CITATION: *Inquest into the death of Edward Jungari Brown* [2012] NTMC 025

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0012/2011
DELIVERED ON:	July 2012
DELIVERED AT:	Alice Springs
HEARING DATE(s):	13 July 2012
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in custody, natural causes**

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Counsel for Correctional Services and the Department of Health:	Ms Ruth Brebner

Judgment category classification:	A
Judgement ID number:	[2012] NTMC 025
Number of paragraphs:	37
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0012/11 of 2012

In the matter of an Inquest into the death of
Edward Jungari Brown

ON 13 July 2012
AT Alice Springs

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. On 3 March 2011, Mr Edward Jungari Brown (the Deceased) was in custody at the Alice Springs Correctional Centre when he experienced chest pains. He was taken to the Alice Springs Hospital, suffered a heart attack and was unable to be resuscitated. The Deceased was 34 years old and died from natural causes.

2. As this was a death in custody, pursuant to section 15 of the *Coroners Act*, an Inquest was mandatory.

3. Ms Elisabeth Armitage appeared as Counsel Assisting and Ms Ruth Brebner was granted leave to appear for the Correctional Services and the Department of health. A thorough investigation was conducted by Detective Senior Constable Timothy Lee. I received into evidence his comprehensive investigation brief, and all relevant medical and Correctional Services files. I also heard evidence from Dr Terence Sinton, Mr Matthew Richards, and Dr Joanna Oakeshott.

4. Pursuant to section 34 of the *Coroners Act* ("the Act"), I am required to make the following findings:

   "(1) A coroner investigating –

(a) a death shall, if possible, find –

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

(iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

5. Section 34(2) of the Act operates to extend my function as follows:

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

6. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(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."

7. Where there has been a death in custody, pursuant to section 26 (1) and (2) of the Act a coroner:

> "(1) Must investigate and report on the care, supervision, and treatment of the person being held in custody; and
>
> (2) May investigate or report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

Background

8. The Deceased was an Aboriginal male born on 1 August 1976 at Alice Springs. He was also known as Edward Raggett. On his birth certificate his mother is recorded by her first name only, Kathleen. Other records refer to her as Kathleen Pollard or Pula. Prison records note his mother's name as Jenny. His father's name is not recorded on his birth certificate or in any records received in this Inquest. The records indicate that the Deceased was in a defacto relationship with Ms Priscilla Brown and had previously been in a defacto relationship with Ms Susan Jungwena. His body was identified by an uncle, Mr Leslie Gorey.

9. Immediately before his imprisonment, the Deceased was living at House 5 Abbots Camp, Alice Springs. It is recorded that from time to time he also lived at Hoppys Camp, Trucking Yards, The Salt Bush Area Stott Terrace, Namatjira Camp, and Papunya.

10. Little is known of the Deceased's background and upbringing other than that which can be gleaned from his medical and custodial records. The records reveal that he went to school at Papunya until grade six, and left when he was 12 or 13. He was never employed and received social security payments. He sniffed petrol for about five years which affected his ability to concentrate, but outgrew this habit. Thereafter he preferred to consume alcohol.

11. The Deceased's custodial records indicate he first came into contact with the law in 1992, when he was still a juvenile. Most of his criminal history involved property offences, particularly the theft of alcohol. Prison staff considered the Deceased to be polite and respectful. During periods of incarceration the Deceased worked as a yard raker, compound cleaner, and in the horticultural work party.

12. The Deceased's medical records indicate numerous presentations following and associated with excessive alcohol consumption and injuries associated with violence.

Relevant medical history

13. On the 13 June 2007, during men's health screening at the Congress Medical Centre Alice Springs, the Deceased was diagnosed with type 2 diabetes. On 20 June 2007 a care plan addressing diet, exercise, smoking, and alcohol was drafted and discussed with the Deceased. The Deceased was prescribed metformin hydrochloride (500 mg twice daily) for his diabetes. Although the Deceased was referred for further education about managing his diabetes, the Deceased was noncompliant with education and his medication regime.

14. On 28 May 2010 the Deceased presented at the emergency department of the Alice Springs Hospital following an assault. Hospital records note that he was known to have type 2 diabetes but record "no regular medication for a long time". The Deceased also presented at hospital on 6 June 2010 for an abscess and on 27 September 2010 for pneumonia.

Circumstances surrounding the death

15. On 22 February 2011 the Deceased was arrested for an offence of unlawful entry and on a warrant for aggravated assault and was received into the prison where he was housed in dormitory 2 of M block.

16. During the prison reception process the Deceased was screened by a prison nurse who noted in his medical file that his blood sugar was high, he was diabetic and not taking his medication, he was a heavy smoker (30 cigarettes a day) and drinker (a carton of wine and beer a day). The Deceased was not in pain or unwell.

17. On 23 February 2011 the Deceased appeared in the Alice Springs Court of Summary Jurisdiction and was remanded in custody.

18. On 25 February 2011, as a continuing part of the prison reception process, the Deceased was examined by the Alice Springs Correction Centre Medical Officer, Doctor Ahmed Abdelsalam. Dr Abdelsalam had access to the medical

file and read the reception notes from 22 February 2011. Dr Abdelsalam conducted a complete physical examination and took blood and urine for testing, which includes testing for blood sugar levels. A finger prick test was conducted for immediate blood sugar results and returned a reading of 24.1 mmol/1 which was considered clearly high.

19. The physical examination included cardiovascular, respiratory, gastrointestinal, skin and neurological examinations. The clinical physical examination did not reveal any immediate problems. The Deceased was not in any pain or discomfort.

20. Because the Deceased was a known diabetic and his blood sugar was high, Dr Abdelsalam started him on diabetes medications, and prescribed Metformin (1000mg twice daily), and Gliclazide (30mg once a day). The drugs were not immediately in stock in the clinic and the Deceased commenced taking the prescribed medications on 1 March 2011.

21. On Thursday 3 March 2011 at 00.40 hours, Prisoner Christopher Daniel from dormitory 2, contacted the gaol communications tower via intercom stating that he required prison officers to come to the dormitory because a prisoner was feeling sick.

22. Senior Prison Officer Matthew Richards, the Officer in Charge of the prison for the night shift, attended M Block with Prison Officers Peter Knight, Steven Greenfield and Mark Nolan. The Deceased was sitting on his bed and informed the officers that he was not feeling well and said "I've got burning pain in my chest", and brushed his hand across his chest. The Deceased looked unwell and appeared sweaty but was coherent. When asked if he was dizzy he said “no”. When asked if he was numb in his arms or could feel pins and needles he replied “no”. When asked if he was on heart medication he replied “no”.

23. PO Richards instructed PO Knight to get a wheelchair and PO Greenfield to get the oxy-viva. Both were located nearby. The Deceased was removed from dormitory 2, placed in a wheelchair which was considered a safe option in case he fainted, provided oxygen, and taken to the medical section of the gaol.

24. In accordance with departmental procedures, the Officer in Charge contacted the on call nurse and informed her of the Deceased's condition. The nurse said to call an ambulance immediately and that the Deceased should be transferred to the Alice Springs hospital. An ambulance was despatched to the prison at 00.53 hours.

25. While waiting for the ambulance the Deceased began vomiting and also suffered diarrhoea. His oxygen therapy was continued.

26. The ambulance arrived at 01.09 hours. The attending paramedics completed their assessment of the Deceased who was conscious with a Glascow Coma score of 15. The Deceased told the ambulance officers that he was diabetic and continued to vomit and complain of abdominal pain. The Deceased was connected to the ambulance ECG monitor. The ambulance departed the prison at 01.41 hours. During transport the ambulance officers realised there might be cardiac issues, they informed the Alice Springs hospital, and conveyed the Deceased to the hospital as a code 1 (emergency lights).

27. On arrival at the Alice Springs Emergency Department at 01.59 hours, the Deceased was sitting up on the stretcher and speaking with the paramedics. He was taken inside for handover to the emergency department staff. During the handover medical staff saw that he went into respiratory and cardiac arrest.

28. A qualified resuscitation team was available consisting of the emergency department registrar, the intensive care registrar, the nursing team leader, two resuscitation nurses and an intensive care nurse. The resuscitation procedures were commenced and continued for about 1 hour with no improvement. A

decision was made by the resuscitation team to stop medical treatment and death was declared at 03.02 hours.

Autopsy

29. An autopsy was conducted on 8 March 2011 by Dr Terence Sinton who found:

 (i) Clinically significant atheromatous coronery artery disease (coronary atherosclerosis),

 (ii) Fluid accumulation in the lungs consistent with acute heart failure,

 (iii) The toxicology analysis contained substances consistent with therapeutic interventions during resuscitation attempts and the prescribed diabetes medications,

 (iv) There was no evidence of trauma.

30. Dr Sinton found that the Deceased died from longstanding coronary artery disease (coronary atherosclerosis). I accept that finding.

31. Dr Sinton told me that smoking and type 2 diabetes are known risk factors for heart disease.

32. In his statement Dr Abdelsalam noted that coronary atherosclerosis takes years to build up. It was his opinion that the few days delay in the provision of the Deceased’s prescribed diabetic medication would have made no difference to the Deceased’s prognosis.

Conclusions

33. I find the Deceased died of natural causes having suffered a heart attack (coronary atherosclerosis). The Deceased’s heart disease was longstanding.

34. The Deceased had been diagnosed with type 2 diabetes in June 2007 but, on the evidence before me, he did nothing to manage his condition via lifestyle changes nor did he take medication for it. It is likely that his failure to manage

his diabetes and his heavy smoking contributed to his longstanding coronary disease. The short delay between prescription and receipt of medication in prison is unlikely to have affected his prognosis.

35. I find that the Deceased's care, supervision and treatment while in custody was reasonable and appropriate. The prison officers responded quickly and followed correct procedure when they received notice of his illness.

36. There are no recommendations arising from this Inquest.

Formal Findings

37. Pursuant to section 34 of the *Coroner's Act* I find, as a result of evidence adduced at the public inquest, as follows:

    (i) The identity of the Deceased was Edward Jungari Brown born in Alice Springs on 1 August 1976. The Deceased resided at Alice Springs in the Northern Territory of Australia.

    (ii) The time and place of death was 03.02 hours on 3 March 2011 at Alice Springs Hospital.

    (iii) The cause of death was coronary atherosclerosis.

    (iv) Particulars required to register the death:

    1. The Deceased was Edward Jungari Brown.

    2. The Deceased was of Aboriginal descent.

    3. The Deceased was unemployed.

    4. The death was reported to the coroner by Correctional Services.

    5. The cause of death was confirmed by post mortem examination carried out by Dr Terence Sinton.

6. The Deceased's mother is Kathleen Pula (also known as Pollard) of Papunya.

Dated this 13th day of July 2012.

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GREG CAVANAGH
TERRITORY CORONER