CITATION: *Inquest into the death of Patrick Michael Heenan* [2006] NTMC 014

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coronial
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FINDING OF:	Mr Greg Cavanagh SM

CATCHWORDS:

Death in Custody, Darwin Correctional Facility, care and treatment, natural cause death.

REPRESENTATION:

Counsel:

Assisting:	Tom Berkely
SOS Australia P/L	David Farqhaur
NT Correctional Services	Ben O'Laughlin

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

No. D0146/2006

In the matter of an Inquest into the death of

PATRICK MICHAEL HEENAN
ON 16 SEPTEMBER, 2006
AT DARWIN CORRECTIONAL FACILITY

FINDINGS

9 March 2007

Mr Greg Cavanagh SM:

INTRODUCTION

1. Patrick Michael Heenan ("the deceased") was an aboriginal male born on the 19 February, 1956 at Darwin in the Northern Territory, and who died shortly before 1130 hours on the morning of Saturday 16 September 2006 in the Medical Centre, Darwin Correctional Facility, Tivendale Road, Berrimah.

2. At the time of his death the deceased was an inmate at the Darwin Correctional Facility. He was a long term prisoner, having been in prison since June 2004. He was not due for release until 29 June 2008.

3. On Saturday 16 September 2006 at about 0900 hours, the deceased and other inmates were taken to the prison oval to play a game of Australian Rules football. The deceased voluntarily participated in the game and at half time complained of chest pains. He was taken to the Prison Medical Centre and lost consciousness on the way. Attempts were made to revive him, but at about 1130 hours he was pronounced deceased by the Visiting Medical Officer.

4. The deceased's death is a death in custody in terms of the *Coroners Act*, and the holding of this inquest is mandatory.

5. Section 26 of the *Coroners Act* provides:

> "(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) shall 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 a 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 shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant."

6. Pursuant to section 34 of the *Coroners Act*, I am also required to find, if possible:

> "(1) A coroner investigating –
>
> (a) A death shall, if possible, find –

(i) The identity of the deceased person;

(ii) The time and place of death;

(iii) The cause of death;

(iv) The particulars needed to register the death under the Births, Deaths and Marriages Registration Act; and

(v) Any relevant circumstances concerning the death."

7. The Inquest was held over two days on 5 and 6 March 2007. Mr Tom Berkley of counsel appeared as counsel assisting me in this inquest. Mr David Farqhuar of counsel was granted leave to appear on behalf of SOS Australia Pty Ltd and Mr Ben O'Laughlin of counsel was granted leave to appear on behalf of NT Correctional Services. The family was not legally represented. A brief of evidence was sent to NAAJA and I am informed, and accept, that the family did not require legal representation. Ms Elizabeth Heenan and Ms Anna Davis, sisters of the deceased, attended the first day of the Inquest and Ms Elizabeth Heenan gave evidence on the second day, 6 March 2006.

8. Witnesses called to give evidence at the Inquest were Detective Sergeant James Boag, Mr Ross Rockman, Mr Callum Blackstone, Mr Peter Talbot, Ms Nicole Salmon RN, Mr Connell Brannelly, Doctor Terence Sinton, Ms Brenda Oakley RN, Doctor Robyn Walker and Ms Elizabeth Heenan. The brief of evidence, which was thorough and comprehensive and complied with Police Standing Order D2 relating to the investigation of deaths in custody, was admitted as Exhibit 1. The radio log for the Darwin Correctional Facility for 16 September 2006 was admitted as Exhibit 2. The deceased's medication, which will be referred to later in these reasons, was admitted as Exhibit 3. The deceased's birth certificate was admitted as

Exhibit 4, and an Affidavit of Identification of a Deceased Person was admitted as Exhibit 5.

9. The post mortem examination of the deceased was conducted by Dr Terence Sinton at 0930 hours on 17 September 2006, at the Royal Darwin Hospital, and the autopsy report was admitted as exhibit 6.

FORMAL FINDINGS

Particulars required to register the death

10. Pursuant to section 34 (1) of the *Coroners Act*, I find:

(a) The identity of the deceased person is Patrick Michael Heenan, an aboriginal male born on 19 February 1956 in Darwin Hospital in the Northern Territory;

(b) The time and place of death was approximately 1130 hours on 16 September, 2006 at the medical facility of the Darwin Correctional Facility (DCF);

(c) The cause of death was natural causes;

(d) The additional particulars needed to register the death under the *Births, Deaths and Marriages Registration Act* are:

i) The deceased was a male of Australian aboriginal origin;

ii) The death was reported to the Coroner;

iii) The cause of death was confirmed by a post mortem examination carried out at 0930 hours on 17 September 2006 by Dr Terence Sinton, Forensic Pathologist at Royal Darwin Hospital;

iv) The deceased's father was Michael Heenan;

v) The deceased's mother was Anna Croforiu;

vi) The usual address of the deceased was Darwin Correctional Facility (DCF);

vii) The deceased was a prisoner at the time of his death.

Relevant Circumstances Surrounding the Death

11. The deceased was a 50 year old prisoner serving a sentence at the Darwin Correctional Facility. He was a long term prisoner, having been in custody since June 2004 and not due for release until 29 June 2008. At the time of his death the deceased had, since 25 August 2006, been incarcerated in the Low Security Unit (LSU) of the Darwin Correctional Facility.

12. At about 0900 hours on Saturday, 16 September 2006, staff at the LSU had organized for the LSU prisoners to play a game of Australian Rules Football on the main oval at the Tivendale Road frontage to the DCF. Approximately 70 prisoners, including the deceased, were allowed to participate or watch the game. The deceased was a voluntary participant in the game, the skill level of which was acknowledged as a bit of "kick and giggle". The game was organised on the basis of 4 periods of 15 minutes (ie. 15 minute quarters).

13. The uncontroverted evidence at the Inquest was that at the half time break the deceased was sitting in the shade of some trees at the prison officer's social club end of the ground, which is the furthest end away from the main entrance to the DCF. He had been exhorting his team to play harder. A prisoner, Mr Rockman, said in oral evidence at the Inquest that the deceased told him during the half time break that the deceased was "paining", and

indicated his chest. Mr Rockman said that he gave the deceased some water but the deceased was still in pain. Mr Rockman tried to attract the attention of Prison Officer (PO) Talbot, at the other end of the ground. When he could not attract the attention of PO Talbot, Mr Rockman walked over to PO Blackstone, who was at the social club end of the ground closest to the deceased. Mr Rockman told PO Blackstone that the deceased was in pain and asked the prisoner officer to look to him. PO Blackstone attended upon the deceased.

14. PO Blackstone noticed that the deceased was moving around but in pain. He realised quickly that the deceased's condition could be serious and he called on his radio to dog squad officers to get PO Talbot to attend at the scene. This was at approximately 1055 hours. PO Talbot attended with a medical kit, thinking that he was to treat a football injury (that being the message passed to him) but upon arrival realised that the deceased's condition was potentially serious and jogged back to the other end of the oval to obtain a prison vehicle to transport the deceased to the DCF medical facility. At 1057 hours a radio call was made by PO Blackstone alerting DCF that a prisoner was experiencing chest pains and requesting medical assistance.

15. When PO Talbot returned with the prison vehicle he, PO Blackstone and Mr Rockman loaded the deceased into the back seat of the prison vehicle. PO Talbot then drove the deceased to the main gate of the DCF. On the way PO Talbot asked the deceased had he ever before had pain like he was currently experiencing. The deceased replied "never".

16. The arrival of PO Talbot's vehicle was expected and he drove directly into the salle-port formed between the main gate and the internal gate of the DCF. Ms Salmon, a registered nurse on duty at the medical centre, met the vehicle in the entrance to the salle-port and administered nitro glycerine spray to the underside of the deceased's tongue in an effort to dilate the deceased's blood vessels. She said in sworn evidence that the deceased was

conscious at that stage, but could only cry out in pain. The vehicle was immediately moved inside the internal gate, near the visitor's ramp, so that the deceased could be taken to the medical centre.

17. Senior PO Brannelly, who was in charge of the DCF that day, noticed the vehicle near the visitor's ramp. He thought it unusual as no vehicles were expected at that time of day. Senior PO Brannelly went to investigate and upon arrival assisted with transferring the deceased from the prison vehicle to a wheel chair. At this time the deceased had become incontinent and was not observed to be conscious.

18. The deceased was then conveyed by wheelchair into the medical facility and placed on a bed. Senior PO Brannelly placed the deceased in the "coma" or "recovery" position. Dr Walker was on duty as the medical officer for the DCF that day. In sworn evidence at the Inquest, Dr Walker described the deceased at this stage as being moribund.

19. Dr Walker and Nurse Salmon, with the assistance of prison officers, immediately commenced CPR and Nurse Salmon attached two defibrillator pads to the chest of the deceased. The deceased was given electric shocks three times in attempt to restore his heart beat. At about this time paramedics from St John's Ambulance service had arrived and they also administered three shocks to the deceased. All the while CPR was continuing when safe to do so. The last shock was administered at 1129 hours. The resuscitation attempts were unsuccessful and, after a further examination of the deceased, Dr Walker pronounced the death of the deceased at 1130 hours.

20. I am satisfied from all of the material before me, including the oral evidence, that prison officers and prison medical staff acted with due despatch in attempting to get medical treatment for the deceased and with appropriate rigour in attempting to revive the deceased. I find that the

response of the prison authorities to the symptoms of the accused was in all aspects timely and appropriate.

The Medical Condition of the Deceased

21. Unknown to the deceased or prison authorities, the deceased was suffering from coronary atherosclerosis. The autopsy showed that this condition had produced stenosis, defined as narrowing of the coronary arteries, estimated by Dr Sinton to be at 80% in the worst affected areas. The autopsy also disclosed that the deceased was suffering from chronic hepatitis, something unknown to prison authorities and, no doubt, the deceased at the time of his death.

22. What was known to the deceased and prison authorities was that the deceased suffered from high blood pressure and diabetes, for which the deceased was prescribed medication, supplied in pill form in measured doses. He was in regular attendance at the clinic.

23. During his investigation into the death, Detective Sergeant Boag located a bubble pill packet in the deceased's cell, labelled in the deceased's name, which contained in each bubble a combination of a Metformin 1000mg tablet (for diabetes), a Nifedipine 5mg tablet (blood pressure), a Atorvastatin 20 mg tablet (high cholesterol) and two tablets of Conversyl Plus 4/1.25 (blood pressure and kidney protection). The packet was issued to the deceased by the prison medical staff to assist in the management of the deceased's known medical conditions. Each bubble contained the measured amount of pills to be taken by the deceased. One bubble contained the pills to be taken in the morning with breakfast and the other bubble contained the pills to be taken with the evening meal. In my view, the fact that some dates on the back of the patient were incorrect did not cause a problem given the oral instructions given by the nurse. There were twenty eight bubbles, enough pills for fourteen days. The pill packet is Exhibit 3 in the Inquest.

24. Both Nurse Salmon and Ms Oakley, also Registered Nurses employed at the DCF at the time of the deceased's death, gave evidence that LSU prisoners were educated in the manner and need for taking the pills upon issue to that prisoner. Once a pill packet was exhausted it had to be returned for a further packet to be issued to that prisoner.

25. Nurse Oakley gave evidence that she knew the deceased well and liked him. She described the deceased as a happy go lucky prisoner but one who was very conscious of both his medical condition and the medication prescribed for him to take. Nurse Oakley said that the deceased would always demand to know what medication he was being prescribed and its purpose. She knew the deceased to be fully informed of the nature and purpose of his medication and how to take it.

26. The pill packet located by Detective Sergeant Boag indicated that the morning doses for 5 days, including the day of the deceased's death, were opened. Oddly, the bubbles contained the evening does for the 4 previous evenings were unopened. Nurses Oakley expressed her surprise with the condition of the pill packet, given what she knew of the deceased and his attitude to medication, which she described as "assiduous".

27. Dr Walker and Nurse Oakley both gave evidence that the failure to take the evening pills over the previous 4 nights would not have contributed to the deceased's death, as the pills were long term agents for the management of his known medical conditions of high blood pressure and diabetes. Dr Sinton, the forensic pathologist, said any contribution would be tenuous at best, and highly unlikely. I am satisfied that the failure to take the evening dose of the prescribed medication did not contribute to the death of the deceased.

28. Dr Walker, Dr Sinton, Nurse Salmon and Nurse Oakley all gave oral evidence to the Inquest concerning the screening of prisoners by way of ECG. The deceased, owing to his age and aboriginality, was given an ECG

every three months. It was conceded by all of those witnesses that this screen is not a useful method for diagnosing atherosclerosis. I accept the evidence of both Dr Sinton and Dr Walker that atherosclerosis is not a condition that is generally tested for given the very invasive procedure used; apparently it is usually only tested for if a person survives a coronary event. Moreover the deceased until the day of his death had never complained about chest pains or exhibited symptoms suggestive of atherosclerosis.

29. Ms Elizabeth Heenan, the youngest sibling of the deceased, also gave sworn evidence to the Inquest. Ms Heenan is the youngest child in a family of 10 children, in which the deceased was the eldest. Ms Heenan told the Inquest that the deceased lived with her prior to his last incarceration. She said that he had never complained to her of chest pains. Ms Heenan also said that if, during the time the deceased resided with her, the deceased had a medical problem, she would know about it as she was the one that usually had to fetch his medication from the nearest pharmacy. She also was not aware of any problems with the deceased's heart. I am grateful that Ms Heenan sat through the proceedings of the Inquest and this effort shows respect to her deceased brother and to the Inquest proceedings.

30. After reviewing all of the evidence, I am satisfied that there was no want of care in the supervision or medical management of the deceased whilst an inmate at the prison. The deceased died from a medical condition that neither the deceased, nor those responsible for his care, were aware of or should have been aware of. In my view, the deceased died suddenly and without warning after suffering a major coronary event that killed him despite the best efforts of prison staff to saved him. Unfortunately, and sadly, Australians unexpectedly die every day of heart attacks similar to that suffered by the deceased, and in circumstances where undiagnosed atherosclerosis is present. Indeed diseases connected with the Heart are one of the major causes of unexpected death in this country, and such deaths will occur from time to time in the prison population despite appropriate care.

31. I have had the advantage of written submissions from counsel for SOS Australia Pty Ltd and counsel for NT Correctional Services, which I found helpful.

CONCLUSION

32. I am satisfied on the basis of the investigation, exhibits and the oral evidence I have heard at this Inquest that the care, supervision and treatment of the deceased prisoner was appropriate, and that he died from natural causes. Specifically, I find that the death was caused by coronary atherosclerosis, and contributed to by the diabetes mellitus, hypertension and chronic hepatitis suffered by the deceased.

33. There is no need to make recommendations arising from the proceedings of this Inquest.

Dated this 9th day of March, 2007

GREG CAVANAGH
TERRITORY CORONER