CITATION:	*Inquest into the death of Desmond Mamarika* [2005] NTMC 018
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0008/2004
DELIVERED ON:	1 April 2005
DELIVERED AT:	Darwin
HEARING DATE(s):	30 November, 1 and 2 December, 2004
FINDING OF:	Greg Cavanagh S.M
CATCHWORDS:	Heart disease, public drunkeness & police response to same, seizure and destruction of alcohol by police.

REPRESENTATION:

Counsel:

Assisting:	Mr Bruxner
Family:	Mr Holdsworth
Police commissioner:	Mr Grant

Judgment category classification:	B
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 018

In the matter of an Inquest into the death of Desmond Mamarika

ON 16 January, 2004
AT Palmerston

FINDINGS

(Delivered 1st April, 2005)

Mr Greg Cavanagh S.M:

Introductory

1. Desmond Mamarika ('the deceased') was born on 20 February 1979 and grew up on Groote Eylandt. He was usually resident there, but at the time of his death he was staying at 22/44 Davoren Circuit, Moulden, (a suburb of Palmerston). He had come to town to be with his daughter and his brother Daniel both of whom were undergoing treatment at the Royal Darwin Hospital.

2. At the request of the deceased's family the deceased was not referred to by name throughout the Inquest, and I order that his name not be published.

3. The deceased died in the early hours of 16 January 2004 at Palmerston.His death was treated as a death in custody for the purposes of the *Coroners Act* and was investigated as such.Under s.15(1)(a) of the *Coroners Act* I am obliged to hold an inquest in circumstances where immediately before death a deceased was a 'person held in custody' (an expression broadly defined in s. 12).

4. I conducted an Inquest into the deceased's death believing that I was obliged to do so. During the course of the Inquest it became apparent that the deceased may not in fact have been a 'person held in custody' immediately before his death.For reasons appearing later in these findings I consider that I was not obliged by s. 15(1)(a) to conduct an Inquest. However, whether or not s. 15(1)(a) applied, I would have exercised my discretion under s. 15(2) to conduct an inquest.

The Hearing

5. The Inquest took place on 30 November - 2 December 2004 at Darwin. Mr Bruxner appeared as counsel assisting me. Mr Holdsworth of the Northern Australian Aboriginal Legal Aid Service ("NAALAS") sought and was granted leave to appear on behalf of the deceased's family. Mr Grant was similarly granted leave to appear on behalf of the Commissioner of Police. Eight witnesses gave evidence at the Inquest.

6. Members of the deceased's family, including his father, his wife and his brother were present for most of the hearing. An interpreter sat with the family throughout proceedings.Senior Sergeant Fred Huysse was the police officer with general oversight of the investigation and compiled the Coronial File (exhibit 4). The Coronial file included statements Huysse and other investigating officers obtained from a number of lay and police witnesses shortly after the deceased's death.

7. Myria Demouilpied, Terri-Lee Kohler and Victor Liddy gave eyewitness accounts of particular events involving the deceased shortly before his death. Four police constables, Sean Stanley, Wayne Tilley, Debra Fisher and David Finch gave evidence of their several dealings with the deceased and his companions between about 12 am and 220 am on 16 January 2004.I found each of the police witnesses to be candid and reliable. There were no important inconsistencies in their accounts.

8. The deceased's brother, Daniel Mamarika, gave evidence regarding his and the deceased's movements over the hours leading up to the death. He also participated in a taped interview with Senior Sergeant Huysse on 16 January 2004 (exhibit 4 folio 12) and gave a statement to Mr Holdsworth on 23 January 2004 (exhibit 10).There are marked and important inconsistencies both within and between the various accounts given by Daniel.

9. English is not Daniel's first language. It was suggested on Daniel's behalf that an interpreter should have been engaged for the purposes of the taped interview. An interpreter was employed when Daniel provided Mr Holdsworth with the statement on 23 January 2004 and when he gave evidence at the hearing. The tape of Huysse's interview with Daniel was played at the hearing and it did not seem to me that Daniel struggled to understand Huysse's questions. Similarly, although Daniel was, on occasion, assisted by the interpreter when he gave evidence, I am confident that he could have managed without that assistance (albeit with patience, cultural sensitivity and the use of plain english).

10. I do not find that the inconsistencies in Daniel's accounts resulted from any failure of communication or comprehension. Instead, I consider that Daniel's capacity to clearly recall the events of the early morning of 16 January 2004 was profoundly affected by his high level of intoxication at the time, as well as his emotional turmoil at his brother's death. In my view the reliability of his evidence is questionable.

11. Although I am satisfied that Daniel endeavoured to provide an honest and accurate account of the events surrounding his brother's death I am ultimately unable to rely on his evidence where it conflicts with the evidence of Constables Stanley, Tilley, Fisher and Finch.

12. There were two potentially important witnesses who did not give evidence at the hearing - Lesley Bowden and Gordon Beasley. Mr Bowden was in the company of the deceased and his brother for much of the time in the hours

leading up to his death. Like the deceased and his brother Mr Bowden was intoxicated. Mr Beasley appears to have joined the group at about the time the deceased died.

13. Mr Bowden and Mr Beasley each participated in taped interviews with investigating police within seven hours after the deceased's death. Transcripts of the interviews are on the Coronial File. Mr Bowden's interview included an allegation that there was an attack on the deceased involving a hit with a baton (or some sort of stick) to the deceased's head. Mr Beasley in his interview disclaimed any knowledge of such an attack - he also says that Mr Bowden told him to tell the police he'd seen an attack. Daniel Mamarika's various accounts lend no support to Mr Bowden's claims.

14. Summonses for the attendance at the Inquest of Mr Bowden and Mr Beasley were issued well in advance of the hearing. The considerable efforts of the NT Police to serve Mr Bowden (about which Senior Sergeant Huysse gave evidence) were unsuccessful. Mr Beasley was located and served the week before the hearing at a remote outstation several hours from Tennant Creek. Subsequent arrangements by my office to arrange for Mr Beasley to attend at the Tennant Creek Courthouse to give his evidence by video were thwarted when Mr Beasley could not be located.

15. It is unfortunate that Mr Bowden (in particular) was not available to give evidence at the Inquest; however, I very much doubt that had I heard from him, or from Mr Beasley, it would have made a difference to my factual findings as set out below. Those findings involve the rejection of Mr Bowden's account regarding any attack upon the deceased using a baton or stick.

Formal Findings

Section. 34(1) Coroners Act

1. the deceased person was Desmond Mamarika Numalkungudaka;

2. the date and place of death was some time between 147 am and 207 am 16 January 2004 at Victoria Drive, Palmerston NT;

3. the cause of death was heart failure;

4. particulars required to register the death -

5. the deceased was male and was 24 years old. He was born on 20 February 1979;

6. the deceased was an Australian resident of Aboriginal origin;

7. the cause of death was established or confirmed by a post-mortem examination and reported to me;

8. no injury contributed to the death;

9. the body was viewed after death by a pathologist, Dr Terence John Sinton;

10. the deceased's parents were Wesley Naiungmapa Mamarika and Rachel Dunagbilingdjua Maminyamanja;

11. the deceased was unemployed.

Relevant Circumstances

16. In the hours between 12 am and 2 am on 16 January 2004 the deceased and at least two others (his brother Daniel and Lesley Bowden) were wandering in a group around the streets of the suburb of Gray and in particular in the

vicinity of the Gray Primary School.The members of the deceased's group were heavily intoxicated. According to Daniel, he and the deceased in particular were "full drunk".

17. There were two groups of police officers on patrol in Palmerston in the relevant period. Constables Stanley and Tilley were unit 419. Constables Fisher and Finch were unit 420. They were patrolling in paddy wagons. Each unit encountered the deceased's group at different times between 12 am and 2 am on 16 January 2004.

18. The first encounter was some time before 12:40 am and involved unit 419. Constables Stanley and Tilley recall an encounter with the deceased and two others in Priest Circuit. According to Tilley the members of the group were intoxicated but not so drunk that he considered taking them into protective custody. The group advised the police officers that they were heading for a relative's house only 50 m or so away. Stanley and Tilley allowed them to go on their way.

19. Tilley gave the following account of this initial encounter (transcript P.114):

> "So you pulled them up at that time, did they appear to you to be intoxicated at that time?---Yes.
>
> Did they appear to be carrying alcohol?---No. I don't have a recollection of them carrying alcohol in the first meeting.
>
> Did you actively consider whether or not to take them into protective custody?---We didn't and given what they told us about going three or four houses up the road to a relative's place and that was where they were going to stay the night we let them go in that direction.
>
> And where was that contact about?---That was in - I believe it was in Priest Circuit.
>
> All right?---And they indicated the - there's two houses, one at 122 and another 89 which are basically directly opposite each other and they indicated one of those houses that they

> were going to which are houses where the Aboriginals live. It's just well known.
>
> And what was the tenor of your dealings with them on that first occasion, were they happy and jovial?---Yes, they were fine, they were just being loud and boisterous and that was why we stopped and had a talk to them, walking up the road. They were obviously intoxicated just having a bit of yahoo walking up the street, we told them to be quiet and carry on and go home."

20. The second encounter between police and the deceased was around 1240 am and involved unit 420. Constables Fisher and Finch had just taken some drinkers into protective custody. They were en route to the Darwin Watchhouse when they encountered the deceased and his companions at the intersection of Victoria Drive and Priest Circuit. Constable Fisher reports that the group was loud and boisterous and testy and that they were unimpressed when she and Finch poured out their alcohol.

21. Constables Finch and Fisher both said in their taped interviews that they would have taken the deceased and his companions into protective custody then and there - however they considered it would not be safe to open the rear door of the police van.

22. Constable Fisher explained the decision as follows (transcript P. 75):

> "... it didn't take us long to realise that these fellows needed to be placed into protective custody. They were very - they were - like I said before just very worked up, very testy. I recall at one stage they - they moved a metre or so towards the back of the van, this stirred the ones that were back in the van, the three that we had from the Anglican Church, they just flared up straight away as soon as we got them anywhere near there. At one stage it passed through my mind to put these three in the back with the three that we had - were already in the van and it wasn't going to happen, we couldn't put them in there together.
>
> You think that would have created a dangerous situation?---Definitely."

23. I note that Constable Fisher refers in the above passage to there being three men in the relevant group. Her taped interview (within hours of the deceased's death) was to a similar effect. Fisher's partner Finch had the same recollection (both in his taped interview and in his evidence). The contemporaneous records tendered at the Inquest (the Computer Aided Dispatch or 'CAD' logs) - which Fisher and Finch accepted as reliable - suggest that they encountered four men on this occasion.

24. When questioned about the discrepancy each maintained that they recalled only three men. I accept that this is their recollection. I consider that the contemporaneous records are probably correct; however, nothing ultimately turns on the inconsistency.

25. Instead of detaining the deceased and his companions unit 420 headed for the Watchhouse and made radio contact with headquarters regarding the need for someone to deal with the deceased's group. Unit 419 attended the location shortly afterwards but the group had moved on.

26. The third encounter between the deceased's group and police involved unit 419. At about 1:23 am unit 419 was dispatched to a phone box at the intersection of the Victoria Drive and Priest Circuit. A "000" complaint had been received regarding a possible bashing on or near the Gray Primary School Oval. The complainants were two teenaged girls (Terri-Lee Kohler and Myria Demouilpied) and were waiting at the phone box.

27. Constables Tilley and Stanley arrived at the phone box at 1:33 am and took details from the two girls regarding what they had seen and heard. Whilst they were doing so, the deceased and his companions approached them. Constable Stanley described the group's arrival in the following terms (transcript P. 133):

> "... I could hear a lot of dogs going off in Priest Circuit and that was what first sort of brought to my attention that there was someone coming down the street. It wasn't until they got

> a bit closer where I could hear a lot of yelling and mainly junk and gibberish and then as soon as it was brought to my attention that there was three walking directly towards us, I sort of took a bit more notice and just basically intoxicated.
>
> Were they loud?---Very loud.
>
> Right, and how would you describe their mood at that time when they first approached you at the phone booth?---Very aggressive, loud, obnoxious, some of their language I couldn't understand. They were just very aggressive in nature. The way they walked, they were unsteady on their feet. Just the pitch of their voice.
>
> So you didn't take them to be happy or jovial, you took them to be aggressive from the very outset?---That's correct."

28. Constable Tilley's evidence was similarly to the effect that the deceased and his companions were noisy; however, he regarded their initial mood as "boisterous" rather than aggressive (transcript P. 116). In their taped interviews and in their oral evidence Tilley and Stanley each recalled that there were three men in the group.

29. They were firm in their recollections despite evidence suggesting that there were four. Myria Demouilpied recalled that there were four. Her companion Terri-Lee Kohler was uncertain whether there were three or four. A radio transmission apparently made by Tilley shortly after the encounter at the phone box also suggests there were four. Again I consider it more likely that there were four in the group; however, I again consider that the inconsistency is immaterial.

30. The deceased and his companions came right up to Tilley and Stanley and engaged them in conversation. Tilley was mainly involved in dealing with the deceased's group. Stanley was talking to the girls. Tilley was anxious to keep the group moving and to quieten them down. He seized from the deceased a one litre plastic milk bottle containing wine and poured it out.

31. According to Tilley at around this time the deceased became agitated. He gave the following evidence (transcript P. 116-117):

> "What happened after you tipped the alcohol out?---Well, I continued to tell them that they needed to go and it was still quite cordial at that stage and they were - they were dancing between us. I mean, I just continued to tell them that they needed to go away because we needed to deal with these two girls and to go to their relatives house wherever that was and after about a minute the deceased become - started to become agitated.
>
> And how did his agitation manifest itself?---Just in bodily movements. He become - he started to puff his chest out, he started to flex - flex his hands, form fists, started to stare me down. His verbal - his verbalisation become more aggressive - - -
>
> Such as?---A couple of times he told me he'd make me, he'd make me. He was trying and telling me that because he's from Groote he's allowed to drink and carry on like this and I told him that's unacceptable he needed to go.
>
> What happened then?---He - he advanced on me, one or two paces. I believed from his demeanour that he was about to strike me.
>
> And what did you do in response to that?---I - I punched him once in the chest area and took a couple of steps backwards.
>
> You punched him once in the chest area, was that the only contact you made with him?---It is.
>
> I think your partner, Stanley, his recollection is that you blocked him with one hand and then pushed him away or punched him away with the other, is that consistent with your recollection?---No I - I don't believe I blocked - I blocked in any way, it was just a reflex punch to create distance."

32. In his taped interview Tilley described the blow as less than a full force punch to the solar plexus. His aim was to create a safe distance between him and the deceased. I questioned Tilley about the amount of force used in the punch and he agreed that it was a "fairly forceful" blow designed not to harm the deceased but to make him move back (transcript P. 117).

33. Expert Police reports of Sergeant Raymond Murphy (exhibit 4 folio 11) and Sergeant John Pini (exhibit 2) were tendered at the hearing. Each observes (and I accept) that Tilley's decision to deploy force against the deceased and the manner in which he struck the deceased, were in accordance with proper and accepted Police procedure and training. In addition I consider that Tilley's response to the deceased's advance was appropriate in the circumstances.

34. Tilley described the events following the punch as follows:

> "What was his reaction when you struck that blow?---He immediately turned and ran off.
>
> THE CORONER: He backed away and then run off or what?---As I've - I've thrown the punch, it's connected, I've taken two steps back - one and a half, two steps back and he's just turned and taken off. Are there any sounds of shock of pain?---A grunt. Like a winded - a winded noise.
>
> Winded grunt noise?---Yeah.
>
> MR GRANT: Did you give chase?---I did, I - I chased the man 10 to 15 metres and by that stage he'd doubled my - my distance - doubled the distance between us and I - I gave up the chase to go back an deal - - -"

35. I asked Constable Tilley why he gave chase (transcript P. 118):

> Now why did you chase him? See it's not immediately apparent to me on the papers why you chase him having achieved your purpose of creating the space between him and you?---Yeah, instinct, I believe is one - one reason and I guess that the thought went through my mind that now I need to arrest this man now because of his behaviour. I'm not exactly sure why I chased him.
>
> That's the answer. You didn't really have any particular reason you just a punch there, he's grunted and you've chased him. Is that why you gave up?---I did. I gave up and thought well, he's gone I'm not going to catch him. I went back to the girls and dealt with that situation.

> So as an instinctive unpremeditated thing, you stepped after him without any real reason?---I beg your pardon?
>
> Without any real reason?---No. No, I - and once I seen the distance that he'd got on me over 10 or 15 metres I realised I was never going to catch him anyway.
>
> Was one of the reasons you stepped towards - you run after him was to give him another belt?---No, of course not.

36. Stanley's account of the punch and the events that followed is not materially different from Tilley's.

37. Terri-Lee Kohler and Myria Demouilpied gave accounts of the physical altercation between Tilley and the deceased that were inconsistent not only as between themselves but which differed in some respects from the police accounts. Terri-Lee recalled seeing the deceased strike Tilley twice to the head but did not recall seeing Tilley strike the deceased (transcript P. 45). Myria said she saw Tilley strike the deceased 'in the tummy' - she thought three times (transcript P. 37). Whilst I am satisfied that Myria and Terri-Lee did their best to provide honest accounts of what they saw I prefer the accounts of Tilley and Stanley, each of whom I regarded as candid and reliable witnesses.

38. Soon after Tilley returned to the phone box the deceased's companions left in the direction the deceased had gone. He and Stanley then ended up their discussion with the two girls who were told to go straight home. At about this time senior constable George Hatzismalis (Tilley and Stanley's supervisor) arrived at the phone box. Hatzismalis, Tilley and Stanley then conducted a search around the Gray Primary School oval in response to the girls' complaint.

39. Police computer records (exhibit 4 folio 32) reveal that at about 1:44 am Tilley and Stanley were patrolling the area behind Gray Primary School - placing the encounter at the phone box before that time.

40. I note here that Tilley, Stanley and Hatzismalis gave priority to investigating the matter reported to them by the two girls. There was the possibility that an assault had been committed and plainly this required immediate action. Were it not for the need to further investigate the girls' complaint there may well have been the opportunity for Tilley and Stanley to locate the deceased and place him in protective custody.

41. The precise movements of the deceased and his companions after the encounter at the phone box are unclear.

42. Police computer records show that an occupant of 122 Priest Circuit (a house located a few hundred metres from the phone box) complained to the police at around 1:45 am that three intoxicated males believed by the occupant to be from Groote had entered the yard. By 1:47 am the occupant reported that the three had left and were headed towards the Gray school. Unit 420 attended at the Priest Circuit house at 1:53 am (in response to the complaint) and spoke to one of the occupants, Victor Liddy. Mr Liddy gave Constables Finch and Fisher a description of the three men and described an altercation with one of the men in which Mr Liddy had a drink knocked out of his hand. From Mr Liddy's description Constables Finch and Fisher both had little doubt that the men were the deceased and his companions. In addition they believed from Mr Liddy's account that the man who had been in the altercation with Mr Liddy was the deceased.

43. Mr Liddy participated in a taped interview and gave evidence at the Inquest; however, he was heavily intoxicated on the night and had no clear recollection of the above incident. Daniel Mamarika's evidence was similarly affected by intoxication, although he dimly recalled a visit to a house in Priest Circuit.

44. I find on the balance of probabilities that following the encounter with Tilley and Stanley at the phone box the deceased and his companions briefly

visited the house at number 122 Priest Circuit. They had left the house by 147 am.

45. The evidence does not enable me to make conclusive findings on the precise course of events in the minutes following 1:47 am. Daniel Mamarika's various accounts of the moments shortly before his brother's death are inconsistent and incoherent (as might be expected given his heavy intoxication).

46. I am prepared to assume (from the events described below) that at some stage shortly after leaving 122 Priest Circuit the deceased collapsed. Whether his companions witnessed the collapse or found him afterwards is uncertain.

47. At 1:58 am Lesley Bowden made a '000' call. A transcript of the call was included in the Coronial File (exhibit 4 folio 28). Mr Bowden urgently requested that the ambulance service and police attend at the Moulden Shops; however it is clear from the events that followed that he made the call from the phone box in Victoria Drive.

48. At around 2 am Constables Tilley and Stanley had just completed their patrol near Gray School. They were driving along Victoria Drive in the vicinity of the phone box when they were flagged down by two highly distressed aboriginal men. The men drew their attention to the deceased who was lying on the road 100m or so from the phone box.

49. Constable Tilley gave the following evidence of what followed (transcript P. 120-121):

> Now so you stopped there and what did you observe?---The two males and the deceased laying in - laying on his back in the gutter.
>
> And what did you do?---Immediately checked for - for signs of life, breath, pulse and things like that and couldn’t find any.

What did you do then?---Me and Stanley immediately started CPR and EAR.

Did you put a call in?---I beg your pardon?

Did you put a call in?---Yes, called - as much as you can in that situation, your hands are pretty full. I let them know that we needed an ambulance and there was a male in full resuss.

THE CORONER: So what did you do, did you give this man - - -?---I did the compressions and Stanley did the breaths.

So Stanley's trying to blow - Constable Stanley's trying to blow air into the man's mouth?---Yes.

And you were pressing his lungs trying to get them to work?---Yes, and trying to do the radio at the same time to let them know that we needed an ambulance.

I want the family to understand what you were doing, that's all. That's why. He's in the gutter?---Yes.

You're on top of him trying to give him some first aid?---Yep.

The other officer's trying to give him first aid?---They turned up - I'm not too sure.

You're speaking into the radio on your shoulder?---Yep.

Calling for an ambulance?---Yep."

50. Very soon afterwards unit 420 arrived. They were just leaving 122 Priest Circuit when they heard Tilley calling for the ambulance. They were at the scene within a matter of minutes. Senior Constable Hatzismalis arrived on the scene soon afterwards. Tilley and Stanley, along with Finch and Fisher maintained resuscitation attempts until the ambulance arrived. Neither they nor the ambulance officers could resuscitate the deceased.

51. I briefly mention here that the Coronial File included transcripts of interviews with two young Aboriginal women, Kylie Stewart and Kerry-Anthia James (exhibit 4 folios 17 and 18), who reported seeing police officers sitting on and hitting the deceased as he lay on the ground. It is

plain to me, and it was accepted by all counsel (including Mr Holdsworth on behalf of the deceased's family) that Kylie and Kerry-Anthia were in fact observing the attempts of Constables Tilley, Stanley, Finch and Fisher to revive the deceased. In the circumstances neither was called to give evidence.

52. Whilst the members of units 419 and 420 were attending to the deceased there were three aboriginal men present: Daniel Mamarika (the deceased's brother), Lesley Bowden and Gordon Beasley. None of the Constables recalled having seen Mr Beasley in their earlier encounters with the deceased's group. Later all three were taken into protective custody.

53. The ambulance left the scene at 2:22 am and arrived at the Royal Darwin Hospital at 2:40 am. The deceased was pronounced dead at 2:59 am on 16 January 2004.

54. It was not suggested to me, and there is no evidence, that there was any shortcoming in the first aid administered by the constables or the paramedics. Instead they are to be commended for their efforts in what must have been extremely trying circumstances.

55. There is no evidence to suggest that the punch by Constable Tilley was a causally significant factor in the deceased's death, and on all the evidence I find that it did not.

56. An autopsy was commenced by Dr Sinton at 9 am on 16 January 2004. It was suspended shortly thereafter to enable a doctor to attend on behalf of the family. Dr Forrest attended at 2 pm and the autopsy proceeded. Reports by Dr Sinton (exhibit 4 folio 34) and Dr Forrest (exhibit 13) were tendered at the hearing. Toxicological tests of samples taken from the body of the deceased at autopsy reveal that the deceased had a high blood alcohol reading at the time of his death together with evidence of cannabis use; all

consistent with the assessment by witnesses of the demeanour of the deceased on the night of his death.

57. In his report dated 25 February 2004, Dr Sinton notes that the deceased had for some time been suffering from severe coronary artery disease and had recently suffered a severe heart attack. He found that the deceased died as a result of his longstanding coronary artery disease, the consequences of which were compounded by severe heart damage and acute aspiration of vomitus into the lungs.

58. Dr Marcus Ilton, a cardiologist who treated the deceased following a heart attack in April 2003, provided a report dated 25 November 2004 (exhibit 11).He notes that the deceased had severe heart disease. His right coronary artery was 80% blocked. The deceased required treatment in the nature of angioplasty (in effect to reopen the artery) but never had that treatment.

59. Dr Ilton commented as follows upon the likely effect of the deceased's physical exertion in the period shortly prior to his death:

> "When he exerted himself just prior to his death, it is quite possible he had insufficient blood flow through the circumflex artery to supply adequate oxygen to the heart muscle at the back and the lower portion of the heart resulting in myocardial ischaemia. Myocardial ischaemia results in the heart muscle not contracting adequately potentially leading to heart failure with build up of fluid in lungs and even further reduction in oxygen supply to the heart muscle. Also when the heart muscle at does not receive enough oxygen for its requirements, changes in heart rhythm (arrhythmias) frequently occur. Fast arrhythmias, such as VT/VF cause sudden death and slow rhythms may result in lots of consciousness and can degenerate into VF but can also result in heart failure. Certainly VF or VT could have explained his sudden collapse and subsequent death...
>
> It is difficult to ascertain how much exertion he experienced, but due to the degree of narrowing of his vessels, he was at significant risk of developing myocardial ischaemia with even fairly modest exertion with an associated risk of developing a

> fatal arrhythmia. The medication that he had been taking would not have been fully protective in this situation. The accumulation of fluid in the lungs as seen at autopsy is consistent with acute heart failure as a consequence of myocardial ischaemia with or without a change in heart rhythm."

60. Dr Ilton did not consider that the deceased's high level of intoxication was a factor that directly predisposed the deceased to heart failure; however, he did observe:

> "... Excess alcohol may have contributed to (the deceased) being less cooperative and agitated therefore leading to increase (sic.) heart rate and increased risk of myocardial ischaemia..."

61. Having regard to all the evidence I find that the deceased died as a result of heart failure. This resulted from a number of factors, most fundamentally the deceased's severe heart disease. The likely trigger for the deceased's heart failure was his brief but intense physical exertion when he ran away from the encounter at the phone box. I also consider that his generally elevated mood on the night (a direct consequence of his intoxication) is likely to have been a contributing factor.

62. As to the relevance of the deceased's various encounters with Constables Tilley, Stanley, Fisher and Finch I make the observations below.

63. It stands to reason that if the deceased had been taken into protective custody he may have lived; however, as events transpired, this just was not an option. On two occasions the competing responsibilities and priorities of the Constables meant that it was not possible for them to take the deceased into protective custody.

64. Also on those two occasions the deceased and his companions had alcohol in their possession seized and tipped out, first by Fisher and Finch and later by Tilley and Stanley. It is clearly possible, although I make no express finding, that the deceased's elevated mood in the hour or so leading up to his

death was contributed to by the seizure of alcohol that he otherwise intended drinking.

65. In confiscating the alcohol the constables were exercising powers under the Summary Offences Act, which relevantly provides:

> 45D. Drinking in a public place
>
> A person who, within 2 kilometres of premises licensed under Part III of the Liquor Act for the sale of liquor, drinks liquor in a public place or on unoccupied private land is...(subject to inapplicable exceptions)...guilty of an offence and the penalty for the offence is the forfeiture of the liquor seized under section 45H at the time of the commission of the offence.
>
> 45H.Powers of police officers
>
> (1) A member may, where he has reason to believe that an offence has been committed against section 45D... seize any opened or unopened cask, flask, bottle, can or other container in the possession of a person whom he believes to be contravening section 45D.
>
> (2) A member shall not seize an unopened cask, flask, bottle, can or other container under subsection (1) unless he has reason to believe it to be a source of liquor from which the person is likely to continue to drink on that or another place or land to which section 45D applies.
>
> (3) Where a member has seized a cask, flask, bottle, can or other container under subsection (1), the member shall -
>
> (a) in the case where the cask, flask, bottle, can or container is opened - immediately empty it, unless the member believes that doing so would provoke or incite a disturbance or disorderly behaviour; or
>
> (b) in the case-
>
> (i) where it is unopened; or
>
> (ii) where it is opened but the member has the belief referred to in paragraph (a),
>
> take the liquor, or cause it to be taken, to the police station to which the member is attached, where it shall be destroyed."

66. The following should be noted in respect of s45H:

> the seizure power under s. 45H(1) is not subject to any proviso to the effect that alcohol is not to be seized in circumstances where the officer believes that to do so would be provocative;
>
> such a belief is relevant only to the question whether the seized vessel is to be emptied 'on the spot' or returned to the police station for destruction (s. 45H(3));
>
> once alcohol is seized under s45H(1) it is seized forever - there is no mechanism for its eventual return.

67. It was not suggested to me, nor do I consider, that any action on the part of Tilley, or any of the constables, was outside the powers conferred by s. 45H. They had little choice but to seize the alcohol from the deceased and his companions.

A Death in Custody?

68. S. 15 of the Coroners Act relevantly provides:

> (1) Where a coroner has jurisdiction to investigate a death and either the body of the deceased person is in the Territory or it appears to the coroner that the death or the cause of the death occurred in the Territory, the coroner must hold an inquest if -
>
> (a) the deceased was, immediately before death, a person held in care and custody..."

69. By s. 12(1):

> "person held in custody" means -
>
> (a) a person in the custody or control of -
>
> (i) a member of the Police Force...
>
> and includes a person in the process of being taken into or escaping from -
>
> (c) the custody or control of a person referred to in paragraph (a);:

70. Applying those provisions to the facts as I have found them, the question arises whether, "immediately before" his death the deceased was a "person in the process of being taken into or escaping from" the "custody of a member of the Police Force".

71. I am satisfied that when the deceased ran away from the incident at the phone box he is likely to have thought that Constable Tilley was chasing him with a view to apprehending him. In the deceased's mind he was escaping the custody or control of Constable Tilley. Although Constable Tilley would undoubtedly have been entitled in all the circumstances to take the deceased into protective custody, his evidence was that he actually had no intention of detaining the deceased - the chase was an instinctive reaction on his part. If Tilley's state of mind governs the question then there was nothing for the deceased to escape.

72. I am inclined however to the view that the deceased's state of mind is the paramount consideration and that when he ran off he was therefore 'escaping' within the meaning of s. 12(1).

73. I do not, however, express a final view on that issue as I consider that the passage of time between the incident at the phone box and the deceased's collapse in Victoria Drive compel the conclusion that the deceased was no longer escaping 'immediately' before he died. I have found in that regard that there was a period of at least ten minutes between the incident at the phone box and the time the deceased collapsed. In that time he visited the house at 122 Priest Circuit before returning to the vicinity of the phone box. Neither act of the deceased suggests that he was still in the process of escaping any perceived threat of detention.

74. In the circumstances I find that the deceased was not, immediately before his death, a person held in custody.

75. It follows from this conclusion that I was not in fact obliged by s. 15(1)(a) to hold an inquest into the deceased's death - although, as I have already indicated, I would in any event have done so under s. 15(2).

76. Another consequence is that my investigation, reporting and recommendatory functions do not extend to the additional mandatory and discretionary matters set out in s. 26. As it happens, there are no matters in that section that I consider would have led to me making comments in addition to those set out below.

77. I should also emphasise that there can be no criticism of the decision by police to investigate the death on the basis that it was a death in custody. In terms of what was known at the time the investigation commenced (namely that the deceased had died shortly following a physical altercation with a police officer who had briefly chased him), that course was plainly appropriate.

78. Although for the foregoing reasons, the question whether the deceased's death was a death in custody is largely academic in the context of this inquiry, I note, and accept, the submission of Mr Grant on behalf of the Commissioner of Police, that the question has statistical significance.

Matters for Comment and/or Recommendation

79. I have considered whether having regard to the circumstances of the deceased's death I ought to make recommendations to the Attorney General regarding a review of the operation of s. 45H of the Summary Offences Act.

80. Despite my reservations about the seizure and destruction provisions (which seem to me to be inherently provocative and which, in their operation, particularly affect Aboriginal people), I do not consider that this is an occasion for me to make recommendations. If the operation of those provisions played any role in the deceased's death it was a remote and incidental role.

81. At the Inquest various concerns were raised on behalf of the family regarding the treatment of Daniel (the brother of the deceased) at and after the interview with Senior Sergeant Huysse.

82. It was suggested by Mr Holdsworth that an interpreter should have been made available to Daniel during Huysse's interview. He further submitted that I ought to consider making recommendations generally regarding the use of interpreters for remote area witnesses. For the reasons expressed earlier in these findings I do not consider that the absence of an interpreter materially disadvantaged Daniel in giving of his version of events to the Coronial Investigator. That being the case, this is not the occasion to make recommendations such as suggested by Mr Holdsworth.

83. Another concern was that Daniel had not at the time of the interview been told of his brother's death. Senior Sergeant Huysse gave the following evidence regarding this subject (t/c 19):

> "At the time of your interview with him did you know whether Daniel was aware that his brother had in fact died?--- At that stage no, sir, I didn't know.
>
> Had you been aware of that is that something that you would have told Daniel? ---Certainly not prior to the interview.
>
> Was there a reason for that?---It's sad but true but had I discussed the issue of the death I have no doubt that would have unduly upset him and really wouldn't have - - -
>
> THE CORONER: You wouldn't have got a record of interview out of him?---No, I couldn't have got it.
>
> So for forensic purposes you decided to tell him after the record of interview? ---That's correct, sir."

84. I accept that in the circumstances (an investigation of what then appeared to be a death in custody and was required as such to be investigated as a homicide) this was an appropriate approach.

85. There was also a concern on the family's part that appropriate arrangements were not made following the interview for transportation for Daniel to rejoin his family. Senior Sergeant Huysse candidly acknowledged that this was a shortcoming (t/c 19):

> "MR BRUXNER: In terms of your own dealings with Daniel that day at the interview and afterwards is there any aspect of those dealings that you yourself consider unsatisfactory from your own point of view?---In hindsight I should have made arrangements to have Daniel and the others taken back to Palmerston, arranged to uplift them because they were at Darwin City and I can only apologise to Daniel for that, I was fairly overwhelmed with work and it's something I really hadn't considered until later. Certainly should that situation exist again I would make arrangements ..."

86. I conclude by observing that this is a case study in the type of problems that sadly arise most nights on the streets of the main population centres of the Northern Territory. Although the tragic conclusion to the events of the early morning of 16 January 2004 was out of the ordinary, the pattern of behaviour leading up to his death was not.

87. In common with their colleagues of similar rank throughout the Territory, the routine policing duties of Constables Tilley, Stanley, Fisher and Finch involve spending a disproportionate amount of time attempting both to control and to safeguard individuals who are in an environment in which they are not used to. The deceased was just such an individual. He was a young adult from a remote community. He had been brought up in a culture that is in many respects alien to urban Australians. English was not his first language. He was extremely unwell with heart disease (although not visibly so). He was drunk and, along with his companions, was wandering around suburban streets at midnight causing disruption.

88. Constables Tilley, Stanley, Fisher and Finch did all that could be asked of them in their various encounters with the deceased (before and after his collapse). They are to be commended. It is nevertheless an extremely sorry

state of affairs that a sick young man a long way from home has died drunk in a gutter from heart failure.

Dated this 1st day of April 2005.

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GREG CAVANAGH
TERRITORY CORONER