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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 Christopher Wurrmerli Murrungun

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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 Christopher Wurrmerli Murrungun (the Deceased) (refer Attachment A).

This Report includes the responses to the Coroner's Report from the Acting Chief Executive Officer (CEO) of the Department of Health (refer Attachment B) and from the Commissioner of Police (refer Attachment C).

The Deceased, a 53 year old Aboriginal male, died at 6:00am on 12 February 2015 after being taken to the Royal Darwin Hospital by Northern Territory Police on 2 February 2015, having been taken into protective custody and found to be too intoxicated for the Watch House.

The cause of death was a 'left intra cerebral and left subdural haemorrhage'.

At the time of death, the Deceased was in the custody of the Police and was a death in custody pursuant to section 12 of the *Coroners Act*. As a consequence, an inquest was mandatory pursuant to section 15(1) of the *Coroners Act*.

Recommendations of the Coroner

Following an inquest into the death of a person in custody, the Coroner must make such recommendations he considers relevant to the prevention of future deaths in similar circumstances (section 26(2) of the *Coroners Act* refers).

The Coroner may also 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:

> '106. I recommend that Police Officers be reminded of the requirements that must be fulfilled for protective custody in the context of transport to hospital specifically where there is an ambulance available.
>
> 107. I recommend that Police find a means to record on their database all episodes of custody including protective custody.
>
> 108. I recommend that Police resolve the lack of compliance with sections 128(2A) and 128A *Police Administration Act.*
>
> 109. I recommend that Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.'

At paragraphs 96-103 of the Coronial Findings, the Coroner made comments that the system of mandatory assessment and treatment did not work and the objects of the *Alcohol Mandatory Treatment Act* were not realised. He also commented that those involved in running the system did not or could not provide sufficient information to determine why the system did not function as intended.

These comments relate to the Department of Health and to NT Police.

Responses to Coroner's Report

A. Response by the Department of Health

A copy of the Coronial Findings was provided to the Acting CEO of the Department of Health on 27 October 2016, in accordance with section 46A(1) of the *Coroners Act* requiring a response which outlines the actions the Department of Health is taking, has taken or will take with regard to the Coroner's comments.

A written response was received from the Acting CEO of the Department of Health dated 27 January 2017, as required by section 46B(1) of the *Coroners Act* (refer Attachment B), to the comments made by the Coroner at paragraphs 96 to 103 of the Coroner's Report. In summary, the Department of Health advises that:

- It is possible that the Deceased could not be admitted to the assessment facility as, in 2013 and part of 2014, the Darwin Alcohol Assessment and Treatment Service (DAATS – now known as Darwin Addiction Assessment Service – DAAS) (the facility) could only admit clients between 9:00am and 3:00pm. The Deceased may have been apprehended outside of those hours, but could not have been held for more than six hours despite being eligible.

- Alternatively, the Deceased may also not have been taken for assessment if the facility was at capacity and did not have available beds. Absconded clients could only be returned to the facility if apprehended by Police and many absconded clients evade detection.

- Since June 2014, admissions have been accepted 24 hours per day and no clients have absconded from the DAAS facility since its relocation in May 2015.

- The *Alcohol Mandatory Treatment Act* also does not require that an intoxicated person be assessed or provided with episodes of care when they are taken to a sobering up shelter or hospital.

- On six occasions when the Deceased met the trigger for assessment, Police records show that no admission was possible because no beds were available. The facility's capacity has increased from eight to twelve beds since that time.

- On five occasions when the Deceased was not taken for assessment, Police records show the reason to be no response from the facility's staff. At the time, a cordless phone was being used at the facility to allow the team leader to take calls while mobile. The cordless phone has now been upgraded to a mobile phone and the facility's layout has been altered to ensure signal reception is available throughout. In addition, a receptionist has been employed during business hours to assist with call taking.

- Records are now also kept of all incidents where Police call to refer clients who meet the trigger for assessment, but cannot be admitted. These records include the reason for non-admission.

I am satisfied that the Department of Health has considered the Report of the Coroner and has taken necessary steps with respect to the comments made.

B. Response by NT Police

A copy of the Coronial Findings was provided to the Commissioner of Police on 27 October 2016, in accordance with section 46A(1) of the *Coroners Act* requiring a response which outlines the actions NT Police is taking, has taken or will take with regard to the Coroner's recommendations and comments.

A written response was received from the Commissioner of Police dated 2 February 2017, as required by section 46B(1) of the *Coroners Act* (refer Attachment C), providing the following responses to the recommendations made by the Coroner at paragraphs 106 to 109 of the Coroner's Report:

106. Police Officers be reminded of the requirements that must be fulfilled for protective custody in the context of transport to hospital specifically where there is an ambulance available.

A broadcast to Police Officers was made on 16 September 2016, reminding members of their duty of care obligations. This was also reinforced at patrol group training sessions.

107. Police find a means to record on their database all episodes of custody including protective custody.

Developing a solution to record protective custody episodes in a searchable database is a top priority to be further considered in conjunction with feedback from current trials. The requirements of this recommendation are ongoing.

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

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 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.

109. Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.

An on-going review of the police fleet is considering Officers' visibility into the cage of police vehicles. A trial of two vehicles is being undertaken to evaluate their effectiveness and this will form part of future budgetary considerations.

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

DATE: 20 FEB 2017

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NATASHA FYLES

ATTACHMENT A

CITATION: *Inquest into the death of Christopher Wurrmerli Murrungun* [2016] NTLC 016

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0029/2015
DELIVERED ON:	2 September 2016
DELIVERED AT:	Darwin
HEARING DATE(s):	10, 11 May 2016
FINDING OF:	Judge Greg Cavanagh

CATCHWORDS:

Death in Custody, protective custody, transporting on cage floor when ambulance available, Police failure to comply with legislation, failure to establish and record identity for the purposes of Alcohol Mandatory Treatment, deceased not subject to scheme despite many episodes of protective custody since scheme introduced

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Commissioner of Police and Chief Executive Officer of Department of Health:	Greg Macdonald

Judgment category classification:	A
Judgement ID number:	[2016] NTLC 016
Number of paragraphs:	109
Number of pages:	23

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

No. D0029/2015

In the matter of an Inquest into the death of

CHRISTOPHER WURRMERLI MURRUNGUN
ON 12 FEBRUARY 2015
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh:

Introduction

1. Christopher Murrungun (the deceased) was 53 years of age at the date of his death. He was born 21 August 1961 at the Groote Eylandt Mission. He was named Wurrmerli.

2. His country was Numbulwar. However in the 1990s he and his family shifted to Darwin and lived in the Bagot Community. He started to drink too much and began hitting his wife. When she left him he drank more.

3. His family tried to convince him to go back to Numbulwar and on one occasion even picked him up in a vehicle and headed off for Numbulwar. However he got out at Katherine and came back to Darwin. He said to his son, "I want to go back Numbulwar, only coffin box we go back home".[1]

4. From 1 July 2013 until the date he was admitted to Hospital for the final time (2 February 2015) he was taken into protective custody by Police on 60 occasions, that is, he was too drunk to look after himself on those occasions. On 28 of those occasions he was taken to the Watch House. On 3 occasions he was taken to the Hospital and on 29 occasions to the Sobering-Up-

[1] Interview Rodney Murrungun p 6

Shelter. On the occasions he was tested for blood alcohol levels they ranged from 0.154% to 0.40%.[2]

5. He was also taken to the hospital by ambulance on a further four occasions due to high levels of intoxication and suspected injuries. [3] He was taken to the Sobering up Shelter on another 8 occasions by Darwin Night Patrol.

6. There were another five occasions when the Police arrested him for breaching Alcohol Protection Orders and drinking in a regulated place. On the occasions that they tested his blood alcohol levels his levels ranged from 0.139% to 0.275%.[4]

7. On 1 July 2013 the *Alcohol Mandatory Treatment 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."

8. 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.

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[2] Exhibits 3, 4 and 5
[3] Exhibit 3 Hospital Records
[4] Exhibit 5 Watch House Records

9. Section 168 of the *Alcohol Mandatory Treatment Act* added sections 128A and 128B to the *Police Administration Act*, in effect, requiring Police to be the conduit by which persons were sent for mandatory assessment. The trigger was a person being taken into protective custody three times in two months.

10. One might have thought that the high number of protective custody episodes relating to Mr Murrungun would inevitably have led to him obtaining the benefits set out in the objects of the *Alcohol Mandatory Treatment Act*.

11. However that did not occur.

Circumstances of his death

12. On 2 February 2015 Mr Murrungun was drinking with his son and his brother and one other person near the Parap toilets. At about 5.00 pm they headed for the Stuart Highway with the intention of catching the number 10 bus back to Bagot Community.

13. Mr Murrungun was weaving over the footpath and seemed to be increasingly unsteady on his feet. His son and his brother realised that he wasn't going to make it to the bus stop. They saw a taxi at the front of the Parap Store and crossed the road to enquire as to its availability.

14. Others were already fighting over the taxi. While standing nearby, Mr Murrungun fell to the ground. His son and brother attempted to pick him up but his body was limp and on each occasion they picked him up he fell back to the ground.

15. Renee Brown from the nearby bottle shop observed them and described what she saw as Mr Murrungun being 'dropped on his head' on a number of occasions. She said he looked like a "rag doll". She intervened, organised for the Police to be called. She found that he was breathing but unresponsive.

16. The deceased's son and brother left and headed for the bus stop.

17. The deceased had been lying on the footpath unresponsive for 29 minutes by the time Police arrived. Ms Brown and a male that had parked near the store stayed with Mr Murrungun until the Police arrived. They are to be commended. It is plain from the CCTV footage that many of the deceased's countrymen walked past with barely a look in his direction as he lay on the footpath.

18. Police tried to rouse him. The evidence was that he would react to painful stimuli by moving a little but was not waking. He would groan occasionally.

19. Two Police pulled his arms until he was sitting upright. Police gave evidence that at that point he did awake[5] but then went straight back to sleep. From the CCTV it is clear that he was unable to sit unaided. As soon as the Police Officers relaxed the tension on his arms he returned once more to lying on the footpath.

20. Police called the Ambulance. It arrived five minutes later. The paramedics were able to rouse him such that he opened his eyes and made further sounds. The Ambulance Officers stated he was not aggressive and just seemed to want to close his eyes and go back to sleep. They made a cursory examination of him and then got the stretcher out and undid the straps ready to load him onto it and take him to Hospital.

21. A conversation then occurred during which the Ambulance Officers mentioned that they had been having a busy day. The Police offered to take Mr Murrungun to the Hospital. The ambulance officers were agreeable.

22. One of the Police Officers took hold of Mr Murrungun's right arm and pulled him to a sitting position. An ambulance officer placed her hand on his upper back so he didn't fall backwards.

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[5] Transcript p42

23. Two officers then took hold under his arms and lifted him to the standing position. He could clearly not hold his own weight and initially his legs remained on the ground but not under his body and not supporting his weight.

24. Police attempted to balance his body over his legs and then attempted to 'walk' him to the caged vehicle. His legs initially stayed behind and dragged on the ground. The Police lifted him higher and then took him to the cage of the Police van.

25. The Police searched him at the back of the van and found a Court Attendance Notice with his name on it.

26. They put him in the cage area of the van on the floor in the recovery position. There was no cushioning for his head and neither his hand nor his arm was under his head.

27. There was no reliable evidence that he was aggressive or violent. The overwhelming evidence was that he could not control his movements and could not sit or stand.

28. On presentation at the Royal Darwin Hospital at 6.40 pm he was recorded as being "drowsy". Police indicated that he was "too drunk for the watch house". They did not mention at the handover that he had been reported to have been dropped on his head multiple times.

29. Over the next four hours he became drowsier and underwent a brain CT scan that showed a "large intra parenchymal haemorrhage with subdural extension and severe distortion of neighbouring brain structures".

30. Dr Lewis Campbell an ICU Consultant at the Royal Darwin Hospital explained that the bleed originated in the substance of the brain and then extended to the lining of the brain. He said there could be detected two ages

of blood suggestive of two bleeds. There were no signs of trauma on either imaging or examination.

31. Further scans two days later did not demonstrate any lesions which would benefit from an operation. After consultation with the specialists at the Royal Adelaide Hospital, Mr Murrungun was managed conservatively. His condition did not improve and he was transferred to the stroke unit where he was palliated and died at 6.45 am on 12 February 2015.

Cause of Death

32. Doctor Lewis Campbell gave evidence that his initial presentation when brought to the Hospital was that he was too drunk for the Watch House. But when his presentation was not consistent with simply being drunk, a CT scan was performed. The scan showed bleeding in the substance of the brain.

33. His medical records note that he had a previous traumatic right subdural and subarachnoid haemorrhage in 2010 that required a decompressive craniectomy.

34. On 1 December 2014 (2 months prior to the incident causing his death) the deceased was at Bagot Community in an intoxicated state. He was said to be falling and hitting his head. He was taken to hospital where a CT Brain Scan identified a left front lobe haemorrhage. He was treated conservatively and the intracranial pressure resolved. At the time of the CT scan in his last admission the blood residue from that bleed was still observable. However there was evidence of two more recent haemorrhages.

35. Doctor Campbell observed the CCTV footage and in his opinion it was possible that the haemorrhage had already commenced when Mr Murrungun was staggering down the road and shortly thereafter becoming unresponsive.

36. Doctor Campbell gave evidence that the haemorrhage commenced in the brain but then burst into the subdural space. He said that considering the

deceased already had damage and scarring to his brain, trauma might have caused the haemorrhage. However he doubted that it was likely to have occurred in the back of the Police van.

37. The Forensic Pathologist Dr Eric Donaldson identified a left sided intra parenchymal haemorrhage 45 x 45 mm which had ruptured into the subdural space.

38. At autopsy he found:

    a. Large left subdural haemorrhage.

    b. Large left fronto temporal cerebral haemorrhage.

    c. Cerebral oedema with shift of midline structures to the right.

39. There were no features indicative of recent scalp or cranial trauma.

40. He found what he considered might have been a third and recent bleed. He was of the view that the deceased died as a result of increased intra cranial pressure resulting from left subdural and left intracerebral haemorrhage.

41. He determined the cause of death to be left intra cerebral and left subdural haemorrhage.

42. In common parlance he died after suffering a number of strokes. Those strokes were unlikely to have been caused by anything the Police or Ambulance Officers did or didn't do.

The provision of the brief of evidence and identification of the issues

43. The death of Mr Murrungun was reported to the Coroner by the staff at Royal Darwin Hospital.

44. The Coronial Investigation Unit obtained the medical records and within the last admission documents it was noted that Mr Murrungun had been taken to

the Hospital by Police. Police were not able access any details of their involvement on that day. I therefore directed that the death be investigated as a death in custody.

45. The investigation of Mr Murrungun's death was undertaken by the Major Crime Squad. The primary Investigating Officer was Detective Sergeant Anthony Henrys. Once more the investigation was of a very high standard and I thank Detective Henrys for his careful and thorough investigation.

46. On 2 December 2015 the investigation report was received from the Investigating Officer and on 7 January 2016 the dates for an inquest into Mr Murrungun's death were set (10 and 11 May 2016).

47. Letters of advice were provided to the family of Mr Murrungun, the Commissioner of Police, the North Australian Aboriginal Justice Association, the Litigation Division of the Solicitor for the Northern Territory and the Chief Executive Officer of the Department of Health.

48. The letters indicated that if further information was sought or a copy of the brief was required the Coroner's Clerk should be contacted.

49. On 14 January 2016 the Solicitor General for the Northern Territory requested a copy of the brief when it became available. No other agency or person requested a copy.

50. On 1 March 2016 an electronic copy of the brief was provided to the Solicitor for the Northern Territory.

51. On 31 March 2016 Counsel Assisting the Coroner sent a letter to the Commissioner of Police stating in part that there appeared to be two primary issues:

> "1. The manner of carriage of the deceased to the Hospital given his condition and the presence of the Ambulance; and

2. The manner of compliance with section 128(2A) *Police Administration Act.*"

52. On 12 April 2016 Detective Henrys obtained a further document titled *"PC Tan Report"* that was said to be the backend of the Integrated Justice Information System ("IJIS") relating to the 14 custodial episodes in the Watch House between 30 January 2014 and 5 June 2014 when the requirement for assessment under the Alcohol Mandatory Treatment Scheme was triggered.

53. The Report suggested that of those 14 occasions, Mr Murrungun was taken for assessment on two occasions. Of the other occasions there were six times that "no bed" appears, five times "no response" appears and once the entry "no transport".

54. On that same day the Counsel Assisting the Coroner sent an email to Mr Michael Kalimnios the Chief Operating Officer of the Top End Health Service enclosing the IJIS report and stating in part:

> "In 2014 he was taken to the Watch House on 24 occasions and was taken to the Hospital on another 6 occasions and to SUS numerous times.
>
> It was therefore of some interest that of all of the visits to the Watch House, Mr Murrungun only made it into the Alcohol Mandatory Treatment system on two occasions in February (the Tribunal did not make an order detaining him) and in March (he absconded).
>
> The Police have provided the table below that is said to be taken from the backend of IJIS that purports to show the reasons he did not make it into the system on other occasions.
>
> You will note that many of the reasons are said to be either "no response" or "no bed".
>
> I am wondering whether you have any information as to whether that is likely to be the case and if so the issues experienced or if not your belief as to the issues."

55. It wasn't until the day before the inquest that responses from Police and the Top End Health Service were received. Both responses were disappointing. They appeared to have been put together with more haste than consideration.

Ambulance v Police van

56. The Police response was under the hand of Acting Deputy Commissioner Chalker. He set out paragraph 55 of the General Orders in the following terms (original emphasis included):

> "55. Where a person is so impaired by intoxication that they cannot walk or be roused, prior to conveyance to a Watch House, the apprehending members are to:
>
> 55.1 in the case of a person **unable to walk**, convey the intoxicated person directly to the hospital or health clinic for a health assessment; or
>
> 55.2 in the case of **unconsciousness** and **unable to be roused**, request attendance of an ambulance service. Only in the case of **extreme emergency** and an **ambulance is unavailable** in a timely manner are members able to convey the unconscious person to a hospital or health clinic.

57. He then stated:

> "On the basis of the information I am aware of, in my opinion the attending members applied the procedures in place for apprehension and conveyance correctly, and carried out their duty appropriately".[6]

58. However, that response appears to have overlooked a number of aspects as detailed in paragraphs "A" and "B" below.

A. Lawfulness of Apprehension

[6] Letter from Deputy Commissioner of Police dated 9 May 2016

The first aspect is that the Police took Mr Murrungun into protective custody in circumstances that do not appear to fulfil the requirements of the *Police Administration Act.*

The relevant part for present purposes is in these terms:

> **"128 Circumstances in which a person may be apprehended**
>
> (1) A member may, without warrant, apprehend a person and take the person into custody if the member has reasonable grounds for believing:
>
> (a) the person is intoxicated; and
>
> (b) the person is in a public place or trespassing on private property; and
>
> (c) because of the person's intoxication, the person:
>
> (i) is unable to adequately care for himself or herself and it is not practicable at that time for the person to be cared for by someone else; or ..."

At the time the Police first arrived on the scene Mr Murrungan was intoxicated, in a public place and it appeared due to his intoxication he was unable to care for himself. However, by the time Police made the decision to apprehend him he was being cared for by paramedics.

It is difficult for Police to argue otherwise as Police were required by the Ambulance Officers to sign to say that they were "accepting the patient" before taking him in the police van to hospital.

The power to apprehend him, for the purposes of transport to the hospital, did not in those circumstances arise.

B. Compliance with General Orders

Clearly paragraph 55 of the General Orders was not contemplating the circumstances where an Ambulance was ready and available to take the

person to hospital. In any event, it shouldn't take a Police General Order to indicate that. Ambulances are designed for just that task.

I was encouraged by the approach of the Ambulance Officers and the Police Officers when giving evidence.

The Ambulance Officers readily conceded that they should not have allowed Mr Murrungun to go in the Police van. I agree, the Ambulance Officers should have taken Mr Murrungun to Hospital.

Likewise, the Police Officers conceded that they should not have offered to take Mr Murrungun to the Hospital. They were doing the Ambulance Officers a favour. As I commented during the hearing, they were not legally in a position to do such a favour:

> "The fact of the matter is, and I hope this gets back to the Commissioner's Office, Mr Macdonald, that police have statutory obligations, responsibilities and rights when dealing with members of the public. They are not in the same position as private individuals who are from time to time able to do people favours like saying to the St John's Ambulance, 'Look, you're a bit stressed at the moment. We'll take him to hospital'."

The reason I commented that I hoped my comments would get back to the Commissioner's Office was that the Police hierarchy appeared generally disinterested in attendance at the inquest. On the first morning there was an Assistant Commissioner and Commander in attendance. But neither returned after lunch. In the afternoon of the first day when Police gave their evidence there appeared only to be an officer supporting the witnesses and on the second day the only police person in the Court, at any time, was the Investigating Officer.

The senior officer in the Police van, Senior Constable Nancarrow was asked about the application of paragraph 20 of the General Order – Custody. It includes the following:

"20. The simplest approach to an understanding of the nature of duty of care is to answer the question – 'How would I want myself or a member of my family to be treated if I or they were in custody?' The appropriate response should invoke issues of reasonableness, lawfulness, humanity, civility and an active concern for safety and welfare. These are matters of reasonableness and should provide no difficulty in application in most situations."

He agreed that if that paragraph was considered the only option would be to use the waiting Ambulance for the transport of the person to hospital.

59. All of the witnesses provided their evidence in a frank and honest way and I commend them for that.

60. I find that the care and treatment of Mr Murrungun was not appropriate and not lawful. However that did not contribute to his death.

Impediments to ensuring safety when using the Police van

61. The trip to the hospital would have been more comfortable on an Ambulance stretcher and the opportunity to observe, and if necessary provide treatment to Mr Murrungun would only be available in the Ambulance.

62. However, had an Ambulance not been available it would have properly fallen to the Police to transport Mr Murrungun in the Police van.

63. Observation into the cage of a Police van is not so easy. The evidence was that it is most difficult to observe people in the cage. Even from the back seat it is almost impossible to see the floor area toward the front of the cage.

64. That was the area in which Mr Murrungan's head was positioned. The Police Officers were not aware that Mr Murrungan had vomited until they got to the hospital and removed him from the van.

65. I commented during the inquest that I found it difficult to accept that with the improvements in camera technology Police were not able to confront the difficulties of observing what was happening in the cage area.

Failure to Comply with Section 128(2A) and S128A *Police Administration Act*

66. Section 128(2A) is in the following terms:

> "A member who takes a person into custody under subsection (1), or any other member, must establish the person's identity by taking and recording the person's name and other information relevant to the person's identification, including photographs, fingerprints and other biometric identifiers."

67. The scheme set up by section 128A, for present purposes, can be summarised as follows:

> "If an adult is apprehended and taken into custody three times in two months the Police Officer must contact a senior assessment clinician to find out whether facilities for assessment and treatment are available and if so must arrange for the person to be taken to the assessment facility."

68. The response from the Acting Deputy Commissioner conceded that Police do not comply fully with those sections. For the purposes of the Alcohol Mandatory Treatment scheme they do not record those taken into protective custody and taken to the Sobering up Shelter, or taken home or taken to the Hospital. Protective custodies are only recorded for that scheme if the person is taken to the Watch House.

69. The Police General Orders only require Police to record protective custody episodes where the person is not taken to the Watch House in their notebooks. That information is not transferred to any database. Those protective custody episodes are not therefore available to count toward triggering the assessment of a person under the Alcohol Mandatory Treatment Scheme.

70. The response from Police indicated that the main issue they had with compliance was that the trigger system was built into IJIS and they had no system for recording protective custody episodes where the person was not taken to the Watch House on IJIS.

71. The Acting Deputy Commissioner stated:

> "The NTPF will be exploring options to refine the wording of 128(2A) of the PAA (*Police Administration Act*) as part of a current PAA Review to ensure it is consistent with the intent and practicalities of the police operating environment."

72. He went on to indicate that police would welcome my support for "clarification of the legislation".

73. However, the legislation is clear. The only issue is that the Police do not comply with it and in the three years since the introduction of the legislation have apparently made little or no effort to comply.

74. There are other issues that arise due to the lack of recording of custodial episodes. Detective Henrys noted that the failing to adequately record these interactions has a "flow on effect in the accuracy of reporting by the organisation to other parties as to the contact of the individual with police". The police Superintendent who analysed the brief before submission to my Office was of a similar view.

75. The non-recording in PROMIS was also an issue that was raised during the investigation into the death of Perry Langdon. In that case it related to the "paperless arrest" procedures rather than the protective custody procedures, but it is worrying that police systems appear not to record a significant number of the contacts between the Police and citizens.

Failure of the trigger to lead to assessment on 12 of 14 occasions

76. As has been noted, Police had recorded in IJIS the reasons why Mr Murrungun was not taken for assessment on 12 of the 14 times the trigger

was activated. On six occasions they recorded the reason as being "no bed". On five occasions "no response" and on one occasion "no transport".

77. The Police do not as a matter of course keep any other notes or make any other entries relating to the failure of the person to be able to be assessed. That is despite the *Police Administration Act* stating that Police "must" contact a senior assessment clinician and "must" arrange for the person to be taken to the assessment facility. That is regrettable.

78. On the one occasion where further entries were found, the "no response" reason had been given. Yet the real reason was different. Rather, a Notice to Appear had been served on the deceased for an offence.[7] That precluded him entering the alcohol mandatory treatment regime. Given those facts the use of the "no response" reason reduces the level of confidence in the balance of the reasons.

79. The reasons are in effect a "tick-a-box" exercise where one out of a significant number of reasons is chosen.

80. I would encourage Police to put into place a system to record their efforts to obtain assessment of any person that triggers the scheme. The mandatory nature of the requirement to do so and potential reasons why that might not occur make such recordings most prudent.

Response by Top End Health Service

81. On receipt of the reasons noted in IJIS, my Office forwarded those to the person in charge of the Alcohol Mandatory Assessment and Treatment Scheme to obtain verification of those reasons and any explanation that might wish to be proffered.

82. The Top End Health Service is run by the Top End Health Board pursuant to the *Health Services Act 2014*. Pursuant to the *Act* there is a Chief Operating

[7] Exhibit 7 – Email from Anthony Henrys dated 11 May 2016

Officer appointed. It was to the Chief Operating Officer, Mr Michael Kalimnios that my Office directed the email and attached table from IJIS.

83. The response from the Top End Health Service did not provide a picture of what was happening on the twelve days when the assessment process was triggered and Mr Murrungun was not taken for assessment.

84. The response said, "at most times during the period there were one or more beds available at the AMT Facility".[8] However, it was then stated:

> "Assessment Service capacity at the AMT Facility during the period was eight beds which enabled the assessment of a maximum of eight persons every nine days." [9]

85. Then in an email to the investigating officer (relating to figures from April 2016) the following was said:

> "Remembering that only two clients per day can be admitted to Assessment due to the intense nature of alcohol withdrawal and the assessment process. This may impact on referrals from Police and the 'no bed available' as I am told there are multiple people meeting the AMT trigger on the same day, operationally intake cannot be spread evenly over the week."[10]

86. What that meant in 2014 when there were less beds, less staff and in relation to the particular circumstances of Mr Murrungun was not explained. There was no analysis of whether other persons were admitted on the twelve days in question and if so at what time.

87. Information was provided by the Top End Health Service to demonstrate that more resources had been provided to the system:

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[8] Letter from Sandra Schmidt, Acting Director of Alcohol and Other Drugs dated 9 May 2016 paragraph 7
[9] Letter from Sandra Schmidt, Acting Director of Alcohol and Other Drugs dated 9 May 2016 paragraph 9
[10] Exhibit 8 – Email from Sandra Schmidt dated 11 May 2016

"As at January 2014 the AMT facility had one full-time SAC (Senior Assessment Clinician), with that doubling to two full-time SACs by July 2014. AMT now has a total of nine SACs in Darwin."[11]

88. Statistics were attached for two periods: the second quarter of 2014 and the last quarter of 2015. Why those periods were chosen was not explained, nor what I should make of them. The statistics were simply reproduced from the Department of Health website.

89. The figures for persons subject to treatment orders in Darwin were similar during the two periods (39 and 41 respectively) in spite of the increased resources:[12]

"a. From April to June 2014 forty-nine people were processed in Darwin, however ten were released before or during treatment or with no order made by the Tribunal.

b. In the period from October to December 2015 fifty-nine people were processed in Darwin. Eighteen were "released" before or during treatment."

90. As indicated earlier Mr Murrungun was taken for assessment on two occasions. On the first occasion, 21 February 2014 he convinced the Tribunal to let him return to his home country in Numbulwar. But he did not return. He stayed in Darwin.

91. He was once more taken for assessment on 15 March 2014, but absconded two days later before assessment could be completed. There is a document on the Top End Health Service file seeking his return. However Police were unable to find evidence on their systems that it had been received by them. I provided leave to the parties to provide any further information clarifying why he was not returned within 48 hours. Further information was provided two months later but it did not clarify why Mr Murrungun was not returned.

[11] Letter from Sandra Schmidt, Acting Director of Alcohol and Other Drugs dated 9 May 2016 paragraph 8

[12] Attachments to letter from Sandra Schmidt, Acting Director of Alcohol and Other Drugs dated 9 May 2016

92. There were another seven triggers for assessment after that time. None resulted in the assessment of Mr Murrungun.

93. Where there has been a death in custody, pursuant to section 26 (1) and (2) of the *Act* a Coroner:

> "(1) Must investigate and report on the care, supervision, and treatment of the person being held in custody; and
>
> (2) May investigate or report on a matter connected with public health or safety or the administration of justice that is relevant to the death."

94. 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."

95. 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."

Comment

96. If all of the protective custody episodes had been recorded, one would hope that the sheer weight of the numbers might have resulted in Mr Murrungun making it into the alcohol mandatory assessment and treatment system. However from the 24 occasions he was held in protective custody at the Watch House there were 14 times the requirement for assessment was triggered.

97. That Mr Murrungun was taken for assessment on only two of those occasions is bewildering. That he absconded and was not returned on the second occasion mystifying.

98. The system for mandatory assessment and treatment did not work. The system for ensuring that Mr Murrungun made it into that system did not work 93% of the time even on the relatively small number of occasions that his involvement with Police was recorded.

99. Those involved in running the system, the Police and the Top End Health Service either couldn't or didn't provide sufficient information as to where and why the system broke down on each occasion to determine why the system did not function as intended.

100. The system did not work on the occasions Mr Murrungun was taken into protective custody and taken to the Sobering up Shelter or the Hospital because those occasions were not recorded in a manner that triggered the system. It did not work on twelve of the fourteen times the system did trigger the requirement for assessment. It did not work on the occasion he absconded from assessment.

101. The system did not work. The objects of the *Act* were not realised.

102. It remains unclear why the agencies put so little effort into preparing for the inquest or why the issues were of so little interest to Police that they did not seek to attend for much of the inquest. I therefore indicated that an inquest into a death that raised similar issues, the death of Marrianne Munkara, would be heard prior to preparation and publication of my findings.

103. I was reassured by the preparation of Police for that inquest and their participation during the course of the inquest. Police are now exploring ways to record all protective custody episodes.

104. Pursuant to section 34 of the *Coroners 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*;"

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

(i) The identity of the deceased was Christopher Wurrmerli Murrungun born on 21 August 1961 at Angurugu, Groote Eylandt in the Northern Territory.

(ii) The time of death was 6.00am on 12 February 2015. The place of death was Royal Darwin Hospital in the Northern Territory.

(iii) The cause of death was Left Intra Cerebral and Left Subdural Haemorrhage.

(iv) The particulars required to register the death:

1. The deceased was Christopher Wurrmerli Murrungun.
2. The deceased was of Aboriginal descent.
3. The deceased was not employed at the time of his death.
4. The death was reported to the coroner by the Royal Darwin Hospital.
5. The cause of death was confirmed by post mortem examination carried out by Dr Eric Donaldson.
6. The deceased's mother was Alice Dumeiyingbayimia Wurramarrba and his father was Arthur Ngalu Murumurungun.

Recommendations

106. I **recommend** that Police Officers be reminded of the requirements that must be fulfilled for protective custody in the context of transport to hospital specifically where there is an ambulance available;

107. I **recommend** that Police find a means to record on their database all episodes of custody including protective custody.

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

109. I **recommend** that Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.

Dated this 2nd day of September 2016.

JUDGE GREG CAVANAGH
TERRITORY CORONER

ATTACHMENT B

NORTHERN TERRITORY GOVERNMENT

DEPARTMENT OF HEALTH

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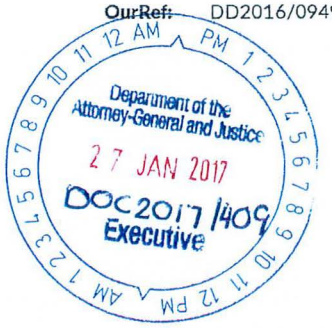

The Hon Natasha Fyles MLA
Attorney-General
Parliament House
GPO Box 3146
DARWIN NT 0801

Dear Attorney-General

RE: RESPONSE TO THE CORONIAL FINDINGS IN THE MATTER OF MR CHRISTOPHER WURRMERLI MURRUNGUN

Thank you for your letter dated 27 October 2016, which provided a copy of the Coronial Findings in in relation to the death of Mr Christopher Wurrmerli Murrungun.

In accordance with Section 46B(1) of the *Coroners Act,* as acting Chief Executive of the Department of Health, I provide a written response to the Coronial Findings. The response outlines the action the Department has taken, is taking or will take with respect to the Coroner's recommendations.

You have identified that comments at paragraph 96 to 103 are relevant to the Top End Health Service (taken also to refer to its precedents in the Department of Health, before the Top End Health Service was formed). I provide advice as follows, using the paragraph numbering from the report for ease of reference:

(96) *If all of the protective custody episodes had been recorded, one would hope that the sheer weight of the numbers might have resulted in Mr Murrungun making it into the alcohol mandatory assessment and treatment system. However from the 24 occasions he was held in protective custody at the Watch House there were 14 times the requirement for assessment was triggered.*

The Department of Health recognises the recording of protective custody episodes as a Police matter and considers that there is no further comment we can provide.

(97) *That Mr Murrungun was taken for assessment on only two of those occasions is bewildering. That he absconded and was not returned on the second occasion is mystifying.*

The Department of Health recognises that the NT Police are responsible for taking persons in protective custody, who meet the trigger for assessment, to an assessment facility. It is possible that Mr Murrungun could not be admitted to the facility as, in 2013 and part of 2014, Darwin Alcohol Assessment and Treatment Service (DAATS – now known as Darwin Addiction

Assessment Service – DAAS) could only admit clients between the hours of 0900 and 1500. Mr Murrungun may have been taken into police protective custody outside those hours, but there would have been a requirement to release him after six hours despite being eligible for assessment. Also, Mr Murrungun may not have been taken for assessment if DAATS was at capacity and did not have a bed available. Absconded persons could only be returned if they were apprehended by police and many absconded persons evade apprehension. Since June 2014, clients have been admitted 24 hours per day. No clients have absconded from the DAAS facility since its relocation to the Stringybark (Stage 2) facility in May 2015.

(98) The system for mandatory assessment and treatment did not work. The system for ensuring that Mr Murrungun made it into that system did not work 93% of the time even on the relatively small number of occasions that his involvement with police was recorded.

On six occasions when Mr Murrungun met the trigger for assessment, the police records show Mr Murrungun was not admitted as there were no beds available in the assessment facility. The facility's bed capacity has increased from eight to twelve since Mr Murrungun's death.

On five occasions, Police recorded that Mr Murrungun was not taken for assessment, noting the reason to be "no response". At the time of Mr Murrungun's death a cordless telephone was used at the assessment facility to allow the team leader to take calls whilst mobilising. The cordless phones have now been upgraded to mobile telephones and a re-designed layout of the site has ensured full signal in all locations. In addition to this a receptionist has been employed during business hours to assist with taking calls and redirecting them to the appropriate clinician.

DAAS now records incidents when police call to refer a person who meets the trigger but the person cannot be admitted, including the reason the person is not admitted; for example, the assessment facility is at capacity and there are no beds available.

(99) Those involved in running the system, the Police and the Top End Health Service, either couldn't or didn't provide the sufficient information as to where and why the system broke down on each occasion to determine why the system did not function as intended.

The Alcohol Mandatory Treatment (AMT) services operate with AMT Clinical Guidelines which provide comprehensive details and guidance on the AMT admission and assessment process. The Top End Health Service has implemented processes for recording all information and calls received from Police. DAAS has been accepting clients 24 hours per day since June 2014.

(100) The system did not work on the occasions Mr Murrungun was taken into protective custody and taken to the Sobering up Shelter or the Hospital because those occasions were not recorded in a manner that triggered the system. It did not work on twelve of the fourteen times the system did trigger the requirement for assessment. It did not work on the occasion he absconded from assessment.

When an intoxicated person is taken to a sobering up shelter or hospital, the *Alcohol Mandatory Treatment Act* does not trigger a requirement for that person to be assessed or to be provided with episodes of care under the *Alcohol Mandatory Treatment Act.*

(101) The system did not work. The objects of the Act were not realised.

Please refer to responses to paragraphs (96) to (98) and (100) above.

(102) It remains unclear why the agencies put so little effort into preparing for the inquest or why the issues were of so little interest to Police that they did not seek to attend for much of the inquest. I therefore indicated that an inquest into a death that raised similar issues, the death of Marianne Munkara, would be heard prior to preparation and publication of my findings.

The Department and the Top End Health Service sought to provide all requested information, however data was not recorded by the Department in 2013-14 in such a way as to provide all the information required. The Department attended the coronial inquest and endeavoured to provide all requested information, both at the inquest and since, to further inform the Coroner.

(103) I was reassured by the preparation of Police for that inquest and their participation during the course of the inquest. Police are now exploring ways to record all protective custody episodes.

The Department of Health recognises that this comment relates to the NT Police.

The Department of Health and the Top End Health Service are committed to continuous improvement of safety and quality in services, and Coronial Findings are an important means of identifying issues to improve systems.

Yours sincerely

J. M. Anderson

Janet Anderson PSM
27 January 2017

ATTACHMENT C

COPY

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 27 October 2016, enclosing the findings of the Northern Territory (NT) Coroner, Mr Greg Cavanagh SM, regarding the death of Mr Christopher Wurrmerli Murrungun.

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

106. Police be reminded of the requirements that must be fulfilled for protective custody in the context of transport to hospital specifically where there is an ambulance available.

Members were reminded of their duty of care by a broadcast on the 16 September 2016. Additionally this was reinforced at NTPF Patrol Group training sessions.

I consider the requirement of recommendation 106 to have been met.

107. Police find a means to record on their database all episodes of custody including protective custody.

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

I consider the requirements of this recommendation to be ongoing.

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

In addition an audit function was introduced to ensure members use their notebooks and to re-enforce the importance of recording 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 launched in September 2016 and is nearing completion. Custody incidents are recorded and can be 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 due for release in April 2017 should improve the identification of persons taken into protective custody.

109. **Police give serious consideration to installing a mechanism to provide Police Officers visibility into the cage area of the Police vans while transporting persons.**

This is on-going and will form part of a wider NTPF fleet review. Currently two transport pods are being trialled and the effectiveness of these will form part of any future budget applications.

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 on David.Rose@pfes.nt.gov.au .

Yours sincerely

Reece P Kershaw APM
Commissioner of Police

2 February 2017