CITATION: *Inquest into the death of Barnabas Naroldol* [2012] NTMC 001

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HEARING DATE(s):	24 and 25 November 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in custody, Coronary atherosclerosis, cardiac hypertrophy, care and treatment whilst in custody**

REPRESENTATION:

Counsel Assisting:	Dr Peggy Dwyer
Department of Health and Corrections:	Mr Tim Barrett
Registered Nurses Calgarett and Michel:	Mr Alan Woodcock
Family of the Deceased:	Mr Jonathon Hunyor

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

D0040/2011

In the matter of an Inquest into the death of

BARNABAS NAROLDOL

ON 12 MARCH 2011
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Mr Barnabas Naroldol was aged only 33 when he died at Royal Darwin Hospital on 12 March 2011. The deceased was an indigenous person and his family preferred that his name not be used throughout the two day inquest held in Darwin in November 2011. Apart from reference to his name in the title of these findings and in this first paragraph, he will be referred to herein as "the deceased" in deference to the cultural sensitivities of his family.

2. The cause of the deceased's death was longstanding atheromatous coronary artery disease and cardiac hypertrophy. Although he was still a relatively young man, the autopsy report showed an abnormal enlargement of the heart, and mild but chronic degenerative disease of the aortic valve.

3. At the time of his death, the deceased was a sentenced inmate at Darwin Correction Centre. He was taken into custody on 11 December 2010, and his sentence of four months and seven days was due to expire on 18 April 2011.

4. Since the deceased died in custody, an inquest into his death was mandatory. Furthermore, section 26(1) of the *Coroner's Act* imposes an obligation on me to "investigate and report on the care, supervision and treatment of the

person while being held in custody". Although it is clear that the deceased died from natural causes, I have considered whether the "care, supervision and treatment" that he received while a prisoner at Berrimah was appropriate and adequate for his medical needs.

5. At the time he first came into custody on 11 December 2010, the deceased was seen by nursing staff and the medical officer at Berrimah Correction Centre as part of the standard screening procedures to determine if he had any obvious physical or mental health needs. None were identified and he was not on any form of medication.

6. On the day of his death, the deceased was feeling unwell. Around mid morning, he was doing some manual labour in the community as part of a team from the Low Security Unit (LSU) and a fellow inmate noted that he was not his usual self and could not perform his work properly. On his return to the prison, at around 2.50pm, the deceased approached prison officers and asked to attend the clinic, complaining of pain in his head, throat, arms and upper chest.

7. The deceased was transferred to the clinic and seen by nursing staff. He did not describe pain in the chest when he was there, but rather pain in his head and a tingling under the skin around his right breast. The prison GP could not be contacted by telephone and, since the nurse thought he was probably suffering a cold or flu, he was released with panadol. Several hours later, he collapsed and, although staff attended quickly to administer CPR, and he was conveyed swiftly to Hospital by ambulance, he did not regain consciousness.

8. Evidence from nursing staff reveals the enormous strain under which they work and the particular difficulties they faced on 12 March 2011. Nevertheless, I find that the care received by the deceased whilst in custody was not inadequate and his death could not have been predicted by staff, nor easily prevented. On the day he presented to the clinic, given the symptoms

he described and exhibited, the standard of care he received was not unreasonable or inappropriate.

9. I have had the benefit of an excellent Officer in Charge, Detective Senior Constable Tanya Larsen-Smith, who prepared a very thorough brief of evidence and was of great assistance during the inquest proceedings.

10. In addition to the Officer in Charge, I heard evidence from Prison Officers Vanessa Butterworth and Michael Macpherson, from Registered Nurses Sharon Calgarett and Joanne Michel and from Medical Officers, Dr David Mathieson and Dr Carol Tainsch. I also heard from Dr Tony Falconer, the then Medical Director for International SOS, a company contracted by the NT Department of Health to provide services at Berrimah Correction Centre.

11. Pursuant to section 34(1) of the *Coroners Act*, I must make findings in relation to:

    (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.

12. Section 34(2) expands upon those functions and states that:

> "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. A broad recommendations power is set out in section 35 (1) and (2) which provides that:

"(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. Further, since I am holding an inquest into the death of a person held in custody, I must also make such recommendations with respect to the prevention of future deaths in similar circumstances as I consider to be relevant (s.26(2)).

15. Although there is no individual who could be blamed for this death, it is possible that better conditions at the Clinic might have facilitated communication between nursing staff and the deceased and led to disclosure of symptoms that would have prompted further testing and treatment. Thus, there are lessons to be learnt from this death and I intend to make recommendations aimed at minimising the risk that another prisoner will die in similar circumstances.

Relevant circumstances surrounding the death

Background

16. The deceased was an Aboriginal person whose traditional country is at Croker Island, located off the north coast of west Arnhem Land, about 260kms north-east of Darwin. Around six or seven years before his death, he moved to Maningrida to live with his wife, Verity Bengerra–Jones on her traditional country.

17. Ms Bengerra-Jones and the deceased had four children together, the eldest aged 8 and the youngest only four months old at the time that he died. He was also the step father of two teenage girls aged 13 and 16. He was

obviously much loved by all his family and they continue to grieve his sad passing.

18. As Officer in Charge, Det S/Con Larsen-Smith made extensive enquiries to determine the state of the deceased physical health prior to coming into custody. She was particularly diligent in doing so, and contacted Maningrida health clinic, Darwin Remote Health, Sunrise Health Services and the Katherine West Health Board, none of which had any records suggesting the deceased had been diagnosed or treated for high blood pressure, nor any other heart related condition, nor indeed any serious illness.

19. Ms Bengerra-Jones gave a statement to police which I am confident contains her genuinely held belief that prior to going into custody, the deceased suffered from high blood pressure and had at some stage been given medication for that condition from the health clinic at Maningrida. I am satisfied, however, that this was not the case. Records suggest that on 9 December 2010, the deceased presented to the Remote Area Nurse with groin pain and was prescribed Ibuprofen (to cease on 12 December 2010) and paracetamol. He was told to do light duties at work and to present the following week if the pain had not resolved. This presentation and prescription so close to the time he went into custody may be the source of his wife's confusion.

20. I note that prior to his incarceration, the deceased was employed in Maningrida by the building industry consortium, Territory Alliance, and he worked as a labourer building houses in the communities.

The health and care of the deceased whilst imprisoned

21. The deceased was taken into custody on 13 December 2010, and, in accordance with standard prison procedures, he went through a screening process that involved being seen by a nurse and then a medical officer.

22. I have had the benefit of reviewing the documentation that was completed by those staff members who saw the deceased. I am satisfied that standard testing revealed no physical or mental health problems. His blood pressure, temperature, pulse, heart rate and oxygen saturation levels were normal at that time. Importantly, the deceased told General Practitioner, Dr David Mathieson, that he had no concerns about prison and was not on any regular medication.

23. The deceased was housed in the LSU and his classification allowed him to be employed in the community in a range of public works.

The health and care of the deceased on 12 March 2011

24. On 12 March 2011, the deceased and fellow inmates left Berrimah Correction Centre at 7.00 am and went to work mowing lawns in the community.

25. Amongst the work party was Mr Lazarus Nabobobb, and he noticed that the deceased did not appear to be well that morning. The deceased was known to be a hard worker, but on this day he didn't seem to be normal - he wasn't working much, his body was tense and he had to sit down and drink some water. The work party finished around midday, had lunch and returned to the Correction Centre. The deceased told Mr Nabobobb that he was going to have a rest because he felt tired and unwell.

26. At around 2.30pm, the deceased approached the reception area of the LSU and told Prison Officer (PO) Vanessa Butterworth that he was in some pain, describing it as "on my head, my throat, my arms and my chest". Officer Butterworth then contacted Senior PO Wade, who called the Clinic and told nursing staff that the deceased was on his way.

27. Officer Michael Macpherson was told by PO Wade that the deceased had complained of chest pains and arm pains and he was instructed to transport the deceased to the medical clinic using the designated vehicle. PO

Macpherson did not note anything unusual about the appearance of the deceased at that stage, and he was able to get in and out of the vehicle unassisted.

28. After a short wait, the deceased was seen at the clinic by Registered Nurse (RN) Sharon Calgarett. The consultation lasted approximately 15 minutes, and to allow them some privacy PO Macpherson sat in the waiting room some distance away. Standard observations for blood pressure, temperature, heart rate and oxygen saturation levels revealed no cause for concern. Typed notes taken around the time of the consultation record the following:

> "Walked into the clinic with no ill effect
> Colour normal
> No SOB (shortness of breath)
> Nil nausea or distress
> c/o (complains of) frontal headlike flu symptoms
> c/o 'tingly skin' over right breast"

29. During the inquest, RN Calgarett gave evidence consistent with the contemporaneous computer notes she had taken. I was told that during his presentation, the deceased was gently rubbing his right chest area, prompting RN Calgarett to ask him if he suffered from chest pain. The deceased denied having chest pain, but described experiencing a tingling under the skin. Nurse Calgarett thought he was likely to be suffering from the flu, or perhaps shingles, both conditions that a number of other prisoners were suffering from. For a brief second opinion, she described the situation to her experienced colleague, RN Joanne Michel, who agreed with her view as to his likely condition.

30. There was nothing to prevent the nursing staff performing an electrocradiogram ("ECG") which is a diagnostic tool available at the Clinic for use in assessing the electrical and muscular functions of the heart.

RN Calgarett gave evidence that she did not consider it to be necessary in the case of the deceased. She would have performed an ECG if there was anything to make her suspicions that he suffered from a cardiac condition, for example, if he was cold or clammy, had shortness of breath, exhibited a grey pallor or complained of chest pains. However these symptoms were absent, and the deceased specifically denied having chest pain during the short period she saw him.

31. Before releasing the deceased, RN Calgarett tried to contact the general practitioner who was on call that weekend, Dr Carol Tainsch. Both she and RN Michel had tried several times that day to get in touch with her but she was not answering her phone. I heard evidence from Dr Tainsch that she had no memory now of what was the cause of the breakdown in communication. However in a report prepared by Dr Tony Faulkner, medical Director of SOS, he suggests that Dr Tainsch did not hear her phone for a period because it was on vibrate. At the time of this incident, Dr Tainsch had only been a locum doctor for the Darwin Correction Centre for one week, and since this was the first weekend she was on call, she was not familiar with arrangements.

32. Had she been able to speak with Dr Tainsch, RN Calgarett would have told her about the deceased's unusual presentation. It is possible that this may have prompted Dr Tainsch to suggest she perform an ECG, although it is at least equally possible that Dr Taisch would have done nothing different to RN Calgarett. In these circumstances, I am not able to say whether the failure of nursing staff to reach Dr Tainsch made any difference to the tragic outcome for the deceased. However it is entirely unsatisfactory that the after hours doctor could not be reached and given the number of locums relied on by both prisons in the Northern Territory, I intend to make a recommendation in relation to this issue.

33. At around 3.00 pm or 3.30 pm, RN Calgarett released the deceased to go back to the LSU, issuing him some Panadol and telling him to come and see her when she did the medical round between 8.00 pm and 9.00 pm that night.

34. Officer MacPherson did not notice any obvious symptoms of discomfort or illness during the short period he spent with the deceased transporting him from the Clinic. However, when he asked the deceased if he was feeling okay, the deceased replied that he had chest pains. Although it is regrettable that this information did not come out during the time he was examined at the Clinic, I am not critical of PO Macpherson for not taking further action at that stage, since the deceased had just been seen and cleared by Clinic staff and it was reasonable for him to think that they had taken a history from their patient and investigated any complaint.

35. Within two hours of returning from the clinic, at around 4.50 pm, another inmate, Yancy Ross, was returning to his cell when he noticed the deceased fall off a chair and land face down on the grass. He immediately attended to assist, and when he rolled the deceased over and saw that he was having difficulty breathing, he put him in a recovery position, located a pulse and called out to other inmates to get help from prison officers.

36. At around 4.58 pm inmate Glendon Mason contacted prison officers using the intercom. It appears that there was some technical problem with the intercom on that day and although prison officers knew that a prisoner from the LSU was trying to communicate with them, they didn't know what the message was. Nevertheless, four prison officers were immediately dispatched to the LSU and they arrived swiftly, calling a code blue at 5.00 pm to indicate a medical emergency. Prison officers immediately commenced CPR, while a response vehicle containing RN Calgarett and another prison officer from the medical section attended at 5.03 pm.

37. At 5.04 pm ambulance officers received the job. At 5.14pm the first ambulance crew arrived and a second paramedic crew arrived at 5.20 pm. Thus it appears that all prison, nursing and ambulance staff responded as promptly as they could do to the Code Blue emergency. They should be congratulated for doing so, as should prisoners Ross and Mason, who tried hard to help.

38. RN Calgarett was understandably very distressed by the incident and although she had already finished a full shift, RN Michel came back in to relieve her for the evening.

Conditions in the clinic

39. I heard evidence from two dedicated nurses working in the prison system. Both of them spoke of their very heavy work loads in March 2011, and of particular challenges on the day the deceased presented.

40. On weekend shifts, there was no medical officer physically present at the clinic but nursing staff had a telephone number for a doctor on call who they could get advise from. If a prisoner needed to see a doctor, they would have to be transferred to Royal Darwin Hospital. That is still the situation at the time these findings are published.

41. In March 2011, there were only two nurses working staggered shifts on Saturdays and Sundays. The morning shift started at 7.00 am and finished at 3.30 pm and the afternoon shift started at 12.00 pm and finished at 8.30 pm. Those nursing staff were expected to cater for the needs of in excess of 600 prisoners who might be housed at Berrimah Correction Centre at any point in time.

42. For a number of reasons, nursing staff were under particular pressure on 12 March when the deceased presented. First, there were two code Blue emergencies for RN Michel while she was performing her morning medication round. Second, the night before had been a particularly busy one

with around 20 new admissions so that the clinic had been left in a chaotic state, third, RN Michel was dealing with an acutely psychotic prisoner and fourth, as I outlined above, the on call doctor could not be reached, despite numerous messages left on her telephone. In her interview with police, RN Michel described the day as "just a disaster. Really".

43. RN Michel was so distressed by her working conditions and particularly by the events of that day, that she wrote a letter to her managers, signed by a number of the nursing staff. It dealt with a number of issues, including nurse to patient ratios, education and training and poor staff support. In her oral evidence, RN Michel described the letter as a cry for help.

44. On behalf of the family of the deceased, Mr Hunyor asked me to accept that there were inadequate numbers of nursing staff on weekend duty in March 2011, and that those poor staffing levels may have a connection to the tragic outcome for the deceased. He submitted that staffing was a "key factor in creating a high pressure environment" in the clinic on that day, and that this may have contributed to the failure of clinic staff to elicit information from the deceased about his chest pains. He also noted the evidence of RN Calgarett that after she responded to the Code Blue for the deceased, she did not use the defibrillator because she was the only trained health professional present, and further that she was unable to establish an IV entry point.

45. I accept the points made by Mr Hunyor, and I certainly accept that the pressures on nursing staff on 12 March were immense. It must be said, however, that in the circumstances of this case, even with more staff and less pressure clinic staff would probably have missed the gravity of the deceased's condition and the tragic outcome would probably have been the same. I am not able to reach a definitive conclusion about that issue.

46. I am both relieved and encouraged to hear that the number of nursing staff on weekend shifts has increased since March 2011. I was grateful for the evidence of Dr Tony Falconner and RN Michel, who spoke of recent efforts

to improve service delivery. I am satisfied that the best way to avoid deaths in the future is to continue to improve staff to patient ratios, thereby improving conditions for nurses and doctors who do such vital work in our prisons and I intend to make a recommendation that encourages those with the necessary expertise to review a number of staffing issues.

The Autopsy

47. I received into evidence an autopsy report completed by Dr Terence Sinton.

48. The significant findings from that report included:

    (i) Severe coronary artery disease, with significant atheromatous stenosis, and evidence of complete blockage of one of the major coronary arteries with old blood clot (coronary artery thrombosis).

    (ii) Abnormal enlargement of the heart (cardiac hypertrophy).

    (iii) Evidence of mild but chronic degenerative disease of the aortic valve in the heart, possibly producing some degree of clinical valve stenosis, and thus possibly contributing to (ii) above.

    (iv) Fluid accumulation in the lungs, consistent with acute heart failure.

49. Dr Sinton was able to conclude that the cause of the deceased's death was:

> "longstanding atheromatous coronary artery disease, the effects of this compounded by concurrent hypertrophic heart disease".

50. As I commented during the inquest, it appears that coronary heart disease is chronic amongst Aboriginal men in the Northern Territory. This community is losing far too many men, at far too young an age. Health researchers continue to highlight the fact that indigenous people in Australia have a life expectancy that is approximately 20 years less than that of non-indigenous people. A brief review of recent articles shows that chronic conditions like coronary heart disease are a major cause of premature deaths among adult Aboriginal Australians and that the rates of cardiovascular disease are much

higher in the indigenous population than in the non-indigenous. Prisoners have been identified as a specific risk group. No doubt the causes are complex, but I would welcome any Government health initiative in or outside the prison that attempted to address this heath issue.

Conclusion

51. I have carefully considered the quality and nature of the health care, supervision and treatment that the deceased received during the three months he was in custody from December 2010 to March 2011. I am satisfied that his death is not caused by a lack of care by any individual staff members and that there was no systemic failure that directly caused his death.

52. Nurses Calgarett and Michel impressed me as competent, truthful and compassionate. They were witnesses that cared about their patients and about improving conditions in the Clinic, particularly the staff to patient ratio.

53. In hindsight, of course, it would have been preferable for the deceased to be given an ECG test when he presented to the clinic on 12 March, but during the 15 minutes he was assessed, there were no obvious indicators of a cardiac condition that would have alerted RN Calgarett to the need for an ECG.

54. One issue that stands out is that shortly before he went to the Clinic, the deceased told prison officers that he had a pain the chest (as well as the arms and throughout his upper body). Further, only minutes after leaving the Clinic, while being transported back to the LSU, the deceased told PO Macpherson that he had a pain in the chest. It is possible that if nursing staff had had more time to spend trying to communicate with the deceased, or if they had been able to discuss his unusual presentation with the GP on call, or if they had access to an Aboriginal health worker to assist in their communications, the information with respect to chest pains would have

been forthcoming. That certainly would have prompted RN Calgarett to perform an ECG, where an abnormality with the heart would likely have been picked up.

55. As is often the case in a coronial inquest, even where no one is at fault, there are things that can be learnt from a tragedy. I intend to make recommendations that reflect what has been learnt from this sad loss.

56. It is a terrible sadness for the wife and children of the deceased that they have lost their husband and father so suddenly, when he was so young, and particularly when he was imprisoned away from home. During the inquest, Ms Bengerra Jones, through Counsel Assisting, told me that the deceased was a really good dad, and he was much loved by all of his six children. I was also told that he was much loved by his siblings – four sisters and one brother –and that although he was the youngest he is the first of them to pass away. He worked hard building houses in the community and he was obviously a skilful and resourceful man. His death is a great loss for the community as a whole, but most particularly for his family.

Recommendations

To the Northern Territory Department of Health

57. That the Department of Health review the appropriate staff to patient ratios and take into account best-practice in Australia when negotiating the contract for the provision of health services at Berrimah Correction Centre.

58. That in negotiating a new contract for the provision of health services, the Department of Health take into account the proposition agreed by Dr Falconer that the tender process should reflect the fact that the Northern Territory prison population is over 80% Aboriginal, a percentage of the population well known to have chronic health problems not experienced by the Caucasian population.

59. That the Department of Health implement a protocol between nursing staff and doctors so that after-hours nurses have a number of options to call doctors if the first one is not available (for example, first, call the on-call doctor at Darwin, secondly, the on-call doctor at Alice Springs, and thirdly, if necessary, the Medical Director of International SOS).

60. That the Department of Health make arrangements for the employment of Aboriginal health workers at Berrimah Correction Centre, to be on each shift to assist clinic staff.

Dated this 4th day of January 2012.

GREG CAVANAGH
TERRITORY CORONER