CITATION:	*Inquest into the death of Eric Gaykamangu* [2003] NTMC 015
TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	D0193/2001
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HEARING DATE(s):	6, 7, 8 August 2002
JUDGMENT OF:	Mr Greg Cavanagh SM

CATCHWORDS:

CORONERS, Inquest, definition of death in custody, protective custody

REPRESENTATION:

Counsel:

Counsel assisting the Coroner:	Ms Elizabeth Morris
Counsel for the Northern Territory:	Mr Peter Barr
Counsel for the Family:	Mr Gerard Byrant
Counsel for the Aboriginal Justice Advocacy Committee:	Mr Chris Howse
Counsel for St Johns Ambulance Service	Mr Christopher McDuff

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

No. D0193/2001

In the Matter of an Inquest into the death of

ERIC GAYKAMANGU
ON 16 DECEMBER 2001
AT INTENSIVE CARE UNIT,
ROYAL DARWIN HOSPITAL

FINDINGS

MR GREG CAVANAGH SM

THE NATURE AND SCOPE OF THE INQUEST

1. Eric Gaykamangu, ("the deceased") was taken into police protective custody at the Peter McAulay Centre due to intoxication on the 7th of December 2001. Around the time Watchhouse staff were about to release him, some five hours later, it was noted that the deceased did not appear well. An ambulance was called by Watchhouse staff. The deceased was taken to the Royal Darwin Hospital on that day by ambulance from the police Watchhouse. He remained a patient until the 16th of December 2001 when he died of a primary intercerebral haemorrhage in the Intensive Care Unit.

2. This death was properly investigated as a death in custody. However the question was raised before me during the Inquest as to whether, at the time of his death the deceased was a "person held in custody" within the definition of s 12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act").

3. The word "immediately" in the *Coroner's Act* is not defined; this word is used in the expansive definition of "death in custody". To determine whether or not someone was in custody immediately before death is something that depends of the circumstances of each case. Factors taken into account include time, geographic location, actions, intervening actions, and other factors peculiar to each incident. In this case the deceased had been taken directly to the Hospital from the police station, without leaving police custody. He was never discharged from the hospital.

4. In my findings into the death of Dandy (D0190/2001) the definition of a "death in custody" was discussed and I quote (P2):

   > "The question of immediacy in terms of police custody is relevant to whether or not the death is a "death in custody" pursuant to the expanded definition of such deaths found in the Act. In my view, I should not take a narrow or restrictive view of the wording having regard to the aims and policy behind the legislation. Furthermore, the care and attention the deceased received while in actual custody, and the decision to release her from actual custody, are all matters to be canvassed in this Inquest. I note the counsel for the Northern Territory Police Force submits that the circumstances of the death do not meet the criteria for a "death in custody", however, he did not press the submission and did not present any argument. Indeed, he agreed that even if the death was not a "death in custody", I had a discretion to hold a public Inquest in any event. I further note that the Northern Territory Police detectives pursuant to my direction investigated the death as a "death in custody" in accordance with Standing Orders."

5. Given the long period (10 days) after detention, intervening medical attention, and the lack of evidence that any injury was caused or contributed to whilst the deceased was in "actual" custody, I do not find that this death was in fact, a death in custody as defined by the *Coroner's Act*. I cannot find any act or

omission of the police that is connected with the death. Indeed, I accept Mr Bryant's initial submission (Transcript P90):

> "MR BRYANT: Well, I think that the difficulty that anyone arguing that this is a proper death in custody is the attractive argument that people may raise that he simply transited the police cells on route to the hospital and was given appropriate care in the police cells and therefore - - -
>
> THE CORONER: Well, that may be the attractive argument because it's the right argument.
>
> MR BRYANT: Well, yes."

In final submissions, Mr Bryant argued that, on a most liberal definition, I should in fact hold that the death was one in custody. I disagree.

6. I note and commend the words of Counsel for the Police Commissioner (Transcript P136/137):

> "In the present case no issue was taken by the fact that a "death in custody" investigation was directed or that an inquest has been held. It is the view of NT Police that a full death in custody investigation is appropriate, even where the death is only possibly a death in custody. If there's any doubt the NT Police will treat a death as a death in custody. The cost of a full investigation is seen as justified in terms of bringing to light all relevant facts and where possible diffusing a concern and eliminating possible suspicion on the part of family members of deceased persons and in the community generally."

7. In any event, the death is a "reportable death" under s 12 (1) (a) of the Act, as it <u>appears</u> to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury. These deaths are required to

be investigated by the Coroner pursuant to s14 (2) of the Act. In my view, it was appropriate, given the circumstances of this death, that an Inquest was held, as one of the issues examined was whether or not the death fell to be determined as a "death in custody". The scope of such an inquest is governed by the provisions of section 26 as well as sections 34 and 35 of the *Coroners Act*. It is convenient and appropriate to recite these provisions in full:

"26. Report on Additional Matters by Coroner

(1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –

(a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

34. Coroners' Findings and Comments

(1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

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

(v) any relevant circumstances concerning the death.

(2) A coroner may comment on a matter, including public health or safety or the administration of justice connected with the death or disaster being investigated.

(3) A coroner shall not, in an investigation, include in a finding or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subs (1)(a)(iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act*.

35. Coroners' Reports

(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.

(2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and the Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

8. The investigation into the death commenced on the 16 December 2001. The Coroner's office in Darwin notified the next of kin through the Aboriginal Liaison Officer at the Royal Darwin Hospital of the Inquest into the deceased's death. The family was represented at the Inquest by Mr Gerard Bryant (a legal practitioner from the North Australian Aboriginal Legal Aid Service Inc). Counsel assisting me was Ms Elizabeth Morris, Deputy Coroner. Seeking and granted leave to appear was Mr Peter Barr for the Northern Territory, (and in particular for the Royal Darwin Hospital and the

Commissioner of Police). Mr Chris Howse for the Aboriginal Justice Advocacy Committee was also granted leave to appear. Finally Mr Christopher McDuff sought leave to appear on the limited basis of being present at the examination of witnesses from the St John's Ambulance Service.

9. The court heard from six witnesses who gave evidence in this inquest. They were:

    1. Detective Senior Constable Martin James – the Police Officer in Charge of the investigation of the circumstances surrounding the death of the Deceased.

    2. Scott Troy Hollingworth – St John Ambulance

    3. Susan Michelle Eastcott – St John Ambulance

    4. Robyn Diane Matten – Police Auxiliary

    5. Daisy Baker - family to the deceased

    6. Vanessa Joanne Barton – Police Auxiliary

10. In addition to this evidence, a full brief of evidence was tendered by Detective Senior Constable James. This evidence included statements from various witnesses and numerous other records of the Police, and Department of Health and Related Services.

S34 Particulars

11. To allow this death to be registered under the *Births, Deaths and Marriages Registration Act* the following particulars are provided to the Registrar:

    (a) <u>The Identity of the Deceased Person</u>

The deceased is Eric Gaykamangu, a male Aboriginal Australian who was born on 5 November 1964 at Milingimbi, Northern Territory. The deceased was given the name Djapininy at birth.

(b) The Time and Place of Death

The deceased died at the Royal Darwin Hospital Intensive Care Unit at 15:30 hours on 16 December 2001 aged 37 years.

(c) The Cause of Death

The cause of death was a primary intracerebral haemorrhage, contributed to by acute alcohol intoxication.

(d) The particulars required to register the death

1. The deceased was a male.

2. The deceased was of Australian Aboriginal origin.

3. The cause of death was a primary intracerebral haemorrhage, contributed to by acute alcohol intoxication.

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

5. Death was from natural causes. There was no evidence of any intervention causing or contributing to the death by a third party.

6. The pathologist viewed the body after death.

7. The pathologist was Dr Derek Alan Pocock, Forensic Pathologist of Royal Darwin Hospital.

8. The father of the deceased is Tony Jigululu. The mother of the deceased is Burumana.

9. The deceased had no fixed place of address.

10. The deceased was unemployed.

THE DECEASED

12. The Inquest heard from a family member of the deceased, viz.Ms Daisy Baker, who is a first cousin to the deceased's mother. The witness confirmed the deceased's parents' names, and that he was born in Millingimbi. The deceased had one sister, Raylene, or Rramang, who lives in Millingimbi. Ms Baker also confirmed the deceased's Aboriginal name as Djapimy, which is similar to the name on the exhibited birth certificate of the deceased.

13. The deceased was raised by his step-father, Matthew Thulumburrk. He went to school in Millingimbi. He travelled around to various communities, including Elcho Island. He had two children on Elcho Island, one was 17 years old, the other around 13 or 14. The mother of these children is a Health worker on the Island.

14. Ms Baker describes the deceased as having a problem with drinking alcohol and kava. His drinking in Darwin was heavy. The family would organise for the deceased to go back to Millingimbi when he had been drinking heavily. She also recalls that the deceased appeared to have epilepsy, because of frequent falling down. She told me in evidence that the deceased was "just a quiet boy", who despite his drinking did not get into trouble, had no record with the police and did not fight.

CORONIAL INVESTIGATION

15. The Coroners Act requires an independent investigation in these circumstances at the direction of the Coroner. Detective Senior Constable Martin James carried out an investigation according to the requirements of Police General Orders D2. That general order specifically relates to the Investigation and Reporting of Deaths in Custody. The investigation

adequately covered the areas required under General Orders, although I have to say, especially in relation to the hospital treatment of the deceased, the brief was somewhat sparse.

CIRCUMSTANCES SURROUNDING THE DEATH

16. From the evidence tendered and heard at the Inquest, I find that on the morning of Friday the 7th of December 2001 the deceased had been drinking alcohol with a group or people. Not all of those present were drinking. About mid-morning the group made their way to the Centrelink office, Knuckey Street, Darwin. Two of the group went inside the Office, the deceased remained outside on the footpath. Shortly after the deceased was seen lying on the footpath. Assistance was sought from Centrelink. Raelene Damarandji, an Aboriginal liaison officer, came out. She saw the deceased lying down, with his head being cradled by one of the group, a Marion Miyalan. In Ms Damarandji's statement she recalls blood coming from the deceased's mouth, ears and the back of his head. She was told by Ms Miyalan that the deceased had been struck by someone, an Andrew Matha.

17. Lyn Stapleton, another Centrelink worker, also saw the deceased with what appeared to be blood in one ear, being cradled by Ms Miyalan. When Ms Miyalan was questioned about this by the investigating officer, she denied seeing someone strike the deceased, or indeed telling the Centrelink worker that someone had. Andrew Matha was later spoken to by police and did recall an incident outside Centrelink where he had struck the deceased once, after the deceased had punched him.

18. Around this time, two Aboriginal Community Police Officers (ACPO's) arrived. Bernie Devine and Shawn Lewfatt were patrolling in the area, saw the deceased lying on the footpath and inquired about his welfare. They were informed that an Ambulance had been called, and so continued about their duties.

19. Subsequently Ambulance Officers Scott Hollingworth and Susan Eastcott attended, and examined the deceased. The deceased gave them the incorrect name of Eric Jambala. They concluded that the deceased was intoxicated. A minor laceration to his lip and head were noted, but all other observations were in the normal range. They requested police attend in order to convey the deceased to a sobering up shelter, and then departed the area. In his evidence Scott Hollingworth told me that he was a qualified paramedic with the St John's Ambulance Service. He arrived on the 7th December 2001 outside the Centrelink Office and attended on the deceased together with his colleague Susan Eastcott. He stated (Transcript P31):

> "And where was the deceased when you were treating him or when you first began to speak to him?---When we first arrived?
>
> Yes?---Yeah, he was – he was lying on the footpath end – with his head on a – on a lady's lap.
>
> At any stage did you take him to the ambulance or did you bring equipment to him?---We brought equipment to him.
>
> And that equipment included what sort of things?---It's our response kit and an oxygen cylinder if we require it and in our response kit's just everything that we would utilise; bandages, BP cuffs, other items – resus bags if required.
>
> And were you the treating officer for the deceased?---Yes.
>
> So it was mostly you who was speaking to the deceased and making observations?---Yes.
>
> And you noticed in your statutory declaration that the deceased had a minor laceration to the back of his head; do you remember that?---Yes.

Was there any blood in relation to that laceration?---Yes, he had blood on his head.

And can you recall where that blood was in relation to his head?---I can't exactly recall if the – the lac – the laceration sorry, was in what location on his head but the blood was all on his right-hand side of his head.

Yes, and was the deceased speaking to you?---Yes.

And you've said in your statement that he told you he'd been drinking moselle on the Esplanade?---Yes, correct.

And did it appear to you that he was intoxicated?---Yes.

Apart from him saying that?---Yes."

And (Transcript P32):

"Witness, how long have you been in St John's Ambulance in the Northern Territory?---In the Northern Territory?

Yes?---Since '97.

Right, what about when you were down in Alice Springs?---Yeah, that's when I started full-time employment. I started as a volunteer before that.

And how many Aboriginal people do you think you would have picked up from streets and sidewalks who were drunk and needed your attention over those years?---Too many to actually count, sir.

Are we talking 10s, 100s, 1000s?---The 100s, not a thousand.

Sorry?---More than a hundred.

Yes, in the hundreds?---Yes.

And (Transcript P33):

> "THE CORONER: And you did a full body length examination?---Just where he was, yes.
>
> MS MORRIS: Did he appear to have been concussed in any way or to have lost consciousness prior to you getting there?---No.
>
> What would you expect to see if he had have been unconscious at some stage shortly prior to you arriving?---A lot of vagueness and probably a drowsy appearance, so a vagueness – he wouldn't recall events, but he did.
>
> And you asked him his name; he gave you the name Eric Jambala and he actually spelled it for you?---He did.
>
> And you were certain that what you wrote down was what he said?---Yes.
>
> I ask that question because we do – there is a slight question over what name he was and what name he's been recorded as - - - ?---Mm, mm.
>
> - - - in computers but that was a definite spelling by him?---Yes.
>
> - - - of Jambala for you, and you also note that he only seemed angry with you or you and your fellow ambulance officer and not the people around him?---That's correct.
>
> Did he report to you that he'd been assaulted in any way?---Yes.
>
> Who did he say had assaulted him?---He said another man but he didn't say a name or he didn't say it was of any origin.

And did he say where he'd been?---He said he – he was punched once in the face.

All right, and could you find any injury as a result of that?---No, no marks on his face, no.

How was his command of English?---Quite good.

Did you feel as though you had any trouble communicating with him apart from his aggression?---No.

And the responses that he gave to your questions were to you appropriate responses?---Direct and accurate."

20. He told me that it was a joint decision with his colleague to call the police to transport the deceased to a sobering-up shelter (or the cells) because the deceased was intoxicated and not ill. He confirmed that so far as he was concerned that at no time (in initial examination or during the period they were with the deceased) was the deceased drifting in and out of consciousness. I accept his evidence. On cross-examination by Mr Bryant, the witness stated (Transcript P43):

"And is it also the case that alcohol can often mask a lot of these symptoms?---Yes.

And indeed I think as you told the Coroner, it's the case is it not that you would have dealt with hundreds of cases of people lying on the footpath or roadway in an intoxicated state?---Yes.

And ordinarily when you see these people you would make an assessment as to whether they're capable of looking after themselves?---Yes.

> And then call the sobering-up shelter or call the police for them to be taken to a shelter?---Yes.
>
> Have there been any instances in your experience where you haven't been satisfied that this person was medically fit and conveyed them to a medical facility?---Yes.
>
> So for example if you observed blood coming from the deceased's ear; that is, pouring out of his ear and/or a fluid coming from his ear, that would be an indicator to you that there may be something more serious?---Yes.
>
> And in those circumstances it would have been proper to convey that person to hospital?---Yes.
>
> But your evidence is you saw nothing of that - - -?---I saw blood – blood on his ear, but not in his ear."

21. Ambulance Officer Susan Eastcott was called to give evidence. I found her to be a credible and impressive witness; her evidence corroborated that of her colleague Scott Hollingworth. On all of the evidence, I find nothing to criticise the ambulance officers about in connection with the death.

22. The two ACPO's returned to the area, saw that the deceased was still on the footpath, and took the deceased into protective custody under the *Police Administration Act*. The deceased was conveyed to the Watchhouse at the Peter McAulay Centre as the Sobering-Up Shelter did not open until 4.00pm.

23. The deceased arrived at the Watchhouse at 13:14hrs, where he was processed and assessed by Auxiliary Matten. Her assessment notes show that the deceased had suicide/health problems, pain and/or injury, signs of infection, and was under the influence of alcohol/drugs. The Watchhouse video shows the deceased on reception into the Watchhouse, there appears nothing particularly untoward and apparent compliance with regular procedures.

24. At 14:08hrs another Auxiliary, Vanessa Barton, commenced an individual offender journal for the deceased. This was commenced as the Watchhouse staff had some concerns about the deceased. Ms Barton was not only a trained Watchhouse attendant but also a qualified paramedic. The deceased was due for release around 18:30hrs. At 18:29hrs a journal entry details the concerns and actions of the Auxiliaries in relation to the deceased. He was brought out of the cells, was hard to rouse, staggered, and appeared to be incoherent in speech. He was unable to stay awake, and lay down on a bench. A video of the Watchhouse action at this stage was played at Inquest and shows the deceased walking out of his cell at the end of the detention period but then slumping down in the reception area. Watchhouse staff spoke to the Watchhouse Commander, Del Jones about their concerns, and permission was given for an ambulance to be called. The deceased was conveyed by this ambulance to Royal Darwin Hospital, where he was admitted.

25. On all of the evidence, I find the police Watchhouse staff fully complied with the custody manual, proper checks on the deceased were carried out and appropriate concern shown for his ill health. I note and accept the words of the investigating officer (Senior Constable James) (Transcript P24):

> "Yes. As part of your investigation you looked at the custody manual of the Northern Territory Police Force?---Yes, that's correct.
>
> And that's a manual that must be adhered to by officers and auxiliaries who have people in their charge?---That's correct.
>
> Both for protective custody and for criminal matters?---That's correct.
>
> And were you able to find from your investigation any times of that manual in relation to the deceased, that the manual wasn't adhered

> to?---No, I – I found that the manual was complied with at all times by watchhouse staff."

26. The deceased was assessed and treated for intoxication and initially what was thought to be gastritis. Three days after admission a CT scan of his head was carried out. This revealed a large mass in the left temple zone. This was thought to be either a tumour or a haemorrhage. A decision not to operate was made upon advice from a neurosurgeon in Adelaide.

27. The next day an MRI was completed, and the results assessed. The deceased was found to have a haemorrhage, not a tumour. Upon further advice, surgery was still determined not to be appropriate. Late on Friday the 14th of December, the deceased deteriorated and a CT scan showed further swelling. An emergency operation was conducted early on the 15th of December, but the deceased did not recover from the operation, and died at 1630hrs on Sunday the 16th of December 2001.

28. Dr Terry Coyne, a specialist neurosurgeon from the University of Queensland was consulted by my office in relation to treatment of the deceased at Royal Darwin Hospital and I accept his opinion (Exhibit 6) and I quote

> "I note that Mr Gaykamangu was brought to Royal Darwin Hospital at 1955 hours on the 07/12/01. I note from the memorandum of Detective Senior Constable James (03/04/02) that Mr Gaykamangu was taken from protective custody to Royal Darwin Hospital because of a persistently decreased level of consciousness despite having been in protective custody for a number of hours."

And:

> "In summary, Mr Gaykamangu died from a left temporal lobe intracerebral haemorrhage with associated oedema. A left temporal lobe haematoma with oedema could be expected to cause a

decreased level of conscious, speech and language disturbance, and a right sided weakness. It would be most likely that this haematoma was the cause of Mr Gaykamangu's persistent decreased level of consciousness which was noted when he was in protective custody, with this decreased level of consciousness being the reason he was transported to Darwin Hospital."

And:

> "It is difficult to know precisely why Mr Gaykamangu showed sudden deterioration in the early hours of the 15/12/01. At this time it was approximately 8 days since the likely onset of his haemorrhage, and it is unusual that at this relatively late stage Mr Gaykamangu's peri haemorrhage oedema would worsen to the point where he developed transtentorial herniation and ultimately died. If such deterioration occurs, it is generally earlier in the clinical course.
>
> I note that following Mr Gaykamangu's relatively sudden deterioration **he received urgent management including surgery and intensive care which seemed appropriate."**

29. At my direction, an autopsy examination was conducted by Dr Alan Pocock, a locum Forensic Pathologist at Royal Darwin Hospital. He concluded, and I quote:

> "This death is the result of a spontaneous haemorrhage occurring in the brain, a condition frequently associated with heavy alcohol abuse. Whilst no other evidence of chronic alcohol disease is identified in the body, the admission of blood alcohol of 0.22% following a period of 6 hours in the watchhouse would indicate that the deceased was very severely under the influence of alcohol at the

> time of his apprehension. Such a level would probably be significantly in excess of 0.3 at the time and the intracerebral haemorrhage could well have started at or before the time he was apprehended and subsequently extended during his time in hospital.
>
> Death is due to natural causes and there is no evidence of any second person being involved in this death."

30. On all of the evidence, I accept the closing submission of Ms Morris that the deceased died as a result of natural causes, viz. primary intracerebral haemorrhage. As to exactly when this haemorrhage commenced is uncertain, and I make no finding in this regard. I note that amongst, other things, Mr Howse of Counsel at the conclusion of the evidence, and before final submissions, sought leave to withdraw, and I granted him leave. Mr Howse agreed that the death, albeit sad, was not controversial in any particular way. I also agree.

31. I have no recommendations to make pursuant to the Act, except to reiterate those contained in my findings regarding Rita Dandy (D190/2001). This case (once again) exemplifies the need for 24 hour well resourced "sobering-up" shelters staffed by trained and qualified paramedics.

Dated this 10th day of April 2003

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Greg Cavanagh

TERRITORY CORONER