CITATION: *Inquest into the death of Yanabilnga Dhubururr Li Gaykamangu aka Francis Gaykamangu* [2014] NTMC 023

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0020/2012
DELIVERED ON:	3 November 2014
DELIVERED AT:	Darwin
HEARING DATE(s):	13 May 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death of young Aboriginal man from coronary artery disease; early recognition/diagnosis of coronary artery disease in young Aboriginal people in particular; connected to Findings in the associated inquest of Dion Daniels**

REPRESENTATION:

Counsel Assisting:	Mr Mark Thomas
Department of Health:	Mr Greg McDonald
Family of the Deceased:	Mr Jared Clow

Judgment category classification:	B
Judgement ID number:	[2014] NTMC 023
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IN THE CORONERS COURT
AT DARWIN IN THE
NORTHERN TERRITORY OF
AUSTRALIA

No. D0020/2012

In the matter of an Inquest into the death of
YANABILNGA DHUBURURR LI GAYKAMANGU aka FRANCIS GAYKAMANGU
ON 29 JANUARY, 2012
AT GAPUWIYAK HEALTH CLINIC

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. On Sunday 29 January 2012 Mr Gaykamangu played a game of Australian Rules football at the oval at Gapuwiyak. At the conclusion of the game he complained of shortness of breath. He was a fit looking young man with no previous documented cardiac history. He went home and remained short of breath. A relative went to the medical clinic, which was across the road from Mr Gaykamangu's house, and sought help from the clinic. Registered nurse Mr Chris Leonard walked to the house, saw Mr Gaykamangu, and requested that he come to the clinic. He did so. Careful observations were made of him, which were that he had blood pressure of 137/92, a respiration rate of 18, oxygen saturation of 100%, a heart rate of 71bpm and a temperature of 36.1 degrees Celsius. He denied chest pain or pain anywhere. He said that he had been playing football (Australian rules) all afternoon and then smoked a few cigarettes afterwards. He denied other drug use. The nurse rechecked his blood pressure manually with the same results. The same results were registered regarding heart rate, respiration rate and oxygen saturation.

2. Mr Leonard asked Mr Gaykamangu if he was feeling better. He said that he was and said that he was happy to walk home unaided. He did so.

3. A short time later (approximately 45 minutes) one of Mr Gaykamangu's relatives returned to the clinic requesting an ambulance urgently. Nurse Leonard immediately left and went across the road and found Mr Gaykamangu lying on his

back in a supine position. On initial examination, he was unresponsive, not breathing and with no palpable pulse. There was no sign of external injury. A small amount of vomit was present around his nose and mouth.

4. Mr Gaykamangu was immediately taken back to the medical clinic. Registered Nurse Mr Simon Brisbane was also called in to assist Nurse Leonard. At 8.05pm the Clinic Manager RN Mr Stephen Hayes arrived. Contact was made by telephone with the on call doctor at Gove Hospital. At 8.40pm after extensive resuscitation attempts were made, which included CPR (cardio-pulmonary resuscitation), the application of adrenalin, defibrillation and intravenous cannulation, Mr Gaykamangu was declared deceased.

5. Police were immediately notified of the death.

6. On 31 January 2012 police and the nurses attended a large family meeting in Gapuwiyak and did their best to explain the provisional cause of death (atherosclerosis) to the family.

7. On 31 January 2012 Dr Sinton conducted an autopsy on the body of Mr Gaykamangu. Dr Sinton discovered that there was a blockage that he estimated at being 80% of the proximal anterior descending branch of the left coronary artery. This caused Mr Gaykamangu's death. Coronary Atherosclerosis, the disease that afflicted Mr Gaykamangu, was longstanding. He was 27 years of age at the time of his death. There was a relevant family cardiac disease history: Mr Gaykamangu's father had been the subject of a quadruple bypass operation at the age of 49.

8. Mr Mark Thomas appeared at the Inquest as Counsel Assisting. Mr Greg Macdonald appeared for the Department of Health. Mr Jared Clow appeared for the family of the deceased.

9. I received into evidence the investigation brief prepared by Sergeant Gary Coles, which comprised in essence of the materials tendered in this matter. In addition, this was supplemented by some additional statements: one from Dr Christine Connors, and a memorandum and statement from Dr Hugh Heggie.

10. Doctor Terrence Sinton gave evidence as did Sgt Gary Coles, Dr Hugh Heggie, Registered Nurse Simon Brisbane, Mr Peter Garawirrtja and Ms Sheree Marrawungu

11. Pursuant to section 34 of the *Coroners Act* (hereafter "the *Act*"), I am required to make the following findings:

(1) A Coroner investigating-

(a) A death shall, if possible, find-
(i) The identity of the deceased person;
(ii) The time and place of death;
(iii) The cause of death;
(iv) The particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*.

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

> "A Coroner may comment on any matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

13. Furthermore, I may make recommendations pursuant to section 35 (1), (2) and (3):

> "(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."

Reported When and by Whom

14. At 8.40pm on 29 January 2012 the Manager of the Gapuwiyak Health Clinic, RN Mr Stephen Hayes contacted Gapuwiyak Police and reported the death.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

Background of Mr Gaykamangu

15. Mr Gaykamangu was a Yolngu man from East Arnhem Land. He was born in Galiwinku on 10 January 1984. He was registered with Births, Deaths and Marriages as Yanabilnga Dhubururr Li Gaykamangu and was also know as Francis Gaykamangu. He was raised in Ramingining by both of his parents until he was 12 years old. His parents separated at that time and his mother moved him to Galiwinku and then to Marpurru Outstation. He remained there for several years and would visit his father in Ramingining on a regular basis. He later settled in Gapuwiyak in about 2007. Once settled there he later met and married Ms Sheree Marrawungu. They had two children together. Mr Gaykamangu enjoyed playing Australian Rules football at Gapuwiyak with his friends in the local community. At the time of his death he was working as a labourer with the CDEP community work program. He had a reputation of being a good hard-working and reliable member of the CDEP team. He had a good reputation in the community and appeared to be healthy. He did not display any signs of a heart condition prior to his death.

16. Mr Gaykamangu had very limited contact with the Gapuwiyak Health Clinic (or any other medical clinic/hospital) prior to his death. He had visited for the fracture of a finger (sustained during a football game) in May 2010, which was reviewed in July 2010. Clinical notes on the file reveal that he also sustained another football injury in March 2007 when he hurt his foot. There were no other matters referred to in his patient history.

17. Importantly, the clinic did not know of Mr Gaykamangu's family cardiac history when they treated him on the day he died. Nor had Mr Gaykamangu undergone an Adult Health Check prior to his death.

Circumstances of Mr Gaykamangu's death

18. The factual circumstances pertaining to the death have already been described in the introduction. There were no factual issues/conflicts that were disclosed in the inquest hearing. The reality was that the Nurse Leonard had no reason to conduct an ECG (electrocardiograph) at the time that he initially saw Mr Gaykamangu on

29 January as there was no symptoms that indicated that this was required. In particular, there were no complaints of pain anywhere- including the chest. The observation data of blood pressure, respiration rate, oxygen saturation rate, heart rate and temperature were within normal limits. When Mr Gaykamangu said that he was feeling better it was appropriate in those circumstances for him to be discharged. The CARPA[1] manual (fifth edition) was clearly complied with

The Autopsy

19. Dr Terrence Sinton conducted the autopsy in this case. I have referred to his findings previously. Dr Sinton elaborated upon this in his evidence at the inquest. He did pay particular attention to the fact that the atherosclerosis or in laymen's terms, hardening of the arteries was longstanding, in other words, it had not developed overnight.

Dr Heggie's evidence

20. Dr Heggie is the acting Chief Rural Medical Practitioner for the Northern Territory. He provided a most helpful explanation to the family of the deceased who were present in court of the coronary disease and the problem in particular with the blockage that had blocked 80% of one particular artery.

21. Dr Heggie had no criticism to make of the treatment delivered by the nurses.

22. The vital part of Dr Heggie's evidence addresses the question of what can be done about this problem. As I have already stated in the associated inquest in regard to Mr Daniels, it is clearly the case that young Aboriginal people are at risk of developing cardiac disease early. I will not repeat what I have said in those Findings in that matter. However, I adopt them for the purpose of these Findings as well. By so doing I do not mean to derogate from the importance of the findings in respect of Mr Gaykamangu. Suffice it to say the same problems apply. The fact that these two young Aboriginal men from Arnhem Land, died within a month of each of each other, of essentially the same problem, after playing football games, after which both smoked cigarettes, is a remarkable coincidence.

[1] Central Australian Rural Practitioners Association Standard Treatment Manual. I accept that this is in effect the "bible" of rural medical practitioners in the NT and that the procedures and protocols described therein ought, ordinarily, be applied.

The fact that the very same artery was blocked in both young men, is not merely a coincidence but a tragedy. Sadly, only this month it was reported to me that another young aboriginal man died of apparent heart disease after playing football in the Borroloola football league grand final.

23. Dr Heggie, said, in essence, that the only way that this problem can be addressed in the case of a young man such as Mr Gaykamangu is by attending the health clinic regularly and, in particular, receiving an Adult Health Check for the purposes of thoroughly examining him, in particular for cardiac problems (which would involve, amongst other things, a cardiac risk assessment). Despite his youth, and his healthy appearance, a key potential problem, was a familial cardiac history. This is a cardiac risk factor. Smoking is another cardiac risk factor as is Mr Gaykamangu's Aboriginality. That is why Mr Gaykamangu needed to be tested- and tested thoroughly. Technology is now available to deal with this, which I again refer to in the findings in the associated inquest.

FINDINGS

24. I find that Mr Gaykamangu died as a consequence of a blockage of an artery that was caused by long standing atherosclerosis. I find that when the nursing staff attended to Mr Gaykamangu on the second and final occasion, that is when he had collapsed, it was then too late to save his life. His final collapse was clearly consistent with a cardiac arrest, which was in the process of swiftly terminating his life.

25. I make no criticism of nursing staff in this case. They acted competently and professionally. The absence of a permanent medical practitioner at the clinic at that time was irrelevant to this case. The nursing staff acted appropriately both in terms of the initial consultation with Mr Gaykamangu on 29 January, and the second consultation, which occurred after Mr Gaykamangu had collapsed. There was no need to call the on call Doctor by telephone at the time of the first consultation because there was no apparent need to do so.

26. I find that essentially the same problem that I have referred to in detail in my Findings in respect to Mr Daniels in relation to young Aboriginal people developing cardiac artery disease at an early age applies in this case. I adopt those

Findings for the purpose of the Findings in this Inquest insofar as they pertain to the specific problem of the early detection of cardiac artery disease in young Aboriginal people. It is simply vital that young Aboriginal people, and men in particular, go to the clinic regularly for a thorough check up which involves cardiac risk assessment as part of as Adult Health Check. Only by doing this will the problem that Mr Gaykamangu had be identified and dealt with. There is clearly medical technology and treatment available to attend to a problem such as Mr Gaykamangu's cardiac problem- if it is identified in time. Because of the severity of Mr Gaykamangu's problem in this case very considerable time would be required to deal with it- almost certainly cardiac surgery at Royal Darwin Hospital would have been required to save his life, and even if that surgery had occurred, his prognosis would be uncertain.

27. In this case, once Mr Gaykamangu collapsed the nursing staff had no time to save him because he had suffered a cardiac arrest, which was about to very swiftly terminate his life, despite the best efforts of the nursing staff.

28. Dr Heggie noted that nursing/medical staff at the Gapuwiyak clinic would not have known about Mr Gaykamangu's familial cardiac history because the sole previous presentation concerned a problem with his finger. Dr Heggie said that they would have no reason to ask about his cardiac history at that time. I accept that evidence. However, I would add that once there is an appearance at the clinic for whatever reason, it would be very wise to make an appointment for an Adult Health check with the patient. I understand that Dr Heggie would very much support that.

29. There is one matter that I will add. Dr Heggie said that cigarette-smoking rates in Arnhem Land are the highest in Australia. Specifically, he said that about 70% of people smoke cigarettes. Dr Heggie said that smoking causes inflammation inside the arteries. This damages them and in many cases will lead to blockages of arteries. Further, smoking makes the heart weak. I note and find that Mr Gaykamangu smoked after the football game. This would have specifically harmed his health and increased his cardiac risk. All Aboriginal people who smoke must understand that they are placing their cardiac health and hence their

lives at risk. They are also placing themselves at risk of dying much earlier than they otherwise would.

FORMAL FINDINGS

30. Pursuant to section 34 of the *Act*, I find, as a result of evidence adduced at the public inquest, as follows:

(i) The identity of the deceased in this case was Yanabilnga Dhubururr Li Gaykamangu aka Francis Gaykamangu, born on 10 January 1984 at Gove District Hospital, Northern Territory. Mr Gaykamangu resided at Lot 122, Gapuwiyak.

(ii) The time and place of death was 8.40pm on Sunday 29 January 2012.

(iii) The cause of death was Coronary atherosclerosis

(iv) Particulars required to register the death:

(1) The deceased adult was Francis Gaykamangu
(2) Francis Gaykamangu was a labourer with the CDEP program in Gapuwiyak
(3) The cause of death was reported to the Coroner
(4) The cause of death was confirmed by post mortem examination carried out by Dr Terrence Sinton on 31 January 2012
(5) Mr Gaykamangu's parents were George Gurrulan Gaykamangu (father) and Ada Dhamarandji (birth name Ada Nawurulawuy) (mother)

31. I offer my condolences to the family of the deceased, many of whom attended this inquest. It is clear that many members of the community held him in high regard.

RECOMMENDATIONS

32. Again, in relation to the early detection of coronary artery disease in young Aboriginal people, I have dealt with this in detail in my Findings and Recommendations in respect to the associated inquest that concerned Mr Daniels. I adopt those recommendations for the purpose of this inquest.

Dated this 3rd day of November 2014

GREG CAVANAGH
TERRITORY CORONER