

CITATION: *Inquest into the death of Addison Japaljarri Anthony*  
[2018] NTLC 001

TITLE OF COURT: Coroners Court

JURISDICTION: Darwin

FILE NO(s): D0198/2016

DELIVERED ON: 11 January 2018

DELIVERED AT: Darwin

HEARING DATE(s): 13, 14 November 2017

FINDING OF: Judge Greg Cavanagh

**CATCHWORDS:** **Death in custody, likely autoimmune disease, medical treatment appropriate, failure of Correctional Services to notify family of illness until after death**

**REPRESENTATION:**

Counsel Assisting: Kelvin Currie  
Counsel for Department of Health: Stephanie Williams  
Counsel for Family: Rachana Rajan

Judgment category classification: A  
Judgement ID number: [2018] NTLC 001  
Number of paragraphs: 87  
Number of pages: 20

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

No. D0198/2016

In the matter of an Inquest into the death of  
**ADDISON JAPALJARRI ANTHONY**  
**ON 14 DECEMBER 2016**  
**AT ROYAL DARWIN HOSPITAL**

**FINDINGS**

Judge Greg Cavanagh

**Introduction**

1. The family have requested that the deceased be referred to as Kwementyaye Japaljarri.
2. Kwementyaye Japaljarri was born 14 October 1981 in Lajamanu. He was the youngest of three brothers born to Teresa Jigili and Tony Anthony. His father also had six children with another wife, Tricksy Anthony.
3. He went to primary school in Katherine, where he lived at the Warlpiri camp. However at the age of 10 years his father died and two years later his mother died. From that point he was raised by Tricksy until her death.
4. He moved to Kalkarindji where he met and married his first wife and together they had a daughter Brinielee. She is now 14 years of age. Toward the end of his life he moved to Lajamanu where he met Patrina Johnson. Together they had a baby named Luke. He is only 1 year old.
5. In the last few years of his life his family knew he was sick. He had been to hospital on a few occasions and they noticed he was losing weight. There are indications that some of his presentations were suggestive of an autoimmune disease.

6. There was mention on 27 August 2013 of Fabry's disease being diagnosed. He is unlikely to have had Fabry's disease and there is no evidence in the notes as to how that diagnosis was made. However it is indicative that some at least of his presentations were seen as having an underlying cause.
7. Dr Simon Quilty, the Head Physician at Katherine Hospital, described Kwementyaye Japaljarri's interaction with the hospitals:

“He was presenting at the Katherine Hospital Emergency Department frequently, up to six times a year. He would Take Own Leave from the wards, or Take Own Leave before being reviewed by a doctor when presenting at the Emergency Department.”

### **Katherine Hospital**

8. On 16 February 2016 he was admitted to Katherine Hospital with muscle aches and pains. He was booked for review on 1 March 2016 via video link to Lajamanu Clinic after the anticipated results of serology tests for autoimmunity. However he did not attend that appointment.
9. The test results were suggestive of an autoimmune disease. That was communicated to the Lajamanu Clinic staff. Kwementyaye Japaljarri presented at the Lajamanu Clinic on 3 May 2016, once more suffering muscle aches and pains.
10. The Doctor at Lajamanu Clinic contacted Dr Quilty and was told that Kwementyaye Japaljarri required complex investigations and he should be readmitted to Katherine Hospital. However Kwementyaye Japaljarri refused to go to Katherine Hospital.
11. In consequence Dr Quilty sought to review him in Lajamanu when he conducted his Outreach Clinic. However on each occasion, Kwementyaye Japaljarri could not be located.
12. On 17 October 2016 Kwementyaye Japaljarri attended Lajamanu Clinic once more with muscle pain. The offer was made that he be readmitted to

Katherine Hospital. But he refused and arrangements were made to see him on the next Outreach visit.

13. Dr Quilty was of the opinion that there were reasons for the seeming indifference of Kwementyaye Japaljarri to his medical issues. He said:

“So one of the challenges with a number of Warlpiri people that I’ve treated in the past is a reluctance to embrace the western concepts of health. Often there’s cultural and almost mystical beliefs in the cause of health problems and I suspected that Mr Anthony probably thought that his illness was related to these cultural issues.”

### **Darwin Correctional Facility Health Clinic**

14. On 21 October 2016 he was arrested in Darwin, convicted and imprisoned for a period of 5 months for low range PCA, driving while disqualified, giving false information and failing to give a sufficient sample of breath. He was due for release on 20 March 2017.
15. It was not the first time he had been imprisoned. From 15 September 1994 until his death he was imprisoned on 21 occasions, primarily for driving under the influence while disqualified.
16. However, there were no systems to inform the Katherine Hospital that Kwementyaye Japaljarri was in prison and so there was no follow up while he was imprisoned relating to his suspected autoimmune disease.
17. On admission to prison he received a physical and mental health assessment from a registered nurse between 6.00pm and 6.37pm on 21 October 2016. He told the Nurse that he drank one “big cask” daily and had been doing so for “a long time”.
18. He was noted to have a “sore on right buttock tender, but no fever or lymph node involvement”. It was a boil. It was treated, dressed and he was booked for further assessment in 2 days.

19. His nephew recalled Kwementyaye Japaljarri arriving at the prison. He said he was “laughing and telling stories”. However after a couple of days the boil started hurting. At the medical centre review two days later it was recorded that the boil was too painful to express. The boil was dressed and he was given codeine and paracetamol for the pain.
20. The next day (the 24th) he was commenced on oral antibiotics (Dicloxacillin), to be taken four times a day for three days. On the 25th he was reviewed and provided with Panadeine forte.
21. On the 27th he attended for a full examination (standard examination required of all inmates 5 days after admission to prison). It was noted that the wound (now described as a “carbuncle”) had grown to three centimetres. The doctor was notified and commenced Kwementyaye Japaljarri on new oral antibiotics (Sulfamethoxazole 800mg and Trimethoprim 160mg twice daily) and referred him to a specialist due to a left eye cataract.
22. Kwementyaye Japaljarri did not want the boil incised and drained. The doctor told him that if it didn’t improve over the next two days that would need to be done.
23. Blood and urine were taken for testing along with a swab from the discharge of the carbuncle. The pathology reports were available the next day. The results from the swab confirmed that he had been prescribed the correct antibiotics.
24. The only matters of concern noted were that he had slightly reduced haemoglobin, a slightly elevated red blood cell distribution width and abnormal cholesterol. It was thought that was due to suffering mild anaemia and being underweight. He was noted to be 184 centimetres tall and weighed 52.3 kilograms.
25. The following day (the 28th) there was still a large amount of discharge from the carbuncle and the area was too painful to touch. The day after (the

29th) the core of the boil remained intact and was still too painful to express. It was cleaned and dressed. That was repeated on the 30th October and the 1st, 3rd, 6th of November.

26. On the 8th November 2016 the Registered Nurse noticed that pathology results from February that year included a positive Extractable Nuclear Antigens (ENA), potentially indicative of an autoimmune disorder. She placed Kwementyaye Japaljarri on the recall list of the General Practitioner. However on the day of the recall (the 10th) he saw a visiting General Practitioner. There is no evidence the ENA results were checked or any consideration given to the possibility of an autoimmune disorder.
27. Kwementyaye Japaljarri was seen on the 12th and his carbuncle dressed. The note on that day stated that the wound was looking good. It continued to improve and he was seen on the 14th, 17th, and then the 27th of November. On that last occasion the note indicated that no more attention was required.
28. However, on 2 December 2016 Kwementyaye Japaljarri presented to the Medical Clinic with a sore throat. It was red. A pus spot was noted and his temperature was raised. He was given paracetamol and asked to wait for one hour for further review. An hour later his temperature had dropped from 38.7 to 37 degrees. He was given intramuscular injections of penicillin (Procaine and Benzathine) and given a three day course of paracetamol with a plan to review in three days. There is no other note on the medical file to indicate that he made any other complaint.
29. That night Kwementyaye Japaljarri became short of breath and complained about his chest. One of the inmates said that he was “walking weak”. His cellmate noted that he was finding it difficult to breathe. He helped him to the “sleep out area” and asked Kwementyaye Japaljarri’s relatives to look after him.

30. However he did not improve and at 12.20am (3 December 2016) the cellmate contacted the Prison Officers via the intercom to report that Kwementyaye Japaljarri had chest pains and couldn't breathe properly.
31. When the officers arrived they found Kwementyaye Japaljarri asleep. They woke him with the assistance of a fellow inmate. He complained of chest pain. He said he had it "since that day".
32. The prison officers asked if he could walk and then walked with him approximately 15 metres to the central hub where a call was made to the on-call nurse and thereafter the Ambulance. A wheelchair was obtained and Kwementyaye Japaljarri was wheeled the 100 metres or so to the Medical Clinic.
33. An ambulance arrived 30 minutes later and transported him to Royal Darwin Hospital, arriving at 2.04am. He was handed over by the paramedics who indicated that the chief complaint was chest pain with a two day history of productive cough with yellow sputum, fevers, tachycardia, tachypnoea and hypotension and with a hard infected boil on his lower back.

### **Royal Darwin Hospital**

34. He was triaged in the Emergency Department at 2.07am. His primary presenting problem was noted to be "likely respiratory sepsis". He had cool peripheries and a central temperature of 38.7 degrees. He had an increased work of breathing and required high flow oxygen. He was also noted to have pleuritic left chest pain. He was treated with antibiotics for respiratory sepsis. It was considered that the sepsis may have emanated from the carbuncle on his right buttock and he was admitted under the surgical team to drain the carbuncle.
35. However his respiratory condition worsened. It was determined that he could not undergo anaesthesia and he was admitted to the Intensive Care Unit

(ICU) where he was stabilised before being taken to theatre the following morning.

36. In the ICU it was discovered that he had severe pulmonary hypertension and investigations as to the cause led to the view that he may have had an underlying autoimmune condition.
37. In the days that followed until his death (12 days after his admission to hospital) he was seen by many medical teams. He was found to have right heart failure and possibly left heart failure.
38. I am grateful to Dr Paul Goldrick an Intensive Care Specialist and Dr Ian Agahari a Consultant Cardiologist, both of Royal Darwin Hospital, for explaining this most complicated case in terms that made it much more understandable.

## **Two Diagnostic Dilemmas**

39. Dr Ian Agahari, explained that the medical complexities of Kwementyaye Japaljarri posed two diagnostic dilemmas.

### **1. Sepsis and autoimmune disease**

40. The first was that he had a fever and raised inflammatory markers. It was thought initially those were caused by the carbuncle on the background of inflammatory disorder. But despite a significant testing regime the cause of the sepsis was not able to be established.
41. His inflammatory markers were significantly elevated with evidence of inflammatory disorder. The clinical picture suggested systemic lupus erythematosus. However he could not be commenced on immunosuppression/glucocorticoids due to the concerns regarding his ongoing sepsis.

## **2. Ongoing bleeding and heart failure**

42. The second diagnostic dilemma related to the cause of the pulmonary hypertension. He had presented with pleuritic chest pain and required oxygen. A CT pulmonary angiogram excluded pulmonary embolus.
43. Testing demonstrated severe pulmonary hypertension with pulmonary arterial systolic pressure of 90 mmHg with a severely dilated right ventricle with preserved systolic function. A repeat echocardiogram performed on 11 December 2016 demonstrated no constrictive pericarditis but global left ventricle systolic dysfunction (LVEF ~40%).
44. There was persistent bleeding until 10 December 2016 causing falling haemoglobin levels (117g/L to 91g/L). That along with pleuritic chest pain made the doctors reluctant to institute therapeutic anticoagulation and antiplatelet therapy. Beta blockers were withheld also, due to the sepsis.

### **Deterioration**

45. At 11.20am on 13 December 2016 a Code Blue was called due to a low blood glucose level. Kwementyaye Japaljarri was provided intravenous dextrose by the rapid response team. It was also observed that he had decreased oxygen saturations, a high respiratory rate and pain in his hands and feet. The oxygen flow was increased to 15 litres a minute and he was given analgesia for the pain. Venous blood gas indicated increased lactate levels. The lactate levels were monitored until they reduced.
46. Overnight Kwementyaye Japaljarri felt cold. He asked for more blankets and obtained three. He was woken at 8.20am on the morning of 14 December 2016 by the nurse for the purpose of taking his medication. He refused the red digestive pills because they made him nauseous. Breakfast arrived five minutes later. He was still cold.
47. The Cardiologist team spoke to him at 9.00am. They charted a plan for further investigative testing. He then watched TV until 10.00am when the

physiotherapist came to do breathing exercises. At 10.10am the bed linen was changed and his blood sugar levels checked. They were found to be low. At 11.15am he was transferred to radiology for further tests. He was complaining of being cold and had numb and painful hands and feet. He was restless and unable to keep still enough for the scan.

48. He was returned to the Critical Care Unit at 12.05pm. His heart stopped. A Code Blue was called at 12.07pm. Cardiopulmonary Resuscitation (CPR) was commenced. At 12.29pm he was deemed stable enough to be moved to ICU. However he lost output once again and could not be resuscitated. His pH was 6.6 and lactate 16. He was declared deceased at 12.51pm. He was just 35 years of age.

### **Cause of death**

49. His sudden deterioration was not expected. The medical investigations were incomplete and it left different views as to the cause of his death. It was generally thought that the cause of death was likely to be due to the pulmonary hypertension likely complicating a connective tissue disease.
50. An autopsy was undertaken by Forensic Pathologist, John Rutherford. His summation was as follows:
- “Cardiac enlargement
  - Firm pericardial adhesions
  - Dilatation of all four cardiac chambers (most noticeably involving the right atrium and right ventricle)
  - Mild to moderate right ventricular wall thickening
  - Marked bilateral pulmonary oedema
  - Marked centrilobular venous congestion of the liver
  - Histological evidence of myocardial inflammation characteristic of that seen in active rheumatic myocarditis

- Histological evidence of resolving pneumonia.”

51. He was of the opinion that the cause of death was “active rheumatic pancarditis and resolving pneumonia”.
52. However, after hearing the evidence of the doctors during the inquest Dr Rutherford thought there could be a better description. He said:

“Having listened to the complexity of the case this morning I am, of course, willing to moderate or change [my opinion as to cause of death] in the light of what we’ve heard ... I would probably put all the components on the same level instead of trying to argue which one was most important.

I think the rheumatic myocarditis is incontrovertible. He had this. It was a major factor in his death ... I say that because rheumatic carditis when present is characterised by this unique cellular reaction called the Aschoff node which is pathognomonic, that is to say it is entirely characteristic of rheumatic myocardial disease and there is no other disease that will produce this pattern.

I think what we’ve heard this morning have been arguments about what can be superimposed on that diagnosis of cause of death and how important the relative components are. So if I were to reformulate the cause of death incorporating what other people have expressed I would say rheumatic pancarditis complicated by pulmonary arterial hypotension, pneumonia and connective tissue disease of unspecified type. Now, expressing it that way doesn’t mean that there is a causal relationship necessarily between the components. It simply acknowledges that they are there. So complicated by pulmonary arterial hypotension, for example, might mean to some that the rheumatic disease caused the pulmonary arterial hypotension but if you were of the view that the pulmonary arterial hypotension were independent you might regard that as being a contributing factor and the wording of that doesn’t force you into either of those ways of thinking.”

53. In the opinion of Dr Rutherford, the cause of death was “active rheumatic pancarditis complicated by pulmonary arterial hypertension, pneumonia and connective tissue disease of unspecified type”. I accept Dr Rutherford’s opinion as to the cause of death.

54. There was disagreement from Associate Professor Peter Boyd. He stated that it was “extremely unlikely for severe rheumatic carditis to cause severe pericarditis and myocarditis without involving the cardiac valves”. He thought it more likely that a connective tissue disease was causing a chronic myopericarditis.

### **Care, supervision and treatment**

55. The *Coroners Act* at section 26(1)(a) requires that where a person dies in custody the Coroner:
- (a) must investigate and report on the care, supervision and treatment of the person while being held in custody.

### **Reviews undertaken of care and treatment**

56. After the death of Kwementyaye Japaljarri the Top End Health Service undertook a Mortality Review as well as obtaining a medical file review from an independent expert, Associate Professor Peter Boyd. Those actions are commendable and demonstrate a desire to learn and improve.

### **RDH Mortality Review**

57. The Mortality Review provides a good overview of the treatment received, identified areas of improvement and made recommendations. The recommendations were as follows:
- “a) Primary Health and the RDH Emergency Department explore a reliable system of handover to ensure relevant clinical information is transferred from protective custody to the RDH. This includes the requirement for verbal handovers to be completed via the ED Access line, twenty-four hours a day and conducted as per TEHS Clinical Handover Guidelines.
  - b) All admitting teams continue to liaise with the ICU team in-person prior to leaving the ICU morning ward round, as directed within the RDH ICU Management Procedure.
  - c) The RDH Executive review the current ICU Liaison Nursing service with the possibility of extending the scope of outreach care to patients recently discharged from the ICU. This may

include the consideration of a step-down high dependency unit to ensure close monitoring of patients in their transition from the ICU.

- d) TEHS develop a system wide training program on the requirements of patient monitoring, track and trigger charts and methodologies in escalating care. This is to run in parallel with DETECT training packages which outlines the patho-physical reasons for clinical deterioration.
- e) Each ward on the RDH provides access to the ‘Cisco Jabber System for Health’ to enable the use of the Aboriginal Interpreter Service Audio Visual Service for all Aboriginal patients by September 2017. This includes training and familiarisation to the system for all clinical staff through communication packages to be developed by the project leads.”

### **Independent Expert Review**

- 58. In the opinion of Associate Professor Peter Boyd, the Director of Medicine at Cairns Hospital, there were a number of areas where management could have been improved but he was of the opinion that those did not affect the outcome. Overall he was of the opinion that the investigation and treatment of Kwementyaye Japaljarri “were appropriate and that no significant other interventions could have been done to save his life”.
- 59. The areas where management could have been improved were:
  - “a) His initial assessment in emergency ... could have identified his respiratory status a little earlier.”
  - b) There was some delay in getting a medical team to take full responsibility of his care, with a number of teams providing consultation with the patient remaining under surgical care. This may have led to slight incoordination of care ... A single medical team taking responsibility for coordinating his care would have been more appropriate rather than the surgeons doing this ...”
  - c) It is possible that further investigation of his earlier presentation with pericarditis [in Katherine Hospital] might have led to an earlier diagnosis, but there is likely to have been

social factors that influenced this, out of the control of the treating doctors.”

60. Dr Charles Pain, the Executive Director, Medical Services for the Top End Health Service also provided a statement noting opportunities for improvement and what had been done:

- “(i) When Mr Anthony was recalled and seen by the doctor at the Holtze Correctional Health Centre, after his ENA results were found, he should have had further investigation to explain why he had results suggestive of an autoimmune disease. This was an omission. Holtze Correctional Health Centre has since tightened the process for reviewing the medical officers recall list, with the senior nurse and the medical officer reviewing the daily recall list to ensure referred clinical issues are identified.
- (ii) An internal review of systems and processes at the Royal Darwin Hospital indicated areas for improvement. It was found that referral to a medical specialist for coordination of care should have been made earlier; when it became apparent there were complex medical problems, in addition to the carbuncle. Recently, the Surgical and Medical Divisions within the RDH have designed a model of shared care for such complex patients. A trial introduction of a shared care model, on a small cohort of patients, will be completed by early 2018.
- (iii) The internal review also found Mr Anthony should have been offered interpreter services to assist in cultural sensitivities, communication with medical staff and for his own understanding of his condition. This may have helped identify that he had presenting complaints in addition to his carbuncle when he attended the Emergency Department. The RDH is in the process of establishing access to the Cisco Jabber System for Health to enable the use of the Aboriginal Interpreter Service Audio Visual services within the ward environment, at short notice.”

61. There was also evidence of a different process and procedure provided by Dr Simon Quilty. He told me that a program called the “Wellness Support Pathway” will be rolled out from January 2018. He said:

“This program would have almost certainly identified that he’d gone to prison. The Wellness Support Pathway is a recognition that Katherine Hospital has a very specific group of mainly Indigenous

people with high rates of homelessness that frequent our ED six or more times a year. And the program is a collaboration between multiple agencies in town and also multiple government agencies to try and come together, work out how we can provide services that meet these people's needs and to actually form meaningful relationships to help them engage in more positive ways in the Katherine Community.

So when people attend Katherine Hospital and they're recognised as a frequent attender, this will be flagged and they'll be reviewed by a senior clinician, by an Aboriginal liaison officer and a social worker and then they'll be referred to a dedicated support service that is now fully funded at Wurli Wurlinjang and will be getting going in the next month. And this is very different from the way Emergency Departments tend to focus their care.

So Emergency Departments tend to focus on promoting acute clinical emergency needs. Not many hospitals in Australia actually look at the social needs of their clients, but in Katherine, this is a very high priority. A lot of the forces that drive them into hospital again and again are environmental and social. So particularly during the hot, wet weather, in the build-up at the moment, people living rough in Katherine get sick because of the weather and come into hospital. And the solution to them isn't just recognising that they have a pneumonia, it's recognising that they have a pneumonia in the context of being homeless and being subjected to very hot, wet weather all of the time. And through this program, we hope to identify needs such as homelessness, identify issues such as incarceration and the opportunities that that provides to engage in healthcare and try and help provide pathways for these people. So it's quite an exciting program that we're looking forward to rolling out in January."

## **ISSUES**

### **Failure of Correctional Services to Advise Family of critical illness**

62. The family were most concerned that they were not notified by Correctional Services that Kwementyaye Japaljarri had been taken to Hospital. Robyn Payton, on behalf of the family said:

"One day in December last year I was at home. I heard people wailing and saw people walking to sorry camp. I asked family what

had happened and they told me Japaljarri had passed away. I was shocked.

It was a real shock to everyone in the community when we heard the news. We were all asking “What happened to him in prison?” We had no idea that he had been in hospital. We had no idea why or how he had passed away ...

I am upset that family was not told that he had been admitted to hospital. The prison should have told the community by notifying us, the clinic or the police of this as soon as he was admitted.

Had family known that he was in hospital, we might have been able to reach out to him, and his family in Darwin, the Rose family and maybe some Jigili family, might have been able to visit him before he passed away. It makes me very sad that he wasn't with any family when he passed away or hadn't seen any family in hospital.”

### **Lack of Interpreter Services**

63. The family were also concerned that “there was no Warlpiri person, like an interpreter” at the prison or hospital. That was an issue also identified by the Mortality Review and Dr Charles Pain who said in evidence:

“We've looked back at Mr Anthony's case and considered where the opportunities might have been to improve our communication with him. If I could briefly suggest where those were. So in Katherine clearly when he was first seen they seem to have done reasonably well in understanding his problem and investigating him. Unfortunately he didn't return to get the results; so I think Katherine does well in this area, and they've introduced a program to enhance the way in which their systems work, and we heard Dr Simon Quilty speak about that.

When it comes to RDH our access to interpreters is limited. In urgent situations, particularly out of hours, for example when Mr Anthony attended our emergency department, it would have been - as you can imagine, we obviously missed the chest pain. It's possible that if we had had access to an interpreter at that time, or perhaps even an Aboriginal liaison officer, we might have had better communication and he might have communicated better with us about the nature of his problems. So interpreter services are really important. We do have access to them, but we recognise the need to improve that, and that is one of the things that we're looking at, is

that we're going to improve access using this Cisco Jabber system, which is a video system.”

64. At the Correctional Centre once his deterioration was detected it was an emergency situation and it wouldn't be expected that an interpreter would have greatly assisted.
65. However, at the Health Clinic he attended on 2 December 2016 an interpreter may well have been able to assist if only to counter the shyness Dr Quilty spoke about.
66. I encourage the Department of Health to make every effort to obtain interpreter services, when able, to assist in such cases.

### **Correctional Services Response**

67. I suspect that with regard to his stay in the hospital, the perceived failure to have a Warlpiri person available was exacerbated because there were no family there. That was because family were not notified by Correctional Services, in whose custody Kwementyaye Japaljarri remained.
68. Enquiries confirmed that there was no notification to family until after he died. Correctional Services do not have a policy for notification to the family that a prisoner is ill or dying.
69. There are obviously good security reasons why a family might not be notified of a prisoner being outside the prison. However where the prisoner is in a serious condition, common sense and ordinary human compassion suggest that for the sake of the family and the prisoner, the family need to be notified.
70. Counsel Assisting spoke with Mr Mark Payne, Commissioner for Correctional Services about this issue. I am most gratified that the Commissioner is of a similar view. He indicated that Correctional Services would put into the Standard Operating Procedure a requirement that family

be advised when a prisoner was taken to hospital critically ill or was there for palliative purposes.

### **Failure to Access the Shared Electronic Health Record**

71. The Department of Health have a system known as the “Shared Electronic Health Record”.
72. That record wasn’t accessed on Kwementyaye Japaljarri’s admission to prison, nor when he had his full health check five days later, nor when he was admitted to Royal Darwin Hospital.
73. The only time it was accessed was 8 November 2016 by the Registered Nurse at the prison Health Clinic. She noticed that the pathology results from February that year included a positive Extractable Nuclear Antigens (ENA), potentially indicative of an autoimmune disorder.
74. She made an appointment for Kwementyaye Japaljarri to see the doctor two days later. But the doctor did not access the Shared Electronic Health Record on that occasion. It is said that was because he was a locum.
75. There is no evidence that if the Health Record had been accessed it would have made any difference to the eventual outcome. However, it is worrying that a record called a “Shared” record is not routinely accessed.
76. In response to those concerns Dr Charles Pain wrote:

“CCSRP's [Core Clinical Systems Renewal Program's] intention is to have "one patient, one record", accessed readily from any device, from anywhere and anytime for all NT health patients. This system will have a much better interface with EMR [Electronic Medical Record] used by external providers so easier access by both parties.”
77. The Health Department’s website provides the following information:

“The Northern Territory Department of Health currently uses four core systems to support client health services. These systems are between 15 and 25 years old and are beyond end-of-life.

In May 2017, the Core Clinical Systems Renewal Program (CCSRP) was funded by the Northern Territory Government in May 2017 for \$259 million over five years. The CCSRП will create a jurisdiction-wide single integrated client-centric health electronic record system for NT Health.

The program goal is to improve client outcomes by providing a contemporary system that works best for NT Health staff and transitions hospitals from paper to digital electronic health records.”

78. Until the delivery of the new system however there is an ongoing need to access the Shared Electronic Health Record. I encourage the Department to ensure that processes and procedures are appropriate to ensure access to that record.
79. Pursuant to section 34 of the *Coroner’s Act*, I find as follows:
- (i) The identity of the deceased was Addison Japaljarri Anthony born on 14 October 1981 in Lajamanu, Northern Territory.
  - (ii) The time of death was 12.51pm on 14 December 2016. The place of death was the Royal Darwin Hospital.
  - (iii) The cause of death was active rheumatic pancarditis complicated by pulmonary arterial hypertension, pneumonia and connective tissue disease of unspecified type.
  - (iv) The particulars required to register the death:
    - 1. The deceased was Addison Japaljarri Anthony.
    - 2. The deceased was of Aboriginal descent.
    - 3. The deceased was not employed at the time of his death.
    - 4. The death was reported to the Coroner by Royal Darwin Hospital.
    - 5. The cause of death was confirmed by Dr John Rutherford.

6. The deceased's mother was Teresa Jigili and his father was Tony Anthony.

## **Comment**

80. The medical treatment of Kwementyaye Japaljarri at Katherine Hospital and the Prison Health Clinic was appropriate. It may have been better informed in the prison if Katherine Hospital had known of his incarceration or the Shared Electronic Health Record had been appropriately accessed. However, it is most unlikely to have altered the course of the illness that took his life. I am encouraged to see that Katherine Hospital is involved in the introduction of the Wellness Support Pathway at the beginning of 2018. I am told that the Pathway should solve those communication issues (at least for that area).
81. At the Royal Darwin Hospital he received appropriate treatment. It may have been that it could have been delivered more expeditiously at various points. However, again the likelihood is that such expedition would not have altered the outcome.
82. His stay in hospital would have been better for him if family had been present. It would also have been better for the family. Correctional Services are accepting of that and I am told will make the necessary changes.
83. The Department of Health have been proactive in seeking to learn from this most difficult of cases. They are to be commended. I trust there will be consideration and action in relation to the recommendations of the Mortality Review. Two of those recommendations are of particular interest given other cases that have come before this court and I include them in my recommendations.

## **Recommendations**

84. I **recommend** that the Commissioner of Correctional Services ensure that appropriate processes and procedures are in place to advise the families of

prisoners whenever a prisoner is under medical care and at significant risk of dying.

85. I **recommend** that the Department of Health ensure that the processes and procedures for accessing the Shared Electronic Health Record are appropriate and that the records are being accessed in appropriate cases.
86. I **recommend** the Top End Health Service develop a system wide training program on the requirements of patient monitoring, track and trigger charts and methodologies in escalating care.
87. I **recommend** that the Top End Health Service take all reasonable steps to ensure access to interpreters for indigenous patients where there is a need due to language or cultural barriers.

Dated this 11th day of January 2018.

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JUDGE GREG CAVANAGH  
TERRITORY CORONER