CITATION: *Inquest into the death of Ishmael Nalaiyir Nangarid* [2020] NTLC 009

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0209/2018
DELIVERED ON:	17 July 2020
DELIVERED AT:	Darwin
HEARING DATE(s):	30 June 2020
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Death in custody of Correctional Services, natural causes**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for the Top End Health Service:	Peter Bellach

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

No. D0209/2018

In the matter of an Inquest into the death of

ISHMAEL NALAIYIR NANGARID

ON 5 December 2018
AT Royal Darwin Hospital

FINDINGS

Judge Greg Cavanagh

Introduction

1. Ishmael Nalaiyir Nawirridj (the deceased) was born 3 March 1967 in Oenpelli to Jibul Ngalwamud Bumarda (deceased) and Joe Gambalgu Nakodjok Nawirridj (deceased). He was the youngest of five siblings. His brothers and sisters were: Leslie, Wilfred (deceased), Kevin and Wendy.

2. He spent the majority of his childhood in Oenpelli, Table Hill and Mandedjkadjang Outstations in Western Arnhem Land. From a young age, he suffered a developmental disorder of his left eye resulting in little or no sight. He did not attend high school and worked as a labourer, a teacher's aide and was a Kunwinjku Aboriginal Artist.

3. In the early 1990's he moved to Maningrida Community. It was at Markolidjban Outstation that he met and married his wife, Marilyn Namundja. Together they had one child, Faylene.

4. The deceased had a complex medical history. He was diagnosed with Hansen's disease (Leprosy) in 1988. In 2007 he was diagnosed with myasthenia gravis, a chronic autoimmune, neuromuscular disease. He was also diagnosed with dysphagia (difficulty with swallowing) and left sided facial droop. The dysphagia caused many medical problems throughout his

life, generally from aspiration of fluid and food into his lungs, causing pneumonia.

5. He developed nephrotic syndrome with minimal change disease, leading to Stage 5 Chronic Kidney Disease along with Chronic Obstructive Pulmonary Disease (COPD) and Ischaemic Heart Disease. He was admitted to Royal Darwin Hospital on 93 separate occasions. He was also incarcerated in Darwin Correctional Centre on multiple occasions.

6. On 25 January 2017, he was arrested for an alleged act of gross indecency (sexual activity in a public place). On 9 August 2017, he was convicted and sentenced to two years and three months in the Supreme Court. The sentence was backdated to account for time served, with a non-parole period of 14 months.

7. On 2 February 2018 he was sentenced to 12 months imprisonment for unlawfully causing bodily harm (kicking his brother to the face and breaking his jaw). The sentence was also backdated to 25 January 2017. The total effective sentence was two years and three months. The sentence expiry date was 24 April 2019.

8. He was eligible for parole on 25 July 2018 however he formally notified the Parole Board that he did not wish to be considered for release. The Parole Board requested resubmission for their 19 September 2018 meeting.[1]

9. From 9 June 2017 due to poor physical health and frailty, he was managed as an aged and frail prisoner. Over the period 8 September 2017 to 5 December 2018, he had been admitted to Royal Darwin Hospital on 6 separate occasions for medical treatment.

10. On 26 November 2018 at 11.00pm, he attended the Health Clinic in the Corrections Centre. He reported being unwell with chest pains and

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[1] Statement of Mark Kruit dated 22 February 2019

headaches. He declined blood tests. He was reviewed by the medical officer who diagnosed him with influenza. Arrangements were made to transfer him by ambulance to Palmerston Regional Hospital.

11. He arrived at the Hospital at 12.19am where he was reviewed and transferred to Royal Darwin Hospital. On 29 November 2018, he was transferred to the Intensive Care Unit (ICU) due to a deterioration in health. At 6.30 pm he was intubated and sedated.

12. He remained critically unwell and on 30 November 2018, his family was advised that he was not expected to survive. On 3 December 2018 his wife, Marilyn and his brother Kevin visited him in the ICU.

13. On 5 December 2018, his condition deteriorated rapidly and he went into cardiac arrest. Advanced life support was undertaken. However, he could not be revived and was pronounced deceased at 6:03am.

14. Forensic Pathologist, Dr Marianne Tiemensma was of the opinion that the deceased died from multiple organ failure due to Influenza A pneumonia, in the context of chronic kidney disease, chronic obstructive pulmonary disease, ischaemic heart disease and myasthenia gravis.

15. Pursuant to section 34 of the Coroners Act, I find as follows:

(1) The identity of the deceased is Ishmael Nalaiyir Nawirridj, born on 3 March 1967 in Oenpelli, Northern Territory.

(2) The time was 6:03am 5 December 2018. The place of death was the Intensive Care Unit, Royal Darwin Hospital.

(3) The cause of death was multiple organ failure due to Influenza A pneumonia, in the context of chronic kidney disease, chronic obstructive pulmonary disease, ischaemic heart disease and myasthenia gravis.

(4) The particulars required to register the death:

1. The deceased was Ishmael Nalaiyir Nawirridj.

2. The deceased was of Aboriginal descent.

3. The deceased was a prisoner.

4. The death was reported to the Coroner by Royal Darwin Hospital.

5. Forensic Pathologist, Doctor Marianne Tiemensma confirmed the cause of death.

6. The deceased's mother was Jibul Nalwamut Gunwinggu and his father, Joe Gambagu Nagorjog Gunwinggu.

16. Pursuant to section 26 (1) Coroners Act I must investigate and report on the care, supervision and treatment of a person held in custody immediately before his or her death.

Care, Supervision and Treatment

17. The deceased was serving his tenth sentence of imprisonment. When he arrived at the prison on 27 January 2017 it was said he had a slight odour of alcohol and "grog shakes".

18. He was assessed as medium security and accommodated in Sector 5. He remained there until 9 June 2017 when his security rating was assessed as "low" on the basis of his poor physical health and frailty. He was transferred to Sector 6. He remained housed in Sector 6 apart from a week in August 2017 after being sentenced and two isolated days the following year.

19. There were a number of incidents reported by Corrections Officers while he was in custody:

- 15 February 2017 – He refused to show the Corrections Officer and the Nurse that he had taken his medication. He took the medication placed it in his mouth, turned the light off and moved to the back of his cell. He said "I have tasted the medication and I have swallowed it". His cell was searched and the medication was not found.

- 18 September 2017 – While eating breakfast that day in hospital, the deceased said he wanted bread. He was told that wasn't part of the diet prescribed by the doctor. He demanded to see the doctor and was told he wasn't immediately available. The deceased is said to have become threatening wielding the breakfast knife. That was taken from him by the prisoner officer. The deceased appeared distressed and yelled out for another 30 minutes. The doctor arrived at 11.15am and told him his diet could be changed to include bread.

- 8 August 2018 – The deceased was at Royal Darwin Hospital on the Renal Ward. At 8.00am he was woken by the nurse and asked to take his medication. He said he was sleeping. Eventually after a number of further requests he did so and asked for breakfast. At 8.30am he was to be taken to the X-ray department. However he refused to get into the wheelchair despite many requests. He said they could come to him. It was explained that he was not in the Intensive Care Unit anymore.

    - The nurse eventually left but returned at 9.20am and asked the deceased to sit on the side of the bed so he could be assisted into the wheelchair. The deceased refused and the Corrections Officer then intervened and put a hand on his leg. The deceased kicked out and was thereafter "stabilised on the bed". The Corrections Officer told him that if he didn't comply he would be handcuffed and shackled to the bed.

    - It was at that point that his oxygen saturations fell and the Nurse called a Code Blue. He was given more oxygen by the Code Blue team but continued to be distressed by what had happened and the Corrections Officer was asked by the doctors to leave the room.

    - The officer contacted the prison and was replaced at 11.30am.

- 7 November 2018 – The deceased was taken by ambulance from the prison to the Royal Darwin Hospital Emergency Department at 3.15am. When he was allocated a bed the prison officer put a shackle on his left leg. The deceased became upset and said he was a "low" (low security prisoner) and that the shackle should be taken off. The officer insisted it needed to stay on and the argument and the deceased's upset lasted another hour. He was still upset at 5.40am when seen by a doctor and was uncooperative and complaining about the officer. The doctor returned at 6.20am and was able to complete the assessment.

- 12 November 2018 – The deceased was at the prison medical centre at 11.00am. The nurse indicated that he would need to wait until midday to receive more medication. He was put in a waiting room. The deceased became upset and thumped and banged on the window. He received the medication at 12.07pm and was wheeled back to his accommodation by another prisoner. The officer writing the incident report stated, "The prisoner's angry behaviour, his willingness to be disruptive and his refusal to comply with Officer's Instructions, make him unsuitable for housing in sector 6."

  - His security rating was upgraded to "Medium" on 23 November 2018. However he was taken to Hospital on that date and did not return to the prison thereafter.

20. The main issues he had while in custody were to do with his health. He was admitted to Royal Darwin Hospital once in 2017 and six times in 2018. His health continued to deteriorate particularly in the second half of 2018. Of his last 146 days, 129 were spent in hospital.

8 September 2017 – 19 September 2017

21. On 8 September 2017 he presented to hospital with weakness to the left side of his face, dysphasia (difficulty speaking) and a productive cough. He had

difficulty closing his eye. Initially his symptoms worsened but then improved significantly with antibiotics and steroids. It was believed that he had an exacerbation of myasthenia gravis in the context of lower respiratory tract infection. He was discharged on 19 September 2017.

29 April 2018 – 3 May 2018

22. On 29 April 2018 he presented to hospital with shortness of breath, difficulty swallowing and had generalised weakness. He thought he may have aspirated into his lungs. It was thought that it was less likely to be a ‘myasthenic crisis’ and more likely that his symptoms were secondary to an infection. He improved with antibiotics and was discharged on 3 May 2018.

8 June 2018 – 27 June 2018

23. On 8 June 2018 he presented to hospital with shortness of breath and progressive facial and peripheral bilateral pitting oedema. He was reviewed by the renal team. He was diagnosed with minimal change disease (kidney disease). His medications were adjusted and frusemide added. He was discharged on 27 June 2018 for outpatient review.

12 July 2018 – 6 November 2018

24. On 12 July 2018 he was admitted to hospital with buttock abscess, scrotal cellulitis and what was thought to be upper gastro-intestinal bleeding. On 15 July 2018 he had the abscess removed and cellulitis debrided. On 21 July 2018 he was transferred to the ICU for respiratory support after a Code Blue was called. He was suffering hypoxic respiratory failure, thought to be due to a combination of severe COPD and fluid overload.

25. It turned into a lengthy admission. He suffered CMV (cytomegalovirus) pneumonitis and multiple episodes where his haemoglobin levels dropped. There was ongoing evidence of upper gastrointestinal bleeding but no site of the bleeding could be identified despite multiple investigations. He was discharged on 6 November 2018 but returned the following day.

7 November 2018 – 10 November 2018

26. On 7 November 2018 he re-presented to the Royal Darwin with hospital acquired pneumonia. He was discharged three days later.

20 November 2018

27. On 20 November 2018 the deceased presented to the Emergency Department with rectal bleeding for two days. He said he had no shortness of breath and his cough had improved since his last admission. He said he mobilised around the correction facility with a stroller. He was advised to have an urgent outpatient colonoscopy.

27 November 2018 – 5 December 2018

28. At 11.00pm on 26 November 2018 the deceased was taken to the Prison Health Clinic. He said he had chest pain and a headache. He had a fever, his oxygen saturations were 92% and his respiratory rate was 50 per minute. It was thought likely that he had the flu. There was a particularly large Influenza A outbreak in late 2018.

29. An ambulance was called and he was taken to Palmerston Regional Hospital. He arrived at 12.19am on 27 November 2018. His blood pressure was up, he had a temperature of 40 degrees and his respiratory rate was high. He was given broad spectrum antibiotics and Oseltamivir (to treat flu symptoms) and transferred to the Royal Darwin Hospital. He arrived at 2.17am. He said he had fevers, muscle pain, headache, cough and a sore throat for the last two days. He was thought to be septic from influenza and possibly pneumonia.

30. After two days of being treated on the ward his breathing deteriorated and he was transferred to the Intensive Care Unit. His oxygen saturations were 78 percent despite supplemental oxygen. He tested positive to Influenza A. He was intubated a few hours later but continued to deteriorate and suffered multiple organ failure and refractory shock. His C-reactive protein levels

continued to rise and his condition deteriorated. It was expected that he would die and his family were contacted.

31. At 5.37am on the morning of 5 December 2018 he lost cardiac output. Cardiopulmonary resuscitation was commenced and continued for twenty five minutes. However he could not be revived and was pronounced deceased at 6.03am.

Review

32. While undertaking a review of his treatment, Dr Goldrick, the Director of the Intensive Care Unit, identified that whilst the deceased was in the Intensive Care Unit (day 5 of admission) there was a drug error in the charting and administering of meropenem (broad-spectrum antibiotic used to treat bacterial infections). That error resulted in the deceased's final four doses of the drug not being administered. Meropenem was being used to cover the eventuality of bacterial infection. However no bacterial infection was identified. In the opinion of Dr Goldrick that did not contribute to his final deterioration and death.

33. Dr Goldrick stated that error however was taken very seriously. The error had occurred because Meropenem hadn't been added to the patients chart on the final day. The charts are replaced every day at 3.00pm. The essential instructions such as medications are recreated on the chart by the junior doctors. The issue was recognised that when the Intensive Care Unit was busy and it was difficult to concentrate, charting the medications manually each time created a risk of error.

34. At that time, in part because of the influenza outbreak the Intensive Care Unit was very busy. To cope with the risks created by the busy environment and the risk of errors, improvements were made:

    a. The critical care pharmacist was at the time employed on a part time basis. That position was made full time;

b. The recharting doctors now wear high-vis jackets to signal others that they cannot be interrupted;

c. Electronic prescribing has been approved for a cohort of the patients in the Unit so that there is no need to re-chart medications for that cohort.

Comment

35. The refusal of the deceased while at the Royal Darwin Hospital on 8 August 2018 to go for an X-ray was escalated by the Corrections Officer putting his hand on the deceased. No doubt it was well-intentioned. He was likely just trying to help the nurse get the deceased into the wheelchair. However, there was no dispute that at the time the deceased was competent to consent or refuse medical treatment.

36. My Office sought from the Department of Corrections their policies, procedures and directions relating to the use of force while escorting prisoners at the hospital. My Office was provided with the Standard Operating Procedure 'Prisoner In-Patient' and the Directive 2.2.8 'Escorts'. Neither of those documents was of assistance.

37. During the course of the inquest Deputy Superintendent Mark Kruit provided evidence. He thought the instruction was in another Directive, 2.2.4 Use of Force, Control and Restraint. However, that document only addresses the subject by omission. That is, such a circumstance is not listed as one in which force can be used.

38. There are obviously circumstances were force can and should be used by Corrections Officers when escorting patients. One of those was seen when the Officer removed the knife from the deceased. However, it is difficult to envisage circumstances requiring the use of force where the prisoner is simply refusing medical treatment and is entitled to do so.[2]

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[2] A prisoner is not entitled to refuse treatment where section 92 *Correctional Services Act 2014* is utilised by the General Manager Corrections requiring the prisoner to

39. I encourage the Commissioner of Corrections to provide a specific direction relating to escorts as to the limits of their powers in such situations.

40. I make no criticism of the health care and treatment of the deceased. I commend the health service on their efforts and willingness to review and improve their procedures. I thank Doctor Goldrick once again for his clear and helpful evidence.

41. In my view, on all of the evidence, the care, treatment and supervision of the deceased was adequate.

42. I make no recommendations.

Dated this 17 day of July 2020.

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GREG CAVANAGH
TERRITORY CORONER

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undergo health care. Sub-sections (3) and (4) indicate force may be used as reasonably necessary in such situations.