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# REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act*

In the matter of the Coroner's Findings and recommendations regarding the death of Marrianne Fire Tikalaru Munkara

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Pursuant to section 46B of the *Coroners Act*, I provide this Report on the findings and recommendations of the Territory Coroner, Mr Greg Cavanagh LCJ, dated 2 September 2016, regarding the death of Marrianne Fire Tikalaru Munkara (the Deceased) (refer Attachment A).

The Report includes the response to the recommendations from the Commissioner of Police (the Commissioner) (refer Attachment B).

The Deceased, a 45 year old Aboriginal female, died at 10:02 pm on 11 November 2015 at the Darwin Sobering up Shelter in Coconut Grove in the Northern Territory.

The cause of death was Bronchiectasis, contributed (but not directly caused) by acute alcohol toxicity, left ventricular hypertrophy and chronic glomerulonephritis.

## Recommendations of the Coroner

The Coroner may comment on a matter, including public health or the administration of justice, connected with a death being investigated (section 34(2) of the *Coroners Act*) and may report or make recommendations to the Attorney-General on a matter, including public health or the administration of justice, connected with the death being investigated (section 35(1) and (2) of the *Coroners Act* refers).

The Coroner made the following recommendations:

'64. I recommend that Police resolve the lack of compliance with sections 128(2A) and 128A *Police Administration Act*; and

65. I recommend that Northern Territory Police take such steps as are necessary to ensure that all episodes of custody including protective custody are recorded in a searchable digital database.'

NORTHERN TERRITORY GOVERNMENT

**Response to Coroners recommendations**

A copy of the Coronial Findings was provided to the Commissioner on26 October 2016, in accordance with section 46A(1) of the *Coroners Act* requiring a response which outlines the actions that the NT Police Force is taking, has taken or will take with regard to the Coroner's recommendations and comments.

A written response was received from the Commissioner dated 2 February 2017, as required by section 46B(1) of the *Coroners Act* (refer Attachment B).

The Commissioner has provided the following to the recommendations made by the Coroner at paragraphs 64 and 65 of the Coroner's Report (numbers reflect the relevant paragraph of the Coronial Findings):

64. A two day workshop was conducted in June 2016 to improve in-field identification and compliance with sections 128(2A) and 128A of the *Police Administration Act*. An audit system was also introduced to ensure the proper use of notebooks and recording the details of persons coming into police custody.

    In-field identification is the subject of a working group that was formed following the workshop and a number of initiatives have commenced. This includes the roll-out of body-worn video to all Police Officers, commenced in September 2016 and nearing completion. Custody incidents are being recorded and can be retrieved as required.

    An application called 'Capture' is also being developed and trialled in Darwin. Capture will enable officers using body-worn video to take a photograph of a person in-field and automatically record the time and location. This will allow members to document custodial transfers to another agency, such as a hospital or sobering-up shelter.

    The roll-out of facial recognition software in April 2017 and a trial of in-field fingerprinting should also improve the identification of persons in protective custody.

65. A means to record protective custody episodes in a searchable database has not yet been implemented; however developing a solution is a top priority to be further considered in conjunction with feedback from current trials. The requirements of this recommendation are ongoing.

I am satisfied that the NT Police Force has considered the Report of the Coroner and is taking necessary steps with respect to the recommendations made.

DATE: 0 1 MAR 2017

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NATASHA FYLES

ATTACHMENT A

CITATION: *Inquest into the death of Marrianne Fire Tikalaru Munkara* [2016] NTLC 017

| | |
|---|---|
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Darwin |
| FILE NO(s): | D0175/2015 |
| DELIVERED ON: | 2 September 2016 |
| DELIVERED AT: | Darwin |
| HEARING DATE(s): | 8 June 2016 |
| FINDING OF: | Judge Greg Cavanagh |
| **CATCHWORDS:** | **Death at Sobering up Shelter, Police systems non-compliant, failure to record protective custody episodes, no referral for assessment for Alcohol Mandatory Treatment** |

**REPRESENTATION:**

| | |
|---|---|
| Counsel Assisting: | Kelvin Currie |
| Commissioner of Police: | Angus Stewart SC |
| Counsel for the family: | Melissa Chung |

| | |
|---|---|
| Judgment category classification: | B |
| Judgement ID number: | [2016] NTLC 017 |
| Number of paragraphs: | 65 |
| Number of pages: | 14 |

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

No. D0175/2015

In the matter of an Inquest into the death of

**MARRIANNE FIRE TIKALARU MUNKARA ON 11 NOVEMBER 2015 AT DARWIN SOBERING UP SHELTER, COCONUT GROVE**

**FINDINGS**

Judge Greg Cavanagh

**Introduction**

1. Marrianne Fire Tikalaru Munkara (the deceased) was born 24 April 1970 at the Bathurst Island Mission on Bathurst Island in the Northern Territory to Clare Palleipukwaria Fire Tikalaru Munkara and Sotero Arrapantiu Jabaru Bird Tikalaru Munkara.

2. She was raised and educated on Bathurst Island and had three children, Andrew Morgan, Mara Murphy and Louise Murphy.

3. In her twenties she began to visit Darwin and became involved in smoking and drinking. As the years went by she spent more and more time in Darwin and often stayed in the long grass.

4. In a report provided by Doctor Death, the following was said about her health:

> "Ms Munkara suffered from severe chronic lung disease due to bronchiectasis and attendant asthma made worse by continuing heavy smoking and chronic resistant infection with TB like bacteria and Pseudomonas bacteria that could not be eradicated. She suffered cor pulmonale, where increased pressure from her lungs causes the right side of her heart to fail. She could walk 30 – 50 meters before becoming too breathless to continue. She was malnourished with weight of 41 kilograms.

> She was admitted to Royal Darwin Hospital 15 times from January to October 2015 ... these admissions were all for her lung and heart disease, usually because she did not take her medications due to or associated with alcohol excess."

5. Her family knew she was very sick and encouraged her to stay off the cigarettes but she continued to smoke. Ms Munkara understood that she was unwell and had told family members that "it was time". She told her sisters to look after her son.

6. On 23 September 2015 a Discharge Summary from the Royal Darwin Hospital in part read as follows:

> "Maryanne is a 45 year old lady from Bathurst Island who has presented to RDH multiple times in the past month with exacerbations of COPD/bronchiectasis, taking her own leave each time. On this occasion she re-presented with increased shortness of breath, having missed her ferry back to Bathurst Island. She was also noted to have troponin rise. Unfortunately Maryanne took her own leave again this admission."

7. She attended the Emergency Department on 7 November 2015. Of that admission Dr Death wrote:

> "Ms Munkara presented to the Emergency Department at Royal Darwin Hospital at 4am on the $7^{th}$ November intoxicated, breathless, aggressive, resistive to examination and saying she had lost her puffer. At midday she was described by nursing staff as alert and oriented. Observation chart showed she was breathing fast, 24 breaths per minute, and had good oxygen levels for her but required 3 litres of oxygen to maintain this. She took her own leave at about 2:30 pm."

8. Ms Munkara was brought into the Emergency Department by ambulance at 4.30pm on 8 November 2015. She had severe breathlessness, breathing at 40 breaths per minute and had very low oxygen levels. She took her own leave just after lunch the following day.

9. She died on 11 November 2015, just two days after taking her own leave from hospital after lunch on 9 November 2015.

## Circumstances of Death

10. During 11 November 2015 Ms Munkarra was on the foreshore area near the BBQ area at Vesteys Beach. She had purchased a number of casks of wine and was drinking it with friends and her sister Beverly. It is lawful to drink alcohol in that area.

11. That evening there were a number of groups in the area. The total number of people was said to be in the vicinity of thirty to forty. The Police were of the opinion that the situation was deteriorating. One of the issues appeared to be that one of the groups had been occupying the BBQ for a number of hours and another of the groups had been waiting and was becoming impatient. Police arrived at about 8.30pm.

12. The deceased was sitting on the ground with another three women. The Police officers approached and formed the opinion the women were intoxicated and were in need of protective custody. They told them they would take them to the Sobering up Shelter and assisted them into the rear of a Police van.

13. The deceased was assisted to the cage by Constable Lisa Fluellen and Constable Steven Dalrymple. She was intoxicated but able to walk. The Police officers in control of the Police van were Lisa Fluellen and Leanna Graetz. They were not aware of the identity of the four women and did not seek to establish their identities. They made no record of their names or that they were taken into Protective Custody. They made no checks of the Police systems to determine whether there were any alerts for the women. If they had done so, they would have found an alert for the deceased. It read:

> "NT Health (Custody Nurse) advised Maryanne MUNKARA suffers from Chronic Obstructive Pulmonary Disorder.
>
> In accordance with the GO Custody she is to be considered "At Risk" for the duration of any custody episode and monitored accordingly."

14. The Police took the four women to the Sobering up Shelter in Nightcliff, arriving at 9.05pm.

15. One of the women had to be assisted from the vehicle and to bed in the Shelter. While that was happening the deceased and the two remaining women made their own way out of the rear of the van and seated themselves in the reception area.

16. The staff at the shelter that night were Emma Day and Anthony Fulton. They knew the identities of all four of the women and noted their arrival. Two of the three women in the reception area went to bed.

17. The deceased sat in the reception area until 9.19pm. She then walked out the front and sat on the concrete step. The Sobering up Shelter staff told her she had to either go to bed or leave. She stayed, alternatively sitting on the concrete step and lying down on the driveway.

18. Just after 10.00pm Anthony Fulton attempted to lift her into a sitting position. She didn't wake and on the CCTV footage appears like a rag doll. She slumped back to the ground. However through the attempts to sit her she had moved to lying across the driveway rather than beside it.

19. Emma told Anthony he would hurt his back and so he left her in that position. She is seen to be breathing at that time. However from two minutes later no further movement or breathing can be detected on the CCTV footage.

20. Despite evidence of one of the staff members that they noticed Ms Munkara breathing after that time, it is more probable that it was assumed she was breathing. It was thought she was just intoxicated and being uncooperative.

21. I am satisfied that Ms Munkara died at 10.02pm.

22. At 10.12pm another Police van arrived. The Sobering up Shelter staff asked the Police to take Ms Munkara with them however they had two males in the

rear of the van, one they had intended to drop at the Shelter (however he was banned). Police asked the staff about Ms Munkara. They were told that she was fine, just intoxicated and being non-compliant. Police indicated that another cage vehicle would be arriving shortly and left.

23. Five minutes later at 10.18 pm, the Police van of Lisa Fluellen and Leanna Graetz arrived once more, transporting another intoxicated person.

24. The Officers checked on Ms Munkara and found she was not breathing. Cardio Pulmonary Resuscitation (CPR) was commenced and the Ambulance called. However the deceased could not be revived and was pronounced deceased at 10.51pm.

25. An autopsy was performed by Forensic Pathologist, Doctor John Rutherford who determined that she died of Bronchiectasis, a chronic deep lung infection. Her blood alcohol reading was 0.215%.

**Ms Munkara's interactions with Police and the Sobering up Shelter**

26. The deceased was well known to Police. The Investigating Officer, Detective Anthony Henrys, noted that from mid-2011 there were 27 episodes of protective custody known to Police in which Ms Munkara was taken to the Watch House. That is, she was too drunk to look after herself on these occasions. There were another 45 episodes of alcohol related interactions.

27. The Sobering up Shelter register noted 122 times Ms Munkara had been there from July 1996 until her death. Seventeen of those times were after 1 July 2013 and on ten of those occasions she had been taken to the Shelter by Police because she was too drunk to look after herself. On the other seven occasions she was taken there by the Darwin Night Patrol.

**The Alcohol Mandatory Treatment Scheme**

28. On 1 July 2013 the *Alcohol Mandatory Treatment Act* ('the Act") commenced. Section 3 set out the objects of the *Act*:

"The objects of this Act are to assist and protect from harm misusers of alcohol, and other persons, by providing for the mandatory assessment, treatment and management of those misusers with the aim of:

(a) stabilising and improving their health; and

(b) improving their social functioning through appropriate therapeutic and other life and work skills interventions; and

(c) restoring their capacity to make decisions about their alcohol use and personal welfare; and

(d) improving their access to ongoing treatment to reduce the risk of relapse."

29. Section 166 *Alcohol Mandatory Treatment Act* added section 128(2A) to the *Police Administration Act* requiring Police to establish the identity of a person taken into protective custody and record it.

30. Section 168 added section 128A and 128B to the *Police Administration Act*. Those sections made protective custody episodes the means by which persons were selected for assessment under the Alcohol Mandatory Treatment scheme. The trigger was a person being taken into protective custody three times in two months.

**Episodes of Protective Custody**

31. Police protective custody episodes with Ms Munkara in March, April and May of 2015 were as follows:

"1. 11.03.15 – 5.21pm – Police took her to the Sobering up Shelter. She stayed until 7.03am the following morning.

2. 26.03.15 – 9.50pm – Police took her to the Watch House. She said she was sick. The nurse said she was too high risk and she was conveyed to the Royal Darwin Hospital (RDH) by Police.

3. 01.04.15 – 5.55pm – Police took her to the Sobering up Shelter (she absconded).

4. 10.04.15 – 5.30pm – Police took her to the Watch House after the Sobering up Shelter refused to take her. She said she had been coughing blood. She was seen by the Watch House nurse and then taken to RDH by Police.

5. 21.04.15 – 7.50pm – Police took her to the Sobering up Shelter (she absconded).

6. 22.04.15 – 6.40pm – Police took her to the Watch House. The nurse gave her oxygen and St Johns Ambulance was called to transport her to RDH.

7. 14.05.15 – 10.08pm – Police took her to the Sobering up Shelter. She stayed until 6.00am the following morning."

32. Clearly Ms Munkara was taken into protective custody the required three times in two months. The requirements to trigger an assessment were present on five occasions during that three month period.

33. However there was no assessment. There are two primary reasons for that:

    1. Police have not established a system to capture all protective custody episodes. Only those where the person is taken to the Watch House are captured and recorded in the IJIS system. That is only done after fingerprinting or biometric facial recognition.

    2. On the occasions when Ms Munkara was taken to the Watch House her protective custody episodes were not recorded in IJIS because she was seen by the Watch House nurse and a recommendation made that she be taken to the Hospital prior to any formal fingerprinting or biometric facial recognition testing.

34. Those reasons raise issues about the legal compliance of the current Police systems with sections 128(2A) and 128A and the effectiveness of those systems in giving effect to the provisions of the *Alcohol Mandatory Treatment Act.*

35. These same issues arose in an inquest into the death of Christopher Murrungun. The hearing was conducted on 10 and 11 May 2016. In that case there were many more episodes of protective custody and yet Mr Murrungun

did not receive the benefit of any treatment pursuant to the *Alcohol Mandatory Treatment Act.*

36. During that hearing Police indicated that their systems did not allow for the recording of all episodes of protective custody for the purposes of the *Alcohol Mandatory Treatment Act.*

37. Police did not however provide an explanation as to why after three years of operation of the scheme they had not sought to become legally compliant. Nor did they indicate any willingness to seek to become compliant. I therefore listed this inquest in a relatively short period of time to allow for further explanation.

**Police Response**

38. The Police Acting Deputy Commissioner Chalker provided an affidavit explaining that it was only shortly before the previous inquest into the death of Mr Murrungun that they first became aware of the non-compliance. However, since that time Police have put together a team to investigate short, medium and long-term solutions and have been making enquiries about various systems for "in the field" identification. Reference was made to South Australia where police have introduced mobile fingerprint devices.

39. It was also indicated that Police were discussing with other stakeholders the possibility of amending the legislation.

40. Part of the problem was expressed to be the level of proof that may be needed by a Tribunal or Court that the person had been taken into protective custody on each occasion. Fingerprint or other biometric identification is obviously of benefit in such situations.

41. The response by Police to the issues raised at this inquest was to a far higher standard than that in the previous inquest and I commend Police for that. I also observed that Police appeared interested in learning from the inquest

and a number of Officers including the Acting Deputy Commissioner were present for the duration of the inquest.

42. There is also another issue raised by this inquest. It was also raised in the previous inquest of Mr Murrungun and the inquest into the death of Perry Langdon in 2015.

**Police failure to record custodial episodes**

43. As I expressed during the course of the inquest, there is a fundamental and broader issue: the lack of recording by Police of all custody episodes including protective custody episodes on a searchable system.

44. Currently, the only requirement in the Police General Orders is to record a protective custody episode in a Police Officer's notebook. That is not particularly useful to the organisation. As happened in the investigation into the death of Mr Murrungun, it wasn't due to Police records that the involvement of Police was discovered. Rather, it was through RDH Emergency Department notes mentioning that Mr Murrungun was brought in by Police.

45. But for that medical note, it is unlikely Police involvement would have been discovered. It illustrates the point that currently the recording of Police involvement in custody episodes (even if it were done in accordance with the Police General Orders) is not adequate. It is not adequate for the purposes of Police accountability, it is not adequate for the investigation of deaths in custody and I very much doubt it is adequate for the protection of Police themselves against allegations of wrongdoing.

46. With the current system Police cannot know how many persons are taken into protective custody, who is taken into protective custody or where that occurs. That lack of information cannot assist any operational analysis or decisions in relation to resource allocation. It also meant that it was not

possible for Police to comply with sections 128(2A) and 128A of the *Police Administration Act* without significant changes to systems being made.

47. The investigation into the death of Ms Munkara also highlighted that so little importance seems to have been attributed to recording protective custody episodes in the Police Officer's notebooks that even that system was not functioning properly.

48. The Police General Orders require that supervisors inspect notebooks "at least on a monthly basis". From the evidence in this inquest that was not happening. The end result was that the identities of Ms Munkara and the other three women were not established or recorded by Police and there was no recording of the protective custody episodes.

49. It would be easy to criticise the particular Police Officers involved. But that would be criticising a very small part of an inadequate and non-compliant system. As such it serves little purpose and detracts from the primary issues. It is obvious that the whole system needs to evolve.

50. There needs to be a recording made of all custody episodes, including all protective custody episodes, in a manner that allows for searching and retrieval.

**The Handover**

51. Police left the four women at the Sobering up Shelter. Without knowing the identity of the women, they were unable to check the Police information systems and without that they were unable to determine whether there were any "alerts" or other issues that should be conveyed to the Shelter staff.

52. For their part, the staff at the Shelter knew the women and their systems at that time did not require Police to provide them with any further information.

**Response by Mission Australia**

53. The Sobering up Shelter is run by Mission Australia. For their part the death of Ms Munkara resulted in considerable reflection and action. They have altered their systems to respond to the issues that were illustrated by the circumstances of her death.

54. The new system requires that persons in protective custody do not leave Police custody or indeed the Police vehicle until the Shelter staff:

> "1. Determine that the person consents to being admitted to the Shelter; and
>
> 2. Complete a "Pre-Admission Assessment" form that was developed in consultation with Police. The form:
>
>    a. Requires the notation of observations of:
>
>       i. signs of intoxication or drug use;
>
>       ii. any visible injuries; and
>
>    b. Records the answers to a series of questions including health questions.

55. There is no place to record the Police handover on the form. I was advised that there was a draft MOU between Police and Mission Australia that required a handover. However consideration might be given as to how that is to be prompted if not on the form.

56. The Police Officer investigating the death of Ms Munkara, Detective Sergeant Tony Henrys, provided significant feedback to Mission Australia as to processes, procedure and equipment that might be utilised to implement a more robust reception system. Mission Australia has taken that feedback seriously and has made many alterations to the manner in which the Shelter operates.

57. Mission Australia has clearly put considerable effort into the analysis and response to the circumstances of Ms Munkara's death. I commend Mission Australia for their efforts.

58. I also wish to commend Detective Sergeant Henrys. He has once more investigated the circumstances of this death objectively, intelligently and thoroughly.

59. I am not of the opinion that this death can be categorised as a death in custody and this inquest was held as a matter of discretion. Despite the issues raised by the circumstances of Ms Munkara's death, the actions or omissions of the Police or the staff at the Sobering up Shelter did not contribute to the death of Ms Munkara.

60. Pursuant to section 34 of the *Coroners Act* ("the Act"), I am required to make the following findings:

> "(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;

61. Section 34(2) of the *Act* operates to extend my function as follows:

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

62. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

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

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

63. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

(i) The identity of the deceased was Marrianne Fire Tikalaru Munkara born on 24 April 1970 at the Bathurst Island Mission on Bathurst Island in the Northern Territory.

(ii) The time of death was 10.02pm on 11 November 2015. The place of death was the Darwin Sobering up Shelter at 2 Caryota Court, Coconut Grove in the Northern Territory.

(iii) The cause of death was Bronchiectasis. Other significant conditions contributing to death but not related to the condition causing death were acute alcohol toxicity, left ventricular hypertrophy and chronic glomerulonephritis.

(iv) The particulars required to register the death:

1. The deceased was Marrianne Fire Tikalaru Munkara.

2. The deceased was of Aboriginal descent.

3. The deceased was not employed at the time of her death.

4. The death was reported to the coroner by the Police.

5. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.

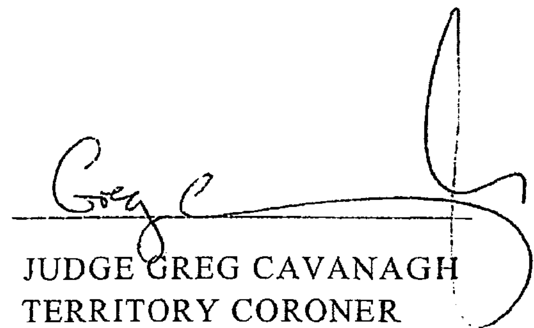
6. The deceased's mother was Clare Palleipukwaria Fire Tikalaru Munkara and her father was Sotero Arrapantiu Jabaru Bird Tikalaru Munkara.

**Recommendations**

64. I **recommend** that Police resolve the lack of compliance with sections 128(2A) and 128A *Police Administration Act*; and

65. I **recommend** that Northern Territory Police take such steps as are necessary to ensure that all episodes of custody including protective custody are recorded in a searchable digital database.

Dated this 2nd day of September 2016



JUDGE GREG CAVANAGH
TERRITORY CORONER

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ATTACHMENT B

COMMISSIONER'S OFFICE

MIN2017/0001-03 : Our Ref

The Hon Natasha Fyles MLA
Attorney-General and Minister for Justice
GPO Box 3146
DARWIN NT 0801

Dear Attorney-General

I refer to your letter dated 26 October 2016, enclosing the findings of the Northern Territory (NT) Coroner, Mr Greg Cavanagh SM, regarding the death of Ms Marianne Fire Tikalaru Munkara.

The Coroner made the following recommendations to the NT Government relevant to the NT Police Force (NTPF) and I provide my response to each, as follows:

**64. Police resolve the lack of compliance with sections 128(2A) and 128A of the *Police Administration Act*.**

In June 2016, a two day workshop was conducted to develop strategies to improve in-field identification and compliance with sections 128(2A) and 128A of the *Police Administration Act*.

In addition an audit function was introduced to reinforce with members, the use of their notebooks to record details of persons who come into police custody.

An in-field identification working group was formed post workshop and a number of initiatives have now commenced. The roll-out of Body Worn Videos (BWV) to all NTPF members was launched in September 2016 and is nearing completion. Custody incidents can now be recorded and retrieved as required.

To supplement the BWV an application called 'Capture' was developed and is currently being trialled in Darwin. 'Capture' allows members in the field using BWV to take a photograph of a person and the time and

location will automatically be recorded. Members can document when custody is transferred to night patrol, paramedics, a clinic or hospital, a place of safety or the sobering up shelter.

Additional initiatives including a proposed trial of in-field fingerprinting and the roll out of in-field facial recognition is due for release in April 2017.

**65. Police take such steps as are necessary to ensure that all episodes of custody including protective custody are recorded in a searchable digital database.**

A solution has not yet been developed to have all custody episodes relating to a person recorded in a searchable digital database. Developing a solution is a priority once we can consider the feedback provided for the current trials.

As such, I consider the requirements of this recommendation to be ongoing.

The NTPF provide biannual updates on the status of Coronial recommendations to the NT Coroner and will continue to do so.

If you have any queries, my contact officer on this matter is the Acting Executive Director David Rose, Office of the Commissioner and CEO Branch, on telephone 8985 8803 or via email David.Rose@pfes.nt.gov.au .

Yours sincerely

Reece P Kershaw APM
Commissioner of Police

2 February 2017

cc. Greg Shanahan, Chief Executive Officer,
Department of the Attorney-General and Justice