CITATION: *Inquest into the death of Terence Daniel Briscoe* [2012] NTMC 032

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
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DELIVERED ON:	17 September 2012
DELIVERED AT:	Alice Springs
HEARING DATE(s):	12 – 22 June 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in custody, care and treatment whilst in Alice Springs Watch House, alcohol toxicity, positional asphyxia**

REPRESENTATION:

Counsel Assisting:	Dr Peggy Dwyer
Northern Territory Police	Dr Ian Freckelton SC
Northern Territory Police Association:	Mr Lex Silvester
Family of the Deceased:	Mr Scott Corish

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

No. A0005/2012

In the matter of an Inquest into the death of Terence (Kwementyaye) Briscoe

ON 4 JANUARY 2012
AT ALICE SPRINGS WATCH HOUSE

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Kwementyaye Daniel Briscoe was only 27 years of age when he died on 4 January 2012, alone in a cell in the Alice Springs Watch House. He was an indigenous man and although he was christened Terence, I am told by his family that it is culturally appropriate to refer to him now, after his death, as "Kwementyaye", so as to cause the least distress for his surviving relatives.

2. At the time of his death, Kwementyaye was being detained in the Alice Springs Watch House pursuant to s 128 of the *Police Administration Act* ("the PAA"), because he was thought to be so intoxicated that he fulfilled the criteria for what is colloquially known as "protective custody". He had committed no crime.

3. Since Kwementyaye died while in police custody, s15 of the *Coroner's Act* NT ("the Act") provides that an inquest into his death is mandatory. Furthermore, s 26(1) of the *Act* imposes an obligation on me to "*investigate and report on the care, supervision and treatment of the person while being*

held in custody". I must also make such recommendations with respect to the prevention of future deaths in similar circumstances as I consider to be relevant (s.26(2)).

4. A broader recommendations power is set out in s 35(2), which provides that:

> "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".

5. Pursuant to section 34(1) of the Act, I must make findings in relation to:

(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.*

6. Section 34(2) expands upon those functions and states that:

> "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".

7. There is no doubt that Kwementyaye had been drinking in a public place, and was intoxicated to some degree by the time he was detained, at around 9.15pm on 4 January 2012. He had been sharing from 30-packs of beer purchased during the day from the Heavitree Gap Store and in the afternoon and evening from the Flynn Drive Supermarket. Unbeknown to police, soon after he was placed in the back of a van to be transported to the Watch

House, he drank about half of a 700 ml bottle of Bundaberg Rum that had been secreted in the pants of another detainee.

8. Kwementyaye is likely to have died in the Watch House at approximately 11.45pm on 4 January 2012, around the time that a number of prisoners in the cell diagonally opposite him heard him choking and gasping for breath and tried in vain to get the attention of police officers stationed in the reception area. His body was not discovered until 1.43am, when a cell check was done by the Watch Commander.

9. Post mortem tests reveal a blood alcohol reading of 0.350 grams/100mL, a level that is within the lethal range. The consumption of the rum was enough to have raised his blood alcohol by 0.211%, meaning that it effectively 'tipped him over the edge', and elevated his intoxication to a state that was potentially fatal.

10. Although the amount of alcohol Kwementyaye consumed is enough on it's own to have killed him, I have listened carefully to the expert evidence of two pathologists and a forensic physician and have reached a conclusion, on all of the evidence, that the probable cause of death is a combination of acute alcohol intoxication, positional asphyxia and aspiration, which ultimately obstructed the airways and led to death.

11. Although Kwementyaye was in custody for less than five hours, from around 9.15pm on 4 January to approximately 2am on 5 January 2012, there were 12 members of the police force directly involved in his care during that period, including the officers who initially apprehended him and Watch House staff covering two shifts that changed over at 11pm on 4th January. All of those members gave evidence in this inquest, allowing the court to understand how the events unfolded. It is a credit to the officers, and their superiors that they did so in such a willing and candid a manner. In addition, I heard from a number of senior police officers with management responsibilities at the time of, and leading up to, Kwementyaye's death.

12. It is abundantly clear that there were multiple failings on the part of individual police officers and senior management that allowed Kwementyaye's death to take place. Indeed, as I understand the evidence, up to ten police officers have been formally disciplined over errors and failures in relation to the deceased on the night of his death.

13. The systemic failures identified in this inquest, including the failure to roster a Watch House Keeper on shift and the failure to roster appropriately experienced staff in the Watch House should have been remedied long before Kwementyaye's death. Similar issues were highlighted in the inquest into the death of Cedric Trigger, another young indigenous man who passed away in the Alice Springs Watch House in 2009. At the inquest into his death in 2010, the Court received assurances from senior management in the NT Police that the systemic issues would be promptly remedied. It is completely unacceptable that it took another death in custody to highlight the persistent failures.

14. In the six months since Kwementyaye died, the NT Police Force has devoted significant resources to identifying what went wrong and to implementing widespread reforms. These include an increase in staff numbers, dedicated Custody Sergeants, nurses stationed in the Watch House part time, improved training and appropriate procedures to audit rostering. This time, the changes made were expeditious and far reaching. This time, the response is appropriate to the calamity of a death in custody.

15. Every officer called before me, regardless of their rank, from the Aboriginal Community Police Officers (ACPO's) and Probationary Constables, through to the Assistant Commissioner, acknowledged those failings and, with humility, they apologised for their role in this unnecessary death.

16. This inquest again highlighted the strain on police working in the community, and at the Watch House, who are expected to detain and accommodate large numbers of heavily intoxicated men and women every

night of the week. The numbers of indigenous Australians taken into protective custody in the NT each month is a national shame, as are the disgracefully high levels of chronic ill heath and early death, related to excess alcohol consumption.

17. The fact that so many detainees suffer from a combination of alcohol toxicity and chronic ill health means that police must care for large numbers of very drunk, very sick people, in Watch Houses that are not designed for that purpose.

18. Counsel appearing for both the NT Police and the NT Police Association have urged the court to make comment about the need for further coordinated action to address the tragically high levels of alcohol consumption in Alice Springs. I have also received submissions from the People's Alcohol Action Coalition and the Department of Health that underline the strain on the community and the health system as a result of binge drinking.

19. The issue of alcohol consumption in Alice Springs was an important issue in this inquest and Kwementyaye's death must be understood in the context of the enormous burden alcohol places on police and health services. While I am mindful of the fact that this inquest did not have the scope for a comprehensive review of alcohol policy in Alice Springs, it is clear that something more needs to be done. I intend to make a recommendation that Government meets urgently with all major stake holders to consider the circumstances of this case, and how Kwementyaye came to have access to an excessive amount of alcohol, and to see if there are further measures that can be taken to deter this sort of binge drinking in and around Alice Springs.

20. I have had the benefit of an excellent brief of evidence that was painstakingly prepared by A/Superintendent (Det. Snr Sgt) Scott Pollock. That brief reflects his thorough, intelligent and independent investigation. The role of Officer in Charge of an investigation of this size and sensitivity

is a very difficult one. Not only did Det. Snr Sgt Pollock produce a highly detailed brief that includes all the requisite evidence, but he did so in a manner which was fearless and impartial. Similar compliments were paid to him by counsel for the family, Senior Counsel for the NT Police and Counsel for the NT Police Association. Detective Senior Sergeant Pollock was assisted in his investigative tasks by Sgt Dave Allen, and throughout the inquest Sgt Allen lent the Court his invaluable technical expertise. The integrity and dedication of those two officers is a great credit to the Northern Territory police force.

21. In order to fulfil my statutory obligation to make the findings required by s 34(1), including consideration of the broader circumstances surrounding the death, I had tendered in evidence the following: the birth certificate of the deceased (Exhibit 1); a 15 volume brief of evidence which included the Investigators overview memorandum, numerous witness statements, expert reports and policy documents (Exhibit 2); 2 USB drives (1copy) with footage of the deceased in custody (Exhibit 3); the Affidavit of Assistant Commissioner Mark Payne (Exhibit 4); a transcript of dialogue between prisoner Williams and police (Exhibit 5); 3 folders of additional statements (Exhibit 6); Affidavit of Dr Christine Connors (Exhibit 7); Affidavit of Dr Steven Skov (Exhibit 8); Additional Statements of Officers Malley, Jones and Murphy (Exhibit 9); Statutory Declaration of Brodie (Exhibit 10); Bundle of photographs (Exhibit 11); Supplementary statement of Assistant Commissioner Mark Payne (Exhibit 12); Statement of Kerr (Exhibit 13); Bundle of DVD's of interviews with witnesses (Exhibit 14); Statement of Grover (Exhibit 15); DVD footage from the Inquest into the Death of Cedric Trigger (Exhibit16); medical files of the deceased (Exhibit 17); Statement from the Briscoe Family (Exhibit 18) and Written submissions of the Police Association (Exhibit 19).

22. I also received written submissions on behalf of the family, the Department of Health and the People's Alcohol Action Coalition. Written submissions,

and supplementary written submissions were received on behalf of the NT Police.

23. I heard oral evidence from the following civilians – Oscar White, Lance Dixon, Caleeb Nipper, Warren McDonald, Anslem Impu, Kyle McDonald, John Jackson and Dennis Sterling. Expert evidence was called from Forensics Officer, Mr Tim Sandry, Forensic Physician, Dr Morris O'Dell, and Pathologists, Dr Terence Sinton and Professor Johan Duflou. The Police Officers who gave evidence were Det. Sen Sgt Scott Pollock, Constable 1/C Gareth Evans, Constable 1/C Anthony Blansjaar, Probationary Constable Alana Grey, ACPO Robyn Parker, ACPO James Brooking, Constable 1/C Daniel Ralph, Acting Senior (A/S) Sergeant William McDonnell, Probationary Constable David O'Keefe, Probationary Constable Janice Kershaw, A/S Sergeant Andrew Barram, Superintendent Delcene Jones (Governance and Accountability Division), Commander Murphy and Assistant Commissioner Mark Payne.

24. The hardest role during the inquest was for the family of the deceased, many of whom attended for all or most of the two week inquest, and who endured it stoically and with grace. It is clear that Kwementyaye was much loved, and the loss to his large family and the broader community is immeasurable.

25. The only positive thing to come from this sad death is that is appears to have been a catalyst for profound and positive change. For the sake of our police force, those they detain and our broader community relations, I hope that this year heralds a new era of enhanced safety in the operation of Watch Houses, and a great improvement in the support that front line officers receive.

Background

26. Kwementyaye Briscoe was an initiated Anmatyerre man whose country was around Napperby, 120kms from the more populous community of Papunya. He was born in an ambulance en route from Napperby to Alice Springs on 2 March 1984. Sadly, his young mother died on 30 June that year, when Kwementyaye was only 4 months old.

27. Kwementyaye was taken into care by his foster mother, Janie Briscoe (his original surname of Dixon was changed to Briscoe after that time) and he grew up in Alice Springs, nourished by a huge family including aunts and uncles, grandmothers and cousins. He spent time in his homeland around Mount Allen and Laramba, and would meet up out bush with his father, Tommy Daniel, he until passed away when Kwementyaye was aged around 20.

28. Although he was clearly a young man of ability, like many indigenous children, his education was incomplete. He went to primary school in Alice Springs, but did not attend secondary school. He did not hold any formal trade or work qualification and he was unemployed at the time of his death.

29. Kwementyaye started to drink alcohol to excess after he turned 18. He had a minor history of juvenile offending (no convictions recorded), but more serious problems were triggered by alcohol abuse and he had five alcohol related convictions recorded on his adult record, although none of them were serious enough to warrant a term of imprisonment. He had been picked up by police and put into protective custody on 31 occasions prior to his death. He was no stranger to the Alice Springs Watch House, having been housed in protective custody there on 20 occasions. He once ended up at the Watch House in Papunya and on a further 10 occasions he was taken to the Drug and Alcohol Service Alice Springs (DASA).

30. At the time of his death, Kwementyaye was renting a room in St Mary's Hostel in Alice Springs. He maintained daily contact with his extended

family and helped to care for his much loved elderly grandparents, Aunts, uncles and cousins.

Kwementyaye is placed in protective custody

31. During the afternoon of 4 January 2012, Kwementyaye commenced drinking alcohol with friends and family and he continued to do so into the evening. At one stage he was seen with a group near Heavitree Gap, in the centre of Alice Springs town, and in the evening he joined a large group of friends drinking in the vicinity of Flynn Oval, approximately 5 kms from the centre of town near the Centralian School, and the Flynn Drive IGA.

32. At 8.47pm, police communications received a complaint from a member of the public concerning intoxicated persons arguing and fighting near Flynn Drive Supermarket. A number of officers were in vehicles in the vicinity of Flynn Drive and the first to be dispatched, at 8.59pm, were Constable First Class (1/C) Gareth Evans and his partner, Constable 1/C Anthony Blansjaar. On arrival they located a male and female behind the school who were not fighting, but were heavily intoxicated and the couple was subsequently detained in protective custody.

33. Constable 1/C Evans then noticed a large group of people sitting along the tree line on the opposite end of the oval and he began walking towards them, while Constable 1/C Blansjaar drove towards them in the police van. There were a significant number of people in that group. In oral evidence, Constable 1/C Evans explained that his initial intention was to see if they had any information about the alleged fighting at the shops, and Constable 1/C Blansjaar planned to drive over towards them.

34. When he was half way across the oval, a young female shouted out to the others in an indigenous language Constable 1/C Evans could not understand and members of the group, including Kwementyaye, began to disperse. As

they did so, Constable 1/C Evans could see bottles of wine, cans of open VB and Bundaberg Rum that had been thrown down or tipped out. The group continued to move and some appeared to cross into Centralian Middle School, prompting Constable 1/C Evans to use his radio to request police back up to attend the Milner Road side of the school and oval.

35. Perhaps in response to the arrival of another police Unit, some members of the group doubled back and started running in the direction they had just come from. Constable 1/C Evans jumped a fence and began to jog after a smaller breakaway group of five or six. At the back of that group was Kwementyaye and when he got close to a large iron gate beside the school, he slipped on the bitumen or dirt and fell. According to Constable 1/C Evans, when Kwementyaye got up after this first fall, he had a small cut above his left eye, described as a "laceration above his eyes that had... burst. There was fresh blood around the cut but it wasn't gushing or dripping down his face" (Transcript, 18.6.12, at p 230).

36. Constable 1/C Evans gave evidence that after falling the first time, Kwementyaye got himself to his feet and started swearing. He ignored a direction to take a step back and when he stepped forward again, Constable 1/C Evans pushed him in the chest with an open left hand, causing him to stumble and fall into the gate, before falling forward. He was then secured on the ground by the officer using a "three point hold position", which involves placing one knee on the side of his shoulder, and securing his right hand behind his back.

37. At that point, other officers who had been called as back up arrived on the scene. Kwementyaye was assisted to his feet by Constable 1/C Evans and Constable 1/C Daniel Ralph and he cooperated in walking to the police van and climbing up inside, without further incident.

38. I have only the account of Constable 1/C Evans to rely on as to how he finally caught up with Kwementyaye, and how he was taken to the ground.

However there is nothing inherently unreliable or contradictory in the evidence given, and I accept his version of events.

39. A person is deemed to be "intoxicated" according to the criteria set out in s 127A of the PAA if:

(a) the person's speech, balance, coordination or behavior appears to be noticeably impaired; and

(b) it is reasonable in the circumstances to believe the impairment results from the consumption or use of alcohol or a drug.

40. The fact that someone is intoxicated is not sufficient of itself to warrant taking them into protective custody. Section 128 of the Act provides that:

(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

(ii) may cause harm to himself or herself or someone else; or

(iii) may intimidate, alarm or cause substantial annoyance to people; or

(iv) is likely to commit an offence.

41. Constable 1/C Evans told the Court that his justification for detaining Kwementyaye was that the way he stumbled and fell suggested he was intoxicated enough to warrant protective custody. He could smell alcohol on his breath and his eyes appeared "droopy" and blood shot.

42. In his record of interview on 19 January 2012, Constable 1/C Evans explained to the investigating officer:

> "Initially due to his aggressive manner towards myself, um, I feared that of that was the reaction he was going to take from me (sic) that he may go on to harm someone else, um, the feeling from Police and going into the school, um, which has been known to be a hot spot within the Gillen area, I feared that there was likeliness (sic) to offences being committed in there, drinking further or actually damaging the school itself".

43. There is little doubt that Kwementyaye had been drinking beer for much of the day and into the evening and his friends suggest that he had consumed a significant amount of the VB that was brought by the group from the take away outlets. Furthermore, he was drinking in a place that had been designated as a non-drinking area, where at least some members of the group had been fighting or arguing to an extent that prompted a phone call to police. I accept the assessment made by Constable 1/C Evans that it was appropriate to detain Kwementyaye pursuant to s 129.

44. The PAA allows police to exercise their discretion to take an intoxicated person home or to a sobering up shelter, rather than to the Watch House (s 131(1)). Although the Act itself does not regulate that discretion, police should be aware of the relevant provision of the Custody Manual, which states, at S 21, that:

> "Police cells should remain the least preferred option for the custody of intoxicated persons".

45. There are further requirements set out in the *Alice Springs Watch House Standard Operating Procedures* (the '*SOP's*') to record the reason why a person is not taken to a Sobering Up Shelter, in preference to the police cells. Under the sub heading *Protective Custody*, S 24.1 required the

following action to be undertaken when detainees are received into protective custody:

> "Watch House staff must determine the reason why a prisoner to be held under s128 of the Police Administration Act was not taken to the sobering up shelter. The reason is to be recorded in the offender journal. If the Watch House keeper is not satisfied with the reason for the attendance of the person at the cells as opposed to the shelter, approval from the watch commander is to be obtained before detention continued".

46. This should have been read in conjunction with S.38.4 of the Custody Manual, which provided that:

> "A Watchhouse Keeper is not to accept a person into custody under section 128 ... unless the apprehending member or members have made all reasonable efforts for the person to be cared for elsewhere while intoxicated. The reason why the person is in custody is to be recorded in IJIS [Integrated Justice Information System]".

47. Although I am not convinced that Constable 1/C Evans gave the range of options much thought that night, I am not critical of him for taking Kwementyaye to the Watch House rather than home or to a sobering up shelter. The shelter was known to have limited places and would not accept customers who were highly agitated. Constable 1/C Evans was responding quickly to what could have become a volatile situation and it is not appropriate to second guess that decision so far removed from the event.

48. I am critical, however, of the failure to comply with the directions in the Custody Manual and the *SOP's*. No entries were made in IJIS by either the apprehending member or Watch House staff. Incredibly, there was no Watch House keeper on duty, a fact that became a major focus of this inquest. The failure to properly consider whether the protective custodies should be housed elsewhere and the failure to record the reasons for the detention in

the Watch House may be yet another problem which stems back to this fundamental error in rostering for the Watch House – the failure to have an appropriate, experienced staff member, taking responsibility for the role of Watch House keeper.

The ride to the Watch House with other detainees

49. Kwementyaye was placed in the back of the police van driven by Constables Ralph and Grey. Some minutes later, three other persons, Oscar White, Lance Dixon, and Caleeb Nipper, were detained and placed into protective custody alongside him in the van. Mr White and Mr Dixon were apprehended in Adamson Avenue and both got into the police van without incident. Caleeb Nipper had been chased down by police and forcibly restrained before being handcuffed and placed in the back of the van.

50. Shortly before he was apprehended, Oscar White had acquired a 700ml bottle of Bundaberg Rum, which had been brought for him by another person from the nearby Flynn Drive IGA supermarket. Unbeknown to police, that full bottle was secreted in his shorts when he climbed up into the van. Constable 1/C Ralph was the officer who detained him and he frankly admitted that although he knew he was required to search all prisoners before they got in the van, he either neglected to search Mr White, or was not careful enough when he did so.

51. Once in the van, the four detainees shared the rum offered around by Mr White. However, Caleeb Nipper was handcuffed and could only drink small capfuls and I heard in oral evidence that Mr Nipper, Mr White and Mr Dixon were sick and vomited during the journey to the Watch House. It was Kwementyaye who drank a substantial amount, managing to consume around half of the 700mls, and pushing himself into a category of extreme intoxication.

52. It is easy in hindsight to be critical of the failure to adequately search detainees, but these events took place at night, in an area police were anxious to leave in case the situation escalated. A thorough search of detainees is necessary for their safety and the safety of officers, but I can well understand how it was neglected in that environment.

Arrival and processing in the Watch House

53. The police van carrying Kwementyaye and the three other detainees arrived at the Watch House at 9.38pm. Constables 1/C Evans and Blansjaar arrived two minutes earlier, at 9.36pm, with three more protective custodies. That meant that the Watch House had to cope with an influx of seven protective custodies arriving at roughly the same time.

54. The Watch House staff on duty that for that afternoon/evening shift (3pm-11pm) were two ACPO's - Senior ACPO Robyn Parker, who had worked at the Watch House for four years, and ACPO James Brooking, who was still relatively new to the police force and had been pulled from reception duties to cover a probationary constable who had called in sick that day.

55. I heard evidence that it is the role of the Watch House Keeper to give directions as to when detainees can be unloaded, where they are to go and when and how they are processed. On this shift there was effectively no Watch House Keeper, and there had been not been for some months. Although ACPO Parker gave evidence that she assumed she was the Watch House Keeper that night because she was senior to ACPO Brooking, she knew that ACPO's had been banned from performing that roll and she did not wear the designated Watch House Keeper badge. I do not accept that she took on the responsibilities of Watch House keeper, and nor should she have had to, given the direction she had previously been given by her managers that this was not appropriate.

56. In the absence of a Watch House Keeper, a practice seemed to have developed where one of the officers would take it upon him or herself to take charge and give directions about the unloading of detainees, perhaps in consultation with whoever was on duty in the Watch House. In this case, Constables Evans and Blansjaar unloaded their three detainees and then watched while the others walked inside. As Constable 1/C Evans explained, by the time both vans got back to the Watch House "everyone was working together", rather than having responsibility for individual detainees.

57. It was evident that there was a level of chaos in the unloading of both police vans, which set the tone for the processing of detainees that night. A lesson in why prisoners should not be unloaded together in this manner is found in the treatment Mr Williams received when he was unloaded from the police van, escorted to the door of the Watch House by Constable 1/C Evans and then let drop from standing height onto the hard floor below. To a lay observer watching the CCTV footage, the actions of the officer appear careless and insensitive. When questioned about this, Constable 1/C Evans agreed that "it doesn't look the best", but explained that he was hurried because he was concerned that there were other detainees who were now at loose in the sally port. In his words:

> "I had an open cage in the [sally port] area. I was trying to prioritise with the people in the back and my partner was standing at the door ..."

58. I accept that Constable 1/C Evans was concerned about the potential danger of having numerous detainees in and around officers, when they were drunk and unrestrained. However it is unacceptable to drop someone from standing height, particularly when they are in protective custody unable to properly care for themselves. The appropriate practice is to unload vans

one at a time so that detainees can be escorted inside safely, and can be treated with adequate care and respect while that is done.

59. Along with the other detainees in the Police van driven by Constable 1/C Ralph, Kwementyaye walked in through the Watch House doors with no difficulty and he was ushered straight into an Observation Cell known as Cell 1. The rum he had consumed in the police van was still to take affect and there was no hint yet of the severity of his alcohol impairment.

Actions in Cell 1

60. Kwementyaye remained in the observation cell with Mr Dixon and Mr White for a period of 20 minutes while Watch House staff and the four general duties police processed other custodies. The first to be dealt with was Mr Williams, who had been dropped by Constable 1/C Evans on the way in. He was particularly challenging in the reception area – he feigned illness, spat at police and shaped up to officers, eventually prompting Constables Evans and Blansjaar to use a 'take down manoeuvre' to contain his aggressive behaviour. That evidence was raised by Counsel for the Police, Dr Freckelton SC, as being of significance in the later assessment of Kwementyaye and his treatment by Constable 1/C Evans.

61. Around seven minutes after he entered the observation cell, Kwementyaye's behaviour appeared to change and CCTV footage shows him obviously agitated. He can be seen to bang on the front of the cell with an open hand, shadow box and take on and off his shirt. Although the CCTV footage appears to show him punching the walls, it is likely he pulled the punches or at least didn't hit the cell hard, because the autopsy report shows no serious damage to his knuckles. His behaviour wasn't violent, but it did suggest that he was unpredictable and upset. I accept that this would have been of concern to any police listening or watching the observation cell, but they cannot seriously have perceived Kwementyaye as a threat, because only a

short time later, at 9.59pm, he was then ordered to come out from the cell to join four or five other detainees who were being 'processed' in reception.

62. On the way into the corridor towards reception, Kwementyaye swayed slightly, turned back and grabbed the door handle, appearing then to lean in to get his shirt that was left on a bench. Constable 1/C Evans noticed that Kwementyaye wasn't following behind the others and he took him by his wrist to escort him to reception. What happened next was the focus of some interest during the inquest and I have carefully reviewed the CCTV footage and listened to the arguments of counsel. While Kwementyaye was being escorted his legs went out from under him and he fell forward onto the floor. I am satisfied that Constable 1/C Evans did not intend Kwementyaye to fall to the ground and he could do little to stop him when he did. The last time Constable 1/C Evans had seen Kwementyaye he was capable of walking unaided into the Watch House, and he had just seen and heard him being active in Cell 1. He had no idea that Kwementyaye had drunk the rum in the back of the police van and there was no reason to assume that he could not support himself. I reject the suggestion made by counsel for the family that Constable 1/C Evans allowed Kwementyaye to fall.

63. Once Kwementyaye fell on the floor, he was dragged by Constable 1/C Evans, (assisted by Constable 1/C Ralph once the dragging had commenced) into the reception area and left sprawling on the floor. Although I have no doubt that Constable 1/C Evans had to think quickly to get Kwementyaye into reception as soon as possible, it was not acceptable to drag him along the floor by his limbs. As his Counsel, Dr Freckelton SC, conceded in his closing submission, it was a poor exercise of judgement by Constable 1/C Evans and there was no sufficient urgency to justify the dragging. Apart from the fact that it is degrading and disrespectful, it meant that the officer could not properly assess Kwementyaye's ability to walk for himself.

64. It is particularly disappointing to me that prior to Kwementyaye's death insufficient leadership had been shown by police Management with respect to the issue of dragging detainees, in spite of what I was promised in the Inquest into the death of *Cedric Trigger*. In that case, when footage revealed that Mr Trigger was dragged from the sally port into reception, senior officers agreed with me that dragging was unacceptable and must not continue. Where possible, prisoners should be assisted to their feet and encouraged to walk, and if they cannot do so, one or more officers should carry them, or transport them using a device like a wheelchair. I intend to make a recommendation to Police to obtain a certain number of wheel chairs for each station so that can be done. I repeat again, lest there be any confusion, the practice of dragging prisoners by their limbs from one part of the ground to the other is unacceptable and degrading and it must stop.

65. When Kwementyaye was dragged into the middle of the reception area, a number of other detainees were being processed around him, including Mr White and Mr Dixon and an older gentleman who was seated on the bench. The reception area appeared chaotic, with four general duties officers moving around giving directions to individuals and the two Watch House staff behind the counter. In the midst of this, Kwementyaye lay on the floor for several minutes.

66. It should have been obvious to anyone paying attention to Kwementyaye at that stage that he was extremely intoxicated. I accept that there had been a rapid deterioration in his functions, and that police were not aware that he had drunk a large quantity of rum, but he was patently incapacitated by the time he was dragged in and left lying on the floor in reception. After observing that he hadn't moved for two minutes, Constable 1/C Evans took a pen and applied pressure to his fingernail to see if he would respond to a pain stimulus, a technique he learnt while working as a security officer at a Hospital. It is clear from the CCTV footage that Kwementyaye's arm tensed

in response, but he was very slow to react. His behaviour in the reception area was entirely abnormal.

67. At one stage Kwementyaye was clearly emotionally distressed and can be seen on the CCTV footage to be sobbing and groaning. He was also, according to the accounts of police officers, laughing, grinding his teeth and slurring his words. He was thought by one of the officers to be speaking in an indigenous language, but I am told by his family that although Kwementyaye learned to understand the Anmatjere language, he could not speak it. He was incapable of taking his own shoes off and he lay on the floor barely moving while another detainee took them off for him at the request of police.

68. The CCTV shows an unedifying spectacle of Kwementyaye lying on the floor for minutes, hopelessly inebriated, while several officers walk around him concerning themselves with the processing of other detainees. I can well understand that the Briscoe family was "angry and hurt" by this, as they told the Court in their eloquent written statement (Exhibit 18).

69. While he lay on the floor, police were joined by Sergeant William McDonell, who was performing the role of Watch House Commander. He appeared untroubled by Kwementyaye's state, in spite of observing a smear of blood on the reception floor caused by a laceration above Kwementyaye's right eye. Sergeant McDonnell merely cleaned up the blood smear, asked who Kwementyaye was and ordered him to get up. Kwementyaye did not respond, but Sen Sgt McDonnell was then distracted by another detainee and he left the area without concerning himself about first aid or giving junior staff any guidance on how to proceed.

Incident involving Constable 1/C Evans

70. After repeated commands from Constable 1/C Evans to get up, Kwementyaye managed with some difficulty to lift his weight up onto the bench seat, but he was obviously unsteady and lacked control of his faculties. Soon after he sat down on the bench, he got up and leant against the wall. He was then sat back down, firmly but fairly by Constable 1/C Evans, who was busy with another task. Kwementyaye stood up again, and this time, instead of firmly guiding him again or giving him a stern verbal direction, Constable 1/C Evans pushed him hard (Dr Freckelton SC did not demure from use of the term "shove") with an open hand and sent him sprawling backwards into the wall.

71. Presumably Constable 1/C Evans was trying to contain and control the situation, but that pushing motion was an inappropriate response to someone so intoxicated and it had the opposite affect to the one the Constable intended. Up until that point Kwementyaye had displayed no aggression in the reception area. After the push, he looked upset and picked up a blue plastic property box that was between him and another prisoner. He did so in a pathetically drunken manner, and the plastic box was easily taken from him by an older man seated beside him who was being processed as a protective custody. Constable 1/C Evans looked relatively unperturbed at that stage and put his foot up motioning for Kwementyaye to put the box down.

72. What happened next was an unfortunate escalation of that incident. Kwementyaye stood up with a clenched fist, and although it stayed down by his side, he did move it behind him a few inches and may have been about to 'shape up'. In response, Constable 1/C Evans grabbed him by the arm and slung him towards the reception counter with undue vigour, causing Kwementyaye to hit his arm and head on that surface. It was submitted on behalf of Constable 1/C Evans that his objective was to move Kwementyaye firmly to the reception counter to be propped up and searched, but instead

Kwementyaye's legs went out from under him and Constable 1/C Evans could not react quickly enough to break the fall.

73. I accept the motivations of Constable 1/C Evans, but the manoeuvre he used was inappropriate to deal with a detainee who was so obviously disabled by the effects of alcohol. I am conscious of the need to see these actions in the context of the evening and to understand them from the perspective of Constable 1/C Evans. To that end, I remind myself of the following factors:

- First, this was a busy shift in the middle of a hot summer and the Watch House was a testing place to be;
- Second, the officer had already had a challenging shift and around half an hour earlier he had assisted Constable 1/C Blansjaar with a take down manoeuvre on an aggressive Mr Williams,
- Third, Mr Williams had been feigning illness in front of police
- Fourth, Kwementyaye had been agitated at the time of detention near Flynn park and was agitated again in the observation Cell, so the behaviour in the reception area was a stark deterioration, and
- Fifth, Constable 1/C Evans had no knowledge that Kwementyaye had consumed the rum in the back of the police van and so was not expecting his level of intoxication to be significantly altered.

74. Dr Freckelton SC reminded me of the phenomenon of 'cognitive dissonance', which is caused by conflicting cognitions (thoughts or perceptions). Cognitive dissonance theory warns us that when people have conflicting thoughts, they will try to seek consonance among their cognitions, or put more simply, they will try to reconcile the conflicting thoughts. One way they do so is by diminishing the importance of one of the discordant facts. That may help to explain why, even though Constable 1/C Evans observed Kwementyaye's hopeless state in the reception area, he did not immediately appreciate how incapacitated he was because he could

not reconcile that with Kwementyaye's earlier ability to walk and run on the oval, walk unassisted through the sally port, and be animated in the observation cell. He may also have been affected by having recently dealt with Mr Williams who was feigning illness and exaggerating old injuries.

75. Although, as Dr Freckelton SC conceded, Constable 1/C Evans should have been more open to reviewing Kwementyaye's change in condition, it is easier to understand his mindset when the whole evening is put in context.

76. I was urged by Counsel for the police to have regard to Constable Evans's verbal conduct, which was described as "restrained, respectful and appropriate". At one point, for example, when Kwementyaye struggled to get off the ground and onto the bench in reception, Constable 1/C Evans held out his hand and asked "do you want help mate?". Kwementyaye put his hand up, apparently to wave away the offer. I agree that the language he used then was appropriate and is to his credit and Constable 1/C Evans is clearly a skilled and well regarded officer. It is a shame that he let himself down when he shoved Kwementyaye back down on the bench and when he slung him so forcefully towards the reception desk. I do not suggest that Constable 1/C Evans intended to be brutal, but his actions were heavy handed, unnecessary and careless.

77. In the circumstances, I do not believe that any offence was committed by Constable 1/C Evans and, indeed, none of the Counsel, including Counsel for the Family, asked me to refer the matter to the Director of Public Prosecutions pursuant to s.35(3) of the *Coroner's Act*.

Removal to Cell 9

78. After Kwementyaye was swung and hit the reception desk, he was spread out on the ground and searched by Constable 1/C Evans, assisted by Constable 1/C Blansjaar and Constable Grey. It is apparent from the CCTV

footage that where his head was positioned, a small pool of blood formed from the leaking wound above his eye brow.

79. At 10.12pm, Kwementyaye was carried face down to Cell 9 by the three officers, with one on each arm and one picking up his legs. ACPO Robyn Parker hurriedly threw a mattress into the cell on an awkward angle which stretched diagonally across the two concrete slabs in the room, and Kwementyaye was placed faced down at the same angle without anyone moving the mattress into a more comfortable position.

80. When Kwementyaye was carried along the corridor, blood from the head wound fell in droplets on the floor. That drew the attention of four or five sober prisoners in cell 16 who saw the blood and called out to the officers, telling them that the man they saw should be taken to hospital. One of those was Warren McDonald, who told the investigating police:

> "They took him around and placed him on the bed, and yeah, just shut the door and walked away. And while we seen him come in, all us boys were in cell 16. We were singing out to him, 'Take him to the hospital and get him checked out or something, you know, he's pissing out blood. He's got blood coming out of his head".

81. His evidence was supported by other prisoners in Cell 16, and is not disputed by the police officer present. Kyle Impu, who is no relation to the deceased or Mr McDonald, gave this evidence:

> ".... [H]e was just laying flat and that blonde lady was holding his legs and two fella's on the side holding his arms ... and he had a cut on his head and it was bleeding and then we told them to give him some medical attention and they didn't seem like they cared".

82. In a Watch House full of prisoners and police officers of various rank, only the prisoners spoke out about the need for immediate medical care. Sadly, their pleas fell on deaf ears, as they would when those same prisoners tried again to get help later in the evening.

83. The cut on Kwementyaye's head was not a serious laceration, but police receive first aid training and should know that any head wound can be a signpost for more serious bruising or concussion. Not only had Kwementyaye fallen over near Flynn Drive, but he then hit his head when he was swung by Constable 1/C Evans and fell into the reception desk. He may well have sustained some sort of concussion on either occasion, even for a few seconds, which would have compromised his welfare.

84. It seems clear that officers were blinded by a view that Kwementyaye was alert and aggressive and would therefore resist medical attention for the cut to his head if it was immediately sought. Further, in the absence of a genuine health assessment, there was a failure to reflect on the dangers of excessive intoxication.

85. After being placed on his mattress Kwementyaye was left alone in Cell 9. What happened for the next few minutes was not observed by police, but it was captured on CCTV and it is harrowing to watch Kwementyaye's pathetic attempts to move into a comfortable position. Seconds after being placed on the mattress, he rolled onto his back and hit his head on the concrete bench. A minute later he attempted to stand up but fell hard onto the bench, hitting his head again. At 10.14pm, he attempted to sit up but fell and landed face down with his head and chest on the bench and the rest of his body on the floor. Any one of these actions had the potential to cause him harm.

86. Soon after Kwementyaye was placed into Cell 9, ACPO Robyn Parker began a series of brief but regular checks which involved her standing in the corridor and looking in to confirm that he was breathing. Prisoners in Cell

16 were watching from their vantage point and once again expressed their concern that the detainee needed medical care. In the statement she provided to the inquest, ACPO Parker had the following recollection of her interaction with prisoners at that time:

> "PARKER: Ah, I think it was Warren McDonald, a prisoner in cell 16, said to me that – um – "Oh, take him to hospital, can't you see he's sick", or, "He's ill or sick", or something, I'm not too sure exactly the words but I remember him saying, "Why don't you take him to the hospital".
>
> POLLOCK: And what did you say?
>
> PARKER: 'I just turned around and I might have been out of line when I said it but I just turned and said, "Well, youse all carry on like this when youse are drunk", and you know, "And when youse are sober you just want to be nice to us", then I – I think I've walked off".

87. The Senior ACPO's reflection that she "might have been out of line" was a serious understatement. She was dismissive of Mr McDonald's concerns, and although she may not have intended to be so callous, her response was careless and arrogant. It is clear that she had no idea how unwell Kwementyaye was and I have no doubt that she now feels a great deal of remorse for her actions.

88. Between 10.16pm and 10.47pm, ACPO Parker conducted seven cell checks on Kwementyaye. The fact that she checked Cell 9 every few minutes and made sure she could see him breathing shows concern for Kwementyaye's welfare that contrasts with her earlier comment. Unfortunately, she still failed to recognise the need for medical attention.

89. While I accept, for the reasons articulated above, that there is a reasonable explanation for why police were initially suspicious that Kwementyaye was

feigning or exaggerating his level of intoxication, there is ample evidence to suggest that they were well aware how intoxicated he was by the time he was placed in Cell 9. The following conversation was recorded at 10.20pm.

"EVANS:	I hope Mr Briscoe's alright.
PARKER:	I just checked him but he's not even on the system (inaudible) put them on the system. (inaudible) then I'll do a cell check (inaudible) already on (inaudible).
EVANS:	I don't know (inaudible) Briscoe is fucking annihilated man.
PARKER:	Where is he?
BLANSJAAR:	(inaudible) he is absolutely (inaudible)
PARKER:	Oh that's him in 9
BLANSJAAR:	Yeah
EVANS:	He is annihilated man.
PARKER:	He can't even move.
BLANSJAAR:	Nah"

90. The blood in the corridor and in reception had to be cleaned up for obvious hygiene reasons. The Watch House Commander, A/S/ Sgt McDonnell, cleaned up the first smear of blood with a paper towel while Kwementyaye was still on the floor of the reception area and after Kwementyaye was placed in Cell 9, Constable 1/C Evans took a bottle of disinfectant and cleaned up the corridor.

91. Although it was appropriate for police to attend immediately to cleaning up the blood or "biohazard" as it has been referred to, it was not appropriate for officers to prioritise that over the administration of medical care. At 10.12

pm, just as Kwementyaye was being carried down the corridor to Cell 9, A/S/Sgt McDonnell attended the area and saw more blood. His subsequent comment of "*Ohhh, I did a biohazard clean just before. What'd he do, fall over again?*" was made with an insouciant sigh. It is deeply disappointing that he did not inquire further about the welfare of the prisoner whose blood was spilt.

When did Kwementyaye receive the laceration to his eye?

92. There was some debate between counsel about when Kwementyaye first sustained the cut to his forehead that later bled at the Watch House. Constable 1/C Evans has a memory of seeing the cut at around 9.15pm, before he was first placed in the three point hold. Constable 1/C Blansjaar told the Court that he noticed the cut when Kwementyaye walked from the police van into the Watch House at around 9.39pm. It was not seen by Constable 1/C Ralph, who assisted Kwementyaye into the police van, nor by any of the detainees who shared the van with him on the ride to the Watch House. However their failure to notice the cut does not mean that it didn't exist at that earlier time. The laceration was small and had not bled much by that time, the van was dark inside, the detainees were intoxicated themselves to various degrees and no doubt Constable 1/C Ralph was acting quickly and under pressure.

93. I accept the evidence of Constables Evans and Blansjaar that there was some sort of laceration by the time Kwementyaye arrived at the Watch House. That is supported to some extent by the blood on the inside of Kwementyaye's shirt, which he took off in Cell 1. It is clear that the cut was not bleeding to any noticeable extent when he was in Cell 1 but it was opened up again when he fell on the way out of Cell 1, or when he was dragged between the Cell 1 corridor and reception. This explains the blood

on the floor of the reception area at around 10pm, which was cleaned up by S/Sgt William McDonnell.

94. The cut appears to have been opened up again, or at least aggravated, after the manoeuvre performed by Constable 1/C Evans at 10.11pm, which caused Kwementyaye to hit the reception desk, and lead to him being forcibly searched on the floor by three officers. That explains the small pool of blood on the reception floor, the drips of blood down the Corridor to Cell 9 and the smears of blood on Kwementyaye's mattress and the concrete blocks in his cell.

95. In my view it is of little consequence exactly when Kwementyaye first sustained the cut. The issue is not when the cut occurred, but rather what was done in relation to it when it came to the attention of police.

Failure to do a health assessment

96. One of the more incredible failings in the care given to Kwementyaye was the lack of any genuine health assessment. Police were obliged to fill out a hand written tick a box form with a checklist of essential questions about the detainees health. They included:

- "Do you have any health problems?
- Do you use drugs?
- Do you take any medication?
- Do you see a doctor for any reason?
- Have you received a blow to the head in the last 24 hours?
- Have you ever tried to hurt yourself?
- Do you feel like hurting yourself now?
- Are there any other health issues I should know about?
- Do you suffer any mental health problems?

- Do you have any injury?"

97. In Kwementyaye's case, the form was signed by Constable 1/C Blansjaar, who ticked "unable to answer" in response to all but one question. The only different answer was to the question asking "do you have any injury", which was ticked "yes", with a notation "cut above the left eye". Constable 1/C Blansjaar admitted that he did not actually ask Kwementyaye any questions, but rather ticked the boxes some time after he was deposited in Cell 9.

98. In 2010, I heard evidence in an inquest into the death of Adam Chandler who died of injuries sustained in the community, that had not been adequately assessed when he came into police care. Mr Chandler was taken to the Darwin Watch House and then allowed to leave without a thorough health assessment having been done. My findings included the following recommendation –

> "I recommend that the Commissioner of Police gives consideration to additional or refresher training for all Watch House Officers on the high standards required of them in relation to the screening of the health of prisoners. I also recommend that the health screening form used include the question "Do you have any injury".

99. In response to that, a new Custody Health Assessment form was designed with a check list that aims to assist the members to make a more in depth inquiry to determine the detainees state of health. It includes the specific question *"Do you have any injury*". Although I appreciate that the new form was introduced to improve the system, this means nothing if officers do not understand its importance and treat it with the respect that it deserves.

100. Kwementyaye was in such a state of helpless intoxication that he was incapable of participating in the questionnaire, meaning that no genuine health assessment took place. In spite of that a box on the form was ticked

to suggest that Kwementyaye was "fit for custody". There is no excuse for such a haphazard, careless attitude to prisoner health. Kwementyaye's lack of capacity, and/or the laceration on his head, should have signalled to Constable 1/C Blansjaar and other officers that he was in need of immediate medical attention.

Failure to record information

101. Police on the afternoon/evening shift admitted that they failed to fulfil their obligations to record Kwementyaye's injury on IJIS and on the white Board (with respect to IJIS, the requirement was set out in the Custody Manual – Watch House Staff 32.6). The recording of injuries should not be dismissed as merely a formal requirement. It serves a purpose in focusing the minds of officers coming on duty about the need for follow up care and close observation of that particular detainee.

102. There was also a failure on the part of Constable 1/C Evans to complete and submit a 'use of force form' relating to the incident with Kwementyaye, as he was required to do (Apprehending members – Operational Safety, Training and Procedures, S.47.1 & S.47.2). The 'use of force forms' are an important way to ensure that staff get guidance as to the appropriateness of their actions, because once they are completed they are submitted to the Governance and Accountability Division and the circumstances of the use of force are reviewed.

The Shift handover

103. At around 11pm on 4th January, the afternoon/evening Watch House shift changed over to the evening/overnight shift (11pm-7am). ACPO's Parker and Brooking were replaced by Probationary Constables, Janice Kershaw

and David O'Keefe. Watch Commander A/S Sergeant McDonnell was replaced by A/S Sergeant Andrew Barram.

104. The failure of the outgoing staff to properly evaluate and understand Kwementyaye's condition had two devastating effects. First, they failed to get him medical care, and second, they passed on inferior information to the officers taking over on the next shift.

105. Between 11 and 11.05pm, a series of conversations took place that are illustrative of a communication breakdown between the two shifts. At 11:00:47pm, oncoming Probationary Constable O'Keefe asked oncoming Watch House Commander Sereant Barram, to review "the guy" in cell 9, although he did not know Kwementyaye's name and did not have an accurate account of what had occurred during the earlier shift.

"O'KEEFE:	Sarge, can you do an assessment of the guy in 9?
BARRAM:	What for?
O'KEEFE:	He's only a PC. He came in, fell over coming in, he's cracked his head open. He's alive, he's breathing. He just looks ... he just looks funny.
BARRAM:	Alright
O'KEEFE:	Have you seen him?
KERSHAW:	(inaudible)
O'KEEFE:	You should go down and have a look he'll have one hell of a kink in his neck when he wakes up".

106. The expression "he's cracked his head open" was an exaggeration, but it is surprising that it did not prompt any of three officers involved in the conversation to consider an urgent medical assessment. When Sergeant Barram and Probationary Constable Kershaw did as suggested by

Probationary Constable O'Keefe and went down to Cell 9 to check on Kwementyaye, they found him asleep and breathing.

107. Sergeant Barram sought further information from the outgoing Watch House Commander, Sergeant Will McDonnell, who was present for a short time when Kwementyaye was first dragged onto the reception floor, and had observed the blood from the head laceration, but had not seen Kwementyaye flung into the reception desk or carried down the corridor. At 11:03:14, the following exchange took place:

"BARRAM:	Have you had a look at this bloke in cell 9?
MCDONNELL:	Yeah, he's got a cut to the (inaudible) there (inaudible) coming in bouncing all around (inaudible) blind mate. If we take him up to the hospital now he would have just gone and we've got [to] chase him so.
BARRAM:	Alright.
MCDONNELL:	It's not a custody incident as such inaudible) so if you want to, I reckon probably he just needs to sleep another hour or so (inaudible).
PARKER:	He was drunk drunk (inaudible)
MCDONNELL:	He goes up there.
PARKER:	And I've done some checks on him all the time (inaudible).
MCDONNELL:	Cause he'll take off and they'll go ah reported missing you know what I mean".

108. Sergeant McDonnell went on to tell Sergeant Barram that Kwementyaye was banging on the cell door while he was in the observation cell and that he "wanted to have a go at the members". This view of Kwementyaye as highly

aggressive and too agitated to accept any care was in contrast to Sergeant McDonnell's own observations of him writhing on the reception floor, but it was a view obviously conveyed by the general duties officers, who had by that time left the Watch House.

109. I repeat what was set out earlier in these findings. Kwementyaye was agitated in the observation cell, but not so agitated that it prevented him being brought out with a number of other detainees. He was by that stage so intoxicated that he struggled to sit up, could not speak properly and was emotionally distraught. His brief and clumsy act of aggression towards Constable 1/C Evans was triggered by being shoved back on the bench by the officer when he stood up. His legs went out from under him when he was flung towards the reception bench, after which he lay motionless while he was searched and carried to Cell 9. A moment's calm reflection on Kwementyaye's condition after he was transported to that cell would have confirmed that he was incapacitated.

110. The stubborn view that Kwementyaye might become aggressive if he was woken for medical care was a fatal error that clouded the decision making of the oncoming officers.

111. In the presence of Sergeant McDonell and ACPO Parker, Sergeant Barram instructed the two probationary constables to keep Kwementyaye under "close obs". Sergeant McDonnell added that that's what their shift had been doing. He suggested that the officers "give him a couple of hours" and then send him to the hospital to go and get some stitches.

112. In spite of the clear direction from their Watch House Commander, Probationary Constables O'Keefe and Kershaw failed to keep Kwementyaye under close observations and in doing so, were utterly derelict in their duty to care for him.

113. There were inconsistencies between the Custody Manual and the Alice Springs Watch House SOPS in relation to what is required for close observations. The Custody Manual requires that:

> "Prisoners should, in so far as is reasonably practicable, be checked every 15 mins in the first half hour of custody and then once every half hour thereafter (Pollock at p 30). A person in custody is to be checked as frequently as possible when exhibiting signs of physical or emotional distress, including anger, or aggressiveness or is otherwise disturbed or suffering from the effects of alcohol or drugs. Such checks are to be conducted for the duration of their time in custody (NT Police Gen Order- Custody Manual – P 34, Para 50.3)"

114. By contrast, the Alice Springs Police Station Watch House SOP's state:

> "As a minimum, wherever possible, cell checks will be conducted at intervals not greater than 15 mins for the first 2 hours of a prisoner's detention and thereafter should be conducted at intervals of no greater than 1 hour for their remaining time in custody. With a violent, depressed or prisoner deemed at risk the checks should be increased regardless of the period in custody (SOP's – Cell Checks – P,10, Para. 11.1).
>
> Sleeping prisoners should be checked to ensure they are breathing comfortably and appear in good health. If the inspecting member has any reason to be concerned about the mental or physical well being of any person in custody they must be woken and checked custody (SOP's – Cell Checks – P,10, Para. 11.3).
>
> Closed circuit television (CCTV) monitors are not to be used as a substitute for personal cell checks carried out by members. CCTV is an aid in the custody of a person, it is not a primary tool of monitoring (SOP's – Cell Checks – P,10, Para. 11.5)".

115. In spite of the confused messages in those documents, both officers understood that close observation meant 15 minute cell checks. As Counsel for the two officers, Dr Freckelton SC put it in his closing, the failure to do the cell checks during the relevant period wasn't attributable to any

confusion caused by a lack of synchronicity between these two forms of documentation - it was that the right thing wasn't done.

116. Only three cell checks were done by Probationary Constables O'Keefe and Kershaw. These occurred at 10.47pm (O'Keefe), 11.01pm (Kershaw) and 11.30pm (Kershaw). Over the next two hours, the two officers rarely left their desks. In evidence they admitted being distracted from their duties by various things, including an iphone, an ipod and the internet. At 1.32am, when Sergeant Barram returned to the Watch House and approached the reception counter, CCTV footage captured the embarrassing spectacle of both probationary constables flicking from the Internet back to IJIS, to avoid being caught out by their superior. That shows a level of immaturity that is completely unacceptable for officers assuming the care of vulnerable prisoners.

117. Not only did Probationary Constables Kershaw and O'Keefe fail to conduct cell checks in accordance with the Custody Manual and Watch House SOPS, but they made no record of the few they did do, in further breach of *Custody Manual* (Watch House staff – *Custody Manual* 32.1).

118. In a further dereliction of their duties, the officers failed to respond to the distress calls made by prisoners in Cell 16, who could see and hear that Kwementyaye was in trouble. In each cell there is a call button that can be activated by detainees if they need to get the attention of officers. That rings in the reception area and will sound every minute until the receiver it connects to is picked up by police. At 11.44pm, prisoner Warren McDonald activated the call button in his cell. It is clear from CCTV footage that around that time, he and fellow prisoners, Anslem Impu and Kyle McDonald, were looking across to Cell 9. Each of these men gave evidence before me and I was impressed by their sincerity and their concern for Kwementyaye.

119. It is likely that the prisoners in Cell 16 were seeing Kwementyaye in the last moments he was alive and at the last opportunity police had to save his life. I heard from Warren and Kyle McDonald and from Mr Impu that they could hear distressing noises from Cell 9, described by the men as coughing, gasping and choking. A review of CCTV footage shows that the last movement of Kwementyaye's body was a very slight twitching of his limbs, at 11.42pm, just two minutes before the call button was activated.

120. When that call button sounded in the reception area at 11.44pm, both probationary constables were distracted by the presence of a detainee who had been brought into the reception by two general duties officers, and was engaging all the officers in conversation. Probationary Constable Kershaw was assisting with searching and processing the detainee, while Officer O'Keefe was listening to the "banter" between the officers. The call rang three times over several minutes, twice when it was pushed by the prisoners in cell 16 and once because it was an automatic reminder at the one minute mark. By the time Probationary Constable O'Keefe answered the call a few minutes after it was first rung, he glanced up at the CCTV screen in front of him and could see that the prisoners in cell 16 were seated back on their mattresses. Instead of trying to speak to the prisoners over the telephone or attending on their cell to follow up on the call, Probationary Constable O'Keefe hung up the receiver.

121. In evidence during the inquest, both Probationary Constables agreed that one of them should have responded to the call. Officer O'Keefe gave evidence that:

> "cause they were in remand they'd been in there for a few days and that they'd been getting taken out for cigarettes and that there was one in particular who'd had a couple of phone calls. So I had that in my mind that they probably would want to either go out for a cigarette or have a phone call".

122. I accept that this was the reason why he did not respond quickly enough to the call button. When the prisoners in Cell 16 used the call button 13 minutes earlier, at 11.31pm, Probationary Constable O'Keefe picked up the phone and was told they wanted a cigarette. No doubt he thought the subsequent call was for a similar request and he was not contemplating the possibility of an emergency. That is an explanation, but not an excuse for the inaction of officers at that time.

123. I heard evidence from prisoners in Cell 16 that they had tried to get the attention of police on more than one occasion, by calling out and using the cell call button. After reviewing the CCTV footage, and hearing relevant oral evidence, I am satisfied that there was only the one occasion, at 11.44pm, when prisoners pressed the call button to get help for Kwementyaye.

124. It is entirely possible, however, that prisoners in Cell 16 called out to police in reception to get help, but were not heard. Officer Kershaw told the inquest that she had shut the door between the corridor and reception area, in order to block out the noise of a prisoner who was at the end of the row of cells where Kwementyaye was housed. Incredibly, Probationary Constable Kershaw gave evidence that there was a sign on the door telling police it should be shut at night. To shut the door between vulnerable prisoners, some of whom are alone in their cell, and officers, who are their only means of getting help, is dangerous and foolhardy. It beggars belief that after doing that, the officers did not respond immediately to a cell call or do regular cell checks.

125. When Sen. Sgt Barram returned to the Watch House at 1.30am, he commenced a round of cell checks and at 1.41am, he noticed that Kwementyaye had not moved from the position he had last seen him in at 11pm. He approached the reception desk to collect the keys to Cell 9, directing the following question to both officers:

"BARRAM: You been doing regular checks of the guy with the cut eye?"

The reply came from Officer O'Keefe:

"O'KEEFE: Yeah, he hasn't moved".

126. The Watch House Commander moved straight to Cell 9, entered it and found that Kwementyaye was not breathing. He yelled for an ambulance to be called and commenced CPR. Both Sgt Barram and Probationary Constable O'Keefe made valiant efforts to save Kwementyaye, but his body was cold and he had probably passed away around two hours earlier. Constable O'Keefe was inhibited when attempting to utilise the plastic face shield and so he conducted mouth-to-mouth resuscitation unprotected, putting his concern for Kwementyaye above his own interests at that time. He is to be commended for that and I note that the family graciously thanked the officers for their first aid efforts.

127. It is unfortunate that neither officer was aware of the existence of a defibrillator, which had been installed in the Watch House several months earlier, but it is not their fault that they were not properly trained in the use of that machine, and it would not have made any difference in these circumstances.

128. Officer O'Keefe compounded the mistakes he made on this shift by lying twice about the cell checks, first when he replied to Watch House Commander S/Sgt Barram that they had been doing regular checks, and second when he called through to Triple 0 and said to the operator "we've been doing regular checks on him". I appreciate the officers frank admissions in his oral evidence. I note that he is a probationary constable and still relatively young, and I accept his evidence that he lied because "it was a moment of panic", and he was "in crisis" and scared about what would happen next. Honesty and trustworthiness are fundamental character traits

for an officer in the NT police force and I can only hope that this incident was an aberration for the officer.

129. Officer O'Keefe showed some strength of character in his sincere apology to Kwementyaye's family, which was offered in these terms:

> "No-one should have to ever bury a son or grandson. It's a terrible, terrible tragedy. I can only apologise that I didn't do my job well enough and I'm very sorry for your loss".

130. The NT Custody Manual provides a clear statement of the duty of care owed by police officers to detainees. It mandates that:

> "Each and every member of the Northern Territory Police Force must exercise reasonable care for the safety and welfare of a person in police custody (General Order- Custody Manual – Para 13.1)".

And further;

> ".... the very fact that Police have the power to deprive a person of their liberty means they, and they alone, assume the role of caretaker and protector to the exclusion of all others. Total responsibility demands the highest standard of care. Complacency at any level or any attempt to avoid or shift responsibility is unacceptable (General Order- Custody Manual – Para 13.3)"

131. Perhaps the simplest expression of that noble principle is found in the exhortation to officers to ask themselves:

> "How would I want myself or a member of my family to be treated if I or they were in custody?"

132. I concur with the conclusion reached by the investigating officer, Det. Senior Sergeant Pollock, that "it was apparent in this case the Police Officer's involved did not meet their professional obligations regarding the stipulated 'duty of care' standards".

133. The coronial investigation revealed a long list of obligations set out in the Custody Manual and Watch House SOP's that were breached by police covering the two shifts that Kwementyaye was in custody for. These were in regard to:

- Completing correct entries in the watch house log (Watch Commanders/Watch House staff – Custody Manual)
- Completing correct entries in the Offender Journal (Watch House staff – Custody Manual)
- Failing to appoint a Watch House Keeper (OIC Alice Springs Police Station/Watch Commanders – Custody Manual 24)
- Failing to undertake a proper 'frisk' search of prisoners (Apprehending member – Duty of Care)
- Failing to undertake regular cell checks (Watch House staff – *Custody Manual* 32.1)
- Failing to complete cell checks on IJIS (Watch House staff – *Custody Manual* 32.6)
- Failing to complete and submit 'Use of Force' forms (Apprehending members – Operational Safety, Training and Procedures S.47.1 & S.47.2).

134. In his closing submissions to me, Dr Freckelton SC made the point that this is not a case where officers should be viewed as brutal or uncaring or inhumane, but rather "[t]his was a situation in which decent people made errors". I unreservedly accept that submission. By way of illustration, I highlight these facts: ACPO Parker made checks on Kwementyaye every few

minutes for the last half hour of her shift, but she was dealing with a detainee who was deemed by a senior officer to be "fit for custody" and she was not fully aware of the dangers of intoxication; Constable 1/C Evans spoke to Kwementyaye firmly but fairly for most of the time in the reception area and was at that stage labouring under the mistaken but genuine belief that he was exaggerating his incapacity; A/S/Sgt McDonnell expressed the view to oncoming staff that Kwementyaye should go to hospital in a few hours time, wanting him to get medical care, but wrongly assuming that he had just been highly aggressive to staff and needed a few hours to sleep that off; and A/S/Sgt Barram had a careful look at Kwementyaye in Cell 9 around 11pm, and showed genuine concern, but having not received accurate information at handover, he did not know the extent of Kwementyaye's incapacity and did not appreciate that urgent care was needed. In those circumstances, his failure was explicable. He did, after all, instruct the two probationary constables that they should keep Kwementyaye under close observation, but was let down when that did not occur.

135. It was clear from the evidence of the General Duties and Watch House staff who appeared before me, that Kwementyaye's death has had a profound impact on them. I was struck by the sincerity of the apologies they offered to Kwementyaye's family and the very real distress that some officers experienced when they realised that their individual failings contributed to the tragic result.

Cause of death

136. I had the benefit of receiving evidence from two of Australia's most experienced and expert pathologists, Dr Terence Sinton, Chief Forensic Pathologist of the Northern Territory and Professor Johan Duflou, Chief Forensic Pathologist of the Department of Forensic Medicine in Sydney. Dr Sinton had performed the autopsy on 5 January 2012 and wrote the official "autopsy report". Professor Duflou, who was retained by representatives for

the family, prepared an additional report for the court after reviewing the brief of evidence, autopsy case file and microscopic slides.

137. Evidence was called very effectively using a method known as "hot tubbing" where the experts give their evidence concurrently, and seated beside each other. It was clear that the two pathologists were in agreement about most of the issues in the case. Importantly, both ultimately agreed that it was possible that cause of death could be either: 1) alcohol toxicity on it's own, or 2) alcohol toxicity, in combination with positional asphyxia and compromised airways. Their point of difference was that Dr Sinton favoured the first cause of death, and felt that there was not compelling evidence to support an alternative in the face of Kwementyaye's high blood alcohol reading, whereas Professor Duflou found, on balance, that the evidence supported a cause of death involving a confluence of factors, including, but not limited to, alcohol toxicity.

138. A thorough internal and external examination was conducted. The external examination revealed a superficial (2 mm) abrasion on the right middle finger and a shallow 15 mm abrasion below the right knee. The only significant finding was the cut above Kwementyaye's left eyebrow, which was described as "a 15mm shallow laceration through skin and subcutaneous tissue only".

139. In the outline of evidence above, there are numerous references to blood spilt from the shallow cut above Kwementyaye's eyebrow. That cut caused a smear in the reception area when he was first dragged in, a small pool where he lay on the floor after hitting the reception desk, droplets of blood down the corridor as he was carried to Cell 9, a large smear on the mattress where he lay face down and smears on the concrete slab in Cell 9. Both pathologists agreed that although the wound bled significantly because of the extensive blood supply to the face and scalp, the cut was shallow and certainly not life threatening.

140. Internal examination revealed no serious injury and no broken bones. There was evident bruising below the facial laceration but that was shallow and of little import. There was no skull fracture, nor any subdural haemorrhage. One finding of potential significance was small areas of deeper bruising on the left side of the head, the left shoulder and the base of the neck that was consistent with trauma to that area.

141. During their evidence in court, both pathologists viewed distressing scenes from the CCTV footage showing the few minutes after Kwementyaye was delivered to cell 9. After he was placed face down on the mattress at 10.12pm, police beat a hurried retreat to the cell and secured the door. Less than half a minute later, Kwementyaye rolled onto his back and hit his head on the floor. He then rolled onto his side, attempted to sit up, and then stand up, before he fell onto the concrete bench and lay his head down there. At 12.14am he attempted to sit up, and then fell back down on his face with his head and chest on the concrete bench and the remainder of his body on the floor. The expert pathologists agreed that although it is impossible to clearly link bruising with impact (not every impact causes a bruise and Kwementyaye had fallen over a number of times before he went into Cell 9) it is plausible that some of the bruising to the head was caused by falls after he was placed on the mattress.

142. A sample of blood taken at autopsy reveals a blood alcohol concentration (BAC) of 0.350grams/100ml, which both pathologists agree is within the lethal range, and is of itself a possible explanation for the cause of death. According to Forensic Physician Dr Maurice Odell, peak intoxication levels are reached between half an hour and two hours after consuming alcohol. Kwementyaye had his last drink before 9.39pm and it is therefore likely that his BAC reached a peak some time between 10.09pm and 11.39pm, and had started to fall by the time of his death at around 11.42pm. It is possible that the BAC was higher than 0.350 for some of the time that Kwementyaye was in custody. Dr Sinton was of the view that the sole cause of Kwementyaye's

death was his level of intoxication, in the absence of clear indicators that other factors (like positional asphyxia) had played a role.

143. In the opinion of Professor Duflou, cause of death is better explained as being due to a combination of positional asphyxia, aspiration and acute alcohol intoxication. On reviewing the histological slides (microscopic examination of the tissues), Professor Duflou found evidence of aspiration of gastric contents in the lungs, suggesting Kwementyaye may have choked on his own vomit. There were changes in the lung tissue under the microscope which were typical of aspiration.

> "These were the presence of proteinateous oedema fluid as opposed to the more standard oedema fluid, but it was very pink coloured fluid in the lung tissue. There was what we call formative pigment and those appearances to me – and then there were collections of bacterial colonies and those are all typical of aspiration" (Prof Duflou, Transcript, 15/6/-7, at p 194).

144. Dr Sinton acknowledged that aspiration was obvious on microscopic examination, but he was not convinced that this was evidence that Kwementyaye choked on his own vomit. In his view, microscopic evidence of aspiration was not an unusual finding and might be present even where there had not been aspiration. He pointed out that there was no macroscopic evidence of aspiration - nothing in the mouth, nothing in the airways beyond the pulmonary oedema and nothing along the oesophagus - to suggest that material had come from the stomach to the mouth, and then been aspirated into the lungs.

145. Although I understand the cautious approach adopted by Dr Sinton, I am ultimately persuaded that, on the balance of probabilities, Professor Duflou is correct. I note the evidence that Kwementyaye's stomach was empty, so you would not expect to see aspiration of food material. There was obviously fluid in the stomach, but vomiting and inhaling fluid would not

necessarily be visible at the time of autopsy, either in the oesophagus or in the bronchi. Professor Duflou felt that his conclusions were supported by the observations of prisoners in Cell 16, who heard gasping and choking sounds coming from Cell 9 at 11.44pm, around the time when Kwementyaye last visible movements. During the inquest. He summarised that conclusion by stating:

> "I felt that the actual presence of [aspiration] under the microscope plus the witness statements really linked that together very nicely".

146. Professor Duflou reviewed CCTV footage and noted that Kwementyaye was positioned face down on the mattress at 10.12pm. Minutes later, he had moved so that his head and chest were elevated on a concrete block and the rest of his body was on the floor, a position he remained in until he died. Given his significant intoxication, it is possible that Kwementyaye compromised his upper airway in that position, resulting in some form of positional asphyxia. It is not unusual to find no evidence of this at autopsy.

147. Professor Duflou also commented on the possible relevance of head trauma to cause of death. Kwementyaye experienced head trauma after the fall in the reception area and on at least one (possibly two) occasions in Cell 9. If that trauma was followed by a period of unconsciousness, even a brief one, then there is a strong possibility of concussion having occurred, which can have subtle effects on a person for hours after the event and may further compromise someone's ability to move themselves into a safer position.

148. After careful review, I have come to the conclusion that the cause of death can be most accurately recorded as the one favoured by Professor Duflou. This is not just because of Professor Duflou's findings upon review of the histological slides, but because that evidence fits with the observations of prisoners. Thus, the cause of death will be recorded as "airway obstruction due to a combination of positional asphyxia, aspiration and acute alcohol intoxication".

Evolving Medical Emergency

149. In order to better understand the cause of Kwementyaye's death, and what could have been done to prevent it, I received a written report and oral evidence from Dr Maurice Odell, a Senior Forensic Physician from the Victorian Institute of Forensic Medicine. He gave very helpful evidence on the effect of gross amounts of alcohol and listed five ways in which it may have contributed to Kwementyaye's death:

> "1.Although alcohol has an initial stimulating effect, as BAC continues to rise it eventually acts on parts of the nervous system responsible for cardiorespiratory functions and consciousness. This causes a depressed conscious state and reduces the drive to breath, which can lead to death at BAC levels above around 0.30%.
>
> 2.Intoxication adversely impacts on balance, coordination and gross motor skills, making it more likely that someone will fall and experience trauma. Dr Odell, like Professor Duflou, highlighted the fact that Kwementyaye sustained blunt trauma to the head during one or more falls whilst in custody, and may have been concussed as a result. If so, the concussion would have accentuated the alcohol intoxication and vice versa.
>
> 3.Alcohol intoxication reduces someone's ability to keep their airways clear by expelling or swallowing secretions like saliva and mucous. It also increases the risk of aspirating vomit (as outlined above, on autopsy Dr Sinton did not find evidence of the aspiration of stomach contents, but Professor Dufou did make such a finding after reviewing the histological slides).
>
> 4.Alcohol intoxication reduces a person's control over their body, which renders them less able to move out of a position in which breathing is restricted because of either obstruction of the airway or compression of the chest.
>
> 5.Ingesting large amounts of alcohol may cause disturbances in body chemistry and acid-base imbalance, and may lead to sudden death".

150. Dr Odell reviewed the treatment and care that Kwementyaye received in custody and noted that it fell short. He concluded that Kwementyaye's situation was *"an evolving medical emergency which went unrecognised"*

and that *"a timely response may well have preventd his death"*. The rapid deterioration in his conscious state should have been a warning sign to officers that he was not fit to remain in their custody.

151. As Dr Odell made plain, the lessons of this case are that it is essential that police officers, tasked with the obligation of caring for prodigious number of heavily intoxicated, and often chronically unwell detainees, are given clear guidance as to when someone in their care is to be referred for medical treatment. There should be protocols in place for monitoring detainees with a reduced conscious state and officers should be trained to have a low threshold for transferring a detainee to hospital (or referring them to a nurse where available) if they have any doubt.

Systemic failures

152. One of the most dispiriting findings to come from an investigation into the death of Kwementyaye Briscoe is that lessons learnt in previous inquests were forgotten or ignored in the lead up to this tragedy. Kwementyaye was the fourth person to die in the Alice Springs Watch House, and the second to die in the new purpose built facility opened in 1999. I have presided as Coroner in the inquests investigating each of these tragic deaths.

153. In 1997 and 1998, two males who had been picked up and detained in protective custody died in the old Alice Springs Watch House within six months of each other. They were the first such deaths in 10 years. Mr Andrew Ross was only 16 years of age and was a young indigenous boy who took his own life by hanging himself in the cells. Mr Bradley Gardiner was a non indigenous man whose accidental death was caused by drug and alcohol toxicity.

154. Those inquests led to a raft of important reforms, including the construction of a modern watch house facility opened in March 1999, and the

introduction of the Custody Manual for "guidance and instruction on prisoner care in the NT" (*Custody Manual General Order*- 24 June 2010, P 4). That comprehensive document is not merely a formality or a set of aspirations. It has the status of a General Order and is to be regarded as "custody best practice" to be followed wherever possible. Furthermore, the *Custody Manual* required the development of local *Standard Operating Procedures* (*SOP's*) for each Watch House in the NT to reflect local realities and conditions. For over a decade the Custody Manual and the Alice Springs Watch House *SOP's* have stood along side each other to provide guidance to police in the performance of their duties.

155. In January 2009, Cedric Trigger died aged 34 as a result of a head injury sustained shortly before he came into custody. When ordered out of the police van, he was unable to walk and police dragged him, handcuffed, to the cell where he later died. In that case, Police mistook his lack of capacity for drunkenness, and no risk assessment was carried out before he was placed in a cell alone. I identified in my findings that the systems implemented after the Ross and Gardiner inquests, over a decade earlier, had broken down. The *SOP's* were not in line with the Watch House Manual, and had the potential to create confusion as to what was required when keeping detainees under close observations. Of most concern, no one had been appointed as Watch House Keeper for some months prior to Mr Trigger's death.

156. In the case of Mr Trigger, in addition to system failures, I was alerted to an unacceptable practice of dragging some intoxicated individuals between cells. Footage captured on CCTV showed Mr Trigger falling from the tailgate of the police van onto the concrete floor a metre or so below, and lying there unassisted for a few minutes before being dragged by police, face down and still hand cuffed, through to reception. Those few minutes captured on the video demonstrated treatment of the deceased which was undignified and inappropriate. Furthermore, it revealed a failure to

appreciate the dangers of not having a detainee medically assessed if it appears that their intoxication renders them unable to move themselves.

157. In the course of the '*Trigger* inquest' I heard from very senior police officers who provided assurances that the systemic failures identified as a result of that death had already been attended to, or would be on an urgent basis. Commander Anne-Marie Murphy told the Court that having reviewed the circumstances of Mr Trigger's death, she had already implemented changes to ensure, *inter alia*, that a designated Watch House Keeper would be rostered on each shift and that further instruction would be given regarding risk assessments.

158. In the course of the hearing, Commander Murphy gave this evidence:

> "Since I've read this file (Trigger) I've had a few conversations with some of my management team about the way the Watch House has been functioning or not functioning in accordance with the Custody Manual, particularly in terms of the Watch House Keeper, and the assessment of people that come in, to make sure that they really clearly understand that we do not want people at risk in the Watch House unless we absolutely have to.
>
> I intend to meet with all the Watch Commanders in their next forthcoming meeting that they have prior to their rosters coming out, to reinforce these assessments and their responsibility in terms of the Watch House. And it's up to them to reinforce that with the various members on their patrols: their supervisors and their patrols which include their Watch House staff".

159. With respect to the issue of keeping detainees in custody when they appeared too intoxicated to walk or speak, I received assurances that this was a rare occurrence, and that a cautious "safety first" approach was now being taken by officers. The following exchange took place between Counsel Assisting, Sergeant Winton (the acting Watch Commander) and myself:

"ROBERTS: "And in your experience, are prisoners sometimes brought in who are not able to have a useful conversation with the watch house staff?"

SGT WINTON: "... Not these days, no. I mean, if they can't answer the questions then they – well, if they're incoherent then no they won't be – they shouldn't be allowed in the Watch House.

ROBERTS: "So what would happen in those circumstances? What would you do...?

SGT WINTON: "...It'd usually be up to the watchhouse staff to either call me for advice or, if I wasn't available, then to call the ambulance straight away or get the members to take them – take the person to the hospital for medical assessment".

CORONER: "Thank you for that, sergeant. It's been my impression over the last few years that that's exactly what happens; that if a prisoner is incoherent and may be incoherent because they're too drunk to answer a question, a safety first approach is taken and they're taken to a hospital, is that right"?

SGT WINTON: "Definitely, sir. That has definitely improved over the years and, yeah, it is in practice, yes".

160. In view of those solemn assurances, it did not seem to me that recommendations were required. As I wrote in my findings in Trigger: But for Commander Murphy's evidence, I would have made recommendations pursuant to section 26 of the *Coroners Act* centred around watch house procedures. However, it is not necessary to do so when I am confident that measures have already been put in place to address these matters". The recommendations I would have made would have related to the need to ensure staff properly understood risk assessment procedures, the need for clear guidance about the inappropriateness of dragging detainees and the need to ensure that someone was rostered on as Watch House Keeper who had the requisite degree of experience and training.

161. Although the facts are not identical, I am dismayed by the similarities between the death of Mr Trigger and that of Kumandjayi Briscoe and repetition in breaches of the Custody Manual and Alice Springs Watch House SOP's. In the death of Mr Trigger as with Mr Briscoe:

a) There was no Watch House Keeper on duty;
b) The practice of the Watch Commander or shift supervisor allocating a Watch House Keeper, as required by the Alice Springs Watch House SOP's, was not being observed in the months leading up to the death;
c) The detainee was placed in the cell without an adequate risk assessment being carried out;
d) Partly as a consequence of the failure to appoint a Watch House Keeper, there was a lack of leadership on the night the deaths occurred; and
e) Police dragged the inert body of a heavily intoxicated detainee along the floor of the Watch House, failing to recognise that such a level of incapacity required them to procure urgent medical care.

162. The undertakings so solemnly made during that inquest did not result in any sustained reform so that some 22 months after Commander Murphy gave evidence another death occurred. The community, of which Kwementyaye and his family were a part, was badly let down by the failure of Management in the NT Police force to implement those changes.

What Systemic Failures?

(1) The failure to adequately staff the Watch House

163. At the inquest into Kwementyaye's death, NT Police acknowledged the failure to act on those promises and evidence was called to explore why the necessary action had not been taken. The Court heard that there was a sincere effort made after the *Trigger Inquest* to implement the promised reforms. Throughout the remainder of 2010 and into the first half of 2011, a Watch House Keeper was duly rostered and they wore a badge to identify their position.

164. Yet some time after August 2011, the practice of rostering a Watch House Keeper was eroded, and with it the safety of the detainees. In part, this appears to have been caused by the transience of staff, including those in senior positions, but that was not the only explanation.

165. The inquest was greatly assisted by the frank and revealing insights provided by Superintendent Delcene Jones, who has been based in the Governance and Accountability Division in Alice Springs since March 2011. That Division was created in January 2011 in Darwin, Katherine and Alice Springs and is responsible for identifying health and safety risks, and suggesting practices and procedures that will mitigate against them.

166. Soon after Superintendent Jones commenced work in her new role, she identified a number of risk factors in the Alice Springs Watch House and raised these issues with officers of similar and more senior rank. In oral evidence, the following exchange took place:

> "DR DWYER: You very quickly into your role became aware of major problems with respect to the Alice Springs Watchhouse. Is that fair?

S/I JONES: Yes. Alice Springs Watch House was managed very differently to the other watchhouse environments that I had experience working with, primarily Darwin or previously Berrimah watchouses.

DR DWYER: And not managed as well, as far as you were concerned?

S/I JONES: The staffing was a lot different because Darwin has a core group of - a stable group of police auxiliaries and experienced members in that area whereas the Alice Springs Watchhouse was rostered with relatively inexperienced people, probationary constables. There wasn't that core group of auxiliaries rostered in the area.

CORONER: That may be the reason for it not being run as well as Darwin but do you agree it wasn't run as well as Darwin and other watchhouses you'd seen?

S/I JONES: Yes, sir".

167. One major concern was the poor rostering practices, namely, the failure to ensure experienced officers were always on shift, the absence of Police auxiliaries, the rostering of ACPO's with probationary constables, and the use of ACPO's as Watch House Keepers. Superintendent Jones raised those issues with the officer in charge of the Watch House, and suggested that police officers with appropriate experience be rostered in the Watch House on a semi-permanent basis, for three to six month periods. No action was taken in response.

168. The Superintendent of each Governance and Accountability Division reports to the Commander of the relevant region. Superintendent Jones reported to the Commander of the Southern Region, a position which was filled by five different individuals in the 10 months between the time Superintendent Jones arrived in March 2011 and when Kwementyaye passed away in January of the following year. Commander Anne Murphy, who had made

such sincere undertakings during the *Trigger inquest*, was the Commander when Superintendent Jones first started, but she was transferred early in 2011.

169. In October 2011, Superintendent Jones made an appointment with then Commander of the Southern Region, Michael Murphy, and reported that she was extremely concerned that local Management had failed to respond to the rostering problems. Commander Murphy, who had read the *Trigger* findings and was aware of the problems they identified, agreed that action was required and that the issues should be raised at a meeting of relevant decision makers to take place the following day. At that meeting all participants expressed their agreement that action would be taken, including rostering more experienced staff for short-term periods and rostering five police auxiliaries at the Watch House on a permanent basis. Nevertheless, in the weeks and months that followed, the situation remained stagnant.

170. The frustration of Superintendent Jones was expressed in a statement tendered in the brief, which she did not resile from in oral evidence. The inquest was told:

> "It's clear placing untrained probationary constables and making them watchhouse keepers is extremely poor management and presents a high risk, however, ownership of rostering and who manages who resulted in finger pointing and little change in the custody area. ...
>
> My recommendations have at times been met with dumb insolence to outright refusal to roster watchhouse staff on a more permanent basis."

171. The failure to staff the Watch House properly is one of the major contributing systemic issues in this death in custody. I note, for example, that on the afternoon/evening shift, ACPO Parker assumed she was the Watch House Keeper, but she had not been designated as such, and in fact

she knew that she was not supposed to be performing the role and did not have the requisite training to perform it. On the evening/overnight shift, neither Probationary Constable O'Keefe nor Kershaw assumed the role or responsibilities of the Watch House Keeper during their shift. As a result, it appears that both thought the other was equally responsible for the management of the Watch House during their shift, but neither committed to undertake or record cell checks and requirements under the *Custody Manual* and Watch House *SOP's* were disregarded.

172. Police Senior Command became aware of the issue of ACPO's working as Watch House Keepers in the first half of 2011. On 15 April that year (9 months before Kwementyaye died), Deputy Commissioner Shayne Maines issued a Memorandum to the Assistant Commissioner, Regional Operations, expressing concern that ACPO's were being used in the role of Watch House Keeper in Alice Springs, and noting that this was '*inconsistent with their roles and responsibilities*'. Oddly, that appears to have been misinterpreted at a local level and ACPO's were taken out of the Watch House all together for a few months. They were eventually allowed back into the Watch House and thereafter the slack practice of allowing them to take over the Watch House Keeper role resumed.

173. It is clear that there was some short term improvement following the *Cedric Trigger* Inquest in 2010. Until August 2011, the roster for the Alice Springs Police Station designated a 'Watch House Keeper' for each shift, and the individual assuming the responsibility wore a badge with that moniker. It is equally clear that the practice ceased after August 2011. Exactly who in senior management is directly to blame for that is not entirely obvious, but it is clear that senior management must be accountable. It was the responsibility of the Divisional Officer and Station Officer in Charge (Alice Springs) to ensure that a Watch House Keeper was designated for each rostered shift (NT Police General Order- *Custody Manual* – P 13, Para 24.1). If there were changes required to a roster (because, for example, an officer

called in sick) then it was incumbent on the Watch Commander to ensure that a Watch House Keeper was appointed for each shift. Higher up the Command there was a responsibility to audit watch house practices and effectively manage the local managers.

(2) The failure to audit staffing practices

174. The issue of inadequate staffing of the Alice Springs Watch House should have been identified by senior management during a monthly review of rostering practices required by the Alice Springs Watch House *Standard Operating Procedures*. Section 38 of those *SOP's* mandates that:

> "At least once per month the Superintendent, Alice Springs Division will cause a Senior Sergeant to conduct an audit of watch house procedures and practices for a 24 hour period".
>
> At least the following will be checked during each audit:
>
> Completeness of and correct entries in the watch house log.
>
> Completeness of and correct entries in the Offender Journal.
>
> Reason for refusal and detail of person refusing protective custodies from the shelter.
>
> The Senior Sergeant will report in writing and a headquarter file will be kept of these reports.
>
> The Superintendent, Alice Springs Division will be responsible for and take corrective action if any deficiencies or problems are identified".

175. Incredibly, there are no available records of any formal Watch House audit being conducted in Alice Springs since the *SOP's* were amended in 1999. There is no record of a Headquarter file relating to audits of the Alice Springs Watch House, suggesting that such a crucial means of checking and supervising the Watch House was either ignored or inadequate.

176. According to one former Superintendent of the Alice Springs Division, audits were conducted sporadically, but were not as thorough or regular as they should have been and had not been recorded as specified in s 38. Michael Murphy, now a Commander of the NT Police attached to Southern Command, was formerly the Superintendent of the Alice Springs Division. In a Statutory Declaration tendered to the Court, he wrote *"audits were conducted from time to time across aspects of watch house practices, but were not formally reported upon as specified in the CSOP's at section 38.* In oral evidence, the Inquest was told that as Superintendent, he was not even aware of the requirement to do monthly audits, let alone record them.

177. The lack of a thorough and regular auditing procedure meant that the Superintendent of the Alice Springs Division did not become aware of the failure to roster a Watch House Keeper after August 2011, and that did not come to his attention at any time prior to Kwementyaye's death.

178. Commander Murphy spoke frankly and took responsibility for his personal mistake, but it is clear from the gaping absence of any records over more than a decade since the revised *SOP's* were introduced that he was following the precedent set by those who had held the position before him. Section 38 gives directions to both the Superintendent and the Senior Sergeant, so that over 13 or so years, the individuals who stood in those positions did not meet the requirements. It appears that urgent action was taken by Commander Murphy to remedy this situation after he became aware of it following this tragic death. On 10 January 2012, he issued an instruction to ensure that monthly audits were compiled with the assistance of the Governance and Accountability Division.

(3) *Lack of adequate training on Watch House Procedures*

179. During this inquest there was an acknowledgment from senior police that more should have been done to ensure that officers 'on the ground' were fully trained on Watch House procedures, specifically, the operation of the Custody Manual and the Alice Springs Watch House SOPS **in practice**.

180. At least in relation to the Custody Manual, there was training in the form of written assessment and reminders. In 1999, all current police received at least one day initial training in the Custody Manual and thereafter, new recruits received training during their six month course at Berrimah. Following the death of Cedric Trigger in 2009, further Custody Manual training was conducted in 2010 and in June that year, an email was broadcast to all sworn officers that contained this reminder: *it is the responsibility of all members to read and familiarise themselves with the revised Custody Manual.*

181. In the view of the officer in charge of this investigation, A/Superintendent Scott Pollock, no current serving Police Officer, including those involved in the care, custody and supervision of Kwementyaye, can maintain that they have not received sufficient Custody Manual or Watch House training. He drew to my attention to the fact that both probationary constables, O'Keefe and Kershaw, had recently passed an exam relating to the Custody Manual during their attendance at the six month training College. Both A/Snr/Sgts McDonnell and Barram reaffirmed that they had knowledge and experience relating to 'duty of care' requirements when they applied for promotion to the rank of sergeant.

182. However what was missing for the junior members (including the ACPO's, General Duties constables and the probationary constables) was practical training and supervision so as to ensure that they understood the importance of the obligations in practice. Certainly part of the explanation for the

failure of the afternoon/evening shift to ensure medical care and the failure of Probationary Constables O'Keefe and Kershaw to do cell checks, is an attitudinal problem. However another part of the explanation lies in the failure of Management to ensure adequate supervision and on the job training. For something as important as duty of care towards detainees learning must be reinforced in the Watch House environment and leadership on those issues must be demonstrated on every shift.

183. Informal mentoring by more senior staff is hopelessly ineffective if senior members are not rostered on shift, or if the officers supposed to be giving guidance are not themselves aware of the SOP's, or do not fully understand the significance of procedures like the health assessment.

184. It is astonishing to me that 14 years after the introduction of *Standard Operating Procedures* in the Alice Springs Watch House and only 18 months after an inquest into the death of Cedric Trigger, nearly every police witness called before me admitted that prior to Kwementyaye's death they were ignorant about the contents, in some case the existence, of those *SOP's*.

185. I appreciate the frank evidence of officers asked about their knowledge of that document. Constable 1/C Evans told the Court that when he commenced work in the Watch House in 2008, there was no formal induction and he was expected to learn by getting instruction from those more senior. In the five years since he arrived in Alice Springs he had never been made aware of the Alice Springs Watch House *SOP's*. Yet on occasions when there was no Watch House keeper designated, he assumed the role himself because he was the most senior person on shift. Clearly Constable 1/C Evans was trying to do his best, yet the fact that he was allowed to assume that role without being given instructions about what it involved or the need to refer to *SOP's*, shows a lack of more senior leadership.

186. If there were one or two officers who were unaware of their obligations, that might suggest an isolated problem, but widespread ignorance shows a failure to train officers as to the significance of the Custody Manual or the *SOP's* in practice.

(4) *The failure to synchronise the Custody Manual and SOPS*

187. Following the *Trigger* inquest, the job of addressing inconsistencies between the Custody Manual and the *SOP's* fell to Superintendent Delcene Jones and Commander (of the Southern Command) Michael Murphy. Commander Murphy, who provided helpful written and oral evidence, explained that soon after he took over his position in February 2011, he reviewed the *SOP's* and identified the need for change. He noted that the *SOP's* duplicated the Custody Manual unnecessarily, lacked relevant information about local services and gave inconsistent instructions as to how often 15 minute cell checks were required. I am confident that plans were under way to address those issues, but this was not done in a timely fashion.

188. As I acknowledged earlier, the failure to update the documents did not directly impact on Kwementyaye's death, because Probationary Constables OKeefe and Kershaw were not confused by any inconsistency between the Custody Manual and *SOP's* (in fact they hadn't read the later document) and both understood that the direction they received to "keep him under close obs" meant they were required to do 15 minute checks. It was complacency and laziness, not confusion, that lead to them being derelict in their duty.

189. While I have no doubt that Alice Springs Watch House presents extraordinary challenges to police officers and management at all levels of the hierarchy, the ultimate responsibility rests with Police Command. Kwementyaye's death highlights multiple shortcomings in custody management, the most significant of which can be summarised as the failure

to roster appropriately trained and experienced staff in the Alice Springs Watch House, and the failure to designate a Watch House Keeper. These issues were recognised by the Superintendent of the Governance and Accountability Division in the year before Kwementyaye died, and raised with the Commander of the relevant region, but still did not result in action being taken in time to save his life. The inquest into the death of Cedric Trigger 18 months earlier generated promises from senior officers, but only resulted in a short term change in rostering practices. In my view and in those circumstances, Police Command must be accountable.

Significant changes since Kwementyaye's death

190. The tragic death of Kwementyaye Briscoe prompted NT Police Command to undertake an immediate and comprehensive review of what went wrong, and to institute a suite of reforms aimed at cementing best practice for the care of detainees in custody. It is clear that Kwementyaye's death was a catalyst for deep reflection and change. The level of commitment of NT Police to transparent internal and external review, as well as to every aspect of this coronial process is, in my experience, unprecedented and deserving of recognition.

191. The Assistant Commissioner has been in court every day of the proceedings, and has been joined on many of the days by the Commissioner himself, and the Deputy Commissioner. That reflects a very genuine commitment to implementing best practice and shows great respect to the coronial process and to the grieving family they sat alongside in court.

192. An overview of reforms was provided to me in the detailed affidavit of Assistant Commissioner Mark Payne, and in his frank and valuable oral evidence. He is well placed to give such testimony, having served as an officer of the NT police force for 28 years (most of that in Central

Australia), and given his current responsibility as overseer of regional operations, which encompasses both northern and southern commands. He took up the position of Assistant Commissioner, Regional Operations, in February 2011 and has been an Assistant Commissioner in a number of other portfolios since 2003.

193. In order to properly understand circumstances surrounding Kwementyaye's death, the NT Commissioner of Police commissioned a number of expert reports. First, an indepth internal investigation identified the mistakes made by individual members and those involved in their management. Secondly, Dr Graeme Edkins, one of Australia's leading human factors and system safety experts, conducted an expert review to identify systems errors. Thirdly, Assistant Commissioner Jamie Chalker, an individual I hold in high regard, undertook an extensive review of the practices and procedures in watch houses across the NT.

194. So comprehensive is the suite of reforms introduced as a result, that I cannot outline each of them in detail in these findings, and will seek instead to highlight those that appear most significant.

Retention and recruitment of staff

195. I heard evidence of the particular challenges that concern police officers and Police Command in Alice Springs. The population has always had complex needs, but over the last two years there has been an increase in antisocial and criminal activity that has seriously stretched police resources. In the words of Assistant Commissioner Payne "the biggest issue we had been facing is the effect of alcohol or liquor abuse in the town and surrounding areas". I understand that those issues were magnified 'post Intervention', when more remote communities were designated dry areas and some drinkers came into the township of Alice Springs.

196. Not only are the issues themselves demanding, but there are particular difficulties recruiting and retaining appropriate staff for the Alice Springs area. Since Kwementyaye's death, gaps have been identified and solutions have been energetically pursued by Police Command. Efforts include recruiting officers from interstate on condition that they undertake a posting outside of Darwin, and developing incentive packages to encourage staff to take on key roles.

A new position of Custody Sergeant

197. In July 2010, the new position of 'Custody Sergeant" (initially named 'Charge Sergeant') was introduced into permanent staffing of the Darwin Watch House, to ensure there was continued supervision and management of that Watch House with the permanent presence of a non-commissioned officer. From 23 January 2012, 18 days after Kwementyaye died, the initiative was expanded and Custody Sergeants were employed at Alice Springs.

198. The Custody Sergeants carry overall responsibility for the operations of the Watch House, including the supervision of staff on duty for the shift and the care and custody of prisoners and Protective Custodies. Custody Sergeants are now rostered on every morning, afternoon and evening shift, increasing the number of police members on each shift to three, and ensuring that there is always a senior officer in the Watch House who can properly mentor junior staff.

199. In his final submissions on behalf of the NT Police Commissioner, Dr Freckelton SC gave the Court this assurance from the Bar Table:

> "Whether somebody has to work back, whether somebody has to be pulled in, whether somebody is sick or on leave or there has been

some kind of a mishap, there is going to be a custody sergeant, all the time".

A fresh commitment to cementing the role of Watch House Keeper

200. The role of Watch House Keeper has been retained and is made more visible. Instead of a small badge, they now wear an unmistakable tabard or vest, which would make it glaringly obvious if they were not on duty.

Auditing and supervising rostering practices for the Watch House

201. Another issue that received immediate attention from Police Command was the need to institute better auditing of rosters and watch house practices. After Kwementyaye's death, the position of Custody Senior Sergeant was created, and at the time of this inquest, they reported to the Superintendent of the Governance and Accountability Division. I heard evidence from Assistant Commissioner Payne that, as a result of ongoing review, there are plans under way to improve the line of accountability from the Senior Sergeants, through to a Superintendent of Police, who would report directly to the Deputy Commissioner of Police. I am told that this is in recognition of the fact that "issues of custody management are not just core business but they're business critical". That realignment of responsibilities is directed to ensuring that the problems identified by Superintendent Delcene Jones will not be repeated.

A review of Cell Checks

202. The introduction of advanced technology into our police systems will provide a sophisticated new means for senior police, even in remote

locations, to ensure that cell checks are taking place within the time frame set out in the Custody Manual.

Updating the Custody Manual and the Alice Springs Watch House SOP's

203. Commander Michael Murphy gave evidence of the urgent and thorough review of the Custody Manual and *SOP's* that took place earlier this year. In particular, I was pleased to hear that *SOP's* were amended to become a clear and concise document that is a short supplement to the Custody Manual emphasising matters of local importance (as had originally been intended) rather than a confusing restatement of the main points in the Manual.

204. On 1 June this year, a revised Custody Manual was published to update roles and responsibilities, including those of the new Custody Sergeant, and the nurses now present in the Watch House.

Reinforcing the duty of care towards prisoners and detainees

205. In order to emphasise certain key elements in the Custody Manual and relevant *SOP's*, posters were created and displayed prominently in the Watch House. In line with the recommendations from the *Edkins Report*, they reinforce the priorities for police charged with the care and custody of detainees. One poster, for example, gives advice to police about the physical and mental signs and symptoms to look out for in detainees.

Revised training on Custody issues

206. Serious efforts have been made to improve the training of police officers in relation to their duty of care to prisoners, in particular, using scenario and

practical based learning. I received into evidence a detailed statutory declaration from Commander Jeanette Kerr, responsible for training at the Berrimah Police College, which sets out some of the recent initiatives. One example of experiential learning is that police are given scenarios that are acted out in a cell block especially fitted out as a Watch House, and they then have an opportunity to discuss those scenarios with experienced officers.

207. The inquest heard evidence that until Kwementyaye's death, there was an absence of any formal process for inducting new police working in Alice Springs Watch House, which meant that some officers did not get the appropriate mentoring and instruction they needed. That is to be addressed by an induction package that will embrace information relating to previous deaths in custody and the findings at inquests. Commander Payne gave evidence of other important changes, including an update of first aid training as it relates to Watch House procedures (e.g to include the dangers of positional asphyxia in the cell environment) and improved defensive tactics training.

208. This is an impressive and comprehensive revision of training needs. It appears to have been informed by research about best practice, but it is also aimed at catering for the unique Territory environment.

The practice of dragging detainees

209. The issue of dragging prisoners and detainees along the floor in circumstances where they are too drunk to support themselves was discussed at some length during this inquest. As I have previously mentioned, it had been an issue during the *Trigger* inquest, during which I received assurances from senior staff members that the practice was not widespread, and would

not be tolerated. Elsewhere in these findings I have expressed my disappointment at having to review that issue again.

210. During this inquest I was told by Assistant Commissioner Payne that Police Command adopts the position that moving people by dragging them is generally not acceptable, and was not acceptable in the case of *Cedric Trigger* or Kwementyaye Briscoe. There may be some extraordinary occasions where there is no other choice but to drag someone a short distance, but that should be reserved for emergencies. Ordinarily, an officer should call for assistance from a colleague, help the detainee to stand, and then walk or carry them to where they need to go.

211. Police Command has reflected on the discussion that took place during this inquest and is considering how best to convey that message to officers. The inquest heard of a commitment to the purchasing of wheelchairs, or some similar simple conveyance, to assist officers to move detainees. Of course, as this inquest highlighted, if they are so incapacitated that they are unable to move themselves, they should be taken to get immediate medical care.

The employment of nurses in NT Watch Houses

212. One important initiative to assist police to diagnose and treat detainees in the Watch House is the employment of trained nursing staff, at least to assist on shifts known to be particularly challenging. The idea is not new, but the NT has been slow to embrace it.

213. The employment of nurses was a recommendation made by the Royal Commission into Aboriginal Deaths in Custody, whose final report was released 21 years ago. Recommendation 127 stated as follows:

> "Police Services should move immediately in negotiation with Aboriginal Health Services and government health and medical

agencies to examine the delivery of medical services to persons in police custody. Such examination should include, but not be limited to, the following:

The introduction of a regular medical or nursing presence in all principal watch-houses in capital cities and in such other major centres as have substantial numbers detained;

In other locations, the establishment of arrangements to have medical practitioners or trained nurses easily available to attend police watch-houses for the purpose of identifying those prisoners who are at risk through illness, injury or self-harm at the time of reception;

The involvement of Aboriginal Health Services in the provision of health and medical advice, assistance and care with respect to Aboriginal detainees and the funding arrangements necessary for them to facilitate their greater involvement;

The establishment of locally based protocols between police, medical and para-medical agencies to facilitate the provision of medical assistance to all persons in police custody where the need arises;

The establishment of proper systems of liaison between Aboriginal Health Services and police so as to ensure the transfer of information relevant to the health, medical needs and risk status of Aboriginal persons taken into police custody; and

The development of protocols for the care and management of Aboriginal prisoners at risk, with attention to be given to the specific action to be taken by officers with respect to the management of:

i. intoxicated persons;

ii. persons who are known to suffer from illnesses such as epilepsy, diabetes or heart disease or other serious medical conditions;

iii. persons who make any attempt to harm themselves or who exhibit a tendency to violent, irrational or potentially self-injurious behaviour;

iv. persons with an impaired state of consciousness;

v. angry, aggressive or other wise disturbed persons;

vi. persons suffering from mental illness;

vii. other serious medical conditions;

viii. persons in possession of, or requiring access to, medication; and

ix. such other persons or such situations as agreed".

214. The need to employ nursing staff in watch houses was an issue in the *Inquest into the death of Adam Chandler*, heard in Darwin in 2010, which had also led to the new Custody Health Assessment form mentioned above. With respect to the employment of nurses I commented and recommended as follows:

> "Counsel for the Commissioner of Police submitted that I should make a recommendation that a nurse or nurses be employed in the two largest Watch Houses, Darwin and Alice Springs ... Detainees are often in poor health. They will sometimes have serious injuries. Adam Chandler's injury was very serious but not obvious to an untrained person ... Recommendation 127a of the RCIADC was that there should be regular medical or nursing presence in all principal Watch Houses in capital cities. .. I recommend that the Commissioner of Police and the Northern Territory Government consider this matter again".

215. On 23 December 2011, just weeks before Kwementyaye's death, Watch House Nurses commenced duty at **Darwin** Police Station and on 23 April 2012, they were stationed for the first time in the Alice Springs and Katherine Watch Houses. At this stage, their hours of duty are 7pm-3am, on Wednesday, Thursday, Friday and Saturdays.

216. The feedback from police working alongside the nurses, some of whom gave evidence at this inquest, is that the presence of nurses is improving the working conditions for police and the care of prisoners. As a result, there are plans to expand the number of shifts nurses are present for and to recruit nurses for the busy Tenant Creek Watch House.

217. Of course there is a heavy financial cost involved and police cannot be expected to implement such a significant initiative without adequate commitment of additional resources from Government. I was informed that the Commissioner of Police met with the Chief Minister of the Northern Territory on 5 June 2012, where he outlined the encouraging results to date and foreshadowed that a cabinet Submission for further funding would be made. I will make a recommendation to the NT Government to give urgent attention to the need to provide all major Watch Houses including Alice Springs, with nurses for an adequate number of shifts.

218. I note the written submission of the Department of Health, received on 6 July 2012, which does not oppose the expansion of nurses in the Watch Houses, but cautions about the need to understand the challenges for those nurses, and other Medical Services that are impacted. The submissions of the Department read:

> "The Department of Heath would like to highlight that any decision to expand nurse services in Watch Houses would necessarily involve further consideration of current constraints facing nursing staff in Watch Houses. These constraints include operating out of functionally challenging facilities and promotion of better facilitated transport linkages to and from the Watch House".

219. I accept that if the number of nurses is increased, it will be important to provide them with a safe environment and sufficient resources to do their job effectively.

220. A further point made in the submission of the Department of Health, is that there is a need for better communication between police and key service providers. It was suggested by the Department that there are currently inappropriate numbers of intoxicated persons apprehended by NT Police and then transported to the local Emergency Department. A significant number of those detainees abscond before they are seen by doctors, potentially

leaving them at risk. Further, the employment of nursing staff in the Watch House will have the effect of increasing awareness of risk and may mean that increasing numbers of detainees are sent to Hospital to be assessed. These issues should not deter the NT Government from funding the employment of nurses in the Watch House, but they do suggest the need for a 'Memorandum of Understanding' between key stakeholders, including Police, the Department of Health and Hospitals.

The Implementation of Coronial findings

221. This Inquest has highlighted the failure to ensure that recommendations arising out of previous inquests result in long term, sustainable change. As a result, the Commissioner himself has undertaken to review any recommendations related to custodial issues that flow from inquiries conducted by the Coroner or Ombudsmen. A register has been created to track recommendations and the Commissioner will receive a relevant briefing every six months.

222. I was comforted to hear the evidence of Superintendent Delcene Jones, who was so forthright in acknowledging problems that existed before Kwementyaye's death, and is now genuinely enthusiastic about the changes that have been made since his death. In response to a question from Counsel for the family, Mr Corish, about whether 'culture' of the Alice Springs Watch House had changed, she had this to say:

> "I think - yes, I do. I think it's changed in a very positive way. The introduction of the watchhouse nurse has been a very positive initiative, coupled with having custody sergeants, senior experienced members in the watchhouse, I believe has mitigated the risk of working in the watchhouse because there's proper supervision and there's also the guidance and medical intervention that's available via the watchhouse nurse and I believe it's becoming more and more embedded with the troops - sorry, the officers that work both within

the watchhouse and out on the road, that duty of care is everyone's responsibility and I believe that the attitude towards custodial care in our cells, both the watchhouse and our court cells, has improved markedly".

223. On behalf of the NT Police Command, the Assistant Commissioner offered this apology:

> "[T]o the family of Kwementyaye Briscoe, on behalf of the Northern Territory Police Force and on behalf of the commissioner of police, the executive and every member, we extend our sincere condolences to you and our most heartfelt apology for what occurred, for our role in that, and we recognise the pain that it has caused you, the grief that it causes you. We understand it and we again apologise that that has taken place. I don't want that to be, and neither does my commissioner, to be a hollow apology. What we need to do and in the process of what we're doing is to ensure that we find out what happened and why it happened for your benefit, for the benefit of the community, but for the benefit of this police force and every member in it to ensure that that does not occur again. Importantly, you've heard evidence from the police officers and you have felt their - the effect on them. It's important for us that we now have quite a number of advocates in respect of death in custody".

224. I commend the Assistant Commissioner and Police Command for that apology, for their attitude to this inquest and for the extensive and excellent reforms introduced since Kwementyaye Briscoe passed away.

Conditions in the Watch House

225. There is no doubt that conditions in the Watch House can be desperately unpleasant and the work for police there is unrelenting and largely thankless.

226. The Alice Springs Watch House is the second busiest in the Territory, ranking just behind Darwin. Most of the work is generated by excess consumption of alcohol and prisoner intakes for protective custody make up the vast bulk of the numbers (Statement of Ass. Com. Mark Payne). I received evidence that between 1 July of 2011 and 31 March 2012, there were 8588 alcohol related incidents in Alice Springs that required police intervention. During the same period, police poured out 8410 litres of alcohol.

227. Over the past four years, staggering numbers of persons have been processed through the Alice Springs Watch House. The figures are:

- 1 April 2008- 31 March 2009 – 12, 391
- 1 April 2009- 31 March 2010 – 14, 444
- 1 April 2010- 31 March 2011 – 9, 515
- 1 April 2011- 31 March 2012 – 9, 356

228. More than 122,000 people have been processed through the Watch House since 2004.

229. I heard from officers that the main role for police performing general duties is to detain inebriated Aboriginal people in protective custody and to respond to domestic violence, usually fuelled by alcohol.

230. I had the impression that there are some shifts, particularly in summer, where a miasma of despair and frustration takes over the Watch House. The smell of intoxicated detainees can be overwhelming and in some situations (although, this was not the case for Kwementyaye), officers cope with individuals who have defecated, urinated or vomited throughout the building. Three of the four detainees in the van that carried Kwementyaye had vomited there, and Constable 1/C Ralph was tasked with hosing that down before he finished the shift. Detainees may be aggressive and

unpredictable, dangerous, depressed or even suicidal, and some come in after fights or accidents and have open wounds. As a result of those oppressive conditions many officers try hard to avoid being rostered on shift there.

Broader issues – Alcohol consumption and Indigenous Health

231. Assistant Commissioner Mark Payne who has over 25 years experience in policing in the NT, can give highly qualified evidence of the misery caused by excess alcohol consumption, particularly in the Alice Springs region. In his Witness Statement he wrote:

> "As a serving Police Officer at Alice Springs, it is my experience that the vast majority of police work involves dealing with persons seriously affected by alcohol through excessive and very extensive liquor consumption. For the most part those seriously affected are indigenous and tend to exhibit evidence of chronic alcohol dependency including symptoms of poor health and hygiene". (Affidavit of Assistant Commissioner Mark Payne).

232. One of the boldest indicators of the resource drain caused by excess consumption are the statistics for Protective Custodies (PC's) detained by NT Police. According to the statement of Assistant Commissioner Payne, a review of the 12 months ending 30 April 2012 reveals:

- NT apprehensions - 25, 966
- PC's taken to home or another chosen place of safety - 3671 (493 in the Alice Springs policing district).
- PC's taken to a sobering up shelter – 12, 421 (5,755 in the Alice Springs policing district).
- PC's taken to Watch Houses across the NT - 19, 689. (5, 755 in the Alice Springs policing district).

- Total number of PC's in Alice Springs – 11,115.

233. I acknowledge that significant efforts have been made by the NT Government to address problem drinking, but something more must be done. The current situation where Police Officers in Alice Springs spend half their time on duty picking up "protective custodies" is simply unacceptable. It continues, in spite of the significant reforms outlined in reports such as *Enough is Enough, Alcohol Reform Report,* July 2011 to end March 2012, NT Government.

234. Kwementyaye Briscoe is but one of many young men whose ambitions, education and health were eroded by alcohol abuse. At the age of 27, he had already begun to show the signs of chronic disease. At autopsy there was evidence of coronary atherosclerosis or hardening of the arteries. He had clearly been binge drinking for around a decade, and alcohol had been involved in each of the adult offences he committed.

235. The shocking statistics of chronic ill health and early death in Aboriginal men and women in Australia, and in the Northern Territory in particular, have received national and international attention. I received into evidence an affidavit from Dr Christine Connors, a Public Health Physician and General Practitioner who is currently the Chronic Conditions Strategy Unit Program Leader with the Department of Health. The statistics she provided show that Central Australia has the highest rates of chronic disease amongst Aboriginal people in the NT. The prevalence rates of diabetes, renal disease and cardiac disease are higher in the Aboriginal population, and they affect individuals at an earlier age.

236. A long term solution to excess alcohol consumption in Alice Springs requires greater cooperation amongst stakeholders (including outlets that sell alcohol) to tackle demand and supply. The NT Police Force shoulders a huge burden from alcohol sales. They cannot be expected to tackle the social

problems that result, in the absence of further initiatives to stop the flow of alcohol in the community.

Formal Findings

237. Pursuant to section 34 of the *Coroner's Act* I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the Deceased was Terence Daniel Briscoe born in the Ambulance en route from Napperby to Alice Springs Hospital on 2 March 1984. The Deceased resided at St Mary's Hostel, Alice Springs in the Northern Territory of Australia.

(ii) The time and place of death was approximately 11.44 pm hours on 4 January 2012 at Alice Springs Watch House.

(iii) The cause of death was the combined effects acute alcohol intoxication, positional asphyxia and aspiration, which ultimately obstructed the airways and led to death.

(iv) Particulars required to register the death:

1. The Deceased was Terence Daniel Briscoe.

2. The Deceased was of Aboriginal descent.

3. The Deceased was unemployed.

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

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

6. The Deceased's mother is Elizabeth Purula Dixon and his father is Tommy Jungarai Daniels (both deceased).

Conclusion

238. I find that the care, supervision and treatment of the deceased while being held in custody by the NT Police was completely inadequate and unsatisfactory and not sufficient to meet his medical needs. This lack of care resulted in his death, that is to say, this death was preventable and it should not have occurred.

239. In the course of his final oral submissions, Counsel for the NT Police, Dr Freckelton SC, made submissions to suggest that the failings identified in this investigation were those of the individual police members who have been formally disciplined, and "some local management issues" (*Transcript*, p 602). However, these were not the isolated failures of one or two rogue policemen in an otherwise well managed environment. In my view, the catalogue of errors is so extensive, and involved so many police officers of various rank, as to suggest mismanagement for a period of time by Police Command at a level higher than just "local".

Recommendations

To the NT Police Force

240. (1) That police be directed that the practice of dragging detainees or prisoners on the ground in the Watch House is unacceptable and should not occur, save for the most exceptional circumstances. Where prisoners are unable or unwilling to walk, they should be assisted to their feet and helped to walk. When this is not possible, more than one officer should assist and carry them wherever that is practicable.

241. (2) That police consider obtaining for each Watch House a wheelchair, stretcher or other suitable device that can be safely stored and used where practicable to transport prisoners who are unable to move themselves.

242. (3) That police implement and maintain rigorous auditing of Watch House rosters to ensure that the role of 'Watch House Keeper' is maintained.

To the Northern Territory Government

243. (4) That the NT government gives urgent attention to providing nursing staff on a daily basis to the Watch Houses in Darwin, Alice Springs, Katherine and Tennant Creek, together with the provision of a suitably equipped medical room within the Watch Houses.

244. (5) That the NT Government convenes an urgent meeting with stakeholders in the Alice Springs Community, including the Licensing Commission, Police, the Department of Health and the People's Alcohol Action Coalition, and commits to all available, reasonable measures to reduce the supply of excess alcohol from take away outlets.

Dated this 17th day of September 2012.

GREG CAVANAGH
TERRITORY CORONER