

CITATION: *Inquest into the death of John Benedict Munkara*  
[2017] NTLC 016

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0145/2016

DELIVERED ON: 29 June 2017

DELIVERED AT: Darwin

HEARING DATE(s): 15 – 16 June 2017

FINDING OF: Judge Greg Cavanagh

**CATCHWORDS:** **Death in Police custody, Police Communications failure to pass on request for an ambulance, no facemask in Police vehicle, no treatment under Alcohol Mandatory Treatment scheme, unlawful discharge from assessment facility**

**REPRESENTATION:**

Counsel Assisting: Kelvin Currie  
Counsel for Police: Stephanie Williams  
Counsel for Health: Joshua Ingrames  
Counsel for Family: Peter Bellach

Judgment category classification: A  
Judgement ID number: [2017] NTLC 016  
Number of paragraphs: 87  
Number of pages: 16

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

No. D0145/2016

In the matter of an Inquest into the death of  
**JOHN BENEDICT MUNKARA**  
**ON 16 SEPTEMBER 2016**  
**AT ATKINS DRIVE, VESTEYS BEACH,**  
**DARWIN**

**FINDINGS**

Judge Greg Cavanagh

**Introduction**

1. The deceased, John Benedict Munkara, was born 17 October 1971 on Bathurst Island into a large family. He was known as a “funny man, who could make everyone around him laugh”. He was 44 years of age at the date of his death.
2. He lived most of his life on Bathurst Island. However in the year 2000 he started spending extended periods in Darwin.
3. During those periods he lived in the ‘Long Grass’ where he drank and smoked. His family worried about him. He was less than 49 kilograms and didn’t appear healthy. When family members visited Darwin they would look for him to provide him with food.
4. From 1 July 2011 until his death on 16 September 2016 he was taken into protective custody by Police and taken to the Watch House on 39 occasions. His alcohol blood levels ranged from 0.157% to 0.417%. Between 26 March 2015 and 20 May 2015 the requirement for assessment under the *Mandatory Alcohol Treatment Act* scheme was triggered on 9 occasions.
5. He was taken for assessment on the last such occasion, 20 May 2015. He told the assessor that he had started drinking at 18 years of age. He had

progressed to having at least 6 drinks of Chardonnay before breakfast and a minimum of another 6 in the evening. If he didn't drink in the morning and evening he got tremors and vomited. He said alcohol made him happy and he told stories.

6. However, after being held at the assessment facility for 113.5 hours he was discharged at 5.00pm on 25 May 2015. The indicated basis for his discharge was the assessor not being able to complete the assessment.
7. On Thursday night, 15 September 2016, the deceased was drinking at Vestey's beach with other persons. He lay down on a mattress and went to sleep.
8. At about midnight two other persons that camped nearby were said to have been attacking him. They were said to have dragged him by his singlet from the mattress and kicked him to the back and the stomach. It was thought that the motive for the attack was that he was sleeping near one of their young aunties.
9. He didn't awake during the attack but others did. One of those approached the attackers and said "don't do that to him, he's an old man and he's sick, you do that to him again and I might do something to you". The attackers were later charged by Police.
10. The next morning at about 7.30am, Darwin City Council Rangers attended the area at Vestey's Beach where the deceased had been sleeping. Others in the group were seen to be drinking and one of the group was verbally aggressive toward the Rangers.
11. The deceased told the Rangers that he had a sore back and asked that they call an ambulance. They asked what had happened. He didn't respond but others in the group called out that he had been "bashed last night".

12. One of the Rangers called the Police Communications at 7.41am. He reported that there was a group of 12 itinerants near the BBQ drinking alcohol. He said one male was a little bit aggressive and another was on the ground saying that he wanted an ambulance because his back hurt. The Ranger said, "I figured we'd give you guys a call as you'd probably be better equipped to assess it".
13. The call-taker, Deanne Nankivill, recorded the information that a male was lying down complaining of back pain but did not record that the Ranger had reported that the male had asked for an ambulance. The call-taker did not alert St John Ambulance to the request.
14. Police (Acting Sergeant Benjamin Streeter, Constable Benjamin Carthew and Constable Nathan Lawrence) arrived at 7.50am in Police Alcohol Policing Unit 556. On arrival, they noted a Larrakeyah Nation vehicle on the right hand side of Atkins Drive. The Police went to the BBQ area.
15. They found a male drinking alcohol and tipped that out on the ground. He was described as being "drunk and hostile". They asked the group to move on. They left the area at 7.56am.
16. About 45 minutes later at 8.42am the Darwin City Council Rangers returned to the area. The group drinking alcohol was still there.
17. The same Ranger called Police Communications again at 8.51am. He asked for police assistance. He said he was trying to issue a trespass notice to the itinerants and they were being a "bit violent".
18. Police (Constable Gavin Ascoli and Constable Jason Chisholm) arrived at 9.37am in caged van 401. They saw the deceased sitting with his back against the automated public toilets. Part of his back was over the doorway. As they approached, a male exited the toilet and mentioned to them that it was difficult for the door to close due to the position of the deceased.

19. Senior Constable Ascoli and Constable First Class Chisolm spoke to the deceased but he did not respond. Senior Constable Ascoli rubbed his sternum. The deceased raised his head a little. Senior Constable Ascoli asked whether he would wake up. He shook his head.
20. The Police were of the opinion that he was well intoxicated and decided to take him into protective custody. They assisted him to his feet and began to walk to the back of the Police vehicle. However, after a few steps he seemed to go limp and they carried him the remaining distance. They decided to take him straight to the Hospital.
21. They sat him on the back of the cage and lowered him onto his back. They checked for a pulse but couldn't find one and so removed him from the vehicle and lay him on the ground. At that point Constable Chisholm called for an Ambulance.
22. That call was made at 9.50am. The log of that call states that they required an ambulance for an Aboriginal male of 40 years of age that was non-responsive, currently breathing and highly intoxicated. A minute later Constable Chisolm called again asking for urgent assistance as the breathing of the deceased had become very shallow.
23. One minute later at 9.52am Constable Chisholm reported that cardio pulmonary resuscitation (CPR) had commenced. He also asked for backup and a mouth to mouth face shield.
24. At 9.59am a Border Force vehicle with four Customs personnel arrived and supplied a face shield and one of them commenced mouth to mouth resuscitation while Constable Ascoli continued with cardiac compressions.
25. At 10.01am Police vehicles 556 and 400 arrived at the location. The face shield was changed for an Oxy-viva unit from car 556.

26. At 10.03am the Ambulance arrived. The paramedics took over the airway and gave the deceased adrenalin and intravenous fluids. Senior Constable Ascoli remained doing the compressions.
27. At 10.10am the deceased was given more adrenalin and an AutoPulse machine was used to undertake the compressions. At 10.15am and 10.20am he was given more adrenalin.
28. At 10.25am the deceased's pulse returned. He was placed in the Ambulance and taken to Royal Darwin Hospital, arriving at 10.38am.
29. On assessment at the Hospital he was unconscious, a laryngeal mask airway was in place but he was found to have pulseless electrical activity.
30. CPR was once more commenced and he was given more adrenalin. His pulse returned after 7 minutes but his blood pressure was very low (50/30) and his PH was 7.8. He was given fluids, an adrenalin infusion and lactate. However his prognosis was very poor and when his blood pressure dropped to 30/20 despite fluids it was considered that further efforts were futile. The adrenaline infusion was stopped at 11.27am and he was pronounced life extinct at 11.33am.
31. An autopsy was undertaken. In the opinion of the Forensic Pathologist, Dr Rutherford the deceased died of natural causes. He listed the cause of death as "coronary artery disease superimposed upon chronic obstructive pulmonary disease with alcohol toxicity as an aggravating factor".
32. The toxicological results indicated that the blood alcohol level at the time of death was 0.36%.
33. At autopsy there was found a 3.5cm laceration of the liver. His liver was described as a "fatty liver" and was therefore said to be susceptible to damage. There was an intra-abdominal haemorrhage of 850ml of fresh blood, presumably from the laceration.

34. There was speculation that the laceration may have been due to a number of factors. The attacks that the deceased had suffered overnight were thought to be as possible cause. The CPR carried out by Police or at the Hospital was also a possible cause, as was the AutoPulse machine that was being used by St John Ambulance for the first time.
35. However, on review the Forensic Pathologist was satisfied that there was no external or other damage from the attacks to indicate that they might have been the cause.
36. The histology also showed that there was no reaction in the cells surrounding the laceration. In the opinion of the Forensic Pathologist that was strong evidence that natural circulation had ceased by the time the laceration occurred. That is, that it occurred after death and likely during the significant attempts at resuscitation.
37. Out of abundant caution the AutoPulse was taken out of service for some months by St John Ambulance to ensure that training for its use was appropriate.
38. What is clear, however, is that the deceased did not die due to the laceration of the liver or loss of blood into his abdomen. The death was of natural causes, it was nevertheless a death in the custody of Police.

### **Death in Custody**

39. The deceased died very shortly after being taken into Police custody. Section 26(1)(a) of the *Coroner's Act* requires that I must investigate and report on the care, supervision and treatment of the deceased while he was being held in custody. Because he died so soon after being taken into custody, there is a limited period to be examined.
40. The Police decision to take the deceased into protective custody was reasonable and appropriate. He was sitting in an area making it difficult to

access the toilet facilities and close the door and when approached was barely responsive and smelt of alcohol. The Police assisted him to his feet and when he collapsed they were there to take his weight. At that point they decided to take him to the hospital. However when they got to the van they checked his pulse and soon thereafter commenced CPR and called for an ambulance. The conduct of the Police Officers who attended to the deceased was of a very high order. The only criticism is the failure to have available a face shield.

41. Mention should also be made of the conduct of the Border Force personnel who supplied the face mask and undertook the breaths. They were not called to give evidence during the inquest but their ready and willing assistance and expertise was also of a very high order.
42. By the time St John Ambulance arrived the deceased had died, however the evidence indicates that the paramedics carried out their duties efficiently and professionally and transported the deceased to Royal Darwin Hospital after re-establishing a heartbeat. I also thank St John Ambulance Service for their attendance and assistance at the inquest.
43. In my opinion the care, supervision and treatment of the deceased was appropriate.

## **Issues**

### **Request for an ambulance not being recorded by call taker**

44. If an ambulance had been called at 7.41am when the Council Ranger passed on the request to Police Communications, the deceased may have received attention and treatment two hours earlier than he did.
45. Two hours later when Police first engaged with him he was barely responsive and died before the ambulance arrived. Why the request was not passed on was therefore of significant importance to the inquest.



46. The fact that the call taker, Ms Nankivill, did not make mention of the request either in the Computer Aided Dispatch (CAD) log or send the request to St John Ambulance became the subject of questioning. The transcript of the vital part of the telephone call was as follows:

Ranger            We had one male who was getting a little bit aggressive so we just drove off, but yeah, they are all pretty mellow. One male was on the ground saying that he wanted an Ambulance cause his back hurt or something like that.

Call taker        Oh right, Okay

Ranger            I figured we'd give you guys a call as you'd probably be better equipped to assess it.

Call taker        Yeah, no worries.

47. But the call taker made no note of the request for an ambulance and the Police that attended were not tasked to assess the need for an ambulance.

48. Having listened to the audio of that call the best that can be said is that the call taker was casual in dealing with the information. The worst that might be said is that she was dismissive, an allegation she rejected.

49. However, whatever the reason, it was not her place to filter the information. She should have noted the request for an ambulance in the CAD entry, a fact she readily conceded.

50. By filtering out that vital information she prevented those checking her entries from being able to correct her mistake.

51. In the opinion of the Police hierarchy the training of call takers was shown to be deficient. Assistant Commissioner Michael Murphy provided evidence that the NT Police force is currently in the process of creating a nationally

accredited course for call takers, dispatchers, call centre supervisors and dispatch supervisors based on the Victorian training package.

52. I was impressed by the ability of the Police to view these matters objectively and work toward fixing the gaps in their systems. I wish to commend Police on their approach to this inquest and on their desire to improve their systems.
53. I was also impressed by the Police Officers who attended Vestey's Beach in relation to this matter on both occasions. They were clearly very caring and compassionate officers and distinguished themselves in both their actions on the day and when giving evidence during this inquest.

### **Face Shields**

54. Once CPR was started, Constable Chisholm opened the First Aid kit in the Police vehicle, looking for a face shield. There wasn't one. He made a call for a backup vehicle with a face shield.
55. It was another seven minutes after commencement of CPR and four minutes after that call until a face shield was provided by passing Border Force personnel. Until a face shield arrived Constable Chisholm held the deceased's head to ensure the airways were open.
56. Two minutes later another Police vehicle arrived with an Oxy-viva device from which the deceased was provided with oxygen. The delay was clearly disappointing and that was conceded by Police.
57. Dr Malcolm Johnston-Leak from St John Ambulance, indicated that compressions alone (that is, no breaths) are "acceptable" according to the Australia and New Zealand Committee on Resuscitation (ANZCOR) guidelines. They state, "*ANZCOR suggests that those who are trained and willing to give breaths do so for all persons in cardiac arrest (CoSTR 2015, weak recommendation, very low quality of evidence)*".

58. However, Police are trained in first aid and to be unable to provide the breaths in CPR due to failure to keep the First Aid kit in the Police vehicle appropriately equipped is not acceptable.
59. Assistant Commissioner Murphy stated that the kit of each vehicle is now checked on a weekly and monthly basis and recorded in a vehicle spreadsheet. Sergeants are required to replenish kits immediately after use and vehicles are taken offline until the kits are replenished.

### **Alcohol Mandatory Treatment Scheme**

60. From time to time the deceased was taken into protective custody and taken to the Police Watch House. He triggered the criteria for assessment (that is, three times in two months) on nine occasions between 26 March 2015 and 20 May 2015.
61. He was taken for assessment on just one of those occasions. The reasons he was not assessed on the other eight occasions were because:
  - a. on one occasion Police were unable to transport him to the facility for assessment;
  - b. On five occasions there were no beds at the facility either because the two intake beds were full or the four male treatment beds were already occupied;
  - c. On two occasions the intake service was closed for a period of 11 days while shifting the service between co-located buildings.
62. On the last occasion the criteria for assessment were triggered, the deceased was admitted to the facility. However after being there for 113.5 hours he was released without receiving treatment.

### **Initial response by Top End Health Service**

63. During the course of the coronial investigation the Top End Health Service (TEHS) were asked to verify the reasons for the occasions the deceased was unable to be admitted to the facility and to explain his discharge without

completion of the assessment on the final occasion. TEHS is the responsible government entity in relation to the Alcohol Mandatory Treatment scheme.

64. The request also asked that TEHS, “provide any information and response as to the circumstances ... for the attention of the Coroner”.
65. The response from Mr Richard Campion, the Acting General Manager of Top End Mental Health and Alcohol and Other Drugs, was provided five weeks later, on 17 March 2017. It consisted of four paragraphs. Three were in essence repeating facts provided in the request. The fourth was in these terms:

“Mr Munkara was released on 25 May 2015 at 1700 hours in accordance with Section 18 of the Act as an assessment could not be completed within the time allowed in Section 17(2) of the Act. The assessment could not be completed as a high volume of persons who met the criteria for assessment were admitted between 20 and 24 May 2015 and the Senior Assessment Clinician could not complete the assessment for each of those persons as per Section 17(2).”

66. That response was extremely brief and unhelpful. It was evident that the Top End Health Service had not bothered to interrogate and analyse its own records. Little attempt appeared to have been made to provide the information required to advance the investigation.
67. Given that in the findings to a similar inquest in September 2016 (*Inquest into the death of Christopher Murrungun*), I noted a similar lack of cooperation and effort from the very same service, my Office sought that a statement be provided by the Acting General Manager of the Top End Health Service.

### **Second response**

68. Two days before the inquest, on 13 June 2017, Ms Sandra Schmidt, the Director of the Alcohol and other Drugs Directorate within the Department of Health provided a statement. It came from the Director, rather than the

Acting General Manager, because the Director had been the General Manager of Alcohol Mandatory Treatment at the time of the events under examination.

69. Ms Schmidt said that in that position she had *“responsibility for high level understanding and development of the implementation policy, regulations, legislation and practice to ensure Northern Territory Government funded services operated within the Northern Territory Alcohol Mandatory Treatment Program and the Alcohol Mandatory Treatment Act (AMT Act)”*.
70. In contrast, to the initial response, her evidence was that the deceased had been assessed. She said he was assessed by the Assessor within the 96 hours allowed by the Act, *“however the report itself was not completed and submitted to the Tribunal within 24 hours of the assessment. Mr Munkara was therefore released on 25 May 2017 by the SAC [Senior Assessment Clinician] pursuant to section 18 AMT Act”*.
71. There was no hint in that statement that the care, treatment and processes of the Alcohol Mandatory Treatment facility had been anything other than appropriate. It was clear from reading her statement that there had been little analysis of the information provided in that statement.

### **Third response**

72. A statement was provided by Mr Richard Campion on the evening before the inquest.
73. For the first time it was obvious there had been some analysis of the information. The second paragraph read:

“The Department including TEHS would like to offer its condolences to the family of Mr Munkara for his tragic death and apologise for failing to provide him an opportunity to engage in treatment options available under the *AMT Act* and any other Alcohol and Other Drug (AOD) Service options.”

74. Mr Campion went on to say that since the date of his first response he had been shown an assessment report dated 24 May 2015 at 1700 hrs. He apologised for the inconsistent information provided and observed that the *Act* had been “misapplied” and that the deceased should not have been released without an order of the Tribunal.
75. The assessment report however that he was shown, although containing the date and time noted, was clearly not complete. The Senior Assessment Clinician undertaking the assessment wrote an email at 5.11pm on 25 May 2015 saying, “I’m sorry but unable to complete Mr Benedict Munkara’s assessment by 5pm ...”
76. During the inquest I was told by Ms Schmidt that there were guidelines that assisted the determination as to when an assessment was completed. A reading of those guidelines provided no real assistance. However there are only the two possibilities. Either the assessment had been completed or it was not.
77. If the assessment was completed, the release was in contravention of the clear provisions of the *Act*. The only means of release after assessment is by order of the Tribunal and section 20 makes it plain that release by the facility of a person after assessment is not an available option.
78. The unavailability of that option appears not to have been appreciated. I was told that the deceased was dealt with in accordance with the practice followed by the TEHS.
79. If the assessment had not been completed within the time allowed (96 hours) and the deceased was held for another 17.5 hours (making a total of 113.5 hours), that would also be in contravention of the *Act*. Section 18 requires release if the assessment is not completed within 96 hours.
80. Whether the assessment was completed or not completed, the action taken by the facility was unlawful. As I noted during the inquest. The mandatory

scheme involves taking away individual liberties. It is therefore most important that such laws be understood and carefully followed.

81. It is widely understood that as of 1 September 2017 the AMT Scheme will be dismantled and replaced by the Banned Drinkers Register (BDR) legislation. Any recommendations relating to the AMT Scheme would therefore have very limited effect.
82. This is however, the second inquest within a month where I have had cause to comment on the failure of the Alcohol and Other Drugs area of the Top End Health Service to follow legislation. It is unlikely that the failures are intentional. However, it does appear that processes and practices are established and continue with little understanding of the law.
83. During the course of the inquest I was provided a document from the Chief Executive Officer (CEO) of the Department of Health outlining a number of actions that are going to be undertaken. One of those related to the forthcoming legislation and was in these terms:

“The Department will ensure front line staff are provided training in interpreting the new [BDR] legislation”.

84. I thank the CEO for her attendance at the inquest and for that assurance. I am also comforted by her other assurances as set out in Exhibit 4. Those include:
  - a. Action would be taken to ensure a robust clinical framework for all coronial matters and sentinel events; and
  - b. Stronger system wide governance would be developed over coronial matters including reporting on implementation of recommendations.
85. One other aspect I made note of during the inquest was the seeming casual approach to ensuring beds were available, ensuring enough staff were

available to assess the persons admitted and the time taken to change facilities without any alternative intake. There was a recognition that not all persons triggering the system would be able to be assessed and treated. To a large extent that appears to have been tied to the available resources.

86. I made comment during the course of the inquest that where governments pass well-meaning laws with therapeutic aims, usually accompanied by a blaze of publicity, it is a legitimate expectation of the community that sufficient resources will be provided to realise those aims.

### **Formal Findings**

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

- (i) The identity of the deceased was John Benedict Munkara born 17 October 1971, on Bathurst Island in the Northern Territory.
- (ii) The time of death was 9.52am on 16 September 2016. The place of death was Atkins Drive, Vestey's Beach in the Northern Territory.
- (iii) The cause of death was coronary artery disease superimposed upon chronic obstructive pulmonary disease with alcohol toxicity as an aggravating factor.
- (iv) The particulars required to register the death:
  - 1. The deceased was John Benedict Munkara.
  - 2. The deceased was of Aboriginal descent.
  - 3. The deceased was not employed at the time of his death.
  - 4. The death was reported to the Coroner by Police.



5. The cause of death was confirmed by Forensic Pathologist, Dr John Rutherford.
6. The deceased's mother was Georgina Munkara and his father was Benedict Munkara.

Dated this 29th day of June 2017.

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GREG CAVANAGH  
TERRITORY CORONER