CITATION: *Inquest into the death of Ryan Smiler [2013] NTMC 14*

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0112/2013
DELIVERED ON:	21 July 2014
DELIVERED AT:	Darwin
HEARING DATE(s):	19 and 20 May 2014
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, Death by natural causes, care and treatment whilst in Custody.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Family:	Philippa Martin
Department of Health & Department of Correctional Services:	Greg MacDonald

Solicitors:

Family:	North Australian Aboriginal Justice Agency (NAAJA)
Department of Health & Department of Correctional Services:	Solicitor for the Northern Territory

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

No. D0112/2013

In the matter of an Inquest into the death of
RYAN SMILER
ON 9 JULY 2013
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

INTRODUCTION

1. This is an inquest into the death of an Aboriginal man on 9 July 2013. In accordance with the request of his family, I shall refer to the deceased as Mr Smiler, or the deceased, during these reasons.

2. Mr Smiler was a 39-year-old Aboriginal man who was born on 27 March 1974 at Wave Hill in the Northern Territory of Australia. He died at approximately 3.18am on 9 July 2013 at the Royal Darwin Hospital ("RDH"). At the time of his death, Mr Smiler was a serving prisoner incarcerated at the Darwin Correctional Centre ("DCC"). Prior to his incarceration he was unemployed and living between the Kalkaringi and Dargaragu Communities in the Northern Territory of Australia.

3. For reasons which will appear below, this death was reportable to me pursuant to s.12 of the *Coroners Act* ("the Act") because it was a death of a person who immediately before his death was a "person held in custody". "Person held in custody" is defined under s.12 of the Act to include a person detained in prison. As a result of being a person held in custody immediately prior to his death, this inquest is mandatory pursuant to s.15(1) of the Act.

4. This inquest was held on 19 and 20 May 2014. Ms Jodi Truman appeared as Counsel assisting. Ms Philippa Martin of the North Australian Aboriginal Justice Agency (NAAJA) appeared as counsel on behalf of the family of the deceased. Mr Greg MacDonald appeared as counsel for both the Department of Health and the Department of Correctional Services. I thank all counsel for their assistance in this matter.

5. A total of seven (7) witnesses were called to give evidence at this inquest, namely; Detective Senior Constable Julie Frost, Dr Simon Quilty, Registered Nurse (RN) Lee Lanyon, Senior Prison Officer (SPO) Mohibur Rahman, RN Lizzie Sekeretti, Dr Lewis Campbell and Mr Paul Quinlan, Acting General Manager of Prison Health at the Department of Health.

6. A brief of evidence containing various statements, together with numerous other reports, police documentation and records were tendered at the inquest (exhibit 1). The deceased's various medical files were also tendered in evidence (exhibit 2), together with the various records held with the Department of Correctional Services (exhibit 3). Public confidence in Coronial investigations demands that when police (who act on behalf of the Coroner) investigate deaths that they do so to the highest standard. I thank Detective Senior Constable Frost for her investigation.

7. Pursuant to section 34 of the Act I am required to find if possible:

> "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 registered the death under the Births, Deaths and Marriages Registration Act;

v. Any relevant circumstances concerning the death"

8. 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".

9. 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

10. Mr Smiler was born at Wave Hill in the Northern Territory to Vera Werrin Wiringali and Smiler Bangaiari who are both now deceased. He had three brothers; William, Banjo and Kerry, and two sisters; Mary and Sonja. He grew up in the Kalkaringi and Dargaragu Communities. He went to Kormilda College in Darwin and completed his schooling to Year 9. He then returned to Kalkaringi Community where he was employed as a civil worker for CDEP. He later became unemployed and was in receipt of unemployment benefits. As a younger man, he was considered a good sportsman, particularly basketball and Aussie Rules football. He played the drums and enjoyed fishing and hunting. He participated in Aboriginal ceremony every year.

11. Mr Smiler had been married on two occasions which both ended in separation. His first wife was Roseanne Skeen to whom he had two children, namely Winston and Bernie Smiler. They lived together at Ringer Soak in Western Australia. Sometime in the mid 1990's Mr Smiler separated from Ms Skeen and he returned to Kalkaringi. His second wife was Sabrina Jerry. They lived together at Kalkaringi but separated approximately one year later. They had no children.

12. Following the breakdown of his second marriage, Mr Smiler's life appears to have revolved around drinking. He was a heavy drinker, known to drink at least six days per week and mainly at the Kalkaringi Club. When this would close of a night time, Mr Smiler would head to the drinking grid and continue to drink grog. Sundays were usually his only day without alcohol coinciding as the day when the Kalkaringi Club was closed.

13. According to the medical records tendered before me, it appears that in about 2009 Mr Smiler became very sick from too much drinking and in fact admitted himself to the Katherine District Hospital (KDH). Those records note that Mr Smiler was under the care of the renal unit and was being

investigated for hypertension and was warned that he needed to stop drinking or he would become very sick and die. Unfortunately it appears on all the evidence that these warnings were ignored by Mr Smiler and he continued to drink heavily.

14. Mr Smiler also had a lengthy criminal history; however most of his offences were traffic offences relating to his abuse of alcohol. It is this sort of offence that was the reason for Mr Smiler's incarceration at the time of his death.

Circumstances surrounding his incarceration

15. In the early hours of Thursday 27 June 2013, Mr Smiler was driving a motor vehicle on the Stuart Highway in Katherine South when he was subject to a traffic apprehension and subsequent breath test. The test returned a positive result. The deceased was arrested and conveyed to the Katherine Watch House for a breath analysis. This returned a reading of 0.071% BAC. It was however noted at the time that the deceased had previously been disqualified from driving in 2011 for a period of five years. He therefore remained in police custody with the intention being for him to appear before the Katherine Magistrates Court the following morning.

16. At around 4:11am, the deceased was processed into the Watch House. During a Custody Health Assessment, the deceased advised Police that he had not taken his warfarin medication for about two weeks and that he had also consumed half a carton of beer since 10pm the night before. He did not however complain of any pain or shortness of breath.

17. At 6:22am, the deceased was charged with driving whilst disqualified and driving with a low range blood alcohol content. At 8:04am, he was conveyed to the Katherine Court House cells and at 8:20am court guards' contacted medical staff at Wurli-Wurlinjang Health Service requesting they attend to assess the deceased and provide him with any relevant medications.

18. In the meantime Mr Smiler also appeared before the relevant Magistrate and pleaded guilty to the traffic offences referred to earlier. He received, relevantly, a sentence of imprisonment for three months to be suspended after serving one month upon a bond for 12 months. This was the sentence he was serving at the time of his death.

Medical intervention – Wurli-Wurlinjang Health Service

19. At around 4:00pm on 27 June 2013, Dr Rodney Jones from Wurli-Wurlinjang Health Service attended at the court house and assessed the deceased. His statement records that Mr Smiler told him he had missed all his usual medications, had been drinking alcohol in Katherine for some time and was short winded. Dr Jones observed that the deceased had difficulty in breathing and wanted to stand or sit up, rather than lay down. His blood pressure was high, as was his heart rate. His respirations were also rapid. The deceased's abdomen is recorded as distended and he was retaining fluid in his legs.

20. Dr Jones concluded that the deceased was suffering from fluid retention secondary to cardiac failure and arrangements were made for the deceased to be conveyed to the KDH via St John Ambulance. The records note that police contacted St John Ambulance at 4:06pm. Dr Jones remained on site until the arrival of St John Ambulance at 4:45pm. The deceased was subsequently conveyed to the KDH via police escort, arriving there at 5:07pm.

Katherine District Hospital ("KDH")

21. Upon arrival to the Accident and Emergency Department of the KDH, the deceased was assessed by treating officer, Dr Maida Akhtar. The KDH clinical notes were tendered before me and indicate that the deceased provided a two day history of shortness of breath and a two day history of leg swelling. Following an examination by Dr Akhtar, the clinical summary notes that the deceased was speaking in full sentences with no increased

"work of breathing". His blood pressure was highly elevated as was his respiratory rate. He was noted to have swelling of his feet and legs up to his knees and swelling of his sacrum and abdominal wall. His admission weight was 105kg. Dr Akhtar's clinical impression was decompensated congestive cardiac failure secondary to cardiomyopathy. This is a serious condition that can lead to heart failure.

22. The deceased was admitted to the Jack Roney Ward at around 8:50pm. The plan for his medical treatment was to provide diuretic therapy, anticoagulant therapy and recommence his usual medications. He was placed on a fluid restriction of 1.5 litres per 24 hours and was to have daily weighs in order to monitor his weight. Due to his earlier ordered incarceration, he remained under police guard throughout his admission.

23. Dr Quilty was significantly involved in the deceased's care whilst admitted at the KDH. Dr Quilty had in fact been involved in Mr Smiler's care during an admission from 27 February until 4 March 2013. He gave evidence that Mr Smiler's presentation during his February 2013 admission was "strikingly similar" to his presentation in June 2013. Dr Quilty stated that during the February 2013 admission Mr Smiler again presented with decompensated cardiac failure and that even at that time it was his opinion that Mr Smiler's cardiac condition was very serious.

24. Dr Quilty was asked whether he had provided any information to Mr Smiler during his February 2013 admission as to the risks that he faced if he continued to be non-compliant and to drink. Dr Quilty stated as follows (tp.14.7):

> "I certainly did. Unfortunately, I think I meet too many young men who are walking fine precipice of life and death as a result of alcohol and Mr Smiler was certainly one of those gentlemen. When I first met him in February I understood from previous tests and cardiology reviews that his heart was in a very poor state and I suggested to him that he didn't have long to live if he continued to drink alcohol, he wouldn't live a long life at all".

25. Dr Quilty stated he reconfirmed this opinion to Mr Smiler during the June 2013 admission (tp.15.8):

> "I said - well I have what I term as a script for people in this situation because I do it so regularly and I warned him that he was a very sick man. I warned him that I expected that he wouldn't live a long life and I warned him that if - well I told him that if he could continue to take the medications that we prescribed then it was likely to prolong his life and I did this with the presence of the police officers".

26. On 30 June 2013, the deceased was deemed by Dr Quilty to be fit for custody and was discharged. Dr Quilty completed a "Fit for Custody" form and discharge letter. In the discharge letter he wrote (by hand) that the deceased was "to attend a Clinic/GP on Wed 03/07/13 for his reg. medications". Dr Quilty stated that during his admission, Mr Smiler's condition had improved significantly and he was asymptomatic. There were no clinical indicators to suggest any thrombosis development although he was not able to confirm this with an echocardiogram. He provided Mr Smiler with enough medication until the requested review by a GP and had reinstituted Mr Smiler on a number of cardiac failure drugs.

27. Dr Quilty did not however recommence Mr Smiler on his warfarin medication. Dr Quilty did however clearly consider very carefully whether to recommence Mr Smiler on such medication (tp.15.5):

> "…when he presented to me for the second time in late June 2013, Warfarin was a much more complex decision. So in June 2013 he damaged his liver so severely from the alcohol that the proteins that make the blood clot had been severely disrupted so he developed what we call a coagulopathy. A coagulopathy results in both a tendency to bleed and a tendency to clot. Initiating that any medication may interfere with (inaudible) clottings is fraught with difficulty and there is a very limited medical literature on how to approach a situation like this and I decided on a course of not continuing with the Warfarin because I thought the risk of bleeding was too great and I was concerned that after he was discharged from prison he would continue to be non-compliant anyway and I went for harm minimisation as an approach".

I accept and understand the basis for Dr Quilty's decision in this regard.

28. Upon discharge, Mr Smiler was transferred back to the Katherine Watch House at around 11:57am. He remained at the Watch House overnight. There were no issues reported or documented throughout the day and overnight. On Monday 1 July 2013, the deceased self-administered his medication under the direction of police. He was subsequently transferred to the Katherine Court House and placed into the custody of Corrections staff. His IJIS records were tendered before me and noted that the deceased appeared in good health upon transfer. The deceased was then driven from Katherine to Darwin with a number of other prisoners. He arrived at the DCC at approximately 12:30pm.

Darwin Correctional Centre ("DCC")

29. Upon his incarceration to the DCC, the deceased was required, as are all prisoners, to undertake an "Initial Risk/Needs Assessment" which is conducted by Corrections staff. This assessment addresses the following areas:

    29.1 Institutional risk/needs;

    29.2 Individual risk factors;

    29.3 Suicide/self-harm;

    29.4 Drugs and alcohol;

    29.5 Psychiatric/psychological;

    29.6 Intellectual disability;

    29.7 Medical history; and

    29.8 Physical disability.

30. During the course of his assessment, when asked about his medical history including heart or any other medical problems, the deceased is recorded as answering "no". Mr Smiler was then transferred to the clinic at the DCC for his medical health assessment.

31. RN Lee Lanyon was the nurse to conduct this assessment. She confirmed receipt of the discharge letter form Dr Quilty at KDH and a "massive bag" of medications. She recalled it was difficult to obtain a medical history from Mr Smiler as he was quiet and did not give much detail. RN Lanyon completed the health assessment which was tendered before me. In the assessment the question marked whether the client feels unwell was ticked "Yes", however RN Lanyon stated that she could in fact specifically recall Mr Smiler and that this entry was a mistake as she did not recall any complaints being made by Mr Smiler at that time. RN Lanyon stated she recalled Mr Smiler (tp.23.2):

> "Well I remember him because he had the discharge summary from Katherine District Hospital and it painted a picture of a very very, very sick man. I remember, we do go through a questionnaire and I remember that most of his answers were contradictory (inaudible)".

32. RN Lanyon stated that she undertook a set of observations which were "quite normal", except his urinalysis, however she expected this given his renal failure. It is apparent from the records that RN Lanyon commenced her assessment at 2.34pm and completed it at 3.25pm. During that assessment she also spoke with Dr Donna Button about Mr Smiler's medications. RN Lanyon recalled that Dr Button in fact spoke briefly to Mr Smiler about his medications, but did not conduct an examination of any sort. Dr Button then ordered the medications as recommended by Dr Quilty, but also added Thiamine and Elevit to deal with possible alcohol withdrawal. RN Lanyon stated that it was her experience that whenever a "long term alcoholic" is incarcerated these medications are generally given as a matter of course.

33. Thereafter Mr Smiler was given the "all clear" and was taken to his cell. RN Lanyon understood at that time that the plan was for Mr Smiler to be put on the automatic recall list to "come in the next day" for a full consult with a doctor and implementation of a personalised care plan. This was in accordance with the patient care information system ("PCIS") in operation at the clinic which generated certain automatic recalls for prisoners to be returned to the clinic following their initial assessment.

34. Although that automatic recall system was in place, Mr Smiler was not seen at the clinic on 2 July 2013. I received evidence that in fact the area where Mr Smiler was housed, namely K Block, was on lock down that day due to staff shortages. RN Lanyon stated that this is one of the ways in which a prisoner may not get seen in accordance with the PCIS automatic recall. She also noted that with the number of recalls each day, it can be that not all are reached. RN Lanyon's experience where a recall for a prisoner was missed was as follows (tp.27.1):

> "Every recalls stays on the system until it's serviced. At the end of it, if we miss - the recalls come up on the day that they're scheduled and we have an automatic printout of all the recalls for the day. If for some reason a person hasn't been able to be seen, court or (inaudible) whatever, at the end of the week, there'd be a printout of all of the recalls that haven't been serviced and that team leader will go through that and call people in".

35. Although Mr Smiler was not seen by the doctor in accordance with the "recall" for 2 July 2013, he was in fact seen by a nurse that morning and received his medication during morning rounds. There is no notation of any issues or concerns being expressed (or observed) at the time that medications were provided by the relevant nurse.

36. I also received into evidence a statement from Stuart Garadji who was a prisoner and shared a cell with Mr Smiler at that time. Mr Garadji told police that he in fact travelled with Mr Smiler from Katherine on 1 July 2013 and after both men were seen at the prison clinic they were then sent to

B block. Mr Garadji stated that Mr Smiler made no complaints of feeling sick at that time. The next morning, being 2 July 2013, they were both moved to K Block. Mr Garadji recalled Mr Smiler receiving medication that morning. He stated that it was not until "supper time" that Mr Smiler made any complaint about feeling unwell. It was Mr Garadji who called for assistance on the intercom at 5.23pm.

37. As a result of that call, a response team was sent to K Block. PO Mohibur Rahman was the Operations Senior and he received the call from communications to respond at about 5.26pm. PO Rahman attended with three other officers at the cell. PO Rahman stated that when he first saw Mr Smiler he appeared "distressed" and "did not look well". As a result PO Rahman determined he should go to medical. PO Rahman stated that Mr Smiler was talking and he asked him if he could walk to medical. Mr Smiler stated he would "try". The officers walked with Mr Smiler for a short distance until he stated he could no longer walk and a wheelchair was then obtained. PO Rahman recalled that they arrived at about 5.30pm at the clinic, where medical staff took over.

38. RN Liza Sekeretti was at the clinic. She recalled that upon his arrival Mr Smiler "was actually twitching on his right hand side" and that he was saying "'my right side is shaking, or cramping and I can't stop it'". RN Sekeretti also noted that his mouth "was towards the left hand side". RN Sekeretti stated that she initially formed the opinion that Mr Smiler was having a stroke. She commenced her observations and decided that an ambulance needed to be called. As she began to take his observations, Mr Smiler started to have "a generalised seizure". She gave him oxygen and he was restrained by the prison officers whilst she called the doctor. After the seizure ended, she observed that Mr Smiler was "groaning" and she was no longer able to engage meaningfully with him. She spoke to Doctor Michael Nixon who recommended that Thiamine and Diazepam be given. RN

Sekeretti understood that this was because of the potential for his condition to be related to alcohol withdrawal.

39. Thereafter she took some further observations and an echocardiogram ("ECG") was also performed in that time. RN Sekeretti continued to monitor Mr Smiler until the ambulance staff arrived and took over. He was then taken to Royal Darwin Hospital in company with a prison officer.

Royal Darwin Hospital

40. A copy of the RDH records was tendered before me. They show that Mr Smiler arrived by ambulance at approximately 6.59pm and was admitted to the Emergency Department ("ED"). Dr Lewis Campbell was a consultant in the Intensive Care Unit ("ICU") and was one of the doctors who attended to Mr Smiler's care during his admission. Dr Campbell gave evidence before me in relation to Mr Smiler's arrival (tp.46.7):

> "…Mr Smiler was unconscious when he arrived at the hospital. He was actively fitting. He was having a seizure on his arrival and he was given further anti-seizure medications to prevent further seizures. He was intubated and placed on controlled ventilation because he was at a very high risk of not being able to breathe for himself and he had an urgent CT scan on arrival to determine why he was having the seizures. That showed an old infarct; that is the evidence of an old stroke in the occipitoparietal region, which is the posterior part of the brain; back part of the brain. Within that there was a calcified lesion which often indicates scarring from an old lesion, such as the stroke. That calcified region can often be the source of electrical activity which causes seizures. There was no acute sign - meaning that there was no sign for why he should have had a fit at that time and not previously. He was a cause for some concern because he had a fever and when I say short, I mean that there were signs of organ failure, so he required medication to keep his blood pressure up. That required ongoing mechanical ventilation and there were signs that his heart was not pumping well enough to supply all his organs".

41. Dr Campbell gave evidence that they attempted to determine the cause of the seizures and there were a number of possibilities (tp.47.2):

> "Generally, when somebody has an old lesion, and there are no signs of new lesions, we will ascribe of the cause of that seizure to the old lesion. Seizures are complex and chaotic and their germination(?) and so there could be that something new had happened possibly even being very unwell systemically, being very unwell from his cause of fever, with the background of that lateral region. Outside of that there were things for which we didn't have any evidence, but which seemed likely in retrospect. It may be that he had suffered another stroke and as a result of that identified thrombus in his heart, breaking off and embolising or travelling through the circulation in his brain. Other possibilities which are probably less likely as more information appears, which were considered initially, but which seem unlikely now, are alcohol withdrawal and a septic focus in the brain; meaning that the cause for his fit was also a cause for his fever, possibly effecting the brain. That seems very unlikely now given his progress and given the initial cause. So the initial impression of the various contributing causes to his fit was that it could have been alcohol withdrawal, sepsis in general, possibly a septic focus in the brain, possibly simply an old calcified lesion from a previous stroke acting as a focus for the seizures. He had treatment for undifferentiated community-acquired sepsis. That would include for an undifferentiated institutionally-acquired sepsis, because obviously in the Territory, our community-acquired sepsis protocol is broader than institutionally-acquired. He had seizure treatment which consisted of benzodiazepines. They themselves are a treatment for alcohol withdrawal and so that was considered to be taken care of at the time. He had treatment for sepsis which includes general organ support and then he was observed for the effects of those treatments".

42. In relation to the potential for alcohol withdrawal to have been the cause of the seizures, Dr Campbell stated as follows (tp.49.7):

> "…so the possibilities of the influences on the likelihood of a seizure were many and still remain many. It's very frequent that we don't have a definite firm diagnosis of what caused a seizure at a given time. Sometimes even when we have EEG monitoring; that's monitoring with the electrical activity of the brain, we still don't even know what it was that initiated that seizure. So looking back at a set of seizures that arose, it's an exercise in relative probability to say what caused it. So the possibility of alcohol withdrawal is real. The possibility that something else had initiated that seizure is also very real and the possibility that a clot from either the atrium or the ventricle could have passed through his brain and caused lack of blood so produces a new seizure focus, is very real as well. It's

> impossible to extricate which of those was the main cause and it’s certainly accepted that there was not one single cause. Sepsis produces many blood components and blood messenger systems at lower than effectual, meaning increased the chances of a seizure. An old stroke provides a seizure focus and provides initiating like a current. It also lowers the risk - sorry - lowers the threshold of a seizure and raises the risk of a seizure. Because the electrical circuits around the size of that old stroke are more prone to passing on (inaudible) activity which is what a seizure looks like. An embolism would further increase the chances of a seizure. But sometimes presents simply as a stroke. It would be more common for it to present simply as a stroke, but it’s possible it could either be due to that. All of these would contribute in a given person so to say that one event is a possibility is very difficult. All I can say is that I can't say that alcohol withdrawal was not involved and that is unfortunately all that I can say”.

43. Dr Campbell was asked whether the fact that Mr Smiler had not consumed any alcohol in the five days that he had been admitted to hospital and then Correctional care may have reduced the possibility that his seizure was alcohol related. He stated as follows (tp.50.3):

> “…although I don’t know if I can say as to what medications he was given in Katherine, so that could have influenced the possibility of alcohol withdrawal. He was placed on an alcohol withdrawal scale there, but I don’t know have access to the individual doses of drugs that he was given. So benzodiazepines as well as alcohol will reduce the probability of alcohol withdrawal seizure. Unfortunately, even alcohol doesn't reduce - doesn't abolish the probability of an alcohol withdrawal seizure. One can still have an alcohol withdrawal seizure simply having reduced the amount of alcohol without stopping and the other factors that alcohol can cause seizures, so there's no safe way to approach alcohol withdrawal seizures that intend to do this. For example, if one were to abolish the possibility of any alcohol related seizures, one would have to get very high doses of benzodiazepines and that would endanger the ability of the person to protect their airway which would put then at very high risk of having serious complications. Again, this is a another area where there is always a risk and benefit issue and I suppose the only institutional approach to it is to have protocols in place. These protocols can never avoid every alcohol withdrawal seizure, so it’s important to have training and protocols to have those protocols adhered to. I know we do that in the Top End Health Service and in general we are very familiar with alcohol withdrawal and it’s something that's

> generally done as a team. I know that he was barely discharged from Katherine Hospital and without having any apparent signs of alcohol withdrawal, so that would be reassuring for Katherine Hospital. Then he was readmitted to Royal Darwin Hospital, he was having a seizure…”.

44. Two echocardiogram were performed on Mr Smiler, being on 3 and then 8 July 2013. Dr Campbell noted that Mr Smiler had (tp.48.1):

> “…previously had severe systolic dysfunction which is severe heart failure with organ failure as a result of that. So that really is very severe heart failure. He had had an atrial thrombus identified in the February 2012 when he came in from the prison after his seizures. The first echo that was done the next day showed a ventricular thrombus. The chambers of the ventricle are in sequence. It may be that the atrial thrombus that was identified in February 2012 had embolised or resolved and that it had nothing to do with the fated event. It may be that it had embolised but only as far as the ventricle which would be unusual but it can be imagined to have and it certainly could have happened, in which case the thrombus in the ventricle on 3 February - on 3 July 2013, could have been that initial thrombus or it could have been a newly arising thrombus. It is possible that the atrial thrombus previously identified, but it just resolved without causing any problems and that this new thrombus had appeared in the meantime. But it’s also possible that the atrial thrombus had already embolised somewhere else. But it’s not possible to determine without a post-mortem whether that had happened”.

45. In this case no autopsy was performed as it was the opinion of Dr Campbell that the cause of death was uncontroversial and the family did not want an autopsy performed. On the question of the cause of death, Dr Campbell stated (tp.48.8):

> “It was just more than likely cardiac arrest and I have no doubt that it was due to cardiomyopathy. The by far the most likely circumstance given the encounters with the previous years with other doctors who have (inaudible) is that that cardiomyopathy was in origin, alcoholic cardiomyopathy and so I've written the cause of death as cardiac arrest caused by alcoholic cardiomyopathy”.

Recommendations/Comments

46. At the commencement of this inquest, counsel assisting requested that I consider whether the medical care provided to Mr Smiler was appropriate, i.e. whether there was anything that could have, or should have, been done that may have avoided the death of Mr Smiler or prolonged his life. I considered this issue carefully during the course of the evidence.

47. It is clear that Mr Smiler was a very, very sick man. According to the medical evidence, he had been diagnosed with hypertension, or high blood pressure, a number of years before his death. He was admitted to the renal unit of the RDH in 2009 for investigation of the same but absconded before treatment could be instituted. According to that statutory declaration of Dr Rodney Jones of the Wurli Wurlinjang Health Service Mr Smiler's major diagnosis was alcoholic cardiomyopathy or heart failure due to excessive use of alcohol. That condition had been present for a significant period of time. It was complicated by his high blood pressure, irregular heart beat and a tendency to form blood clots inside his heart cavities.

48. In 2012 he was found to have a left atrial thrombus, or blood clot, in his heart. In February 2013 he was admitted to the KDH with decompensated heart failure, i.e. his condition was worsening. It appears that throughout all this time he was drinking very heavily and he was not complying with the medications that were being provided to him. He was warned by Dr Quilty (in no uncertain terms in fact) about the seriousness of his condition, his prognosis of a very limited life expectancy and of the need to comply with his medications. It appears however that the deceased ignored all those warnings or was simply unwilling or unable to make any changes so as to improve his chances of survival.

49. It was his continued abuse of alcohol that once again brought him to the attention of police, and it was his continued abuse of alcohol that resulted in him coming to the attention of medical authorities when he identified to the

police that he was not compliant with his medication. It was then as a result of the police seeking medication for Mr Smiler that it was discovered that his condition was getting worse and he was required to be hospitalised at the KDH.

50. I consider the care provided to Mr Smiler at the KDH was appropriate in all the circumstances. In my opinion, Mr Smiler was extremely fortunate that he came back under the care of Dr Quilty who had treated him previously and was aware of his condition. Although Dr Quilty did not recommence Mr Smiler upon warfarin (an anti-coagulant for treatment of his atrial thrombus) I consider that decision to have been reasonable for the reasons identified, i.e. Mr Smiler had developed a coagulopathy (a tendency to bleed) from his alcohol related liver disease, was continuing to drink very heavily and was non-compliant with his medications. As a result Dr Quilty considered it too dangerous to recommence warfarin.

51. In relation to the appropriateness or otherwise of that decision I note that Dr Campbell stated as follows (tp.48.10):

> "First of all, I'd just like to say that I agree with that decision having read the rationale for it and having reviewed Mr Smiler's history prior to that event and in retrospect his sudden deterioration after that decision, reinforces the wisdom of it. So that's really the opinion that I have to offer is that it was the correct decision. Although it's always an individual risk at benefit decision. In Mr Smiler's case, the dangers of Warfarin would have been immense because he had previously attended with injuries sustained while intoxicated and he would have been at very high risk of severe injuries if he were on Warfarin when he sustained them. On top of that, Warfarin's effects on clotting are not consistent with time and by that I mean, initially on starting Warfarin, some of the blood components which are affected by, first the ones that that want to allow clotting, so originally at starting Warfarin there is a short period when the likelihood of a clot forming or propagating in its early form is much higher. Thereafter, the likelihood of a clot forming or propagating falls and it becomes lower than it was before. In a situation in a specialised case up to many of our patients is further complicated by having liver disease and in liver disease those same blood components are affected at an unpredictable rate and the

> integrity of blood vessel wall is affected so that at the same time clots are more likely to form spontaneously and in the wrong place and are also more likely not to form in the spots that (inaudible). That just makes it extremely difficult to predict what the risk is, but with that knowledge yes it is very much higher with chronic liver disease; with the knowledge that any inconsistency albeit in the administration of Warfarin leads to risk of the clotting and of bleeding at different times. I think it was certainly a safety based decision not to give him Warfarin and I think probably the right decision".

52. I accept the evidence given by Dr Quilty. In light of the evidence of Dr Campbell, I make no criticism of that decision. I consider it was appropriate in all the circumstances.

53. In relation to the question of care provided at the DCC Clinic, whilst I consider it would have been preferable that Mr Smiler had been examined by a doctor at the DCC Clinic in accordance with the PCIS recall on 2 July 2013, I do not consider that the failure for him to be seen on that day contributed in any way to his death. I am not satisfied that had Mr Smiler been seen by a medical practitioner on 2 July 2013 that his would have changed his circumstances at all. It is clear from the statement of Mr Garadji that it was not until after supper on 2 July 2013 that Mr Smiler made any complaint about his health. I also note that whilst he had a complicated and chronic medical history, his condition was stable. He was examined by RN Lanyon who clearly took appropriate care when examining Mr Smiler and was aware of his medical history and various serious conditions. I consider the care provided by the clinic was appropriate.

54. I find that the care provided at the RDH was exemplary and there can be no criticism of the efforts made to care for Mr Smiler upon his admission. As Dr Campbell stated, by that time Mr Smiler's prognosis was poor and the likely outcome was death or severe disability. As I stated at the conclusion of the evidence, it is my finding that all the doctors, nurses, police and correctional services staff that were directly involved with Mr Smiler acted

appropriately, properly and compassionately and I make no criticism whatsoever of the care they provided.

55. However, as I also noted at the conclusion of the evidence, I consider that there should be more importance given to the conduct of the initial assessment by the doctor at the clinic at DCC. If it is to be accepted (as it should be accepted) that the majority of prisoners who are incarcerated have chronic illnesses (and in some cases are very sick just like Mr Smiler) then the sooner the doctor can conduct that initial assessment, the better for all concerned. I wish to make it very clear however that I do not consider that the failure for that initial assessment of Mr Smiler by a doctor to occur on 2 July 2013 was in any way causative of his death.

56. In terms of that review, it is clear that the PCIS system is integral in creating the "recall" of prisoners for review. It appears however that if prisoners are not reached in the initial recall, the prisoner then does not get listed in another recall until the following weekend. I was concerned about that aspect of the evidence given the importance of prisoners being seen in a timely fashion. Since the completion of the evidence, I have received a written submission from Counsel for the Chief Executive Officers of the Department of Health and Correctional Services. A copy of that submission was provided to all represented parties.

57. Within that written submission it is noted as follows (relevantly from paragraphs 5 and 6):

> "The Department of Health has now decided to modify the PCIS Recall Report process or procedure, such that the Recall Report for each and every day will publish the names of inmates triaged at reception examination as urgent or high priority requiring medical examination. That is, those inmates will remain on the Recall Report for each day, until examined by a medical practitioner. This modification is in the process of being implemented.
>
> ... The Department of Health is also reviewing Clinic procedures to reiterate that CARPA guidelines and recommendations are applied,

including in relation to examination by a medial practitioner within 24 hours of reception where necessary”.

58. I have considered these further submissions carefully. Given that both Departments appear to be putting in measures to ensure that prisoners are seen in a timely fashion and are making their own changes in this regard, I have no recommendations to make arising from this inquest other than to make comment that work should be continued towards ensuring prisoners are seen as soon as possible.

59. All in all, I find that the care, supervision and treatment of the deceased whilst in custody and prior to his death, was satisfactory and not subject to criticism.

Formal Findings

60. On the basis of the tendered material and oral evidence given at this inquest, I am able to make the following formal findings:

    i. The identity of the deceased was Ryan Smiler who was born on 27 March 1974 in Wave Hill in the Northern Territory of Australia.

    ii. The time and place of death was at approximately 3.18am on Tuesday 9 July 2013 at the Royal Darwin Hospital.

    iii. The cause of death was cardiac arrest caused by alcoholic cardiomyopathy.

    iv. Particulars required to register the death:

        a. The deceased’s full name was Ryan Smiler.

        b. The date and place of death was 9 July 2013 at the Royal Darwin Hospital.

c. The deceased was male born on 27 March 1974 and was 39 years of age at the time of his death.

d. The deceased was of Aboriginal descent.

e. The cause of death was cardiac arrest caused by alcoholic cardiomyopathy.

f. The cause of death was reported to the Coroner.

g. The cause of death was confirmed by ICU consultant, Dr Lewis Campbell, after an autopsy was deemed unnecessary.

h. The deceased's mother was Vera Werrin Wiringali and his father was Smiler Bangaiari who are both now deceased.

i. The deceased usually lived at House 81, Daguragu Community or at the Kalkaringi Community in the Northern Territory of Australia;

j. The deceased was unemployed.

Dated this Monday the 21st day of July 2014

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GREG CAVANAGH
TERRITORY CORONER