CITATION:	*Inquest into the death of Marcellus Tipiloura* [2005] NTMC 055
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coroners
FILE NO(s):	D0144/2003
DELIVERED ON:	31 August 2005
DELIVERED AT:	Darwin
HEARING DATE(s):	1, 2 November and 3 December 2004
FINDING OF:	Mr G Cavanagh SM

CATCHWORDS:

Coronial Inquest, death in custody, death from self-inflicted wounds, involvement of police, ambulance officers treatment, reception at hospital.

REPRESENTATION:

Counsel:

Assisting the Coroner:	Mr Jon Tippett Q.C
St Johns Ambulance Service:	Mr Steve Southwood Q.C
Northern Territory Police:	Mr R Bruxner
Family of Deceased:	Mr G Francis

Judgment category classification:	A
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0144/2003

In the matter of an Inquest into the death of

MARCELLUS TIPILOURA
ON 5 OCTOBER 2003
AT EMERGENCY DEPARTMENT –
ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 31 August 2005)

Mr G CAVANAGH SM:

1. This death is properly categorised as a death in custody. At the time of his death, Marcellus Tipiloura ("the deceased") was a person that police officers were endeavouring to detain and disarm. The deceased, therefore, was a "person held in custody" within the definition in s.12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act"). His death is a "reportable death" which is required to be investigated by the Coroner pursuant to s.14 (2) of the Act; a mandatory public inquest must be held pursuant to s.15 (1)(c).

2. The scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of the Act. It is convenient and appropriate to recite these provisions in full:

> "26. Report on Additional Matters by Coroner
>
> (1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –
>
> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to

by injuries sustained while being held in custody; and

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

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

27. Coroner to send Report, &c., to Attorney-General

(1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.

34. Coroners' Findings and Comments

(1) A coroner investigating –

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

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

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

(v) any relevant circumstances concerning the death.

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

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

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

35. Coroners' Reports

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

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

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

3. The inquest hearing commenced on Monday, 1 November 2004 and evidence and submissions closed on Friday, 3 December 2004. Mr Jon Tippett was counsel assisting me and I thank him. Mr Steve Southwood Q.C applied for leave to appear for St John Ambulance Service, Mr R Bruxner applied for leave to appear for the Northern Territory Police, Mr G Francis applied for leave to appear for the family of the deceased; I granted leave. Mr Bruxner applied for leave to withdraw prior to the completion of the inquest given the state of evidence in relation to the Northern Territory Police (such evidence not appearing to result in any criticism of police behaviour).

CORONERS FORMAL FINDINGS

4. In accordance with the statutory requirements under the Act, the following are my formal findings arising from this inquest:

i. Identity: The deceased is Marcellus Tipiloura (also known as Marcus Tiploura, and registered at birth under the name of Liam John Tipiloura), a male Australian Aboriginal, who was

born on 2 June 1977 at Darwin in Northern Territory of Australia.

ii. The time and place of death: The deceased died on the 5 October 2003 somewhere between travel by ambulance from 12 Marshall Court, Malak at 3.38pm and arrival at Royal Darwin Hospital at 3.45pm during which time his heart stopped beating. After emergency treatment to restart his heart failed, he was pronounced dead by treating doctors at 4.10pm.

iii. The cause of death: The cause of death was a cut throat inflicted by the deceased himself.

iv. The particulars required to register the death are as follows:

a) The deceased was a male;

b) The deceased was of Aboriginal origin;

c) A post mortem examination was carried out on 6 October 2003 and the cause of death was as per paragraph 3(iii) hereof;

d) The pathologist viewed the body after death;

e) The pathologist was Dr Nigel Buxton, Locum Forensic Pathologist, Royal Darwin Hospital;

f) The father of the deceased is Damien Paramaralijuna Tipiloura;

g) The mother of the deceased is Marie Gertrude Pirraingungtamila;

h) The deceased resided intermittently on Bathurst Island and 12 Marshall Court, Malak at the time of his death;

i) The deceased was not employed in any occupation at the time of his death.

Treatment of the deceased whilst in custody

5. I find that there is no evidence of the involvement of any suspicious circumstances relating to the death of the deceased and, accordingly, no report is required under s.35(3) of the Act. Furthermore, I find that the deceased did sustain injuries during the attempted detention by police which caused or contributed to this death, however such injuries were self-inflicted and not the result in any way of police action.

THE RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING RECOMMENDATIONS

6. The deceased brought about his own death on the morning of 5 October 2003. The Forensic Pathologist, Nigel Buxton, described the cause of death as "suicidal cut throat". The circumstances of his death were traumatic, both for the members of his family and the members of the emergency services who attended to him in the minutes before he died. He was born Liam John Tipiloura. He was never accustomed to using his given names and preferred Marcellus for as long as family members could remember. His sister, Rosemary Tipiloura, and her son, Mr Robbie Collins, who attended this inquest throughout the hearing of evidence, confirmed that the deceased never used the Christian names set out in his birth certificate. The deceased was an Aboriginal man who came from Bathurst Island in the Northern Territory. He was only 26 years of age when he died. The deceased was a loving father and a loved husband. His abuse of alcohol and cannabis resulted in much angst, family disturbance and violence, and eventually led to his tragic death. Before he died he told his wife that he felt ostracised and hated by members of his own family. The evidence of this inquest demonstrated that the truth was quite the opposite. Further, the evidence

shows that no family member could have done anything more to avoid the tragedy that was Marcus Tipiloura's death.

7. On Sunday 5 October 2003, Christine Rosemary Lynch telephoned the police on emergency number 000. The time was 2.34 in the morning. She told police "I'm in a domestic violence situation" and "my ex husband's got a knife and wants to kill himself". She told police emergency that her husband was in her house and when asked by the operator, "so what did he say to you?" she replied, "that he wants to - that he wants to kill me and himself, please hurry up." She continued to speak to the police operator as police unit 414 was despatched at 2.36am to Ms Lynch's premises at 12 Marshall Court, Malak. It was not the first time that police had been despatched to 12 Marshall Court at the request of Ms Lynch, for she had experienced threats of violence and actual violence at the hands of her estranged husband Marcellus Tipiloura in the past. The violence that had erupted between them had resulted in Ms Lynch obtaining a full non contact domestic violence order against her husband. They had been together for nine years. In that period they had four children together, Danianna (now eight years old), Courtney (now seven), Peter (now four) and Marie (now twenty-eight months). The children are well cared for.

8. The previous evening Ms Lynch had flown in from Bathurst Island. She had the youngest two children with her. She got home from the airport at about 6.00pm and found the deceased at home. He acknowledged to her that he was not really supposed to be there. Ms Lynch told police that he was aware of the non contact restraining order and that he had been legally advised as to the implication of such an order by his legal representative from "Legal Aid". Nevertheless, the deceased remained at 12 Marshall Court, Malak. At about 7.30 on the evening of Saturday 4 October, the deceased left the Malak residence to walk to the shops. He took his little boy, Peter, with him. He returned not long afterwards with a half carton of Melbourne Bitter beer. Ms Lynch had been exposed to the deceased's violent mood swings

after he had consumed alcohol in the past which he often did in association with smoking marijuana. On seeing the beer in her husband's possession, Ms Lynch said to him, 'please don't drink, you know if you're going to drink, please go somewhere else. The park or your sister's house." Marcus replied, "No, I'm going to drink here." To which, Ms Lynch responded, "You know you always argue when you're drunk." As a precaution, Ms Lynch went to a room in the house she described as the "safe room". It was a room that was barred and could be locked so that no-one could enter it and once inside and locked in, Ms Lynch was safe from any violent mood swings experienced by her husband. She and the children had dinner and watched TV and then a DVD. Later, due to the deceased's behaviour, Ms Lynch went into the safe room. At approximately 9.00pm, she came out of the safe room momentarily to find the deceased drunk. She also believed he had been smoking marijuana although she did not observe this. Ms Lynch requested the deceased to "go to your sister's house now, because the kids have to go to sleep". The deceased replied, "no, I want to stay a bit longer". The deceased and Ms Lynch began talking. Initially, he wanted to know why it was that his sister did not come around and visit his children at the Malak house. He told Ms Lynch he believed his sister hated him and that Ms Lynch also hated him and had arranged things so that he could not be with her and the children. Ms Lynch told the deceased, "I don't hate you. You know, you've got to stop drinking. You've got to stop smoking. You've got to help yourself first if you want to get back with me and the kids. So just leave all the things you've got with your family." Ms Lynch went on to tell him that she would always support him but that he had to help himself first. That brought a final response from the deceased who told her, "Alright, I'm going to kill myself".

9. It was not the first time that the deceased had told his wife he wanted to hang himself or kill himself. He had said it on occasions in the past. Ms Lynch told the inquest that he would say it "when he was like, when he was

drunk. But he wouldn't say it when he was sober, just when he was drunk and he was smoking." At the point at which the deceased threatened to take his own life, Christine had already retreated back into the locked safety of the "safe room". From that place she listened to his movement about the house and his ranting about people not liking him and other personal matters including the constant threats that he would kill himself. That behaviour continued for some time. Then the deceased went very quiet. Ms Lynch told police that at that point, "I knew something was wrong because usually just he's, you know, more of an angry type when he gets drunk. He just used to yell." At that point, Ms Lynch rang the police. At the time she made the telephone call she believed that the deceased had a knife, although she had not actually seen it. She concluded he had a knife because he was saying, "I've got a knife, I'm going to kill myself."

10. Another witness, Nicholas James Lynch, who also resided at 12 Marshall Court, Malak, had been woken by the deceased raising his voice in the house. There was pandemonium and Nicholas remained awake although he tried to go back to sleep. Nicholas told police in his statement (Folio 4 exhibit 1), "then it was quiet for a little while and that's when I heard that knife sharpening." He remained in bed until the police arrived.

11. It was intended that Nicholas Lynch be called as a witness in the inquest, however, he could not be located by officers assisting the Office of the Coroner. His sister, Ms Lynch, was unable to assist as to his whereabouts. However, a detailed statement was obtained from him by investigating police only a very short time after the death of the deceased and there is nothing, either in that statement or in the activities of Mr Lynch, that might indicate that the account given by him to police was anything but frank and the produce of his best efforts to recall the events of the morning.

THE ARRIVAL OF POLICE

12. Four officers attended at 12 Marshall Court, Malak on Sunday 5 October 2003 in response to Christine Lynch's call for assistance. Constable Alan Bruce Davis was accompanied by his partner, Constable Ben Rossiter and Constable Ashley James Dudson was accompanied by his partner, Senior Constable John Walker. Constables Dudson and Walker had been attending an unrelated job when they heard over the police radio that unit 414 carrying Rossiter and Davis was on its way to an incident where a man had made threats with a knife. They arrived at 12 Marshall Court within 30 seconds of the arrival of Davis and Rossiter.

13. Constable Davis had been advised by radio that the most likely unlocked entry point to the house was the back door. Initially, they made an inspection of the house by torch light. Constable Dudson opened the door and Constable Davis moved into the house. The other officers followed them into the house and into the lounge room. They determined that that area of the house was clear. They moved through the house. Constable Davis moved from the lounge room across to a cupboard that was immediately to his left and up against the kitchen. There were three doors to the cupboard. Constable Davis described the cupboard as like a linen press cupboard. As he got the first door he grabbed it with his right hand and opened it slightly. By the time he had opened the door approximately half way he saw an Aboriginal male in the cupboard. The man was holding a knife. Constable Davis does not have a clear recollection of where the knife was exactly being held, but he believes around the man's chest area. Constable Davis immediately slammed the door and put his foot against it and said words to the effect of, "he's in here". Constable Rossiter was present with him and had his hands on the door handle. The door remained closed for a second or two. Constable Dudson and Walker walked towards and behind Constable Davis and Rossiter. Constable Davis said, "spray

him". At that time, according to his recollection, the officers all had Aerosol Subject Restraints (ASRs) referred to as OC spray.

14. Constable Davis opened the door and Constable Walker simultaneously sprayed the deceased in the cupboard. At that point, the deceased fell out of the cupboard and onto the floor. The police officers stepped back. The deceased was on his hands and knees facing down towards the bedrooms. Constable Davis could see that he was bleeding and that his departure from the cupboard resulted in him "splattering a lot of blood everywhere." He remained in a "doggy position" just on his hands and knees and a stream of blood poured from his throat area. The blood was not pulsating or spurting as might be expected in relation to an arterial bleed. It just flowed. Constable Davis could see a cut in the deceased's neck about three inches long. He immediately grabbed the nearest material "stuff" he could find and covered the throat area in an effort to staunch the flow. As he did so, he could hear a slight gurgling sound and he thought "suction wound". He yelled out to the other police officers to call an ambulance. Then he yelled to Constable Dudson to "get me some plastic, some gladwrap". He removed the cloths from the deceased's neck that he had been using to staunch the flow of blood and applied a plastic covered bandage about 25cm by 15cm that Dudson had found to the neck, in the belief that it might have stopped any suction wounds, that is air escaping from the wound.

15. Constable Alan Davis gave evidence to the inquest. He was examined by Counsel for the Northern Territory Police, Mr Bruxner. He was asked to describe the appearance of the deceased when he opened the cupboard door. He said, "big black fella. White eyes. (transcript p40.4). He said the deceased was "carrying a knife (transcript p40.4). He went on to tell the Coroner, "No, I mean he was big because I'm only short and a linen press was, I mean, it's this far off the floor" (transcript p40.8). He was asked by the Coroner did he feel threatened at that stage, at which he replied, "Oh shit, yeah" (transcript p40.9). Indeed, he told me that he got quite a

"shock". Furthermore, he ended up being covered in the deceased's blood and bodily fluids, including spittle. The deceased was not a big man. His weight was 68kg and he measured 174cm in height. Other police officers commented in the course of giving their evidence, that they were surprised at his strength, bearing in mind he was such a small man. He was asked what his aim was in deploying the OC spray in the circumstances to which he replied, "I wasn't dying. He had a knife" (transcript p41.2). While his explanation is understandable, other officers in the immediate vicinity and just as exposed to the possibility of the deceased breaking free of the cupboard and attacking them with the knife, told the Inquiry that the reason for the deploying of the OC spray was to disorientate and disable the deceased so that they could remove the knife from his possession. Constable Davis's description of events as they unfolded included, in part, a comment to Detective Senior Constable Mark Stringer in his Record of Interview (Folio 6, Exhibit 1), "stupid fucker, bloody black blokes, fucking bastard". It is clear from the evidence that the explanation for that remark included the fact that Constable Davis was considerably, and understandably, emotionally affected by his attempts to clam and restrain the deceased for travel to hospital. This emotion was still present when Constable Davis made his statement to police at 0639 hours on Sunday 5 October 2003. Indeed, the Constable's uniform was still covered in the blood of the deceased when he gave his interview.

16. No issue was taken by any party to the words used by Constable Davis in his record of interview; the words exhibited frustration and emotion and did not describe an attitude (racist or otherwise) held by Constable Davis or any one of the other police officers connected with the circumstances surrounding the death of the deceased. At page 47 of the inquest transcript, the following exchange took place which included an express thanks by the family of the deceased to Constable Davis (transcript p47):

"CONSTABLE DAVIS: I don't think it was directed at a particular race of people. I think it was just – I was just really pissed off with what had happened. I was really angry with what had happened.

Mr Southwood?

MR SOUTHWOOD: I've got no questions, if your Worship pleases.

THE CORONER: Mr Francis?

MR FRANCIS: I've no further questions for this witness, your Worship.

THE CORONER: Mr Francis acts for the family of the deceased. Right?---Yes sir.

And they've just instructed him not to ask any questions on that?---Okay.

Thank you.

Thank you Mr Francis. That's all right.

MR FRANCIS: Your Worship, if I may, perhaps what the family have asked me to pass on their appreciation at Constable Davis's efforts."

17. It was Constable Davis who gave evidence that the deceased spoke to him in words to the effect of, "you are holding me too tight. I can't breath". (transcript p42.10). Constable Rossiter said he believed he heard words spoken (transcript p52.8). However, none of the other police officers said the deceased spoke. Rather, they heard the deceased making sounds, grunts and such like but that he did not speak. Having regard to the deceased's injuries, it is quite possible that the deceased did not speak but rather the deceased made sounds and gestures from which Constable Davis concluded he may have been holding the deceased too tightly or that the deceased was having difficulty breathing. In the final analysis, it is unnecessary to arrive at a concluded view upon the matter.

18. Senior Constable Davey arrived soon after. He had heard police communications despatch one of his own units from the general duties section of the Casuarina Police Station where he was acting in the capacity of Acting Sergeant and decided to attend the residence to assist the members. Upon arrival, Acting Sergeant Davey went straight into the premises and saw three members of the police team in a lounge room and an Aboriginal man lying on the floor. He noticed there was a considerable amount of blood in and about the lounge room. Constable Rossiter had responded to Constable Davis's call for an ambulance. He raced outside and used the police radio in one of the police vehicles. When he returned to the lounge room he noticed, "a heap of blood on the floor" and the deceased propped up against the back wall being retrained by other members. Constable Davis continued to apply the bandage to the wound as the deceased thrashed and squirmed about on the lounge room floor. The floor had become slippery with blood and the wound continued to discharge blood heavily. It was Constable Davis's intent to try and calm the deceased and stop him from thrashing around so that he was better able to staunch the flow of blood and determine what to do next. The deceased fought and refused to cooperate with police attempts to calm him. He spoke to Constable Davis throughout, complaining that he could not breathe and that he was being held too tight.

THE ARRIVAL OF THE AMBULANCE OFFICERS

19. At 0248 hours, the request for an ambulance was received by St John Ambulance. Four minutes later the ambulance was despatched and seven minutes later the ambulance arrived at 12 Marshall Court, Malak. The ambulance contained student paramedic grade 2, Antony John Kwiatkowski, who had been in the employ of the St John Ambulance Services for four years and paramedic level 1, Darryl Kenneth Shaw, who had been a volunteer member of the St John Ambulance services for two years and then a full time officer for four years.

20. Upon arrival, the ambulance officers found four or five police officers holding the deceased down with one of them holding a bandage to his throat area and controlling the bleeding. Mr Kwiatkowski told Detective Senior Constable Allan Milner that upon arrival he asked to have a look at the wound to see how bad it was, but the police officer applying the bandage to the throat area told him that as soon as he takes the bandage off, or relieves the pressure, "it just spurts everywhere". So Mr Kwiatkowski did not bother to look at the wound at that stage. He described the deceased as quite combatative and struggling. He said there was quite a lot of blood on the floor, splattered on the walls and his attempts to obtain pulse and blood pressure were not successful.

21. Paramedic Darryl Shaw, injected 5mg of the drug Midazolam (a type of sedative) to calm the deceased down and relax him. That injection did not appear to have any effect and a further 5mg was given which also had no effect. It was decided that another injection of 5mg of Midazolam should be given, after which some "good relief" was achieved. The deceased was then moved to a scoop stretcher and restrained by being tied to that piece of equipment, after which he was moved into the back of the ambulance.

22. Constable Dudson drove the ambulance to the Accident and Emergency Department of the Royal Darwin Hospital (RDH) on a lights and sirens Code 1. The paramedics continued to work on the deceased in the back of the ambulance. Paramedic Shaw told Detective Senior Constable Mark Stringer that it was only en route to the hospital that they had a first opportunity to actually see the injury and its extent. Paramedic Shaw described the wound as "extremely severe and fairly horrific". The deceased had actually severed his trachea and even though he was breathing, he was breathing through the wound in his throat. The wound was approximately 10-15cm long by 8-10cm wide. The deceased rapidly deteriorated en route to hospital.

23. Darryl Shaw told police that the normal procedure used by paramedics for a patient in any sort of respiratory compromise is to get an ora-pharyngal airway down their mouth and keep the oxygen going. In this case, however, the situation was significantly complicated by the fact that the patient's mouth was not connected to his lungs. The deceased's cardiac rhythm went into ventricular fibrillation and almost immediately thereafter his heart stopped completely so that CPR was commenced until such time as the ambulance arrived at the hospital.

24. Paramedic Darryl Shaw gave evidence that "our best option would be to get the patient onboard the ambulance as quickly as possible. Transported to Royal Darwin as quickly as possible and effect intravenous fluid resuscitation en route" (transcript p92.10). He said that the only obstacle to that course of action was the behaviour of the patient himself (transcript p93.4). He told the inquest that the use of Midazolam, which he described as "a simple nervous system depressant", was more efficaciously introduced into the patient intravenously rather than intramuscularly although either route is available. Because of the "violently combative nature of the patient" (transcript p93.9) he was unable to introduce the drug intravenously and, consequently, the onset of the effects of the drug and the resultant calming in the patient's condition took more time. The evidence did not disclose the possible time differential that the need to take the intramuscular route brought about and, hence, the need for additional time to be spent at the scene in preparation for the patient's transportation to hospital.

25. Paramedic Shaw was asked whether, in his view, and within the context of his training and the equipment available to him, there was a better drug suited to the control of patients such as the deceased who are violently unsettled and, therefore, a possible risk to ambulance staff if transported in that condition. To which he responded, "no sir, Midazolam is my drug of choice according to my protocols" (transcript p96.4). Mr Shaw went on to say that since the events of 5 October 2003, the protocols governing steps to

be taken during major trauma situations have been altered so that paramedics are now authorised to inject up to 30mg of Midazolam into a patient, instead of the limit of 15mg, to which Mr Shaw had to adhere when attending the deceased. At the time of giving evidence, Mr Shaw did not have the drug protocol. Mr Southwood QC, advised that he had instructed his solicitor, Mr Grove, to put together a bundle of the protocols including the updated ones which he proposed would be tendered during the course of Dr May's evidence. That has taken place.

26. Dr May provided a report that was admitted into evidence (Exhibit 10). Dr May is the Deputy Director of the Department of Emergency Medicine at Royal Brisbane & Women's Hospital; he is a very well qualified medical expert in the field. His report was a response to criticisms, advanced by Dr Didier Palmer, that the administration of sedation by paramedics was sub optimal clinical management and that the length of the time from the laceration to the arrival of the deceased at the Emergency Department, could have been significantly shortened so that the deceased's life could have been saved. Dr May's view was that it was unsafe, in his view, for both personnel and the patient to be transported prior to stabilisation of the patient and that the paramedics attending the deceased observed the protocols governing the type and extent of treatment they could extend to the deceased. Dr May disagreed with Dr Palmer that the time differential could have been reduced because of the particular circumstances pertaining to the deceased's behaviour and the need for physical restraint prior to transport, due to the risk of injury both to the deceased and personnel transporting the deceased.

27. It is accepted by all witnesses, lay and expert alike, that the situation that confronted the paramedics as they attempted to prepare the deceased for transport to hospital, was extremely difficult from the point of view of management and that they attempted their best to achieve the best outcome

for the deceased within the protocols that pertained to the proper discharge of their duties at the time. In short, they did the best they could.

28. However, the criticisms of Dr Didier Palmer arise in circumstances where he has a thorough knowledge and understanding of the workings of the St John Ambulance Service in the Northern Territory and the proper application of emergency medical procedures to situations of severe trauma such as the one examined by this inquest are such that I recommend that the St John Ambulance Service thoroughly examine Dr Palmer's critical comments in order to achieve a better outcome in situations of severe trauma in the future if that is, indeed, possible. The doctor's written report is Exhibit 4. It would appear from the alteration of protocols that the St John Ambulance Service has already examined the circumstances of this case and taken steps to alter protocols where it is obviously believed that the alteration presents the possibility of a better delivery of service, and therefore, outcome for the patient.

29. At the beginning of this inquest, Mr Tippett Q.C suggested in his opening remarks that the following issues arose:

    (i) Whether valuable time was lost waiting for the beneficial effects of the drug Midazolam to take effect when the injection of other drugs such as morphine would have been the preferred course of treatment to efficiently prepare for the removal of the deceased from the residence to the hospital?

    (ii) Could the bleeding have been more appropriately staunched or otherwise dealt with?

    (iii) Was the reason for the extensive period of time spent at the scene by ambulance officers explained by the violent, aggressive nature of the deceased?

(iv) Whether too much time was spent at the scene at which the severe trauma was suffered by paramedics when the nature and the extent of the injury appeared to require surgical attention immediately?

30. In the final analysis, none of the answers to the above questions call for criticism of any police, emergency personnel or emergency service by this inquest. The period of time spent at 12 Marshall Court, Malak by ambulance officers and police prior to the transportation of the deceased to hospital, is explained by the violent and aggressive behaviour of the deceased. It is part of the tragedy that the deceased interfered with the capacity of others to care for him. His behaviour is explained in the evidence as arising from the nature of the trauma he caused to himself. There is also the possibility that the nature of his injuries prevented him from communicating with police so that he struggled to be free of constraint that he may have believed affected his ability to breathe. In the final analysis, a precise explanation for the deceased's behaviour must be speculative. I pause to note, that there was some speculation at the Inquest that OC spray may have increased the trauma of, and lack of cooperation of the deceased. Dr Palmer, in his capacity as a medical expert, says he does not think so.

ROYAL DARWIN HOSPITAL ACCIDENT AND EMERGENCY.

31. The ambulance arrived at the Accident and Emergency Department of RDH at 0345 hours. The Director of Emergency Medicine at RDH, Dr Didier Palmer, was called into the hospital when the ambulance made the hospital aware of the situation. Dr Palmer arrived approximately four or five minutes after the patient arrived at the hospital, having been called out from his home. He observed that the deceased had suffered a sharp laceration to the anterior part of the neck. The anterior neck structures were on view, including the strap muscles, the major vessels and the trachea, which has

been 100% transected. When Dr Palmer saw the deceased, he had already had a breathing tube inserted into the transected trachea. At that point, the deceased did not have an "output" which means that he was in cardiac arrest and that hospital staff were performing cardiac massage and administering advanced cardiac life support. Dr Palmer continued the advanced cardiac life support. Efforts were made to stem the bleeding. There was not much bleeding after a number of vessels had been ligated, but there was no response to the advanced life support and after about 20 minutes in the Emergency Department and 40 minutes of cardiac arrest in total, Dr Palmer made the decision to pronounce death at 0410 hours on 5 October 2003.

32. An autopsy was carried out by Dr Nigel Buxton, Locum Pathologist, Forensic Pathology Unit, RDH at 0900 hours on 6 October 2003. The autopsy was carried out in the presence of Mortuary Attendant Nigel Lynn, Sergeant Jo Foley, CIB and Senior Constable Pat Hegan and Senior Constable John Bowen, Coroner's Constables. Dr Buxton found an incised wound of the anterior lateral neck present. The wound measured 145mm in length, extending from a point 60mm to the left of the mid line in a right latero-superior angle to a point 70mm below the lobe margin of the right ear. He concluded that the death of the deceased was due to a suicidal cut throat, with the knife wound being taken from the right side to just part the mid line on the left side. The wound severed the trachea and small arteries of the neck but did not severe the carotid arteries of the jugular vein. He found the presence of extensive aspiration of blood. He offered the opinion that, in his view, the wound was not survivable even if medical aid had been available immediately.

33. A toxicology report by Forensic Scientist Heather Felgate was obtained on 10 November 2003, which showed a blood alcohol level of 0.139%. The screening test for amphetamines, cannabinoids and opiates was positive for the presence of cannabinoids in the blood serum.

34. Detective Senior Sergeant Greg Lade carried out the coronial investigation in accordance with the requirements of Police General Order D2. That General Order specifically relates to the investigation and reporting of deaths in custody. Paragraph 3.2 directs that each investigation into the death of a person held in custody, be carried out on the presumption that it is a homicide. Paragraph 3.5 provides that the investigation is to be conducted by experienced investigators and that the officer in charge should be of or about the rank of Superintendent. The member in overall charge of an investigation is to liaise with Counsel Assisting the Coroner and carry out the directions given by the Coroner.

35. In accordance with his obligations, Detective Sergeant Lade arranged for all prospective witnesses in relation to this matter to be interviewed on audio tape as soon as possible. Christine Lynch was spoken to at 0559 hours on Sunday 5 October and the last witness to be spoken to was Dr Didier Palmer at 8.32 am on Sunday 5 October 2003. As a result of the witnesses being interviewed very shortly after the traumatic events that took place at 12 Marshall Court, Malak, and later at RDH, a number of witnesses were still significantly emotionally involved in the events as they had unfolded at the time they made their statements to police on audio tape. It is clear that if one listens to the audio tapes, that the police officers who attended at 12 Marshall Court found the experience deeply disturbing and extremely upsetting.

36. Detective Senior Sergeant Greg Lade is to be commended for the thoroughness and immediacy of his investigation into the death of the deceased.

37. Two matters remain for comment, viz. (1) the use of an Aerosol Subject Restraint (OC spray) and (2) the quality of care once the police had determined that the deceased was severely injured. Sergeant John Pini of the Territory Response Section of the Northern Territory Police gave

evidence that the usual appropriate force option for a person armed with a knife is a firearm. I understand that police defensive tactics instruction does not recommend the use of any other option against a person armed with a knife, except in special cases of which this was not one. It is Sergeant Pini's opinion, as set out in his statement, that the situation did not allow for firearms to be safely used due to its confines and the fact that there were other innocent persons in the premises who were not clear of the area. Furthermore, the police officers were able to put a temporary barrier between themselves and the deceased with the knife by shutting the cupboard door which presented options for containing and disarming him. I conclude that police officers attending 12 Marshall Court, discharged their duties appropriately regarding the use of restrains. After the deceased had cut his own throat causing such a significant wound, police attempts to bring him aid were severely hampered by the deceased's own behaviour, involuntary or otherwise, which resulted in approximately four police officers trying to restrain him in order to render aid to him. Efforts to restrain the deceased were greatly hampered by the loss of much blood, which made gripping the deceased and holding him down on the floor extraordinarily difficult, with the result that police officers were floundering around with the deceased and slipping and sliding in his blood as they maintained their efforts to attend to him.

38. The attendance of police at 12 Marshall Court, Malak in response to the emergency telephone call of Christine Lynch was prompt. Upon arrival, police were faced with a difficult and dangerous situation which they handled as efficiently as the circumstances permitted. In particular, it is to be noted that while the deceased was in the possession of a weapon, police did not draw their own pistols preferring instead to attempt to remove the knife from the possession of the deceased using OC spray to incapacitate the deceased. They engaged in the implementation of the procedure quickly and appropriately. Their later attempts to apply first aid to the deceased and

restrain him so that he could be safely transported to RDH. The circumstances were traumatic for the police officers involved and they are to be highly commended for the manner in which they discharged their duties.

39. The St John Ambulance Service promptly attended to the police request for an ambulance. The ambulance officers, Shaw and Kwaitkowski, are to be commended for the manner in which they discharged their duties within the protocols that governed the discharge of those duties at the time. The behaviour of the deceased clearly required them to modify the steps they would ordinarily have taken before transporting a severe trauma patient, such as an inspection of the patient's wounds. They had, as the most significant objective, the safe transportation of the deceased to hospital as soon as possible. The level of agitation of the deceased, combined with the authorised injectable limit of 15mg of Medazlin, meant that additional time was spent at the scene which, in part, is also explained by the need to introduce the Midazolam intramuscularly as distinct from intravenously. The intravenous introduction of the drug would have resulted in a far quicker response in the deceased.

40. Other than the recommendation contained in paragraph 28 hereof, I have no other recommendations or comments to make.

Dated this 31st day of August 2005

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Greg Cavanagh
Territory Coroner