CITATION: *Inquest into the death of Peter Raymond Jacobs* [2009] NTMC 004

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0107/2008
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FINDING OF:	Mr Greg Cavanagh SM

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Death in custody, Police duty of care, Watch House procedures, Medical treatment.

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman

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

No. D0107/2008

In the matter of an Inquest into the death of
PETER RAYMOND JACOBS
ON 25 MAY 2008
AT HIGH DEPENDANCY UNIT - ROYAL DARWIN HOSPITAL

FINDINGS

20 February 2009

Mr Greg Cavanagh SM:

INTRODUCTION

1. Peter Raymond Jacobs ("the deceased") was a 49-year-old Aboriginal man who was born on 5 April 1959 in the North Midlands District Hospital in Three Springs, Western Australia. At the commencement of this inquest I was alerted to the fact that the deceased had also been known by the name of Peter Anthony Cameron with a date of birth of 5 April 1953. Because the deceased's identity is relevant to these findings, I will deal with this issue at the outset.

2. The deceased was taken into protective custody on 5 April 2008 under the name Peter Raymond Jacobs. It is clear from the evidence before me that he was well known to police under that name. The name Peter Anthony Cameron was in fact the name and date of birth upon which the deceased was identified after an examination took place of his fingerprints by forensic section member, Rory MacCarthy of the fingerprint section of the Northern Territory Police.

3. During the course of these proceedings, I also received into evidence two medical files for the deceased under the name Peter Raymond Jacobs. I also

had tendered before me a birth certificate for Peter Raymond Jacobs born on 5 April 1959. A search of birth certificates registries discovered that a registration of birth under the name Peter Anthony Cameron does not exist.

4. I also heard evidence from the officer in charge of the matter, namely Detective Constable Christina O'Connor, that the next of kin of the deceased, namely Mr Lance McGrath, identified the deceased as Peter Raymond Jacobs. He also confirmed however that the deceased was known to use the alias of Peter Anthony Cameron. In all the circumstances I am satisfied that the deceased was named, and is identified, as Peter Raymond Jacobs.

5. Mr Jacobs died at approximately 7.15am on 25 May 2008 in the High Dependency Unit (HDU) at the Royal Darwin Hospital (RDH). At the time of his death the deceased was unemployed, living in the long grass and was well known to Darwin Police in the local area.

6. At approximately 6.12am on 5 April 2008 the deceased was apprehended by police under s128 of the *Police Administration Act* due to his level of intoxication. Upon being placed into a cell at the Darwin Police Station, the deceased collapsed onto the floor and appeared to undergo a seizure. Shortly thereafter police conveyed the deceased to the RDH, where he was admitted.

7. Because Mr Jacobs was in the protective custody of police immediately prior to being taken to the hospital on 5 April 2008, his death was reportable to me, as the Coroner, pursuant to *s12* of the *Coroner's Act* ("the Act"). That section defines a "person held in custody" to include:

> "A person in the custody or control of a member of the Police Force"

As a result, and pursuant to s15(1)(a) of the Act, this inquest is mandatory.

8. Further, had it been argued that because Mr Jacobs was in fact in hospital for a further 7 weeks and 1 day following being taken into protective custody, that he was not *"immediately before death a person held in ... custody",* I would still consider this inquest to be mandatory pursuant to s.15(1)(b) of the Act. I base this finding on the evidence contained in the autopsy report of Dr Sinton tendered in evidence before me that the morbid condition giving rise to the condition leading directly to death was acute blunt force head trauma.

9. Given that the evidence is that the deceased suffered an injury to his head whilst in the protective custody of police, I consider it appropriate for there to have been an inquiry into the circumstances of his death.

10. Because of my findings in this regard, s26 of the Act is relevant and provides:

> "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 the 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"

11. Pursuant to section 34 of the Act I am also required to find if possible:

> "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 registered the death under the Births, Deaths and Marriages Registration Act;

v. Any relevant circumstances concerning the death"

12. 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"

13. This inquest was held on 19 February 2009. Ms Jodi Truman appeared as Counsel assisting on each day of this inquest. There were no other formal appearances; although I note that notice of the inquest was placed in the NT News and sent to the deceased's next of kin.

14. Five witnesses were called to give evidence at this inquest, namely:

a. The Officer In Charge of the coronial investigation, namely Detective Constable Christina O'Connor;

b. Constable Wayne Hartley;

c. Constable Linda Sayers;

d. Police Auxiliary Brendan Shervill; and

e. Dr Terrence Sinton, Director of the Forensic Pathology Unit at RDH.

15. A brief of evidence containing the transcribed recordings of 5 civilian witness statements and 8 police statements, together with other reports and

police documentation was tendered at the inquest (exhibit 1). Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that involve police, they do so to the highest standard. I thank Detective O'Connor for her objective investigation.

Formal Findings

16. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings in relation to the death of Mr Peter Raymond Jacobs, as required by the Act:

i. The identity of the deceased was Peter Raymond Jacobs who was born on 5 April 1959 North Midlands District Hospital, Three Springs in Western Australia. I note that the deceased was also known by the alias Peter Anthony Cameron with a nominated date of birth of 5 April 1953.

ii. The time and place of death was at approximately 7.15am on Sunday 25 May 2008 at the High Dependency Unit at the Royal Darwin Hospital.

iii. The cause of death was acute Bronchopneumonia, as a consequence of recent intracranial and intra-cerebral haemorrhage.

iv. Particulars required to register the death:

a. The deceased was male.

b. The deceased's name was Peter Raymond Jacobs and his mother was Pearl Jacobs.

c. The deceased was of Aboriginal descent.

d. The cause of death was reported to the Coroner.

e. The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton.

f. The deceased lived as an itinerant in the long grass in the Darwin local area.

g. The deceased was unemployed.

Circumstances surrounding the death

17. Relevant events leading up to police involvement on 5 April 2008

Detective O'Connor gave evidence that she searched police records during her investigation and discovered that between 1993 and 2008 the deceased had been the subject of at least 215 separate apprehensions under s128 of the *Police Administration Act*, (ie. taken into protective custody by Police because he was too drunk to look after himself). Detective O'Connor also noted that this number did not include additional times when the deceased had in fact been conveyed to a sobering up shelter, rather than remaining in police custody. It is clear from the material obtained that the deceased was a well-known alcoholic.

The hospital files tendered also record a history of severe alcohol abuse, with details of injuries sustained whilst intoxicated either through falls or assaults. Along with those incidents of injury, there was also an extensive history of severe alcohol abuse related medical problems.

I heard evidence from Detective O'Connor that as part of her investigation she discovered an attendance by police upon the deceased on 4 April 2008. I find that at about 10.12am, a 000 call was received by police from a Mr Kevin Hart who requested police attend at the ruins of the Old Town Hall in Smith Street, Darwin. A transcript of the taped conversation conducted with Kevin Hart on 28 May 2008 formed part of exhibit 1.

I find that on 4 April 2008 Mr Hart had been drinking with the deceased at the Old Town Hall ruins and that they both had been drinking fairly heavy. I find that at one stage the deceased stood up, his knees gave way and he fell backwards hitting his head very hard on the cement. I note the description

from Mr Hart in his statement that the deceased "*just hit his head really hard*" and that when this occurred he heard "*a bang*". Mr Hart goes on to state "*I just seen a lot of bang of his head*".

18. As a result, Mr Hart rang 000. Both St Johns Ambulance and Police attended at the scene. I note transcripts of recorded statements taken from Constables Mark Derksen and Gabriel Mercep, who attended, also formed part of exhibit 1. Those statements confirm that they attended upon the deceased at the Town Hall ruins, sometime after 10am, and that the deceased told them he had basically been "*just having a sleep*", and did not want any assistance.

19. Also tendered before me was a copy of the St Johns Ambulance notes for the attendance on that day (exhibit 7). These record the Ambulance crew arrived at the scene at approximately 10.31am. The deceased "*very loudly told crew to go away*" and "*refused to have obs taken*". I infer from the words "obs" that this refers to observations. I note that at the bottom of the St Johns Ambulance attendance there appears to be a signature of the deceased in the area of the form indicating that he had refused treatment/transport to a hospital despite such treatment/transport being advised.

20. Unfortunately, although it is clear that there was a significant enough fall by the deceased as to result in an audible sound, and for a fellow itinerant to have concern enough to call 000, I am unable to determine the significance or otherwise of any injury the deceased may have suffered on that day.

21. I heard evidence from Detective O'Connor that some time after 4.30am on 5 April 2008 the deceased was observed by staff from "Nocturnal Security Services" to be intoxicated and asleep at the old NTEC building car park in Litchfield Street. I note transcripts of recorded statements from Mr Ian Spooner and Security Officer Mr Corey Holz were tendered as part of exhibit 1. Those statements make clear that the security officers, after

several attempts, were eventually able to wake the deceased and requested that he move on.

22. Mr Holz recalls that the deceased was "*obviously intoxicated*", was having a bit of trouble getting up, and was "*very aggro*". Mr Holz states that he assisted the deceased by removing him from the car park and then put him down outside the front gate and asked him to wait. At that point in time Mr Holz states that Mr Spooner telephoned for the police because the deceased appeared "*obviously too drunk*" and they didn't want him to "*get hurt*" or "*get into trouble*" because of his intoxication.

23. I had tendered before me (exhibit 4) a "Summary of Events Chronology" which recorded all relevant events as per contact with police communications ("COMMS") in relation to the deceased. That records the phone call from Mr Spooner as being received at 4.58am.

24. Mr Holz states that despite asking the deceased to wait, the deceased left the area. He watched the deceased walk off and as he saw him walking up towards Darwin Centrelink, he saw the deceased fall onto the ground, on his back, with the back of his head hitting the ground. Mr Holz states in his statement that the deceased did not appear to do anything with his arms to attempt to stop himself from falling, and that he fell straight onto the bitumen.

25. Mr Holz is recorded as saying that it took the deceased a while to get back up, but then he got back up as if nothing had happened. Mr Holz states the deceased was on the ground for no more than 5 minutes. Thereafter Mr Holz stated that the deceased's walking became a "*bit better*" and that "*he wasn't staggering as much*". Both Mr Holz and Mr Spooner went on with their duties and saw the deceased again at approximately 5.30am on Woods Street, but had no further dealings with him at that time.

26. Again I am unable to establish from the evidence before me the significance or otherwise of any injury the deceased may have suffered from the fall witnessed by the security officers in the early hours of 5 April 2008.

Police Involvement on 5 April 2008

27. I heard evidence from Detective O'Connor that after receiving the call from Mr Ian Spooner, police constables Hartley and Sayers were dispatched by police communications to locate an "intoxicated person" at approximately 6.05am. Those officers are recorded in exhibit 4 as discovering the deceased and taking him into protective custody under s128 of the *Police Administration Act* as a result of his level of intoxication at 6.12am. The deceased is recorded in exhibit 4 as arriving at the Darwin Watch House at approximately 6.17am.

28. Also tendered before me as part of exhibit 1, were 4 DVD recordings of the closed circuit television ("CCTV") footage taken at the Darwin Watch House. Those DVD's record the processing of the deceased at the Watch House and his placement into cell M5.

29. Constable Hartley gave evidence that shortly after closing the door to the cell, the deceased appeared to take a few steps, but then fell to the ground and began shaking as if to be suffering a fit or seizure of some kind. Constable Sayers and Auxiliary Shervill supported this evidence. I pause to note that the CCTV footage also clearly shows these events. Both Constable Hartley and Auxiliary Shervill gave evidence that upon seeing the deceased fitting, Auxiliary Shervill reopened the cell door and Constable Hartley placed the deceased into the coma position.

30. I heard evidence that the reason the deceased was taken to the Darwin Watch House, rather than a sobering up shelter was because it was the early hours of a Sunday morning, and the officers understood that the doors to the sobering up shelters actually closed at 2am and therefore there would not be

a place available for the deceased. In this regard, Detective O'Connor stated that as part of her investigations she discovered the sobering up shelter hours were 4pm to 2am Monday to Saturday. I also had tendered in evidence a pamphlet for the sobering up shelter confirming these hours (exhibit 8).

31. Detective O'Connor also stated in evidence that in accordance with s17.1 of the Custody Standard Operating Procedures, police were required to record the reason why the deceased had not been conveyed to a sobering up shelter. I heard evidence that this recording had not occurred. Constable Hartley gave evidence that the reason for this is that the receiving hours of the sobering up shelters are well known to police and therefore the notation was not made because the deceased's apprehension was outside those hours. I consider very little turns on this point.

32. After the deceased had finished "fitting", I heard evidence from Constable Hartley that a decision was made to move the deceased and take him to hospital. Constable Hartley stated that at that time he was aware that there was a fatal accident on the Stuart Highway, which he knew was causing a drain on the resources of both police and ambulance. Constable Hartley stated that given it was a very busy time of shift, he made a determination that there would be a significant time delay if they awaited attendance of St John Ambulance to convey the deceased to the hospital. He therefore formed an opinion that the best option in the circumstances was for police to get the deceased to the hospital as quickly as possible. Constable Hartley gave evidence that he formed the opinion that the fastest way of doing that would be to take the deceased himself, via a police vehicle.

33. I also heard evidence from Constable Linda Sayers in relation to her recollection of events. Constable Sayers stated that she was at the Watch House desk at the time that the deceased was placed into the cell. She did

not see the moment when the deceased fell, however she became aware of it very soon thereafter.

34. Constable Sayers gave evidence that her recollection of the reason why police decided to take the deceased in the back of the police vehicle, rather than by ambulance, was because police wanted to get the deceased to the hospital as quickly as possible and that she had "recent" experience with the ambulance where they had been extremely busy and had taken a considerable period of time to arrive. Constable Sayers stated that she considered the police taking the deceased was the quickest way she could think of in terms of getting him to the hospital and getting him medical help.

35. Police Auxiliary Brendan Shervill also gave evidence as to the events at the station. Auxiliary Shervill stated that he also considered that they should get the deceased to the hospital for an assessment as soon as possible and he saw the officers take the deceased in the back of a caged vehicle.

36. As part of exhibit 1 there were also recorded statements from Sergeant Megan Blackwell, who was the Shift Supervisor on the morning of 5 April 2008, and from Senior Sergeant Gary Smith, who was the Watch Commander for that shift. Both senior officers confirmed in their statements that as part of the requirements of the Custody Manual, the Watch Commander or Shift Supervisor should be notified by members of any requirement of a person, who has been taken into protective custody, requiring medical attention. Each senior officer confirmed in their recorded statements however that at the relevant time they were in attendance at a fatal motor vehicle accident on the Stuart Highway in the area of Armidale Street just before Goyder Road, which required a great deal of man power from the Darwin sector and St Johns Ambulance. Each confirmed that they were contactable via mobile or radio.

37. I note that the Custody Manual was also tendered in evidence before me as exhibit 5. Relevantly the Custody Manual states at Part 4 "Safety and Welfare are Primary Responsibilities". At Part 4.1 the manual states:

> "The primary consideration in relation to a person in custody or a person who police are considering taking into custody is the safety and welfare of the individual. Where a person exhibits signs of illness or is unconscious and cannot be roused or if any other doubt exists as to the persons condition:
>
> 4.1.1 that person should be conveyed immediately to the casualty area of the nearest hospital or medical centre; or
>
> 4.1.2 an ambulance should be called; or
>
> 4.1.3 medical attention should be given at the place where the person is in custody,
>
> whichever appears the most appropriate in the circumstances"

38. On the evidence it does not appear unreasonable that the police would have had in the forefront of their minds a desire, especially where it was difficult to rouse a sensible response from the deceased, to take him to hospital as quickly as possible.

39. Perusal of the CCTV footage contained in exhibit 1 depicts Constable Hartley and Auxiliary Shervill drag the deceased by his arms from the cell to the vehicle located in the sally port of the Darwin Watch House. At first blush, it could be argued that such footage is confronting. I heard evidence from Constable Hartley and Auxiliary Shervill however that the reason why the deceased was dragged in such a manner was because they were concerned that if the deceased did commence fitting again, they considered that he needed to be placed in a position where he was close to the ground so as to avoid any further injury.

40. I pause to note here that the video footage tendered in evidence does not depict any attempts to carry the deceased. However I accept the evidence given to me by Constable Hartley and Auxiliary Shervill that they did attempt to do this. I also accept their evidence that at the time they considered that the way in which they took the deceased out to the vehicle to be the most appropriate in the circumstances.

41. The video footage then depicts the deceased being placed in the back of a caged police vehicle. Prior to being placed in that vehicle there does not appear to have been anything placed into the cage to protect the deceased from any further injury. I heard evidence from Constable Hartley that in hindsight the best option probably would have been to have put a blanket into the cage to secure the deceased's head, however I note the evidence of Constable Sayers that she considers that a blanket could have made the surface slippery, and therefore more dangerous, for the deceased in the back of the vehicle. I do not consider that there can be any criticism of the officers in terms of their placement of the deceased in the cage and find they did what they thought best for the deceased at the relevant time when they placed him into the coma position in the rear of the vehicle.

42. I note the "Summary of Events" (exhibit 4) records the police vehicle being en-route to the RDH at 6.30am. Neither Constables Hartley nor Sayers could recall if they stopped the vehicle on the way to check on the deceased, although Constable Sayers states that she "*always*" pulls over if someone is in the back to check out their condition and therefore she considers this is what she would have done on this occasion. I accept that evidence.

Attendance at Hospital

43. The "Summary of Events" (exhibit 4) records police arriving at RDH with the deceased at 6.42am on 5 April 2008. As stated previously the hospital files for the deceased were tendered in evidence as exhibit 2. Also tendered in evidence, as part of exhibit 1 was the transcript of the recorded statement

taken with Professor Bartholomew Currie, a staff specialist physician and Professor in medicine at RDH. Dr Currie was one of the physicians on medical unit 4 at the RDH at the time of the deceased's admission.

44. Relevantly from the transcript of the statement from Dr Currie I note that the deceased was initially admitted under the care of Dr Kevin Smith, under the general surgery unit of the RDH. The hospital notes record the deceased as having two seizures in the emergency department. It is noted in the transcript of the statement from Dr Currie that the initial CAT scan showed bilateral contusion (or bruises) to the fronto-parietal portion of the deceased's brain, in addition to a small subdural haematoma (or blood clot) in the left parietal temporal region. In his statement Dr Currie stated such injuries were consistent with a history of head injury or head injuries and the deceased was commenced upon treatment for a head injury with anti-epileptic or anti-seizure therapy with a drug called Phemytoin.

45. In his statement Dr Currie is recorded as stating that the contusions were not something that would be operated on immediately and would simply be watched over.

46. Contained in the RDH file (exhibit 2) were numerous references to the deceased being described as "*sleepy, irritable, confused and aggressive*", but there were also times where the deceased was cognisant enough to at one stage even have removed himself from the ward.

47. Dr Currie stated in his statement that on the 23rd April 2008 the physicians' section (his section) of the hospital was approached for the first time by the surgeons to take over the care of the deceased. Dr Currie stated that at that time the surgeons considered that the head injury was resolving, but were concerned that the deceased still had a fluctuating conscious state; at times appearing lucid, and at other times being irritable and disorientated. I pause to note here that the RDH records also show that despite having fallen off the bed in the early hours of the morning of 25 April 2008, a CT scan

conducted on 28 April 2008 records the "*cortical contusions resolved. Vasogenic oedema frontal lobe has decreased since last study*".

48. Dr Currie's statement records that by the time his unit were approached, the deceased's head injury was already noted to be on the background of severe cirrhosis of the liver (permanent and irreversible scarring of the liver) attributed to a combination of alcohol and Hepatitis B infection, with a category C of cirrhosis, which he described as a very poor prognosis. Dr Currie's statement records that the Registrar of the physicians medical unit, namely Dr Ed Raby, conducted a thorough assessment of the deceased on 23 April 2008. As a result, it was diagnosed that the fluctuating conscious state of the deceased was due most likely to Hepatic Encephalopathy. The physicians therefore instituted a plan involving specific therapy for Hepatic Encephalopathy.

49. I received evidence that Hepatic Encephalopathy is damage to the brain and nervous system as a result of a complication of liver disorders. The disorder causes changes in reflexes, consciousness and behaviour that can range from mild to severe. Dr Currie stated that in terms of the diagnosis of Class C cirrhosis, the deceased had a 45% chance of surviving for a further 12 months, and a 35% chance of surviving for a further 24 months. It is clear from the statement of Dr Currie that the deceased had significant health problems. In this regard I also note the autopsy report of Dr Sinton, which formed part of exhibit 1, which noted the deceased as suffering long-standing brain, liver and coronary artery disease.

50. The deceased was formally transferred to the medical unit on 2 May 2008, at which point in time Dr Currie took over the care of the deceased. Treatment continued in the medical unit thereafter and on 17 May 2008 a further CT scan was performed which showed further resolution of the previous trauma changes to the deceased's brain and that there was no haemorrhage at that stage. It appears clear on the evidence that as at 17 May 2008, the trauma

from the blows to the head occurring on 4 and 5 April 2008 appeared to have resolved, and what remained were the old changes as a result of previous blows.

51. Dr Currie's statement sets out that on 17 May 2008, despite the treatment being provided, there was evidence of changes in the white blood cells consistent with the possibility of a further infection. Dr Currie's statement makes clear that by this stage, whilst the deceased's condition had fluctuated from day to day he appeared clearly worse and Dr Currie believed that this was as a result of a respiratory infection and pneumonia, caused by aspiration due to the deceased's fluctuating altered conscious state.

52. Dr Currie explains in his statement that what this means is that although at times the deceased was able to eat and drink, there were also times where his conscious state fluctuated and he may have aspirated (or breathed in) some of his oral secretions. As a result, as at 18 May 2008, the diagnosis of Hepatic Encephalopathy was now being complicated by the pneumonia. Dr Currie's statement sets out that they then began an intravenous drug called Timentin.

53. The statement of Dr Currie records that after 24 hours of Timentin there was some improvement, however the deceased's state continued to fluctuate and relatives were contacted in relation to the deceased's state and the likelihood of its permanency. It is clear from the statement of Dr Currie that unfortunately, despite all of the attempts to improve the deceased's condition, he continued to deteriorate on the ward.

54. Dr Currie is then recorded as stating that consideration was given to transfer to the HDU for treatment using "high flow oxygen". This was a relatively new technique available in the HDU at RDH where a patient is able to get almost 100% oxygen, without having to place a tube into them and sedate or ventilate them. Dr Currie stated that this treatment had turned around a number of pneumonia patients in the past that would have either died or

required intubation and ventilation. Dr Currie's statement records that because of the severity of the deceased's Hepatic Encephalopathy it would not have been of benefit to him to ventilate him. Therefore the option of high flow oxygen was considered preferable.

55. The statement of Dr Currie records that on 23 May 2008 the deceased was transferred to the High Dependency Unit and plans were made for the use of high flow oxygen. In the unit the deceased was co-managed with the intensive care doctors and the physicians, which continued to include Dr Currie. Despite the use of the high flow oxygen the deceased continued to deteriorate, and ultimately died at 7.15am on 25 May 2008.

56. Dr Currie's statement records that the cause of death was "*clearly the pneumonia*" which had developed during his time in hospital and was as a result of his altered conscious state, which was related to the Hepatic Encephalopathy from the severe cirrhosis.

57. In this regard Dr Sinton gave evidence that in his opinion it was the fall most recent to the deceased's collapse (ie that occurring on 5 April 2008 in the watch house) that was the one most likely to have been responsible for the acute blunt head trauma seen at autopsy. Dr Sinton did state however that the deceased's general health was "*awful*" and he considered it extremely unlikely that the deceased would have survived for much longer than he did. Dr Sinton specifically identified the deceased's cirrhosis and noted it was a terminal condition. Dr Sinton agreed that, in terms of health, the deceased was basically a "walking time bomb".

Findings and Recommendations

58. I find that everything that could have been done for the deceased at the Royal Darwin Hospital was done. There can be no criticism of the level of care provided by the hospital in relation to Mr Jacobs.

59. Counsel assisting suggested at the commencement of this inquest that one of the questions to be considered by me was whether there was anything that could have been done better by police in their apprehension of the deceased and their response to him following his seizure at the Darwin Watch House.

60. As noted earlier in these findings, although it could be argued that the video footage taken from the CCTV cameras at the police station is confronting, I consider that the explanations given to me during the oral evidence taken from Constables Hartley and Sayers, together with the evidence of Auxiliary Shervill, are satisfactory in terms of what they considered to be the most appropriate action in relation to the deceased at that time.

61. It must be recalled that this occurred in the early hours of a Sunday morning, after what I consider would no doubt have been an extremely busy Saturday night in the Darwin Watch House. The deceased was intoxicated, and concern was had in relation to him causing further injury to his head, should he fit once again.

62. In terms of the placement of an intoxicated person into the rear of a police cage who has just been witnessed to suffer a fit, without the placement of any item/s into the rear of the police cage to protect that persons head from further injury, I accept that the individual police officers involved considered at the time that they were placing the deceased in the safest position they could to get him to hospital as quickly as they could. I also accept Constable Sayers evidence that police periodically stopped on the way to check the condition of the deceased. I note the deceased was at the time in police protective custody and therefore it was not appropriate to lay him on the back seat.

63. As I stated during the course of this inquest it is my finding that the actions of police to the situation they were faced with, when the deceased collapsed in the cells at the Darwin watch house were a good example of how things should be done by police when faced with such a situation. I repeat my

congratulations to the police officers involved in relation to their actions on that day.

64. I find that the relevant officers endeavoured to do all that they could to get a man (who appeared to require urgent medical assistance) to hospital as quickly as possible, in circumstances where they considered it more likely than not that there would be significant delays if an ambulance were called. I do not consider this inappropriate, and I would not want it to be the case that in such circumstances, where there is an apparent immediate/urgent need for medical attention, that police would simply "wait it out" on an ambulance when they knew in all likelihood it would be a significant period of time before one would arrive.

65. I am satisfied on the basis of the investigation, exhibits and oral evidence that I have heard and received at this Inquest, that the actions taken by the Northern Territory Police were reasonable and were done with the intention of prioritising the deceased's immediate medical needs. That is to say, I have no criticisms to make of the NT Police in relation their duty of care. Indeed, I commend their performance in this regard.

66. I am also satisfied that the action taken in relation to the medical care of the deceased at the RDH was appropriate and all reasonable attempts were made to try and keep the deceased alive following his admission. Unfortunately due to the deceased's extremely poor general health, which effectively made him a "walking time bomb", and the complications that arose therefrom, I find that his death could not be avoided.

67. I have no recommendations to make arising from the proceedings of this Inquest.

Dated this 20th day of February 2009.

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GREG CAVANAGH
TERRITORY CORONER