CITATION: *Inquest into the death of Desmond (Kumintji) Jambajimba Tilmouth* [2015] NTMC 003

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0006/2014
DELIVERED ON:	19 February 2015
DELIVERED AT:	Alice Springs
HEARING DATE(s):	17, 18 and 19 February 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, Alice Springs Correctional Services, natural causes, care and treatment.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Department of Correctional Services	Greg Macdonald

Judgment category classification:	[2015] NTMC 003
Judgement ID number:	A
Number of paragraphs:	58
Number of pages:	18

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

No. A0006/2014

In the matter of an Inquest into the death of
DESMOND (KUMINTJI) JAMBAJIMBA TILMOUTH ON 8 FEBRUARY 2014 AT ALICE SPRINGS HOSPITAL, ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Desmond Jambajimba Tilmouth was born at Napperby Station in the Northern Territory on 1 July 1963. He died on 8 February 2014 at only 50 years of age. Out of respect for the family and the cultural practice of avoiding use of the Christian name of an Aboriginal person who has passed away, I will hereafter refer to the deceased as Kumintji, with the exception of the formal findings.

2. On 22 August 2013 Kumintji received a total sentence of 9 months imprisonment for driving whilst disqualified and restoration of an earlier suspended sentence. That sentence was ordered to be served at the Alice Springs Correctional Centre ("ASCC") and scheduled to be completed on 21 May 2014.

3. At the time of his incarceration however Kumintji was not a very well man and had not been so for some time. He suffered from a number of medical conditions including high cardiovascular risk, type 2 diabetes, cirrhosis, oesophageal varices, ischaemic heart disease with a previous myocardial infarction (i.e. heart attack), hypertension and renal disease stage 5 (i.e. end stage) requiring haemodialysis. He also suffered from an umbilical hernia which caused him continuous discomfort and aggravation. As a result,

during his period of incarceration he was seen regularly by the medical staff at the ASCC and attended regular dialysis sessions on 4 occasions each week outside of the gaol.

4. On 5 April 2014 Kumintji complained about his hernia and was seen by the after-hours on call nurse at the ASCC. He was given pain relief and remained at the ASCC. On 6 February 2014 he underwent his usual dialysis and returned without complaint. That evening however he again fell ill and was again seen by the after-hours on call nurse who spoke with the District Medical Officer about Kumintji's condition. He was observed for some time but remained at the ASCC. On 7 February 2014 he left the ASCC to attend his usual dialysis; however when he arrived at the renal facility the nurse on duty advised ASCC staff that Kumintji should go to the Alice Springs Hospital ("ASH") immediately. Thereafter he was transferred to the ASH.

5. Kumintji was seen by a number of doctors at the ASH who diagnosed that his umbilical hernia was now incarcerated (i.e. trapped), and probably strangulated, and could not return to its normal position without surgery. He was advised of the significant risks of the surgery due to his pre-existing medical conditions, but insisted on the surgery taking place. The operation occurred and was considered successful. However shortly thereafter he suffered a number of cardiac arrests and despite the care provided to him by ASH staff he was pronounced deceased at 4.15am on 8 February 2014.

6. Notwithstanding that Kumintji died at the ASH, he was at the time of his death in custody of the Northern Territory Department of Correctional Services ("NTCS"). Accordingly I find that this was a death in custody pursuant to section 12 of the *Coroners Act* ("the Act"). As a result, and pursuant to s15(1) of the Act, this Inquest is mandatory.

7. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Greg Macdonald was granted leave to appear on behalf of the Department of Health and Department of Correctional Services. I also note that a number of family members attended at the inquest including Kumintji's mother,

Peggy, his sister, Doreen, and his brother, Samuel, together with other relatives and friends. I thank them for the respect that they showed during the course of this hearing and the information that they provided me about their loved one. Their involvement was very important.

8. A total of nine (9) witnesses gave evidence before me, namely Detective Sergeant ("Det. Sgt") Tony Henrys, Registered Nurse ("RN") Mary Ferrer, RN Dorian Dent, RN Lavinia Spottiswoode, Prison Officer ("PO") Feroz Vilsing, Samuel Tilmouth, Superintendent ("Supt.") William Yan, Dr Terence Sinton and Dr Jacob Ollapillil.

9. A brief of evidence containing various statements, together with numerous other reports, police documentation, and miscellaneous records were tendered into evidence (exhibit 1). I also received into evidence all of the deceased's medical records (exhibit 2), a report of Dr Hugh Heggie (exhibit 3) and various NT Correctional Services Directives (exhibit 4). The death was investigated by Det Sgt Henrys who prepared a thorough investigation brief and I thank him for his assistance.

10. Pursuant to s.34 of the *Act*, I am required to make the following findings:

    (i) The identity of the deceased person;

    (ii) The time and place of death;

    (iii) The cause of death;

    (iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*"; and

    (v) Any relevant circumstances concerning the death.

11. I note that section 34(2) of the *Act* also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

> "(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 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"

12. Additionally, where there has been a death in custody, section 26 of the *Act* provides as follows:

> "(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) Must 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 the 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 must make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant"

Background

13. Kumintji was born on 1 July 1963 at Napperby Station, which is approximately 200km north west of Alice Springs in the Northern Territory. He was the first child of Peggy Nunguarai and Sandy Jungala Tilmouth (deceased) and had four (4) siblings, namely Doreen, Samuel, Tommy and Jane Tilmouth. He grew up around the Mount Allan area which is approximately 300km northwest of Alice Springs, off the Tanami Track and

in the Aboriginal community of Yuelamu. He completed some schooling in Yuendumu but left in year nine.

14. His first wife was Carol Frank; however she passed away in a motor vehicle accident many years ago and he considered himself married to Barbara Tilmouth at the time of his imprisonment. He had worked as a young man for the Yuendumu Council as a labourer and on Mt Allan Station as a stockman. However in his later years because of his poor health and alcohol abuse he moved into Alice Springs and was unemployed at the time of his imprisonment.

15. As previously referred to, Kumintji had been incarcerated since 22 August 2013. During his time in custody he was seen regularly by staff at the medical clinic located at the Alice Springs Correctional Centre ("ASCC"). In fact Kumintji was seen every day on medication rounds in order to receive his medicine and was a regular attendee at the clinic, which at the relevant time was operated by the Department of Health under the auspices of Remote Health.

16. Upon his admission into custody at the ASCC, Kumintji was already diagnosed as suffering a number of serious medical conditions. According to his medical records he was recorded as suffering two (2) previous myocardial infarctions (commonly known as a heart attack). He had commenced kidney dialysis in October 2011, however there were numerous records of non-compliance which had also resulted at times in admission to ASH. Kumintji had also undergone amputations of his small toes as a result of his diabetes. In February 2013 he was recorded as suffering from an umbilical hernia.

17. In addition to the regular treatment Kumintji received from medical staff at the ASCC and via dialysis outside of the prison, I received evidence that Kumintji also attended for assessment and treatment in relation to the following:

17.1 On 8 November 2013 he was seen at ASH in regard to a possible surgical resolution of his hernia problem. Following assessment however it was determined that the risk of surgical intervention was too high and he was found not fit for surgery. As a result the hernia was to be treated conservatively and was releasable through manipulation.

17.2 On 2 December 2013 he was sent to Adelaide for specialist cardiac assessment at the Royal Adelaide Hospital in regard to possible surgery for his heart condition with the insertion of a stent. Again following assessment it was determined that the risk of surgical intervention was too high and he was found not fit for surgery.

Events at ASCC leading up to hospitalisation

18. During his incarceration Kumintji would attend upon the Alice Springs Renal Unit (aka Nephro-Care) for dialysis every Monday, Wednesday, Thursday and Friday. This was one additional day more than any other prisoner; such was the significance of his condition. He was at renal disease stage 5, which meant he required haemodialysis as his kidneys were no longer functioning on their own.

19. Whenever a prisoner returns from dialysis to the ASCC they are assessed by the nurse at the prison clinic. During that assessment the prisoner is asked how they are feeling and their observations are taken. On Wednesday 5 February 2014 Kumintji returned to the ASCC at about 7.00 pm and was recorded as having a "happy face" score of 1, meaning he was feeling "quite happy". At approximately 9.20pm however a call was made by PO Feroz Vilsing to the after-hours nurse on duty, namely RN Heather Black, advising that Kumintji had been complaining about abdominal pain.

20. RN Black decided to attend at the ASCC to see Kumintji personally. Her observations and records were placed in evidence before me. She noted that Kumintji was complaining about abdominal pain and she noted his protruding umbilical hernia. This was not unusual however given his condition. His observations were taken and recorded as "normal". RN Black also noted that Kumintji had been attempting to reduce his hernia by

pushing it back in himself. This had unsurprisingly resulted in pain and he was encouraged to leave it alone.

21. RN Black recorded hearing bowel sounds during her observations. This was important as it meant that Kumintji's bowel was working. She also however made contact with the District Medical Officer ("DMO") on duty at the time, namely Dr Rahma Targett, to discuss Kumintji's condition and appropriate treatment. The Primary Care Information System ("PCIS") notes record that agreement was reached to administer pain relief, namely Endone, and to continue observations for any bowel obstruction with a review to be conducted the following day. According to the records, that pain relief was administered and RN Black advised ASCC staff to contact her if there were any further concerns. No further contact was made.

22. On Thursday 6 February 2014 Kumintji again attended dialysis. There were no issues recorded at the renal unit. He returned to the ASCC just before 7.00pm and was again recorded as having a "happy face" score of 1, i.e. "quite happy". At approximately 9.18pm however ASCC staff were advised that Kumintji was feeling unwell. PO Feroz Vilsing was again on duty that evening and telephoned the after-hours on call nurse, namely RN Lavinia Spottiswoode, about Kumintji's condition. Both PO Vilsing and RN Spottiswoode gave evidence before me. PO Vilsing stated that he was informed that Kumintji had been vomiting and was feeling nauseous and he reported these observations to RN Spottiswoode.

23. RN Spottiswoode recalled being initially advised that Kumintji had been vomiting "about a bagful" and was in pain. RN Spottiswoode stated that she made a decision to attend at the prison in order to see Kumintji personally; particularly given he had been seen by RN Black only the night before. RN Spottiswoode recalled assessing Kumintji and conducting observations upon him. She recalled that he was his "usually chatty self" and did not seem in any pain when he was at the clinic. She examined his stomach and noted it was soft and so too was his hernia. Importantly, RN Spottiswoode noted

that she could hear bowel sounds, which again was significant and meant that there were no obstructions. All other observations were "normal" and Kumintji did not vomit at all during the time that he was at the clinic.

24. RN Spottiswoode also made contact with the DMO who, on that evening, was Dr Rodney Whyte. She recalled their conversation was about 15 minutes long and that during that call Dr Whyte was accessing Kumintji's PCIS records. She recalled Dr Whyte asking if Kumintji's bowels had been opened and that initially Kumintji stated "no". However a prison officer then pointed out that he had heard Kumintji had diarrhoea that day, to which it was eventually established that Kumintji's bowels had been opened recently. Again this was important as it was a further indicator that his bowels were working and there was no obstruction at that time.

25. Appropriate treatment was discussed with Dr Whyte and a decision made to administer Maxalon to try and stop the vomiting. After the Maxalon was administered, RN Spottiswoode conducted another set of observations which were normal and then spoke with ASCC staff. Agreement was reached at that time to place Kumintji into a cell in G Block so that he could be observed in case he continued to vomit. I note that no pain relief was provided, further supporting RN Spottiswoode's evidence that she did not observe Kumintji to be in "pain".

26. RN Spottiswoode gave evidence that when Kumintji was advised that he was to be sent to G Block he became "agitated" and wanted to return to his usual block. RN Spottiswoode stated this reaction made her suspicious as to whether he was genuinely unwell. She told him he would be going to the observation cell and she left after advising ASCC staff to contact her if there were any concerns. No further contact was made.

27. RN Spottiswoode stated very clearly that it was her opinion that Kumintji did not need to go to the hospital at that time. She noted that his observations were good, he was "busy chatting" throughout, he did not vomit whilst he was in the clinic and he "walked out of the clinic". She

therefore did not consider he needed to go to the hospital and that if she had, then he definitely would have been sent.

28. PO Vilsing gave evidence that the decision to place Kumintji into G Block was made so as to enable ASCC staff to continue observations that evening but also to have officers "close by" should Kumintji require assistance again. PO Vilsing gave evidence that at no stage did Kumintji require further medical attention that evening and there were no further issues.

29. I received evidence that placement of Kumintji in G Block by PO Vilsing was not in accordance with the usual procedures at ASCC. G Block is an area used for the purpose of observing prisoners who are "at risk", i.e. at risk of self harm. Supt Yan stated that it was his opinion that although this was not an area for medical observations, the decision made by the prison officer in charge, namely PO Vilsing, was appropriate and enabled ASCC staff to react quickly should anything further occur with Kumintji.

30. At 8.30am on Friday 7 February 2014, Kumintji was moved from G Block back to his usual accommodation. ASCC records note that at about 11.00am he was transferred to the reception area to be processed for transfer for his scheduled dialysis. He was in the reception area for approximately 30 minutes and observed by ASCC staff throughout. At approximately 11.35am he is recorded as departing the prison (along with the other prisoners undertaking dialysis that day). It was noted that prior to departure Kumintji had indicated that he felt sick and he was provided with a vomit bag for the journey.

31. The group of prisoners, including Kumintji, arrived at the Alice Springs Renal Unit at approximately 11.50am. Upon arrival it was noted that Kumintji had used the bag during the journey and did not look well. ASCC staff advised renal unit staff that Kumintji was unwell. I received evidence from Acting Clinic Manager and RN Mary Ferrer that she was on duty that day and recalled being advised about Kumintji. She stated that when she saw Kumintji he was walking around but she discovered he had been

vomiting a “greenish” fluid and appeared “very sick”. She spoke to the prison officers in attendance and advised that Kumintji was too sick for dialysis and should be taken to the Emergency Department (“ED”) at the ASH. Arrangements were then made by ASCC staff to transfer Kumintji from the renal unit to the ASH.

32. Tendered in evidence before me were statements from each of the ASCC officers involved in the transfer of Kumintji and the other prisoners to the renal unit that day. I also had tendered before me the statements of each of the other prisoners who were with Kumintji. I considered those statements very carefully. I do not consider that Kumintji’s condition was being ignored by any person on that day and in fact I find that proper attention was being given by ASCC staff to ensure he was seen by a medical practitioner.

Events at the ASH

33. Upon his arrival at the ASH, Kumintji was seen by the nurses and observations undertaken. He was subsequently assessed by the ED doctors at about 2.07pm and then the renal registrar and surgical registrar at 3.10pm. He was diagnosed as having an irreducible incarcerated umbilical hernia. I received evidence from Dr Jacob Ollapallil, who is a Consultant Surgeon at the ASH and also the Head of Surgery. Dr Ollapallil stated that an irreducible incarcerated umbilical hernia is a complication that occurs when the protruding abdominal tissue (i.e. the hernia) becomes trapped (i.e. incarcerated) and can no longer be pushed back into the abdominal cavity. This reduces the blood supply to the section of trapped intestine and can lead to umbilical pain and tissue damage. This can be very serious, particularly if the trapped portion of the intestine is completely cut off from the blood supply (strangulated hernia), which can result in tissue death (gangrene) occurring. This can go on to be life threatening as infection can then spread throughout the abdominal cavity. Dr Ollapallil stated in evidence that if such an infection occurs this can lead to a very painful death.

34. A CT scan was undertaken at 5.26pm and confirmed a large umbilical hernia of 7.7 x 14.5 x 9 cms in size. This also contained a loop of small bowel with markedly dilated proximal bowel loops (i.e. noticeably larger and close bowel loops). Further investigations were carried out and suggested there was probably a strangulated bowel. Emergency surgery was therefore required to prevent ischaemia, i.e. restriction of the blood supply, and perforation of the strangulated bowel.

35. Because of Kumintji's extremely poor health generally, Dr Ollapallil stated that Kumintji was reviewed by the Anaesthetic team and the Intensive Care Unit ("ICU") team. Dr Ollapallil attended on behalf of the surgical team to assist with the surgery itself. He gave evidence that "all three teams were of the view that the patient was high risk for anaesthetic and surgery", but that these risks were discussed with Kumintji and he was "very insistent" that he wanted the surgery and "fully accepted the risks". Kumintji consented to the surgery despite the fact that he was told very clearly he only had about a 10% chance of survival.

36. Dr Ollapallil gave evidence that a combined decision was made by the consultant surgeons, anaesthetists and ICU to operate. Because of the very high risks associated with the surgery, the Director of Medical Services was also informed. The renal team also assessed Kumintji and it was the opinion of the renal physicians that dialysis (that had not yet been able to take place for that day) should occur prior to surgery. As a result, zero fluid removal dialysis was organised and it was arranged that Kumintji would undertake the surgery as soon as dialysis was completed.

37. At approximately 8.45pm Kumintji was prepared for surgery which commenced at 10.35pm. Dr Ollapallil gave evidence that he found that the small bowel was "extremely congested inside the hernia sac" and that a "constriction ring on the bowel was evident". He also discovered blood stained ascitic fluid in the hernial sac. Dr Ollapallil released the tight hernial orifice and wrapped with a warm saline pack. At this time the bowel

gained colour and the viable bowel was returned to the peritoneal cavity. A drain tube was inserted for the fluid and a Mayo repair of the hernia was done. The surgery was completed at 11.40pm and considered successful.

38. Kumintji's vitals were stable throughout the operation except for a mild drop in blood pressure which was treated with small doses of inotropes. He was therefore extubated at the end of the operation but he suddenly developed a pulseless electrical arrest ("PEA") and a Code Blue was initiated at approximately 11.48pm and CPR commenced.

39. Due to the efforts of medical staff, cardiac output was soon obtained and Kumintji was moved to the recovery room where unfortunately he suffered another PEA at approximately 1.50am on 8 February 2014. Again he was given further CPR. He was stabilised and then sent to ICU where he again had another ventricular fibrillation ("VF") arrest and was defibrillated.

40. Discussions were held between the renal, ICU and surgical specialists and a decision made that due to Kumintji's "irreversible comorbidities" he was not to be treated with further aggressive CPR. At 4.15am on Saturday 8 February 2014, Kumintji was found by the ICU Registrar not to be responding and he was declared deceased.

Cause of Death

41. An autopsy was undertaken by Dr Terence Sinton on 12 February 2014. His report was tendered into evidence as part of exhibit 1 and Dr Sinton also gave evidence before me. In his autopsy report, Dr Sinton noted the significant findings at autopsy to include the following:

> "(i) Recent abdominal surgery confirmed;
>
> (ii) Intact but damaged small bowel showing changes of ischaemia (reversible oxygen deficiency), however there was no evidence of acute infarction (irreversible oxygen deficiency);
>
> (iii) Approximately 500mL of frank blood present in the abdominal cavity;

(iv) Clinically severe atheromatous coronary artery disease (coronary atherosclerosis);

(v) Evidence of at least one previous heart attack (old myocardial infarction) likely a consequence of (iv) above;

(vi) Abnormal enlargement of the heart (cardiac hypertrophy) likely caused at least in part by (v) above;

(vii) Extensive fluid accumulation in the lungs consistent with acute heart failure;

(viii) Atrophic and scarred kidneys consistent with chronic inflammatory damage, sufficient to have caused some degree of chronic renal failure. There was also evidence of bilateral kidney stone formation;

(ix) Fracture ribs on both sides of the chest in a manner consistent with attempted CPR".

42. In his evidence (and in order to assist the family) Dr Sinton stated that in layman's terms Kumintji had three (3) significant health problems:

42.1 "Really serious heart disease". He noted that the heart was severely damaged and had "blocked off" vessels which resulted in Kumintji's heart being "much larger" than normal;

42.2 "Severe damage and disease" of his kidneys; and

42.3 "Hernia at the front of his belly".

43. Within his report, Dr Sinton stated that it was his opinion that Kumintji:

> "… likely died in acute heart failure as a result of longstanding coronary artery and heart disease. The effects of his heart disease were likely acutely and severely exacerbated by the subsequent development of a strangulated hernia, life threatening in its own right, and the need for this to be urgently corrected surgically. Similarly the longstanding kidney disease was likely to have impacted acutely on both the damaged heart and the damaged bowel".

44. As a result Dr Sinton determined that Kumintji died of myocardial infarction (i.e. a heart attack) as a result of coronary atherosclerosis. I accept this finding.

45. During his evidence Dr Sinton stated that he considered that Kumintji's "sudden" heart attack occurred because of all the damage that had occurred as a combination of his 3 main health problems.

46. During the course of this inquest, counsel assisting advised one of the "worries" the family had about the death of Kumintji was that on the morning of 7 February 2014 he had spoken to his sister, Doreen, and he was having "happy talk" and "talking family". She, and the entire family, was therefore very distressed and upset to find out the next day that he had passed away and they could not understand how this could occur.

47. To try and assist the family in this regard, Dr Ollapallil gave evidence in layman's terms that whilst Kumintji may have "looked and sounded normal" he was "critically ill". Dr Ollapallil stated in his evidence that Kumintji's heart had very poor blood supply. He stated that the vessels were "almost completely blocked" and that there was "hardly any blood flow" to the heart. He noted that Kumintji had been seen by the Royal Adelaide Hospital cardiac team to see if a stent could be inserted to help with blood supply, but they decided that it was "too completely blocked" and that if they "tried" to insert the stent that "it could have ruptured" and therefore it was too risky.

48. Dr Ollapallil also stated that Kumintji's "kidneys were not working" and that was why he was on dialysis. He was "diabetic" and "his liver was not good". Dr Ollapallil also noted that there was "bleeding into the tummy" and Kumintji's hernia was "bad as well, but he was not fit for surgery". Within his statement tendered before me, Dr Ollapallil noted that the chance of Kumintji surviving without surgery were

> "… almost nil due to the fact that he had a strangulated hernia and without surgery this would progress to ischaemic bowel and perforation".

49. Dr Ollapallil further noted that due to Kumintji's severe cardiac disease and end stage renal failure, his death:

"… in my opinion, is an expected one".

Issues for further consideration

50. Other issues were also raised for consideration upon the evidence. These are as follows:

    50.1 The nature and standard of the care provided to Kumintji during his period of incarceration at ASCC;

    50.2 The nature and standard of the care provided to Kumintji during his period of admission at ASH; and

    50.3 The "worries" of the family as to Kumintji's sudden passing and the lack of contact with a family member before his surgery was performed.

<u>The nature and standard of the care provided to Kumintji during his period of incarceration at ASCC</u>

51. Kumintji had been incarcerated since 22 August 2013. He was seen on a regular basis by staff at the medical clinic at the ASCC. It is clear that clinic staff were very familiar with Kumintji and provided appropriate and considered care to him at all times. I received evidence that in terms of the afterhours attendance of both RN Spottiswoode and RN Black that this was "unusual" and showed the degree of concern that both nurses had in relation to Kumintji's care.

52. As for the Corrections staff, I note that it appears from the records that whenever contact was made concerning Kumintji's health, they promptly attended to his cell and gave him appropriate attention. Some reference was made in the materials to there being a shortage of ASCC staff on the evening of 6 February 2014; however both RN Spottiswoode and PO Vilsing made clear that had a decision been made that Kumintji required hospitalisation the relevant arrangements would have been made by ASCC staff. I accept this evidence.

53. I consider the care provided to Kumintji during his period of incarceration at ASCC by both the medical staff at the clinic and the ASCC staff was appropriate and satisfactory. In fact I consider that Kumintji received medical care as a result of his incarceration that he would not have otherwise received in the community.

<u>The nature and standard of the care provided to Kumintji during his period of admission at ASH</u>

54. I have already outlined the evidence given before me as to the care provided to Kumintji following his admission to the ASH. It is clear to me that considerable effort was made by all members of medical staff at the ASH to save Kumintji's life, both by undertaking the surgery to his obstructed hernia and strangulated bowel, but also the subsequent CPR undertaken following the surgery. However, I agree with the opinion expressed by Dr Ollapallil that due to Kumintji's significant and severe cardiac disease and end stage renal failure along with his other significant and long standing health issues, that Kumintji's death was to be expected. I make no criticism whatsoever of the care provided to Kumintji at the ASH. I consider that they did all that they could.

<u>The "worries" of the family as to Kumintji's sudden passing and the lack of contact with a family member before his surgery was performed.</u>

55. The involvement and participation of Kumintji's family in this inquest is very important and I have considered their concerns very carefully. I have no doubt it was a big shock to them to hear that their loved one had died after Doreen had only spoken to him the day before and he sounded "happy" to her. After having considered carefully the medical evidence however as to just how quickly Kumintji's condition could have changed, I am satisfied that it is quite possible that when he was speaking to his sister, Kumintji felt well, but that his condition deteriorated very quickly and needed to be addressed.

56. Whilst I understand the family's distress in not being informed about the surgery before it took place, I also note that given Kumintji was an adult and able to freely give consent to the surgery that there was no obligation for the ASH to seek the consent of a family member. I do note however the evidence of Dr Ollapallil that attempts were made to contact the next of kin recorded on the hospital file, but that the call was not answered. It is clear however that there was no time to waste and that this was an emergency and the surgery needed to occur. Whilst it is always preferable that attempts be made to contact the next of kin in these sorts of circumstances, such contact should never delay the emergency surgery being undertaken.

Decision

57. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

    i. The identity of the deceased person was Desmond Jambajimba Tilmouth who was born on 1 July 1963 at Napperby Station in the Northern Territory of Australia.

    ii. The time and place of death was approximately 4.15am on 8 February 2014 at the Alice Springs Hospital.

    iii. The cause of death was myocardial infarction caused by coronary atherosclerosis.

    iv. Particulars required to register the death:

        a. The deceased was Desmond Jambajimba Tilmouth.

        b. The deceased was of Aboriginal descent.

        c. The death was reported to the Coroner.

        d. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton on 12 February 2014.

e. The deceased's mother is Peggy Nunguarai and his father was Sandy Jungala (deceased).

f. At the time of his death, the deceased was a sentenced prisoner incarcerated at the Alice Springs Correctional Centre in the Northern Territory of Australia.

Recommendations

58. I have no recommendations arising from this inquest.

Dated this 19th day of February 2015.

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GREG CAVANAGH
TERRITORY CORONER