CITATION:	*Inquest into the death of Warren Maminyamanja* [2005] NTMC no 053.
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0097/2004
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HEARING DATE(s):	14, 15, 16, 17 March and 17 May 2005
FINDING OF:	Greg Cavanagh SM
CATCHWORDS:	Death in Custody, Prison Medical Services, Duty of Care

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
NT Correctional Services and Corrrections Medical Services:	Ms Katherine Gleeson together with Mr David Farquar
Justice Advisory Committee:	Mr Chris Howse

Judgment category classification:	A
Judgement ID number:	2005 [NTMC} 053
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No.

In the matter of an Inquest into the death of

WARREN MAMINYAMANJA
ON 13TH June 2004
AT DARWIN

FINDINGS

(Delivered 26TH August 2005)

Mr Greg Cavanagh SM:

INTRODUCTION

1. Warren Maminyamanja ("the deceased") was an Aboriginal male born on 15 April 1971 at Groote Eylandt, Northern Territory. He died at 11.52am on 13 June 2004 in the Intensive Care Unit at Royal Darwin Hospital. At the time of his transfer to Royal Darwin Hospital on 10 June 2004, he was a person detained in custody at Darwin Correctional Centre, Berrimah and therefore he was a person in custody within the meaning of the *Coroners Act* and the holding of this inquest is mandatory.

2. Pursuant to section 34 of the *Coroners Act*, I am required to find, if possible

> "(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*; and
> (v) any relevant circumstances concerning the death;"

3. In addition, as this is a death in custody, section 26 of the *Coroners Act* applies. That section provides:

> "(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) shall 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 a 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 shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant."

4. Ms Helen Roberts appeared as counsel assisting me in this inquest. Mr Christopher Howse sought and was granted leave to appear for the Aboriginal Justice Advocacy Committee. Ms Katherine Gleeson appeared for the Northern Territory Correctional Services (NTCS) and the Corrections Medical Service. There was no appearance for the family of the deceased. A brief of evidence had been supplied by my office to the North Australian Aboriginal Legal Aid Service (NAALAS) and to the Miwatj Legal Service which services the Groote Eylandt area. The Northern Territory Legal Aid Commission (NTLAC) sought and was provided with a copy of the brief on the basis that the Commission is funded to represent clients from the Miwatj area at inquests in certain circumstances. The message received through my office, from Ms Julie Franz, shortly before the commencement of the inquest was that they, being the NTLAC, did not have instructions from the family and therefore were not proposing to appear. I am, however, satisfied in terms of regulation 9 of the Coroners Regulations that the family of the deceased are aware that this inquest is to be held.

5. Thirteen witnesses were called to give oral evidence at the inquest. Lorraine Wurramarba, the wife of the deceased gave evidence along with Macreena

Bara and Paul Wurramarba by means of video link from Alyangula. Also called were Constable Adam Raimondo, prison officer Paul Clarke, Registered Nurse Maureen Langdon, Acting Superintendent (Darwin Correctional Centre) Phillip Brown, Dr Gary Lum, Professor Bart Currie, Doctor Caine English, Ms Wendy Hunter (Deputy Director NTSC Program) Doctor Chris Wake (Corrections Medical Service), Mr Christopher Manners (Deputy Director Operations NTSC). Also before me were several other witness statements as part of the coronial brief of evidence tendered as Exhibit 1. Also in evidence were medical files belonging to the deceased; a Correctional Services file and several other documents to which I will refer in the course of these findings.

6. During the course of the inquest some issues relating to the contractual arrangements between NTCS and Corrections Medical Services arose. As a result, the inquest was adjourned on 17 March 2005 to resume on 17 May 2005 with an additional witness called on that date addressing the issues raised. On that occasion, and on final submissions, Mr David Farquhar appeared, with Ms Gleeson, for NTCS and for Corrections Medical Services.

FORMAL FINDINGS

7. Pursuant to section 34(1) of the *Coroners Act*, I find:

(a) the identity of the deceased person is Warren Maminyamanja, who was born on 15 April 1971 at Groote Eylandt NT;

(b) the time and place of death was 11.52am on 13 June 2004 in the Intensive Care Unit at Royal Darwin Hospital [Occurrence of death form signed by Dr Simon Van Hooland, ICU Registrar at Royal Darwin Hospital];

(c) the cause of death was Septicaemia resulting from Melioidosis. Other significant contributing conditions of the deceased were Coronary Atherosclerosis, Pulmonary Emphysema and Cardiac Hypertrophy [Autopsy Report of Dr Sinton dated 3 September 2004];

(d) the additional particulars needed to register the death under the *Births, Deaths and Marriages Registration Act* are:

(i) the deceased was a male person of Aboriginal origin;

(ii) the death was reported to a coroner at 13.30 hours on 13 June 2004 by Dr Van Hooland of Royal Darwin Hospital;

(iii) the cause of death was confirmed by a post-mortem examination being an autopsy carried out on 15 June 2004 by Dr Terence Sinton, Forensic Pathologist at Royal Darwin Hospital;

(iv) the deceased person had been admitted to Royal Darwin Hospital on 10 June 2004, and was transferred from the Emergency Department to the Intensive Care Unit where he was under the care of Dr Sarah Collins, ICU Consultant, during this admission until his death.

CIRCUMSTANCES

8. The deceased was a 34 year old Aboriginal man from Groote Eylandt. He was married to Lorraine Wurramarba. In the time prior to his death the deceased was in Darwin with wife who was receiving medical treatment and he and his wife were living at a hostel in Darwin. On 22 May 2004, the deceased was arrested on some outstanding warrants after an incident at the hostel and taken to the Watchhouse. On 23 May 2004, he was taken to the Darwin Correctional Centre having been refused bail during the course of the day. A reception assessment was completed at 10.20am on 23 May 2004 by a prison officer in accordance with the usual practise. The deceased was housed in a remand block of the prison. On 24 May 2004, he went to court and was remanded in custody to reappear on 26 May 2004. On 25 May 2004, the deceased attended the prison medical clinic for his medical reception.

9. At that time, and currently, medical care and treatment to prisoners at Darwin Correctional Centre was provided by Corrections Medical Services,

a business name for the company Chris Wake Pty Ltd, by a means of contract between that company and NTCS.

10. The relevant conditions of that contract are in evidence (Exhibit 5). The contract provides for the provision of primary health care services to all Top End institutions for the period 1 December 2000 until 30 November 2003 and was extended in early 2004 until 30 November 2005. Relevantly, the contract provides as follows:

> "84. Clause 4.2.5 requires the contractor to:
>
> > "Provide a comprehensive medical and health assessment of all prisoners and detainees of the Institutions within 24 hours of initial reception, by the Visiting Medical Officer or a Registered Nurse. Where the initial reception procedure is conducted by a RN, then the VMO shall follow this up with their own full examination within a further 48 hour period (or 72 hour period should a public holiday intervene)."
>
> 85. Clause 4.2.38 reads:
>
> > "Provide an emergency after-hours phone service to an on-call Registered Nurse or the Visiting Medical Officer, including after-hours re-attendances at the Institutions by a RN 1st on-call, and the Visiting Medical Officer 2nd on-call."
>
> 86. Clause 4.2.40 reads in part:
>
> > "…Similarly if an inmate requests treatment by the Medical Service, they are required to be seen by the VMO or RN within 48 hours of notification, or earlier depending on the urgency of the situation."

11. On 25 May 2004, the deceased underwent a prison medical reception at which he said he felt well. The examination was conducted by Registered Nurse Wendy Langdon. Ms Langdon, is a very experienced nurse, particularly in the prison system having worked there for about six and a half years. She recalled the deceased as "quite chatty". A standard blood

test taken subsequently reported a slight elevation of his white blood cell count. She noticed that he had a 'tubigrip' bandage around his right knee.

12. On 26 May 2004, the deceased was bailed and released from custody, and he reunited with his wife. She gave evidence that he drank two cartons of moselle and smoked cannabis during the day; later arguing with her and fighting with her. He dragged her into the One Mile Dam at Stuart Park and there pushed her head under the water against her will. Relatives called the police. The deceased refused to come out of the water, moved to deep water and then got into difficulties with his head submerged at one point. Police officers waded through the reeds and rescued him, during which time he struggled and had to be dragged onto the bank, arrested and put in the back of the police paddy wagon.

13. Accordingly, he was received back at the prison again on 27 May 2004. At his reception conducted by Prison Officer Clarke, he was noted to have a swollen left arm, skin off his knees and face but indicated when asked that he did not wish to see a doctor. Prison Officer Clarke followed the usual procedure which involved printing out an identity form relating to the prisoner and placing it in the medical in-tray to indicate that the person was a new reception. The routine involved a nurse coming into the prison reception area each day and collecting those documents as well as photocopying the daily movement sheet recording prisoner movements. Although this was done, there was no medical reception performed on the deceased on this occasion as it should have been.

14. I am satisfied that Prison Officer Clarke followed the usual procedure providing documentation indicating that the deceased was a new reception at the prison, despite having only been absent for less than 24 hours. I have also heard evidence that the procedure he followed has been improved by the additional step of placing a red dot next to the name of newly received prisoners (Exhibit 4). I infer from the evidence of Dr English and Nurse

Langdon that it may not have been appreciated that he had been liberty for that period, rather, an assumption had been made the prisoner had simply been at court given the very short period of time which he was absent before being re-arrested. This error, of itself is not of great significance particularly taking into account the evidence of Dr English to the effect that he would not have been given another full examination anyway (transcript p98):

> He wouldn't have had bloods taken, or urine taken. It had only been a couple of days. If it had been a couple of months, we might whip off another full blood count or something but yeah. He would get seen by somebody in the clinic.
>
> And checked his mental state?---If - we used to call it eyeball. If somebody had only just gotten out and come back in, we'd bring them in for a bit of a - in fact, we called it an eyeball. Just gave them bit of a look-over and you know just have a good chatter to know that we know that they're back in again and you know maybe, at least they'd get eyeballed.

In addition to Exhibit No 4, I have heard evidence that the entire computer system is to be streamlined and modernised. (Statement of Chris Manners, and transcript p181). Given the confusion with documentation revealed at this inquest, including the computer appointment system at the medical centre, this is a welcome step.

15. On Saturday 29 May 2004, the deceased submitted an urgent request to see what he described as a "medical nurse" about his swollen right knee. The method for prisoners to seek access to medical treatment other than by urgently summoning prison officers, is for them to complete a written document which is placed in a box and collected daily by a nurse. There is no doctor at the prison on the weekends and so the medical request forms collected over the weekend are not seen by the doctor until the next Monday. Dr English gave evidence that Mondays and Tuesdays are the busiest days at the clinic because the doctor has the weekend's requests to go through. He read through all weekend requests and arranged

appointments for those prisoners who had requested them, by means of a triage system based on what was written on the document. He arranged for the deceased on this occasion to see him at the medical clinic on Wednesday 2 June 2004. (I pause here to note that 2nd June was well after the 48 hour period within which a newly received prisoner is to see a doctor pursuant to contract clause 4.2.5)

16. The deceased was seen on 31 May 2004 by Nurse Langdon on her general drug round to the "C" Cell Block. Although she does not specifically recall seeing him on this occasion, she was reminded by notes she made recording "requesting to see medical for sore knee very swollen and warm". In evidence she said if she thought the knee was hot, rather than warm, then she would have made arrangements for the deceased to see the doctor earlier but it was not hot and therefore she did not think it was urgent. On Wednesday 2 June 2004, Dr English examined the deceased and noted in the medical record:

> "Injured his right knee back in the late 90's and appears to have had an arthroscopy/construction at some stage. Presents today with a very swollen knee. On exam effusion (accumulation of fluid) ++++, tender. Not warm. Ligaments appear intact. Cannot remember injuring it again this time. Three days ago it just "came up". For Brufen TT bd. To elevate during the day and at night. Needs extra pillows. Given a compression bandage. Need OPD ortho review and x-ray. Happy with same."

The doctor also arranged for further blood tests and a chest x-ray and x-ray of the knee

17. Following this examination, the deceased presumably would have been seen in his cell block by nurses twice daily for the administration of the anti-inflammatory drug prescribed and apparently made no further comments of being unwell. This is consistent with the statements of his cell mates who essentially said that he appeared well up until 10 June 2004 when he became very ill.

18. On 3 June 2004, a chest x-ray was taken from the deceased; the result was normal. On 8 June 2004, Dr English received and reviewed the full blood count results and arranged for a nurse to take further blood on 10 June 2004, one basis being that the white blood cell count remained elevated. On 10 June 2004, the deceased attended the medical clinic where Nurse Langdon took further blood and he gave no particular indication of being unwell. At 9.00pm on that date, Lachlan Lalara, a cell mate of the deceased, notified the prison officers that the deceased was ill. Nurse Miller attended and noted he had a high temperature, low heart rate and he needed oxygen. She spoke by telephone to Dr English who ordered the patient's transfer to hospital. I find, with the assistance of the expert evidence of Professor Currie, that the treatment, once the deceased arrived at the hospital, was appropriate and adequate. Unfortunately, the administration of antibiotics was too late to save the deceased's life.

19. The deceased died from melioidosis, a disease which presents with a broad spectrum of clinical conditions and has a variable rate of onset from slow to extremely aggressive. The majority of cases in the NT are associated with the wet season and exposure to surface water and mud. In the absence of specific microbiology tests, melioidosis is difficult to diagnose. I quote from the evidence of Professor Currie, an expert in meliodosis, from Menzies School of Health Research (transcript p73):

> THE CORONER: Doctor, were you here when I was asking the other doctor about my general perception? And that is it's one of the most dangerous diseases in the Northern Territory because you can acquire it and if you're not a wuss, go from no external symptoms to a bit of a wheezy chest to a bit of a cough to death within a few days?---Yes, that's - - -
>
> Without going to the doctors?---Yes, that's certainly the case and we follow all the cases of melioidosis in the Territory. In fact for the last 15 years, there've been 415 cases that we have fully documented, 66 deaths amongst those cases. And a minority of the cases including a substantial number of the deaths have been the scenario that you're describing.

MS ROBERTS: So do I understand professor that you're saying that given the history of this deceased which is that assuming he acquired the infection on 26 May, he's then apparently been relatively well clinically until just a few days before his death and that's something that you said was slightly unusual or - - -?---Yes I think that is unusual. It's certainly still the likely scenario but it is unusual.

THE CORONER: I suppose it depends on how strong the individual's body is in fighting it?---Yes.

Would that be an expectation?---Absolutely. In the 66 deaths we've had every single one of them has had a defined risk factor, one of the risk factors that we define for melioidosis. It doesn't mean that healthy people don't die from melioidosis. They do commonly in places where there's not such good medical care and in North Queensland there's been a number of deaths in healthy young people. But of our 66 deaths in the Top End, they've all had a defined risk factor which diabetes and heavy alcohol intake are the two commonest.

And at the time at which this deceased was actually admitted to the hospital, he was extremely ill. That's the case with the disease, isn't it?---Yes.

And he was given all the possible treatments at that time?---Yes.

THE CORONER: Well, he probably wasn't going to get well, but die wasn't he?

---From my reading of the - I wasn't involved in his management but I looked through all the hospital records and the autopsy and the various records sent to me from the prison and he was clearly critically ill when he got into hospital. And it had been a very dramatic decline over a period of possibly less than 24 hours. And once he got to hospital, his managers recognised immediately how critically ill he was and he got our standard therapy for melioidosis which these days has enabled us to keep a number of people alive in the last few years who would certainly have died five years ago. So despite those efforts at the hospital, he still died.

MS ROBERTS: Now you also commented, or you've given your opinion in court professor that the swollen knee which you've noted is documented to - he's complained about it on 29 May, is likely to have been the first clinical manifestation of the infection. And again, are you basing that on the fact that that is the most likely scenario given the history and information that you have?---Yes, the main

> reason for my thinking that's likely is that when he was eventually admitted to hospital, the knee was aspirated. A sample was taken from the knee and that was positive for the bacteria, so the bacteria was present not only in his bloodstream causing the severe blood poisoning but was also present in that knee which had been swollen previously. The thing that is unusual about that presentation with the swollen knee was that it was quite clear from the medical records at the prison that the knee was specifically documented as not being hot, and I think Dr Lum previously mentioned that when you have infection in the knee you really would be expecting the knee to be hot. That's a classic sign of infection in the knee, so that makes it all a little unusual, but weighing it all up, my opinion is that the bacteria had clearly spread in my opinion spread to his knee and that, when he presented with a swollen knee, that was actually the first manifestation of his melioidosis. But he was also, from the prison records, clearly well at that time. It was noted that he didn't have a temperature although I can't recall a temperature - it said afebrile, rather than a specific temperature being documented and over the subsequent days, there was no presentations with any evidence of infection. So we had a man who had a swollen knee which wasn't hot and that was about it until he presented on that last presentation, deteriorating rapidly so there was a time interval there where it appears as though he was well apart from his swollen knee

20. When Dr English saw the deceased on 2 June 2004, he did not put a needle into the deceased's knee to take a sample of the fluid there for two reasons. One was because having taken history from the patient and having felt the knee, which was not hot, he formed the view that it was probably not infected; and given the prison conditions putting a needle into his knee may have, in fact, increased the risk of infection from environmental factors. Dr Gary Lum, a pathologist at Royal Darwin Hospital gave evidence that if a sample had been taken on that day he would not necessarily have expected it to grow the melioidosis organism at that stage (transcript P66-67). Dr Currie specifically did not criticise the treating doctor, Dr English, for failing to take a sample for testing on 2 June 2005. He said (transcript P75):

> MS ROBERTS: To you professor, as an expert in this disease would a swollen knee combined with a history of being under the water at One Mile Dam, and I'm not suggesting that the doctor had that history, but would that suggest to you melioidosis or is that an obscure diagnosis on only those two pieces of information in June?

> ---Look, on those two pieces of information I think the standard of care would be probably not considering melioidosis but you'd only need one more thing to really say you need to put a needle in that knee and take some fluid off and that would be a hot knee. And then which of course may be many other things, gout or trauma from an injury, but given that the knee wasn't hot I think my opinion was was that the decision made by the medical officer in the prison was an appropriate judgment at that time. Of course all this is in retrospect and so if a needle had have been - if that knee had have had a needle aspiration taken at the time, it may have changed the course of the - you know the course of the illness.

21. Based on the evidence of Dr Currie and Dr Lum, I find no basis for any criticism of the treatment given by Dr English to the deceased, in particular his failure to advert to the possibility that melioidosis was the cause of the deceased's symptoms, which at that time were merely a swollen knee with a history of a chronic problem there. The subsequent discovery of the raised white cell count pointed only to a generalised immune response, which could have originated from any number of factors in a patient with the lifestyle of the deceased. The evidence does not even necessarily establish that the swelling in the knee was in fact as a result of a melioidosis infection; it may have been a concurrent problem. Professor Currie was of the view that the most likely infection occurred at the One Mile Dam during which the deceased probably aspirated water from the dam into his upper airway and possibly his lungs, or through the mud or water through cuts and abrasions. Dr Lum agreed that the evidence of this and the pathology results were consistent with him having acquired the infection at the One Mile Dam. The period for development of these serious symptoms was consistent with the usual time development of the disease from infection. Dr English does not recall being aware that the deceased had been immersed in the waters of One Mile Dam prior to him conducting his examination of him. Indeed, he was asked whether he recalled the deceased telling him that he was underwater (transcript P90):

> "…---No. He didn't mention it at all. I specifically asked him. I said: 'Have you fallen over? Has anything happened recently in the

past three days or little while that may have caused that?' I've got written down here and he said: 'Three days ago I just came up". That was his exact words, the knee just came up. So I had asked him had he remembered injuring it and he said no.

So he didn't tell you about being under the water in the One Mile Dam and being dragged out by the police and dragged into the back of the police van?---No.

He essentially just gave you no possible reason for his knee being a bit swollen on that particular occasion?---It wasn't like he just said: 'No' and that was it. He said: 'No I can't remember injuring it. It just came up about three days ago'. Perhaps he was holding back, he didn't want me to know that he had that tussle with the police. don't know. It wasn't brought up at all.

In terms of the tap, the knee, the aspirate – that was something you considered doing and rejected for a reason?---I considered doing that but in the absence of any visible(?) entry site at the time in terms of injury where the bug could have gotten access into his knee joint, I decided that – to address it but it's not always as clean as it could be and quite often when it's not severe it just makes it end up getting infections that they wouldn't otherwise get. So I was reluctant to you know, introduce a large needle into this guy's knee joint and because of the environment unless I really had to. Had I though there was an infection, I would done it but like I said everything at that time looked at it to being a contusion, due to a strain. And it could have possible made matters worse by introducing a needle to get an aspirate."

22. During the inquest, questions were raised about the possibility of screening prisoners, on a routine basis, for the risk of melioidosis. The evidence of Dr Lum, in particular, explained that there are a number of difficulties with doing this, including the fact that general broad spectrum testing for melioidosis is neither effective nor cost effective. (transcript p64):

> Now doctor, you've explained about testing on people who present with symptoms or sick people and how you would go about testing them, what about a well person. Is there a way to see if they are carrying the infection but otherwise well?---In somebody who presents in a well state, that is they're not febrile, they have no symptoms, no cough, no pain - - -

> THE CORONER: You've got a sore knee for example?---If somebody comes in with a sore knee - - -
>
> An inflamed knee?---With an inflamed knee, then it wouldn't be the first thing that came to mind that this person has melioidosis. It's possible but then in our environment, a more likely explanation would be gonorrhoea of the knee rather than melioidosis based on just the sheer numbers of positive specimens we have through the laboratory. So in somebody who comes in who's got say a sore knee but otherwise well, you wouldn't expect to see or grow the organism. However, if somebody does have a sore knee and if it's inflamed and if you collected a specimen then we would want to look at that specimen microscopically and we would also want to set that specimen up for culture and culture may well reveal positive growth of the organism. But in somebody with no symptoms at all, then to go looking for the organism, the only way is to do it looking for antibodies and as I've said, with people who have been here for some time, if they're locals they may well have been exposed and they well have low levels of antibody and our vernacular for that is that's just noise, that's just background noise and doesn't really mean much in terms of the person being - carrying the disease or infected a such. The other thing that we could do would be to do things like throat and rectal swabs but in somebody who is well, if they don't have a cough and they're not productive of sputum then they're probably not going to be swallowing sufficient colonised sputum so that they're colonised in their throats and rectums anyway. So that's probably not much use. You could collect blood for culture but in somebody who's well, it's highly unlikely that their blood is going to have sufficient numbers of organisms or any organism at all to grow on culture. You could do some tests for just general non-specific inflammation but because they're so non-specific, it wouldn't point you in one way or another whether it was melioidosis or any other sort of infection.

23. However, it remains important to continue to raise the profile of the disease melioidosis which is dangerous and is a disease which is more likely to cause problems in the prison population, due to additional risk factors present for many Aboriginal prisoners given their generally poor state of health. In his submissions on behalf of the Northern Territory of Australia and Corrections Medical Services, Mr Farquhar has discussed this issue in considerable detail. At paragraphs 46 to 63 of his submissions, I am advised that NTCS is already liaising with the Department of Health and Community

Services about a number of general issues relating to the health services to be provided to prisoners and this more specific issue, being the potential danger of melioidosis, has been drawn to both agencies attention. I am also advised that the Northern Territory of Australia and Corrections Medical Services support a recommendation that screening questions particularly designed to alert medical personnel to a higher risk of melioidosis in a particular patient be utilised and that recommendation has been forwarded to NTCS, Corrections Medical Services and the Department of Health and Community Services for appropriate action. In these circumstances, I make no further formal recommendation in this area.

PROVISION OF MEDICAL SERVICES TO PRISONERS AT DARWIN CORRECTIONAL CENTRE

24. An issue which assumed great prominence at this inquest was compliance, or the lack of compliance with the regulatory and contractual requirements for the provision of primary health care services to prisoners at Darwin Correctional Centre, including the deceased. Health care services for adult prisoners are provided for in general terms in the *Prisons (Correctional Services) Act*. Section 28 of that Act provides for the Director of Correctional Services to specify the medical duties of the visiting medical officer. The most recent Determination issued pursuant to that section is the "Director of Corrections Determination No. 4" dated 18 May 1981. That document sets up a roster for a medical officer to be at various correctional institutions, some of which no longer exist, at particular times. It is properly conceded by the Northern Territory Government that that schedule and, Determination 4 itself is out of date and does not reflect the obligations and duties of the Northern Territory towards prisoners under its care. The Determination is to be entirely replaced by the contract specifications currently being developed for a new contract for prison medical services, which I am told is scheduled to be introduced on 30 November 2005 (statement of Wendy Hunter, paragraph 9).

25. I have referred above to the contract between NTCS and Corrections Medical Services for the provision of health care services to Darwin Correctional Centre, and extracted the relevant clauses of that contract. It is clear from the terms of those clauses that the drafting of the contract was based upon recommendations emerging from the Royal Commission into Aboriginal Deaths in Custody (RCIADIC). Recommendation 150 provides:

> " That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical; dental; mental health; drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services. Health services provided within correctional institutions should be adequately resourced and staffed by appropriately qualified and competent personnel. Such services should be both accessible and appropriate to Aboriginal prisoners. Correctional institutions should provide 24-hour a day access to medical practitioners and nursing staff who are either available on the premises, or on call."

The Northern Territory has supported and implemented this recommendation from the outset.Recommendation 156 reads:

> "That upon initial reception at a prison, all Aboriginal prisoners should be subject to a thorough medical assessment with a view to determining whether the prisoner is at risk of injury, illness or self-harm. Such an assessment should be provided, wherever possible, by a medical practitioner. Where this is not possible, it should be performed within 24 hours by a medical practitioner or trained nurse. Where such assessment is performed by a trained nurse rather than a medical practitioner then examination by a medical practitioner should be provided within 72 hours of reception, or such earlier time as is requested by the trained nurse who performed such earlier assessment or by the prisoner …"[the balance relates to psychiatric assessment]

The Northern Territory has responded to the recommendation in the following terms:

> "All prisoners received into Northern Territory prisons undergo thorough medical assessment as soon as possible after reception.

> Subject to the availability of medical resources, this recommendation will be implemented."

While the Royal Commission's 339 recommendations of 1991 do not carry the authority of legislation, the Northern Territory has accepted responsibility for 291 of the recommendations (the remaining 40 are matters for the Commonwealth and 8 are for the other specified States and Territories).

26. Clearly recommendation 156 is reflected in clause 4.2.5 of the contract. In summary form I shall describe that clause as a requirement that a medical reception be conducted *by a doctor*.

27. Dr Chris Wake, Director of Corrections Medical Services, was interviewed by investigating police and gave evidence at this inquest on 16 March 2005. He described what was referred to as a "trial" carried out during 2004, involving varying the reception system from that specified in the contract document, so that each prisoner upon reception was seen by a nurse except in specified circumstances. The conditions which would mandate a prisoner seeing a doctor were if the prisoner asked to see a doctor; if the prisoner had any serious documented medical conditions or medications; or if the nurse was of the view that the prisoner should see a doctor. The doctor would then have more time to attend "satellite clinics" (attending the blocks to see sick prisoners). Dr Wake readily agreed that this procedure was different from what was provided for in the contract to which he was a party. At (transcript p137):

> "MS ROBERTS: In your interview you described this procedure as a trial, and now you say, on page 6 'Mr Maninyamajia's death occurred in the first part of that trial, the trial was essentially agreed with Corrections'. Now, can I just ask you a couple of questions about that. You'd agree with this – the trial whereby not all prisoners saw a doctor upon reception was something different from what was provided in the contract that you have with correctional services in relation to the provision of medical services to prisoners upon reception?---Yes

> And in fact the contract provides that, at clause 4.2.5, that the reception medical assessment should be performed within 24 hours of initial reception by the visiting medical officer or registered nurse and it goes on to say 'Where the initial reception procedure is conducted by a registered nurse then the VMO should follow this up with their own full examination within a further 48 hour period or 72 hour period should a public holiday intervene.' You're familiar with that clause, doctor?---Yes.
>
> So that in effect that requires that leaving aside the time periods for the moment, all prisoners are seen upon reception by a doctor?---Yes.
>
> And the trial that you refer to, did not involve all prisoners being seen upon reception by a doctor?---Not for the first nine months, for the second three months it did.
>
> So I'll concentrate on the first nine months then. You say in your interview the trial was essentially agreed with Corrections. Can I ask you, when you say Corrections who are the people, the individuals to whom you refer?---There were a number off discussions throughout January 2003 until November 2004. There were six in effect outlining the critical state of health services for a number of reasons in Darwin prison and outlining the need to manage that if indeed we were to control adverse risks and be able to complete our work. There were no less than six meetings and the last two were with ex-commissioner (inaudible), Eric Raydon and Christopher Manners. I'd also point out that at that time, the department itself was critically short of middle managers. If you like, Corrections had been fairly much stretched to the bone."

28. Dr Wake was emphatic that the underlying purpose of the "trial", from his point of view, was to give the one doctor who was available Monday to Friday more time to see patients who were "manifestly sick", and have the nurses see those who were not necessarily so. He said (transcript p148):

> "...It was a pragmatic response to a situation which needed management and could not be managed by the condition of the level of staffing necessary."

29. Dr Wake gave evidence that he suggested to Corrections personnel that they should "vary the contract to make it fit" but that it was decided between all persons present that the system should simply be trialled and reviewed at the end of an agreed period. In terms of who which "Correction Personnel" Dr

Wake was dealing with, the evidence is not entirely clear. At one stage he said that he dealt with Mr Dave Moore (former Director of Corrections) and Mr Chris Manners. At another stage Dr Wake said some of the discussions were with senior Public Servants such as Mr Richard Coates, the CEO of the Department of Justice. Mr Chris Manners gave evidence before me on 17 May 2005. He was the acting Director of Corrections, for part of the time that the contract between Corrections and Dr Wake was being renegotiated. I heard evidence there were a number of matters being discussed during the renegotiation phase including, critically, money. Mr Manners was insistent that his discussion with Dr Wake were at a "policy level" and that the variation from doctor to nurse receptions was an "operational decision" with which he was not involved. He appropriately conceded that no-one at the time in Corrections considered the recommendations of the Royal Commission into Aboriginal Deaths in Custody (transcript p178-179). Further, he conceded in response to a question from me that the "administrative management of the contract was not adequate" (transcript p179). In relation to the nurse/doctor receptions, he said (transcript p193):

> "Now in your evidence earlier on you said that you had nothing to do with the setting up of this trial, that's so, isn't it?---I said I was unaware of the trial at the time I was involved. I was involved in the negotiations regarding the contract extension during that which were high level negotiations in terms of extending for two years.
>
> THE CORONER: So it had nothing to do with money, was it?---Resources, money, a level of service provision for the two years, whether you have to go to a new contract or whether you can do this while you're doing the specifications for the other. I was not aware of – or not involved in setting up that satellite clinic."

30. It was put to Mr Manners by Mr Howse that in setting up the satellite clinic and trial of nurse receptions, that the Superintendent in so doing bypassed the requirements of Clause 4.2.5 of the contract. In response to that question, Mr Manners said (transcript p194):

> "When the superintendent – now the superintendent of course, obviously bypasses because 4.2.5. doesn't he, when he agrees with Wake to set this entire nurse reception trial in motion?---What I believe it is, is an operational decision made at the work place, that actually in relation to practice, in this case, the medical service, and I repeat that it was not a reduction in the resources available, but just better utilisation of those resources in that it would be – it would be your doctor on recommendation from him, because in terms of your medical practice, you take notice of the VMO, because we're not medical practitioners and in terms of service delivery and then it would be a senior management decision at the institution. To that end, it's a variation to your practice that does not reduce the resources available to serve up to 415 prisoners."

31. I found Mr Manners evidence to be honest, but unimpressive in his explanations as to just how and why he and the department were persuaded by Dr Wake to vary the contract provisions I am not persuaded that a variation from a careful recommendation of the Royal Commission into Aboriginal Deaths in Custody is acceptable on the basis that it was an "operational decision" and/or made on the recommendation of a medical practitioner. Dr Wake was forthright in his evidence that he was aware that the practice was inconsistent with the contract, however in his clinical judgment it was the best use of the one doctor that he had employed to service the contract. The Northern Territory Government, on the other hand, ought have given much more careful consideration, indeed some consideration to the fact that what was going on was a departure from recommendation 156 of the Royal Commission's recommendations.

32. The trial of nurse only assessments was ceased in September 2004. As a result of this deceased's death and issues which must have been highlighted during the investigations into that death, the new Director of Correctional Services wrote to Dr Wake on 3 January 2005. In that letter (Exhibit 7) the Director required that any future variation of the contract be done in accordance with the procedures set out in the contract. Further, the Director requested that Corrections Medical Services identify those prisoners who, during the trial period, were not given a comprehensive medical assessment

by the doctor, and provide that assessment as soon as possible. That was done. I note, of course, that this deceased was part of the "trial", in that his reception was carried out by a nurse not a doctor.

33. In the submissions on behalf of the Northern Territory Government, Mr Farquhar puts the following:

> "87. The specifications of the contract have been reviewed and are being upgraded with a view to a new contract for the provision of medical services to NT prisons commencing in December 2005. The new contract will be an outcomes based contract in line with the health profession's national best practice. This means that the contract will include set performance indicators and measures, with the changes following the recommendations of the August 2003 review of the provision of primary health services to the correctional centres in the NT. [Evidence of Ms Hunter T.113]
>
> **Review of Primary Health Care Services to NT Correctional Centres**
>
> 88. The Coroner has received a copy of the independent and external review commissioned by NT Correctional Services to consider the adequacy of the contractual arrangements with Corrections Medical Services with the aim of improving future contract specifications and contract management. [Ex. 7 Attachment to statement of W.M.Hunter]
>
> 89. The author of the review found:
>
> > "Overall Corrections Medical Services complies with the contract specifications and is providing a comprehensive range of services that are comparable with services provided in interstate prisons. The evidence demonstrates that Corrections Medical Services provides an effective cost-efficient service that adds to the prisons service as well as the wider community in the area of public health."
>
> 90. Corrections Medical Service is a member of the Australian Council of Healthcare Standards, and has national accreditation that the services provided by it meet the standards required for private hospitals and private day hospital facilities.

91. However, the Reviewer also concluded that the health service contract specifications and management, the clarity of funding responsibilities, and communications between the key stakeholders all required improvement, and made 10 specific recommendations to that effect.

92. The recommendations led to the appointment in November 2004 of a full-time position within NT Corrections to manage the existing prison health services contract and to review and upgrade the contract specifications. It also resulted in the more active involvement of the Department of Health and Community Services in setting the specifications for and monitoring the health services in the prisons. [Ex. 7 para. 6 statement of Ms Hunter]."

34. While all of this heartening, I remain somewhat concerned by a complete reliance on a national standard, due to the particular conditions which exist in the Northern Territory. We have a very high percentage of prisoners from remote Aboriginal Communities, and those prisoners have particular health needs. In the context of my focus upon the Royal Commission recommendations, I was somewhat concerned by some answers given by Mr Manners in relation to questions about the future direction of the newly upgraded contract. At transcript p209, he said:

> What we will do is with the new specifications we will seek the expertise of health professionals, how that should look into the future. Now whether that is an increased representation of nurse professionals with reference to a VMO I'm not qualified to comment. But we will be looking at it, and you are correct in as recently as yesterday ***our manager of prison services has attended two prisons in Queensland where they do not have a doctor and a reception prison where they do not have a doctor in attendance at all***. The prison actually operate with health professionals on reception. So we will take – look recognising that the dynamic of the Territory population and our prison population we will seek the advice of – the expert advice and best – current best practise in the new contract specification. And we will be listening to other people and know what they're telling us, not ourselves."

35. He went on, in answer to questions put to him, to say that any new contract would "seek input from our key stakeholders", but would not necessarily

and automatically implement or mirror Recommendation 156. Mr Howse made the point in his submissions that there had not been or did not appear to have been input from Aboriginal health professionals in relation to the terms of the new contract.

ON-CALL DOCTORS

36. Another issue which was raised at this inquest was the requirement in the contract that there be available a doctor on-call 24 hours for emergency medical treatment to a prisoner if that were required. The relevant clause is Clause 4.2.38 which provides that Corrections Medical Service should provide a "emergency after hours phone service to an on-call registered nurse or the visiting medical officer, including after hours re-attendances at the institution by a RN first on-call, and the VMO second on-call."

37. On the night upon which the deceased became very ill, Dr English was contacted by telephone after Nurse Millar had attended his cell. Nurse Miller described his symptoms to Dr English who he advised that the deceased should be transferred immediately to hospital. There is no issue with that decision. However, Dr English gave evidence that he never visited the prison whilst on-call (but off duty) during the 10 months he was employed there. He said (transcript p95):

> "Now was there ever an occasion when you were asked while you were on call when a query was raised with you on the telephone from the prison, that you actually visited the prison?---No. If somebody – because at that point that the nursing staff who were the first on call would have already seen them so I would have discussion with them. If there was required, if they were sick enough for me to have to go into the prison to visit them, I didn't much around. They'd just get them straight into the emergency department of Royal Darwin. I had a good working relationship with the staff there so there's no point me going into the Darwin Prison and they having – wasting 30 minutes to go in and say yes, this person needs to be seen in hospital. We're just a clinic. We don't have the facilities to know really look into something emergency-based so we'd always on the safe side and we'd send them straight into prison – up to the hospital, sorry."

38. It was put to me that this evidence came as a surprise to NTCS as "other doctors had both previously and subsequent to Dr English's period of employment, attended at the prison on after hours calls". It is acknowledged in the NTCS submissions that there is an expectation that the visiting medical officer will attend the prison after hours on occasion as part of the emergency service. One problem I have with this submission is that it is at odds, with Dr Wake's frank acknowledgment that one weekend in four, Dr English had the weekend off and Dr Wake took the job of the "on-call doctor". Clearly, as Dr Wake lives in Alice Springs there could be no possibility that he could attend the prison. He did not appear to regard this as a problem when I asked him about it in evidence (transcript p144). If the NTCS requires an after hours emergency medical service provided by an on-call doctor to attend the prisons, then this requirement needs to be adequately funded and appropriately implemented and enforced.

39. The Northern Territory of Australia has appropriately acknowledged through its Counsel that its responsibility and duty of care to all prisoners must be routinely subject to public scrutiny and independent review, as has been provided in this inquest. I find that the medical care and treatment given to the deceased on this occasion at Darwin Correctional Centre was adequate. If he had been seen in accordance with the contract he would have been seen at least twice by Dr English. Given Dr English's evidence, and the evidence of Professor Currie and Dr Lum in relation to the development of the disease Melioidosis, it remains only a slim possibility that this would have made any difference to the ultimate outcome. Nevertheless, the deceased deserved the medical care for which the Northern Territory Government had contracted with its service provider, Corrections Medical Services. It is of extreme concern that the practice that was being employed at the prison was not only at odds with the contractual requirements between the Northern Territory Government and Corrections Medical Service, but was at odds with the Royal Commission recommendations which underpinned the

provisions of the contract. It is of similarly great concern that that variation took place apparently without the knowledge of any senior policy makers within the Government, including the person at that time ultimately responsible for the contract. I am told that the current practice is in accordance with the provisions of the contract as it should be. However, that contract is undergoing review. I am informed, and accept, that that review is directed towards a significant improvement in services in many areas, including the implementation of a more sophisticated method of recording prisoners movements which it is hoped will avoid any misunderstandings of the type which affected this deceased upon his second reception to the prison. However, I remain concerned that the Royal Commission recommendations are only going to be "taken into account" in determining specifications for the new contract. In order to address that concern I make the following recommendation.

RECOMMENDATION

40. I recommend that the recommendations 150 and 156 of the Royal Commission into Aboriginal Deaths in Custody, be reflected in any revised specifications in the contract for primary health care for prisoners of Northern Territory Government correctional institutions.

Dated this twenty sixth day of August 2005.

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GREG CAVANAGH
TERRITORY CORONER