CITATION: *Inquest into the death of Bundy Bandiwanga Namarnyilk NTMC [2016] 005*

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0031/2015
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FINDING OF:	Mr Greg Cavanagh SM
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REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Family	Matthew Derrig

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

No. D0031/2015

In the matter of an Inquest into the death of
BUNDY BANDIWANGA NAMARNYILK
AT ROYAL DARWIN HOSPITAL,
DARWIN
ON 18 FEBRUARY 2015
FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Bundy Bandiwanga Namarnyilk ("the deceased") was born at the Liverpool River in West Arnhem Land, near Maningrida on 1 December 1958. He died on 18 February 2015 at 56 years of age. Out of respect for the family and the cultural practice of avoiding use of the Christian name of an Aboriginal person who has passed away, I will hereafter refer to the deceased as Mr Namarnyilk (or the deceased), with the exception of the formal findings.

2. On 27 February 2012 Mr Namarnyilk was arrested for serious sexual offences. They were offences for which he did not obtain bail. As a result he was remanded in custody at Oenpelli before being transferred to Darwin. At the time of his death, he was serving a sentence in excess of 14 years imprisonment at the Darwin Correctional Centre ("DCC") Holtze in the Northern Territory with a non-parole period of 10 years and 1 month. His earliest release date was therefore 27 March 2022.

3. Following his incarceration after his arrest on 27 February 2012 Mr Namarnyilk provided a history which included various medical conditions, most notably Type 2 diabetes and heart disease. He also reported previously being a heavy smoker. He was provided with his prescribed medications

whilst in prison and there was nothing of significance noted in his prison medical records until 4 February 2014.

4. At that time Mr Namarnyilk complained that he was experiencing a sore throat and sought medical attention. He was initially provided Panadol but continued to experience a sore throat until he was eventually referred to the Ear, Nose and Throat ("ENT") clinic at the Royal Darwin Hospital ("RDH") on 30 April 2014. Investigations were subsequently conducted and it was ultimately discovered that Mr Namarnyilk was in fact suffering from a differentiated squamous cell carcinoma, which is an extremely aggressive type of throat cancer.

5. Investigations were undertaken and treatment provided but it quickly became apparent that Mr Namarnyilk's cancer was terminal and he was eventually transferred into the care of the Palliative Care Unit at the RDH. This is where he remained until 18 February 2015 when, at 10.27am on that day, he was pronounced deceased.

6. Notwithstanding that Mr Namarnyilk died at the RDH, he was at the time of his death in custody of the Northern Territory Department of Correctional Services ("NTDCS"). Accordingly I find that this was a death in custody pursuant to section 12 of the *Coroners Act* ("the Act"). As a result, and pursuant to s15(1) of the *Act*, this Inquest is mandatory. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Matthew Derrig was granted leave to appear on behalf of the family of the deceased.

7. A total of three (3) witnesses gave evidence before me, namely Senior Constable ("Snr Const.") Michael Whiting, Dr Mohamed Zubair and Dr Hugh Heggie.

8. A brief of evidence containing various statements, together with numerous other reports, police documentation, and miscellaneous records were tendered into evidence. I also received into evidence the original files held

by the RDH and Royal Adelaide Hospital ("RAH"). The death was investigated by Senior Constable ("Snr Const.") Whiting and I thank him for his investigation and assistance.

9. Pursuant to s.34 of the *Act*, I am required to make the following findings if possible:

(i) The identity of the deceased person;

(ii) The time and place of death;

(iii) The cause of death;

(iv) Particulars required to register the death under the Births Deaths and Marriages Registration Act"; and

(v) Any relevant circumstances concerning the death.

10. I note that section 34(2) of the *Act* also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

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

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

(3) .....

11. Additionally, where there has been a death in custody, section 26 of the Act provides as follows:

"(1) Where a Coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the Coroner –

(a) Must investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and

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

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

Background

12. Mr Namarnyilk was born at the Liverpool River in the Northern Territory to Spider (Baida) Namirrgi and Daisy Gunyulma; who are both now deceased. He was educated in Darwin and spent the majority of that time living with a friend of the family. It is not established what year of school he completed however his family describe him as "well educated". Thereafter he lived the majority of his life in Gunbalanya (aka Oenpelli), an Aboriginal community located in west Arnhem Land. He had a number of jobs during his life including as a ranger in Kakadu, road maintenance in Arnhem Land and also at the Gunbalanya Club.

13. He married three (3) times with his first two wives now deceased. From those three marriages he fathered four (4) children to his first wife, four (4) children to his second wife and two (2) children to his third wife. After separating from his third wife he commenced a relationship in about 2003 with a woman who resided in the Warruwi Community on Goulbourn Island. To protect the identity of the victim of his sexual offending, I will not record the name of Mr Namarnyilk's final partner; however it is clear that in about 2006 Mr Namarnyilk began committing sexual offences against her then 11 year old daughter. Mr Namarnyilk maintained a sexual relationship with that child between 1 June 2006 and 31 December 2008.

14. This child finally built up the courage to complain and on 27 February 2012 Mr Namarnyilk was arrested at Oenpelli. Following his arrest he was interviewed by police and made substantial admissions to the offending, but sought to place blame upon the child victim for the offending. He remained in custody from that time on, eventually being sentenced on 14 February 2013 to a period of 14 years and 4 months backdated to the time of his arrest. His non-parole period was later amended on appeal to 10 years and 1 month making his earliest release date 27 March 2022.

15. Mr Namarnyilk's medical records indicated that he was diagnosed with Type 2 diabetes in 2001 and heart disease in 2009. He was prescribed medication for these diagnoses which was provided to him on a regular basis during his period of incarceration at DCC. His history also included chronic kidney disease, Hepatitis B, recurrent pancreatitis, hypercholesterolemia and hypertension. He also had a recorded history of heavy smoking.

Medical attention following incarceration

16. Upon his incarceration to the DCC, Mr Namarnyilk continued to receive his prescribed medication and therefore he regularly presented to the clinic for reviews and check-ups predominantly for insulin and blood sugar level checks for his diabetes. He was also regularly seen on the clinic medication "rounds" at the prison.

17. There was nothing of significance noted in his prison medical records until 4 February 2014 when Mr Namarnyilk started to experience a sore throat for which he sought medical attention. He was initially provided with Panadol for the sore throat; however he continued to have difficulties and it appears from the evidence that after that initial complaint he either made requests to see a doctor about his sore throat, or spoke about his sore throat to staff, on a number of occasions. During this time treatment included being examined, further pain relief if necessary and also antibiotics.

18. Due however to the continuation of instances that the deceased experienced a sore throat and because prison doctors were unable to establish a cause, a decision was made to refer Mr Namarnyilk to the ear, nose and throat (ENT) clinic at Royal Darwin Hospital on 30 April 2014.

19. It appears from the records that the specialist clinic was able to see Mr Namarnyilk for the first time on 14 May 2014. He attended the ENT clinic on that day, where doctors conducted a flexible nasendoscopy. This involves using a thin, flexible tube with a very small telescope at the end, which is passed into one of the nostrils. This revealed a swollen larynx through the supraglottic area which had a right piriform mass. The supraglottic area is the upper part of the larynx. As a result of discovering this mass, further investigations were ordered including an MRI and CT scan of the neck.

20. Results from those scans on 23 May 2014 confirmed the presence of a large piriform fossa mass. The piriform fossa is a recess on either side of the laryngeal orifice. After discovery of this mass, Mr Namarnyilk had a further review on 30 May 2014 with the ENT day procedure unit. At that time a panendoscopy was conducted. This is an examination of the airways and throat with a small camera under anaesthetic and biopsies are taken. This revealed an ulcerating mass in the right piriform fossa extending to the cricothyroid level inferiorly, and 1 cm below the tongue base superiorly. A biopsy was taken and concluded that the mass was differentiated squamous cell carcinoma. This is typically a well-known and aggressive type of cancer. In basic terms he had a serious and very aggressive throat cancer.

21. A further review at the ENT clinic was undertaken on 11 June 2014 where the findings were discussed with Mr Namarnyilk. The records indicate that he was advised that he required a total pharyngolaryngectomy. This is an operation to remove the entire voice box and pharynx, which is the area at the back of the mouth and throat. It was discussed that he would also

require a bilateral selective neck dissection, post-operative radiotherapy and/or chemo-radiation. Mr Namarnyilk agreed to such treatment.

22. Due to the nature of the surgeries, Mr Namarnyilk's treatment plan was then discussed with the Head and Neck Cancer Multidisciplinary Team at the Royal Adelaide Hospital ("RAH"), which confirmed surgical intervention and post-operative treatment. The necessary arrangements for transfer were then made and on 7 July 2014, Mr Namarnyilk was transported to the RAH under a two man escort from the DCC.

23. Mr Namarnyilk undertook surgery on 9 July 2014 where surgeons completed a total laryngopharyngectomy. During that surgery however, a large nodal mass at the junction of the internal jugular vein and subclavian vein was found. The subclavian vein is a large blood vessel at the top of the chest. Approximately fifty (50) percent of the mass was cut out, but the remaining tumour was left in-situ due to the high risk of vein injury with further dissection and the need for a sternotomy procedure to be performed. In basic terms it became clear that Mr Namarnyilk's cancer had grown and spread to involve the vital blood vessels in the right side of his neck and could not be entirely removed.

24. Unfortunately, following that surgery on 29 July 2014, Mr Namarnyilk sustained a surgical neck wound infection. As a result he required further surgery on 1 and 21 August 2014 to deal with the infection and was placed on a six week course of an antibiotic used in the treatment of serious infections caused by bacteria. After he was determined to be well enough, Mr Namarnyilk commenced radiotherapy on 23 September 2014 which continued for the next six weeks. He also later commenced hyperbaric therapy. Unfortunately he developed significant facial and left neck swelling and a CT scan revealed two (2) large collections once again confirming squamous cell carcinoma.

25. At this time, the rapid progression of his disease was discussed with Mr Namarnyilk and, in consultation with him; a decision was made for palliative support care. This initially commenced in Adelaide but was then further complicated by Mr Namarnyilk having a urine infection and further complicated by his ongoing diabetes management.

26. A decision was made that such treatment could be conducted in Darwin where he could be closer to family. During his surgeries at the RDH however a tracheostomy tube had been inserted to assist him to breathe and a percutaneous gastric tube (PEG) had also been inserted to provide him with food. He was therefore not medically fit to return to the DCC.

27. On 7 December 2014, Mr Namarnyilk was transferred back to the RDH from Adelaide with view of further palliation. Initially Mr Namarnyilk was received under the ENT team for ongoing care as there was not a hospice bed immediately available. Following review by that team, it was determined that because of his clinical state Mr Namarnyilk was not suitable for palliative chemotherapy and also not suitable for any further surgical intervention. Again this was discussed with Mr Namarnyilk.

28. On 18 December 2014 Mr Namarnyilk was accepted for palliative care hospice admission, and was transferred there on 29 December 2014. He was provided with symptom management and end of life care during which time the DCC maintained one prison guard with Mr Namarnyilk at all times. As a sentenced prisoner Mr Namarnyilk remained the responsibility of DCC and Northern Territory Correctional Services ("NTDCS").

29. As anticipated, Mr Namarnyilk gradually deteriorated with the progression of his disease. I received a statement from prison officer ("PO") Alex Cox who was on duty on 18 February 2015 that at about 9.43am that day, he observed Mr Namarnyilk to take a sustained breath, after which, he appeared unresponsive. As a result PO Cox alerted medical staff who assessed Mr

Namarnyilk and he was later pronounced deceased by Dr Kane Vellor at 10.27am on 18 February 2015.

Cause of Death

30. An autopsy was undertaken by Dr Eric Donaldson on 20 February 2015. His report was tendered into evidence as part of exhibit 1. As counsel assisting indicated at the commencement of the inquest, the cause of Mr Namarnyilk's death was uncontroversial and Dr Donaldson was not required to give evidence before me. Dr Donaldson noted the significant findings at autopsy to include (relevantly) the following:

> (i) "Previous laryngopharyngectomy with extensive scarring of soft tissue structures within the neck.
>
> (ii) Pharyngo-cutaneous fistula.
>
> (iii) Tracheo-oesophageal fistula.
>
> (iv) Locally advanced residual poorly differentiated squamous cell carcinoma in the right side of the neck.
>
> …
>
> (vii) Bilateral upper lobe and right middle lobe bronchopneumonia.
>
> (viii) Moderate to severe atherosclerosis of the right coronary artery.
>
> (ix) Mild left ventricular hypertrophy.
>
> (x) Atrophic and scarred pancreas consistent with previous pancreatitis
>
> (xi) Haemorrhagic bladder mucosa with inflammatory exudate in keeping with catheter related urinary tract infection.

31. Dr Donaldson expressed his opinion that the immediate cause of Mr Namarnyilk's death was:

> "… acute bronchopneumonia which has arisen as a result of locally advanced poorly differentiated squamous cell carcinoma in the neck

> which was not able to be cured by surgery with radiotherapy. In addition the complications of scarring in the neck and fistulae, which have developed as a result of his treatment, would not have helped and may have contributed to his demise. Pneumonia within the upper lobes of the lung, suggest aspiration as a possible cause".

I accept these findings.

Issues for further consideration

32. The issue clearly raised for consideration within this inquest is whether Mr Namarnyilk was provided with an appropriate level of care from both NTDCS and Department of Health ("DOH") whilst he was a prisoner at the DCC. The reason that the care provided by both Departments needs to be considered is because whilst NTDCS is responsible for the prison at the DCC, the DOH is responsible for the medical clinic at DCC with Remote Health having taken over responsibility for management of the prison clinic on 1 October 2012.

<u>The standard of the care provided by NTDCS to Mr Namarnyilk during his period of incarceration at DCC</u>

33. Mr Namarnyilk had been incarcerated at the DCC since shortly after his arrest on 27 February 2012. He was assessed in accordance with the NTDCS policies and there appears to be no complaint in relation to his treatment by NTDCS staff during the period of his incarceration.

34. During the course of the proceedings there was criticism made on behalf of the next of kin that Mr Namarnyilk had made a number of requests to see a doctor for his sore throat, or complained about his sore throat, and that therefore he should have been referred to a specialist earlier than he was.

35. I note that whilst there may have been a number of requests made during the period 4 February 2014 until his formal referral on to the ENT on 30 April 2014, it is clear that there were also a number of other occasions where Mr Namarnyilk was seen by medical staff for unrelated health needs and either

indicated the sore throat was "resolving" or made no complaint at all. Given it is clear from the evidence that Mr Namarnyilk knew how to make a complaint about any health issues he had, was seeing medical practitioners regularly on rounds, and how to arrange to see a doctor at the clinic, I do not consider that there was anything untoward in the time taken to refer Mr Namarnyilk to a specialist. I also do not consider in all the circumstances that it was unreasonable that medical staff at DCC continued to conduct their own assessments in an attempt to determine the cause and whether they could resolve the issue.

36. I also note the evidence of Dr Heggie following his review of the treatment provided, that it was his opinion that Mr Namarnyilk was given:

> "… appropriate treatment by the nursing staff of the medical centre according to the Central Australian Remote Practitioners Association ("CARPA") Standard Treatment Manual with simple analgesia or penicillin injection being the treatment for a viral sore throat or a streptococcal infection respectively."

37. In addition Dr Heggie noted:

> "In Australia the second most common reason for visiting a health practitioner is a sore throat and adults on average suffer from 2-3 sore throats per year. Given that Mr Namarnyilk had episodes of sore throat which he stated had resolved each time initially, and examination was normal, it was reasonable to consider that these were viral in origin and when it persisted, he was treated as a possible streptococcal bacterial throat infection which was also reasonable. Indigenous Australians are more susceptible to streptococcal infections than the rest of the population.

38. In light of that evidence, I do not consider the time taken for specialist referral to have been made to be unreasonable. I do not consider it a reasonable proposition that there be a specialist referral made each time a prisoner complains of a sore throat.

39. In addition, upon that referral taking place, I consider the investigations carried out by the ENT service to have been exemplary and prompt and I

note that no criticism has been raised in relation to the care and treatment the ENT service, or the RDH, provided.

Would earlier referral have made a difference in this case?

40. This is always a difficult question to consider given that coronial inquests are about considering matters in hindsight, however I note the evidence by Dr Heggie that:

> "Mr Namarnyilk had an extremely aggressive form of throat cancer in an anatomical location that did not present until at an advanced degree".

41. In relation to the type of cancer that Mr Namarnyilk was diagnosed as suffering, Dr Heggie noted that:

> "Hypo-pharyngeal cancers are often 'poorly differentiated' (that is they lack normal features, tend to grow and spread faster, and have a worse prognosis than other types of cancer).
>
> Such cancers are difficult to diagnose early in the disease process because patients are usually asymptomatic.
>
> Small tumours … account for only 1-2% of all patients seen. Most patients present when their disease is advanced, at which point the prognosis is poor. The rate of metastases is high, with spread to the neck present in 50-70% of cases at presentation".

42. Dr Heggie also provided evidence of how quickly such cancers spread with most progressing "over weeks to months" and that in general terms "(t)reatment of this type of cancer is very difficult". In relation to Mr Namarnyilk specifically I note that Dr Heggie provided evidence that:

> "This cancer would have begun at least some months before he developed any symptoms and this type of tumour spreads rapidly to surrounding tissues including large blood vessels in the neck.
>
> Given the location and aggressive nature of his tumour of the hypopharynx there was no unreasonable or significant delay in him being referred for diagnosis. The time frame for seeing a doctor is

unlikely to have changed the progression of his carcinoma, treatment options or survival".

43. I accept this evidence from Dr Heggie and I do not consider that earlier referral, even if I were to find there was a delay, would have made a difference in this case. I consider that once his illness was discovered, all reasonable care and treatment that could be provided was provided. There is no evidence to suggest any failure to attend to his needs.

44. I consider the care and treatment provided to Mr Namarnyilk during his period of incarceration at DCC by both the medical staff at the clinic operated under Remote Health within the DOH, and the care provided by DCC staff employed by NTDCS, was appropriate and satisfactory. In fact I consider that Mr Namarnyilk received a standard of medical care during his incarceration that he would not otherwise have received in the community.

45. I have already outlined the evidence given before me as to the care provided to Mr Namarnyilk during his admission to the RDH and then transfer to RAH. It is clear to me that considerable effort was made by all members of medical staff at the RDH to initially discover what was wrong with Mr Namarnyilk's health and then to determine whether anything could be done by way of treatment to save his life. Further, that once it was clear that only "end of life" care could be provided, this was done and he was transferred back to Darwin to be closer to family. I make no criticism whatsoever of the care provided to Mr Namarnyilk at the RDH or RAH.

<u>Whether decisions made in terms of Mr Namarnyilk's continued custody arrangements following his return to Darwin were reasonable</u>

46. Providing care for a terminally ill person is difficult in normal circumstances. It is all the more complicated and difficult when that person is a sentenced prisoner, and particularly so for serious criminal offending.

47. I note that there was criticism made on behalf of the family of the decision by NTDCS to

47.1 refuse to allow family to stay overnight with Mr Namarnyilk whilst he was in palliative care and

47.2 refuse to allow Mr Namarnyilk to have leave to return to Oenpelli and pass away with family and on country.

48. It is clear from the evidence that each of these decisions were made in accordance with the NTDCS Directives that were applicable to each request. A copy of each of those Directives was tendered before me. I note that neither Directive is a publically available document.

49. With respect to the decision not to allow family to stay overnight, it is clear from the evidence that it is not the case that Mr Namarnyilk was not seeing his family at all. He was. They were just not allowed to stay overnight. I also note that as a prisoner, it is clear that visits from family per se are set out in the Directive as being a privilege and not a right. Mr Namarnyilk was being provided that privilege and reasonably so. I also anticipate that overnight visits represent all sorts of additional complications, concerns and challenges for NTDCS staff. Not only must there be consideration to the prisoner but there must also be due regard to community protection and safety of hospital staff.

50. Whilst I accept that Mr Namarnyilk at that time was immobile, there is a risk that must always be considered as to how to properly manage contact with family particularly in circumstances where the prisoner is dying and family are likely to be significantly distressed at the state of their loved one. There is nothing in the evidence before me to suggest that the decision by NTDCS to refuse family to stay overnight was unreasonable. Mr Namarnyilk was being permitted family visits and I do not criticise NTDCS for the decision made in relation to such a request.

51. In relation to the decision to refuse leave to enable Mr Namarnyilk to return to Oenpelli and pass away with family and on country, I also do not consider there is any evidence to suggest this refusal was unreasonable. The request was made on Friday 6 February 2015 and refused promptly on Monday 9 February 2015. The basis for the decision to refuse highlighted the seriousness of Mr Namarnyilk's offending and that whilst his health was deteriorating rapidly; there was also a responsibility to the victim of his offending and the community generally. Whilst I do find that the response provided was "blunt" in its delivery, it is apparent that it was in accordance with the Commissioner's discretion.

52. As an aside I also consider the matter to be somewhat academic in all the circumstances given that it is clear from the medical evidence that at that stage Mr Namarnyilk had a cuffed tracheostomy tube which meant he required ventilation with a respirator or breathing machine making any transfer logistically extremely difficult. I also note the evidence by Dr Heggie that it was his professional opinion that Mr Namarnyilk was simply "too sick to travel". I therefore do not consider this refusal to have been unreasonable and I make no criticism in regard to either refusal by the Commissioner of NTDCS.

53. I note that during submissions it was requested on behalf of the family that consideration be given to the making of a recommendation that NTDCS make their Directives as to leave requests and prisoner in-patients publically available. I decline the invitation to make a formal recommendation. However I do consider that it would be of assistance to legal practitioners acting on behalf of prisoners and/or their families to have some knowledge of the matters taken into account by the Commissioner when requests for leave, or overnight visits for family, in relation to terminally ill prisoners are made.

54. In these circumstances I request that the Northern Territory Department of Corrections give consideration to the publishing of public guidelines outlining the matters to be addressed when seeking the exercise of the Commissioner's discretion for terminally ill prisoners to be granted a Leave of Absence or permitted overnight visits whilst an In-patient to hospital.

Decision

55. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

i. The identity of the deceased person was Bundy Bandiwanga Namarnyilk who was born on 1 December 1954 at Liverpool River in the Northern Territory.

ii. The time and place of death was approximately 10.27am on 15 February 2015 at the Royal Darwin Hospital.

iii. The cause of death was acute bronchopneumonia secondary to locally advanced, poorly differentiated squamous cell carcinoma within the right side of the neck.

iv. Particulars required to register the death:

a. The deceased's full name was Bundy Bandiwanga Namarnyilk.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Eric Donaldson on 20 February 2015.

e. The deceased's mother was Daisy Gunyulma (deceased) and his father was Spider (Baida) Namirrgi (deceased).

f. At the time of his death, the deceased was a sentenced prisoner incarcerated at the Darwin Correctional Centre in the Northern Territory of Australia.

Recommendations

56. There are no recommendations arising from this inquest.

Dated this 22nd day of April 2016.

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GREG CAVANAGH
TERRITORY CORONER