CITATION: Inquest into the death of Raymond (Kuminjay) McDonald [2015] NTMC 008

TITLE OF COURT:	Coroners Court
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HEARING DATE(s):	9 and 10 March 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, Death by natural causes, Treatment and care whilst in Custody**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Department of Correctional Services	Ben O'Loughlin
Family of the Deceased	Brianna Bell

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

No. D0015/2014

In the matter of an Inquest into the death of
RAYMOND (KUMINJAY) MCDONALD
ON 18 JANUARY 2014 AT DARWIN
CORRECTIONAL CENTRE, BERRIMAH
IN THE NORTHERN TERRITORY
OF AUSTRALIA

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Raymond McDonald was born in Darwin in the Northern Territory of Australia on 3 June 1965. He died on 18 January 2014 at only 49 years of age. Out of respect for the family and having regard to cultural practice, I will hereafter refer to the deceased as Kuminjay, with the exception of the formal findings.

2. At the time of his death Kuminjay was serving a sentence of twelve (12) years imprisonment with a non-parole period of 8 years at the Darwin Correctional Centre ("DCC") then located in Berrimah. He was not due for parole until 21 December 2014. He was housed in cell 10 of K-Block and shared that cell with Selwyn Nelson. Mr Nelson said good night to Kuminjay at about 7.30pm on Friday 17 January 2014. When he attempted to wake him the following morning, he was unable to do so and called for help. DCC officers and a nurse attended but discovered Kuminjay was deceased at approximately 8.40am on 18 January 2014.

3. Kuminjay's death was a "reportable death" because he was "in custody" of the Northern Territory Department of Correctional Services ("NTCS") when

he died. As a result, and pursuant to s15(1) of the *Act*, this Inquest is mandatory.

4. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Ben O'Loughlin was granted leave to appear on behalf of the Department of Health and Department of Correctional Services. Ms Brianna Bell appeared on behalf of the family of the deceased.

5. A total of fifteen (15) witnesses gave evidence before me, namely Senior Constable ("Snr Const.") Wayne Smith, Rosaleen McDonald, Prison Officer ("PO") Simon Bryant, PO Anthony Clarke, Registered Nurse ("RN") Linda Simmonds, Dr Terence Sinton, PO Michael Collins, PO Nicholas Chalkley, PO Matthew Ryder, PO Mark Osborne, PO Alan Dowler, PO Ashley Quinn, Dr Hugh Heggie, Dr Marcus Ilton and Superintendent ("Supt.") Grant Ballantine.

6. A brief of evidence containing various statements, together with numerous other reports, police documentation, NTCS file and all medical records for Kuminjay were tendered into evidence (exhibit 2). The death was investigated by Snr Const. Wayne Smith and I thank him for his assistance.

7. Pursuant to s.34 of the *Act*, I am required to make the following findings if possible:

    (i) The identity of the deceased person;

    (ii) The time and place of death;

    (iii) The cause of death;

    (iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*"; and

    (v) Any relevant circumstances concerning the death.

8. I note that section 34(2) of the *Act* also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 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.
>
> (3) A Coroner shall report to the Commissioner of police and Director of Public Prosecutions appointed under the *Director of Public Prosecutions Act* if the Coroner believes that a crime may have been committed in connection with a death or disaster investigated by the Coroner"

9. Additionally, where there has been a death in custody, section 26 of the *Act* provides as follows:

> "(1) Where a Coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the Coroner –
>
> a. Must investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and
>
> b. May investigate and report on the matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A Coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody must make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant"

Background

10. Kuminjay was born in Darwin in the Northern Territory to Violet Nagamara and Alan Jabaldjari McDonald who are both now deceased. He spent his childhood at Ali Curung and attended school there before moving to Yirara College in Alice Springs. It is unknown precisely what year level he reached at school, but he had a basic level of reading and writing skills. When he finished school he returned to live with his family in Ali Curung. The only other education he received was at Batchelor College when he trained to be a motor mechanic. He was known to work sporadically during his early adult life as a motor mechanic, stockman and carpenter.

11. Growing up as a child Kuminjay was reported as suffering from a "personality disorder" making him prone to temper tantrums and aggressive outbursts. He suffered from auditory hallucinations and his family recall he had "Casper the Friendly Ghost" as an imaginary friend. He reported that he would hear voices telling him to hurt people. He was initially diagnosed as psychotic and then eventually as suffering from schizophrenia. He would receive regular anti-psychotic injections within the community when he was not incarcerated.

12. In addition to his mental health issues, Kuminjay also suffered a number of physical health problems. As a child he had his left kidney removed and suffered "chest related" problems. His medical records set out that he suffered from the following conditions:

12.1 Chronic alcohol abuse;

12.2 Head injury;

12.3 Latent tuberculosis, which meant he was infected with tuberculosis but did not have the disease;

12.4 Chronic otitis media, which is a term used to describe inflammation of the middle ear; and

12.5 Helicobacter pylori infection which caused gastritis and oesophagitis.

13. Kuminjay's involvement with the law and the detention/prison system commenced early in his life. After leaving school he was reported to drink excessive amounts of alcohol often leading to involvement with authorities. He later went on to abuse other substances such as marijuana and solvents, particularly petrol.

14. At fifteen (15) years of age, Kuminjay was convicted of indecent assault and breaking and entering. He was subsequently placed into the care of the 'Director' until he was seventeen (17) years old. During this time he lived at 'Giles House' and is reported as living with foster carers. Thereafter he was known to live between Ali Curung, Tennant Creek and Alice Springs and in this period he married twice and had a daughter to his second wife however his daughter's identity is unknown.

15. Between 1982 and his death, Kuminjay spent the majority of his life in prison for 'sexual' related offending:

15.1 On 10 December 1982, he was convicted of three counts of indecent assault and sentenced to 18 months imprisonment, released on a good behaviour bond after serving 6 months;

15.2 On 29 April 1986, he was convicted of two counts of assault and sentenced to eighteen (18) months imprisonment, with a non-parole period of ten (10) months;

15.3 On 13 April 1989, he was convicted of one count of aggravated sexual assault and one count of sexual assault with intent to have carnal knowledge. Kuminjay was sentenced to 4 years imprisonment on the aggravated sexual assault and 12 months imprisonment on the sexual assault. These sentences were ordered to be cumulative upon one another and he received a non-parole period of 2 years.

15.4 On 26 November 1993, he was convicted of assault with intent to have carnal knowledge and sentenced to imprisonment for four (4) years with a non-parole period of 2 years.

15.5 Finally on 4 December 2006, he was convicted of one count of sexual intercourse without consent and was sentenced to twelve (12) years imprisonment, with a non-parole period of eight (8) years. The offence had been committed in Tennant Creek on 16 May 2006 and he had been in custody since his arrest on 21 June 2006. He was initially incarcerated at Alice Springs Correctional Centre ("ASCC") but later transferred to the DCC. It was this sentence that he was serving when he passed away.

Medical attention following incarceration

16. Whilst incarcerated, Kuminjay continued to receive medication and treatment for schizophrenia. He received an intramuscular injection of an antipsychotic drug every two (2) weeks. From time to time his medication was changed and he was seen by a visiting psychiatrist at the prison. In terms of his mental health; Kuminjay was declared 'at risk' on six (6) separate occasions between 5 July 2006 and 27 December 2011.

17. Kuminjay was also a regular visitor to the medical clinic at the DCC for various complaints. As a result of such attendances he was seen by cardiologist, Dr Gregory Chacko, on 10 August 2010 at the Darwin Private Hospital. This examination revealed that Kuminjay had frequent ventricular

ectopics with a structurally normal heart, i.e. extra heart beats from time to time but no evidence of heart disease. There was no evidence at that time of significant arrhythmia, i.e. irregular heartbeat.

18. Between 19 December 2011 and 2 January 2013, Kuminjay also presented to the medical clinic at the DCC on at least sixteen (16) separate occasions complaining of 'chest pains'. In that same period he completed twelve (12) electrocardiogram ("ECG") tests with results varying from those that were "unremarkable" to those indicating that he had a prolonged corrected QT interval.

19. I received evidence that a QT interval is a measure of the heart muscle recovery after each contraction. When the QTc is long, different segments of the heart may recover at different rates making fast ventricular rhythms more likely. The normal QTc interval in males is less than 450 per millisecond. One of Kuminjay's ECG's recorded an interval of 510 per millisecond. According to the evidence of Dr Marcus Ilton, Kuminjay's QTc interval was (tp.52.9):

> "… slightly or lightly increased in lengths. So the normal range for a male would be up to 450 milliseconds. So certainly up to 5 − or below 500 it's regarded as a mild prolongation, 500 milliseconds".

20. A prolonged QTc interval places a person at high risk of ventricular arrhythmias, i.e. an irregular heartbeat. However, as was noted by Dr Ilton, a prolonged QTc interval can occur in the general population with 13 different genetic inherited forms and with certain diseases and medications. It does not therefore mean that automatically death will result, merely an increased *risk* of arrhythmia.

21. During this period of time Kuminjay's blood pressure also varied from 119/61 to 168/120 and his resting heart rate varied from 40bpm to 78bpm. Treatment ranged from administering antacid medication to referrals for further tests. Between 8 and 21 May 2012 Kuminjay complained of fainting

episodes; however the cause was never identified. During this period his blood pressure was recorded at 135/90.

22. On 24 October 2013, Kuminjay's ECG results showed prolonged QTc and on 4 November 2013, he presented to medical staff complaining of chest pains. It was during this consultation that Kuminjay's blood pressure was recorded at 168/120, which is extremely high. He was attended upon at the time by an aboriginal health practitioner who noted in the records that Kuminjay refused treatment from a doctor and stated that he "didn't care" if he had a heart attack. I will return to this aspect later in these findings.

23. On 11 December 2013, Kuminjay presented to medical staff complaining of chest pains, however during the consultation he appeared well and the decision was made to administer Gastrogel, an antacid medication. I note however that another ECG was conducted on that date which was abnormal and his blood pressure was recorded at 160/76, which is again extremely high. A further ECG was undertaken on 2 January 2014 and this was also abnormal, noting a "prolonged QT interval" with a QTc of 510. His blood pressure was 141/71.

Events leading up to discovery of the deceased

24. As previously noted, at the time of his death Kuminjay was incarcerated at the DCC and housed in cell 10 of K-block. Prior to the closure of DCC at Berrimah, K-block was a 'medium' security block located within the main prison facility. Kuminjay shared this cell with another prisoner, namely Selwyn Nelson. Mr Nelson has since been released and is no longer a prisoner in Darwin. Attempts were made by police to locate him but they were unsuccessful. However, a recorded statement had been taken from him by police hours after the discovery of the death and this was played into evidence during the course of the inquest.

25. Mr Nelson outlined that he and Kuminjay had known each other since they were children. In fact Kuminjay was Mr Nelson's uncle. They had shared a cell with one another for approximately 4 months. I note there were no recorded incidents between them and it appears from all the evidence that they got along well. Prison records for Friday 17 January 2014 reveal that Kuminjay left K-block at approximately 9.10am to attend the education building. He returned sometime later and between 10.29am and 3.00pm was seen walking around K-block. He later played a game of cards inside cell 8 with a group of other prisoners. This particular card game required the prisoner's to gamble their personal food items. Kuminjay lost all his food early, so he sat-out, not playing for a period of the game.

26. I received a copy of the statements of each of the prisoners involved in that game. With the exception of one, each reported that the entire group, including Kuminjay, were all laughing and generally having fun. I am satisfied on the evidence that Kuminjay was generally in good spirits and at one stage was seen dancing in front of the group. I do not find there was any indication that he was unwell or unhappy.

27. At the end of the card game, one of the other prisoners gave Kuminjay some noodles, tuna and a packet of soup because he was hungry and had lost all his food. It is believed he ate these inside his cell. At 3.00pm K-block was routinely 'locked down', which means all prisoners returned to their respective cells. Kuminjay and Mr Nelson were therefore 'locked down' together in cell 10. Mr Nelson stated that after lock down, he and Kuminjay talked about Tennant Creek, Alice Springs and Ali Curung. Kuminjay also spoke about getting out on parole in the future. There were no issues reported between them.

28. Supper was served and Mr Nelson recalled that Kuminjay only ate a small amount, complaining he was too full, but he saw him drink some tea. At approximately 7.30pm Mr Nelson recalled saying good night to Kuminjay

and going to bed. Mr Nelson slept on the top bunk directly above Kuminjay and recalled lying in bed and listening to music on his head phones. He saw Kuminjay use the toilet on two (2) occasions and return to bed. At about midnight or 1.00am Mr Nelson turned off his radio, put it away and went to sleep. Mr Nelson did not hear or see anything unusual that night; however I note that he also described himself as hard of hearing.

29. Mr Nelson recalled waking at approximately 7.00am on Saturday 18 January 2014when one of the prison officers "called out" to "wake up". He got up, made his bed and had a cup of tea. He noted that Kuminjay was still in bed but he thought he "might get up late". When Mr Nelson heard the medical staff coming around for the medication run he tried to wake Kuminjay by voice and touching his shoulder. When he was unable to wake Kuminjay, he "sang out" for the "boss" to help.

Action taken by prison and medical clinic staff

30. Prison Officer ("PO") Simon Bryant was the officer who heard Mr Nelson call out and he gave evidence before me. He recalled entering into K Block with a nurse and another prison officer just after 8.30am. A short while later he heard Mr Nelson call out for "boss". He went over to the cell door and saw Mr Nelson standing over Kuminjay "shaking him" and saying "he won't wake up". PO Bryant got the attention of the nurse on the medical rounds, namely RN Linda Simmonds. He then unlocked the cell door and saw RN Simmonds check for a pulse.

31. PO Bryant stated that whilst the nurse was checking on Kuminjay, he was looking around the cell "for any foul play, for any weapons or anything for self harm". He did not notice anything out of the ordinary. He then recalled the nurse saying that Kuminjay was dead and advised him to call a Code Blue, which is a call for a medical emergency. PO Bryant went to the office and advised the block officer who called the code. He returned to the cell and was present when the response team and ambulance officers attended.

32. RN Linda Simmonds also gave evidence. She recalled entering into K Block at approximately 8.30am and being "gestured" by PO Bryant to "rush from the other side of the block to (Kuminjay's) cell". She too recalled Mr Nelson saying he could not wake Kuminjay. She stated that she entered the cell and checked for a pulse, but was unable to locate one. She noted Kuminjay felt "cold", "full rigor mortis had set in" and he had "evacuated his bladder onto the bed". There was "no chest expansion, there was no breathing". She noted no injuries on Kuminjay's body and she recalled that his "cell mate", Mr Nelson, appeared to be "quite shocked and horrified by what had happened".

33. PO Anthony Clarke was the only other officer immediately at the scene when the cell was first opened. He had been escorting RN Simmonds on the medical rounds. His evidence accorded with that of PO Bryant and RN Simmonds as to how events unfolded. I accept their evidence.

Cause of Death

34. An autopsy was undertaken by Dr Terence Sinton on 20 January 2014. His report was tendered into evidence as part of exhibit 2 and Dr Sinton also gave evidence before me. Dr Sinton carefully viewed the body of Kuminjay and stated that there were no signs of any recent injury upon the skin. There was also no evidence of soft tissue or bony injury upon the body. He noted specifically that the skull and bony skeleton were "intact, with no evidence for any recent bony trauma".

35. Dr Sinton's significant findings at autopsy were as follows:

> "(i) A Body Mass Index (BMI) calculated at 33, consistent with the deceased being mildly overweight.
>
> (ii) An abnormally enlarged heart (cardiac hypertrophy) of uncertain origin.
>
> (iii) Fluid accumulation in the lungs, consistent with acute heart failure.

(iv) Evidence of past inflammatory and vascular damage to the right kidney (chronic glomerulonephritis) of sufficient severity to have caused some degree of chronic renal failure.

(v) Absence of the left kidney, likely the result of past surgical intervention".

36. Dr Sinton expressed his opinion that Kuminjay died as a result of longstanding heart disease, i.e. cardiac hypertrophy. The effect of this was compounded by chronic renal failure, i.e. chronic glomerulonephritis. I accept these findings. I note that Dr Ilton expressed the opinion that Kuminjay suffered a ventricular arrhythmia or sudden cardiac death. Dr Ilton stated that the findings from Dr Sinton's autopsy demonstrated there was no evidence of acute heart attack, but there was left ventricular hypertrophy and evidence of congestive oedema in the lungs which was consistent with a ventricular arrhythmia causing death.

37. When asked about Dr Ilton's report, Dr Sinton stated that in fact he was "staggered by the concurrence of all three reports" provided by himself, Dr Ilton and Dr Heggie and he saw "no points of dissent". He agreed that all three medical professionals appeared to support the finding that Kuminjay's death was heart related. I note that Dr Heggie also indicated there was no evidence that Kuminjay died from an "acute coronary event", but it was possible that he had developed a "sinister cardiac arrhythmia leading to an electrical cardiac arrest".

38. I find, on balance, that Kuminjay died as a result of cardiac hypertrophy, i.e. long standing heart disease.

Issues for consideration

39. Because this was a death in custody, section 26(1) of the *Coroner's Act* requires that I investigate and report on the care, supervision and treatment

of Kuminjay whilst in custody and any matters that caused or contributed to his death. In this regard I considered carefully the following matters:

39.1 The standard of care provided by NTCS staff during Kuminjay's incarceration;

39.2 Whether there was any evidence of any foul play which contributed to this death;

39.3 Whether Kuminjay's health issues were properly being investigated by medical staff during his period of incarceration.

The standard of care provided by NTCS staff during Kuminjay's incarceration

40. Kuminjay had been a prisoner at the DCC for a number of years following his transfer from ASCC. He was well known to both prison and clinic staff as a prisoner who regularly attended at the clinic. I found no evidence however to indicate that such regular attendances impacted upon the promptness of NTCS staff to attend to the needs of Kuminjay.

41. One of the issues that did concern me initially in this inquest was the regularity and appropriateness of bed counts during the evening shift. I had tendered into evidence a copy of the "Darwin Correctional Centre, Standard Operating Procedure 9.10" ("SOP 9.10") as issued on 8 February 2013 and in place at the time of this death. It is a directive to ensure counts and checks are conducted of prisoners during all shifts.

42. It makes provision for form and informal counts to occur and in relation to "Nightshift Counts", the following is specified (see 5.10):

> "Officers on Night shift are required to conduct a minimum of 5 full body counts per shift at intervals not exceeding 2 to 3 hours in between".

43. In relation to how these are conducted, the directive goes on to state:

> "These body counts are to be conducted in a manner that ensures where practicable, that prisoners are not deprived of sleep;
>
> When sighting a prisoner during a body count, officers involved must be convinced beyond any doubt, that they have actually sighted a reasonable part or parts of a prisoner's body and that, in doing so, there is detected evidence of body movement or some other sign of life, in order to account for that prisoner's presence;
>
> If there is any doubt as to a prisoner's presence or condition an officer is to knock loudly enough to cause the inmate to stir and request the inmate to respond that he/she is ok;
>
> If there is no response from the prisoner the SPO is to be called to open the cell with 2 other officers present to ascertain the prisoner's condition".

44. I received evidence from each of the prison officers who performed the body counts during the relevant night shift from 7.30pm on Friday 17 January to 7.30am on Saturday 18 January 2014. In accordance with the SOP 9.10 there should have been 5 counts conducted during that shift. It is apparent from their evidence that only 4 counts were conducted during that shift being as follows:

1. First round starting at approximately 1930hrs and completed at approximately 2200hrs;

2. Second round starting at approximately 0030hrs and completed at approximately 0110hrs;

3. Third round starting at approximately 0325hrs and completed at approximately 0405hrs;

4. Fourth round starting at approximately 0545hrs and completed at approximately 0640hrs

45. I also had a copy of the relevant page from the "Journal" for K Block tendered into evidence and it showed the recording of the counts for K block as occurring at 2041hrs, 0100hrs, 0400hrs and 0558hrs. As can be seen, this

means that there was no compliance with SOP 9.10 in relation to "intervals not exceeding 2 to 3 hours". In addition there was no reference to compliance with the requirement that there be "evidence of body movement or some other sign of life" detected.

46. I note that each officer on duty during that shift openly and frankly admitted that this was the case and agreed that they did not comply with the provisions of the SOP. I do however note the evidence of Senior Prison Officer ("SPO") Michael Collins who identified that there had been a large number of new prisoners received into the prison during that shift. In addition there was another prisoner who required medical assistance and staff were required to move him to the clinic for treatment. He stated it was not usual for there to be the sort of delay that had occurred between the first and second count and the other officers involved agreed with this evidence.

47. In terms of the purpose of the security and body count directive, SPO Collins stated that it was his understanding that the purpose was (tp.39.9):

> "… to see the prisoners, to see that the doors are – the locks are intact, the security is intact, the prisoner is present".

48. During the course of the evidence I had the following exchange with SPO Collins (tp.40.2):

> "THE CORONER: Prison Officer, these checks, seems to me, are more for security purposes than anything else; make sure prisoners aren't playing up or getting up to no good and they're not trying to escape and that they're still in their cells, securely housed. Is that right?---Yes, sir.
>
> That's what I thought. It's not so much to see whether they're sick or not, because you don't get close enough to see that, do you?---No, sir. And they have – and they have the intercom.
>
> They have the intercom inside - - -?---Yeah.
>
> - - - if they need to call for help?---We get – we get a lot calls during the night to go and attend to prisoners and it might be nothing or it

might be that it is a medical problem that we would call and mention - - -

I'm just trying to get a handle on the real reason why we have these two-hourly or three-hourly checks of prisoners?---To make sure they're there, sir, yes.

To make sure they're there?---Yes, that's right.

That's right, that is to say, make sure they're not playing up and not trying to escape or make sure they haven't escaped?---Yes."

49. Again, each of the other prison officers involved agreed with this evidence.

50. On the issue of the requirement of checking for "bodily movement" or "signs of life", I also note the evidence of PO Anthony Clark, who stated that when the SOP first came out it was followed closely, but there were then a number of complaints from prisoners about "getting woken up". As a result, the practice changed and he stated (tp.18.8):

> "Yeah, it was just to make sure they were there and it was just a visual observation, no (waking)".

51. Importantly, I note that SOP 9.10 sets out its "Directive" as:

> "1.1 To ensure that the ***security*** of Darwin Correctional Centre is not compromised, formal and informal counts and checks will take place during all shifts" (my emphasis added).

52. It goes on to identify its "Purpose" as:

> "2.1 To ensure around the clock ***accountability*** of all prisoners in lawful custody at Darwin Correctional Centre.
>
> 2.2 To limit the chances of ***escape*** or ***self harm*** by prisoners.
>
> 2.3 To detect any ***absence*** of prisoners from their approved place of work or accommodation area" (my emphasis added).

53. It appears clear, and in accordance with the evidence of the prison officers themselves; that the purpose (and therefore emphasis) of the SOP for the body count is to ensure security rather than to assess the medical health of

the prisoner. I accept there is reference to the issue of self harm but I note that there is constant assessment of prisoners by prison officers (and medical staff) of this issue at all times. I also note there is no evidence to suggest self harm in this case and I therefore say nothing further on this issue.

54. Whilst I cannot be satisfied about when precisely Kuminjay passed away, given that he was in a state of full rigor mortis at the time of his discovery at approximately 8.40am, it appears that he had been deceased for a number of hours and was therefore not alive during a number of the relevant body counts. I do find however that it appears that even if it was discovered quickly that he was not breathing by either his cell mate or the prison officers involved that this is not likely to have had any significant impact upon the unfortunate outcome of his death.

55. I make this finding on the basis of the evidence of Dr Ilton who set out within his report that:

> "… in the setting of a ventricular arrhythmia it is likely he would have either become unconscious within 3-5 seconds or if he had been asleep not actually regained consciousness and therefore unable to alert his cell mate".

56. Dr Ilton also went on to note:

> "In regards to any specific treatment for the cardiac arrest, the only way he could have been saved would have been if he was on a cardiac monitor at the time of the onset of arrhythmia with staff or inmate able to at least perform basic life support and then access to staff with advanced life support and cardiac defibrillators to restore sinus rhythm. Obviously in this setting this was not possible and there was no prior indication to warrant heart monitoring".

57. I therefore find that whilst there was failure to comply with the SOP 9.10 on this occasion; it did not contribute to this death. I also find that the care and treatment provided by NTCS staff to Kuminjay McDonald was appropriate in all the circumstances and I make no criticism.

58. During the course of this inquest, and because of the relevance of SOP 9.10, I had tendered into evidence a statutory declaration from Commissioner Kenneth Middlebrook addressing the issue of night shift counts (exhibit 9). Commissioner Middlebrook's statement noted the commencement of night shift counts in the 1970's and their formalisation in the 1990's. Commissioner Middlebrook noted the "changes" in the Northern Territory prison system since then, particularly detailing:

58.1 Incorporation of the intercom system into every prison cell;

58.2 The fact that 75% of prison cells have more than one prisoner in them making it "more likely that correctional officers will be notified if there is an incident"

58.3 Increased training for correctional officers to identify "at risk" prisoners; and

58.4 Increased return to work programs meaning prisoners are more likely to "want or need" a full night's sleep.

59. Commissioner Middlebrook also noted that current interstate practices were as follows:

59.1 Victoria, New South Wales and the ACT do not check prisoners that are not on special observation after lock down;

59.2 Queensland were in the process of reviewing their night headcounts, but presently perform 4 head counts per night; and

59.3 South Australia required intervals not exceeding 2 hours.

60. Commissioner Middlebrook reported it was his view that night time body checks and safety checks "should no longer form part of the Standard Operating Procedures". As a result a re-draft of procedure had been prepared removing their requirement. It is clear that close consideration has

been given by Commissioner Middlebrook to this issue over a period of time. Given his skills and experience he is the person appropriately qualified to make such assessments and changes should he consider them necessary and I make no criticism of his decision in this regard. As stated previously, I find that any failure to comply with the SOP 9.10 on this occasion did not contribute to this death and I therefore say nothing further on this issue.

Whether there was any evidence of any foul play which contributed to this death

61. As set out earlier in these findings, PO Bryant stated that whilst the nurse was checking on Kuminjay, he was looking around the cell "for any foul play, for any weapons or anything for self harm". He did not notice anything out of the ordinary. There were no signs of a struggle within the cell itself. RN Simmonds also noted no injuries on Kuminjay's body and recalled that Mr Nelson appeared "quite shocked and horrified by what had happened".

62. I also had the statement of Snr Const. Tim Sandry tendered into evidence before me as part of exhibit 2. Snr Const. Sandry is a long standing, extremely qualified, crime scene investigator and forensic officer. His statement outlined the examination that he undertook of the scene and of the deceased. Photographs of the cell and of the deceased in situ were also attached to his statement. Snr Const. Sandry carried out a careful examination of Kuminjay's body whilst it was still in the cell and he noted no recent injuries to "the back and lower leg area", or to "the skull and scalp area". Snr Const. Sandry also rolled the body of the deceased over and again he noted no visible injuries. I note that these findings are consistent with those made by Dr Sinton during the course of his autopsy.

63. During his statement to police, Mr Nelson stated that he thought he saw blood on Kuminjay's pillow. In this regard I note that RN Simmonds stated that she did a close examination of Kuminjay and found no evidence of any

blood on his pillow or from his nose. Likewise there is no reference to such an important forensic finding within Snr Const. Sandry's statement. I also note that Dr Sinton was specifically asked about the suggestion of blood on Kuminjay's pillow and he stated as follows (tp.32.3):

> "MS TRUMAN: His Honour's received some evidence that's caused the family a little bit of concern and that is that one person thinks they may have seen some blood on his pillow when he was first discovered in his cell. Do you carry out any examination of the nasal passages, or that area, during the course of an autopsy?---We always look externally and internally in all those cavities around the throat and the mouth, yes.
>
> And you said you always do that?---Yes.
>
> In terms of your findings with Kuminjay, did you find any evidence of blood or any injury in his nasal cavities?---None in the nasal cavity, or in the mouth or in the throat".

64. I find that it is more likely than not that in his state of shock at finding his relative deceased; Mr Nelson simply made a mistake as to what he believed he saw. I find that there is no evidence of any foul play that contributed to this death.

<u>Whether Kuminjay's health issues were properly being investigated by medical staff during his period of incarceration</u>

65. As noted previously, Kuminjay was seen regularly at the clinic and also daily on the medication rounds. RN Simmonds indicated that she recalled seeing Kuminjay at least every 3 to 4 days on average at the clinic. According to the records, between 19 December 2011 and 2 January 2013, Kuminjay presented to the medical clinic at the DCC on sixteen (16) separate occasions complaining of 'chest pains'. RN Simmonds stated that it was her opinion that on some of these occasions Kuminjay was "crying wolf" as he knew that in making such a complaint it would mean he would be sent to the clinic and "break up his day". On those occasions, despite his complaint, he would attend at the clinic "with a big smile on his face".

66. Whilst initially I was concerned with such a description I accept the evidence given by RN Simmonds that whilst there were occasions where doubt was held as to the veracity of Kuminjay's complaints, he was always attended upon appropriately and not simply ignored or fobbed off by the clinic staff. This is seen by the medical records themselves and also the number of ECG tests that were undertaken in that same period. RN Simmonds also stated that although Kuminjay may have shown no signs of any actual medical issues, his complaints were taken seriously on each and every occasion and the protocols set out in the CARPA ("Central Australian Rural Practitioners Association") Manual were followed. I note that Dr Heggie also gave evidence that it was his opinion, after reviewing all the clinic records, that all protocols pursuant to CARPA were followed during each attendance at the clinic. I accept this evidence.

67. During the course of the evidence I was concerned as to whether more could, or should, have been done given the numerous attendances at the clinic and the results of the ECG tests showing changes and a prolonged QTc level. I was also concerned by the evidence relating to events on 4 November 2013, when Kuminjay presented to medical staff at the clinic complaining of chest pains. This was the consultation when Kuminjay's blood pressure was recorded at 168/120 and although concern was raised with him as to the risk of heart attack, the notation by the aboriginal health practitioner was that Kuminjay refused treatment from a doctor and stated that he "didn't care" if he had a heart attack.

68. Dealing firstly with the issue of refusal to see a doctor for further treatment, I note the evidence of RN Simmonds that (tp.26.7):

> "Every client has a right to refuse medical treatment, including their medications. All we can do is make note of the fact that they presented in clinic with a complaint and refused to attend, to the end of their consult".

69. RN Simmonds did go on to note however that more often than not the prisoner will listen to the advice that is being given (tp.26.9):

> "THE CORONER: But do I take it, that if they were there with acute serious health problems, you wouldn't send them back to the - - -?---Absolutely not, if - - -
>
> - - - you'd either send them to hospital or keep them in the clinic?---Absolutely, if they present and all indications are they are having an event - - -
>
> They're really sick?--- - - - then we – we can – all we can do is encourage them to stay, tell them we need to go to hospital and generally, they listen to use, when we tell they're really sick and they need to stay, they listen.
>
> And in what circumstances, if any, okay, would you refer someone for an assessment of their capacity to be making?---If they presented to me with disorganised thinking, if they were hearing auditory hallucinations, anything that's – anything to me that is not quite right in regards to normal behaviour. I have – do many mental health referrals for clients and has to do with how they present and how they behave in front of me to decide whether I'm going to refer them or not.
>
> Would you ever request the block officers to keep an eye on somebody after they left the clinic?---No, if someone needs observational time, whether it be 15 or half hourly observations, they're kept in clinic.
>
> Did you ever do that for Kuminjay?---No".

70. Dr Heggie was also questioned about this refusal and stated that health providers "can't inflict … investigations or treatments" on patients. He stated that if a prisoner refused treatment, he would expect his clinic staff to (tp.64.3):

> "It's mostly negotiating in a meaningful way, talking to the patient, talking to Kuminjay about what the blood pressure is. And I regularly talk to clients using car tyre pressure as a good example and a car tyre pressure of 30 is normal. A car tyre pressure of 50 is not normal and a tyre pressure of 80 is seriously abnormal. And so it's about proving the client with health literacy to understand what the issue is, what the implications for that issue would be, both short

> and long-term. But in the end, providing the information in a non-judgmental way, in a meaningful way. And we do have Aboriginal health practitioners who work in the health centre and at the time Kuminjay was there there was an Aboriginal health worker who can speak Arrernte and (inaudible). And so we can sometimes provide also health literacy through the use of language".

71. Dr Heggie also gave evidence that he did not expect staff to place the prisoner "at risk" in such circumstances. He stated (tp.64.6):

> "It depends what you mean at risk, number one. At risk in the prison setting is (inaudible) I've worked at the prison, is − that's quite − a number of different meanings. It certainly has a meaning in terms of self harm. It certainly has a meaning if the person is acutely unwell. But no, this definitely would not have been at risk. The blood pressure was elevated at a level where it was not immediately dangerous. But in the long term, and I'm talking about five or 10 or 15 years of sustained blood pressure readings of that level, could lead to as the cardiologist described, a thickening of the heart muscle which makes the heart muscle stiff and it doesn't function as well and that leads to other problems. And also can lead to (inaudible) potentially renal impairment. But there was no evidence of that".

72. Dr Heggie was also asked what circumstances he would expect clinic staff to be sending a prisoner, who was refusing medical treatment, for a mental health assessment of their capacity to make a decision and he stated (tp.65.1):

> "You can − and this is done in the Corrections environment as in other primary care environments, you can use a cognitive assessment tool. There is one that is called KICA which is developed by the Kimberley Health Board that is used for Aboriginal people to measure their cognitive function. There was no evidence of cognitive impairment in terms of his decision making in other domains. And you don't have isolated cognitive impairment just about your health or your medications. It's a global problem or a problem with all of your functions in your life about making decisions about functioning in the place where you live, relationships, communication".

73. In relation to the issue of the numerous attendances at the clinic and the ECG results showing changes in the QTc level, I note that both Dr Ilton and Dr Heggie considered a further cardiac evaluation would have been

beneficial and should have occurred. Dr Ilton stated within his report (at para.8(g)):

> "In the presence of ECG's demonstrating long QTc a further cardiac evaluation would have been beneficial with repeat echocardiogram helping confirm development of left ventricular hypertrophy secondary to high blood pressure. This would provide further evidence for the importance of treatment for his blood pressure including beta blockers which would have reduced the risk of this event happening ***but not preventing this fully***" (my emphasis added).

74. As Dr Ilton stated in his evidence before me however that the introduction of beta blockers (tp.59.2):

> "… may have reduced the risk of this event happening but would not have stopped it".

He went on to note:

> "But there's actually no guarantee that that (i.e. the beta blockers) would have prevented this from happening"

75. Dr Ilton set out two recommendations within his report as a result of this death and I consider it appropriate that there be recommendations made along the lines of those identified by Dr Ilton and I will do so.

76. I consider it important to note however, just as I have in previous inquests, that there are a significant number of deaths reported to me each year involving unexpected heart failure where the deceased has had no pre-existing symptomology and has died extremely suddenly and with little to no warning. As a result, I am not satisfied that further evaluation by a cardiologist or further cardiac screening would have necessarily resulted in any change in treatment for Kuminjay or avoided the unfortunate outcome of his death. I consider the care and treatment provided by the medical staff at the clinic to have been appropriate in all the circumstances. I do however find that, where possible, further cardiac evaluations and screening should occur in the circumstances identified by Dr Ilton.

Findings

77. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

i. The identity of the deceased person was Raymond McDonald who was born on 3 June 1965 in Darwin in the Northern Territory of Australia.

ii. The time and place of death was sometime between 7.30pm on 17 January 2014 and 7.00am on 18 January 2014 at the Darwin Correctional Centre at Berrimah.

iii. The cause of death was cardiac hypertrophy.

iv. Particulars required to register the death:

a. The deceased's full name was Raymond McDonald.

b. The deceased was of Aboriginal descent.

c. The death was reported to the Coroner.

d. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 20 January 2014.

e. The deceased's mother was Violet Nagamara and Alan Jabaldjari McDonald who are both now deceased.

f. At the time of his death, the deceased was a sentenced prisoner incarcerated at the Darwin Correctional Centre in the Northern Territory of Australia.

Recommendations

78. That the Northern Territory Department of Health ensure that all prisoners with electrocardiograms ("ECG's") developing prolonged QTc intervals should be referred for further cardiac evaluation by a cardiologist.

79. That the Northern Territory Department of Health ensure that all prisoners with recurrent chest pains, even those considered atypical, be referred for further cardiac screening and risk stratification.

Dated this 13th day of April 2015.

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GREG CAVANAGH
TERRITORY CORONER