CITATION: *Inquest into the death of Jeremy Tunkin aka Lawrence Tunkin* [2018] NTLC 025

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0051/2017
DELIVERED ON:	26 November 2018
DELIVERED AT:	Darwin
HEARING DATE(s):	16 & 17 October 2018
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in Custody, Natural Causes, Communication problems with hearing impaired prisoners, AutoPulse resuscitation devices**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Central Australia Health Service	Stephanie Williams
Department of the Attorney General and Justice	Helena Blundell

Judgment category classification:	A
Judgement ID number:	[2018] NTLC 025
Number of paragraphs:	67
Number of pages:	22

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

No. A0051/2017

In the matter of an Inquest into the death of
JEREMY TUNKIN aka Lawrence Tunkin
ON 8 FEBRUARY 2017
AT ALICE SPRINGS CORRECTION CENTRE, ALICE SPRINGS

FINDINGS

Judge Greg Cavanagh

Introduction

1. Jeremy Tunkin ("the deceased") was born in Alice Springs on 25 February 1978 to Warren Tunkin and Maringka Tunkin. The deceased's name on his birth certificate is recorded as Lawrence Tunkin, however it is understood that at a young age his mother changed his first name to "Jeremy" and he was widely known by that name.

2. The deceased's father died from liver disease in 2011. He is survived by his mother and two elder brothers, Alfred Tunkin and Liam Tunkin. The deceased had no children but was close to his extended family and particularly his mother. It is clear he was a much loved family member.

3. According to his family the deceased was born deaf, however medical records indicate this may have been an acquired condition. Records tendered from the Alice Springs Hospital indicate that in 1984 the deceased underwent an audiometric test and was diagnosed with mild to moderate hearing loss in his right ear and mild hearing loss in his left ear.

4. It is clear however that the deceased's hearing degraded over time and in 2014 he underwent an audiological assessment with Australian Hearing and was diagnosed with moderate to severe mixed hearing loss in the right ear and a severe mixed hearing loss in the left ear. Arrangements were made

for a Cochlear implant to be installed, but the deceased never attended the appointment.

5. An unfortunate impact of the deceased's hearing problems was he had extremely limited schooling. This meant he had a limited understanding of English; he could speak some words but communicated mostly through Aboriginal sign language and the Pitjantjatjara language.

6. Despite these difficulties, it appears the deceased lived a happy lifestyle growing up in the Amata Community ("Amata"). He played football for the Amata Bombers, played drums in a local band and enjoyed hunting. The deceased also worked for periods in Amata in the area of land management taking great pride in caring for his grandfather's country.

7. Although the deceased was unmarried at the time of his death, he had been in a long term on again off again relationship with Meredith Daniels ("Ms Daniels"). The couple commenced their relationship in about 2007 and often travelled together to Alice Springs. Unfortunately when in Alice Springs the deceased had easy access to alcohol and often drank to excess. As a consequence of this alcohol abuse it appears that the relationship between the deceased and Ms Daniels often became volatile and involved numerous reports to police.

8. The couple were reported to have "ended" their relationship in 2010, but it is clear they continued to see one another from time to time up until 2016. Northern Territory Police ("police") records show that between 1 December 2009 and 30 January 2016 there were a total of twelve (12) domestic violence incidents were recorded on PROMIS involving the deceased and Ms Daniels.

9. It is this relationship and its volatility that ultimately resulted in the deceased's imprisonment. On 18 January 2016 the deceased assaulted Ms Daniels in Alice Springs after he found her in the company of another man, namely Gary Powell ("Mr Powell"). The following evening the deceased approached Mr Powell in the carpark of a unit complex armed with a steel

rod and knife. The deceased struck Mr Powell a number of times to the face, head and arms with the rod. As a result of the blows Mr Powell fell to the ground and at this time the deceased stabbed him with the knife to the forearms, left ankle and thigh. Fortunately Mr Powell managed to run away from the scene and alerted police.

10. On 5 February 2016 the deceased was arrested and charged with aggravated assault and unlawfully cause serious harm for the assaults on Ms Daniels and Mr Powell. The deceased was also charged with two further counts of aggravated assault relating to earlier assaults on Ms Daniels. He was remanded into custody and on 6 February 2016 was received by Northern Territory Correctional Services ("Corrections") at the Alice Springs Correctional Centre ("ASCC"). This was the deceased's first custodial episode with Corrections and it is where he remained until his death.

11. On 11 October 2016 the deceased pleaded guilty to the assaults on Ms Daniels and Mr Powell in the Supreme Court before Justice Blokland. He was sentenced to a total aggregate sentence of five (5) years commencing 5 February 2016 with part of his sentence suspended. The deceased's conditional release date was determined to be 4 August 2019 and his full time date of discharge was 4 February 2021.

12. Despite all of this; it is clear from the evidence that the deceased was an exemplary prisoner. In fact one of the Corrections officers who gave evidence stated that "if all prisoners were like (the deceased) it would be great". The deceased was employed for a period as a cook and then when he was transferred to the Low Security Cottages ("the Cottages") he was employed as a cleaner. It is apparent that he was well regarded by Corrections staff for his work ethic and was trusted enough that it had been agreed that he would take over as the cleaner of the Officer's Post at the Cottages following the release of another prisoner. It is apparent that he was also well liked by his fellow prisoners who clear cared about him.

Events leading up to his death

13. At about midday on Sunday 6 August 2017 (just after receiving lunch) the deceased was in dorm E1 of the Cottages. It is apparent that at this time a number of the deceased's dorm mates observed the deceased to be in discomfort. Each of those dorm mates reported in their statements that they believed the deceased was suffering "chest" pain. A number of those prisoners also reported that they had conveyed to Corrections staff that the deceased was suffering chest pains. This evidence was repeated by three (3) of the deceased's fellow prisoners who gave evidence before me.

14. A number of Corrections officers also gave evidence before me. They reported that although their attention was drawn to the deceased by his fellow prisoners; they had understood that the deceased was complaining of a "sore throat" or issues to do with his throat or neck area. Each of the officers was clear that at no time did they believe the deceased was suffering from chest pain and in fact gave evidence that had they believed it was chest pain they would have called a "Code Blue" for immediate medical assistance.

15. Be that as it may, it is clear that as a result of concerns for the deceased, arrangements were made by Corrections staff for him to attend at the medical centre at the ASCC. In relation to the chief complaint that was identified at that point in time; there is again some divergence in the evidence. Senior Corrections Officer ("SCO") Keven Lane who was the Corrections officer on duty at the medical centre that day, recalled that he received the call from the cottages about the deceased and that it was his recollection that the deceased was complaining of "some sort of ache in his shoulder". In evidence SCO Lane stated that he believed he had been told that there was a problem with his "shoulder, neck or upper body". SCO Lane agreed however that he had made a contemporaneous record in the medical centre diary and that this recorded that the deceased was "complaining of aching upper body" and that the nurses were "advised".

16. It is apparent that initially arrangements were made for one of the nurses to attend at the cottages but it was subsequently requested by clinic staff that the deceased would be brought to the medical centre. According to CCTV footage obtained from ASCC, Corrections Officer ("CO") Graham Henwood walked the deceased from the main gate of the cottages at approximately 12.32pm and then drove him from the cottages to the medical centre. CO Graham gave evidence that it was always his understanding that the deceased was complaining of a problem with his throat.

17. I have watched the CCTV footage. It depicts the deceased holding his right arm across his upper torso area with his hand directly under his throat. The area where his arm is located is more easily described as his chest area; however it could also be described as under his throat. The CCTV footage then depicts the deceased walking into the medical centre at approximately 12.41pm. At that time he is seen to be rubbing his upper torso area with his left hand, before placing his right hand again on his upper torso. The deceased is directed by SCO Lane to the waiting area where he sits for 25 minutes. In that time he is seen to be drinking a cup of water and intermittently using both hands to rub/hold his upper torso. Again, an area more easily described as chest area, but not far from his throat.

18. At 1.09pm the deceased is taken into the treatment area by Registered Nurse ("RN") Tony Augustine. RN Augustine gave evidence before me and stated that initially he had trouble communicating with the deceased because of his hearing disability. RN Augustine revealed that he had extensive dealings with persons with hearing disabilities and therefore worked hard to ensure he was satisfied with the level of communication he was able to have with the deceased. As a result of their communication, RN Augustine believed that the deceased was complaining about having drunk "white stuff", however he wished to make sure and therefore sought help from the morning team leader RN Emma Jones.

19. RN Jones also gave evidence and confirmed being requested by RN Augustine to offer assistance. RN Jones also had difficulties communicating with the deceased but recalled him touching his throat during their interaction and she believed there was something wrong with his throat. RN Jones stated however that she was "not sure" and therefore told RN Augustine to do a set of observations. According to the medical records and RN Augustine's own recollection, those observations were "normal".

20. During the course of her involvement with the deceased, RN Jones recalled that because she believed there was a problem with his throat and mention had been made that it may have been something he drank, she arranged for him to be shown a kettle. RN Jones stated however that she believed that when the deceased was shown the kettle he gave a look of "why are you showing me the kettle?" RN Augustine on the other hand stated that he recalled that when the deceased was shown the kettle he positively indicated to the inside of the kettle and he was therefore satisfied that the deceased's complaint had to do with having drunk calcium (i.e. "the white stuff") out of the kettle. As a result he sought to reassure the deceased that he would be okay.

21. SCO Lane also recalled the kettle being shown to the deceased and that he believed that the deceased was complaining about "white stuff" inside the kettle. SCO Lane stated that after he heard this he returned to his post for medical staff to finish with the deceased.

22. Both RN Jones and RN Augustine recalled that request was made for another prisoner to be sent over to the medical centre to help assist with communication with the deceased. CO Tiffany Hamlyn-Milner was the officer to receive that call and stated that she believed it came from "one of the nurses". In her evidence before me; CO Hamlyn-Milner in fact recalled that nurse to be "Nurse Emma". As a result CO Hamlyn-Milner determined to send prisoner Brian Ajax. Arrangements were made, however CO Hamlyn-Milner stated that just as prisoner Ajax was about to go through

the gates she received a call from the medical centre telling her "don't worry about it" and that they had "found an interpreter from the management zone".

23. In regards to this call, both RN Augustine and RN Jones state that they did not call the cottages and cancel the assistance of another prisoner. RN Jones stated she did not recall having any further involvement with the deceased and was therefore not aware as to what happened with the request for assistance after it had been made. RN Augustine stated that after his involvement with the deceased (including the conversation about the kettle and his observations of the deceased) he was satisfied that the deceased's concerns had been appropriately dealt with and he arranged for him to be returned to the cottages. RN Augustine made very clear that if he had not been assured that the deceased's complaint had not been appropriately identified; he would never have allowed the deceased to return to the cottages. I accept this evidence.

24. SCO Lane was the only other person able to access the phone at the medical centre that day and he stated in evidence that he was "not involved in organising an interpreter" and did not recall that being discussed. The CCTV footage and call logs obtained from the medical centre do not fully corroborate SCO Lane's account:

    24.1 RN Augustine is depicted as walking out of the treatment room at 1.23pm and speaking to RN Jones and SCO Lane at the main desk.

    24.2 RN Jones is then seen picking up the phone (call logged at 1.24pm). It is apparent that this is the initial call to the Cottages requesting another prisoner.

    24.3 At the same time SCO Lane and RN Augustine are seen to walk to the holding cell and open the door. The cell door is closed with SCO Lane and RN Augustine walking into the treatment room and over to the deceased.

24.4 They are joined by RN Jones a short-time later.

24.5 At 1.28pm RN Jones walks out of the treatment room and returns with a kettle.

24.6 At 1.29pm both RN Jones and SCO Lane walk out of the treatment room and return to the main desk.

24.7 At this time SCO Lane picks up a desk phone and makes a call. The call records indicate that this call was 43 seconds in length and was made to the Cottages.

25. The deceased remained in the medical centre until 1.35pm when he was escorted out by SCO Lane. CCTV footage shows that at 1.37pm SCO Lane walks back to his desk and is seen to make a 7 second call to the management zone office and then a 36 second phone call to the cottages. The phone logs show that none of the other phones apart from SCO Lane's phone were used to contact the cottages after RN Jones' initial call at 1.24pm.

26. Whilst there is this inconsistency in the oral evidence of SCO Lane and the CCTV footage and phone records, I do not consider a great deal turns upon it. It is clear that RN Augustine was satisfied with the level of communication he had with the deceased that day and considered it appropriate that he be returned to the cottages. This was the case even though an interpreter had not been used.

27. Shortly after 1.35pm the deceased returned to the cottages. A number of his dorm mates reported in their statements that the deceased still "looked worried" and "not okay". However in evidence before me two (2) of his fellow prisoners stated that the deceased said he was "alright" and that he ate his lunch meal and later ate his evening meal.

28. Later that evening, at approximately 11:30pm, one of his fellow prisoners recalled being in 'B' dorm watching TV when the deceased came to see

him and complained about "chest pain". He shared some tea with the deceased and told him he should see medical, but the deceased said "Nah, I'll be right".

29. The following morning on Monday 7 August 2017, two of the deceased's fellow prisoners gave evidence that the deceased had stated that he had been vomiting during the night. One of those prisoners stated however that the deceased said he was "now alright". Although these reports were made by the deceased to these prisoners, there appears to have been no reporting of any concerns on that day to either Corrections staff or staff at the medical centre either by the deceased or by any of the other prisoners.

30. On the morning of Tuesday 8 August 2017 another prisoner told police he went to see the deceased to see if he was okay. He recalled that the deceased told him he was "fine" and as a result they both left to go to their work within the prison. It is apparent that the deceased attended muster and then collected his cleaning equipment from the officer's post and walked to the dining area where he began cleaning on his own.

31. At approximately 9.15am the deceased was observed lying unresponsive on the floor of the kitchen/dining area by prisoners who immediately alerted Corrections officers. Upon this discovery a 'Code Blue' (i.e. medical emergency) was called over the public address system. Corrections officers commenced CPR during which it appears the deceased vomited before a medical team including several nurses and two doctors arrived shortly-thereafter and took over CPR.

32. A pharyngeal airway was inserted and bag mask ventilations commenced. An AED was also used and the deceased was shocked eight (8) times. At approximately 9.50am two (2) ambulances arrived with five (5) paramedics who took over care of the deceased. An intraosseous was used to deliver a single dose of adrenalin and a mechanical CPR device known as the Autopulse Resuscitation System ("Autopulse device") was used on the deceased for a period of ten minutes. At 10.15am CPR was ceased and

paramedics in consultation with the onsite medical staff declared life extinct. The deceased was 39 years of age.

ISSUES:

Findings at autopsy

Cause of Death

33. The body of the deceased was examined by Forensic Pathologist, Dr John Rutherford on Wednesday 9 August 2017. Dr Rutherford provided a detailed report setting out the various examinations he conducted both externally and internally and determined cause of death to be attributable to acute myocardial ischaemia, coronary artery thrombosis and coronary artery atherosclerosis. At no time during the course of this inquest was that opinion put into doubt and I accept the opinion expressed by Dr Rutherford and am satisfied that this was the cause of death.

34. I received evidence that the deceased was known to be a heavy smoker but he otherwise had no history of cardiovascular disease or any other conditions in his medical records. The deceased's family reported to police that about one to two years prior to his death he had complained to his brother, Liam, and his mother, Maringka, that he was suffering from chest pain. His family report that they encouraged the deceased to attend the local clinic to get a check-up, however the medical records obtained from Amata Clinic have no record of this ever occurring.

35. Records from the ASCC medical centre show that on 9 June 2016 the deceased presented to the Centre complaining of "left chest wall pain" that had "started after dinner". Numerous tests including an ECG were performed which showed "normal sinus rhythm". The deceased was given paracetamol and 20 millilitres of Gastrogel after which it appeared that his "pain settled 15 to 20 minutes later" and he was released back into general population. There are no other records of any heart or chest pain concerns thereafter.

36. As previously noted, when the deceased attended the medical centre on 6 August 2017; observations were taken and all were "normal" prior to the deceased being returned to his cell. I have already noted the evidence as to his appearance and any statements made by him when he returned to the cottages.

37. In relation to the divergence in evidence as to the deceased's complaint to his fellow prisoners versus the Corrections officers, Dr Rutherford was asked whether such differing descriptions were "explicable/understandable" in light of his findings at autopsy. In this regard Dr Rutherford stated as follows:

> "Cardiac pain is classically described as being sited in the central chest and radiating down the left arm. However, the classic descriptions do not cover all manifestations. Sometimes people have pain only on the chest, only in the left arm, only in the right arm, down both arms, in the neck or any combination. The character of the pain may be described as sharp, crushing, aching or sore. The fact the pain of cardiac origin does not necessarily lie in the region where the heart is anatomically located is explained in embryological terms. In the early days to weeks after conception, the embryonic structures that will form the heart originate just below what ultimately will evolve into the head and neck followed by migration down into the chest at a later stage and, in doing so sharing primitive nerve structures with the neck and arms. Pain subjectively felt in one part of the body but originating in a different part is described as "referred" pain. This is often the case with the heart. It is not, therefore, surprising that the decedent may have complained of pain in the chest and/or pain in the neck; the latter may have been described, or interpreted as a "sore" neck. Thus, both types of witness descriptions may be correctly attributed to cardiac pain."

38. I do not consider that any witness has sought to intentionally mislead me about what they recall seeing or hearing from the deceased as to what was wrong with him on 6 August 2017. The deceased does appear to be holding his chest area from time to time in the CCTV footage however that does not mean he did not also appear to be complaining about issues to do with his throat on that day. Each alternative is entirely plausible. I consider the real issue to be whether communication with the deceased to determine what was wrong with him was adequate on that day. This relates to the

appropriateness of his care, supervision and treatment whilst in custody and I will turn to this aspect later in these reasons.

Autopulse device and injuries found

39. Also found by Dr Rutherford at autopsy was damage to the spleen and liver, together with bleeding into the abdominal cavity and extensive symmetrical rib fracturing. Dr Rutherford stated as follows:

> "I do not usually see damage to this extent with standard manual resuscitation techniques but have now seen it twice in association with the use of a mechanical resuscitation device (AutoPulse). Such injuries have been reported in the literature. It is unlikely that in this particular case the damage contributed to death but there is a real possibility that in other cases it might have done so".

40. Given these additional comments, further information was sought from Dr Rutherford. I considered this appropriate as there have been a number of deaths recently that have come to the attention of my office which have also recorded injuries sustained as a result of the use of the Autopulse device. In fact in the case of the *Inquest into the Death of John Benedict Munkara* [2017] NTLC 016, St John Ambulance ("SJA") ceased use of the Autopulse device for a number of months in the abundance of caution to ensure training for its use was appropriate.

41. Dr Rutherford provided a further report specifically addressing whether the injuries he considered attributable to the Autopulse device and stated as follows:

> "I do not believe that the damage that could be attributed to use of the AutoPulse machine contributed to death in this case because the volume of blood loss into the abdominal cavity was low (circa 100 mL) which would have minimal effect on the circulating fluid volume. The small amount of blood in the peritoneal cavity would be in favour of passive loss after effective natural circulation had ceased.
>
> The literature suggests that the nature of some of the injuries sustained when an automatic device such as the AutoPulse machine has been deployed (posterior rib fractures and abdominal organ lacerations) are different to those seen with manual chest

> compression (anterior rib fractures and sternal fractures). The number of cases reported in the literature is still relatively small and drawing definitive conclusions about causality is currently problematic.
>
> There are mixed reviews in the world literature. Gao et al found that there were better results with the AutoPulse machine than with manual compression techniques in respect of initial resuscitation rate, 24-hour survival rate and hospital discharge rate; indications were that cerebral functioning was also better but the results in this area were not statistically significant. Koster et al concluded that the use of the Lucas compressor did not cause significantly more life-threatening visceral damage than manual cardiac compression but for AutoPulse more serious damage could not be excluded. Prinzing et al remark that automatic resuscitation machines (Lucas and AutoPulse) achieve better perfusion of heart and brain in laboratory settings but in "real world experience" there was no significant improved survival compared to manual resuscitation.
>
> In summary, even if it is accepted that the AutoPulse machine causes potentially life-threatening injuries such as laceration of upper abdominal organs (predominantly liver and spleen), it might still be argued that the benefits of effective mechanical respiratory ventilation and cardiac massage would outweigh organ damage (which theoretically could be treated by blood transfusion and surgical intervention). Whilst suspicions persist, there is, in my view, insufficient data to justify abandoning the use of the machine."

42. I also received evidence from SJA on the issue of the Autopulse device. Associate Professor Malcolm Johnston-Leek who is the Medical Director of SJA in the Northern Territory attended the inquest and provided a written response acknowledging that the Autopulse device has been the subject of some concern in relation to injuries sustained following its use and that in fact it has been the subject of consideration by St John Clinical Services over which Associate Professor Johnston-Leek has oversight.

43. Associate Professor Johnston-Leek did however identify that although there has been several discussion papers, determination by both the Clinical Quality Committee and the Medical Advisory Panel of SJA, a Cochrane review and regular discussion with Dr Rutherford; the evidence at the present time in relation to such devices "is limited, inconsistent,

underpowered and not of sufficient quality to give an answer one way or the other".

44. In such circumstances Associate Professor Johnston-Leek stated that the use of the Autopulse device was "an area that needs further monitoring and auditing" and that this was particularly so given the circumstances that there was "no information of survivors or those for whom an autopsy has not been performed" in relation to the impact of the device. Associate Professor Johnston-Leek further noted that there were "just over 110" cases of cardiac arrest that SJA attended each year, i.e. "9-10 per month on average over the entire NT" and that as a result this was "too low to extract meaningful trends in the short term using (SJA NT) data alone".

45. Ultimately the evidence received from Associate Professor Johnston-Leek was that "so far" (based the available literature and evidence) it could not be stated that the Autopulse device had caused or contributed to any death and particularly not to this death. He confirmed that SJA was continually auditing its resuscitation cases and that it was "noted that resuscitation times have extended … with and without the use of the Autopulse device". Associate Professor Johnston-Leek noted that the "(m)edical evidence available supports the contention that extended resuscitation times with or without use of mechanical compression results in increased incidence of other resuscitation injuries" and that this was also "being addressed through (SJA) clinical quality program".

46. As I stated during the course of the inquest, I am pleased to receive evidence that establishes that SJA is being proactive in this area. This is extremely important and whilst I do not find that the injuries caused by the Autopulse device contributed to this death on this occasion, I do have a lingering suspicion about the use of such mechanical devices. This is particularly so in relation to the Aboriginal population (and particularly Aboriginal men) who are known to have serious pre-existing health conditions and damaged organs often caused by alcohol abuse. This often

leads to the sad reality that the "age" of their bodies is not directly correlated to their biological age.

47. However, in the circumstances of this death I am not prepared to make guesses about the device. The evidence in this inquest establishes that the Autopulse device did not cause this death. As I indicated, I am pleased to hear that SJA are continuing to monitor the use of the device, however I will make no further comment with respect to the device in relation to the circumstances of this death.

Incorrect administration of adrenaline dose

48. As earlier noted, at approximately 9.50am when the two ambulances arrived and five (5) paramedics took over care of the deceased, an intraosseous device was used and a single dose of adrenalin was administered during the course of resuscitation. The SJA paramedic who administered that dose, namely Mr Brock Hellyer, frankly admitted that the deceased was administered "4 x 1 mL of Adrenaline 1:10,000" and that he "should have received 4 x 1 mL/mg of Adrenaline 1:1,000".

49. As to this error, Mr Hellyer provided a statement that the prognosis on arrival was not "totally unsalvageable" but was "towards that end of things as opposed to being likely to be revived". Mr Hellyer stated that he considered the error with the adrenaline to be "highly unlikely" to have made a difference with respect to the deceased's death and that there was "not real good solid evidence" for its positive effect. Given this acknowledged error, further information was sought from Dr Rutherford as to his opinion as to the impact (if any) of that error. Within his additional report Dr Rutherford stated as follows:

> "The main purpose of giving adrenaline is to convert a flat electrocardiographic line (which is not amenable to treatment by a defibrillator) into ventricular fibrillation (which is amenable to conversion to a normal heart rhythm by a "defibrillator"). It is my understanding that the decedent was already in ventricular fibrillation when encountered by paramedics and, therefore, the administration of adrenaline is neither here nor there. In any case,

> the difference between a 1 in 1000 concentration and a 1 in 10,000 concentration is unlikely to have been biologically significant, given that the natural adrenal glands would have been releasing quite a lot of adrenaline regardless. I therefore do not believe that the "error" was material to the chances of the decedent's recovery. Further, the main factor the determine is whether a person survives or not is the extent of the natural disease. In Mr Tunkin's case, the narrowing of the coronary arteries was severe in 2 of the 3 main branches and there was superimposed coronary artery thrombosis. Whilst survival with resuscitation attempts is possible in such cases, the odds are heavily stacked against restoring life whatever measures are taken."

50. In relation to this issue I also received evidence from Associate Professor Johnstone-Leek of SJA who also frankly recognised that the dose of adrenaline given to the deceased was "not the usual dose as per SJA resuscitation". Associate Professor Johnstone-Leek however also noted that after analysis it became clear that this had occurred "because the crew used the incorrect vial of adrenaline then in use". He noted that:

> "At that time St John used 1:10000 vials (10 mls) and 1:1000 vials (1 ml). Both contain 1 mg adrenaline (the standard cardiac arrest dose. Since then St John has ceased using the 1:10000 (10 mls) formulation and only carries the 1:1000 vials so that this potential source of error would be negated. In this case I believe that the lesser dose did not contribute to the demise of the patient given the clinical situation and subsequent international studies on adrenaline use in cardiac arrest".

51. I am satisfied that the error in relation to the administration of the single dose of adrenaline did not cause the death of the deceased. I am also satisfied as to the evidence concerning what has been done by SJA post this death to ensure such an error is unlikely to occur again.

Care, Supervision and Treatment

52. Section 26(1)(a) of the *Coroner's Act* requires that I must investigate and report on the care, supervision and treatment of the deceased while he was being held in custody. This is obviously important in this death given the issues relating to the deceased's limited ability to communicate due to his hearing loss. This is in terms of both the communication he was able to have

with Corrections staff and with Central Australian Health Services ("CAHS") staff within the medical clinic.

53. In this regard I received evidence from both Corrections and CAHS as to the care, supervision and treatment provided by each department and the action taken post this death.

Evidence from CAHS

54. I received evidence from Dr Jeff Brownscombe who is the Director of Medical Services of CAHS Primary Health Care ("PHC"). CAHS PHC provides the health services to the ASCC. Dr Brownscombe provided a detailed statement and gave evidence before me. Attached to his statement were numerous documents including the Root Cause Analysis ("RCA") undertaken by CAHS. Both Dr Brownscombe's statement and the RCA were detailed and impressive.

55. As I stated during the course of the inquest; the undertaking of an RCA in advance of the inquest and the commencement of action relating to the recommendations from that RCA prior to this inquest is commendable. Many times responses following a death are defensive. It is very helpful to see a proactive, responsive, objective, analytical response and one that is so clearly focussed on learning from the death.

56. The RCA noted that the lack of communication of information concerning possible chest pain on 6 August 2017 "in combination with (the deceased's) deafness and expressive language difficulties (both in his mother tongue and English) have more than likely significantly contributed to missing a potential opportunity for intervention that could have changed the outcome". As a result the RCA made seven (7) recommendation:

56.1 "Maintain a register of clients with specific or complex care needs and ensure this resource is available to regular and agency staff.

56.2 Provide staff training on identifying and accessing appropriate interpreter services. Ensure this is documented and monitored at a system level.

56.3 Provide better policy guidance for managing clients with combined hearing and speech difficulties and integrate this with the offender management plan.

56.4 Develop an information sharing protocol between CAHS, NT Corrections and Police to ensure the communication of key information that impacts the provision of care. Preferably at point of entry into ASCC.

56.5 Employ an Aboriginal Health Practitioner (AHP) at the ASCC healthcare centre.

56.6 Ensure that for new longer stay patients, contact is made with the usual clinic to obtain a medical summary for the PCIS record. Encourage staff to access the shared electronic record.

56.7 Investigate the optimal use of telehealth at ASCC to improve access to services and improve quality of care".

57. Dr Brownscombe provided evidence as to what has been done and is being done by CAHS with respect to each of these recommendations. As stated earlier it is clear that a very proactive approach is being undertaken and I encourage the CAHS to continue with this approach. Whilst it was acknowledged by Dr Brownscombe that "in hindsight Mr Tunkin had likely been experiencing chest pain prior to the consultation and in the lead up to his death", as I stated during the inquest CAHS does not work in the field of perfection. This is particularly so in remote areas like Alice Springs and in locations like the clinic at the ASCC.

58. Whilst I am pleased to see that CAHS accepts in hindsight they could have done a little more, I do not consider that they did anything particularly

erroneous when dealing with the deceased on 6 August 2017 when he attended the clinic and I make no criticisms of the care, supervision and treatment provided by CAHS to the deceased.

Evidence from Corrections

59. Superintendent William Yan ("Supt. Yan") gave evidence and provided a detailed statement as to the internal investigation conducted by Corrections to review the response, processes and procedures relating to the deceased following his death. Supt. Yan is the General Manager of the ASCC and was responsible for overseeing the investigation. Both Supt Yan's statement and the details he provided concerning his investigation were thorough and impressive.

60. Supt Yan frankly admitted that whilst it appeared that the deceased could communicate "to a degree" with officers, it was evident that some staff may have "overestimate(d) their abilities to adequately communicate with offenders. And in this case it is evident that this may have attributed to some ineffective communication at a number of stages in the lead up to this death". He noted that prior to this death "ASCC did not have a procedure devoted to dealing with prisoners with a hearing loss" and as a result he had instructed that a process be developed and a Standard Operating Procedure ("SOP") developed for communicating with offenders who have hearing and speech difficulties.

61. Supt Yan stated that as a result SOP 10.4 "Procedures to Support Prisoners with Hearing Loss" had been prepared with the assistance of the Department of Health and introduced to ASCC in May 2018. He noted that discussions were "underway with Darwin Correctional Centre to extend SOP 10.4 into (that) facility".

62. Supt Yan also identified that it appeared there had been limited sharing of information between the medical clinic and Corrections as to matters relating to the deceased; noting there is "no interface between PCIS and IOMS for information sharing or raising warning flags". I indicated during the course

of the inquest that I was concerned to hear this was the case given that I have previously made strong and clear recommendations in a number of inquests now concerning the importance of information sharing between the two agencies in relation to prisoners. Supt Yan stated that he believed that as a result of those previous recommendations there had in fact been significant improvements in the sharing of information concerning "major" issues in relation to prisoners, but that this death had "highlighted" the need for better information sharing concerning what may be seen to be "less significant" issues such as difficulties with hearing and speech.

63. Supt Yan stated that changes were continuing in this regard and that he intended to "commence discussions with the Department of health for the development of a protocol to be followed by ASCC Correctional Officers and the ASCC Clinic for the purpose of communicating the setting of health warning flags within IOMS so that notification of non-confidential health issues are available to all officers".

64. As I stated during the course of the inquest; I am impressed with the investigation and action taken by Corrections in advance of this inquest. I note that it had been accepted that areas had been identified where things could have been done differently and that improvements had been made and are being made to attempt to avoid similar issues into the future. Just as I noted with the CAHS, it is very helpful to see a proactive response being undertaken by Corrections and one focussed on learning from the death. I do not however consider that there is any basis to criticise the care, supervision and treatment provided by Corrections to the deceased during his time in custody.

Formal Findings

65. Having considered all of the evidence provided to me, both tendered formally and given in oral evidence, I am satisfied that the care, treatment and supervision given to the deceased both by Corrections and the CAHS was appropriate. I am impressed with the proactive approach taken by each

of the agencies and the appropriate concessions made as to areas of improvement and action taken in that regard. I do not consider there is any basis for criticism to be made of either agency and find that the improvements to their various systems are to be applauded and given such improvements I do not consider it necessary on this occasion to make any recommendations.

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

(i) The identity of the deceased was Jeremy Tunkin (aka Lawrence Tunkin) born 25 February 1978, in Alice Springs, Northern Territory.

(ii) The time of death was 10.15am, 8 August 2017. The place of death was Alice Springs Correctional Centre, Alice Springs.

(iii) The cause of death was acute myocardial ischaemia, coronary artery thrombosis and coronary artery atherosclerosis.

(iv) The particulars required to register the death:

1. The deceased was Jeremy Tunkin (aka Lawrence Tunkin on his registered birth certificate).

2. The deceased was of Aboriginal descent.

3. The deceased was a prisoner and not employed at the time of his death.

4. The death was reported to the Coroner by the Alice Springs Correctional Centre staff.

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

6. The deceased's mother is Maringka Tunkin and his father was Warren Tunkin (deceased).

Recommendation

67. I have no recommendations to make arising from this inquest.

Dated this 26th day of November 2018.

_____

GREG CAVANAGH
TERRITORY CORONER