CITATION: *Inquest into the death of Marshall Yantarrnga* [2005] NTMC 012.

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FINDING OF:	Mr G Cavanagh

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Coroners: Inquest, ambulance service, failure to convey patient to hospital

REPRESENTATION:

Counsel:

Assisting:	Ms Lyn McDade
St Johns Ambulance:	Mr Reeves QC
NT Aboriginal Advisory Comm:	Mr Chris Howse

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

No. D0039/2004

In the matter of an Inquest into the death of

MARSHALL YANTARRNGA
SOMETIME BETWEEN 29 FEBRUARY & 1 MARCH 2004
AT DARWIN

FINDINGS

(Delivered 29 March2005)

Mr GREG CAVANAGH:

1. Marshall Yantarrnga (hereinafter called "the deceased") died sometime between 10:17pm on 29 February 2004 and 0125 hours on 1 March 2004 at 8 Milkwood Circuit, Karama. His death was unexpected and therefore a reportable death pursuant to Section 12(1) of the *Coroner's Act* ("the Act"). An inquest into his death was held at my discretion pursuant to Section 15(2) of the Act.

2. The Inquest was held in Darwin on 7 February 2005. Ms McDade appeared as Counsel Assisting the Coroner. The family members of the Deceased namely Susan Bara, the aunt of the deceased, her daughter Beverley Mamarika and her partner, Michael Payton attended during the inquest. They are traditional Aboriginal persons originally from Groote Eylant. They were living in Darwin at 8 Milkwood Circuit at the time of the deceased's death. The deceased had been with them for a couple of days before he became unwell and died. The family was not formally represented at the Inquest however, they were able to inform me of their attitude to the Inquest through my Counsel Assisting. I note that the Northern Australian Aboriginal Legal Aid Service (NAALAS) was advised of the Inquest. St John Ambulance

(NT) Incorporated ("St John") was represented by Mr Reeves QC, instructed by Messrs.Ward Keller and appeared with Mr Grove, and NT Aboriginal Justice Advocacy Committee (AJAC) was represented by Mr Chris Howse.

3. I had intended to hear evidence from 12 witnesses during the Inquest. However, at the commencement of the Inquest Mr Reeves QC, on behalf of St John, made a number of concessions and read a prepared statement onto the record. That statement said:

> "MR REEVES: Your Worship pleases. Your Worship, I'm instructed to make a statement by the people I represent, which includes St John's Administration and the ambulance officers concerned.
>
> THE CORONER: Yes.
>
> MR REEVES: As appears from the statements of the two ambulance officers who attended on the deceased earlier on the evening before his death, they believe he expressed the wish not to be transported to the Royal Darwin Hospital and instead to attend Danila Dilba on the next day. However, with the value of hindsight and mature reflection, the ambulance officers and the St John's Administration believe that the deceased should have been transported to the Royal Darwin Hospital, notwithstanding his wishes, because of the observable scarring on his chest, that counsel assisting has mentioned, and his complaints of pain without any obvious detectable cause. So they make that concession.
>
> In that respect, St John's agree with the opinion expressed by Dr Palmer in his report.
>
> THE CORONER: That's the Director of Emergency Medicine at the Royal Darwin Hospital, yes.
>
> MR REEVES: Yes, your Worship. Particularly at pages 4 to 5 where he sets out the policy that should be adopted. And as a consequence of the situation, St John's have introduced as of last September a new policy along the lines of Dr Palmer's opinion, and also implemented an audit system whereby 'ambulance not required' or ANRs are all checked to ensure that the policy is fully complied with. That is, the forms that are filled out when

> an ambulance not required occurs are checked afterwards by Mr McKay to ensure that the policy is fully complied with.
>
> St John's believe that this new policy and audit system will significantly reduce the chances of a similar situation occurring again.
>
> In view of the position I've just expressed, your Worship, we respectfully submit that there is little to be gained by embarking upon an examination and cross-examination of the various witnesses to establish what the deceased said or did not say about whether he wished to be transported to the Royal Darwin Hospital that night."

Mr Reeves QC also tendered two additional statements, one by Michael James McKay, the Deputy Operations Manager for the Northern Region for St John in the Northern Territory, and Matthew Davis, an Ambulance Officer employed by St John. The statement of Mr McKay was an addition to the statement he had made to the Coronial Investigating Officer and outlined the policy changes St John had made to standard operating procedures relating to "ambulance not required" ("ANR"). The statement indicates that in September 2004 the new "ANR" policy was disseminated to all ambulance officers and that the ambulance service had adopted the views of Dr Didier Palmer in his report of 30 April 2004 concerning ANR policy. St John has also implemented a audit system of all cases involving a recording of "ANR' rather in lieu of the random auditing of ambulance officer's records previously employed. Further that St John have since 2000, employed an Aboriginal Liaison Officer/Public Education Officer who has amongst his duties the provision of cultural awareness and training for St John's trainee paramedics. Mr Matthew Davis' statement indicates that he has been teaching cross cultural communication issues to new trainee paramedics since 2003 at St John, and that St John have now contracted with Nungalinya College to provide a 2 days course at the College for trainee ambulance officer on cross cultural communication. I note the comments of Mr Reeves QC., counsel for St Johns in this regard (transcript p.29):

> "Firstly, they have had a cultural awareness training program in place since the year 2000 and they have implemented that cross-cultural communication training program since the year 2003. Of course, neither of those programs, or indeed any form of training will remove the cultural differences, they will always exist and they will always affect the interaction between Aboriginal people and non-Aboriginal people, particularly in this context. The training is not intended to remove the cultural differences, obviously.
>
> In addition, St John's have moved to further improve and expand their cross-cultural communication training program by involving Nungalinyu College in a training program for new recruits, and my learned friend's picked up on the fact that is addressed to new recruits."

4. As a consequence of the concessions and the statements tendered, I directed my Counsel Assisting to ascertain from the family whether or not they wished to tell their story under oath from the witness box. The family advised my Counsel Assisting that they did not and were content for me to consider the transcripts of statements taken from them by the Coronial Investigating Officer. I reserved my decision as to whether I would hear evidence from the Ambulance Officer until Tuesday 8 February 2005. After consideration I formed the view that the calling of evidence, given the concessions made by St John would not assist me to any significant degree. I received into evidence the Coronial Investigation file prepared by Detective Senior Constable Cooper, which contained all relevant statements and reports relating to the death, the deceased's medical files, an extract from the registrar of Birth Deaths and Marriages and the post mortem report of Dr Sinton. The Inquest concluded with Counsel for St John and my Counsel Assisting making submissions to me.

5. Mr Howse sought leave to withdraw from the Inquest and I granted him leave to do so. I should indicate that Mr Howse made his position clear that as the representative of AJAC he did not represent the family's interest but the wider Aboriginal interest. Having heard the concessions of St John and read the additional statements tendered by them, referred to above, I

understand he formed the view that there was no issue left in the Inquest that touched upon his portfolio as an advocate for Aboriginal interests generally.

6. The deceased's family had no difficulty with my referring to the deceased throughout the Inquest by his name and accordingly, I will continue to do so in my findings.

CORONER'S FORMAL FINDINGS

7. Pursuant to Section 34 of the Act, I find, as a result of the evidence adduced at the Public Inquest the following:

(a) The identity of the deceased was Marshall Yantarrnga an Aboriginal male who was born at Darwin in the Northern Territory on 25 February 1967.

(b) The time and place of death was sometime between 10:27pm on 29 February 2004 and 0125 hours on 1 March 2004 at 8 Milkwood Circuit, Karama, Darwin.

(c) The cause of death was coronary artery thrombosis resulting from coronary atherosclerosis with other significant conditions contributing to death being mitral valve disease, aortic valve stenosis, old myocardial infarction, cardiac hypertrophy and an old cerebral contusion.

(d) Particulars required to register the death are:

1. The deceased was a male

2. The deceased was Marshall Yantarrnga

3. The deceased was an Australian resident of Aboriginal origin.

4. The death was reported to the Coroner.

5. The cause of death was coronary artery thrombosis.

6. The Forensic pathologist was Dr Terence Sinton and he viewed the body after death.

7. The deceased's mother was Tamiella Wantiliakwa Andilyaugwa.

8. The deceased's father was Harry Nakaramba Yangtarana Ongaguripa Andilyaugwa.

9. The deceased resided in Darwin

10. The deceased had no usual occupation

11. The deceased was aged 37 years having been born on 25 February 1967.

RELEVANT CIRCUMSTANCE CONCERNING THE DEATH

8. On 29 February 2004 the deceased was staying with family members at 8 Milkwood Circuit, Karama. He became unwell, complaining of being very sick at about 9:55pm on Sunday 29 February 2004. One of the family members namely, Beverley Mamarika at the request of the deceased asked her neighbour Jey Lamech to call "000" for an ambulance. The emergency medical dispatcher at St Johns Ambulance, Coralie Ann Holland, asked Jey Lamech for further details. Mr Lamech spoke with Beverley Mamarika and then informed the emergency operator that the ambulance was sought for a male about 30 years of age who was complaining of pain and fever.

9. At 10:17pm on 29 February 2004, the dispatcher sent Ambulance No 23 to Milkwood Circuit, Karama. The ambulance officers who attended were Ben Minchin, Paramedic, Jodie Dixon, a student ambulance officer, and Adrian Rossiter, a volunteer St John attendant and enrolled nurse. The ambulance

arrived at the Milkwood Circuit home at about 10:32pm. The deceased at this time was lying on a futon divan in the lounge room area. Beverley Mamarika, her husband Michael Payton were with the deceased when the ambulance officers attended. Susan Bara, the aunt of the deceased and the children of Beverley and Michael were asleep.

10. The deceased complained to the ambulance officers that he had pain in his chest and rib area. This was duly recorded on the St John patient sheet as "pain to RUQ (right upper quadrant)". He also complained of being unable to sleep. He advised the ambulance officers that he had not been drinking since Friday, 27 February 2004. Dixon initially attended the deceased but handed over to Minchin who then conducted an examination of the deceased and recorded his vital signs on the patient sheet. Both Minchin and Dixon report that the deceased's observations were satisfactory. The ambulance crew were in attendance at Milkwood Circuit for approximately 8 minutes during which time they assessed the deceased and obtained a history from him.

11. The ambulance officers were unable to determine why the deceased was in pain but nonetheless, did not transport him to hospital. They did note that the deceased had a midline thoracic scar and they made some inquiries about it. The midline scar should have, in my view, alerted the ambulance officers to the possibility that the deceased may have had a history of heart disease, as it is clearly indicative of heart surgery. In fact, it is more than likely that at the time the ambulance officers attended the deceased on 29 February 2004 he was suffering from heart failure, and the pain he was complaining of was probably caused by the inability of his heart to effectively pump blood, causing blood to pool over his vital organs, in particular his liver which is located in the right upper quadrant. The ambulance officers did not comply with the (then) existing procedures relating to ambulances not being required ("ANR"), in that they did not have the deceased sign any document indicating that he refused to be transported (something they should have

done). The statements of the ambulance officers provided to the Coronial Investigator make it unclear as to whether they were aware of the "ANR" policy of St John at the time they attended at Milkwood Circuit. The statement of the deputy operations manager for St Johns Mr Michael McKay tendered at the commencement of the Inquest informs me that St John have done much since the death in respect of the "ANR" policy, and how that has been communicated to its officers.

12. Unfortunately, an ambulance had to be called again a little while later to the residence at about 0125 hours on 1 March 2004. The same ambulance No 23 attended. The deceased was found dead.

13. The deceased did have a history of heart disease. He had undergone major surgery to replace his Mitral Valve in 1996. As a consequence of that operation, he was required to take anticoagulants, in particular Warfarin and antibiotics to prevent infection. It is clear from his medical file that at the time of his death, he was non-compliant with his medication regime. I note from the report of Dr Ilton on 4 October 2003 the following comments:

> "Thank you for referring this pleasant 36 year old gentleman from Umbakumba and Groote Eylandt for follow up of his rheumatic mitral valve with replacement of a St Jude prosthesis at Royal Adelaide Hospital in 1997. He has not had any definite follow up for at least 3 to 4 years and certainly no recent echocardiogram. He denies taking any warfarin or having any regular LA bicillin.
>
> Clinically he denies any symptoms of chest pain, lightheadedness or shortness of breath and has had no symptoms suggesting embolic event. He has mild to moderate intake with cigarettes. He keeps quite active fishing on a fairly regular basis.
>
> On examination today his pulse was 60 to 70 in atrial fibrillation with a blood pressure of 142/88. JVP was 2cm and there was no ankle oedema. On auscultation he had mechanical first and second heart sounds with the first heart sound being more dominant, with a soft systolic murmur in keeping with possible tricuspid regurgitation. The heart

sounds were consistent with a normal functioning Starr Edwards mitral valve. There was no evidence of left or right heart failure and his dentition was in reasonable condition although he does not regularly clean his teeth. His ECG today confirms atrial fibrillation with a fairly slow ventricular response of approximately 54 to 60 beats power minute with no specific ST changes. Echocardiogram has confirmed the presence of a Starr Edwards mitral valve prosthesis which had moderate obstruction with an estimated valve area between 1.3 to 1.5cm2 and no detectable MR although this could not be excluded due to the mitral prosthesis. The left atrium appeared dilated but left ventricular size and systolic function appeared normal, as did the right ventricle. There was moderate tricuspid regurgitation with delayed right atrium. Pulmonary artery pressures were normal. The aortic valve was trileaflet and sclerotic with mild aortic regurgitation without stenosis.

The mitral valve prosthesis is functioning adequately with evidence of involvement also of the aortic valve with mild aortic regurgitation. The pulmonary pressures are satisfactory which also implies adequate function of the mitral prosthesis. In view of the abnormal aortic valve and the previous history of rheumatic heart disease, he really should be on LA bicillin or at worse oral penicillin at least to the age of 40 if not for life according to the guidelines.

The other obviously extremely important issue is that his underlying atrial fibrillation and mechanical valve make it imperative that he be on anticoagulation and he has been lucky that he has not had an embolic event to date. I would be grateful if you could start warfarin as soon as possible, aiming for an INR or 3 to 3.5, commencing warfarin at 5mg daily. He will need to continue to have regular dental reviews and he could have a further follow up in 12 months time with repeat echocardiogram and he can go on to the priority 2 listing at this stage."

14. An issue at the Inquest was whether or not the ambulance crew refused to transport the deceased or whether he refused transportation. I have no doubt on the evidence that there was some confusion at the relevant time contributed to by communication difficulties. In any event, St Johns through Mr Reeves QC. concede that in the circumstances of the deceased's

presentation, he should have been transported to hospital for a review at Accident and Emergency. I also accept the statement of Dr Didier Palmer and his comments concerning this particular death. I note that St John have also accepted and adopted his recommendations in improving their "ambulance not required" ("ANR") protocol and training for their officers.

15. However, on the available evidence I can infer that the family of the deceased called an ambulance fully expecting that it would convey him to hospital so that the source of his pain could be investigated. The deceased was a full blood Aboriginal man who appears to have been stoic when assessed by the ambulance officers. There was no reason for the ambulance officers to enter into any discussion about whether or not the deceased wanted to go to hospital or whether he would rather wait and consult with a medical practitioner the next day. Given the circumstances in which they found the deceased I find that the deceased should have been transported to hospital for assessment. I do note that the ambulance officers in their statements to the Coronial Investigating Officer claim that the deceased refused transportation. In my view their statements do not so much establish a refusal, but, rather, at best, an acquiescence by the deceased not to be transported.

16. Jey Lamech, the neighbour who called the ambulance was so concerned by what he observed on 29 February and 1 March 2004, that he complained to the Health Complaints Commissioner about the failure of the ambulance officers to convey the deceased to hospital. In his statement to the Coronial Investigator he made it clear that he was of the view that the ambulance officers had exercised bad judgement. The ambulance officers made a "judgement call" in an operational setting and I am reluctant to be too critical of them, however I do find that their "judgement call" on the night (with the benefit of hindsight) was mistaken and wrong.

17. The supplementary statements provided by St John at the commencement of the Inquest clearly show that the Service has taken into account the circumstances of this death and other recent deaths involving the Service, which have been the subject of Coronial Inquests and I commend them for that. I also commend St John for the concession made through Counsel at the commencement of this Coronial. In the instant case an Indigenous family clearly had difficulties communicating with Caucasian ambulance officers and vice versa. Anything that can be done, bearing in mind that the clientele of St John are predominately Indigenous persons, to prevent a similar occurrence is to be encouraged and supported, **AND I SO RECOMMEND.**

18. Ambulance officers must accept that they are not diagnostic physicians. That is not their role. Their role is to stabilise patients and transport them to hospital for assessment. I am not prepared to find that by failing to transport the deceased the ambulance officers in any way contributed to the death of the deceased, particularly given his medical history, however their failure to transport him certainly denied him access to timely emergency medical assessment. I adopt the words of Dr Palmer in reminding ambulance officers and St John as their employer, that they are not and should not be "the decision making gateway to access to emergency assessment"

Dated this 29th day of March 2005.

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GREG CAVANAGH
TERRITORY CORONER