CITATION: *Inquest into the death of David John Pendergast* [2002] NTMC 024

TITLE OF COURT:	CORONERS COURT
JURISDICTION:	Coronial
FILE NO(s):	A0043/2001
DELIVERED ON:	9 May 2002
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HEARING DATE(s):	7 & 8 May 2002
JUDGMENT OF:	Mr Greg CAVANAGH SM

CATCHWORDS:

Coronial Inquest, death in custody, death from natural causes, medical facilities at the prison.

REPRESENTATION:

Counsel:

Counsel assisting the Coroner:	Mr Mark JOHNSON
Counsel for Correctional Services	Mr John STIRK

Judgment category classification:	A
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IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0043/2001

In the Matter of an Inquest into the death of

DAVID JOHN PENDERGAST (Deceased)
AT ALICE SPRINGS CORRECTIONAL CENTRE
ON 10 JUNE 2001

FINDINGS

THE NATURE AND SCOPE OF THE INQUEST

1. This death is properly categorised as a death in custody. At the time of his death, David John Pendergast (the deceased) was a person detained at the Alice Springs Correctional Centre, a prison. This prison is usually known as Alice Springs Gaol. The deceased, therefore, was a "person held in custody" within the definition in s.12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act"). His death is a "reportable death" which is required to be investigated by the Coroner pursuant to s.14 (2) of *the Act*; a mandatory public inquest must be held pursuant to s.15 (1)(c).

2. The scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of *the Act.* It is convenient and appropriate to recite these provisions in full:

> **"26. Report on Additional Matters by Coroner**
>
> (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.
>
> **27. Coroner to send Report, &c., to Attorney-General**
>
> (1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.
>
> **34. Coroners' Findings and Comments**
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> (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.

(2) A coroner may comment on a matter, including public health or safety or the administration of justice connected with the death or disaster being investigated.

(3) A coroner shall not, in an investigation, include in a finding or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subs (1)(a)(iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act.*

35. Coroners' Reports

(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 the 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."

CORONERS FORMAL FINDINGS

7. In accordance with the statutory requirements under *the Act*, the following are my formal findings arising from this Inquest:

i. Identity: The Deceased is David John PENDERGAST, a male Aboriginal Australian, who was born on 26 February 1970 at Penrith in New South Wales.

ii. The time and place of death: The Deceased died in Block D of the "Cottages" section of the Alice Springs Correctional Centre on 10 June 2001 at around 10.40pm.

iii. The cause of death: The cause of death was coronary occlusion, which was contributed to by atheroma.

iv. The particulars required to register the death are as follows:

a) The Deceased was a male;

b) The Deceased was an Aboriginal;

c) A post mortem examination was carried out on 13 June 2001 and the cause of death was coronary occlusion which was contributed to by atheroma;

d) The pathologist viewed the body after death;

e) The pathologist was Dr Derek POCOCK, a locum at the Alice Springs Hospital;

f) The father of the Deceased is not known;

g) The mother of the Deceased is Jeanette Suesan SKINNER;

h) The Deceased resided at the Alice Springs Correctional Centre at the time of his death; and

i) The Deceased was not employed in any occupation at the time of his death.

Treatment of the deceased whilst in custody

8. I find that there is no evidence of the involvement of any other person or any suspicious circumstances relating to the death of the deceased and, accordingly no report is required under s.35(3) of *the Act*. Furthermore, I find that the deceased did not sustain any injuries whilst being held in custody which caused or contributed to this death.

The relevant circumstances concerning the death including Recommendations

9. Late in the evening of Sunday 10 June 2001 the deceased died from a major heart attack. He was a serving prisoner at the Alice Springs Gaol who was aged 30 years at the date of his death. He was pronounced dead at 12.32am on Monday 11 June.

10. The investigation into the death commenced on 11 June 2001 when police attended at the scene. The Coroner's Constable in Alice Springs contacted police in Katherine who then notified the next of kin, Shirley MacDonald, who indicated she did not object to an autopsy being carried out.

11. The details of the inquest were duly advertised in the "Centralian Advocate" on 9 April 2002. The former partner of the deceased was notified, as was the Central Australian Aboriginal Legal Aid Service. The public inquest was held at the Alice Springs Magistrates Court, commencing on Tuesday, 7 May 2002. Counsel assisting me was Mark Johnson. Mr John Stirk sought leave and was granted leave to appear as counsel for the Northern Territory Government.

12. I heard from seven witnesses who gave evidence at the inquest. Detective Sergeant Kesby, who I congratulate for his excellent work in investigating this particular death; Evelyn Falconer, a prison officer; James Neil, prison officer; Dennis Pfrunder, prison officer; Patricia Archer, former nurse at the Alice Springs Correctional Service; Peter Rainbird, Deputy Superintendent Alice Springs Correctional Service and Tony Scrutton, a former prisoner at the Alice Springs Correctional Services. In addition to this evidence a full brief of evidence was tendered by Detective Sergeant Kesby. The brief included numerous statements and other documentary records, and was very thorough.

13. The deceased had been in a de facto relationship with Shirley MacDonald for about 7 years, up until he was imprisoned in 1998. They lived in the "long grass" mainly at Mandorah near Darwin. He received a sentence of imprisonment for manslaughter of 6 years and 6 months with a non-parole period of 3 years 3 months, backdated to commence on 19 June. His earliest

release date on parole would have been 19 September 2001, ie. 2 or 3 months after his death.

14. Initially the deceased was imprisoned at the Darwin Correctional Centre, however in November 1999 he was transferred to the Alice Springs Correctional Centre. He remained there until his death. There were some initial problems with his health, but after he was diagnosed by Doctor Christopher Wake with a chronic mental illness, being schizophrenia, and placed on medication his health improved remarkably. Eventually he was receiving daily medication of 20 milligrams of Olanzepine.

15. The work assessments of the deceased were good. His security level progressively reduced and at the time of his death he was at the lowest security rating (which was E). He was housed in the minimum security cottage facilities at the Alice Springs Correctional Institution. He was in block D with eight other prisoners.

16. These cottages are situated outside the main security fence of the prison and there is a basic honesty system in place. The purpose of the cottages is to prepare prisoners for outside life and to allow for more responsibility to be placed upon them. Prison officers are on duty at the cottages from 8 am to 8pm daily. Outside of these hours, number and health checks are conducted at the cottage facility two hourly, being at 10pm, midnight, 2am, 4am and 6am.

17. At the time of each count the names of the prison officers, count total, and any related matters are recorded in the Cottage Journal, which was exhibited during the course of the inquest.

18. The evidence indicates that the deceased was behaving in a normal manner on the day of his death. There was no indication of ill health or mental abnormalities. His normal routine was maintained. He spent most of the afternoon watching TV and smoking outside the cottage. At 4pm he had a light dinner of cold chicken salad. He received his medication. He was watching TV at around 6pm. At 7pm a muster was conducted and he was observed to be behaving normally, with no reports of any physical problems. Further checks confirmed this during the course of the evening. He was spoken to by a prison officer just after 10pm and appeared quite normal. He told the prison officer he was going to bed. At about 10.40pm the deceased was asleep, lying on his back on his bed, when he began to convulse. Some of the other prisoners in the cottage stated that a tapping came from the general area where the deceased was asleep. This tapping was apparently caused by the deceased's right hand knocking against his bedside cabinet during a convulsion.

19. His breathing became raspy and laboured at this time. Other prisoners attempted to help him. He did not respond. He began to vomit over his pillow and his breathing became very shallow and intermittent, with long periods between breaths. Prisoner Scrutton was amongst those who came to assist. He turned the lights on. He then attempted to administer emergency

help by way of Cardiac Pulmonary Resuscitation (CPR) and Expired Airway Resuscitation (EAR). Prisoner Hargrave helped.

20. Prison staff were alerted by making a telephone call to the tower. This phone is situated near the administration area of the cottages, about 50 metres from cottage D. The phone rings directly through to the main tower. Attempts were made to push the duress alarm situated in the dorm, but this was found to be inoperative. There are no video surveillance cameras situated in the cottage area.

21. At about 10.45pm Prison Officer Falconer was situated in the tower top; she received the phone call. There was a report that the deceased was foaming at the mouth. Falconer immediately called Senior Prison Officer Pfrunder, the Officer in Charge (OIC) of the prison for that night. He immediately attended the gatehouse and departed for the cottages in company with Prison Officer Neil.

22. It was raining heavily; they made the journey to the cottages in a prison vehicle. The officers in the tower noted in the Communications Journal that Prison Officers Pfrunder and Neil departed the gatehouse at 10.50pm. It is a distance of about 300 metres. They found the deceased lying on his back in his bed and his face was blue in colour. He was surrounded by prisoners who were attempting to assist him.

23. There is no evidence to suggest that the prisoners in the cottage did anything else but act in good faith to assist the deceased. Prison Officer Neil gave

evidence to me that he had considerable experience as a medic while serving in the British Army (including dealing with the dead and dying). He left me in not much doubt at all that the deceased was dead upon Neil and Pfrunder's arrival.

24. However, this did not stop the officer's from administering help and they did all they could to resuscitate the deceased. He was placed in a stable position and Neil cleared his airway and attempted to take his pulse. No pulse could be located. The prisoners were removed and CPR was commenced by Prison Officer Neil. That went on for some time with no apparent effect. Pfrunder made a phone call, requesting an ambulance. He called Nurse Patricia Archer, who was on duty. He then contacted Senior Superintendent Rainbird on his mobile phone and gave him a briefing of the situation.

25. The "Oxy-Viva" kit from the medical room was obtained and the use of that took place at the same time as Neil was still attempting CPR on the deceased. The "Oxy-Viva", a continuous flow mask, was placed on to the deceased to assist with the emergency resuscitation procedures. Pfrunder and Neil had been instructed in the use of the Oxy-Viva machine and they were proficient and qualified in first aid.

26. The ambulance arrived at 11.23pm, after it was called at 10.59pm. There was heavy fog at the time and it was unsafe to travel at speed. Further

resuscitation attempts took place. Adrenaline was tried. All attempts at resuscitation were unsuccessful and treatment was discontinued at 11.39pm.

27. As required, Deputy Superintendent Rainbird advised police communications of the death and police arrived a little after midnight and secured the scene, (pursuant to Police Standing Orders), as a crime investigation scene. Full examinations were conducted. Forensic members arrived. Videos and photographs were taken.

28. The visiting medical officer, Dr Christopher Wake, attended. He examined the deceased at 12.32am and pronounced him dead at that time. An autopsy was performed by Doctor Pocock who stated the cause of death was coronary occlusion which was contributed to by atheroma. Toxicology did not reveal anything suspicious and apparently the deceased had very severe heart disease problems, which had remained undiagnosed and were very unusual in a man of his age. Certainly there was nothing to suggest he had such bad heart disease prior to his death.

29. There was a coronial investigation which I find was thorough and comprehensive. It was in accordance with Police Standing Orders. I find that the deceased died from a massive heart attack. His heart disease was undiagnosed and the heart attack was not anticipated and nothing could have been done by the prison staff or by any of the prisoners to prevent the tragic death of this man.

30. I have no adverse comments to make about anyone in respect of this death, although I do have some recommendations to make. The evidence in this inquest revealed that the cottages at the prison were originally fitted with a duress alarm. Because of problems with cabling these duress alarms are not operational; in fact they had almost been constantly non-operational for the past 4 years.

31. Counsel for the government frankly conceded and properly conceded, in my view, that duress alarms must have had some purpose if they were originally installed in the cottages. I agree with him and I can imagine situations where a telephone some tens of metres away from an emergency scene may not be enough to raise alarm such that people should come running, whether it is for medical reasons or indeed other reasons which one can imagine in prisons. There should be some kind of alarm where someone can just press the button or smash the glass, as it were. And it ought to be attended to and I recommend that it is.

32. It is a sad fact that approximately seventy five per cent of the Northern Territory prison population is Aboriginal men (see evidence outlined in Inquest into the death of Waniyun Marika – findings delivered on 1 February 2000), and ischaemic heart disease is comparatively very prevalent (as compared to caucasian men) in Aboriginal men (see evidence outlined in the Inquest into the death of Clive Impu – findings delivered on 19 October 2001)

33. It is to be noted that deaths of Aboriginal persons caused by heart disease are not uncommon in Northern Territory prisons and I recommend that the emergency medical resources available to prisons reflect this reality.

Dated this 9th day of May 2002

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Greg CAVANAGH

TERRITORY CORONER