CITATION: *Inquest into the death of Wendy Walangitj Garmu* [2006] NTMC 088

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0183/2004
DELIVERED ON:	10 November 2006
DELIVERED AT:	Darwin
HEARING DATE(s):	25, 26 & 27 July 2006
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death as a result of stabbing, medical treatment thereafter, possible preventable death.

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
Solicitor for the NT: (Police & Territory Health)	Mr Ron Holdsworth

Judgment category classification:	B
Judgement ID number:	[2006] NTMC 088
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0183/2004

In the matter of an Inquest into the death of

WENDY WALANGITJ GARMU
ON 26 OCTOBER 2004
AT INTENSIVE CARE UNIT – ROYAL DARWIN HOSPITAL

FINDINGS

(10th November 2006)

Mr Greg Cavanagh SM:

INTRODUCTION

1. Wendy Walangitj Garmu ("the deceased") was an Aboriginal woman born on 2 August 1959. She died on 26 October 2004 in the Intensive Care Unit, Royal Darwin Hospital following an emergency evacuation from the Gove District Hospital. Ultimately her cause of death was a stab wound to the chest with certain complications. This Inquest was held as a matter of my discretion pursuant to section 15 of the *Coroners Act*.

2. Pursuant to section 34 of the *Coroners 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
>
> (v) any relevant circumstances concerning the death"

3. Ms Roberts was counsel assisting me at this Inquest. Mr Holdsworth of the Office of the Northern Territory Solicitor, sought and was granted leave to appear on behalf of the Commissioner of Police and the Department of Health. The death of the deceased was investigated on my behalf by officers from the Major and Organised Crime Unit in Darwin. Detective Senior Constable Isabelle Cummins assisted Ms Roberts in the preparation for the Inquest and was present at the hearing of the matter. The brief of evidence compiled by her (and her colleagues) was tendered (Exhibit 1). In addition, I was assisted by the expert opinions of Dr David Gawler, Vascular and General Surgeon at Royal Darwin Hospital, and Dr Didier Palmer, head of Emergency Medicine at Royal Darwin Hospital (Exhibits 2 and 3). The Department of Health legal team was of great assistance in seeking and obtaining those reports.

Formal Findings

4. Pursuant to s. 34 of the Act, I find, as a result of evidence adduced at the public Inquest as follows:

(i) The identity of the deceased person was Wendy Walangitj Garmu, born on 2 August 1959 at Lake Evella in the Northern Territory.

(ii) The time and place of death was at Royal Darwin Hospital at 12:56pm on 26 October 2004.

(iii) The cause of death was hypoxic brain injury following the development of a hemopneumothorax resulting from a stab wound to the chest.

(iv) Particulars required to register death:

(a) The deceased was female.

(b) The deceased's name was Wendy Walangitj Garmu.

(c) The deceased was an Aboriginal Australian.

(d) The cause of death was reported to the Coroner.

(e) The cause of death was confirmed by post-mortem examination carried out by Dr Noel Woodford.

(f) The deceased's parents' names are not known but her family come from Gapuwiyak and Marpuru.

(g) The deceased was unemployed at the time of her death and was living at Nhulunbuy.

Circumstances of her death.

5. At about 7:45am on Friday 22 October 2004, police and ambulance officers were called to an area near the Gove Surf Club in relation to a complaint of a woman having been stabbed. On arrival the deceased was identified as the injured female and was taken to Gove District Hospital where she was seen by Dr Anton Wal in the Emergency Department. Medical treatment was provided and she was discharged shortly afterwards. She apparently returned to the beach area with her husband, Donald Ganambarr. On the Sunday 24 October 2004 at about midday the ambulance was again called to attend to the deceased. When they arrived they were directed by her husband to her and she gave a history of having been in pain all night and unable to walk (with a previous stab wound). Upon arrival at the Emergency Department at Gove District Hospital she went into cardiac arrest. Emergency resuscitation attempts were immediately made. About 45 minutes into this treatment it was observed that she was suffering from a pneumothorax. Although she was able to be resuscitated to the point of having her heart restarted and circulation and breathing established, she remained in a coma and died at Royal Darwin Hospital on 26 October 2004.

6. Criminal proceedings were commenced in relation to the stabbing injury to the deceased. Hazel Yunupingu was charged with criminal offences in relation to the stabbing. A committal hearing on a charge of Dangerous Act

causing Death took place and she was committed for trial. However, the charges were discontinued by the Director of Public Prosecutions prior to that trial. Ms Yunupingu was summonsed as a witness before me. She appeared to answer her summons and had some discussions with Ms Coroneo of the North Australian Aboriginal Justice Agency based at Gove, and also with my counsel assisting. She sought to claim a privilege against self incrimination, and on that basis declined to answer questions about the circumstances of the injury to the deceased. I decided that in all of the circumstances of this case, it was not in the interests of justice to require questions to be answered in accordance with the terms of s. 38 of the *Coroners Act* and she was excused.

7. There are a number of statements in the police brief from people who were in the vicinity on the night or early morning that the deceased was stabbed on 24 October 2004. All of the involved persons, including the deceased, had been drinking for a numbers of hours. Many of them did not recall the incident or told the police they did not recall the incident. There were two witnesses summonsed to give evidence before me who did give a statement to police in which they nominated Ms Yunupingu as the person who had stabbed the deceased. After a conference with my counsel assisting, neither of those witnesses were called to give evidence on the basis of her assessment that they were unreliable, or would not have assisted the Inquest. One of those witnesses sought in conference to withdraw his statement, and I therefore do not rely on that statement. The other witness, Jennifer Yunupingu, said in conference that while her statement was true, she had no recollection now of the events. She was also so shy, and reluctant to speak about the issue (this was evident when she was called in the committal proceedings) that she would not have been able to assist the court. I am still able to rely on her statement, and I do so.

8. Therefore, the only witness to the infliction of the injury who was available to give oral evidence was Donald Ganambarr, the deceased's husband. His evidence was that he saw a person who he describes as his niece, known to

him as Dela, but also known as Hazel Yunupingu, stabbing his wife. It was an argument over alcohol, or money to purchase more alcohol.

9. I found him to be a credible witness. He described where the wound occurred and explains that he went to the hospital with his wife on the first and again on the second occasion. He said that either after the stabbing or perhaps after he and his wife had returned from the first hospital visit, the person he referred to as Dela (who is also Hazel Yunupingu) apologised to his wife for stabbing her. Mr Ganambarr was under the impression that the dispute between the two women had been relatively minor and had been resolved.

10. The deceased was admitted to Gove District Hospital emergency department at 8.00am, presenting with a stab wound to the posterior upper chest. Dr Wal described it as the area over the scapula (shoulder blade). Dr Wal has worked at Gove Hospital for about 10 years with a year in Alice Springs when he first came to Australia from Port Moresby. He saw the deceased that morning and he gave her a local anaesthetic and physically explored her wound which is, looking at it using his hands. He assessed it as 1½ centimetres wide and about 4 to 5 centimetres deep, he cleaned it and stitched it up. He did not order any x-rays of the wound. He formed the impression that she had been drinking. He remembers Senior Constable Williams coming into the hospital to make enquiries and telling him that the patient would soon be discharged. She was discharged about 10:45am. Dr Wal's decisions on the treatment and discharge were the subject of criticism.

11. By the time he gave evidence before me, Dr Wal had reviewed and considered the reports of Drs Palmer and Gawler. Dr Palmer said in his report that the emergency department management of thoracic stab wounds, even where those wounds are apparently asymptomatic, should be dealt with as follows (Exhibit 2):

> " *All thoracic (and upper abdominal, lower neck) stab wounds mandate erect CXR.

> * A normal CXR does not exclude significant injury.
>
> * All patients should be admitted for observation (and re-examination and re-xray prior to discharged)."

12. Dr Gawler in his detailed report said the following (Exhibit 3):

> "In any stab wound of the chest or even at the lower neck or upper abdomen or loin, a chest x-ray is essential. This is because there is always the risk of penetration of the pleural space or even the pericardial space. This can result in pneumothorax or bleeding."

13. He then goes on to say that in his opinion the patient should have been admitted for observation for the following reasons (Exhibit 3):

> "…Even if a chest x-ray had been done and had been normal, there would have to be concern about the circumstances of this patient's environment after discharge. In particular there was the possibility that all those around her would be drunk and in no fit state to observe her progress or arrange for her to return to hospital should she deteriorate."

14. It is now known, of course, that the stab wound had penetrated the pleural space and had created a 2 millimetre deep laceration of the upper lobe of the lung. What then occurred was bleeding and a tension pneumothorax which can be described in simple terms as air leaking out of the lung which cannot pass back into the lung. Pressure builds up and eventually the lung collapses and cardiac function is impeded. This can obviously cause death.

15. A pneumothorax takes some time to develop. The time can vary in a particular case. At the time that the deceased was seen by Dr Wal, she was demonstrating no symptoms. Dr Wal was asked about his treatment decisions (transcript p35):

> "The first point is that both of those doctors say that in circumstances of a stab wound to the chest area one of the things that ought to have happened is that the patient ought to have been given a chest X-ray. Did you consider a chest X-ray in these circumstances?---I must admit I'm very saddened by what's happened.

I'm sorry?---I'm saddened by what's happened and I sort of realise that there's been an error made. It's badly probably my fault in that aspect but I just want to you know clarify what's ---

Please do?---What actually – you know what – excuse me – what you know my part around that. Firstly you know I basically you know looked at the wound and that's what we normally do and I think what ended up happening was that you know the patient would have lifted her arm up and when she got stabbed and so what happened the clavicle – not the clavicle, the scapula or shoulder blade as you know is not completely rigid, there's some movement on it so what actually happened was the shoulder blade actually moved off and the stab wound had actually gone through the chest, but once it- when she presented to the hospital and when we explored the wound, the wound actually landed on the scapula penetrating the scapula. So if I had moved the shoulder we would have found it but I didn't move the shoulder to actually see what happened to the wound after that. So because of that we missed injury that had actually gone through the chest wall by the scapula moving and covering the wound up, so that's why I on looking at the hole and listening to the chest and there was no other signs to suggest there was anything going on inside the chest. I did not do a chest X-ray then and also observed the patient.

So - - -?---But on looking back now a chest X-ray would have been probably the right thing to do.

All right, if you'd taken a chest X-ray what would you have been looking for?---Well we'd be looking things like air and fluid in the lung or blood. Just looking back at what – you know the series of event that have happened – she had obviously come in for at least four hours. She was in hospital for another couple of hours before or so before she left so she wasn't showing any signs of you know chest compromise, it's just what we're looking for. You know if she did have a big bleed it would have been very obvious in the first few hours, so that's – or early, that would have been very obvious. That's part of the reason you know checking out and looking at it from a clinical point of view she wasn't compromised at all and then just looking at the wound we were happy that there wasn't any real need to get an X-ray because – but obviously (inaudible) there was an error in that shoulder cavity wound. So unless we would have moved her shoulder around and see what happened to the wound it was ---."

16. Dr Wal went on to explain that a lot of his experience with stab wounds was in remote communities and he explained that in those places he would not

have the option of an x-ray unless he flew the patient to Gove, nor would he have the option of admitting the patient for observation, so he had to rely on a physical exploration of the wound to assess its severity. He went on to say when asked whether there was such a thing as a general policy with regard to the treatment of such wounds he said "what I would probably do now is get x-rays because of what happened" but then again "as I said I go to communities check patients out and stitch them up and if its not necessary for them to come in for x-rays and it won't need to be observed, so if you know if I am completely satisfied then I wouldn't necessarily get an x-ray but if I'm doubtful I would probably get an x-ray. But having said that then I would probably change my practice and get x-rays on everyone."

17. The evidence before me is that even had a chest x-ray been taken, it is possible that the pneumothorax would not have developed to such an extent to have been detectable. Had the patient been kept in for an observation period, she may or may not have exhibited symptoms of the bleeding and developing pneumothorax during that time. Therefore it cannot be said that had Dr Wal followed the suggested correct procedure, or the procedure that both Drs Palmer and Gawler say ought to have been followed, the deceased's death would necessarily have been prevented. However, that does not suggest that those things (i.e. chest x-ray and observation) ought not to have been done; they ought to have been done in this case and Dr Wal acknowledged that frankly and genuinely.

18. When the deceased was brought to hospital the second time it was around 1:00pm on 24 October 2004. Dr Gawler noted that the cardio pulmonary resuscitation ("CPR") carried out at that time was ineffective and was always going to be so due to the undiagnosed tension pneumothorax. There was about 45 minutes of resuscitation after the deceased went into cardiac arrest. That was actually ceased before the diagnoses of tension pneumothorax was made and treatment for that was able to be commenced. What Dr Gawler said about that was (Exhibit 3):

> "In a situation of cardiac arrest post penetrating chest trauma, if this is known, or even fractured ribs, there is a case to be made for insertion of an intercostal catheter forthwith because a tension pneumothorax is a potent cause of cardiac arrest in its context. I think therefore with the aid of the 'retrospectoscope' it would have been advisable to consider the possibility of tension pneumothorax immediately this patient arrested and to have inserted an intercostal tube or perhaps just a large bore needle into the pleural space very early in the period of resuscitation. In the presence of a tension pneumothorax no amount of CPR would be of any use."

19. One of the doctors dealing with this incident, that is the second admission, was Dr David Munro who was working at that time in Gove Hospital and had been there for about 6 months. Dr Munro had also seen the reports of Drs Gawler and Palmer when he gave evidence. He said in oral evidence before me that he could not recall precisely when he discovered that the patient had a history of a stab wound, but he thought it was "well into the resuscitation process". His evidence in the committal proceedings, on the other hand implied (although did not state precisely) that the history of being stabbed in the chest was conveyed to the emergency department doctors by the ambulance officers at the time the patient was brought in. There is insufficient evidence for me to resolve this question, as there were of course a number of other people and medical practitioners and nurses there at the time, including the medical superintendent of the hospital, Dr Nick Ogmyvitis. Dr Munro agreed with the proposition that CPR would be largely ineffective in the presence of a tension pneumothorax. But he said that he was not aware of the tension pneumothorax until later on in the resuscitation and he was then asked a question (transcript p23):

> "…Is it the case that the reason for not considering that diagnosis, was because you weren't aware of the history of the stab wound?--- Correct."

The Police Investigation

20. When the police first dealt with the stabbing of the deceased on 22 October 2004, they were told or they had gained the impression that the injury was definitely not life threatening and not apparently serious. On that basis, I

am told they did not make any particular efforts following up obtaining a statement from the victim, the deceased. On that day, although intoxicated, she was conscious, walking and talking and probably able to give a history.

21. At the scene of the stabbing somebody, whether it was the deceased's husband or the deceased herself is not entirely clear, told police that the person who had stabbed her was Hazel Yunupingu. Ms Yunupingu was one of the people who was taken into custody that day by police. A number of people were intoxicated and were detained on that basis. Senior Constable Williams attended the hospital at 10:25am. He made notes of his conversation with Dr Wal where he said "4 to 5 centimetres deep in skin cut on shoulder blade". He also had a conversation with the victim in which she said that somebody called Dela Burawunga, "a young girl" stabbed her. Senior Constable Williams did not know that Hazel Yunupingu was also known as Dela. Senior Constable Williams was told that the victim was soon to be released from the Hospital and he said to her, or her husband, that they ought to attend at the police station after they were released to make a statement.

22. That afternoon, Senior Constable Williams released Hazel Yunupingu from custody on the basis that there was "no complaint and no corroborating evidence". He acknowledged that he had not approached Donald Ganambarr for a statement nor made any further enquiries of whether the victim had been released from hospital, nor driven around trying to find her to confirm whether she wanted to make a statement. Mr Charles Rue was the Senior Sergeant of police in October 2004 at Nhulunbuy Police Station. He recalled that it was Donald Ganambarr who nominated Hazel Yunupingu as the person who had stabbed his wife. Senior Sergeant Rue knew that Hazel Yunupingu was also known as Dela. Senior Sergeant Rue said that he would expect that in this type of case for the police to attempt to find out when a victim was going to be released from hospital and if she had already been released "it's a matter of chasing her up to see if its possible to get a statement". He said that it was not always the case that the hospital staff

would be willing to advise police of when patients were released. He then explained it this way (transcript p46):

> "…I'd probably say we started out very serious, it was a stabbing. It looked as though it could be life threatening, we set up a crime scene, we got our witnesses. We got what we thought was the offender, we went to that level. It was then a matter it's only a I suppose from medical reports it's three stitches and she's all right so it's a minor injury and I suppose the priority is then we moved onto something else and addressed it as it went. So, yes we de-scaled it rather than up-scaled it and we had to up-scale it again on the Sunday. So, yes."

23. As I indicated during the hearing of the matter, I do not have any criticism to make of the police and I find the explanations for what occurred to be reasonable. As to the coronial investigation in relation to the death of the deceased, I find that it was well done and Detective Senior Constable Cummins was of great assistance during the preparation of the matter.

Conclusion

24. I find that the deceased died from complications of a stab wound to the chest. I find that the stab wound was inflicted by Hazel Yunupingu on 22 October 2004. The making of a section 35(3) *Coroners Act* report is made redundant by the concluded legal proceedings already mentioned herein. The expert medical evidence is that additional investigations to those actually performed by Dr Wal on 22 October 2004 ought to have been carried out. That is an error that has been acknowledged. I find that if those investigations had been carried out, this death may potentially have been prevented but I put it no more highly than that. I make no further comments about the resuscitation on 24 October 2004.

25. The Department of Health has been of significant assistance to me in this matter. They have obtained statements of opinion from two very busy medical practitioners, and provided those to my counsel assisting in time to be considered for the Inquest. The witness Dr Wal has been frank and helpful in his evidence before me. However, I have heard nothing by way of

submissions or evidence from the Department of Health in relation to any follow up action that had been taken with regard to the conceded error on 22 October 2004 at Gove District Hospital. If I had heard that the matter had been discussed in a formal way with Dr Wal, that it had been formally reviewed and some steps had been taken to ensure it did not occur in the future, I would most likely have been satisfied to leave the matter there. However, in order to be sure that has in fact occurred, I make the following recommendation.

Recommendation

26. I recommend that the Chief Executive Officer of the Department of Health & Community Services, and the responsible Chief Medical Officer(s) review the performance of Dr Wal in relation to this matter and provide appropriate professional mentoring, counselling and direction to him.

Dated this 10th day of November 2006

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GREG CAVANAGH
TERRITORY CORONER