CITATION: Inquest into the death of Graham Murrurkuwuy [2002] NTMC 032

TITLE OF COURT: CORONERS COURT

JURISDICTION: Coronial

FILE NO(s): D0088/2001

DELIVERED ON: 13 August 2002

DELIVERED AT: Darwin

HEARING DATE(s): 4, 5, 6, March 2002

JUDGMENT OF: Mr Greg Cavanagh SM

CATCHWORDS:

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

REPRESENTATION:

Counsel:

Counsel assisting the Coroner: Mr Martin Carter

Counsel for Correctional Services Mr Garry Schneider

NAALAS (Watching brief): Mr Warren Hunter

Judgment category classification: A

Judgment ID number: [2002] NTMC 032

Number of paragraphs: 37

Number of pages: 16

IN THE CORONERS COURT

AT DARWIN IN THE NORTHERN

TERRITORY OF AUSTRALIA

No. D0088/2001

In the Matter of an Inquest into the death of

GRAHAM MURRURKUWUY
ON 19 JUNE 2001
AT BERRIMAH PRISON

FINDINGS

THE NATURE AND SCOPE OF THE INQUEST

1. On the 19th June 2001, the deceased was a serving prisoner at the Darwin Correctional Centre ("Berrimah Gaol"). At 9.15am on that day, he became ill and prison staff became concerned for his welfare. The Medical Centre was notified. At about 10.00am medical staff arrived to find the deceased to be lying on the floor of his cell B7, in L Block at the Darwin Correctional Centre (called the "Disabled Prisoners Cell"). They had been called to the cell by the Prison Superintendent. Attempts were then made to resuscitate the deceased and at 10.23am these attempts were abandoned. The deceased was pronounced dead. This death is properly categorised as a death in custody. The deceased was a "person held in custody" within the definition of s 12 (1)(b) of the Coroners Act 1993 (NT) ("the Act").

2. Further, the death is a "reportable death" which is required to be investigated by the Coroner pursuant to s14 (2) of the Act. As a consequence of the deceased dying in custody, a public inquest must be held pursuant to s15 (1)(c) of the Act. 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 Coroners 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

(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."

3. The investigation into the death commenced on the 19 June 2001 as a result of police attending the scene. The Coroner's office in Darwin notified the next of kin in Millingimbi of the Inquest into the deceased's death and the deceased's step brother Mr Billy Buywan responded. Through his representative, Mr Warren Hunter (a legal practitioner from the North Australian Aboriginal Legal Aid Service Inc), Mr Buywan made it known to the Coroner at the beginning of the public Inquest on the 4 March 2002 that the next of kin did not wish to be represented. The public inquiry then commenced and Mr Hunter remained in the body of the court for most of the hearing with a watching brief. Mr Hunter addressed the court at the end of the evidence on the 6 March 2002. Counsel assisting me was Mr Martin Carter and Mr Garry Schneider appeared as Counsel for Northern Territory Correctional Services, (part of the Department of Justice).

4. The court heard from seven witnesses who gave evidence in this inquest. They were:

1. Detective Sergeant Gary Barnett – the Police Officer in Charge of the investigation of the circumstances surrounding the death of the Deceased.

2. Bernice Jane Heath – Prison Officer, Berrimah Gaol

3. Rodney Paul Williams – Prison Superintendent, Berrimah Gaol

4. Julie Ralph-Flint – Registered Nurse, Berrimah Gaol

5. Clinton James Shipp – Prisoner at Berrimah Gaol

6. Doctor Robert Szabo – Formerly Medical Officer (Locum) (This evidence was given by video conferencing. Dr Szabo was present in Canberra during the video conference).

7. William Robert Sommerville – a former prisoner at Berrimah Gaol at the time of death.

5. In addition to this evidence, a full brief of evidence was tendered by Detective Sergeant Barnett. This evidence included statements from various witnesses and

numerous other records of the Police, Correctional Services, and Department of Health and Related Services.

S34 Particulars

12. To allow this death to be registered under the Births, Deaths and Marriages Registration Act the following particulars are provided to the Registrar:

(a) The Identity of the Deceased Person

The deceased is Graham Murrurkuwuy (sometimes spelt Mururguwui), a male Aboriginal Australian who was born on 2 February 1952 at Milingimbi, Northern Territory. The deceased was also known as Graham Wilson and his date of birth was also referred to as 1 January 1955 and 2 May 1952 in some records.

(b) The Time and Place of Death

The deceased died at the Darwin Correctional Centre some time between 9.50 and 10.23 hours on 19 June 2001 aged 49 years.

(c) The Cause of Death

The cause of death was recorded as cor pulmonale and chronic bronchitis and emphysema. The death was due to natural causes.

(d) The particulars required to register the death

1. The deceased was a male.

2. The deceased was of Australian Aboriginal origin.

3. The cause of death was cor puliminateas as reported to the Coroner.

4. The cause of death was confirmed by a post-mortem examination.

5. Death was from natural causes; the deceased had suffered from a diseased heart and lungs for a long time. There was no evidence of any intervention causing or contributing to the death by a third party.

6. The pathologist viewed the body after death.

7. The pathologist was Dr Michael Zillman, Forensic Pathologist of Royal Darwin Hospital.

8. The father of the deceased is Charlie Curungung. The mother of the deceased is Topsy Yiganani.

9. The deceased had no fixed place of address save for Berrimah Prison.

10. The deceased was a pensioner.

THE DECEASED

6. The Inquest did not hear from members of the family of the deceased. The deceased is not believed to have been married and did not have any known children. Further his parents were believed to have predeceased him.

7. The deceased was born at Milingimbi in the Northern Territory and, according to medical records, this was on 2 May 1952. Northern Territory Correctional Services records refer to his date of birth as being 1 January 1955. The Aboriginal population records, held by the Registrar at Birth, Deaths and Marriages record his date of birth as 2 February 1952. Not much is known of the deceased but suffice to say that some background is referred to in the report by Detective Sergeant Gary Barnett. For the last twenty years the deceased had lived life as an itinerant and had a history of substance abuse including consumption of methylated spirits. In addition the deceased was a cigarette smoker and one of the contributing factors to the heart disease was chronic emphysema and asthma caused by cigarette smoking.

8. At the time of his death the deceased was serving a sentence of three months imprisonment for the offence of criminal damage. The offence leading to the conviction happened after the deceased was refused admission to the St Vincent De Paul's shelter in Westralia Street, Darwin. He threw a brick at a white utility vehicle owned by the St Vincent De Paul's Society. He was arrested as a result. Having pleaded guilty to the offence of criminal damage he was sentenced to the mandatory term of three months imprisonment. There is a warrant of imprisonment on the Coronial file dated 1 April 2001. The effect of the imprisonment was to isolate him from the unhealthy lifestyle he had endured prior to the imprisonment. For most of the term of his imprisonment the deceased was held in the disabled persons cell at "L Block". This cell is about 120 metres from the prison medical centre and is fitted with wheelchair access. He was examined by Dr Szabo the day before his death and visited by Nurse Julie Ralph-Flint at about 8.00am on the morning of his death. Nothing unusual was seen that could have forwarned them of his impending demise.

CORONIAL INVESTIGATION

9. The Coroners Act requires an independent investigation in these circumstances at the direction of the Coroner. Detective Sergeant Gary Barnett and his officers carried out an investigation according to the requirements of Police General Orders D2. That general order specifically relates to the Investigation and Reporting of Deaths in Custody.

10. Detective Sergeant Gary Barnett's report is thorough and insightful. I have no doubt that his opinion that the evidence reveals that death was from natural causes is correct. This conclusion is not only supported by the medical evidence but also is reflected in the testimony of all those witnesses to the death including Mr Shipp, Mr Sommerville and Prison Officer Heath, who were present when the deceased died.

11. The Forensic Pathologist's (Dr Pocock) report established that no other persons were involved in the death and the cause of death is consistent with the observations at the scene.

CARE, SUPERVISION AND TREATMENT IN CUSTODY

The Deceased's Medical History

12. The Royal Darwin Hospital medical records relating to the deceased revealed that the deceased had a long history of failing health from a number of different ailments including emphysema, asthma, low blood pressure, peptic ulcers and anal bleeding.

13. The Darwin Prison had, at the time leading up to the death on 19 June, a Medical Centre approximately 120 metres from L Block. The Medical Centre was staffed by a locum, Dr Szabo, and one nursing sister. Other nurses worked shifts and were not on duty that morning. Dr Szabo was on duty from approximately 8.00am and Nurse Ralph-Flint, from approximately 7.30am. In all, there were approximately four hundred prisoners in custody on the morning of the death.

14. Between 2 April and 19 June 2001 the medical staff had treated the deceased on many occasions. Evidence from the interview between police and Dr Szabo establishes that he had examined the deceased on 31 May soon after joining the prison medical team. Further, Dr Szabo had referred the deceased to Royal Darwin Hospital for further examination after the deceased had complained of abdominal pain the day before he died. The deceased had suffered from some anal bleeding but this was not apparent on the examination of 31 May.

15. As a result of Dr Szabo's examination, the deceased had been driven to the Royal Darwin Hospital by St Johns Ambulance on 18 June 2001. Doctor Lum at Royal Darwin Hospital examined the deceased that day with particular reference to the complaint of abdominal pain and anal bleeding. It had previously been decided that the deceased would be admitted to the hospital on 21 June for an examination. The deceased was taken back to the prison from the hospital after 3.30pm on 18 June 2001.

16. At 0800 on the morning of his death, Nurse Julie Ralph-Flint saw the deceased in his cell. The visit occurred after cell doors had been opened for the day; it was a routine visit. At the hearing on 4 March, Nurse Ralph-Flint stated that she spoke to the deceased at that time and he was mumbling away to himself as usual. There was nothing about him that

forewarned her of the rapid approach of death. She then left the deceased and went on her usual medication rounds.

17. After the medication round, Nurse Ralph-Flint returned to the medical centre to commence other work, including assisting at the psychiatric clinic, and then assisting in a morning clinic conducted by Dr Szabo. Nurse Ralph-Flint stated in evidence that, on that morning, the optometrist was at the clinic.

Medical Treatment available at the point of death

18. One of the issues that arose during the Inquest was the response time taken by the medical staff to attend to the deceased in "L" Block.

19. At 0915 a telephone call was made by Prison Officer Heath reporting that the deceased had defecated "all over himself". Nurse Ralph-Flint stated that cleaning the deceased up was not a priority as she was assisting Dr Szabo in a busy clinic at this time. This is confirmed by Dr Szabo in his interview and he answered that he did not believe it was Nurse Ralph-Flint's job to clean up a prisoner. I do not find any evidence to support the proposition that this message gave the Doctor sufficient reason to break off the clinic at that point to attend a prisoner who had defecated.

20. It is clear when following the chronology of events as described on page 3 of Superintendent's Williams report and from reading the "L Block" day journal, that the deceased's condition was discussed between the on duty cell block officer Heath and a previous cell block officer May. Prison officer May had concerns regarding the health of the prisoner and according to his statement (attached to the file), he passed his concerns onto several persons including PO Heath. This discussion took place at about 0810 hours on the day of the death. From then on, Heath kept a close watch on the deceased and at about 0855 she made an observation that the prisoners condition was deteriorating. Over the following hour several prison officers, Herbert (Index 35), Craven (Index 38) and Lawson (Index 36), became involved in obtaining further medical assistance for the ill prisoner.

21. It was not until about 1000 hours that Dr Szabo and Nurse Ralph-Flint were actually instructed to go to the prison block by Superintendent Williams. Superintendent Williams made this direct instruction as a result of information given to him by prisoner officer Heath who was concerned enough as to deceased's condition that she rang the highest ranking officer in the prison directly.

22. I find on the evidence that all relevant prison officers passed on to other prison officers and Nurse Ralph-Flint, accurate descriptions of the deceased's condition as they saw it. It appears that Nurse Ralph-Flint understood each message she was given and acted on that information after taking into account her previous knowledge of the prisoners current medical condition and symptoms.

23. Her actions, resulting in her receiving further information from prison officer Lawson that the prisoner had soiled himself and needed cleaning up were consistent with her current knowledge of the prisoner's health. Her current knowledge being that he suffered from abdominal pain the previous day and had been seen by both Dr Szabo and Dr Lum (at Royal Darwin Hospital) the previous day and that, at 8.00am, she had seen him in his cell when he was mumbling to himself.

24. Specifically, Nurse Ralph-Flint had been given the following information regarding the deceased's health:-

(i) that he would not get up off the floor (prison officer Heath)

(ii) he was too weak to get off the floor (prison officer Heath and others)

(iii) his breathing was short and difficult (prison officer Heath)

(iv) he had soiled himself – (prison officer Heath)

(iv) there was blood in his faeces

25. None of this information was new information to the nursing sister and she was not aware that death was imminent. The information conveyed to her concerning the deceased's failing health was information that was consistent with her knowledge of his day to day vital signs. She agreed to attend the cell block after the usual morning clinic was completed and clean up the prisoner.

26. Similarly, the behaviour and condition of the prisoner was, in the opinion of Senior Prison Officer Lawson, consistent with the normal day to day appearance of the deceased. Prison Officer Lawson states he went to see the nursing sister after he had been to see the ill prisoner himself and that "my thoughts weren't that he was going to die like other prison officers thought. I was thinking of hygiene, who's going to clean him up."

Attempts to resuscitate the Deceased

27. Dr Szabo and Nurse Ralph-Flint arrived at L Block at 1000 hours to attend to the deceased. They went into immediate full resuscitation procedures. Being unable to revive the deceased, Dr Szabo pronounced life extinct at 1019 hours. There is a discrepancy between the time that Dr Szabo pronounced life extinct and the time recorded in the memory of the automatic heart starting machine. This discrepancy between 1019 and 1023 is insignificant. I find that breathing and pulse had ceased before they arrived.

28. When the doctor and Nurse Ralph-Flint arrived at the cell, they did not have with them the automatic heart start machine (defibrillator). This was sent for and quickly arrived with the assistance of one of the prison officers. The prison telephone call register records that the ambulance was requested at 1009 hours and at 1018 hours. I find that the

ambulance was called after life had expired. All that could be done to resuscitate the deceased had been done before the Ambulance arrived.

29. The Prison Clinic was equipped with a defibrillator, commonly called a Heart Start Machine. This machine was equipped with an electronic memory. It was taken by the Police with the consent of the manager of medical equipment, Mr Trevor Reissen. Data was recovered from the memory of the machine and later interpretated by Dr Marcus Ilton, a cardiologist at the Darwin Private Hospital. The defibrillator recorded that life had terminated prior to the machine being switched on and that death was consistent with a cardiac arrest. This places the time of death before 10.00am.

Autopsy Results

30. On 20 June 2001, an autopsy was carried out by Dr Zillman. His initial findings were that the deceased died of natural causes. A copy of initial findings is attached to the file Exhibit 1 (Index 16). Dr Zillman ceased to practice in the Territory and Dr Derek Pocock then reviewed the autopsy records. Dr Pocock reported:- "where the cause of death is still being given as provisional it is my opinion that in this case the final cause of death should be read as follows:

"1a Cor pulmonale

1b Chronic bronchitis and emphysema."

Dr Pocock continues in his report that the death was sudden and due to natural causes with no evidence of any involvement by other persons.

31. The evidence indicates that it took prison medical staff less than 5 minutes to arrive at L Block when they were required to attend by the Prison Superintendent Williams. In evidence from Nurse Ralph-Flint, it seems that she received only one message and that was the message at 0915 - to the effect that the deceased had defecated. There is therefore a period of approximately 45 minutes from the message at 0915 to the arrival at 1000 when the deceased's health declined very rapidly and life expired. I find that the prison officers, particularly prison officer Heath, did all they could to prevent his death. I refer to the evidence of prisoner Mr Sommerville contained in the recorded conversation that forms part of the transcript 21 June 2001 (transcript p14):

"There's one thing that, and I think should go on the record and I don't when, where it goes or what happens but it's very important I think that in my view any way, that Ms Heath did just everything she possibly could have done".

And further,

"There should be no criticism of her whatsoever".

32. Mr Sommerville was the last witness in the inquest. He had no interest in the outcome of the proceedings, was present at the time and was in the position to observe the conduct of the prison staff during the period up to the time medical staff arrived. I find that his evidence as to times are approximate (indeed he acknowledged that to be his evidence). Mr Sommerville's evidence was similar to prisoner Shipp's evidence (Shipp being in a nearby cell at the relevant time), and I quote (transcript p.40):

"Do you think everything that could be done was done?---Yeah, I think pretty much so, he was a fairly sick."

33. I find that in the final 45 minutes of the deceased's life, prison officers did all that they could to prevent his death. They relayed to the medical staff accurate symptoms, as they observed them, of the deceased and those symptoms were understood by medical staff. Medical staff had no information that would have changed their current diagnosis and as such did not see any need to immediately break off the morning clinic. Clearly a doctor in immediate attendance would have recognised the sudden decline in the health of the deceased but it remains doubtful that even then, such a person could have prevented the death.

34. I have had the benefit of hearing and observing in evidence the prison medical staff, and in all the circumstances, I do not think that they ought be criticised for not attending to the deceased sooner than they did. The deceased's plight in the last hour of his life was obvious to the prison officers, however as sick as he was (and without the benefit of face to face appraisal) the medical staff made a judgment that their attention could be delayed. That judgment was there to be made and in my view hindsight evaluation does not result in it being something I should criticise. I do note that the new medical observation unit should remedy in the future any delay in treatment in similar cases.

Emergency Code Blue

35. An issue raised by Nurse Ralph-Flint, in her interview with Detective Sergeant Barnett, was the absence of a medical emergency code for internal prison communications. She stated that medical staff were operating within the prison without a medical emergency code. As a result of the comments by Nurse Ralph-Flint the Prison Superintendent has introduced a medical emergency protocol "Code Blue". A copy of the Code Blue was tendered in evidence (Exhibit 4). An emergency protocol has been introduced which ought alert medical staff to the apparent seriousness of a medical emergency outside of the medical centre.

Medical and at risk observation centre

36. Exhibit 4 details the construction of a Medical at Risk Observation Centre adjacent to the Prison Clinic. This centre became operational after this death. With the opening of the new Observation Centre prisoners in very poor health can be placed in cells next to the Clinic where they can be kept under closer observation than was previously possible. It is

relevant to quote the Superintendent of the prison who gave evidence before me (Mr R Williams) (transcript p.20):

You have a lot of Aboriginal prisoners within that prison, don't you?---At the moment we're averaging about 65% and that's purely because the Indonesian numbers are so high.

And it's a sad but notorious fact that a lot of Aboriginal people have health problems, isn't it?---They certainly do have health problems.

Usually health problems that aren't bad as the average Caucasian prisoner?---Aren't as bad or worse.

Aren't as bad?---I think the health problems are worse than the average Caucasian.

That's what I meant. So knowing that, does your prison go out of its way to have systems in place to deal with that face?---I think the – through the provision of the Corrections Medical Services, the out-sourcing has actually improved the quality of care for all prisoners, but especially Aboriginals. Probably in the last four to five years there's been a major increase in the resources applied at the prison for all health."

And (transcript p.25):

I'm pleased to hear all that, but you're telling me also that in terms of prisoners being educated as to the facilities including the emergency facilities, your're not going to just leave it at a printed handbook?---No, we're not we're actually going to have a video. I believe it takes into account about six major Top End languages.

Top End Aboriginal languages?---Top End Aboriginal languages, plus central Australia and Indonesian and English. Actually it's going to be a DVD."

37. In view of the introduction of the medical emergency "Code Blue" and the building of the observation unit (planned before the death) there are no specific recommendations that arise from this Inquest. I commend those pro-active measures taken by prison authorities.

Dated this 13th day of August 2002

Greg Cavanagh

TERRITORY CORONER

top of page

Last Updated: 19/11/02