CITATION: *Inquest into the death of Ronnie Beasley* [2017] NTLC 002

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0029/2015
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FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Custody, natural causes**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie

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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0029/2016

In the matter of an Inquest into the death of

RONNIE BEASLEY
ON 20 JUNE 2015
AT ALICE SPRINGS HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Ronnie Beasley (the deceased) was a 40 year old Aboriginal man at the time of his death. He was born on 15 August 1974 in Alice Springs Hospital to his mother, Rita Morgan and father, Peter Bangawa Beasley.

2. The deceased grew up in Ampilatwatja, a Community about 320 kilometres north-east of Alice Springs on the Sandover Highway. He went to the Ampilatwatja primary school and then to Yirara College in Alice Springs.

3. It is believed the deceased had at least five children. To Harriet Nungari Wilson he had Rodney Beasley (1991) and Elvina Beasley (1996). To Yolanda Jarina Holmes he had Shentalia Beasely (1999) and Magnolia Beasley (2006). To Janelle Campbell, his wife at the time of his death he had one son, Ronnie Beasley Jnr, born two months after his death.

Health

4. The deceased had long standing heart problems. He appeared from at least 1995 to have recurrent rheumatic fever. In 1995, 1999 and again in 2004 he was taken to hospital with complete heart block (third degree atrioventricular block where the contraction signals from the atria are blocked before reaching the ventricles). On each occasion it resolved spontaneously.

5. In most years the deceased was admitted to hospital with acute pancreatitis secondary to excessive alcohol intake. He had longstanding hypertension and hypercholesterolemia but otherwise was generally in good health.

6. In March 2015 the deceased was seen by the cardiologist, Dr Michele McGrady on her visit to Ampilatwatja. He was tired at the time which the doctor believed was due to his chaotic lifestyle and poor nutrition.

7. His ECG on that date showed mild left ventricular hypertrophy with normal contraction but features of diastolic dysfunction (decline in left ventricle performance). The doctor made recommendations about improving his diet and decreasing his salt and alcohol intake.

Incarceration

8. From 2006 the deceased had been to prison on short sentences of up to six weeks for aggravated assault, breach of restraining orders and driving while intoxicated.

9. On 16 December 2014 he received a sentence of six months for driving while disqualified, to be served as a Community Custody Order. On 27 January 2015 a warrant of apprehension issued for breach of that order and on 1 May 2015 he was resentenced to 163 days imprisonment. He was due for release on 9 October 2015.

10. After going into custody he was cleared medically for the low security housing and working at the Barkly Work Camp. He was a well behaved prisoner and from 15 June 2015 he was housed in the Cottage Complex with an Open security classification. The Cottages are outside the main fence of the prison. The deceased said he would like to engage in work and community work during his time in custody.

11. On 19 June 2015 the deceased was assigned to Work Party B and performed voluntary lawn maintenance in Alice Springs. They started at 8.10am and returned to the prison at about 12.30pm.

12. That afternoon he called his wife on two occasions. The first was at 2.26pm and the second at 6.35pm. He was in good spirits and appeared to be laughing on the phone. His wife said that he made no mention of any chest pain or other health issues during those calls.

Circumstances of Death

13. Just after 11.00pm that night the deceased asked a fellow inmate to tell the Corrections Officers that he had chest pains. The other inmate went to the Officer Post at the Cottages at about 11.04pm.

14. Correctional Officer Secombe went to the deceased and found him sitting on the bottom bunk. The Officer asked the deceased if he was suffering chest pains. He said “yes”. Officer Secombe then returned to the Officer Post and informed Correctional Officer Farlow at 11.05pm. They then both returned to the deceased. They found him lying on his bunk clutching a blanket. He had shallow breathing.

15. Correctional Officer Farlow assisted the deceased to the Officer Post where he was provided oxygen from the Oxy Viva unit, while Correctional Officer Secombe contacted the Officer in Charge to initiate a ‘code blue’ and organise an Ambulance.

16. Initially the deceased sat in an office chair. He had a dry mouth and was given half a glass of water to sip. Soon after, the deceased requested that he lie on the floor. Both Correctional Officers assisted him in getting down to the floor. His breathing became more laboured and the oxygen level was turned up. He was provided with a blanket and an office chair was laid down so its back cushion could provide a pillow.

17. The deceased said his chest was tight, like a big weight was on it. He did not lose consciousness but was clearly deteriorating and a second call was made for the Ambulance. The operator was told:

> "the prisoner is going downhill, having trouble breathing, he is on Oxy Viva. At the moment he's cold and shivering, he's wrapped in a blanket, he's dry in the mouth, he's been given small sips of water."

18. At 11.40pm the Ambulance arrived. The paramedics were of the opinion that the deceased was speaking freely and did not appear to be in "too much distress". The deceased told them that he had a "sharp burning" pain in his chest. The pain was not radiating to other areas and he was "mildly short of breath".

19. The paramedics placed the deceased on an ECG monitor at 11.44pm and provided him with aspirin and Glyceryl trinitrate (GTN) at 11.51pm. He swallowed the tablets with water. Soon after he asked for a bag. He said he was going to vomit. A bag was obtained and he vomited into it. The paramedics thought that may have made him feel a little better. He was asked if he felt better and he said he did not.

20. Not long after that the ECG monitor indicated that the deceased was going into ventricular fibrillation. His eyes then rolled back into his head, he went stiff and started agonal breathing and then became unresponsive and pulseless.

21. The paramedics commenced CPR and at midnight at 12.02am, 12.08am and 12.14am gave the deceased shocks with the defibrillator. However he continued to deteriorate. At 12.15am intravenous access was established and the deceased was given Amiodarone (an antiarrhythmic medication).

22. However he failed to respond and so with a Correctional Officer helping in the back of the Ambulance they headed for Alice Springs Hospital.

23. They met another ambulance on the way and took on one of the paramedics to help out. At 12.21am and at 12.40am he was given adrenaline but again did not respond.

24. They arrived at the hospital at 12.45am. The Emergency Department doctors took over the resuscitation efforts. However the deceased did not respond and he was declared to be life extinct at 12.58am.

Cause of Death

25. The doctors thought that he likely died of ventricular fibrillation due to a myocardial infarction. The Coroner was notified by the hospital staff at 1.20am.

26. An autopsy was performed that found that the deceased died of ischaemic heart disease due to left ventricular hypertrophy and coronary artery atherosclerosis. The average left ventricular width was 2.1 centimetres whereas the right ventricular width was 0.4 centimetres. The three main branches of the coronary arteries had "non-calcific atherosclerosis with up to approximately 60% focal narrowing in each".

27. In effect, he died of natural causes from longstanding heart disease.

Reason for Inquest

28. By reason of the deceased being held in custody, his death was a reportable death. By reason of section 15 of the *Coroners Act* (the Act) an inquest must be held for the same reason.

Care, Supervision and Treatment

29. Where there has been a death in custody, pursuant to section 26 (1) of the *Act* a coroner:

    > 1) "Must investigate and report on the care, supervision, and treatment of the person being held in custody;"

30. The care, supervision and treatment of the deceased appeared appropriate until the time that the Correctional Services Officers were notified of the deceased's chest pain.

31. The Correctional Services Officers were notified at about 11.04pm. The call was made to "000" at 11.14pm. There may be some discrepancy between the clocks used by the Ambulance and Correctional Services because the Correctional Officers state the "000" call was made at 11.11pm.

32. Be that as it may, the fact that an Officer went to the deceased and then left him to go and get the other officer would seem unnecessary in an age with electronic communication. That they both went to see the deceased without the 'Oxy Viva Unit' or a wheelchair seems unnecessary. To then assist the deceased to walk to the Officer's Post would seem to be a strange reaction to a person potentially suffering cardiac arrest.

33. Enquiries were made of the Alice Springs Correctional Centre as to those issues. Management indicated that the Officers should have utilised communication by portable radio and should have either used a wheel chair to transport the deceased or taken oxygen to him.

34. Management immediately conducted an investigation and thereafter generated a checklist of available emergency equipment including wheelchairs and notified the Coroner's Office that *Standard Operating Procedure 9.28.7* (Nightshift Post Orders) would be updated to *"reinforce the responsibility of Officers to carry a portable radio at all times"*. It is pleasing to note the responsiveness of Corrective Services to improving their systems and I commend them on that.

35. Any delay, however, at that point is unlikely to have had a significant effect on the outcome. The deceased was still conscious and did not appear to be in too much distress when the paramedics arrived 26 minutes later.

36. I find that the care, supervision and treatment of the deceased was of an appropriate standard.

Formal Findings

37. Pursuant to section 34 of the *Coroner's Act*, I find as follows:

   (i) The identity of the deceased was Ronnie Beasley, born on 15 August 1974, in Alice Springs, Northern Territory, Australia.

   (ii) The time of death was 12.58am on 20 June 2015. The place of death was Alice Springs Hospital in the Northern Territory.

   (iii) The cause of death was ischaemic heart disease due to left ventricular hypertrophy and coronary artery atherosclerosis.

   (iv) The particulars required to register the death:

      1. The deceased was Ronnie Beasley.

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 the Alice Springs Correctional Centre.

5. The cause of death was confirmed by Forensic Pathologist, John Rutherford.

6. The deceased's mother was Rita Morgan and his father was Peter Bangawa Beasley.

Dated this 13th day of January 2017

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JUDGE GREG CAVANAGH
TERRITORY CORONER