CITATION:	*Inquest into the death of Sampson McLeod Paii* [2005] NTMC 054
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Coroners
FILE NO(s):	D0059/2003
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FINDING OF:	Mr G Cavanagh SM

CATCHWORDS:

Coronial Inquest, death in custody, death from natural causes, medical facilities at the prison.

REPRESENTATION:

Counsel:

Assisting the Coroner:	Ms Elizabeth Morris
For Correctional Services:	Ms Kathryn Gleeson
For Dr Christopher Judkins:	Mr P McIntyre
For Aboriginal Justice Advocacy Committee:	Mr Chris Howse

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

No. D0059/2003

In the matter of an Inquest into the death of

SAMPSON MCLEOD PAII
ON 12 MAY 2003
AT ICU – ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered 26 August 2005)

Mr G CAVANAGH SM:

1. This death is properly categorised as a death in custody. At the time of his death, Sampson McLeod Paii (the deceased) was a person detained at the Berrimah Correctional Centre, a prison. This prison is usually known as Darwin Gaol. The deceased, therefore, was a "person held in custody" within the definition in s.12 (1)(b) of the *Coroners Act* 1993 (NT) ("the Act"). His death is a "reportable death" which is required to be investigated by the Coroner pursuant to s.14 (2) of the Act; a mandatory public inquest must be held pursuant to s.15 (1)(c).

2. The scope of such an inquest is governed by the provisions of sections 26 and 27 as well as sections 34 and 35 of the Act. It is convenient and appropriate to recite these provisions in full:

> "26. Report on Additional Matters by Coroner
>
> (1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –
>
> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to

by injuries sustained while being held in custody; and

(b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.

(2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant.

27. Coroner to send Report, &c., to Attorney-General

(1) The coroner shall cause a copy of each report and recommendation made in pursuance of s 26 to be sent without delay to the Attorney-General.

34. Coroners' Findings and Comments

(1) A coroner investigating –

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

(i) the identity of the deceased person;

(ii) the time and place of death;

(iii) the cause of death;

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

(v) any relevant circumstances concerning the death.

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

(3) A coroner shall not, in an investigation, include in a finding or comment a statement that a person is or may be guilty of an offence.

(4) A coroner shall ensure that the particulars referred to in subs (1)(a)(iv) are provided to the Registrar, within the meaning of the *Births, Deaths and Marriages Registration Act*.

35. Coroners' Reports

(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 the 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."

3. The handing down of these findings has been deliberately delayed pending the findings in a later and similar death (viz. Maminyamanja).

CORONERS FORMAL FINDINGS

4. In accordance with the statutory requirements under the Act, the following are my formal findings arising from this inquest:

i. Identity: The deceased is Sampson McLeod PAII (aka Samson McLoyd Paii), a male Australian or Torres Strait origin, who was born on 17 February 1968 at Thursday Island in Queensland.

ii. The time and place of death: The deceased died at Royal Darwin Hospital on 12 May 2003 at around 2.33pm.

iii. The cause of death: The cause of death was Disseminated Lymphoblastic Lymphoma.

iv. The particulars required to register the death are as follows:

a) The deceased was a male;

b) The deceased was of Aboriginal / Torres Strait Islander origin;

c) A post mortem examination was carried out on 13 May 2003 and the cause of death was as per paragraph 4(iii) hereof.

d) The pathologist viewed the body after death;

e) The pathologist was Dr Terry Sinton, forensic pathologist, Royal Darwin Hospital.

f) The father of the deceased is not known;

g) The mother of the deceased is Beulah PAII;

h) The deceased resided at the Berrimah Correctional Centre at the time of his death; and

i) The deceased was not employed in any occupation at the time of his death.

Treatment of the deceased whilst in custody

5. I find that there is no evidence of the involvement of any other person or any suspicious circumstances relating to the death of the deceased and, accordingly no report is required under s.35(3) of the Act. Furthermore, I find that the deceased did not sustain any injuries whilst being held in custody which caused or contributed to this death.

THE RELEVANT CIRCUMSTANCES CONCERNING THE DEATH INCLUDING RECOMMENDATIONS.

6. The deceased was a sentenced prisoner at Berrimah Correctional Centre and was transported on the morning of 12 May 2003 to Royal Darwin Hospital. Despite intensive medical attention, he was pronounced dead at 2.33pm the same day.

7. The deceased was received on 26 January 2003 into the gaol. He received a medical check from Registered Nurse Barrett. Nurse Barrett, at this time, recorded the weight of the deceased as 65 kilograms. On all of the evidence, I am persuaded that Nurse Barrett made a mistake in recording the weight, and it was much more likely that the weight was 89 kilograms.

8. The deceased submitted a medical request form on 2 April which resulted in him seeing a doctor on 4 April. He was diagnosed with muscular skeletal pain resulting from doing push-ups. There were two further medical request forms submitted with: 'Can I see the doctor thanks' on 14 April 2003 and 'headache' on 30 April 2003. I am concerned that the request of 14 April to see the doctor was not able to be met until 1 May 2003, which is the next time that the deceased saw a doctor after filling in those two forms.

9. On 1 May 2003, Dr Chris Judkins (an employee of the contractor viz. "Corrections Medical Services") saw the deceased, he noted a variety of symptoms which could be indicative of any number of conditions and requested an urgent echocardiograph. This was not an unreasonable course for him to take. Dr Judkins is a relatively junior doctor, and more experienced doctors have told me that they would have ordered some further tests at the same time. However, at the inquest, no medical expert has said that Dr Judkins actions were unreasonable. Dr Judkins would not have known that the disease that the deceased suffered from was so extensive or aggressive, that in terms of treatment, time was of the absolute essence. The sad fact was that the deceased had a rare and extensive cancer of an

aggressive type. Having said that, it was also not unreasonable to order the extra tests and the expert voices of experience in relation to this were unanimous in that respect.

10. On 9 May 2003, the deceased was escorted to the Darwin Private Hospital by Prison Officer Peter McConnell. Prison Officer McConnell noted from the outset of the journey that the deceased appeared very unwell and had difficulty both walking and breathing. On arrival at the cardiac unit the echocardiograph was performed by a technician Scott Pulsted; he does not recall the deceased having any particular health problems and remembers him being able to remove his own shirt and climb up on the examination bed. He performed the cardiograph and found nothing that could be interpreted as providing any serious cause of concern. The deceased left the cardiac unit in company with Prison Officer McConnell however, his condition then deteriorated to such an extent that Prison Officer McConnell thought of taking him to the Accident & Emergency section of the hospital. Prison Officer McConnell told me in evidence (transcript p25):

> "And when you took him to the hospital you noticed even prior to him getting in the method of transport that he was crook, is that correct?---I did notice, your Worship, I had noticed quite a few things about him which I could tell you if you want.
>
> Yes?---I noticed that he had severe oedema in his legs. I knew him beforehand, I knew - - -
>
> THE CORONER: Oedema is swelling isn't it?---Swelling yeah, very swollen bloated legs, yeah.
>
> Bloated legs yes?---Yeah. I mean I knew him previously 3 months beforehand and he was a normal Aboriginal islander; sort of skinny legs, and when I saw him that morning he had really bloated legs; he was pale, ashen colour almost and he had difficulty in breathing; difficulty walking too far or he would be out of breath, so he wasn't well.
>
> MS MORRIS: Normally do transport – for a one-man escort to the hospital what sort of vehicle would you use?---Just a normal prison van, whatever is available.

And the prisoner would normally be in the back of that van?---Normally in the cage, yeah.

Where did you put the deceased?---I put him in the back seat of the vehicle your Worship.

And why was that?---He just couldn't get into the back. You normally have to – it takes a bit of effort to get into the van, step up, put your hands on the bar and get up, and he just couldn't do it.

And was that unusual to transport a prisoner like that?---In the back seat of a – yeah it is pretty unusual really especially if it's somebody you don't know. I mean it's been done before but - - -

THE CORONER: You used your initiative, he was too sick to be conveyed in the usual way?---That's correct your Worship, yeah."

11. And (transcript p28):

"And when you arrived back at the prison you handed him over to the medical staff?---I did yes.

And that was to Nurse Barrett, is that right?---It was your Worship, yes.

Did you express to her clearly your concerns about him?---I did your Worship I told her what had happened exactly at the hospital, how he'd basically almost collapsed on a number of occasions, he couldn't walk, he was out of breath, the colour of him, his swelling. I explained everything and my concerns.

And then you were relieved of possession of Mr Paii?---That's correct.

And you didn't see him again or have any dealings with him again after that?---No I haven't since then."

12. And (transcript p31):

"You were actually queried by the people at the sally port as to why you had him in the back seat and not in the cage?---That's correct because it's normal procedure unless it's a very very trusted prisoner, maybe a yellow shirt, low classification and someone you know very well.

> And you actually said to the person at the sally port that you believed this man was a death waiting to happen?---Sudden death waiting to happen, yeah."

13. Prison Officer McConnell transferred the deceased to the nurse at the prison personally and conversed with her. Dr Wake stated it is very unusual that a patient is handed over from a prison officer to a nurse; Nurse Barrett made no mention of this being out of the ordinary. She remembers little of the actual conversation in contrast with Prison Officer McConnell who remembers telling her all of his concerns.

14. It is possible, with hindsight, that Prison Officer McConnell has emphasised his concerns because of his worry for the deceased and the subsequent death of the deceased. It is also possible Nurse Barrett has an uncertain memory because she didn't treat the concerns seriously enough. What is certain from the evidence is that Nurse Barrett was a very busy person. But even if those two things are taken into consideration when looking at the evidence of those two witnesses, it appears that there has been a communication problem in passing on the information from Prison Officer McConnell to the nurse and eventually to the treating doctor.

15. Nurse Diane Barrett as to Prison Officer McConnell's conversation (transcript p34):

> "I want to take you back to when you saw Mr Paii in the clinic when he was brought to you by the prison officer who has just gone out. Do you know Prison Officer McConnell?---Yes.
>
> And had you had dealings with him before he brought you Mr Paii?---Yes.
>
> Do you have a distinct recollection of him handing over Mr Paii to you on 9 May?---I remember him coming – bringing him into the medical centre, yes.
>
> Do you remember the conversation and the things that he told you about Mr Paii's condition?---No not really, no.

Do you recall whether or not he told you that he was very concerned about Mr Paii's health?---I don't actually recall him saying that, but yeah I knew he was concerned."

16. And on May 9, medical notes as follows (transcript p35):

"THE CORONER: What do your notes say?---I am still looking for them. I've just got 'Brought to medical and returned from hospital appointment. Looks unwell, feel swollen' and then I've got his observations.

Read it all out?---Sorry, 'blood pressure 140/80, pulse 104, ECG done, SATS 95 percent, support stockings to both legs. Seen by Dr Judkins. Returned to block with feet elevated as much as possible'.

MS MORRIS: The support stockings was that something that you instituted, did the patient request it or Dr Judkins?---No Dr Judkins.

Dr Judkins told you that the patient should be provided with support stockings.

So you didn't make any notes there about any information that Prison Officer McConnell had told you?---No.

But you do recollect having a conversation with him about the prisoner?---I don't actually, no."

17. And (transcript p37):

"If you could turn to 9 May 2003. Did you make some notes about Mr Paii on that day?---Yes I did.

Could you just read those for the record?---I've just got 'Sampson Paii to clinic on return from echo at RDH. Looks unwell and oedema plus plus in both legs. Returned to block after oxygen and observation for approximately 45 minutes to rest and wear support stockings'.

Returned to block after oxygen did you say?---Yes and observations for approximately 45 minutes.

So the deceased was on an oxygen mask while he was with you?---Yes initially.

18. And says regarding the death three days later (transcript p41):

> "When you heard that the man had died were you confident that there was nothing that you could have done to prevent the death?---Yes.
>
> Were you further confident that there was nothing that you could have done to better assess his condition when he presented to you?---I did our basic nurses observation and then handed him over to the doctor and it's the doctor's job to actually diagnose."

19. The key issue is that Prison Officer McConnell's concerns about the symptoms of the deceased were not passed onto Dr Judkins. By the time Dr Judkins saw him, the deceased was more relaxed and had been on oxygen and did not at all appear as sick as he apparently had been.

20. Dr Judkins conferred with the deceased, he was given some support stockings for his legs to relieve the pressure from the oedema, and he was then returned to his prison block with advice to keep his feet elevated as much as possible.

21. Dr Judkins, as to May 9 attendance on deceased, he said he was not fully appraised of Prison Officer McConnell's comments (transcript p59 and p60):

> "A little while ago his Worship mentioned to you the comments that McConnell had said about this man's condition on the 9th. Might you have done something different if you were appraised of those comments on the 9th?---Yes I certainly think that the statement that Mr McConnell makes indicates that this gentleman is having quite severe difficulty with fairly mild exertion and that's something that obviously he didn't demonstrate inside the medical clinic and it's something that Mr Paii didn't actually raise as a concern unfortunately as well. I think that if I had known that he was having such difficulty with mild exertion then that would definitely warranted further investigation at that point.
>
> Lets say hypothetically you were apprised of that information what different investigation – what may differently have happened?---Okay. In a gentleman who is having quite a lot of exertion – quite a lot of – with slight exertion and also a gentleman who is potentially flat, I would have thought that would have probably warranted review in ED given this was a Friday afternoon and likely not to have

had a lot of input over the weekend from the medical staff at the prison.

THE CORONER: What's ED mean?---I'm sorry, emergency department.

MR McINTYRE: And where is that?---That's at Royal Darwin Hospital.

No doubt you have – when did you first become aware of the patient's decease?---That would have been on the Monday. I normally arrive at work at 8 o'clock in the morning and at that point I was informed that Mr Paii had been transferred to hospital. I then subsequently rang the ED doctors and then subsequently the ICU doctors where he was transferred just to give them a bit of background and history on what had proceeded over the previous – it would have been 11 – 10 days. Then I'm not too sure exactly when I found out that he was deceased, possibly Monday afternoon or early Tuesday morning.

Can you recall who it was that you rang on the Monday morning?---I can't recall. I spoke to people – one of the ED public registrars and I spoke to an RMO – registered medical officer in the ICU but I don't remember the names.

Did you initiate those phone calls?---Yes I did.

You made a phone I think on Friday to the cardiologist, is that correct?---That's correct yes.

Why did you make that phone call?---Mr Paii returned from his echo that had been completed, I wanted to let the cardiologist and cardiologist registrar know that the echo had been completed so that they were able to then go and review that echo and arrange as I've requested them to do a review in the cardiology outpatient clinic.

And when did you actually expect to get the report?---The report I would not have expected to be officially available until the next week possibly later in the next week, though I would have been able to phone through and ask them to fax the report through probably Monday, Tuesday rather than waiting for it to be sent out (inaudible) delay.

You've since seen that report haven't you?---I have, yes.

And what does that disclose in terms of the diagnosis that you were dealing with on the 9th – on 1 May sorry?---It essentially indicates that the echo report is actually quite normal and my initial thoughts about - - -

THE CORONER: Sorry there was a bit of a glitch in the sound then, did you say it essentially indicated that the what was normal?---The echo report – the echocardiogram was normal.

Normal, right?---For a man of his age.

MR McINTYRE: And what bearing might that have had on your preliminary diagnosis back on the 1st?---Okay, I think certainly that would make me – instead of that there must be some other process going on that I would need to do further investigation – an alternative means of investigation.

And when you say something else going on I think you mean something other than the regurgitation, is that right?---Yes, that's correct. When it was a normal echo – an echo looks at the structure and the function of the heart, so the structure and function of the heart was normal for a man of his age, so that would make me think that the cause of his symptoms is not related to tricuspid regurgitation but to some other cause.

The word you've just used before the word regurgitation was inaudible on the recording of your statement?---On the statement.

What is that word?---Tricuspid is one of the 4 valves in the heart, it's the valve that goes between the right atrium and the right ventricle. Tricuspid regurgitation is blood flowing back over that valve that that valve is faulty and I felt at the time that that would certainly be a potential cause for the symptoms that Mr Paii presented with.

THE CORONER: Doctor are you saying to me that you thought that his general state of ill health and swelling was caused by heart problems?---I did think that yes.

And that on receipt of the results of the heart examination which showed the heart was normal, that would have set you off on looking for other reasons?---Absolutely, yes.

Which do I take it would have led to the finding of exactly why he was unwell?---I suspect that would be correct yes."

22. On Monday 12 May 2003, the evidence established that the deceased's condition had deteriorated and he was discovered lying on the floor in a pool of his own urine about 5:30. Prisoner Ernest Stockham states he called for help by using the alert button and the call was logged at 5:37, and then another call at 5:52 and 5:59. In relation to those calls, one of the issues at the inquest was the lack of information in the first call to assess the degree of assistance required. All the prison officer at the other end of the alert ascertained was that the prisoner was sick and his name. I recommend that prison instructions require the communications officer to ascertain the basics of what level of response is required when an alert button is pressed.

23. The other issue about those calls was the length of time it took to respond. The calls were logged at 5:37, 5:52, 5:59 and it appears that prison officers actually arrived at around 6:02. So that response time is 15 minutes from the first call, 10 minutes from the second call. In the final analysis, the delay would not have made any causal difference in relation to the death, however, I recommend that the prison authorities endeavour to have a system established that results in better response times. Furthermore, unfortunately once again, this inquest has heard evidence that recorded times on the monitoring system were wrong. I make a recommendation that the monitoring system be regularly checked for accuracy of time recording.

24. On the evidence, it is apparent that if there was an awareness from the start that the deceased had difficulty breathing, the response time would have been much shorter. In relation to those breathing difficulties, there was evidence that there was some oxygen – Oxyviva-equipment at various places around the prison. It was not provided to the deceased; no-one had training in its use. I recommend that prison officers receive training in Oxyviva so that there are at least some people at the prison at night able to give appropriate treatment with the equipment, especially given the lack of medical professionals in attendance at the prison "after hours". Oxygen may assist somebody until ambulance personnel can arrive because of course that

the prison is a little way out of town, it will always take them at least 10 minutes to arrive unless they happen to be driving past.

25. Once the ambulance arrived, the treatment at the prison was appropriate and the treatment from Royal Darwin Hospital was also appropriate and no adverse or any comment can be made in relation to that.

26. The cause of death is the lymphoma that was found and diagnosed at the post mortem by Dr Terrence Sinton. The question arises, should that rare condition have been diagnosed earlier and would it have made any difference?

27. Dr Chi-Hung Hui, Specialist Haematologist Consultant at the Royal Adelaide Hospital (transcript p64):

> "Can you tell us – once you have that form of cancer can you deteriorate very quickly?---That is conceptually regarded by (inaudible) to be a very aggressive type of lymphoma and it's the (inaudible) emerges with acute lymphoblastic leukaemia. So the two diseases are consider (inaudible) cannot be distinguished.
>
> And when you say it's an aggressive form of tumour or cancer what does that mean for the patient?---Meaning that it is a rapidly deteriorating condition usually.
>
> From the autopsy report and what was found at the autopsy are you able to say how long Mr Paii would have had this cancer?---I would think that it would be a problem of a few weeks at least but usually not more than many months."

And:

> "You've read the medical reports about the deceased's symptoms leading up to his death, without the diagnosis that was made at autopsy would those symptoms have led you to believe that it was possible that he had leukaemia?---Without other blood test result it would be extremely difficult to tell that he has lymphoblastic lymphoma.

So the blood test is the crucial test?---The blood test and perhaps some imaging like a chest X-ray would help to sort out (inaudible) the different disability that will lead to the diagnosis.

But the physical symptoms without medical testing – the physical symptoms, what you could see and he could feel, would that lead you to believe that he may have leukaemia or would they also lead you to believe there may be a number of other diagnoses?---There can be many (inaudible) differential diagnosis."

28. And (transcript p73):

"THE CORONER: Doctor I had read your report and I understood it to say as follows. He was physically fit and able enough to put up with all the ills that were in his body until there come a weekend where he just went rapidly downhill and died?---That is what I believe is happening yes.

MR McINTYRE: My question doctor is this: I just wonder whether this sort of a rapid event – I wonder whether it might happen sometimes in waves; I wonder whether towards the end a patient might reach a place where it looks like he can't compensate any more but nevertheless he gets over it for a short period but eventually it crashes. What would you say about that?---That is possible, for example it sort of triggers – sort of his ability to compensate, may be triggered off by physical exertion or infection or fever.

So it may have been the case that there was some sort of decompensation going on earlier on in the day of 9 May but that with some resting he managed to recompensate for that. Is that a possibility?---I can say he certainly would get worse with physical exertion, fever for example, an infection, etcetera.

What about physical exertion, when he's got these oedemas in his legs, he walks a decent distance, he tries to go upstairs, that sort of thing?---The oedema is one thing but I am suspecting that's the big mass in his chest wall and his anaemia (inaudible) his capacity. For example with physical exertion that would place more demand on his body and when he can't cope with it he will collapse.

Doctor can I put this to you, what I'm suggesting as a hypothesis – just as a hypothesis – is it possible that this might be some explanation for the inconsistency in observations of this man on 9 May. Is that possible?---Yes."

29. Professor Kenneth Bradstock, Medical Practitioner, Senior State Specialist in haematology at Westmead Hospital gave evidence and said as to weight loss by the deceased (transcript p103):

> "Thank you, professor. If that treatment, the chemotherapy, had been instituted on 9 May when it follows his disease was more advanced than it was on 1 May, would it also have followed that his prognosis would be less positive because of the later treatment?---Well, again I can only really guess what was happening. I think I made a point that by the Monday the 12th he was beyond hope. He had such severe metabolic disturbances that no one could have saved him. Whether he was treatable on 9 May you can only guess, really. It's possible that this man had quite advanced metabolic problems, renal failure, acidosis and so forth. That would have been very difficult to get him through and to treat him. I, you know - obviously it's hard to know for sure, one can only say that the earlier that he had - could have been picked up then the better his chances would have been.
>
> Professor, you posited an opinion in your report that the system of screening wasn't adequate; it seemed to concentrate more on infectious diseases rather than, for example, renal or kidney problems. Given the information in Dr Wake's statement about a change in the screening procedures at the prison, does that affect your opinion?---Look, I'm not an expert on prison medicine. I don't pretend to be. In a way I guess it was a somewhat naïve comment looking at a system that I'm not at all used to. I was surprised that there isn't a regime of doing routine blood testing for blood count parameters, kidney and liver function tests at newly inducted prisoners into the system. I guess that comment is somewhat reinforced by some of the things that are - some of the remarks that Dr Wake made about the general medical status of many of the members of the prison. He commented that there's a high proportion of indigenous prisoners and they have a lot of health problems. If that's the case I guess it's even a little more surprising that what would be considered to be fairly routine screening tests aren't done to pick up some of the inherit problems that might be present in these people."

30. And (transcript p104):

> "Yes?---So I mean that seems to be some sort of advance over what was done before. I mean they clearly have a commendable program for screening for the special problem, especially infectious disease problems and diabetes that are present in the indigenous prisoners. But I think what this case particularly illustrates is that the system

isn't really keyed up for unexpected events. This was a very rare tumour. I mean there was some messages built in there about the inability of the system as it was at the time this prisoner died to pick up unexpected events, as opposed to the events that occurred pretty commonly like infectious disease and so forth.

I suppose, one could say at the end of the day, if they're going to do some blood tests they may as well do a complete, as near as possible, list of them or more of them. Is that too hard to do, when you send away a sample of blood?---I thought that the sorts of tests that I suggested would be - what would be considered to be fairly routine in a general practice population at least, you know, around the area where I work in Western Sydney that in other words a person coming in to see a general practitioner with a problem or a lot of general practitioners would say it would be fairly routine to do a blood count and to do some basic chemistry test for kidney and liver function in particular, just as a general screen. This would not be so much in a young healthy population but more so in perhaps a geriatric population or people who've got no medical problems.

So alcoholics as well?---They're fairly basic, yes. I note the comment about cost restraints, but we're not talking about, you know, an extensive battery of expensive tests."

31. Professor Bradstock's is of the opinion that he, himself, may have done things a little different than Dr Judkins (transcript p112):

"Now it would be correct to say given the galaxy of health problems an Aboriginal population might throw up in a prison environment that a grave responsibility appears to be placed on the shoulders of junior practitioners here in the Territory?---He did seem to have a lot of responsibility. I'm not privy to what back up there was for him. He mentioned ringing the cardiology registrar at the Darwin Hospital. So he clearly had access to other sources of expert medical opinion. I don't know what other senior people he had to lean on for difficult situations. I mean my superficial impression which I gained from reading the documents was that this doctor was operating pretty much on his own, but I really don't know what the precise back up was. If he had no fall back, medically speaking, dealing with a large prison population with health problems we've discussed before, then I guess I would be concerned about the relatively junior doctor being left with that degree of responsibility. But I guess that's something for the court to explore with other witnesses. I just raise that concern which I had as a distant observer of the process, I guess."

32. However (transcript p112):

> "One thing that would be fair to say though, wouldn't it, would be this, this lymphoma is just the kind of disease that a junior doctor is going to get into trouble with because it's rare. That would be fair to say, wouldn't it?---Well, the average medical practitioner would not see one of these during their working life. So it's pretty unfair to criticise somebody for failing to recognising the T-cell lymphoblastic lymphoma. However as I mentioned before one of the problems that I see with the system, this again is as a distant observer, is the potential problems in failing to recognise rare or unusual or unexpected problems, things that are out of the ordinary for the prison population and responding quickly to those sorts of problems. So I guess that the death of this prisoner illustrates that particular problem for the prison medical system."

33. And (transcript p116):

> "Are there any conclusions in that report of Dr Kyaw's with which you disagree or you would like to specifically say, 'I disagree with'?---The next point is about the issue of diagnosis intervention and prognosis and I mean the emphasis here is that the survival – whether this would save the deceased is uncertain. And I'm just concerned that people are trying to say that this man's prognosis was so bad that the treatment would not have helped him, that there was no hope.
>
> Yes?---And I don't think that the court should accept that.
>
> Dr Kyaw gave evidence in this court that in his opinion the treatment and tests sought by Dr Judkins on 1 May were appropriate and reasonable, do you agree with that conclusion?---Well, I've already stated my opinion about what should have been done on 1 May."

34. And (transcript p117):

> "Yes, but if it's the case that there was no weight loss apparent?---I don't think the issue of weight loss on 1 May was important. On 1 May we had a man presenting with a heart murmur, with shortness of breath, with quite significant oedema of his lower legs and no clear explanation for that constellation of findings. And I indicated what I thought would be reasonable to do if a medical practitioner saw somebody with those problems.
>
> Let me tell you this then that if I told you that Dr Kyaw was of a different view and gave evidence contrary to what you've said, what

would you say about that?---I guess we are all entitled to our opinions.

35. The question as to whether or not the deceased may have been assisted by earlier treatment and the odds of his survival as a result of that assistance is not the subject of a precise answer. Expert medical evidence called at the inquest, appears to give different percentages, some have percentages in common, others are at odds. Ultimately, I am of the view that it is probable that the deceased would have died even with an earlier diagnosis and treatment. The cancer appeared to be just too advanced and aggressive. That is to say, the deceased had a rare disease that might have been picked up earlier and the experts are divided as to whether his chances of survival would have been increased.

36. Without hindsight, but with more experience than Dr Judkins, all the other doctors called at the inquest say they would have ordered more extensive tests at an earlier stage. In my view, the options taken by Dr Judkins was not unreasonable in the circumstances in relation to his assessment of his condition and his diagnosis.

37. In relation to the medical checks that prisoners undergo on admission, evidence has been given by Dr Wake that the system has now changed; a pilot program was trialled at Alice Springs and if it had have been run in Darwin, the deceased would have been identified with renal abnormalities. The pilot program was to do with blood testing new admittees; this pilot was successful and apparently the procedure is now done regularly. Some abnormalities, while not leading to actual diagnosis immediately, would have picked up things that were wrong with the deceased if he was admitted today.

38. This death, once again, unfortunately highlights the difficulties in the provision of health services to Aboriginal and Torres Strait Island people because of cultural differences. These factors resulted in the deceased not

making recorded extensive complaints. He was not aggressive in his health complaints. In my view, there has to be some recognition by medical professionals dealing with Aboriginal prisoners that they will be less strident and less demanding and less verbally aggressive in the way they complain about their health. Simply put, such prisoners are likely to be much shyer than others.

39. Dr Chris Wake was asked several questions by Mr Chris Howse (from the Aboriginal Justice Advocacy Centre) relating to the profit motive behind the setting up and operations of the private company (owned by him and his wife) that runs 'Corrections Medical Services'. I am not sure as to what end these questions were aimed at, however, in my view the privatisation of prison medical services that occurred several years ago, and continues today, is a matter of Government policy that, at this stage, calls for no comment from me.

40. Dr Chris Wake gave relevant evidence and I quote some portions as follows (transcript p133):

> "MS GLEESON: Doctor, could you, please explain the relationship between yourself and, I understand, Chris Wake Pty Ltd Corrections Medical Services and Northern Territory Correctional Services, please?---Northern Territory Correctional Services tenders the primary health care contracts for the Northern Territory prisons. C.J. Wake Pty Ltd is my family - rather is my company and the registered business name is Correctional Medical Services. I am the director of the Correctional Medical Services and we operate primary health care services to Darwin Prison, Alice Springs Prison, Arunta House Juvenile Detention Centre and Don Dale Juvenile Detention Centre."

And:

> "THE CORONER: Well, before you answer that, doctor, I'm not sure he said it that simplistically or with a tone of any criticism. My memory was that he said at a distance he was at he wasn't sure that the doctor - what the doctor had in terms of back up medical help, although he did note that the doctor was well able to ring the Royal Darwin Hospital cardiology unit."

41. Mr Howse (transcript p131 & 132):

> "Dr Wake, you describe yourself as director of medical services at Northern Territory Prisons, is that correct?---Yes.
>
> Is that a salaried position?---No, no, no. As I said we tender for the contract by the Northern Territory Government.
>
> When you say 'we', do you mean the company of which you are director?---I mean myself and my wife. We are both the directors.
>
> I see. So that company looks after provision of primary medical services for the whole of the Territory for Correctional Services, is that correct?---Yes.
>
> Of course it's an outfit which is run at a profit?---Pardon?
>
> It is an outfit, I take it, that is run with a view to making a profit?---I must say - well, yes is the answer to that. But of course it wins its tenders against not for profit organisations like for instance Correctional Health Services and the Central Australian Aboriginal Congress Centre. So the amount of money that comes is in fact equivalent, if you like, too not for profit organisation, who I note take most of their extra monies in management fees or management benefits. And I also note that we have been benchmarked, that's Corrections Medical Services have been independently benchmarked as providing a services which is equivalent in every way to that provided by the South Australian and West Australian prison service.
>
> Note, Dr Wake, that I didn't ask you to justify the service, which has been successful in getting that tender. But the answer to my question is 'yes' that it is a for profit organisation, that's so, isn't it?---And I reply, yes."

And (transcript p139):

> "MR HOWSE: That's all right. Let me put this to you, Dr Wake. I put it to you in the first place that Prof Bradstock has said that a reasonable medical practitioner in the general practice scenario outside of the prison would have ordered the following tests as of May the 1st when presented with the constellation of symptoms that Mr Paii presented with. And I'm quoting now from Prof Bradstock's report:
>
> > My view is that more extensive investigation should have been conducted at this time. The finding of dependent

oedema in a relatively young man is highly abnormal than significant. Potential.....a blood count by a chemical profile and liver function tests would have been indicated as well as a chest X-ray.

Now what do you say about the evidence that I have put to you from Prof Bradstock that a reasonable practitioner in the general practice scenario would have ordered precisely those tests?---He would have ordered them at some time but not necessarily on that first occasion. The question put to me earlier was, 'Was Dr Judkins' behaviour reasonable on 1 May in the light of what he saw?' I've given evidence already that, yes, I do believe it was reasonable. Were there other things that could have been done? Yes, I agree with Prof Bradstock. Was is it imperative that they be done on 1 May? No, it wasn't.

Do you then disagree with the opinion expressed by Prof Bradstock, that opinion being that it would be reasonable for a medical practitioner in the general practice scenario to order these tests. Do you disagree with that proposition?---No, I don't disagree with that. I don't disagree - - -

THE CORONER: Excuse me, you don't disagree with that just as you don't disagree with Holmwood saying it would have been reasonable also?---Absolutely not. It would be reasonable. There were a range - - -

Thank you, that's enough, doctor. You agree it would have been reasonable."

42. And (transcript p140):

"Now what that means is that - I suggest to you, that a reasonable medical practitioner in the shoes of Dr Judkins faced with these symptoms on that day should have ordered those tests, shouldn't have he?---As I said, there is a range of reasonable responses."

43. And (transcript p141):

"So therefore what your report suggest is that the member of the public outside of prison ought to expect this as a minimum when presenting with these symptoms, that's what you're suggesting, isn't it?---Not of necessity. What tests are done, Mr Howse, depends entirely on presentation of the individual senior doctor and from what I can read from the various reports, Mr Paii was not presenting as desperately seeking any medication on 1 May. He had some

swollen ankles, it was only a few weeks before that he'd been doing press-ups and I think in that regard Dr Judkins' response was targeted and reasonable. If you ask me would I have done a little more, well, I probably would. Both those responses are reasonable. There is a reasonable range of response for what was seen on the 1st."

44. And (transcript p143 & 144):

"Doctor, taking you to 1 May 2003, you've read a series of specialist reports about your dealings with Mr Paii on that day, haven't you?---Yes, yes.

You recall a report of Prof Bradstock?---Yes, I do.

Have you also read the report of Dr Holmwood?---Yes, I have.

Now both of those gentleman suggest that you ought to have ordered a wider series of tests on that date when you saw Mr Paii, that's correct, isn't it?---I do believe they suggest that, yes.

Yes. On the basis of the evidence that you have, by way of symptoms from Mr Paii, they suggest that the wider range of tests would have been appropriate given that it might have thrown up the correct diagnosis rather than fastening on the echo cardiogram, is that so?---Yes.

Do you disagree with what they say?---I agree that there are a number of causes for his presentation that do require investigation. My feeling at the time was that this was a coronary cardiac condition and that I was progressing down that path to investigate that. Certainly with a negative echo result then I feel that those tests are certainly warranted at that point.

Just taking you back to what you saw on 1 May. You understand that what both gentlemen suggest is that the range of symptoms on that date suggest the range of causes covered by the extra tests, that's what those suggest, isn't it?---Yes, they do- - -

In other words - sorry?---As (inaudible).

In other words what they suggest is that when you saw Mr Paii and his symptom complex that would have flagged to you that those tests were necessary at that time? That's what Doctor Holmwood and Prof Bradstock suggest in their reports, correct?---I think necessary, but not specifically necessary at that time. Simply in retrospect they would have been - they would have been very useful to have results

or tests performed at that time. But with the symptom complex that I saw I felt that it was worth pursuing the cardiac causes as the most common and likely cause of the symptoms and then do more tests.

It was certainly worth; we're all in agreement aren't we, that it was worth pursuing the cardiac option with what you were shown, we agree about that, aren't we?---Yes.

But it was also worth as of 1 May pursuing the other options, wasn't it?---In retrospect it certainly would have been worthwhile those at that point, yes."

45. I have already made some recommendations herein. I would add a recommendation that the prison authorities examine the tender requirements for the provision of nursing staff at Berrimah prison as it appears that the provision of one only nurse (as in this case) may lead to problems of communication between doctors and nurse; these problems caused by the busy nature of the work.

46. I also recommend that, in view of communication problems that may flow from the cultural sensitivities and shyness of Aboriginal prisoners, that consideration be given to the provision of Aboriginal health workers to assist nurses at the prison.

47. Finally, I recommend that the prison authorities, together with Northern Territory Department of Health and Community Services personnel, review the medical evidence at this inquest and, in particular, the expert reports of of Dr Chi-hung Hui (exhibit 7); Dr Kenneth Bradstock (exhibit 11) and Dr Chris Holmwood (exhibit 14) with a view to assessing just what health checks and tests are appropriate on admission to prison.

Dated this 26 day of August 2005

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Greg Cavanagh
Territory Coroner