CITATION: *Inquest into the death of Marcio Jose Lay Nheu* [2000] NTMC 50

TITLE OF COURT:	Coroner's Court (NT)
JURISDICTION:	Coroners
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DELIVERED AT:	Darwin
FINDING OF:	Mr G Cavanagh

CATCHWORDS:

Death in Custody, belief as to crime committed, Hospital procedures, liason between Police and Hospital staff.

REPRESENTATION:

Counsel:

Assisting:	Mr J Tippet
NT Police Service & NT Health:	Mr D Farquhar
Family of Mr Nheu:	Mr P Elliott

Solicitors:

NT Police Service & NT Health	Cridlands
Family of Mr Nheu:	Mr Ray Minahan

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

No. 9915706
87/99

In the matter of an Inquest into the death of

MARCIO JOSE LAY NHEU

FINDINGS

(Delivered 1 November 2000)

Mr Cavanagh SM

THE NATURE AND SCOPE OF THE INQUEST

1. Mario Nheu was declared brain dead at 1015 hrs on 7 July 1999. He remained on a ventilator at the Royal Darwin Hospital until his heart stopped at 1625hrs on the same day. His death was certified by Dr Riddel the attending surgeon. Macio Nheu was born in East Timor on 4 March 1973. He was 26 years old when he died.

2. On the evening of 5 July 1999 the deceased was apprehended by police in the immediate vicinity of the Karama Tavern. The apprehension took place shortly after he had received a blow to the head and had fallen striking his head on the ground. He was taken into police custody and transferred to the Royal Darwin Hospital. There he was attended to until he was discharged once more into police custody. He was returned

to the Berrimah Police Complex and placed in the cells. At 6.49am on the following morning the deceased was observed not to be breathing.

3. By virtue of the fact that the deceased had been in police custody immediately before being transported to the hospital, where death was later certified, the death in this matter became a death "in custody" within the definition of that term in Section 12(1) of the **Coroners Act** *(*"the Act"). The death is required to be investigated by the Coroner pursuant to Section 14(2) of the Act and a public inquest must be held. This Inquest is also governed by the provisions of Sections 26,27,34 and 35 of the Act.

4. This public Inquest commenced at Darwin on 6 June 2000 and concluded on 8 June 2000. Counsel assisting me was Mr Jon Tippett. Mr Tippett was appointed by me pursuant to Section 41 (2)(b) of the Act. Mr David Farquar was granted leave to appear for the Northern Territory of Australia and the Commissioner of Police. The family of the deceased was represented by Mr Peter Elliott. A representative of the family was present throughout the Inquest.

5. At the Inquest I received extensive documentary evidence which included an exhaustive report by Detective Sergeant Roger Newman, statements of 32 witnesses, the deceased's hospital file, Watch House Log, Offender Journal, transcripts of emergency transmissions, Report on Autopsy, Pathology and Toxicology report, video taped re-enactments and a collection of Section 8 Reports made pursuant to the provisions of the *Poisonous and Dangerous Drugs Act* relating to the deceased's use of prescription medication prior to his death.

CORONERS FORMAL FINDINGS

6. Pursuant to Section 34 of the Act, and upon the evidence adduced at the Inquest I find as follows:

7. The identity of the deceased person was Marcio Jose Lay Nheu, a male, born 4 March 1973 in East Timor.

8. The time and place of death was at Royal Darwin Hospital at 4.25pm on 7 July 1999.

9. The cause of death was closed head injury. The mechanism of death was extra dural haemorrhage arising from a fracture of the skull. The deceased had received a blow with a torch over the left parietal occipital region of the skull that resulted in bruising and haematoma. The deceased lapsed into unconsciousness and emergency surgical procedures designed to evacuate the haematoma were unsuccessful. The result was irreversible brain damage leading to brain death.

10. The particulars required to register the death are:

11. The deceased was a male.

12. The deceased was of East Timorese ethnic Chinese origin

13. The cause of death was reported to the coroner

14. The cause of death was confirmed by post-mortem examination

15. The cause of death was closed head injury leading to extra-dural and sub-dural haemorrhage

16. The pathologist viewed the body after death

17. The father of the deceased was Jose Nheu

18. The usual address of the deceased was 20 Mahogany Crescent Darwin Northern Territory

19. The deceased did not have an occupation at the time of death

RELEVANT CIRCUMSTANCES CONCERNING DEATH INCLUDING REPORTS AND RECOMMENDATIONS

The Background of the Deceased Person

20. Marcio Nheu ("the deceased") was born in East Timor. He and the rest of the family which included three brothers migrated to Australia in 1994. His father Jose Nheu had been a consular liaison official to East Timor. The family initially settled in Melbourne and later moved to Darwin in 1996. The deceased remained behind although over the years prior to his death he made regular trips to Darwin to visit the other members of the family. Those trips usually resulted in him staying in Darwin for periods of about two months. The deceased returned to Darwin in September of 1998 and remained there until his death.

21. It would appear that in the period he was living away from his family, the deceased became an habitual user of prescription drugs and possibly illicit drugs. According to his father the deceased's problems with drugs began in Melbourne in about 1995. In Darwin that habit continued. Reports from the Northern Territory Poison Centre show that between 1/9/98 and 5/7/99 he had attended upon numerous medical practitioners in Darwin and obtained prescriptions for such drugs as, MS Contin, Temazapam, Euhypnos, Diazapam and Rohypnol. The fact the deceased was unemployed at the time of his death is likely to have been directly related to his dependance on drugs.

Conduct of the Deceased Prior to the Events at Karama Shopping Centre

22. On the morning of Monday 5th July 1999 the deceased visited the residence of a friend, Ronnie Fraser. While there he stole one of Fraser's old prescriptions for Temazapam. The deceased then went to the Winnellie Newsagency at between 11.00am and 12.00pm where he attempted to alter the prescription so that he could recover the medication for himself. That was done openly in front of Newsagency staff. It would appear from his actions the deceased may well have been affected by drugs at that time.

23. The deceased then went next door to the Winnellie Pharmacy were he tried to pass the altered script to obtain drugs. The Pharmacy staff had been forewarned that he would attempt to use the forged prescription and upon its presentation refused to fill it out and contacted police. At about 1.30pm Detective Senior Constable Rob Gordon and Detective Senior Constable Juanita Harris from the Drug Enforcement Unit

attended at the Winnellie Shopping Centre. Initially they could not locate the deceased. Then they were advised that a man known to Newsagency staff had walked into the nearby toilets. The police entered the toilets where they encountered the deceased. The police walked him into the car park at which point he was searched. A small amount of cannabis, five syringes, three swabs and another prescription for Temazapam was found on his person. The deceased was also found to be in possession of a "demonstrator bottle" of aftershave. Police ascertained the aftershave was from the Pharmacy and after speaking to staff at that premises determined that no charges would be pressed.

24. The police officers reached the opinion that the deceased needed to go through "detox". An infringement notice was given to the deceased for the possession of cannabis and a police unit was arranged to convey the deceased to the detoxification centre at the Sobering Up Shelter on Dick Ward Drive. He was dropped of at that establishment by police and placed in the hands of a staff member, Michael Wallace. The deceased was known to staff at the shelter. The police left and began driving into the city. Shortly afterwards they were contacted by shelter staff and advised that the deceased had left the shelter. Officers Harris and Gordon then retraced their route to Nightcliff.

25. They found the deceased walking along Bagot Road. After conversing with him, he requested that the officers take him to a telephone box so that he could make a telephone call. After assessing the situation officers Harris and Gordon decided that the best thing to do would be to take him home to his father's residence. They drove the deceased to 20 Mahogany Crescent and dropped him off there at 3.16pm.

26. The deceased spoke to his father who was home when the police delivered the deceased to the premises. The deceased then left the family home and went to the Karama Shopping Centre where he presented a legitimate prescription for 40 Temazapam at the pharmacy, Karama Chem-Mart. He only purchased half the script (20 tablets) as he did not have enough money to buy all 40 capsules. Later the deceased borrowed money from friends he met at the shopping centre and purchased the other half of the prescription.

27. The prescription that deceased had filled out on that occasion had been issued by Dr Penaloza on 11 April 1999 from his Trower Road Surgery.

Incident at Karama Shopping Centre

28. What occurred in the period between dispensing of the Temazapam and when next the deceased's behaviour came to the attention of other persons cannot be found in the evidence.

29. The evidence does, however, support the conclusion that he was probably under the influence of prescription drugs when he was observed some time prior to 6.50pm in the vicinity of the Karama Tavern. The Toxicology report of Senior Forensic Scientist Peter Harpas shows that the deceased's blood contained 2.7mg/L Temazapam; No other drugs such as alcohol, amphetamines, morphine or other common drugs were detected in his blood.

30. At 5.45pm Mr Chris Inskip, a patron of the Karama Tavern, was in the toilet of the tavern when the deceased abused him and took up a fighting pose described by Mr Inskip as a "Jackie Chan" pose. Mr Inskip left the toilets and reported the matter to the manager of the

Tavern, Mr Steven Pocock. At about 6.30pm the deceased again used the toilets. On that occasion Mr Pocock was cleaning the toilets. He left while the deceased used them. Upon his return Mr Pocock found the toilet in a mess. There was blood on the walls, floor, cubicle, sink and doors. There were also wads of paper with blood on them and several empty capsules on the floor. The empty capsules had most likely contained Temazapam, however they were not recovered as Mr Pocock put them in the rubbish bin.

31. A security guard Paul Ross whose statement to police was received into evidence but who was unavailable to give evidence at the Inquest located the deceased and brought him to see Mr Pocock. Pocock then warned him off the premises.

32. A short time later the deceased was seen in the bottle shop area of the Karama Tavern where he engaged in strange and aggressive behaviour. Mr Stephen White, the bottle shop attendant at the time, gave evidence that having observed the behaviour of the deceased he locked himself in the cool room of the bottle shop. Mr White described the behaviour he witnessed as *"disturbed"*. He said that the deceased was *"obviously suffering from something - he was bizarre"*, the behaviour was *"erratic"* and *"emotional"*. Mr White went on to say *"Well I was worried for my safety, basically"*. I had an opportunity to observe Mr White who presented as an apparently physically strong and well built person. The behaviour he saw included, amongst other things, the deceased kicking over signs and throwing signs into the bushes. White called Paul Ross the security guard on a walkie talkie. Although the deceased was quite a small person the fact that *" he looked (to White)*

like he was ready to go off his nut" caused White to take the somewhat extraordinary action of locking himself in the coolroom.

33. As a result of the radio call to Ross made by White, Pocock and Ross located the deceased at the Karama Newsagency. From there they escorted him to the front area of the shops. It was at that point the incident which resulted in the attendance of police and the deceased's eventual hospitalisation began. Pocock advised the deceased that he was not allowed onto the premises of the Karama Tavern in future. the deceased then *"got agro"*

34. Mr Pocock gave evidence at the Inquest. He told of how the deceased had walked in front of he and Ross to the main entrance doors of the shopping centre. Once there the deceased had a conversation with the two men about being banned from the Karama Tavern. During that conversation Mr Pocock said the deceased *"pulled out a syring of blood and pointed it at the security guard and himself*" and said *"you want some of this"*. In his statement to police Mr Pocock said the deceased *"pulled a wallet out of his pocket of his tracksuit pants and opened it up and produced a syringe, drew the syringe and pointed it at the security guard"*. Pocock told Ross to keep his distance while Pocock went off to ring the police. Pocock gave evidence that he returned to the saloon bar of the hotel to use the telephone when the security guard came in through the door followed by the deceased *"with the needle out"*. Mr Pocock then ran through to the office and rang the police. Mr Pocock said he *"feared for his life with the needles"*.

35. The transcript of the emergency telephone call between the police operator and Pocock has Mr Pocock advising that the deceased *"Just followed myself and the security guard in asking us if we wanted some of what he's got in his syringe whatever it is"*. He went on to describe the deceased as an *"Asian with black track pants, and a white & singlet"*.

36. After speaking to police Pocock went outside and observed the deceased walking up the footpath towards a take-away food outlet, "Red Rooster". At that point Pocock told the security guard to follow the deceased and he waited at the entrance of the shopping centre for the police to arrive. The deceased, with Ross a short distance behind him, then went around a corner, out of his sight.

37. It is apparent from the evidence that the deceased and the security guard walked to a position in the vicinity of a video store. A conversation took place there that was overheard by witnesses Jeanette Speirs and her partner Mr Jesper Maansson. They drove their vehicle into the parking bay in which the deceased was standing as he spoke to Ross. Those witnesses did not give evidence in the Inquiry as Ms Speirs was expecting her first child at any minute. However they gave detailed statements to police which formed part of Exhibit 1, the coronial file.

38. Ms Spiers had been a security officer at the MGM Casino. She said the conversation between the deceased and Ross was acrimonious. She told police, *"The security guard was you know, telling him (Nheu) oh fuck off you Asian piece of shit ... you know, being racist and egging him on to hit him, fight him"*. She described the attitude of the "Asian guy" as

one of not wanting any trouble *"but he wouldn't leave"*. She said the security guard was *"pushing up against him (Nheu) and "bumping him with his chest, sort of thing"*. Spiers went on to tell police (the security guard) *"you know saying that he was going to flog him and he was gonna hit him and kill him and all sorts of stuff and the little Asian goes, I haven't done anything, you know I'm just a little bloke, you know I can't do any harm to you, youse are big blokes..."*. She did not see any blow delivered to the deceased. Her description of the conversation between the deceased and Ross is of a far more acrimonious and insulting nature than that attested to by Pocock or Ross in his statement to police. Ross did not give evidence at the Inquiry. I was advised by my Counsel Assisting that efforts had been made to serve him with a subpoena but that he had left the Territory and could not be found. Later the same day he did make a statement to Constable Des Green. I accept the version of the conversation as relayed to police by Ms Spiers.

39. I find that the security officer Ross acted in a provocative and belligerent manner towards the deceased shortly before the deceased was injured. That fact may explain to some extent the behaviour of the deceased both earlier in the area of the bottle shop and later during the confrontation he had with Ross outside the video store. The police officers' Harris and Gordon who had dealings with the deceased earlier in the day described his behaviour as quiet and polite.

40. Spiers described to police another male coming to assist the security guard. That person, on the evidence, was Rodney Paul Foster. Foster did not make a detailed statement to police on the advice of his solicitor. He was called to give evidence at the Inquiry before me but

declined to answer any questions about the incident on the basis that any answers might tend to incriminate him. The evidence suggested that the crime of "dangerous act", contrary to the provisions of Section 154 of the **Criminal Code Act**, may have been committed by Forster in striking the deceased with the Maglite torch in the fashion and with the force described by witnesses. I was therefore bound by the provisions of Section 38 of the **Coroners Act** which precludes me from compelling a witness from answering any questions that may tend to incriminate that person. After giving his name, address and occupation Mr Foster indicated he did not wish to answer any further questions, consequently I excused him from giving further evidence.

41. I am not able to determine therefore what intentions Mr Foster had in mind while he was in the company of Ross. Nor can I determine how he came to be in the vicinity and whether or not he had previously spoken to the deceased.

42. In his typed statement to police Ross said "*Rod Foster then approached me and asked what was going on. I told Rod to hang onto my torch as I thought it might get in the way if I had to defend myself. Rod took my torch."*

43. Ross told police in his statement that the deceased ignored a direction given to him by Ross in terms of *"Get your fucking hand out of the bag"*. He stated to police, the deceased then lunged at him with a syringe in his hand. "*Rod then approached from behind and struck Nheu on the back of the head with my torch. Nheu fell to the ground. The syringe was still in his hand so I took the torch from Rod and*

carried the needle away. Nheu was still on the ground, then grabbed another syringe from his bum bag. I carried it away also."

44. Other eye witnesses to the incident included Mr Brian Weatherall. He had arrived in the area to go to the bank. He was a non drinker and I found him an impressive witness. Mr Weatherall also engaged in a video re-enactment of the incident conducted by Detective Sergeant Roger Newman. He told me that the blow delivered to the deceased was "*a full swing with a torch, full blow, two hands.* He saw a man come *out through the carpark, behind some trees, and just run straight towards the back of him (the deceased) when he (Nheu) wasn't facing him."* Mr Weatherall told police the deceased just "*fell flat"* after he was hit, he fell straight down "*like a dead weight next to the cement pathway onto the bitumen and his head bounced"*. He saw the deceased hit the side of his head on the ground. The sound of the torch striking the deceased "*made a real big thud"*. He said "*that there was no need that he could see for such a blow to be delivered"* . At the time the deceased was struck he had his hands down by his sides and "h*e didn't threaten anyone"*. After the blow had been struck Mr Weatherall told me "*I heard the bloke that hit him over the head (say) 'Stand back', you know, 'he's got needles on him', or something."* Immediately afterwards he observed a security guard come up and take the torch from the other security guard and then remove two syringes from the right and left hands of the deceased.

45. Another eye witness, Carolyn Reynolds described what she considered to be a "baton" being wielded by the person who struck the deceased. As events unfolded she at first believed she was witnessing a *"drug bust"*. She said the deceased was hit with *"significant force*" and that

at the time he was not doing anything she could observe to attract the administration of the blow. After Mr Nheu fell to the ground as a result of the blow she saw "*a syringe roll from the gentleman's hand"*. She went on to say that "*I didn't think it was safe for me to go and offer first aid with needles and things there ... and the concern that these gentlemen had for getting these needles led me to believe that it could have put my life in danger, so I didn't proceed."*

46. I accept the evidence of the eye witnesses as people who were endeavouring to describe as accurately as they could the observations they made of the deceased being struck by Mr Foster. The blow was a sickening blow delivered with great force. At the time of its delivery the evidence supports the conclusion that the deceased was not actively threatening the security officer, Ross. However it is clear that Foster was aware of potential danger from the needles. It is also clear that the deceased had at least one and probably two syringes in his hands which he had retrieved from his bum bag before the incident.

47. While Mr Foster did not give evidence he did make a statement to police in which he said "w*hen I hit the Asian with the torch I really believed he was going to stab Paul with the syringe, and intervened only to stop this happening. I did not want to hurt him, I just wanted him to drop the syringe. I don't think I hit him too hard but when he fell he hit the corner of his head on the ground which caused a cut to his right eye".*

48. As I have remarked earlier I did not have the advantage of Mr Foster giving evidence before me and I am not therefore in a position to assess what weight should give to the assertions made by him to police.

49. I find that the deceased was struck heavily to the left side of the head by a Maglite torch wielded with both hands by Mr Foster who had quickly run from behind and to the left of the deceased to deliver the blow. I find that the blow caused the deceased to fall to the ground probably striking his forehead on the concrete curbing as he did so.

50. I find that the force of the blow and the manner in which it was administered was such as to be likely to cause death or serious injury to the deceased. I further find that the deceased was not engaging in any acts that were an immediate threat to the safety or well being of any other person at the time the blow was delivered.

51. Having regard to the findings I have made I have concluded that a crime may have been committed in connection with the death of Marcio Nheu and in accordance with my duties as set out in Section 35 (2) of the **Coroners Act** and I propose to make a report to the Director of Public Prosecutions and the Commissioner of Police.

52. Police Constables Kerry Harris and Desmond Green arrived at the scene at approximately 6.50pm. They found the deceased squatting on the ground in an Asian squat. They saw a blood filled syringe about 8 feet away from where the deceased was positioned. Constable Harris had dealt with the deceased in the past and had some concerns about his state "*especially if there was blood involved*". An ambulance was called. The ambulance records show that St Johns Officers Saunders and Dowson attended to the deceased at 7.50pm and that after the service had been called they took only 14 minutes to arrive at the scene. The time given by Constable Harris of his arrival is likely to be

incorrect as police immediately called for an ambulance as soon as they arrived.

53. Ambulance officer Virginia Dowson gave evidence that upon her arrival she was told by a security person there*," he'd (Mr Nheu) been hit with a torch above the right eye. We were advised that this patient could become violent, that's why he was already secured in the back of the paddy wagon"*. The deceased was conveyed to the Royal Darwin Hospital in the police vehicle. The ambulance drove behind the police vehicle to maintain observation of the deceased while he was conveyed to hospital. The trip to the hospital took approximately seven minutes. The ambulance had radioed ahead to advise hospital staff of the injuries the patient had sustained and of the fact that the ambulance officers had been precluded from carrying out a full assessment of the deceased.

The First Admission to Royal Darwin Hospital

54. The Royal Darwin Hospital notes show that the deceased arrived there for his first admission at 8.12pm. He was greeted by the triage nurse, Sandra Head. She gave evidence at the Inquest that she had been advised prior to his arrival that the deceased had been threatening people with a blood filled syringe and that he had suffered a hit to the head. She triaged the deceased as a category three(3). A category three, she explained, describes a patient who needs to be seen urgently, that is within 30 minutes. A memorandum compiled by Ms Marienne Shanahan and directed to Ms Robyn Cook of Legal Services Territory Health Service states that *"Patients who are triaged as category 3 are for people who usually have complicated and potentially serious medical conditions that require much time and skill to examine,*

diagnose and treat. Ideally these patients should have one nurse and one doctor to attend to them."

55. After the deceased arrived he was placed in a wheelchair. That procedure is used when the patient is at risk of being aggressive. The chair prevents such patients from hitting out or kicking. When nurse Head first saw the deceased he was hitting the side of the police van in what appeared to her to be some form of agitation. The police gave nursing staff a brown bag which contained a broken bottle of Temazapam 200milligram that was supposed to contain 20 tablets. Nurse Head counted only 11 in the bottle. She said there was a query whether he might have overdosed on the Temazapam but they did not have any proof at that stage.

56. A history was taken on presentation. It reads "*was at pub in toilet - IVDU, walked out and shoot blood into air over heads of people - punched in head"*. It can be readily seen that the history taken was quite inaccurate. Precisely what led to such an inaccurate history being taken is not clear. It is of significance to contrast the hand written history with the typed note of Nurse Head which reads *" DID POLICE AND AMBULANCE. HIT WITH TORCH OVER R EYE, POST THREATENING SECURITY WITH BLOOD FILLED SYRINGE. ? OD*

57. The deceased was referred to Dr Charles Ellis for treatment. Dr Ellis completed his medical degree at Monash University in 1995. He became a Registered Medical Officer class 2 at the Royal Darwin Hospital in January 1997. In January of the following year he appointed as a RMO 3. At the time the deceased became his patient he was

working in Accident and Emergency. That department had a specialist on duty at all times. On the 5th of July 1999 the specialist was Dr Gregory Treston an emergency physician.

58. Both Dr Ellis and Dr Treston gave evidence before the Inquiry. Dr Ellis told police that he became involved with the deceased as a result of hearing some loud verbalising coming from one of the cubicles, he looked at the computer and saw the deceased was next and so he decided to go in and see what was happening. Dr Ellis then examined the deceased and noted, "*laceration above R brow, bruising and haematoma over L parietal region. Obs stable"*. He said he had "*a feel of it (the left parietal region) but got like felt boggy sort of squashy*. He carried out the initial assessment next to the cubicles however Dr Ellis said the deceased became more drowsy, "s*o I got concerned and took him to the resuscitation area of the emergency department.* That evidence appeared to differ from the explanation that he first gave to police as to how he came to see the deceased. However, no point was made regarding it during the proceedings. In the resuscitation area he took blood form the deceased's leg by the insertion of an intravenous cannula. Initially he rated the deceased at level 12 on the Glasgow Coma Scale. That scale I was told is an indicator of neurological function and the possible presence of a closed head injury. Dr Ellis said that prior to the deceased's discharge his score on that scale had risen to 15. The doctor interpreted that score to mean "*everything is at the higher limits. I mean everything is normal....*" Dr Ellis had been told that the deceased may have taken up to 11 Temazapam tablets.

59. Shortly after placing the deceased in the emergency area of the department Dr Ellis approached Dr Treston in the corridor of the

Accident and Emergency Department and said "*I need to speak to you about this guy"*. At that time Dr Ellis said he was concerned that he might be injured by being jabbed with a needle should he try and suture the wound over the deceased's right eye due to the fact that the deceased was being unco-operative. He asked Dr Treston if he could glue the laceration. The deceased was known to medical staff as having tested positive for Hepatitis C. He said he could not remember if he asked Dr Treston to look at the bruising and swelling to the left side of the deceased's head. He said in evidence that he did not speak to the deceased about the injury to the parietal region of his head. However Dr Elliot said he did know, when treating the deceased, that the head injuries he saw were the result of his patient being struck by a Maglite. I received the torch that struck the deceased into evidence. It is a heavy instrument. Dr Ellis appeared to know what a Maglite torch was. The doctor said he was unaware that the deceased had fallen and cracked his head on the footpath.

60. Dr Ellis told me that he spent some 40 to 50 minutes with the deceased "*on and off"*. He did not carry out any x-ray or CAT scan. He explained that the reason for not doing so lay in the fact that x-rays are unreliable (a view supported by the emergency specialist Dr Treston) in detecting injuries to the head. He went on to say that he wouldn't do one "*because that is what I have been told."*

61. Dr Treston is a specialist in emergency medicine. He told the Inquiry that a CAT scan would only be ordered in relation to a suspected head injury if the patient's level of consciousness had deteriorated, or if he failed to improve. He did not think a CAT scan should necessarily have been ordered, looking at the circumstances in retrospect, as the deceased's conscious state had improved. It is apparent on the

evidence, to which I will shortly advert, that the deceased may have shown a change for the better in the Glasgow Coma Scale(GCS). However it is very doubtful if it could be said that he had improved to the point where it was prudent of hospital staff to take the step of discharging him.

62. Dr Ellis agreed in cross-examination that the fact the deceased had a GCS score of 15 did not mean anything in relation to the diagnosis of serious head injury. Dr Treston the specialist said that a low GCS was significant as possibly indicative of head injury while a score of 15 was very reassuring. On discharge Dr Ellis said the deceased looked unwell "*but not like he initially came in"*. When he was discharged his face was quite pale and he left the Accident and Emergency department in a wheelchair. Quite how the deceased had left "*not like he initially came in"* I am unable to determine on the evidence.

The Discharge of Marcio Nheu from Royal Darwin Hospital

63. How the decision to discharge the deceased came about, and the criteria applied to it, is not altogether clear. Dr Ellis told me that it surprised him a little bit that Dr Treston said "*you can sew that(eye laceration) up and he can go"*. Although the doctor thought the deceased remained unwell and that it was his usual practice to keep persons with head injuries under observation for 4 hours he did not express any concerns to Dr Treston in his surprise. The reason for not doing so he said was basically "*a pecking order thing"*. Further he said "*I told him everything that I knew and if he is of the opinion that the person is safe to go home, then I mean he has had a lot more experience than me, so I'm happy with his opinion"*. Later Dr Ellis said "*I just felt comfortable with the fact that he(Treston) thought the person was safe to go home"*.

64. Dr Treston on the other hand told me that "*Dr Ellis is the registrar... and he sees the patient, takes a history, and then if he's got a problem or a question he needs advice on, he will come and discuss it with me*". He said that "m*y recollection of what occurred was if his eyebrow is sutured up, if his GCS improves, if he's able to go somewhere with responsible people to look after him, then he can go*". His evidence was that as Dr Ellis was the treating doctor and the decision to discharge would be his. Dr Treston told me that he did not authorise the discharge of the deceased. He was asked to attend to the deceased's injury to his right eye by giving advice as to whether it could be glued. He said "*that if his attention had been drawn to a boggy sort of squashy area in the parietal region he would have paid close attention to it*". While Dr Ellis said in evidence that he was surprised by the fact Treston was prepared to discharge the deceased, Dr Treston described the situation in the following terms;

> *"I guess I'm surprised at that (the deceased's state of well being on discharge) because I would've thought that if he (Dr Ellis) had a problem, he would've then just come back to me and said did I think this guy is unwell".*

65. I found Dr Treston to be a reliable witness and I accept his evidence where that evidence may differ from the evidence given by Dr Ellis. I find Dr Treston was not asked by Dr Ellis to examine the deceased's injury to the left parietal region. I find that Dr Treston was not consulted by Dr Ellis in relation to whether the deceased was well enough to be discharged and that he did not authorise the discharge.

66. The Royal Darwin Hospital contacted police and advised that the deceased was able to be collected from the hospital by them. Senior

Constable Michael Moss and Sergeant Keith Glaister drove to the hospital. Constable Moss noted in his note book that he arrested the deceased at the hospital at 9.30pm and from that estimated that he and Glaister had arrived at between 9.05 and 9.15pm.

67. Not long after their arrival Constable Moss queried hospital staff if the deceased was fit to leave. He told me he had the feeling that the deceased should not have been going into police custody. A number of his observations contained in his statement to Detective Sergeant Newman bear repeating and I have set them out below.

> *"1. I wasn't too happy about taking him in his state. He didn't, he seemed to have deteriorated as in, I tried to have a conversation with him, asked him if, trying to establish if he understood what was going on, where he was and what was happening, because at that point I actually arrested him. I didn't get a good response from him at all. I just identified myself to him and asked if he understood what was going on and what was his name. There was no acknowledgement there at all. I got his name off the hospital records and his date of birth. He needed to be assisted off the trolley and into a wheelchair and taken out to our car.*
>
> *2. I know I expressed concerns about him coming into our custody but the hospital assured us that he was right to go.*
>
> *3. We didn't want him in our custody because of his medical condition*
>
> *4. The biggest thing that stood out to me was that he was not comprehending.*
>
> *5. I carried out another Section 140 on him advising him he was under arrest... but all he could really say was that he wanted to go to sleep."*

68. It is clear from the excerpts I have taken from his evidence, as set out in the statement, the police had genuine fears for the deceased's well-

being. I conclude from the observations of police and the evidence of Dr Ellis that the deceased continued to be disorientated, unresponsive and obviously unwell at the time of his discharge from the hospital. I find that the deceased's condition was such that he should not have been discharged into the custody of police. I am reinforced in my conclusion by Dr Ellis's own view that ordinarily he would have kept a patient exhibiting symptoms like those displayed by the deceased under observation for at least 4 hours. Dr Ellis told the Inquiry "*I probably would have kept him longer".* Why he did not do so is difficult to understand. I am told that the deceased was not discharged because of lack of facilities or under staffing at the hospital. Indeed Dr Ellis told the Inquest that he had sufficient time to deal with his patient.

69. Once the deceased had been transferred to the waiting police vehicle Constable Moss noticed that he had a bandage on his leg. As a result of that observation Moss stated "*I asked people what that was and they said Oh he still had a drip pug in him, so they went and got a nurse, took the drip plug out and I expressed concerns then that we did not want him in our custody"*

70. Constable Moss went on to say, *"While the cannula was being removed the nursing staff were giving the him (Nheu) instructions on when they were straightening the leg out, but he didn't seem to be able to comprehend".*

71. Dr Ellis recalled that incident in the following terms:

> "Just after he'd left I started writing my notes and all of a sudden I realised that he still had the cannula inside, so I raced out to tell them, and the nurse who was there, said it was alright, I've already taken it out".

72. I was told that the Accident and Emergency Department was busy, as it usually is, on the evening the deceased was admitted, however as I have already pointed out there was no complaint about the time that was available to properly attend to the deceased. The cannula incident leaves me with the impression that the deceased may not have been as carefully reviewed prior to discharge as should have been the case.

The Deceased's Custody at the Berrimah Police Complex

73. Officers Moss and Glaister drove carefully back to the Berrimah Police Complex. They observed that throughout the trip the deceased was sitting up in the back of the van. On arrival the deceased got down from the van and walked into the cells without assistance. He was received into the Watch House at 10.22pm on 5 July by Auxillary Donaldson. Constable Moss told the Watch House Keeper what he knew of the situation. Constable Moss as I have already mentioned carried out another Section 140 (**Police Administration Act**). The deceased did not say anything "*all he could really say was that he wanted to go to sleep"*.

74. At the Watch House Constable Moss chose to investigate the background to the deceased coming into police custody. He read statements taken from witness*es* to the earlier events at the Karama Tavern and outside the video shop. He found that the deceased had been hit with a Maglite torch and he relayed that information to Watch House staff. He told the Inquiry that he related the drowsiness he observed in the deceased at the Watch House as possibly being connected to a head injury. Constable Moss also said in evidence that it was his experience having dealt on a number of occasions with

people in a similar condition to the deceased that such persons are usually kept *"appreciably longer"* in the hospital than was the deceased.

75. Auxiliary Donaldson gave a lengthy and detailed statement to investigating officers that was admitted into evidence before me. She said the deceased appeared to her to be very intoxicated by a drug because she could not smell any alcohol on him. She tried to ask him a few questions but he was non responsive. While the deceased was in the Watch House receiving area he kept saying he was cold and moaning. His nose also started to bleed at the counter. She recorded in the offender journal that she had been informed the deceased had been hit on the head and she tried to ascertain how hard the blow was. Donaldson then contacted the Watch Commander to attend in the cell area because "*we had received this person into custody who was in a bit of a bad way"*.

76. The deceased was placed in male cell number 6. He was searched and a Detention Assessment Screen was administered. The results of the screen formed part of Exhibit 1. It shows that the deceased was assessed as having positive suicide signs and health problems, being in obvious pain or injury and as being under the influence of drugs. A "Health Alert Advising Query" was raised which remarked that the "*offender is a known IV drug user and is a suspected Hep C carrier*".

77. A cell check was then arranged to be carried out every 15 minutes. A break down of the cell checks demonstrate that on most occasions they were conducted every 15 minutes or less. However it can be seen from the break down some checks were not made for up to 28 minutes. If a

procedure is put in place to carry out cell checks every 15 minutes then it should be adhered to. That was not done on all occasions in this case. A period of 27 minutes had elapsed between the previous cell check and the one which resulted in the discovery that the deceased was unconscious the following morning. However I am satisfied on the evidence that the circumstances of the deceased's death are unrelated to any issue of whether a cell check was carried out at the stipulated time.

78. At 10.45pm Auxiliary Kenneth Lewis relieved Auxiliary Donaldson in the Watch House. At the change over specific reference was made to the fact that the deceased had earlier been in the Royal Darwin Hospital, that he had suffered a head injury and that he had possibly injected himself with some form of drug. During the night the deceased was checked. No real concerns were held for him over that period. Auxiliary Lewis told investigators that the deceased's sleeping pattern was normal, on occasion he was snoring, but otherwise his breathing was noted as normal.

79. At 6.49am on 6 July Auxiliary Lewis carried out a cell check. He observed that there did not appear to be any breathing movement in the prisoner. He immediately entered the cell and tried to rouse the deceased. There was no response. He checked for body temperature. It seemed to be normal. He pushed the deceased's shoulder back towards the wall of the cell to try and see his face and in so doing Lewis noticed there were some fluids coming from the deceased's nose or mouth. Constable Shepherd entered the cell. They called for assistance from Auxiliary Liam Samuels and Auxiliary Robert Bailey. Lewis then made an effort to clear the deceased's airways after placing him on his side. Samuels then arrived in the cell and immediately

rendered assistance. The deceased was placed on his back on the bed. Cardiac Pulmonary resuscitation was commenced. It became awkward to maintain resuscitation on the bed so the deceased was placed on the floor.

80. Samuels continued mouth to mouth resuscitation. The resuscitation mouthpiece that had been supplied to Watch House staff was, in the circumstances of this emergency, inadequate for the purpose. That piece of equipment is called a "Logikal Resus-O-Mask. In the course of administering mouth to mouth resuscitation Auxiliary Samuels received the deceased's blood and sputum into his mouth. He continued however to carry out resuscitation. He did so in the knowledge that the deceased was a known Hepatitis C carrier. His actions in trying to revive the deceased are deserving of the highest praise. Auxiliary Samuels performed his duty well beyond that which could have been expected in the circumstances and he is to be commended for his commitment and his bravery.

81. Auxiliary Donaldson told me in evidence that she is a medic in the Army Reserve and trained to use Oxyviver resuscitation equipment. The Oxyviver has a non return valve that prevents sputum and other bodily fluids from entering the mouth of the person undertaking the resuscitation. She said that she had on occasion expressed her views as to the inadequate nature of the equipment available to Watch House staff for the administration of mouth to mouth resuscitation. She showed me two mouth pieces that Watch House staff are required to carry on their person or that are kept in a safe in the Watch House for emergencies such as the one which arose in this case.

82. Counsel for the Commissioner of Police, Mr Farquar tendered in evidence an Internal memorandum of 18 December which advise the Inquest that there were two types of mask that Watch House members had been trained to use and which were available in the Watch House at the time the deceased was in custody. One of those types was the "Logikal Resus-O-Mask". The memorandum also advises me that following discussions with Assistant Commissioner Wernham about the possibility that the "Logikal Resus-O-Masks" may not be suitable for police use those masks have been withdrawn from service.

83. Mr Farquar also provided me with a memorandum from Superintendent Ey dated 7 June 2000 that indicates the Commissioner is presently taking steps to address the what I would describe as inadequate resuscitation apparatus that was available to the Watch House staff on 7 July. From that memorandum I note a Laerdal OXI-sok is being trialed in the Peter McAulay Watch House. I gather from the memorandum the problem that became apparent as Auxiliary Samuels stoutly tried to save the deceased's life is being addressed. I pause to comment, that this case has demonstrated how important it is that, equipment suitable to dealing with circumstances such as arose here is introduced by the Northern Territory Police Service as soon as reasonably possible.

84. After Auxiliary Samuels had received blood into his mouth another mask was obtained and the efforts to resuscitate continued. The ambulance arrived at 7.35am and shortly thereafter the deceased was conveyed to the Royal Darwin Hospital. The immediate family of the deceased was notified at 8.20am that the deceased had been hospitalised by Constables Ian Davie and Alan McDonald.

85. At the hospital the deceased was received by Dr Vafa Naderi who called the attending surgeon Dr Peter Riddel. At that time it was noted that the deceased had fixed, dilated pupils, which were indicative of clinical death or at least brain death.

86. A CT scan was carried out which revealed that the deceased had a haematoma on the left side of the skull. At approximately 10.00am Dr Riddel performed a craniotomy and in the course of that procedure it was recognised that there was little hope of recovery for the deceased. The surgery disclosed a large fracture to the left side of the head. The fracture was 10cm long running from front to back, and 3cm in width. The depression of the fracture was between 1cm and 3cm. Underneath the main part of the fracture Dr Riddel found a large clotted area which when removed revealed an actively bledding vessel which was the cause of the haematoma. Dr Riddel repaired the vein and the deceased was returned to the Intensive Care Unit of the hospital. He was kept under observation until 9.00am on Wednesday 7 July when Dr Mark Oliver conducted a series of brain stem function tests to establish whether the deceased was brain dead. The hospital notes show that at 9.45am *"There was no evidence of brainstem functioning"*.

87. At 11.00am on 7 July, Dr Oliver spoke to family members of the deceased who had gathered at the hospital. He explained to them that Mr Nheu was dead. The family requested that the deceased stay on life support. However as Mr Nheu was dead, life support was removed at 4.25pm. The family was contacted immediately by hospital staff.

IMPORTANT ANCILLARY ISSUES

The Discharge of the Deceased from Royal Darwin Hospital

88. Counsel Assisting Mr Tippet, asked Dr Treston what prevented the hospital from keeping the deceased in hospital and treating him for a head injury that ultimately resulted in his death. Dr Treston's response I have elected to set out in full as it will need to be addressed by the relevant authorities.

89. "The factors were that his presentation was atypical, in that he presented with a GCS that improved rather than stayed the same or decreased, and a normal observation for head injuries is to screen people who are having a decrease in conscious state. The second would be, from what I am hearing from you today, is there seems to be a big communication gap somewhere, and that people had concerns which were sort of privately held and they didn't communicate them and mechanisms weren't in place to deal with those concerns". Counsel for the Royal Darwin Hospital, Mr David Farquhar, submitted in this regard "we don't submit that treatment of Mr Nheu was in any way affected by lack of resources, lack of staff, lack of time, lack of CT scans, lack of X-ray facilities. What we say though, sir, is that it is a matter of communication." Indeed, Mr Farquhar concluded in final submissions that the deceased should not have been released from the Hospital when he was.

90. I note that the problem of communication also extended to the patient's history (the history being an important diagnostic tool). The history as known to the staff of the Accident & Emergency Department at the Hospital on the night of the admission was deficient, reliance on 2nd

and 3rd hand summeries passing from police to ambulance staff to nurses to doctors usually does (and did)result in inaccuracies.

91. I was not told during the Inquest what mechanisms ought to have been in place in order for the factors referred to by Dr Treston to be addressed and the problems resolved. I did not hear of any mechanisms that might account for staff who don't have particularly forceful personalities and may not voice their professional opinions loudly enough. It simply is not good enough for a treating doctor in an Accident & Emergency Department to hold an opinion in relation to a patient being treated by him that it was a "surprising" decision by a superior to authorise the patient's discharge WITHOUT VOICING THAT OPINION and discussing the matter with the superior. This is what apparently happened to the deceased. In my view the hospital should review its procedures in the Accident and Emergency Department with the view of eliminating the factors of which Dr Treston spoke where ever that can reasonably be done. I have found that the deceased was very unwell and should not have been discharged from the hospital. The problem did not arise from a lack of resources or available time to treat. The fact that those matters had no part to play in the failure to properly treat the deceased's injuries is of significant concern. While the deceased's Glasgow Coma Score may have been somewhat misleading, his out ward physical signs such as incoherence, difficulty walking and restlessness should have in themselves determined that he remain longer in hospital care. Added to that, was the masking effect of the drugs which hospital staff believed, on evidence provided to them, that the deceased had probably ingested.

92. I am not satisfied that Dr Ellis sufficiently took into account the masking effect of drugs. Clearly that could, and may well have in this case, lead to a wrong diagnosis of the patients condition. Dr Ellis said his usual practice was to keep patients with suspected head injuries under observation for up to 4 hours. No reason was put before me as to why that was not appropriate in this case. The fact that Dr Ellis thought the deceased could be discharged does not remove the deceased from the general category of head injured patients who may be discharged but are not because sufficient observation has not been carried out. It seems to me that if a protocol is not put in place so that head injured patients are dealt with in a particular manner, as a matter of course, problems such as the ones I have been informed of, in this case, may reoccur with similarly tragic results. That is so especially where the masking effects of drug ingestion are at risk of being present.

Failure to X-ray or CAT scan

93. I received into evidence a report authored by Dr Anthony Brown. Dr Brown is a Senior Staff Specialist in the Department of Emergency Medicine at the Royal Brisbane Hospital. That report advises that the Royal Brisbane Hospital routinely CT scans patients who present with any abnormality of mental status such as confusion, drowsiness, aggressive or inappropriate behaviour (even if such behaviour fluctuates) and appear to be suffering from the effects of head trauma alone. Dr Brown was of the opinion that the deceased should have had a CT scan.

94. However I am satisfied that I should not assess the procedures at the Royal Darwin Hospital by using the protocols of a large city teaching hospital such as Royal Brisbane. I hasten to point out that the relevant authorities at Royal Darwin Hospital should appraise themselves of the

content of the report and examine the usefulness of the matters set out therein in any reassessment they may undertake in relation to developing new protocols for the treatment of head injured patients.

95. A CT scan would have revealed the extent of the deceased's injuries and he would most likely have undergone surgery that would have saved his life. I find that the death of Mr Nheu may have been a preventable death if he had not been prematurely released from Hospital and received appropriate treatment.

THE POLICE INVESTIGATION

96. The police investigation conducted by Detective Sergeant Roger Newman was of the highest order. It was exhaustive and the material gained and the issues it canvassed resulted in the dramatic reduction of the need for court time to be annexed to the hearing of the Inquest. Further well constructed video re-enactments with all eye witnesses allowed me to thoroughly assess the events immediately preceding the administration of the blow that caused the injury leading to death. Sergeant Newman is to be commended for the quality of the investigation.

97. The actions of the police officers who dealt with the deceased prior to and after his hospitalisation were at all times reasonable and taken in the interests of the deceased and the community. From early in the day of 5 July the steps that were taken to deal with the deceased's behaviour disclose concerned and sincere attempts to assist the deceased and to resolve his difficulties in a sensitive fashion and I recommend them to their superiors.

98. Of outstanding note are the actions of Auxiliary Liam Samuels. His continued attempts to resuscitate the deceased after receiving blood into his mouth, which to his knowledge was from a person designated as Hepatitis C positive, are worthy of the highest praise. He is to be commended and recommended to his superiors. In this regard Counsel for the family of the deceased, Mr Peter Elliott said in final submissions.

> *"it appears that Auxiliary Samuels placed Mr Nheu's welfare above his own and the family deeply appreciates that and would like it to be on the court record that they appreciate that. And – but they have no – that's the only submission in relation to the police and none insofar as criticism goes".*

99. The nursing staff at the Royal Darwin Hospital carried out their duties in a thorough and efficient fashion in the care of the deceased. They were at all times subject to the decisions of the medical staff to whom all patients triaged at level 3 are allotted.

CONCLUSION

100. This is a tragic case of a death which may well have been prevented. The Royal Darwin Hospital must expect that it's Accident and Emergency Department will not infrequently continue to receive into its care patients with difficult and complex symptoms such as those the deceased displayed on 5 July 1999 and be in a position to extend to such persons appropriate treatment.

RECOMMENDATIONS

101. That the Northern Territory Department of Health address the lack of communication between medical and other staff in the Accident and Emergency Department of the Royal Darwin Hospital identified in this Inquest by undertaking a review of the procedures or protocols it has in place for the assessment and treatment of patients with head injuries or suspected head injuries.

102. That the Commissioner of Police liaise with the Northern Territory Department of Health with the intent of putting in place a protocol for the release of patients into the custody of police.

Dated this 31 day of October 2000

GREGORY R CAVANAGH
TERRITORY CORONER