CITATION: *Inquest into the death of Jacky Barakal* [2005] NTMC 025

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0065/2003
DELIVERED ON:	10 May 2005
DELIVERED AT:	Darwin
HEARING DATE(s):	29 October 2004 & 10 March 2005
FINDING OF:	Mr David Loadman
CATCHWORDS:	CORONERS: Inquest, Telephone request for medical assistance – communications problems MANINGRIDA

REPRESENTATION:

Counsel:

Assisting:	Ms Judith Kelly
Northern Territory Department of Health and Community Services and Northern Territory Police Fire and Emergency Services:	Mr Gerard Bryant

Judgment category classification:	B
Judgement ID number:	[2005] NTMC 025
Number of paragraphs:	39
Number of pages:	14

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

No. D0065/2003

In the matter of an Inquest into the death of

JACKY BARAKAL

FINDINGS

(Delivered 10 May 2005)

Mr DAVID LOADMAN:

1. Jacky Barakal (hereinafter called "the deceased") died at approximately 5.30 am on 24 May 2003 at Lot 539 Maningrida Community, in the Northern Territory. 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 the Coroner's discretion pursuant to Section 15(2) of the Act.

2. The Inquest was held at Maningrida on 29 October 2004, and resumed in Darwin on 10 March 2005. Ms Kelly appeared as Counsel Assisting the Coroner. The family members of the Deceased namely Angela Kelly, the wife of the deceased, his son, Lincoln Jalimana and his sister-in-law, Doreen Jinggarrabarra, gave statements to the investigating police officer Sergeant Musgrave which were admitted into evidence. In addition, Angela Kelly and Doreen Jinggarrabarra gave oral evidence at the inquest at Maningrida.

3. The family was not formally represented at the Inquest. Northern Australian Aboriginal Legal Aid Service (NAALAS) was advised of the Inquest. Mr Peter Tiffin, from NAALAS, appeared for the family in opposition to an application by counsel for Northern Territory Health and the Police for the inquest to be held in Darwin rather than Maningrida. That application was only partly successful. It was ordered that the inquest be held in Maningrida on 29 October 2004 but that the evidence of the nursing sister, Liane Giambuzzi be given at a later date in Darwin. In the event, not all of the evidence was completed on 29 October and the evidence of Sergeant Musgrave and Dr Anne Lowell was also heard in Darwin at the resumed hearing on 10 March 2005.

4. Northern Territory Health and Police were represented by Mr Gerard Bryant instructed by the Solicitor for the Northern Territory.

5. The following documents were tendered during the inquest:

EXHIBIT C1: Extract from the Aboriginal Population Records certified the Deputy Registrar of Births, Deaths and marriages, relating to the deceased.

EXHIBIT C2: Police Investigation file consisting of:

(a) Statement of Angela Kelly dated 24.03.04 (handwritten and typewritten versions)

(b) Statement of Doreen Jinggarrabarra dated 15.03.04

(c) Autopsy report of Dr Terrence John Sinton dated 27.08.03

(d) Consent for autopsy

(e) Statement of Liane Giambuzzi dated 24.09.03

(f) Statement of Lincoln Jalimana dated 17.02.04

(g) Affidavit of identification of Ben Pascoe dated 25.05.04

(h) Report of Sergeant Ray Musgrave dated 17.02.04

(i) Supplementary report of Sergeant Ray Musgrave dated 30.04.04

EXHIBIT C3: Bundle containing:

(a) letter from Deputy Coroner to Superintendent Bryson, NT Police dated 04.03.04

(b) memorandum from Superintendent Bryson to Officer in Charge, Maningrida Police Station dated 10.03.04

(c) letter from Superintendent Bryson to Deputy Coroner dated 13.05.04

EXHIBIT C4: Report of Dr Anne Lowell dated 23.06.04 (with attached CV)

EXHIBIT C5: Report of Dr Doug Duthie dated 28.10.04

EXHIBIT C6: Tape recording of interlocutory proceedings

EXHIBIT C7: Brochure of Aboriginal Interpreter Service

EXHIBIT H1: First On-Call procedures in place at Maningrida Health Clinic as at 24 May2003

EXHIBIT H2: Department of Health and Community Services NT Remote Health Branch Review of Remote Health Centre After Hours Emergency Response Systems and Capability (conducted after the death of the deceased)

EXHIBIT H3: Curriculum Vitae of Ms Liane Giambuzzi

6. In addition, the Coroner heard oral evidence from the following witnesses:

(a) Angela Kelly

(b) Doreen Jinggarrabarra

(c) Dr Anne Lowell

(d) Sergeant Ray Musgrave

(e) Liane Giambuzzi

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 Jacky Barakal (also known as Baragal/ Baragol), who was born on 2 January 1949 at Maningrida in the Northern Territory.

(b) The time and place of death was approximately 5.30 am on 24 May 2003 at Lot 539 Maningrida Community, in the Northern Territory.

(c) The cause of death was Coronary Atherosclerosis contributed to by Pulmonary Emphysema.

(d) Particulars required to register the death are:

1. The deceased was a male

2. The deceased was Jacky Barakal.

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 Atherosclerosis compounded by severe emphysematous lung damage

6. The nurse's dealings with the deceased did not contribute to his death.

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

7. The deceased's mother was Minnie Marbaijiba.

8. The deceased's father was Macassar Jacky Yagaragalalil.

9. The deceased resided in Maningrida.

10. The deceased had no usual occupation

11. The deceased was aged 54 years having been born on 2 January 1949.

12. On the evidence in this Inquest there is no matter or issue arising which warrants adverse comment on matters of public health or safety or the administration of justice.

RELEVANT CIRCUMSTANCES CONCERNING THE DEATH

8. On the night of 24 May 2003, the deceased was at his home at Lot 539 Maningrida Community. He complained to his family about chest pains.

9. There are differences between the statements of the various witnesses as to the exact sequence of events which occurred that night. [These statements form part of EXHIBIT C2.]

10. The nurse, Liane Giambuzzi states that at about 4.45 to 5.00 am, she received a call from the deceased's wife, Angela Kelly stating that "Jacky Baragal" had taken a fit. Once she had established that he was a grown man, not an infant, she asked if he had fallen down and had a loss of consciousness. Angela didn't know so she put the deceased's son, Lincoln, on the phone. He answered "No," to both questions and said that his father had sat down. She asked Lincoln if his father had been drinking alcohol. He said, "Yes." She asked if he was drunk, and he said, "Yes." She asked if he had really taken a fit and Lincoln said, "No." She then suggested that perhaps Jacky had drunk too much alcohol and maybe he should lie down and have a sleep. Lincoln said, "So you are not going to come out then?" and she told Lincoln, "I have no medicine for someone who has drunk too much alcohol."

11. Ms Giambuzzi said that just past 5 o'clock in the morning, she received a second call from Angela saying that Jacky had a chest infection. She asked a number of questions about symptoms that might be expected from a chest infection and received negative answers. She told Angela that a chest infection was not an emergency and gave her information about the clinic's opening hours. Although Angela seemed slightly upset at this response, she did not insist that the sister should attend immediately.

12. At 5.30 am, Ms Giambuzzi received a third call, this time from Gove Hospital. She was told that Angela in Top Camp had rung Gove Hospital regarding an old man who was short of wind and that the nurse in Maningrida refused to help. She said that she then rang Angela who said that Jacky was short of wind. She told Angela she would be there in five minutes.

13. She arrived at the house between 5.30 am and 5.40 am. Jacky was not breathing and had no pulse. He was still slightly warm. The best information she was able to obtain from those present was that Angela had noticed the absence of breath after the call she made to Gove Hospital. She formed the judgment that the deceased had stopped breathing more than 5 minutes previously and that CPR would therefore be of no benefit. The evidence was that people who cease breathing for more than 5 minutes are likely to suffer irreversible brain damage. An additional factor in this decision was that she had no one to assist her should she commence CPR.

14. The deceased's wife, Angela Kelly, said that early in the morning, some time after mid-night, her husband began feeling sick. He was complaining of having chest pains and had been vomiting. Her son,

Lincoln Jalimana, rang the Health Clinic, but when he came back he said the nurse would not come. She then went to the next door house and phoned the clinic. She told the nurse that it was an emergency and that her husband was in pain. The nurse told her to bring him in the morning.

15. Her husband was still complaining about chest pains and told her to ring Gove Hospital. She did so. She told them her husband was very sick but the nurse at Maningrida wouldn't get out of bed. The nurse at Gove said she would phone the doctor. After that, the nurse at Maningrida phoned her and said she would be there in 10 minutes. By the time she got home after the call to Gove, her husband had passed away.

16. The deceased's son, Lincoln Jalimana, said that the deceased had been drinking and playing cards. When he came home he vomited and complained of having a sore chest. Angela rang the clinic first, and then told Lincoln to call because they didn't listen to Angela about it being an emergency. He said that when he called the nurse said she would be there in about five minutes but she took longer. In the mean time his dad was getting worse.

17. Doreen Jinggarrabarra, the deceased's sister in law, was in the house on the night her brother in law died. In her statement she said that at about 5.00 am he was sitting on the verandah. He said he was feeling sick and started vomiting. In her oral evidence she also mentioned that he had complained of chest pains. She said that the deceased's son, Lincoln, ran off to make a phone call to get help for his father. He came back and said that he had rung Maningrida clinic but the nurse said she would not come. She said

that Angela then phoned Gove Hospital. Doreen went to have a rest. A short time later Lincoln knocked on her door. Doreen went into the kitchen and saw Lincoln's father lying on the floor. He had passed away. Just after that, the nurse came.

18. The statement of Liane Giambuzzi was taken on 24 September 2004 from notes she had written up in the deceased's medical records on the morning of 24 March 2004.

19. The police officer investigating the death did not interview the family members until much later. The statement of Doreen Jinggarrabarra was taken on 15 March 2004; the statement of Angela Kelly on 24 March 2004; and the statement of Lincoln Jalimana on 17 February 2004. Sergeant Musgrave said that at the time the deceased died, there was nothing to indicate that there were suspicious circumstances surrounding the death. Accordingly, he made a decision to wait for a period of time before taking statements from the family in order not to intrude on their grief. Then Angela Kelly left Maningrida for Lajimanu and Lincoln became involved in ceremonies. In addition, the police at Maningrida had a large work load and had resource problems. Since then they have been allocated an extra police officer and an ACPO.

20. Because of the timing of the statements, Ms Giambuzi's recollection of specific events is likely to be more accurate in its detail. However, the detailed sequence of events is unimportant. It is clear that the family made a number of phone calls to the sister on call, Liane Giambuzzi. She made the judgement that the matter was not urgent and did not attend. Eventually the family called Gove

Hospital who called Ms Giambuzzi. Ms Giambuzzi attended the deceased's residence at about 5.30 am, by which time the deceased had passed away. On Ms Giambuzzi's estimates, from half an hour to fifty five minutes had elapsed between the time of the first call for help to the time when she arrived to find that the deceased had already passed away.

21. There is no reason to doubt that Angela Kelly believed, rightly, that her husband was gravely ill and tried to communicate that fact, and the urgency of the situation, to Ms Giambuzzi. In her oral evidence she said that she believed she had communicated effectively with Ms Giambuzzi but that Ms Giambuzzi wouldn't get out of bed.

22. There is no reason, either, to doubt Ms Giambuzzi's oral evidence that if she had known that the deceased was suffering from chest pains, or was gravely ill, she would have attended straight away.

23. It is clear that the communication between the two parties was inadequate.

24. The evidence of Dr Duthie, in his report dated 28 October 2004 [EXHIBIT C5], is that, in this case, it is very unlikely that an earlier attendance by Ms Giambuzzi, or a doctor, could have had any effect on the outcome for the deceased. However, in other circumstances, an inability to effectively communicate the need for urgent medical assistance could mean that potentially life saving assistance arrives too late or not at all.

25. Dr Anne Lowell is a speech pathologist with a graduate diploma in language studies and a PhD from the faculty of medicine at the

University of Sydney. Her doctoral thesis was on the influence of conductive hearing loss on communication and learning in an Aboriginal school. She has worked among Aboriginal people in the Northern Territory since 1994. She provided the court with a report commenting upon the communication difficulties evident from the statements of the witnesses. Her report also set out strategies which can prevent or minimise such communication difficulties. [EXHIBIT C4] Those strategies are the subject of cross-cultural training courses.

26. In her oral evidence Dr Lowell said that it is not uncommon for an Aboriginal person and a non-Aboriginal person to speak to each other, for each to believe that they are communicating effectively, and for later questioning of each to reveal an almost total failure of communication.[1] She also spoke of the Aboriginal interpreter service and commented on the desirability of health professionals and others having dealings with Aboriginal communities having training in the use of interpreters in order to gain the most benefit from them.

27. EXHIBIT C7 is a brochure published by the Aboriginal Interpreter Service giving details of the services available. This service is provided by the Northern Territory Government. The brochure includes a brief questionnaire which may be used to determine if an Aboriginal language interpreter is needed.

28. Sergeant Musgrave said that the brochure is available at the police station at Maningrida but the police in Maningrida make little use

[1] There is, of course, no reason to suppose that such communication difficulties are confined to communications between indigenous and non-indigenous Australians.

of the Service, although he has occasion to use interpreters from time to time. He did not feel the need to use an interpreter in taking the statements from the family members in this case as he believed their English was adequate to the task and that they were communicating effectively.

29. Liane Giambuzzi gave evidence that when she was first employed by the Northern Territory Health Department, she underwent a very brief period of cross-cultural training which she rated as unhelpful. Before she went to Maningrida she had further training which she rated as more helpful. (By then she had also had experience with indigenous cultures in Oecussi Enclave, East Timor and Kenema, Sierra Leone and thorough training by the International Committee of the Red Cross.)

30. Ms Giambuzzi also gave oral evidence about the role of Aboriginal health workers and said they performed a valuable service. She said the clinic was often short staffed and that there were problems recruiting and retaining Aboriginal health workers.

31. Ms Giambuzzi also said that she believed the chances of the urgency of this particular case being effectively communicated would have been improved if an interpreter had been available, or if the point of first contact between the family and the health service had been through an Aboriginal Health worker. She said that Aboriginal Health workers were rarely on call after hours, at least partly because the Department had difficulty recruiting and keeping them.

32. The Aboriginal telephone interpreter service is available 24 hours a day. The evidence of Ms Giambuzzi was that it was rarely, if ever,

made use of at the Maningrida clinic. Whether use of the service would have improved communications in this case is not known. Mr Giambuzzi said she thought it might have. Angela Kelly said she did not think it would have. This evidence must be assessed keeping in mind Dr Lowell's evidence about the possibility of failure of communication even when both parties believe they are communicating effectively.

Powers under s 34(2)

33. Pursuant to s 34 (2) of the *Coroners Act* the Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death being investigated.

Matters for comment

34. Counsel assisting the coroner filed written submissions and in paragraphs34 to 38 dealt with issues concerning interpreters, aboriginal healthworkers and cross cultural training.

35. On behalf of the Department of Health and Community Services ("DHCS")and The Northern Terrritory Police Fire and Emergency Services("NTPFES")Mr Bryant filed submissions("Bryant's Submissions") and the accuracy and objectivity of the comments in paragraphs19 to 27 are accepted and embraced by the coroner.

36. In relation to the nurse her actions and reactions are beyond criticism and the comments in paragraph 31 of Bryant's submissions are strongly endorsed as correct.

37. It is noted that there are 5 identified areas where remedial action has or will be taken to endeavour to alleviate a repetition of any

similar occurrence in the future being those set out in paragraph 37 of Bryant's submissions. Further paragraph 48 of Bryant's submissions indicate additional action being taken as set out. Those matters or actions in the Coroner's perception are appropriate and no more is necessary.

38. The Coroner adopts as correct the commentary contained in paragraphs 39 to 42 of Bryant's submissions. The vagaries of interpreters being utilised with little visible benefit is often apparent in many if not most adversarial hearings both civil and criminal. Such is often the case where languages such as Italian are the subject of interpretation in the hands of NAATI grade 3 interpreters and in the Northern Territory such grading in any aboriginal language is non existent.

39. In relation to the matters set out in paragraph 49 to 56 of Bryant's submissions it is the fact that the station was understaffed and the matter has been remedied. No adverse comment is made in relation to the delays in the production of an Investigating Officer's Report. The contrition expressed in paragraphs 57 and 58 of Bryant's report is acknowledged and accepted.

Dated this 6th Day of May 2005

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D.LOADMAN