Coroners Act, 1996

[Section 26(1)]

Western *Australia*

RECORD OF INVESTIGATION OF DEATH

Ref No: 26/10

I, Evelyn Felicia VICKER, Deputy State Coroner, having investigated the death of ***Dennis NJAMME*** *with an inquest, held at the* ***Perth Coroner's Court, Hay Street, Perth,*** *on* ***24, 25 and 30 August, and 2 September 2010,*** *find the identity of the deceased was* ***Dennis NJAMME*** *and that death occurred on* ***21 June 2008*** *at* ***Greenough Regional Prison*** *as a result of* ***ischaemic heart disease in a man with known diabetes and hypertension*** in *the following circumstances:*

Counsel Appearing :

Mr Jeremy Johnston assisted the Deputy State Coroner
Mr Nicholas Egan (State Solicitors Office) appeared on behalf of the Fremantle Hospital and Health Service and also on behalf of the West Australian Country Health Service.
Ms Robyn Hartley (State Solicitors Office) appeared on behalf of the Department of Corrective Services
Ms Wendy Hughes (Aboriginal Legal Services) appeared on behalf of the family

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INTRODUCTION

The deceased (Mr Njamme) was born on 25 March 1968.[1]

Mr Njamme had a history of significant risk factors for ischaemic heart disease. In January and April 2008 he reported episodes of chest pain. He was examined by a cardiologist in May 2008 and an appointment was booked for a coronary angiogram examination on 2 July 2008.

At approximately 11am on 21 June 2008, he collapsed while playing football at the Greenough Regional Prison (GRP). Efforts to revive Mr Njamme were unsuccessful. He was pronounced dead at 11.32 am. He was 40 years of age.

The fact Mr Njamme died while in custody invokes the requirement for an inquest under the provisions of the *Coroners Act 1996.*

BACKGROUND

Mr Njamme had been brought up and resided predominately in the communities around the Halls Creek area, in the Kimberley region of Western Australia. The last school Mr Njamme attended was Balgo Primary School. His wife, Angela Gordon, and his family all live in the Kimberley region.

Mr Njamme had, at different times, been incarcerated at Broome, Greenough, Roebourne and Casuarina Prisons. He

[1] Transcript 24/08/2010 pp5-7 The police records give his birth date as 1 January 1966. All medical and prison records indicate 25 March 1968, and Sgt Howes conceded that the police date may have been inaccurate. Mr Njamme's family agreed with the date 25 March 1968.

was described as a quiet prisoner who did not often come to the attention of staff.

Mr Njamme had a medical history of diabetes mellitus with nephropathy, hypercholesterolemia, hypertension, obesity, and had a family history of heart disease. He also drank alcohol and smoked heavily. Mr Njamme had deafness in his left ear, having had tympanoplasty surgery in August 2004. He reported recurrent ear infections and bilateral perforations.

Medical practitioners treating Mr Njamme had real difficulty obtaining relevant information from him about his symptoms. Doctors repeatedly reported he was a poor historian, and the medical notes contain inconsistencies in basic information he provided to medical staff at different times.

While Mr Njamme was residing in and around Balgo, for at least 14 months from February 2006 until April 2007, he was non-compliant with his prescribed medications. As a result his diabetes, high blood pressure and cholesterol were not controlled. He attended the Balgo and Ringer's Soak remote area medical clinics occasionally. He was drinking to excess regularly, and smoked between 5 and 20 cigarettes each day.

THIS TERM OF IMPRISONMENT

In 2003 Mr Nammje was sentenced to a total of 7 years imprisonment for armed robbery and doing grievous bodily harm. He was released on parole on 24 January 2006. He breached parole by offending, and was charged and convicted

of unlawful wounding in May 2007. He was sentenced to an extra 4 months. The breach of parole meant his maximum release date was 3 October 2010.

On 6 May 2007 he was received at Broome Regional Prison (BRP). He remained there 9 days before being transferred to Casuarina where he spent the next 276 days until 18 February 2008.

TREATMENT AND MOVEMENT HISTORY MAY 2007 TO FEBRUARY 2008

On 6 May 2007 Mr Njamme was received in BRP, on remand, prior to his sentencing listed for 14 May 2007. His initial nursing assessment on 7 May noted his hearing deficit, hypertension with a blood pressure 150/100, diabetes with blood sugar levels (BSL) of 16 (the normal range being 5 to 8), and that he had been non-compliant with prescribed medication since his prior release from BRP in January 2006.

The Total Offender Management System (TOMS) was updated with respect to Mr Njamma.

On 9 May 2007 a 5 page health summary was sent from the Yura Yungi Remote Area Health Clinic (YYRAHC), at Ringer's Soak containing information and notes for Ringer's Soak and Balgo clinics. The health summary records diabetes mellitus (NIDDM), hyperlipidemia, and hypertension. The only time Mr Njamme attended a community clinic in 2006 was on 13 August.

It was not until 9 March 2007, at Ringer's Soak, that he requested any medications. Medications were again arranged on 15 April 2007 at Balgo, and also blood and urine tests. On that day the notes record he "says he's been out of meds 'a long time' ".

The YYRAHC summary was sent to BRP and apparently reviewed by Nurse Waters on 13 May 2007, when she saw Mr Njamme and recorded his BSL as 18.5 and blood pressure at 130/92.

After being sentenced for unlawful wounding on 14 May, he was transferred from BRP to Casuarina Prison on 15 May 2007.

The medical notes record that Mr Njamme was seen by Dr Patterson at Casuarina on 25 May 2007. Dr Patterson had reviewed the YYRAHC facsimile sent from BRP containing the notes pertinent to Mr Njamme's history in the community. Dr Patterson prescribed daily 1.5g metformin hydrochloride for diabetes control. Dr Patterson requested blood and urine tests and planned to review him in 2 weeks. The other medications mentioned in the TOMS Medical Status printout for 7 May 2007, were not prescribed at that time.

On 6 June 2007, Dr Patterson noted no bloods had been taken and arranged for this to be done the next day, and also the following week.

Between 11 and 20 June 2007, the test results were reviewed by Dr Patterson, as they arrived. Some of the results indicated an above average risk for coronary heart disease and poor glycaemic control. The albumin/creatinine ratio (ACR) was also elevated pointing to the development of diabetic nephropathy.

Mr Njamme next attended the medical clinic on 27 November 2007, and was reviewed by Dr Patterson who requested further tests be done, to be repeated in 6 weeks. He also prescribed Simvastatin 40mg each night for hypercholesterolemia, and Ramipril 2.5mg daily for hypertension, and increased the dose of Metformin to 2g. The notes show bloods and urine were collected on 3 December 2007.

On 5 December Dr Patterson again reviewed Mr Njamme having obtained the most recent test results. Gliclazide 60mg daily for diabetes was added to Mr Njamme's prescription and Dr Patterson planned a further review in 6 weeks after the next tests,

Dr Patterson's note 24 January 2008 is as follows:

Blood pressure 132/86, pulse 66. No HbAIC level had been sent to the lab, he queried "why not done?" and noted to re-order again urgently.

Mr Njamme had reported an "episode of central chest heaviness/tightness on walking this morning. Pain stopped when stopped walking ie 1-2 minute episode. Felt shortness of breath. No radiation of pain. No vomiting, no sweating, no cough, no sputum. Not had chest pain before.

No family history of IHD" (Ischaemic Heart Disease).

On examination, Mr Njamme's chest sounds were normal and the chest was clear. There was no chest wall tenderness.

Dr Patterson queried IHD, and prescribed Aspirin 100mg daily and Atenolol 50mg daily. He advised Mr Njamme to speak to nurses immediately if there was any future chest pain of any duration. He planned a review in 1 week, and to refer to a cardiologist.

Dr Patterson referred Mr Njamme to Fremantle Hospital Cardiology. His referral states in part: the current problem is "a recent episode of chest pain on exertion which settled with rest. He has significant risk factors for ischaemic heart disease. Please review for possible IHD". The past history is "Hypertension, NIDDM [diabetes mellitus]; Diabetic nephropathy; Hypercholesterolemia; Obesity" and "Smoker".

Although the referral form states "urgent", it appears the first available appointment was booked for 19 May 2008.

Dr Rowbottom reviewed Mr Njamme on 31 January 2008. The progress notes indicate:

"Blood pressure 160/99, pulse steady at 96. Said he had pain in chest last week while sitting. It lasted a couple of minutes. Did not have GTN (glyceryl trinitrate nasal spray) at the time but now has it in his possession to use when required. Increase Atenolol to 50 mg bd (twice/day) and monitor daily blood pressure, pulse and for chest pain. Medical Officer review in one week or earlier if needed".

The progress notes for 24 and 31 January demonstrate Mr Njamme's poor ability to relate his medical history and symptomology. When diagnosing IHD, there is a difference between chest pain at rest (sitting) and chest pain on exertion. Mr Njamme did not attend for an electrocardiogram test (ECG) and blood pressure monitoring scheduled for the next day. He attended on 5 February for the ECG, blood pressure and pulse readings.

On 6 February 2008, Dr Rowbottom noted there had only been one blood pressure reading taken in the last week 155/90, while on this day it was 155/92. He reported "no further chest pain".

Mr Njamme was transferred to Greenough Regional Prison (GRP) on 18 February 2008. The TOMS Medical Status report, printed at Casuarina on 17 February, was not substantially updated. It contained the same information as at 7 May 2007,

except it mentioned the appointment at Fremantle Cardiology booked for 19 May 2008.

Mr Njamme's medical file was transferred to GRP.

TREATMENT AT GREENOUGH REGIONAL PRISON (GRP)

The GRP progress notes for 20 February 2008 record a Diabetes Care Plan was initiated by Nurse Rice.

Dr Gilles saw Mr Njamme on 25 March 2008 and completed the first 3 monthly assessment of the Diabetes Care Plan. In evidence she stated the purpose of initiating this form was to monitor his diabetes over a period of time.

She noted his diabetes was diagnosed years ago, and there was a family history of diabetes. Smoking is described as "every day lots", alcohol: "lots outside – none in prison". His diet was poor, and she recalled he regularly ate toast with butter and jam. For exercise he was walking around the oval. She recorded his weight to be 111kg.[2]

Dr Gilles reviewed the blood and urine test results and noted the haemoglobin HbA1C was getting better, but was still bad, his albumin/creatinine ratio was raised showing evidence of diabetic nephropathy. Coversyl was prescribed to treat this. She noted "watch the renal function and needs regular review" in three months.

[2] Transcript pg184, 25.08.10

There is a blank Cardiovascular Disease Care Plan (CVD Care Plan) in Mr Njamme's Department of Corrective Services medical file. It had not been initiated but was present. Dr Gilles made no entries in this document and apparently remained uninformed of its relevance to his ongoing medical care.

She stated she did not place the blank CVD Care Plan on file and they were not in common usage during early 2008. She agreed using a CVD Care Plan would have focussed her mind on the treatment of any cardiac problems. Dr Gilles also said the two forms were much the same, but agreed there were material differences.[3]

Dr Gilles stated the advantage of the CVD Care Plan would have been the specific questions about symptoms relating to cardiovascular disease such as angina. There is also an area which talks about specialist referral. This might have alerted her to the Cardiologist appointment booked for 19 May had it been initiated from the medical records.

Dr Gilles concluded a combined diabetes and cardiovascular disease Care Plan would be a great idea. It is not uncommon for patients to require monitoring for both diseases, and the information for both plans is the same in many respects.[4]

Dr Gilles did not see Dr Patterson's referral to cardiology despite its presence on TOMS. She stated had she been aware

[3] Transcript pgs 215-6, 25.08.10
[4] Transcript pg 218 – 25.08.10

of that referral it would have broadened her focus to include his cardiac situation as well. Also she would have asked some specific questions about his cardiac pain and tried to illicit any symptoms he had in relation to his cardiovascular system.[5] She apparently did not have time to review his notes from Casuarina.

Dr Gilles saw Mr Njamme on 11 April 2008 and noted he needed bloods checked for review in 3 weeks.

GERALDTON REGIONAL HOSPITAL EXAMINATION (GRH)

After Mr Njamme's review on 11 April he attended the medical centre at about 11:00am on 15 April 2008 suffering chest pains. This was consistent with the advice given to him in January to immediately see a nurse if this happened. The notes state: brought to clinic "complaining of chest pain. Has had since yesterday. Usually uses a GTN spray. No arm pain. Does feel hot, but thinks it may be the laundry and work. Skin feels clammy. Nil nausea. Nil headache. Dennis used spray about 4 pumps."

At 11.15am, he stated the pain had gone. An ECG was performed and the results were sent by facsimile (together with the TOMS Medical Status report) to Geraldton Regional Hospital (GRH) for their opinion. Bloods were taken for urea and electrolytes (kidney function).

[5] Transcript pg 183, 25.08.10

At 12 noon, Nurse Bridson was advised by GRH a doctor had reviewed the ECG and Mr Njamme would need admission. She arranged an ambulance and sent the bloods and urea to the hospital for analysis. The TOMS Medical Status report, and his current medications list went with Mr Njamme and were included in the GRH medical file.

Mr Njamme was initially seen by nurses in the emergency ward. He appeared calm and co-operative with no pain. He said he "had similar pain yesterday but did not tell anyone" and that the pain occurred while he was working in the laundry.

He was reviewed by Dr Sunil Reddy who noted Mr Njamme was hard of hearing and "extremely poorly communicative".

Mr Njamme reported a history of two days intermittent chest pain, with an episode yesterday of unknown duration while working in the laundry, relieved by GTN spray. Mr Njamme denied any nausea, vomiting, radiation, dizziness or palpitations. There was "a repeat episode today lasting 15 minutes while working in the laundry" also relieved by GTN. He disclosed a history of similar episodes in the past.

Dr Reddy noted the past history: Diabetes type II, hyperlipidemia, hypertensive, poor compliance with medications, heavy smoker, and queried possible IHD.

The plan was admission to the High Dependency Unit (HDU)

through the chest pain pathway. The usual practice when admitting patients through the chest pain pathway is to admit them for a minimum of 12 hours for cardiac monitoring and serology testing. If at the end of the 12 hours all investigations are negative, the patient is discharged.[6]

Dr Reddy also noted as part of the plan Mr Njamme would need an exercise stress ECG arranged.

Mr Njamme was monitored in the HDU overnight 15 April 2008. He had chest x-rays, repeated ECG examinations and blood tests. As part of the investigation, he underwent a full blood count, testing of urea and electrolytes, cardiac enzymes and reactive protein testing.

In the morning on 16 April, he was reviewed by the Senior Medical Officer, Dr Amgad Said. The examination of Mr Njamme took approximately 45 minutes. Dr Said is now a consultant physician and stated he reviewed the hospital file including Dr Reddy's notes, the information submitted by GRP, the chest x-rays, and all the ECG and blood/urea test results.

Dr Said commented Dr Reddy's general examination and the systemic examination conducted at the time of Mr Njamme's admission were unremarkable.[7]

[6] Transcript pg 120, 24.08.10
[7] Transcript pg 122, 24.08.10

The repeat ECG's and cardiac enzymes results remained normal. The ECG's were similar to Mr Njamme's previous ECG on 5 February 2008. Dr Said stated the x-ray was normal.

The cardiac enzymes are tested in patients who have chest pain to see if they have had a heart attack or other heart damage. Chest pain can be due to indigestion, strain on chest muscles or other causes. The type of chest pain felt during exercise, which stops when the person rests, is called stable angina.

Dr Said stated he was looking for evidence of damage to the heart, evidenced by CK elevation and positive results for Troponin. Mr Njamma's results did not indicate damage to the heart muscle.[8]

The medical discharge summary by Dr Said on 16 April 2008 states: "Diabetes Mellitis, Non Cardiac Chest Pain"… "Hypertension, Hyperlipidemia". The tests were all normal. Follow up orders: "Normal follow up with GP".

Dr Said stated he believed he was aware of the fact Mr Njamme was due to see a cardiologist in May, from having viewed the TOMS Medical Status report and the reference at the bottom of the printout to "Appointments: … 19.05.08 @1415hrs FPH Cardiology".

[8] Transcript Pgs 124-5, 24.08.10

Dr Said did not arrange or recommend an exercise stress ECG in accordance with Dr Reddy's plan, because this was something the cardiologist would have to consider at the examination in May.[9]

Dr Said's discharge summary was seen and signed by Dr Gilles on 18 April 2008 when she reviewed his file. She also read over and signed the MR10 initial medical assessment form completed in Broome on 7 May 2007. Dr Gilles remained unaware of Mr Njamme's cardiologist referral.

Dr Gilles recorded Mr Njamme's weight as 111kg, and noted it had increased since his admission. The notes state: "discussed diet, toast, butter and jam needs watching." They discussed pathology results, renal noted as bad. They discussed stopping smoking, and that he was definitely contemplating this. They discussed exercise and suggested it needed to increase. Dr Gilles' note for 18 April 2008 states in part: "ECG – no evidence pain linked cardiac. He needs stress exercise ECG to see what's going on, and to review in 1 month."

Dr Gilles said the exercise ECG could have been done in Geraldton. Dr Gilles stated she would have filled in a referral form for the exercise ECG and given it to the medical secretary to arrange the booking, however there is no evidence a stress ECG examination was booked.

[9] Transcript Pg 127, 24.08.10

On 15 May 2008, Mr Njamme was transferred to Casuarina Prison for the cardiology examination at Fremantle Hospital on 19 May. Apparently Dr Gilles was unaware he had been transferred for a medical reason. No updated history was provided for Fremantle Hospital Cardiology.

CASUARINA PRISON

Dr Fraser Moss is the Director of Health Services, Department of Corrective Services. He agreed the GRH cardiac monitoring tests, being essentially negative, did not mean Mr Njamme hadn't suffered angina. He agreed angina was the result of a demand on the heart which it couldn't meet.

When Mr Njamme experienced pain, he slowed himself down. By the time he arrived at GRH and the tests were done, nothing showed. Dr Moss thought the fact of the admission to GRH suffering chest pain, was relevant information for a cardiologist subsequently examining Mr Njamme.[10]

Dr Moss stated it would be reasonable to expect a patient to tell a cardiologist about being sent to hospital suffering chest pain 5 weeks earlier.

However, he believed it would be possible, and may be beneficial in the case of a prisoner who could not adequately describe his history, for the medical referral to be updated

[10] Transcript pg 100, 24.08.10

with relevant history. Negative results may still be informative.

On 19 May, Dr Lee, Cardiology Registrar at Fremantle Hospital, examined Mr Njamme. He noted Mr Njamme's recollection of the episode of chest pain was poor, "he cannot remember and cannot characterise". As far as Dr Lee was aware there had only been one episode of chest pain and that was the basis of the referral made on 24 January.

Mr Njamme claimed he had a strong family history of heart disease whereby his sisters had heart attacks in their 30's. Dr Lee also noted his significant risk factors for coronary artery disease. He examined him to be clearly overweight.

The ECG trace results were normal.

Dr Lee suggested an exercise ECG would be the next investigation to perform but considered it would be technically difficult given Mr Nammje was in restraints. He was in the custody of G4S security officers who when asked about the possibility of removing the restraints, replied it was not possible. The waiting list for an exercise stress test in 2008 was about two weeks.[11]

Mr Peter Illich (then Acting Superintendent GRP) stated in his evidence an ECG stress test could be performed without the prisoner being in restraints. In 2008 prison administration

[11] Transcript pg 33, 24.08.10

could have arranged to remove restraints for such an appointment. An on-going discussion with G4S, the contracted prisoner transport services provider, has currently resulted in a less rigid approach to strict use of prisoner restraints, where the prisoner and the environment are considered to be secure.[12]

Dr Lee stated he remembered Mr Njamme not being forthcoming. His history was difficult to elicit, even with direct questioning. He had no recollection of chest pain and denied having any further episodes of chest pain since the January referral had been made.[13]

Dr Lee stated, "I couldn't obtain any history about his chest pain because he said he does not remember that particular episode, and so he denied ever having chest pain".[14]

Mr Njamme reported he was no longer getting chest pain, and based on that history, his last episode of chest pain was in January. He was on appropriate medications, and he was booked into the next available angiogram list. If he had complained of unstable symptoms, chest pain at rest or chest pain with less exertion, then Dr Lee would have admitted him to hospital immediately for an urgent angiogram.[15] Dr Lee remained completely unaware of Mr Njamma's admission to GRH in April 2008.

[12] Transcript pgs 54-5 & 67-8, 24.08.10
[13] Transcript pg 31, 24.08.10
[14] Transcript pg 32, 24.08.10
[15] Transcript pgs 35-6, 24.08.10

Dr Lee booked an angiogram instead, with blood tests to be performed prior to the angiogram. The angiogram was booked for 2 July 2008.

Dr Lee described the coronary angiogram as the 'gold standard' test which gives accurate information about the coronary arteries.[16] He said he would normally do a left ventriculogram as well as the angiogram, to pick up gross scarring and to see how well the heart pumps.[17]

In relation to what exercise was appropriate for Mr Njamme, Dr Lee stated he would recommend the patient not exercise until they had the angiogram if there was ongoing heart pain. If they were no longer getting chest pain then usually it was a stable situation.

If a patient is exercising without any problems Dr Lee would recommend they should continue to exercise because they are at low risk of having a cardiac event. He would advise to continue to exercise, particularly if already exercising and not experiencing chest pain.[18]

Dr Lee stated that in a person with stable angina, exercise encourages the body to form new collateral branches to arteries. In that case exercising is beneficial and has never been proven to accelerate plaque rupture. He agreed exercise, including playing football, would assist with management of

[16] Transcript pg 32, 24.08.10
[17] Transcript pg 38, 24.08.10
[18] Transcript pg 34, 24.08.10

Mr Njamme's diabetes, weight control and other issues.[19] Dr Lee emphasised he always advised patients to stop exertion as soon as they experience chest pain.[20]

Dr Lee wrote back to Dr Patterson at Casuarina, (as the referring doctor), with the results of his examination. He concluded "Mr Njamme has had an episode of chest pain that he cannot remember and cannot characterize in the setting of significant risk factors for coronary artery disease. His ECG today is normal." Although the letter is dated 19 May 2008, it was not received at Casuarina until 28 May, and some days later it was sent to GRP to be filed.

Mr Njamme was transferred back to GRP on 26 May 2008.

Dr Gilles next saw Mr Njamme on 30 May. She did not take notice of the preceding progress notes indicating he had been transferred to Casuarina, and was not aware of the letter from Dr Lee, sent to Dr Patterson. She reviewed the latest pathology results and was thrilled to note Mr Njamme's HbA1C level was 5.8% (reduced from 7%), also his weight had reduced to 101kg from 111kg. Mr Njamme reported he was trying to decrease food and was now training.

Dr Gilles reviewed the Diabetes Care Plan and noted he had lost weight, was trying with his diet, was still thinking about giving up smoking and had increased his exercise.

[19] Transcript pg 42, 24.08.10
[20] Transcript pgs 47-8, 24.08.10

In evidence Dr Gilles indicated she had no idea, and had not considered, that would include training for football. She did not question him about the level of his increased exercise. It was beyond her comprehension football was on the agenda for Mr Njamme.

Her notes make no reference to the exercise stress ECG referral she had proposed on 18 April, 6 weeks before. She stated it was not uncommon for referrals to not be actioned or to be cancelled.

FOOTBALL AT GRP

The GRP football competition comprised four teams; each playing a game every weekend from March, throughout winter. Training was usually twice a week, with drills to improve skills as well as running and stretching for fitness. Training can be intense at times, particularly if the team is in contention for the premiership. There is only an hour's time allocated so it is not usually too demanding. Mr Njamme was a regular player and had played most of the games in June.[21]

During the week commencing 14 June 2008, Mr Njamme's cell mate, Frederick Ball described Mr Njamme as crying a lot and being very stressed. Mr Njamme had told Mr Ball his nephew had been killed during the week, his brother had died, and he had lost three other relatives in a car accident.[22]

[21] Emails from V Tanti Activities Officer GRP, via Ms Hartley, 30.08.10, Transcript pgs 156-7, 25.08.10

[22] Exhibit 1, Annexure 21

The unit 3 Occurrence Book entry for 19 June refers to two recent deaths among Mr Njamme's relatives. The report for 21 June states Mr Njamme was told that day his step-daughter had been in a car accident, and was in hospital. Mr Njamme must have heard this news during the morning prior to playing football.[23]

Dr Said agreed the deceased's psychological state, including if he was suffering stress and depression, could contribute to cardiac risk factors precipitating cardiac arrest.[24]

21 JUNE 2008

Mr Njamme was playing for the prison team known as the 'Saints' against the 'Roos'. Players and spectators gathered at the oval at about 9.39am and the game began at 9.52am. Each quarter lasted about 20 minutes with a 5 minute break between quarters. The third quarter began at 10.45am.[25]

The game was being umpired by Alan Fairley, a primary school teacher in Geraldton, and Stephen Carlyon, a prison officer at GRP, but off duty at the time.[26]

Mr Carlyon and Mr Fairley are qualified umpires through the Great Northern Football League. They are paid a fee to umpire

[23] Exhibit 7, Unit occurrence book
[24] Transcript pg 133, 24.08.10
[25] Exhibit 4, Surveillance tape recording. The video surveillance cameras were recording images of the sports ground during that morning. The video system has a time clock display. Ex 2, Annexure 38 lists relevant times.
[26] Report Det Sgt Howes, pg3

games. Mr Carlyon was there in his private capacity and was not exercising his role as a prison officer.[27]

At GRP, prisoners could be restricted from playing sport by the use of a 'no sport list'. Prisoners were put on the list if they were unfit for work, if they had injuries or illnesses likely to be exacerbated by playing sport, or for disciplinary reasons (sport is considered a privilege).[28]

There has been a change to the 'no sport list' policy since June 2008. Prisoners, who are now identified as having cardiac risks, or other chronic diseases, can be restricted from playing by medical staff.[29]

Dr Said identified two specific cardiac risks associated with football, relevant to Mr Njamme. Dehydration would cause the heart to work harder. Secondly, a very minor trauma, even a minor tackle or bump has the potential to disrupt heart rhythm.[30]

Mr Njamme had played a reasonably good game at Centre Half-forward, or in the Forward Pocket, and had kicked a few goals.[31] Christopher Tomlins was playing Full Back for the Roos and observed Mr Njamme had taken a few bumps throughout the game but nothing out of the ordinary.

[27] Transcript pg 65, 24.08.10
[28] Transcript pg 66, 24.08.10
[29] Transcript pg 67, 24.08.10
[30] Transcript pg 134, 24.08.10
[31] Transcript pg 156, 25.08.10

Mr Tomlin did not see Mr Njamme get hit by any person and he was not knocked off his feet at any stage.[32]

During the third quarter, Mr Tomlin reported he saw Mr Njamme about 5 meters away, fall to his knees and then forward on to his stomach, with his right arm out in front of him. Mr Tomlin tried to stop the game, as "Mr Njamme looked like he was having a fit. He was shuddering a little bit and making noises, like he was snoring". Mr Tomlin reported this occurred at about the 7 minute mark of the third quarter.[33]

The non-controlling umpire, Mr Fairley, was alerted by some players a man was lying on the ground in the Saints' right forward pocket. Mr Fairley estimated this time to be about 10:55am.[34] The surveillance video clock appears to record the game stopping at 10.59-11.00am, approximately 14 minutes into the third quarter. Immediately before this, the play appears to be in the Saints' forward area.[35]

Mr Carlyon stopped the game and the ball went out of bounds. The umpires, and some players went to where Mr Njamme was surrounded by nearby players. He was put into a coma position by the players and Mr Carlyon. On the video Mr Carlyon can be seen kneeling adjacent to Mr Njamme at 11.01am.[36]

[32] Exhibit 1, Annexure 20
[33] Exhibit 1, Annexure 20.
[34] Exhibit 1, Annexure 4
[35] Exhibit 4
[36] Exhibit 4

Mr Carlyon stated that during the course of 25 years of umpiring and 40 years involvement in football he has seen players go down on the field, but this was the first occurrence he had encountered involving cardiac arrest. He assumed, because play had been in the vicinity, it must have been a knock related to the play, although he didn't actually witness Mr Njamme fall.[37]

Mr Carlyon stated Mr Njamme appeared semi-conscious, his eyes were rolling around, there was some grass and other debris around his mouth and he looked to have fallen on his stomach. Mr Carlyon described Mr Njamme's breathing as almost like snoring, a fairly loud gasping noise. He said to the prisoners, "He's okay. He's breathing." He adjusted Mr Njamme into the recovery position.[38]

Mr Fairley stated Mr Carlyon asked him to call to prison officers to ask for medical assistance, which he did. Being umpires, neither Mr Fairley nor Mr Carlyon were equipped with radios.[39]

Officer Dawson was watching the game and supervising spectators. He called on the radio that a player was down on the oval.[40] The radio broadcasts are able to be heard on all the operational radios available to officers at the prison.

[37] Transcript pgs 160-2, 25.08.10
[38] Transcript pg 150, 25.08.10
[39] Exhibit 1, Annexure 4
[40] Exhibit 1, Annexure 17

Officer Ellis stated Officer Dawson's call was unclear due to windy conditions on the oval, but he understood a player was down on the oval. He walked over to the group of players, Mr Carlyon and Mr Njamme.

Mr Carlyon asked Officer Ellis to call the medical centre, for assistance, and ask for a medic to come to the ground.[41]

Officer Ellis had not seen any incident, but thought Mr Njamme "must have had a clash of heads where two blokes have hit one another and might have got knocked out. I was expecting him to come to in a half a minute or so, but nothing eventuated".[42]

Officer Ellis stated he called the medical centre twice and didn't receive a response, so he called central control and said he needed a nurse and a stretcher to the oval.[43]

Officer Carolyn Pizzey was on duty as the disciplinary officer at the medical centre. She was aware there was a football game on the oval which would have started at about 9.45am. She had a radio and stated the nurse on duty, Leonie Heinsen, also had a radio which was generally left free standing in the centre rather than being worn by the nurse.

Officer Pizzey made timed entry notes in the Medical Reports and Occurrences book. The times were taken from the clock

[41] Transcript pg 150, 25.08.10
[42] Transcript pgs 167-8, 25.08.10
[43] Transcript pg 169, 25.08.10

in the medical centre or possibly her watch. She used a scrap of paper for many of the contemporaneous entries on 21 June, but they were transcribed accurately into the book after she returned to the medical centre from the oval. [44]

The note for 1100hrs, however, was an estimate for the note "Call from oval for medical assistance, stretcher and Officer Smith and Pizzey to oval."[45]

Times noted by Officer Pizzey are 3-4 minutes earlier than those on the surveillance video.[46]

Officer Pizzey assumed Nurse Heinsen had heard the radio call for assistance from Officer Ellis. She went to get the stretcher off the wall. She had just removed the cover when Officer Smith arrived from the front gate to assist.[47]

Nurse Heinsen had not heard the call and was busy, either attending to a prisoner or with pharmacy orders. She recalled Officer Pizzey came in and said "You've got a footy injury". Nurse Heinsen expected the patient would be brought in. A short time later, Officer Pizzey returned and clarified they were required at the oval. Nurse Heinsen grabbed a trauma backpack and left the medical centre with Officers Pizzey,

[44] Transcript pg 249, 30.08.10
[45] Transcript pg 232-3, Transcript pg 240, 30.08.10
[46] Exhibit 6, 4, Exhibit 2, Annexure 38. The time noted by P.O. Pizzey for the return to the medical centre with Mr Njamme is 1110, whereas the time on the surveillance video showing the stretcher entering the administration centre is 1113. The respective times given for the arrival of the ambulance in the sally port are 1127 (Pizzey) and 1130 (video).
[47] Transcript pgs 242, 245, 247, 30.08.10

Smith and the stretcher.[48] As the group emerged from the administration block she could see Officer Ellis pacing from the western end of the oval, and he called on the radio again for the stretcher.[49]

Officer Pizzey stated they were not under the impression it was an emergency because there was no 'Code Red' called. This is a medical emergency, which is a top priority call for urgent assistance.

Officer Ellis believed, in hindsight, it was his responsibility to call a code red as the first on duty officer to arrive at the scene. He did not call it as a code red medical emergency, "I'll be honest about that. That sort of tore me apart for a few days. … Even when I was off duty, I was thinking about that's what I should have done, but at that stage, I didn't realise it was an emergency."[50]

It was generally believed Mr Njamme had been knocked out, no one realised he had suffered a heart attack.[51] He was in the recovery position and was still breathing.[52]

Officer Ellis could hear Mr Njamme's breathing from his position, about a metre away. It sounded like snoring or heavy breathing.[53]

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[48] Transcript pgs 254-5, 30.08.10
[49] Transcript pg 237, 30.08.10
[50] Transcript pg 237, 30.08.10
[51] Transcript pg 237, 30.08.10
[52] Transcript pg 169-70, 25.08.10
[53] Transcript pg 170, 25.08.10

Dr Lee was asked for his interpretation of the officer's observation of breathing. He stated: "We see this a lot, obviously, and it's essentially agonal breathing and they are not actually breathing." It appeared to Dr Lee, Mr Njamme had suffered a malignant arrhythmia, and despite the attending officer's belief, he was not breathing effectively. Chest compression can be of benefit in these circumstances.[54]

Mr Carlyon had been trained in CPR about 15 months before. He stated he understood from that training CPR should only be commenced when the person was not breathing, and did not have any pulse. Mr Carlyon did not feel for a pulse.[55]

On the surveillance video footage the stretcher can be seen being carried onto the oval at 11:07[56]. People with Mr Njamme believed he was still breathing albeit very shallowly.[57]

When Nurse Heinsen arrived with the stretcher, she observed Mr Njamme wasn't moving. She asked, "How long has he been down" and someone said, "A good five minutes." She assessed him visually, noting no movement, no respirations, and flaccid limbs. She saw blood mixed with saliva which had come from his mouth, on his left upper arm. She took his pulse and checked his eyes. She could not feel any pulse, and his eyes were not responding. She could hear and see he wasn't

[54] Transcript pg 51, 24.08.10
[55] Transcript pg 147, 25.08.10
[56] Exhibit 4.
[57] Transcript pg 155, 25.08.10

breathing. She stated she was unsure if there was a pulse, but she couldn't feel it due to his size. [58]

Nurse Heinsen was surprised. She had expected a totally different situation. She stated she thought about commencing CPR, but felt it not to be a safe situation due to the presence of numerous anxious prisoners. Nurse Heinsen accepted she did not ask for the area to be cleared of prisoners, and that there were a number of officers present. [59]

The surveillance video shows a number of prisoners appear to move away from the area as the stretcher arrives. Nurse Heinsen can be seen as Mr Njamme is lifted onto the stretcher by Mr Carlyon and another officer, with three or four prisoners actively assisting. Another three prison officers and Mr Fairley can be seen close by observing, as well as another four prisoners.[60]

After the stretcher was lifted by the prisoners and Mr Njamme was secured, Nurse Heinsen again felt for a pulse, but there was none. She stated she asked if there had been a collision and the prisoners indicated there had not.

There was some discussion about the way to get into the medical centre or whether to go directly to the Sally Port. They decided to go directly to the medical centre.[61] Officer Boyle went to the front gate to call the ambulance. Officer

[58] Transcript 256-261 30.08.10
[59] Transcript 256-261, 30.08.10
[60] Exhibit 4 at 1109
[61] Transcript 261, 30.08.10

Ellis tried to see if the medical centre could be accessed by a rear security door without success.

In evidence Nurse Heinsen indicated she felt she didn't have complete control of the situation because the "prison officers basically have control". [62]

The first time Nurse Heinsen actually suggested CPR should be commenced, was when the group were at the entrance to the administration centre. It was decided they would just keep moving.

At the medical centre, Nurse Heinsen, assisted by Prison Officers Smith, Voyer and Pizzi, conducted CPR on Mr Njamme, utilising both oxygen and a defibrillator.

This procedure was continued using the defibrillator as a guide and continued until the ambulance arrived.

The ambulance officers made further revival attempts with their defibrillator. The efforts were unsuccessful. Mr Njamme had suffered a malignant myocardial infarction resulting in complete heart failure.

He was pronounced dead at 11:32am.

[62] Transcript 262, 30.08.10

POST MORTEM EXAMINATION

The post mortem examination of Mr Njamme was undertaken by Dr Gerard Cadden on 25 June 2008 at the State Mortuary.

Dr Cadden found multifocal coronary atherosclerosis. It was particularly severe within the left anterior descending artery. There was multifocal scarring of the myocardium, pulmonary congestion and oedema, generalised atherosclerosis and obesity.

Dr Cadden concluded death was as the result of ischaemic heart disease in a man with known diabetes mellitus and systemic hypertension.

Dr Cadden gave evidence to the effect the extent and location of the deceased's atherosclerosis placed increased pressures on the heart muscle to supply the body with oxygenated blood. The strain on the heart muscle had existed for sometime preceding his death and had been severe enough to cause areas of ischaemia in the deceased's heart muscle which would further exacerbate the difficulty in supplying oxygenated blood to the body. This put the deceased at great risk of cardiac failure at almost any time.

Dr Cadden indicated an angiogram would have disclosed the myocardial difficulties for the deceased where as an ECG may not.

With respect to exercise Dr Cadden agreed with Dr Lee people suffering the cardiac problems shown by the deceased were well advised to commence moderate gentle exercise and control their weight as a protective measure from myocardial infarction. However, sudden bursts of extreme activity could exacerbate the load on the heart muscle and contribute to an infarction.

Regardless of the exercise issue which could, if excessive, exacerbate his situation, the reality was the deceased could have suffered a malignant myocardial infarction at any time because of the pre-existing state of his cardiac disease.[63]

CONCLUSION AS TO THE DEATH OF DECEASED

I am satisfied Mr Njamme was a 40 year old Aboriginal male with a medical history of hypertension, diabetes mellitus and was under investigation for suspected cardiac disease at the time of his death.

He also suffered a hearing deficit which may have exacerbated a problem in hearing and absorbing medical advice. This would be in conjunction with his tendency to neglect his health while in the community and not being assisted by access to regular medical review.

It is clear he was non-compliant with medications when not in a custodial environment.

[63] Transcript pg 103-114, 24.08.10

On Mr Njamme's most recent period of imprisonment, commencing in May 2007, investigations commenced at Casuarina Prison with respect to Mr Njamme's general state of health as a result of some of his blood test results. By early 2008 he had reported an episode of central chest tightness on exertion which Dr Patterson queried as ischaemic heart disease. He instructed Mr Njamme to speak to nurses immediately he had any similar repeat symptoms.

Dr Patterson was concerned enough about Mr Njamme's presentation to refer him to Fremantle Hospital cardiology. This resulted in an appointment booked for 19 May 2008. He was also prescribed a glyceryl trinitrate nasal spray (GTN).

Prior to Mr Njamme's cardiology appointment in May he was transferred to GRP in February 2008. His medical status on TOMS was not updated other than the fact of the appointment at Fremantle Cardiology on 19 May 2008.

Once at GRP there was more concern with Mr Njamme's diabetes than his potential cardiac issues. Dr Gilles was very focused on attempting to improve his general health and thereby assist his diabetes. She did not focus on cardiology issues despite the referral on TOMS of which she remained unaware.

Dr Gilles was most anxious Mr Njamme reduced his weight and commenced gentle exercise. She reviewed full blood and urine tests for him and was concerned he be regularly

reviewed. She did not note the blank CVD care plan in his medical file.

In evidence Dr Gilles stated the care plan for diabetes and cardiovascular diseases are very similar. However, she was concerned her failure to register the blank CVD care plan on his file resulted in a lack of focus in her mind on his potential for cardiovascular disease, such as angina, or alerts her to ask about the cardiologist's appointment. She was aware he was a poor historian and was not convinced he would have been able to answer her questions. Dr Gilles did believe a combined cardiovascular and diabetes care plan would be beneficial.

On 15 April 2008 Mr Njamme followed the earlier advice from Dr Patterson and attended at the GRP medical centre reporting chest pains. The nurse reviewing him performed an ECG and the result was sent to GRH Emergency Department, together with his TOMS medical status report outlining the cardiology appointment in May. He was sent to GRH for investigation. GRH recorded no abnormal results for Mr Njamme and it was believed his chest pain was not cardiac in origin. The fact the test results were negative does not exclude cardiac disease.

On 18 April 2008 Dr Gilles noted the deceased needed an exercise ECG. She believed this would be performed in Geraldton and remained completely unaware of the cardiologist's review at Fremantle Hospital in May. There is no

evidence arrangements were ever made for Mr Njamme's exercise ECG.

Mr Njamme was transferred to Casuarina on 15 May 2008 in preparation for his examination at Fremantle Hospital Cardiology on 19 May 2008. There is no reference to this in Mr Njamme's medical file progress notes.

Dr Lee, Cardiology Registrar at Fremantle Hospital examined Mr Njamme but had very little history with which to work. He was only aware of the one episode of chest pain, the basis of the referral in January. He could only observe the other obvious risk factors for coronary artery disease. Dr Lee wished to perform an exercise ECG but the issue of restraints was a problem. Dr Lee believed an angiogram to be more diagnostic and one was booked for 2 July 2008.

Mr Njamme was transferred back to GRP on 26 May 2008. Dr Lee's report would have been sent to Dr Patterson at Casuarina Prison prior to being forwarded to GRP for his medical file. The difficulty with this process was that Mr Njamme's medical file had no reference to the fact of his attendance at the cardiology review on 19 May 2008. As such the doctors at GRP remained oblivious of that issue.

This is a very unsatisfactory systems problem.

When Dr Gilles next saw Mr Njamme the report from Dr Lee, we assume, was not on the deceased's medical file. She was

only aware of the results of testing she had ordered and which was now on file. There is no reference to her request for a stress ECG and the fact it had not been done.

Dr Gilles was very happy Mr Njamme appeared to have lost weight and he informed her he was "training". Dr Gilles did not for one moment imagine the deceased meant he was training for the footy competition.

It was in the setting of Mr Njamme's cardiac issues being investigated, but not by his current medical practitioner, that he came to be involved, we assume, in the football competition. It appears to have consisted of a couple of hours a week quite intense exercise, in sustained bursts. This would have put considerable stress on a system, already indicating it was compromised, by his intermittent chest pain.

Added to the exercise was the fact Mr Njamme had bad news on the morning of the football game which may have contributed to a heightened level of stress.

At approximately 11:00am on 21 June 2008 Mr Njamme collapsed while playing football at the GRP. The game was stopped and he was placed in the recovery position. It was unclear to those around him as to the reason for his collapse. It was confusing for those seeking medical attention for him as to whether he had fallen as the result of play or as the result of a medical condition. This contributed to a failure to immediately call a code red.

There was an initial belief by those in proximity to Mr Njamme he was breathing. CPR was not commenced immediately which may have been his only chance for a positive outcome. I emphasise the "may" as the post mortem medical evidence would seem to indicate Mr Njamme's cardiovascular system was so compromised he may have had a malignant myocardial infarction without exertion, without stress, and have been irretrievability compromised even if CPR had commenced immediately. Mortality rates for myocardial infarctions are high, even in a hospital setting.

A radio call was made to the prison medical centre requesting the attendance of the nurse with the stretcher. When the stretcher arrived the nurse could not find any pulse or signs of life. Mr Njamme was lifted onto the stretcher and taken to the prison medical centre. A call was made for the attendance of St John Ambulance Officers.

By the time Mr Njamme had been transported to the medical centre where CPR was instituted he could not be resuscitated. He had suffered a malignant myocardial infarction resulting in complete heart failure.

I find death arose by way of Natural causes.

COMMENTS ON THE SUPERVISION, TREATMENT AND CARE OF THE DECEASED

a) Medical records and continuity of care

The biggest concern with Mr Njamme's medical history for his 2007/2008 term of imprisonment revolves around the lack of cohesion between the various medical practitioners reviewing Mr Njamme. This was not assisted by his difficulty with narration of his medical history, however, that is common in indigenous prisoners. There should have been enough information on his medical file to give any doctor a comprehensive understanding of his issues despite his inability to consistently narrate appropriately.

There is no doubt the doctors involved with Mr Njamme were concerned to give him good medical treatment but the accessibility of documentation did not allow for that advice to be comprehensive and consistent. I suspect proper time to review his medical file as a whole, due to appointment pressures, may also be a resourcing issue for visiting doctors.

Dr Gilles, as his most recent medical adviser, although suspecting a cardiac issue may need investigating, never really focused upon that issue satisfactorily. If she had been aware of his referral for cardiology review, due to prior chest pain, it is probable her concern with his cardiac health would have been more proactive.

I find it quite astounding there was no reference in Mr Njamme's medical progress notes to the fact he had

actually attended a cardiologist at Fremantle Hospital on 19 May 2008.

The negative effect of this was two-fold:

Had Dr Gilles been aware of the imminent referral, she would have been able to provide Dr Lee with a better history than was provided by a copy of his TOMS entries.

Further, on Mr Njamme's return, and her next review, she would have understood there had been active investigation of his cardiac problems which were continuing. This may have triggered a renewal of her belief there was an issue she needed to take into account when discussing his medical health with him.

The issue of what was appropriate exercise for someone in Mr Njamme's situation was never considered due to none of his medical advisors being in possession of all the relevant information. Essentially, until he had an exercise stress test or the angiogram, his exercise should not have been as demanding as the football training and playing he apparently took upon himself.

The difficulty in maintaining a cohesive and comprehensive medical history where prisoners receive input from a number of practitioners in different locations has been recognised by Prison Services Health Directorate.

On 2 September 2010, Dr Fitzclarence attended court to demonstrate a pilot project which is being trialled in the Department of Corrective Services (DCS). It commenced in April 2008, and since March 2009, has been used throughout the prison system. It is still being refined. It is called EcHO and is a patient management information system for clinicians in the prison system.[64]

I am still concerned, however, the issue of the failure to note Mr Njamme was due for cardiology review, had had a cardiology review, and was awaiting a report with a plan, including an angiogram, would have been omitted in the same way it was in the progress notes. It was on TOMS, but not easily located on the medical file unless Dr Gilles had referred back to the progress notes of January 2008.

External medical specialists are not able to input on EcHO and it would need to be done by relevant medical practitioners in the prison system. If unaware of a review or investigation it will not be entered in EcHO. However, the fact information would reach the file immediately on input at head office is an advantage, provided medical practitioners have time to access all the relevant data screens.

It is whilst EcHO is still being developed, issues such as the overall continuity of care can be addressed, so they may be overcome. I understand the content of Dr Lee's report would now have been transferred to EcHO on receipt and therefore

[64] Transcript 02.09.10, PG 302-322

become available on Mr Njamme's medical record in a timely manner. Hopefully, there is also an alert new data is available to be accessed by the next reviewing practitioner.

I note submissions from Aboriginal Legal Service (ALS) with respect to the use of indigenous health workers to accompany indigenous prisoners on outpatient appointments and the availability of funding through the Mar Mooditj Foundation.

Geraldton Regional Aboriginal Medical Service (GRAMS) currently provides doctors to GRP and supports the use of indigenous health workers at GRP. One would assume an accompanying health worker would be familiar with a prisoner's medical file and so be in a position to provide a full and proper history.

These initiatives should be encouraged in an attempt to involve aboriginal prisoners with their health care and educate them for return into the community. It could be an invaluable tool in the provision of improved medical services to the indigenous community.

b) Leadership in a medical emergency

I completely accept Prison Officer Ellis realised very quickly he should have called a Code Red with respect to the incident on the football oval when Mr Njamme collapsed.

I also accept it was initially thought he collapsed as the result of play, rather than a medical event. Possibly that was even

more of a reason to call a "Code Red" but I am satisfied this was an entirely innocent omission on the part of the prison officers in attendance. It appears everybody was confused as to what had occurred and the obvious and appropriate course of action was overlooked.

I can only emphasise training is designed to take over where confusion abounds. Where one is unsure of the nature of the medical emergency then it is imperative it is called in at the most serious level.

The second aspect of concern as to the occurrence on the football oval was the attending nurse seemed to suffer some confusion as to her appropriate role. I understand there is a tension in prisons, whether in the recreational setting or not, between welfare and security. The nurse's issue is welfare, and that is paramount. It is up to prison officers to be concerned about security.

There should have been no confusion in any attending health practitioner's mind as to their role, and no confusion that once having stated what should happen, it was up to the prison officers to facilitate that as they saw fit.

While on the subject of leadership in a medical emergency, I would also touch on the issue of prisoner restraints in a situation where they are attending specialists' appointments for medical investigations. I appreciate the security personnel attending hospital reviews with a prisoner have very specific

orders with respect to restraints, but there must be some prior recognition of the fact restraints may not be ideal. If a medical practitioner requires restraints be removed for the purposes of any procedure then there should be an ability to respond to the issue in a timely manner.

I believe this issue has already been addressed. If it has not it needs to be done. I would have thought the suggestion indigenous health workers attend outpatient visits with indigenous prisoners could be very beneficial in these sorts of circumstances.

c) Cardiopulmonary Resuscitation (CPR)

I am concerned the issue of the appropriateness of conducting CPR as soon as possible has arisen at this time. It is many years since I have felt the need to comment on the adequate resuscitation of a collapsed prisoner. Usually prison officers implement appropriate resuscitation techniques very quickly as a result of their training.

I am anxious it seems more recently, due to a problem with adequate staffing I suspect, prison officers appear to be lapsing in their first aid training and as a result are not confident in implementing resuscitation techniques. I am aware CPR guidelines have changed over time which is all the more reason to ensure adequate numbers of officers attend refresher courses.

I note recommendations before now have referred to prisoners also being trained in CPR and that issue has been covered in some prisons. I believe that would also alleviate the safety issue referred to by the nurse in the case of Mr Njamme. Prisoners who feel they can contribute to an emergency are less likely to become fraught and anxious if they perceive appropriate measures are being taken or that they can positively assist in some constructive way.

It is very important prison officers, in particular, remain up-to-date with their CPR and first aid training, if only to give them confidence to assess and implement relevant CPR very rapidly. I am sure part of that training these days covers the difference between agonal and spontaneous 'breathing' and the benefits of cardiac compressions.[65]

RECOMMENDATIONS:-

1. **At this early stage in the implementation of EcHO I am anxious the progress notes aspect of the system ensures recording of contemporaneous medical investigations in an obvious manner. This will allow a proper updated and relevant history to be provided to external consultants and advise in-house doctors of the investigations which are currently being conducted with respect to individual prisoners.**

[65] Transcript Pg 51, 24.08.10

2. **The initiative by GRAMS to use indigenous health workers in GRP be supported while accepting prison security is an issue which will always provide some tension with welfare issues. These need to be addressed.**

3. **I understand there is funding available for indigenous health workers via the Mar Mooditj Foundation. This is based on submissions from ALS on behalf of Mr Njamme's family. Unfortunately I did not have the opportunity to hear from the Foundation in person. If a mechanism can be developed whereby security concerns are protected, I strongly urge prison authorities to work cooperatively with external sources of funding where possible. The use of indigenous health workers where prisoners need to attend consultant reviews and ongoing investigations could be invaluable. This will ultimately contribute to the community as a whole by using the window of opportunity provided for input to indigenous health issues while indigenous prisoners are in custody.**

4. **Training with respect to calling a Code Red where there is a medical emergency which has not yet been defined be impressed upon prison officers.**

5. **Appropriate, adequate and ongoing CPR training be provided to prison officers and appropriate prisoners.**

6. **There be a clear direction to nurses attending medical emergencies they are to provide leadership in the welfare arena, which will allow attending prison officers to appropriately concern themselves with security issues.**

EF VICKER
DEPUTY STATE CORONER

17 March 2011