CITATION: *Inquest into the deaths of Angel Blanco-Puerto, Phillip John Robert Lindsay, Barry Gaykamangu, Hannu Kononen* [2007] NTMC067

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0147/2005 D0155/2005 D0161/2005 D0046/2006
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FINDING OF:	Mr Greg Cavanagh SM

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REPRESENTATION:

Counsel

Assisting:	Mr Michael Grant QC
St John Ambulance:	Ms Nicole Dunn

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

No. D0147/2005
D0155/2005
D0161/2005
D0046/2006

In the matter of an Inquest into the deaths of

ANGEL BLANCO-PUERTO
ON 18 AUGUST 2005
AT 11/1 WELSH COURT MALAK

PHILLIP JOHN ROBERT LINDSAY
ON 5 SEPTEMBER 2005
AT 4/17 ANNEAR COURT, STUART PARK

BARRY GAYKAMANGU
ON 12 SEPTEMBER 2005
AT MINDAL BEACH, DARWIN

HANNU KONOONEN
ON 3 APRIL 2006
AT 31 KAOLIN ROAD, VIRGINIA

FINDINGS

(12 November 2007)

Mr Greg Cavanagh SM:

THE BACKGROUND TO THE INQUEST

1. On 29 March 2005, I handed down my findings in the *Inquest into the death of Marshall Yantarrnga* [2005] NTMC 012. Mr Yantarrnga died at some time between 10:17 p.m. on 29 February 2004 and 1:25 a.m. on 1 March 2004. The circumstances of that death were that the St John Ambulance (NT) Inc service ("St John") had been called to the deceased's residence. He was complaining of pain and fever. The attending ambulance officers were

unable to determine the cause of the deceased's pain. The deceased had a history of heart disease which had required surgical intervention in the past. He had a mid-line thoracic scar which was clearly indicative of previous heart surgery. Those signs and the uncertainty notwithstanding, the ambulance officers did not transport the deceased to hospital.

2. St John was again called to the deceased's residence later that night. On arrival at the deceased's residence, he was found dead.

3. In September 2004, in response to the death and subsequent expert opinion provided by the Director of Emergency Medicine at the Royal Darwin Hospital, St John introduced an "Ambulance Not Required" policy.

   The policy provided that an Ambulance Not Required ("ANR") response may only occur if:

   (1) the patient is adamant that he or she does not wish to be conveyed to a medical facility; AND

   (2) the patient signs the ambulance officer report form stating that he or she is refusing transport; AND

   (3) each member of the ambulance crews signs the ambulance officer report form.

4. Under the policy, if the patient refused to sign the case card, this was to be noted on the ambulance officer report form and both officers were to sign the note.

5. If the crew believed a patient's condition to be potentially life-threatening and the patient still refused transport, the duty officer was to be called.

6. During the course of the inquest into Mr Yantarrnga's death, there were various concessions made by St John to the effect that the deceased should have been transported to the Royal Darwin Hospital given the signs and

symptoms he was manifesting. It was further conceded that as a consequence of that situation, St John had adopted the “Ambulance Not Required policy” to reduce the chances of a similar situation occurring. The primary purpose of the policy was, to adopt the words used in that inquest, to avoid the situation where ambulance officers assumed the role of the decision-making gateway to access to emergency assessment.

7. Over the space of three weeks in August and September 2005, some five months after that inquest, there were three deaths in similar circumstances. On each of those occasions, ambulance officers were called to attend upon a person apparently in some difficulty. On each occasion, the person was observed, treated and refused transportation to the hospital. On each occasion, the duty officer was not called. On each occasion, the person subsequently died.

8. During the course of November 2005, coronial investigators took statements from the two ambulance officers involved and from the Deputy Operations Manager of St John. In each of those statements, there was significant focus on the question whether the patients' conditions were potentially life-threatening, whether the duty officer should have been called, and whether the patients should have been transported to hospital. The Deputy Operations Manager ventured in his statement that in one of those circumstances the duty officer should have been called. The Deputy Operations Manager also stated that the policy was up for annual review, and that review would cover matters such as whether the policy was working and whether the wording was appropriate.

9. In April 2006, there was a further death in similar circumstances.

10. These subsequent deaths, and the fact that the wording of the former policy was subject to internal review, gave rise to an apprehension that either the policy and/or the manner in which it was being applied on the ground, was not satisfactory and required address. In those circumstances, it was

determined to conduct an inquest into the deaths. Given their common features and the commonality of St John witnesses, the inquests were heard together between 23 and 26 April 2007.

THE NATURE AND SCOPE OF THE INQUEST

11. Section 34(1) of the *Coroners Act* ("the *Act*") details the matters that an investigating coroner is required to find during the course of an inquest into a death.

The section provides:

"(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; or

(b) a disaster shall, if possible, find –

(i) the cause and origin of the disaster; and

(ii) the circumstances in which the disaster occurred."

12. Section 34(2) of the *Act* operates to extend my function as follows:

(2) A coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

13. The duties and discretions set out in subsections 34(1) and (2) are enlarged by s35 of the *Act*, which provides 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."

14. It should be noted at the outset that so far as the causes of death are concerned, there is no doubt that all four men died of the natural causes described in the respective autopsy reports.

15. I set out below, in respect of each deceased:

    (1) the findings mandated by subsection 34(1) of the *Act*, namely the identities of the deceased persons, the time of death, the medical cause of death, and the particulars required to register the death; and

    (2) the relevant circumstances concerning the death, together with issues arising from those circumstances relevant to public health and safety.

16. There is little dispute on the evidence in relation to the relevant circumstances concerning each death.

ANGEL BLANCO-PUERTO

17. Angel Blanco-Puerto died on the morning of 18 August 2005. He was 65 years of age.

18. The deceased had a medical history of ischaemic heart disease, diabetes and schizophrenia. He had previously been hospitalised with congestive cardiac failure. He was a long-standing patient of Top End Mental Health Services.

19. On the day before his death, Jacinta Lipp, a case worker with Top End Mental Health Services, attended on the deceased. This was part of a regime whereby Ms Lipp would see the deceased at his home every two weeks to

check on his progress. Ms Lipp was called to give evidence during the course of the inquest. In her assessment, made over the period from June 2004, the deceased generally did not have impaired judgement and was able to make his own decisions in relation to the activities of daily living.

20. On the day of her visit, the deceased stated initially that he was too unwell to get up and open the door for Ms Lipp. She was aware of his history of heart problems and called the ambulance. The deceased was eventually able to open the door. The ambulance officers who attended were Mark Grayden and Antoni Kwiatkowski. Both officers were called to give evidence during the course of the inquest. Michael Mackay, the Deputy Operations Manager for the Northern Region was also called to give evidence in relation to Blanco-Puerto's circumstances and in relation to the other three deaths.

21. The evidence of Ms Lipp and the ambulance officers in relation to the attendance upon the deceased is consistent in all material respects.

22. As well as the deceased's history of heart problems, Ms Lipp was aware that the deceased was non-compliant with his medication. She advised the attending ambulance officers of the deceased's cardiac history. The ambulance officers found irregularities in the deceased's ECG. Those irregularities were not indicative of any cardiac event, or indeed any potentially life-being threatening condition, particularly in light of the fact that the deceased complained only of abdominal pain which had abated after he had gone to the toilet.

23. The ambulance officers nevertheless advised the deceased to come to the hospital. The deceased declined to do so and signed the ambulance officer report accordingly. The ambulance officers checked that the deceased was not having any breathing difficulties and left. Ms Lipp then arranged for community carers to conduct daily checks on the deceased.

24. A community carer attended at 11 a.m. on the following day. There was no response.

25. The community carer attended again at 2:20 p.m. She looked through the kitchen window and observed the deceased slumped backwards in a chair. She phoned police. After a forcible entry was made, it was determined that the deceased was dead and that *rigor mortis* had already begun to set in.

26. The post-mortem examination disclosed relevantly that:

    (1) the deceased had widespread jaundice;

    (2) the deceased had extensive and clinically severe coronary artery disease;

    (3) the deceased had an abnormal enlargement of the heart consistent with past infarction;

    (4) the deceased had chronic hepatitis; and

    (5) the deceased had acute liver damage as a consequence of prior heart failure.

27. The forensic pathologist concluded that the deceased had died of acute heart failure as a result of long-standing damage from coronary artery disease.

28. The deaths were referred for expert medical opinion from Dr Didier Palmer, the Senior Staff Specialist in Emergency Medicine at the Royal Darwin Hospital, and Dr Michael Flynn, who until recently was the Medical Director of the Ambulance Service of New South Wales. Both experts prepared reports in relation to the matter. I received Dr Palmer's written reports at Exhibit 3, and also took oral evidence from him during the course of the inquest. I was advised by counsel assisting and counsel for St John that in light of the evidence already heard during the course of the inquest, it

would not be necessary to take oral evidence from Dr Flynn. I received his written reports at Exhibit 4.

29. For reasons that will become apparent in the discussion of the subsequent deaths, it is useful to draw at the outset some broad comparison between the evidence of Dr Palmer and that of Dr Flynn. Dr Palmer's consideration of the four deaths included an examination and assessment of the correctness of the clinical judgements that were made as to whether each patient's history and presentation was indicative of a potentially life-threatening condition at the time of the relevant attendance by St John. On the basis of that assessment, Dr Palmer went on to consider whether, in respect of each death, there had been compliance with the ANR policy in place at the material time.

30. By way of contrast, Dr Flynn's reports do not seek to examine or "go behind" the correctness of the clinical judgements that were made. In other words, Dr Flynn's opinion proceeds on the assumption that the ambulance officers correctly assessed each patient's condition, and that in each case the patient's history and presentation was not indicative of a potentially life-threatening condition. Dr Flynn's opinion in relation to whether or not there was compliance with the ANR policy proceeds on that assumption.

31. So far as Mr Blanco-Puerto is concerned, Dr Palmer expressed the opinion that the assessment and documentation was of good quality. In his view, the deceased was competent to refuse consent and did not appear to have an immediately life-threatening condition. He concluded that the ANR protocol was appropriately applied.

32. Subject to the qualification expressed above, Dr Flynn was of the opinion that the standard of the ambulance documentation in relation to the attendance was of a high order, that the deceased met the criteria for making an informed decision to decline transportation, and that the attending officers complied with the policy.

33. The general consensus in the medical and other opinion received during the course of the inquest is that on the basis of the deceased's complaints and presentation it was not possible to say that the deceased's condition at the time of the St John attendance was life-threatening or potentially life-threatening. The deceased was a 65-year-old man. Although there was a general awareness of his cardiac history, there was otherwise limited information available on presentation. I note particularly that the deceased was observed to be orientated in time and place, that he was not experiencing any shortness of breath, and that he was not experiencing chest pain. The pain the deceased had earlier experienced was described as being abdominal in nature and had been relieved when he went to the toilet.

34. Having regard to that evidence, I can and do find that the assessment and documentation was of good quality, that the deceased was competent to refuse consent, that the deceased did not appear to have an immediately life-threatening condition, and that the ANR protocol was appropriately applied in the circumstances.

35. The mandatory findings pursuant to s34(1) of the *Act* are as follow.

(1) The identity of the deceased is Angel Blanco-Puerto, who was born in Cabanararas, Spain on 2 May 1940.

(2) The deceased died at his home at 11/1 Welsh Court, Malak in the Northern Territory of Australia on 18 August 2005.

(3) The cause of death was acute heart failure as a result of long-standing damage from coronary artery disease.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was of Spanish descent;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Terence Sinton, the Director of the Forensic Pathology Unit at the Royal Darwin Hospital;

(vi) the father of the deceased is unknown;

(vii) the mother of the deceased is unknown;

(viii) at the time of his death the deceased was resident at 11/1 Welsh Court, Malak in the Northern Territory of Australia; and

(ix) the deceased was not employed at the time of his death.

PHILLIP JOHN LINDSAY

36. Phillip John Lindsay died in the early hours of 5 September 2005. He was 55 years of age.

37. He was an information technology technician employed by the Department of Health and Community Services. His previous medical history was unremarkable. The deceased's long-term de facto, from whom he had separated shortly prior to the death, advised investigating officers that he had been under stress at work and had a poor diet. The deceased had also been a smoker for approximately 40 years.

38. The bare facts of the death are as follow.

39. At 1:48 a.m. on 5 September 2005, the deceased called St John complaining of chest pain. A unit was dispatched from the Parap station at 1:49 a.m. The unit arrived at the deceased's residence at 1:55 a.m. and got to the deceased at 1:57 a.m.

40. On arrival, the deceased was observed to be lying on the floor. He advised the ambulance officers that he had been suffering stress at work and may have eaten "off" fish and chips for dinner that night. He had been woken up with tightness in his chest and cramping in his hands and neck. The deceased was initially hyperventilating but had a strong regular pulse. He calmed down during the course of treatment. He was administered aspirin. The observations taken over the course of the first attendance disclosed:

(1) the deceased's pulse settled from 100 to 88;

(2) the deceased's respiratory rate eased;

(3) the deceased's systolic blood pressure fell from 120 to 110;

(4) the deceased's temperature and colour were at all times normal; and

(5) the deceased's pain abated.

41. The ambulance officers advised the deceased that he should be transported to the Royal Darwin Hospital for further investigation. The deceased apparently claimed he was fine and refused. The ambulance officer report form was completed accordingly. The crew left at 2.18 a.m.

42. The deceased made a further call to St John at 2:28 a.m. The same crew was dispatched and arrived at the deceased at 2:34 a.m. The deceased was found slumped in an armchair. He was not breathing. He had no pulse. The crew commenced cardiopulmonary resuscitation and drug therapy. The deceased's cardiac output gradually deteriorated and he expired.

43. Again, the ambulance officers in attendance were Mark Grayden and Antoni Kwiatkowski.

44. The post-mortem examination disclosed:

(1) clinically severe coronary artery disease with complete blockage of one of the main arteries;

(2) severe degenerative damage to the mitral valve in the heart;

(3) an abnormally enlarged heart; and

(4) accumulation of fluid in the lungs consistent with acute heart failure.

45. The forensic pathologist concluded that the deceased died of acute heart failure as a consequence of longstanding coronary artery disease compounded by the coexisting degenerative disease of the heart.

46. It was Dr Palmer's evidence that on the first attendance the deceased clearly had a potentially life-threatening condition. The patient clearly had an acute coronary syndrome until proven otherwise regardless of the easing of the pain. He fulfilled the criteria for the duty officer to be called in accordance with the policy. The substance of Dr Palmer's evidence in relation to the appropriate response to the deceased's condition may be found in the following passage:

> "…. Now the observation has been made that a feeling of indigestion might just be a sign of indigestion rather than anything more sinister. What do you say to the proposition that the involvement of any cardiac syndrome was probably excluded upon the patient's pain abating, upon his breathing calming, and upon the officers receiving an account that he thought he might have eaten off fish and chips the night before?---Well this – this is basically old fashioned thinking, and that – that set of points that you purport it's been realised in emergency medicine
>
> THE CORONER: Sorry, is that – when you say old fashion thinking that explanation being acceptable is old fashioned thinking?---Indeed.
>
> Is that what you're saying?---Yes, your Worship. And if I could explain 15, 20 years ago – 15 years ago that's how emergency physicians actually treated patients. We would have someone in with chest pain, which may be a typical, it may sound like reflux or something else, and we do a blood test and heart tracing and a chest x-ray and the patient would go home. And various studies showed that up to – up to three to five percent of those patients either died or had an implant within three months of them being discharged. And it didn't matter whether you were been seen by a very senior consultant

> or a junior medical officer, the history was very unreliable. And so over the last 15 years we have completely changed the way we deal with people with chest pain and we risk stratify them and we always assess them in hospital and we perform what we call nine hour Troponin tests, which are blood tests nine hours after the maximal pain and also do their ECGs and heart tracings etcetera, and then we also do an exercise stress test. Now after all of those things are done the patient and they're all negative, the patient has a risk of death or in fact has a heart attack within three months of about 1:3000 and that is a culturally acceptable level and something we can't improve on with present technology. And so that is – we designed the way we approach chest pain and so anyone with chest pain of more than ten minutes duration needs to be medically assessed.
>
> MR GRANT: And when you're talking about a medical assessment you're talking about an assessment in an institution like a hospital or a general practitioner's office?---Not a general practitioner's officer. In rural Australia where you might have very, very long transit times generally there would be a medical area where the patient could be seen. But generally they need to be observed for at least nine hours and often longer. Usually even in rural Australia the patient would be transferred out to a hospital environment."

47. Dr Palmer's opinion in relation to the significance of the deceased's clinical presentation found general support in Dr Sinton's evidence. Dr Flynn's conclusion was the same as that drawn in respect of Mr Blanco-Puerto's case, again on the assumption that the attending officers' clinical determination in relation to the status of the patient's condition was correct.

48. It would appear from the evidence that the attending ambulance officers initially considered that the deceased's condition was potentially life-threatening, but decided that by the time of their arrival, or by some stage during the course of their attendance, the condition had stopped being so. Officer Kwiatkowski frankly and properly conceded during the course of his evidence that, with the benefit of hindsight, that was not the case. He stated relevantly:

> "All right, did you consider that his condition was potentially life threatening?---To start with, we treated it that way until we got the history out of him.

And by the end of the attendance you concluded that it wasn't a potentially life threatening condition?---That's correct.

I take it from you from what you've told us, in terms of recommending transport for all the people you attend upon, that you err on the side of caution in relation of the seriousness of their condition?---That's correct.

And did you err on the side of caution when you were treating Mr Lindsay?---Yes, we advised him to come up with us.

The symptoms that he had when you attended, the tightness in the chest, that sort of feeling, like indigestion, cramping or numbness in the hands, do you agree that they're all classic indicators of some sort cardiac syndrome?---Some of them can be.

And in the face of those symptoms, as you say, you necessarily formed the view that they were potentially life threatening, the conditions were potentially life threatening?---To start off, I thought that way.

And of course the only reason that you would have changed that assessment, would have been if you'd satisfied yourself that some sort of cardiac condition was excluded or that it was somehow proved to you that it wasn't heart related?---That's correct.

And I take it from your statement and what you tell is in it, that the manner in which you were satisfied or you were able to exclude any cardiac problems and the manner in which it was proven to you that it wasn't cardiac related, was the story he told you about the off fish and chips the night before, the fact that he'd calmed down, and the fact that he's pain abated during the course of your attendance on him?---Plus our ACG reading, cardiac (inaudible).

Which of course cannot exclude anything, but it showed no irregularity?---That's correct.

Do you agree with the proposition that really, in those circumstances, the only way to exclude or prove that there wasn't some sort of cardiac syndrome, was a full battery of tests at the Hospital or a GP's practice or something like that?---That's correct.

Given then that you couldn't prove or exclude the involvement of some cardiac syndrome, didn't it remain the case at all time during your attendance, that his condition was potentially life threatening?---In hindsight I suppose, yes."

49. Mr McKay made a similar concession during the course of his evidence, where he stated:

> "If I could move back to Mr Lindsay's situation, you say in your first statement at the bottom of page 2, the second last paragraph there, 'In the case of Phillip Lindsay, the Duty Officer should have been called.' That's the bit that Mr Young got you to make the typo correction in?---Yes.
>
> That is an assessment that you've made following your review of the case cards and the materials in that matter?--- Yes. In hindsight, that is what should have happened.
>
> Because, in your view, clearly the tightness in the chest and the feeling of indigestion and the cramping in the hands were indicative of some sort of potentially life threatening situation?---Yes, obviously worst case.
>
> THE CORONER: Okay, your answer is yes to that?---Yes.
>
> You qualified your previous answer by saying 'with hindsight', however, I understood you to be saying even without hindsight, if you had been the ambulance officer attending Lindsay, you would have - - -?---Correct, yes.
>
> Called the Duty Officer?---Yes.
>
> So that is without hindsight?---That is without hindsight, correct."

50. Having regard to this evidence, there is little doubt that the patient did have a potentially life-threatening condition, that the only means of excluding the presence of a life-threatening condition was evaluation at a hospital or similar institution, and that the duty officer was not called in accordance with the policy. Having made this finding, however, it is not possible to say whether the outcome would have been any different had the protocol been followed. It can only be put as a possibility.

51. The mandatory findings pursuant to s34(1) of the *Act* are as follow.

    (1) The identity of the deceased is Phillip John Lindsay, who was born in Victoria on 19 April 1950.

(2) The deceased died at his home at 4/17 Annear St, Tipperary Waters in the Northern Territory of Australia on 5 September 2005.

(3) The cause of death was acute heart failure as a consequence of longstanding coronary artery disease compounded by the coexisting degenerative disease of the heart.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was Caucasian;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Terence Sinton, the Director of the Forensic Pathology Unit at the Royal Darwin Hospital;

(vi) the father of the deceased is John Nelson Lindsay;

(vii) the mother of the deceased is Morris Lindsay;

(viii) at the time of his death the deceased was resident at 4/17 Annear St, Tipperary Waters in the Northern Territory of Australia; and

(ix) the deceased was employed as an Information Technology Technician at the time of his death.

BARRY GAYKAMANGU

52. Barry Gaykamangu died between 3 a.m. and 9 a.m. on Monday, 12 September 2005. He was just short of his 50th birthday. He was from Milingimbi, but was in Darwin at the time of his death.

53. The deceased had a complicated medical history. In 1988, he was admitted to the Royal Darwin Hospital with signs and symptoms of T12 paraplegia. He was subsequently transferred to the Royal Adelaide Hospital. Investigations there revealed that the deceased's paraplegia was attributable

to a spinal abscess caused by a pseudomonas bacterial infection. The deceased was confined to a wheelchair.

54. Thereafter, the deceased was treated frequently for pressure sores on his buttocks and hips. He had a concurrent history of alcohol abuse.

55. In December 2004, the deceased was transferred to the Royal Darwin Hospital for treatment of those pressure sores. From that time until his death, he was treated periodically at the Royal Darwin Hospital but frequently absconded and lived periodically in the long grass. The deceased was known to St John and had previously been transported to the Royal Darwin Hospital by that service in response to reports by family members. He was also well known to staff at the emergency department of the Royal Darwin Hospital.

56. The deceased was hospitalised between 24 May and August 2005. The deceased absconded from hospital on 10 August 2005.

57. At 12:52 p.m. on 11 September 2005, St John was called to attend upon the deceased at Mindil Beach. The crew arrived at 1:21 p.m. on that day. The crew took basic observations. The deceased declined any medical examination and refused transportation to hospital. The officers departed at 1:42 p.m.

58. Again, the ambulance officers in attendance were Mark Grayden and Antoni Kwiatkowski.

59. The deceased spent the rest of the day and that night in company with relatives at the beach. He was apparently distressed at certain times during the night. The deceased's sister attempted to wake him at 9 a.m. She was unable to do so. St John was again called and on arrival found the deceased displaying no signs compatible with life. His skin was cool to the touch and *rigor mortis* had set in.

60. The post-mortem examination disclosed the following relevant matters:

(1) severe decomposition, larval infestation, inflammation and abscesses to the lower body; and

(2) severe damage to the liver and kidneys.

61. The forensic pathologist concluded that the deceased likely died from acute septicaemia as the result of an old but chronically inflamed fracture of the deceased's left thigh and attendant abscess.

62. Dr Flynn's opinion in relation to this death was as for the Blanco-Puerto matter, and subject to the same qualification.

63. The first issue that arose in relation to this death was the failure of ambulance officers to identify the severe decomposition, larval infestation, inflammation and abscesses to the deceased's lower body during the course of their attendance on him. They did not conduct any extensive examination of the deceased. By reason of his previous attendances at the Royal Darwin Hospital, Mr Gaykamangu was known to Dr Palmer. That matter was addressed in Dr Palmer's evidence in the following terms:

> "I just want to ask you some questions about particular aspects of his presentation. We know now from the post mortem examination that at the time the ambulance officers attended he was suffering from larval infestation of the feet and the anal and genital region at the time of the attendance. We also know that he was wearing long trousers, apparently jeans, and long blue socks covering bandages on his feet. You've noted in the second paragraph on page 3, fourth last line in that paragraph: 'He refused examination of his ulcers.' In the circumstances of ambulance officers attending at Mindel Beach on a patient that hasn't called the ambulance himself, is that refusal conclusive in terms of the obligations of the ambulance officers thereafter?---I think this needs to be viewed in the context of a man with heart conditions known very well to health services virtually every health practitioner throughout Darwin sitting certainly in the emergency services

> THE CORONER: Can you speak up please?---Sorry. Certainly in the emergency services well known to everyone. This man regularly did not want his ulcers examined. And there were times when he came to the emergency department and refused to have his ulcers examined and we had to abide by those wishes because he was able to consent to that refusal. And – if he refused I think you've got to allow him the ability to consent.
>
> MR GRANT: So in a word then that refusal was conclusive?---I think it was, yes."

64. That evidence also needs to be considered in light of the evidence from the attending ambulance officers to the effect that they did not observe anything that would have alerted them to the gross deterioration under the deceased's clothes. Mr Kwiatovski's evidence in particular was that there was nothing to alert him to the presence of larval infestation, and that he had previously identified and treated infestations of that nature in the course of his duties as an ambulance officer. During the course of the inquest, I also received an indication to similar effect from the Coroner's Constable who attended at the scene of the death.

65. I also have regard to Dr Sinton's evidence to the effect that it would have been impossible to identify the larval infestation and decomposition without removing the deceased's clothing, and that the abscess of the femoral bone would also not have been identifiable without removing the deceased clothing. In all the circumstances, the ambulance officers cannot be criticised for failing to identify the decomposition and larval infestation.

66. The same cannot be said in relation to the apparent determination that the deceased was not suffering from a potentially life-threatening condition. During the course of the examination of the deceased, it was determined that he had a systolic blood pressure of 70. Dr Palmer's evidence in relation to that matter was as follows:

> "Thank you, if I could then move then to address the issue of the patient's blood pressure. You've noted the observation of his systolic blood pressure was 70. On what basis do you say that's potentially

life threatening?---Systolic blood pressure of 70 is always abnormal until proven otherwise in an adult. This man's – that's a low blood pressure in any textbook of medicine. This man also had a raised pulse rate and those two things together mean – suggest shock. Now that can be due to either infection or blood loss or a few other reasons, but those are the two main reasons. And that is a red flag that it needs to be investigated because this is – well if someone is in shock their circulatory system is failing to the point where it can't maintain their blood pressure that is a sign of impending bad events.

Doctor, is advice in those circumstances or was advice from the patient that his blood pressure was always or routinely low sufficient to allay any fears that the – it might be an indication of a life threatening condition?---I don't think so, not at a level of 70. We have many patients, young, particularly thin, particularly women who had blood pressure which hover at 80 to 85, but we're often cautious about those patients and we need to have a long track record of their blood pressure being that low. 70 is something that we would never accept.

Just on that issue of the patient's weight, we've heard from one of the ambulance officers that the fact that the patient was thin that he had suffered from a spinal injury, and that he was oriented in time and place and capable of interacting with the ambulance officers together with his assertion that his blood pressure was usually low was enough to satisfy the ambulance officers that there was no potentially life threatening condition represented by that low blood pressure. What do you say to that proposition?---I disagree with that. The – it's a combination of features. A stand-alone blood pressure of 70 cannot be ignored and cannot be explained without medical investigation. That combined with the patient being someone with loss of core mobility and particularly combined with having a high pulse rate cannot be ignored and explained as being normal.

THE CORONER: And, doctor, I take it you would go a bit further and say, 'An ambulance officer attempting to explain away that blood pressure with that explanation is going to make a diagnosis which shouldn't be doing and that really should be something for the hospital doctor to do'?---I mean - - - It's the last time to (inaudible) the gatekeeper?---Yes. I've discussed that in police reports the gatekeeper of care and really you know my view, your Worship, but the ambulance officer should not be the gatekeeper of care and the diagnosis needs to be made by medical practitioners in the emergency department who are in the hospital. But that is grouping things together and forming a diagnostic opinion. I quite agree.

> Yes?---This is a red flag sign and should automatically trigger certain events. And it should certainly trigger the fact that this person was critically ill and potentially life threatening."

67. Later in his evidence, Dr Palmer made the following further observations in relation to the blood pressure issue:

> "Doctor, you've discerned from Mr Gaykamangu's hospital notes that his blood pressure, systolic blood pressure varied between 95 and 110 at his hospital presentations. How does that rate on the scale?---Well he has a relatively low blood pressure.
>
> Relatively low?---Yep.
>
> A description of low blood pressure might have been reference to that sort of range rather than the 70 range?---That's – that's what we'd assume low blood pressure is. Anything lower than that – well lower than 90 systolic needs to be explained. For example in my emergency department we have a protocol where any blood pressure reading below 90 systolic on any occasion the senior doctor needs to be notified."

68. So much was also conceded by Mr McKay in evidence. He stated:

> "So, you accept that any ambulance officer confronted with a systolic blood pressure of 70, has to harbour concerns as to whether that is an indication of a potentially life threatening situation?---Correct, yes.
>
> And in those circumstances they should err on the side of caution?---Should always err on the side of caution.
>
> And should continue to assume that there is a potentially life threatening condition until it is excluded or proved otherwise by appropriate testing?---Correct.
>
> And as I understood your response to his Honour, hearing from the patient himself that he usually had a low blood pressure, seeing that the patient was lucid and responsive, and seeing that the patient was paraplegic, wasn't sufficient testing to prove or exclude the existence of a potentially life threatening condition?---Not in my opinion, no."

69. I accept that evidence and consider that the attending ambulance officers should have identified that the deceased had a potentially life-threatening condition. That is not the end of the matter. Under the policy, the

determination that the deceased have a potentially life-threatening condition would have required the duty officer to be called. The evidence from the ambulance officers, which I also accept, is that they offered, and the deceased refused, transportation to hospital. That gives rise to two ancillary issues. The first is the issue of consent to transport. The second is the question whether, had the duty officer being called, the deceased would have accepted transportation to hospital.

70. Dr Palmer's evidence in relation to the issue of consent was as follows:

> "MR GRANT: All right. A number of matters flow from that. The first is under the terms of the policy if the condition is considered to be potentially life threatening the duty officer should be called. You are of the opinion that the duty officer should have been called in these circumstances?---Yes, as per the ANR policy.
>
> All right. We then get to the next point, which is what the appropriate response is in the event that the patient remains adamant that he wasn't to be transported. What do you say in relation to that situation?---I think we entered here on to – into issues of consent. I think that this – if I could just step back one place, just the contacting of a senior officer is a check on process. It means that the patient realises, 'This actually is very serious', and may well change – just the simple act of doing that may well change the patient's mind. The second issue you relate to, if the ambulance officer – the duty officer was called and then the patient still refuses well that becomes a question of whether they're able – the patient is able to consent and that consent is judged.
>
> And there wouldn't appear to be any indication in the materials you've considered to support the proposition that this patient was incapable of consent?---I think that would need to be a judgment at the time and that consent needs to be based upon various things. There – there are – in Australia ethically speaking we are often guided by the rule of see(?) which is a legal judgment regarding consent and that rests on the patient being able to understand their medical condition, being able to understand the consequences of their condition, being able to repeat that to you, being able to accept and believe that and then making a decision which may agree with the health practitioner or not agree with the health practitioner. As long as they are not impaired either by mental illness or by significant physiological compromise due to a head injury, due to – for example

shock, due to structural brain injury then they are able to make a decision consent to treatment or not consent to treatment.

THE CORONER: And must the medical practitioner respect that decision?---We must always respect that decision.

Now what about the other way though where you are convinced that the person is saying, 'No. Don't touch me', but have you ever gone the other way despite that and said, 'No. Well I am going to touch you despite your no', have you done that?---I think there's an element of judgment always. And my belief is that we would be – if we were to do that we are protected by the court if it were to get to that stage.

Well we're talking about extreme examples?---Yes. But there is an element of – it's where you draw the line. You don't want to be overly paternalistic, but equally you do want to act in people's best interest."

71. Dr Palmer's opinion in relation to the deceased's likely response had the duty officer been called was as follows:

> "Then finally, doctor, in relation to Mr Gaykamangu you say at the bottom of page 3 that on the basis of your reading of his notes and your many professional dealings with him you don't think that any intervention, I presume that includes the attendance of the duty officer, would have persuaded him to attend hospital if he didn't want to go. Why do you say that?---It's based on many professional dealings with this man. If he – once he decided he was going to do something that's it he did that thing. He had been to hospital on many tens if not hundreds of occasions and had discharged himself before treatment, before seeing a doctor, just after seeing a doctor, he decided what he wanted to do, and that was a regular occurrence.
>
> And you observed earlier in the abstract that calling the senior officer is both important in terms of the process and may give the patient cause to consider given that a senior officer has been called. I take it from your previous response you don't think that would have operated particularly on Mr Gaykamangu's mind?---We've got ample experience with this man of junior medical officers, for example, seeing and deciding to leave and then consultants being brought in and trying to re-explain the seriousness of things and the patient is still electing to leave. So that's what I base that decision on or that comment on."

72. Having regard to the totality of the evidence in relation to the deceased's condition, I make the following findings. The decomposition and larval infestation was not reasonably detected by the ambulance officers at the time. It was not open to them to force any more invasive examination upon the deceased. The deceased's systolic blood pressure of 70 was indicative of a potentially life-threatening condition. That condition should have been identified by the attending officers. The only way of excluding the presence of such a condition was evaluation at hospital. As the attending officers did not identify the presence of a potentially life-threatening condition, the duty officer was not called when the deceased refused transportation to hospital. Had the deceased's condition been properly recognized, the ANR policy would have required the attendance of the duty officer in those circumstances. Having made this finding, it is necessary to make the further observation that the deceased was competent to refuse consent and it is unlikely that he would have been persuaded to attend hospital even had the duty officer been called and attended.

73. The mandatory findings pursuant to s34(1) of the *Act* are as follow.

(1) The identity of the deceased is Barry Marririny Gaykamangu, who was born at Milingimbi on 17 September 1955.

(2) The deceased died at Mindil Beach in the Northern Territory of Australia on 12 September 2005.

(3) The cause of death was acute septicaemia as the result of an old but chronically inflamed fracture of the deceased's left thigh.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was of Aboriginal descent;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Terence Sinton, the Director of the Forensic Pathology Unit at the Royal Darwin Hospital;

(vi) the father of the deceased is Jawa;

(vii) the mother of the deceased is Lambin;

(viii) at the time of his death the deceased was of no fix address..

(ix) the deceased was not employed at the time of his death.

HANNU KONONEN

74. Hannu Kononen died at approximately 9 a.m. on 3 April 2006. He was 49 years of age. At the time of his death, he was employed as a Trades Assistant with the Power and Water Corporation.

75. He had a history of hypertension and heart problems culminating in the open heart surgery in February 1998. He remained on medication for that condition to the time of his death.

76. Approximately one month prior to his death, the deceased woke with pains in his chest and was taken to the Royal Darwin Hospital by his wife. He was diagnosed as suffering from an acute myocardial infarction and was admitted to hospital for one week. He was discharged on 12 March 2006.

77. On the evening of 2 April 2006, the deceased experienced difficulty breathing and was observed to be pale and clammy. His wife called St John. The ambulance officers arrived at 8:15 p.m. The attending officers were Sharon Swan, Helen Conneely and an observer from the Australian Army.

78. The deceased was given oxygen and his observations taken. The attending officers were given details in relation to the deceased's medical history, including the infarct he had suffered one month previously.

79. There is some conflict between the wife's recollection and that of the ambulance officers in relation to the manner in which need for the deceased's transportation to hospital was addressed. That matter is dealt with further below.

80. As it transpired, the deceased was provisionally diagnosed as suffering from anxiety and did not accept transportation to hospital. The next morning, the deceased insisted that his wife attend work. She did so reluctantly, and made an appointment for the deceased to see his general practitioner later in the week. She rang her husband at about 8:30 a.m. and could not raise him. She then called a neighbour and asked her to check if the deceased was all right. The neighbour found the deceased slumped over on the lounge in his residence. The St John was called. The deceased could not be assisted.

81. The post-mortem examination concluded that the deceased died of acute heart failure as a result of longstanding coronary artery disease compounded by aortic heart valve disease and the recent heart attack.

82. It was Dr Palmer's evidence, by way of summary, that the deceased clearly had a potentially life-threatening condition and that the diagnosis of anxiety could only be made after excluding potentially life-threatening events, which would require extensive medical evaluation in hospital.

83. Dr Flynn expressed a similar view. He concluded that the attending officers made an incorrect clinical assessment of a patient with significant history and symptoms. Having drawn that conclusion, however, Dr Flynn opined that the officers had nevertheless complied with the policy in force at the time. That latter opinion is put on the basis that the ambulance officers, having failed to identify the potentially life-threatening situation, were not

obliged under the terms of the policy to call the duty officer. That does not, of course, excuse the initial failure.

84. The medical evidence is unanimously to the effect that the deceased clearly had a potentially life-threatening condition and I find that to be so. The diagnosis of anxiety could only be made after excluding potentially life-threatening events, which would require extensive medical evaluation in hospital. The duty officer not called. In substance, then, the policy was not followed.

85. That is a matter that was conceded in evidence by Officer Swan in the following terms:

> "With hindsight though, given what we know now and given what transpired the following morning, do you agree that, at that time his condition was probably characterised as potentially life threatening?---I will concede that, yes.
>
> Do you agree with the proposition that you should always err on the side of caution and consider the condition to be potentially life threatening until it's able to be excluded or proven otherwise?---Yes.
>
> Do you agree that had you adopted that particular principle, when you were attending on Mr Kononen, the only way of excluding or proving otherwise, would have been to take him to hospital for the appropriate test?---Yes."

86. Mr McKay also conceded that to be the case. Again, however, it is not possible to say that the outcome would have been any different.

87. I return now to the dealings between the deceased and the attending ambulance officers in relation to his transportation to hospital. The wife's recollection is that she was pressing her husband to be taken to hospital because his breathing was still not right and the circumstances of the "turn" were alarming given her husband's recent history. It was her impression that the ambulance officers did not suggest that the deceased should go to hospital and left the matter entirely to him. It is the wife's belief that if the

ambulance officers had advised the husband to go hospital he would have taken that advice.

88. Officer Swan provided a statement to investigating police and was called to give evidence during the course of the inquest. Her statement suggests that she offered transport to the deceased but that he declined. While she acknowledged that his medical history was potentially life-threatening, she did not believe he was in any immediate danger at the time. That was subject to some elaboration during the course of her oral evidence on the following terms:

> "All right, now you say, I think that you don't have a specific recollection of discussions that you had with Mr Kononen, but are you able to tell his Honour whether or not you sought to insist that he go to hospital on that night?---Not specifically whether insist is the right word or not, I don't know.
>
> I think you say in your statement that he was offered transport to hospital. Would you agree that indicates something less than advising him to go to hospital and most certainly something less than insisting he go to hospital?---That's what it sounds like, but that was just the terminology used in my statement.
>
> Well is fair to say, you gave him the option of going to hospital or staying home and either calling the ambulance later if he needed it or going to hospital with his wife? ---Yes, that's fair.
>
> That's a fair statement?
>
> THE CORONER: Sorry, you're nodding your head, does that mean yes?---Yes."

89. Officer Conneely also provided a statement to investigating police. She has since left the employ of St John and at the time of the inquest was resident somewhere in the Republic of Ireland. I received her written statement into evidence. That statement contains a recollection that the attending ambulance officers advised the patient to go to hospital due to his ongoing condition but that he was reluctant to do so. I also received into evidence the statement provided by the Army observer who was in attendance on the

night. That statement is to the effect that the ambulance officers gave the deceased the option of going to hospital.

90. I was particularly concerned during the course of the inquest to view, hear and appreciate the wife's evidence in order to determine whether she was reconstructing matters as a loving and grieving wife, perhaps emotional about the death, might be expected to do. Even with those matters firmly in mind, however, she presented as a credible, honest, objective witness who didn't appear to be exaggerating in terms of her memory. I accept her evidence. In any event, in light of Officer Swan's evidence that she simply offered transport to the deceased but that he declined, it is not strictly necessary to prefer the evidence of the deceased's wife over that of Officer Swan.

91. The importance of the dealings between the attending ambulance officers and the deceased in relation to hospital transportation is evident from Dr Palmer's evidence in the following terms:

> "We come then to the question of the extent to which an ambulance officer is required to advise or insist or cajole a patient to attend hospital. What's your view there in relation to the appropriate level of pressure, if you like, to be brought to bear on a patient who has a potentially life threatening condition, but who refuses to be transported to the hospital?---There's all sorts of persuasion which is possible. You take it seriously. By your demeanour you take it seriously, you act concerned, and you explain that, 'I think that there's a significant chance of you dying if you do not come to hospital'. And you give all that information to the patient and they have to be able to accept that it is a very serious situation, and not for example put it down to anxiety or give them an alternative. There are all sorts of ways of transmitting that into the communication and if that were to fail then at that point the introduction of a senior officer may well just push the person over the brink into making the correct decision, the correct, from a medical stand point, decision.
>
> THE CORONER: Are you saying not – one of the things to do is not give them an alternative?---Well I think - - -

That's what you just said, didn't you?---Indeed. I did say that. I mean an alternative – particularly an alternative which is about the – the fifth to tenth part of the differential diagnosis. There are many other things I would like to rule out before that diagnosis is achieved. And occasionally you do have a diagnosis of anxiety, but that can only be decided after extensive investigation and giving an easy alternative gives a – an easy path. People tend to go down the path of least resistance.

Like for example when you think you should go to hospital, but you don't really want to, 'Well if you get any sicker come in with your wife a bit later on' that's not so far as you're concerned good practice?---No. It is allowing the patient a more comfortable way, which may not be the right decision, but it is also giving your – your support in your position as an ambulance officer or a doctor if you are doing that to that decision, which is an incorrect decision in my view."

92. The matter was also addressed in Mr Mackay's evidence in the following terms:

"If I could then deal with a couple of matters raised in your two statements. First of all, in your first statement when you are discussing the policy that was introduced in September 2004,?---Yes.

You say that it was drafted to be in line with the Convention of Ambulance Authorities. What did you mean by that?---They are now called Council of Ambulance Authorities, or then Convention of Ambulance Authorities, have a position statement on ANR'ing patients. It was basically to come in line with that, which is not to dissuade people from going to the hospital.

So that is all it was, to - - -?---Yes.

Is there a culture within St Johns to in fact go the other way, and try and persuade people to go to hospital, or is that a matter that is simply left to the choice of the individual?---We would prefer to see people persuaded to go to the hospital?

THE CORONER: You would want your officers, if they professionally think someone needs to go to hospital - - -?---To transport - - -

To go the next step and try and actively persuade someone who should go to

hospital but doesn't want to go to hospital?---Correct. Yes.

MR GRANT: Was it you that reviewed the paperwork in relation to the death of Mr Kononen?---Yes.

That is the later death?---Yes.

Having - have you also had opportunity to read the statements that were given by the St John Ambulance officers and the wife of the deceased?---Yes, I have.

And are you able to form a view having regard to that material, as to whether there was an adequate or sufficient level of persuasion exercised by the ambulance officers on that occasion?---There probably wasn't enough persuasion on that case. But I wasn't there, so it is very hard to actually make that call."

93. I agree that ambulance officers should attempt to persuade patients to accept transportation to hospital in the event that there is any uncertainty. Whilst that might be difficult to articulate in terms of a policy formulation, it is an institutional position that could be reinforced by way of hard-nosed educational sessions using examples such as this death.

94. The mandatory findings pursuant to s34(1) of the *Act* are as follow.

(1) The identity of the deceased is Hannu Kari Tapani Kononen, who was born in Finland on 30 October 1956.

(2) The deceased died at 31 Kaolin Rd, Virginia in the Northern Territory of Australia on 3 April 2006.

(3) The cause of death was acute heart failure as a result of longstanding coronary artery disease compounded by aortic heart valve disease.

(4) The particulars required to register the death are:

(i) the deceased was male;

(ii) the deceased was of Finnish descent;

(iii) a post-mortem examination was carried out and the cause of death was as detailed above;

(iv) the pathologist viewed the body after death;

(v) the pathologist was Dr Terence Sinton, the Director of the Forensic Pathology Unit at the Royal Darwin Hospital;

(vi) the father of the deceased is Leo Aramis Kurki;

(vii) the mother of the deceased is Mirjam Vieno Ilvenon;

(viii) at the time of his death the deceased was resident at 31 Kaolin Rd, Virginia in the Northern Territory of Australia; and

(ix) the deceased was employed as a Trades Assistant at the time of his death.

95. Some explanation is required in relation to the deceased's details as recorded above. During the course of the inquest received into evidence the certificate of citizenship and Finnish birth certificate for Mr Kononen. Those documents disclose that his birth name is actually Kurki. The deceased's wife has explained that Kononen is actually his stepfather's name. The deceased has always gone by the name Kononen. So far as the deceased's wife is aware, the deceased was not formally adopted and did not formally change his name by deed poll. I will report that matter to the Registrar for Births, Deaths and Marriages. Thereafter, the precise manner in which the deceased's death is registered is a matter for that organisation.

FINDINGS OF GENERAL APPLICATION AND RECOMMEDATIONS

96. Having dealt with the individual circumstances of each death, it falls to make certain findings and observations of general application to the circumstances. I would observe at the outset that the St John officers who gave evidence were obviously well-trained, well-motivated and frank in

their evidence. The circumstances of these deaths show that even well-motivated, hard-working officers such as these can, in an emergency situation, make errors of clinical judgement. They should not be subject to harsh criticism for doing so.

97. It should also be noted that the officers didn't all agree with each other in terms of the appropriate clinical judgement on each occasion. Mr Grayden, for example, had different views to those expressed by Mr Kwiatkowski. That is not unusual, and I found all the officers who gave evidence to be frank with the court. None of them was trying to be evasive and I did not detect any disingenuity in anything they said. In particular, Mr McKay, who wasn't directly involved in any of these attendances, expressed views without attempting to tailor his evidence to protect his organisation from criticism.

98. I also find that St John has been laudably proactive in terms of the promulgation and review of the ANR policy. As stated at the outset, be 2004 policy was introduced in accordance with certain recommendations made by Dr Palmer in the context of the Yantarrnga coronial inquest. It was in fact implemented before the findings of that inquest were handed down. The policy was formulated in accordance with the Dr Palmer's stipulations and Dr Flynn's evidence was to the effect that the policy deals appropriately with the relevant issues and considerations.

99. The policy has since been reviewed, and was formally updated on 28 November 2006. That updated policy incorporates the notion of "priority" signs and symptoms, and goes on to stipulate what those signs and symptoms include with reference to, amongst other things, chest pain and abnormal breathing. Those amendments are appropriately adopted and adapted to deal with the shortcomings that have been identified in the clinical decision-making processes during the course of this inquest, and particularly in the cases of Lindsay and Kononen.

100. During the course of the inquest I received evidence to the effect that there is a third version of the policy which hasn’t yet been promulgated. I received that draft policy into evidence at Exhibit 9. Most significantly, that policy proposes an amendment that would oblige attending ambulance officers to explain fully the risks and possible medical complications associated with refusing transport, and would oblige the attending officer to read the ANR clause to the patient verbatim to satisfy himself or herself that the patient understands what they are about to sign. Again, that is an amendment that is appropriate and adapted to the circumstances of the Kononen case.

101. I did receive some evidence from one of the ambulance officers during the course of the inquest to the effect that the policy is too wordy, too legalistic and too difficult to apply on the ground. I do not accept that criticism of the policy. In my opinion, a perusal of the document discloses that it is written in plain English and in relatively simple terms. The officer in question is required to determine whether or not there is a potentially life-threatening condition and, if so, to advise the patient that he or she should be transported to hospital. Should the patient decline, the duty officer is called. That is all the officer on the scene is required to do in order to discharge his or her responsibilities. There is nothing in the policy that should give rise to any difficulty in comprehension. Such difficulty as there is lies in the clinical judgement as to whether the patient is suffering from a potentially life-threatening condition. As Dr Palmer observed during the course of his evidence, that is a difficult judgement for any health professional to make, whatever their level of training may be.

102. Of course, the adoption of an ANR policy does not ensure that officers are aware, familiar and compliant with it. That is a matter for education and training. I received evidence during the course of the inquest that at least two officers, Officer Swann and Conneely, didn’t receive training in the content and application of the protocol. I also heard what would appear on

its face to be conflicting evidence from Mr McKay to the effect that there is what could best be described as an intensive "one-on-one" training program in relation to the content and application of the policy, at least in respect of the 2006 policy. Mr McKay was at some pains to say that he couldn't guarantee that every officer had undertaken the training because there were people on leave or otherwise absent.

103. Even allowing for Mr Mackay's evidence, it would appear that, in the past at least, not every officer has been appropriately trained in the content and application of the policy. Having said that, I am satisfied that there is now an appropriate mechanism in place now to ensure that all officers are trained for that purpose.

104. I also received conflicting evidence in relation to the attendance of the duty officer. It is not express in the policy whether or not the duty officer is required to attend in person when called. That would seem to be the implication of the policy. I heard some isolated evidence to the effect that in some cases of potentially life-threatening conditions the duty officer has occasionally attended by way of telephone or radio communication. It appears to me that if one of the aims of calling the duty officer is to put more pressure on a resistant patient to go to hospital, it’s really not going to achieve that end if he or she is not there personally to do that.

105. Although I am unable to find conclusively that that has occurred in the past, I would observe that insofar as there is any doubt in relation to the matter the policy should be amended to reflect that the duty officer attends personally rather than by any sort of remote means.

106. There is one matter that is properly the subject of the recommendation in accordance with the *Act*. During the course of the inquest I heard evidence in relation to initiatives that have been proposed by St John in order to improve clinical governance. The St John Growth Budget 2006-2009, together with a draft of a strategic framework for the development of the

service, comprise Exhibit 13. Those documents deal with the clinical governance issues addressed by Mr McKay in evidence.

107. The most significant proposal in that respect was the creation of five new clinical support officer positions. The purpose of these positions is to ensure that there is an officer in the nature of a watch commander or a shift supervisor on each shift to provide support and conduct clinical audits in relation to the operations of ambulance officers on the ground. The position would also provide an extra paramedic resource to ensure that the quality of the clinical judgments that are made by ambulance officers continues to improve. The "shift supervisor" positions are those identified in the Growth Budget as 5 CSO, Darwin for the 2007-08 financial year.

108. St John, through Mr McKay, clearly advocates for the funding and creation of these positions. The importance of this form of supervision was given some objective attention in Dr Palmer's evidence in the following terms:

> "…. Now finally, doctor, as a result of previous coronials and in accordance with their own internal processes the St John Ambulance have given consideration in recent times to the question of clinical governance and particularly some sort of on the scene supervision or auditing of the sort of clinical judgments that were made in these four cases. I don't know how much you know about the operation of the organisation, but they have a duty officer who is present during the day shift but there is no watch supervisor, if you like, for the rest of the 24 hour period of each day. There's a proposal by the ambulance to procure further funding to put on a watch supervisor for each of the three daily shifts. So that that person can be available at the base, go on to the road, go out to visit jobs and assess the sorts of clinical judgments that are being made. What do you think about the advisability or otherwise of that sort of position?---I think for this policy to work in a long term, in a culturally changing sort of way it's imperative that that sort of position is created. If you have – during the day you have a duty officer and during the – I do know a little bit about the ambulance operations, and during the nights you have someone who is at home but on call. There is naturally going to be big workloads and so there's – the big workload is going to disturb families and it's going to create some dissidence and therefore may not encourage the flow of information and the attendance of a senior officer. If you have a specifically designated

> role that the person is being paid for to perform then that will facilitate those higher level decisions being made on a 24-hour basis. And without that I don't think that you will get the ANR policy really taking effect more than it is now."

109. At the end of the day, St John is primarily reliant on funding from the Territory government, through the agency of the Department of Health and Community Services. Dr Palmer is the head of Emergency Medicine with the Department of Health and Community Services. Having regard to Dr Palmer's evidence to the effect that it is imperative to have clinical support officers in order to improve the quality of the clinical judgements that are made on the street, I recommend that the Department of Health and Community Services gives favourable consideration to St John's application for funds for that purpose. The evidence shows that at least two out of the four cases under consideration during the course of this inquest would have benefited from such input.

Dated this 12th day of November 2007.

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GREG CAVANAGH

TERRITORY CORONER