced and forceful submissions of Mr Young and Mr Currie. The police took the deceased into protective custody at a time when he was objectively seriously ill. Under the various legal and administrative provisions which regulated police conduct on the fateful night, the police were entitled to do what they did. They were entitled to call out the aboriginal health workers to check the health of the deceased in the cells. However, in my opinion, this should not have happened. A person in police custody complaining of chest pain and shortness of breath should be taken to a hospital if available or, in this case, to the local aboriginal community health clinic for proper medical assessment.

51. There were enough objective signs made known to the relevant police officers to indicate that the deceased had seriously compromised health and had a background of an unhealthy drinking lifestyle. The deceased should have been released to the community clinic which had a range of diagnostic equipment and urgent access to a medical practitioner for the medical practitioner's opinion.

52. I recommend that the Commissioner of Police and the Department of Health review the legal and administrative procedures that were applicable in this case with a view to their revision. I make comment that is inappropriate for aboriginal health workers, no matter how experienced or well trained, be put

in a position to opine on the health of a person in detention or custody where that person complains of chest pain or shortness of breath.

53. Persons who complain of or are observed to have symptoms like chest pain or shortness of breath should be sent immediately to a hospital where available or a local clinic and the opinion of a medical practitioner obtained as to the care of the detained or arrested person.

54. There is another issue relevant for some other death which was touched on in these sad proceedings. This is the fact that at least two of the potential witnesses in this inquiry had committed suicide and several others including an experienced aboriginal health worker were at risk of suicide or on suicide watch and who were thus not called to give evidence. This is a tragedy. Suicide in our community goes to very basic issues of public health and safety.

55. I thank all counsel for their assistance.

Dated this 1st day of September 2008.

_____

GREG CAVANAGH
TERRITORY CORONER