CITATION: *Inquest into the death of Carl Francis Walker* [2010] NTMC 062

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0222/2009
DELIVERED ON:	29 October 2010
DELIVERED AT:	Darwin
HEARING DATE(s):	30 September, 1 October 2010
FINDING OF:	Mr Greg Cavanagh
CATCHWORDS:	Death in Custody, natural causes, importance of medical notes

REPRESENTATION:

Counsel:

Assisting:	Ms Elisabeth Armitage
Department of Health and Families:	Ms Ruth Brebner

Judgment category classification:	A
Judgement ID number:	[2010] NTMC 062
Number of paragraphs:	33
Number of pages:	9

IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0222/2009

IN THE MATTER OF AN INQUEST INTO THE DEATH OF
CARL FRANCIS WALKER
ON 30 SEPTEMBER 2010
AT ROYAL DARWIN HOSPITAL

FINDINGS

(Delivered)

Mr Greg Cavanagh:

INTRODUCTION

1. Mr Carl Francis Walker ("the Deceased") was 65 years old and serving a term of imprisonment when he died at the Palliative Care Unit at Royal Darwin Hospital on 30 November 2009. On 16 October 2009 he was admitted into the emergency department of Royal Darwin Hospital from the Berrimah Correctional Centre having suffered a burst appendix, and underwent surgery. The Deceased's post-operative recovery was complicated by bowel perforation and transection, peritonitis and sepsis. He required further operations to address these complications and consented to two further surgical procedures. However, the Deceased then stated that he wanted no further aggressive treatment. He was transferred from the Intensive Care Unit to the Palliative Care Unit on 31 October 2009. He continued to receive palliative care including pain relief and sedation until his death.

2. The death was reported by Dr Maureen Mitchell. This inquest was mandatory pursuant to s15 of the *Coroners Act* because the Deceased was in custody at the time of his death.

3. Pursuant to section 34 of the *Coroners Act*, I am required to make the following findings:

> "(1) A corner 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;

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

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

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

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

6. Counsel assisting me at this inquest was Ms Elisabeth Armitage. The Department of Health and Families was represented by Ms Ruth Brebner. The death was investigated by Senior Constable Warren Scott and I received into evidence the investigation brief, medical records and Correctional

Services records. I heard oral evidence from Dr Terence Sinton, Dr David Read, Dr Edward Yeboah, Dr Sabu Thomas and Dr Arun David.

7. The deceased had no immediate family in Australia but was supported by two friends during his incarceration and hospitalisation. Ms Linda Hassel and Ms Rhoda Crockett assisted this inquest by providing statutory declarations to the investigating officer.

Formal Findings

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

   (i) The identity of the Deceased was Carl Francis Walker, born 31 March 1944. The Deceased was incarcerated in Darwin Correctional Centre, but was residing at the Palliative Care Unit, Royal Darwin Hospital, in the Northern Territory of Australia.

   (ii) The time and place of death was11:45amon30 November 2009 at the Palliative Care Unit, Royal Darwin Hospital.

   (iii) The cause of death was peritonitis and necrosis of the bowel following a ruptured appendix.

   (iv) Particulars required to register the death:

      1. The Deceased was Carl Francis Walker.

      2. The Deceased was born in Hindhead, United Kingdom.

      3. The death was reported to the Coroner.

      4. A post mortem examination was carried out by Dr Terence Sinton, who confirmed the cause of death.

      5. The Deceased's mother was Hilda Walker.

6. The Deceased was residing at the Palliative Care Unit, Royal Darwin Hospital when he died but was otherwise in custody at Berrimah Correctional Centre.

7. The Deceased was unemployed.

Relevant Circumstances Surrounding Death

9. The Deceased was born in the United Kingdom in 1944. He had a difficult childhood and did not know his biological father. He left England when he was about 8 years of age and migrated to Australia with his mother. They settled in a small community outside Adelaide. The Deceased attended school but was reported to be a lonely and isolated child. When the Deceased was 21 his mother returned to England. The Deceased maintained contact with his mother until her death in 1999.

10. On leaving school the Deceased attended a Teacher's Training College. The Deceased taught in schools in Adelaide for 11 years before moving to Alice Springs in 1970. He became an Australian citizen on 30 May 1974. After 16 years in Central Australia, the Deceased moved to Darwin. He worked primarily as an Indonesian translator and teacher. He travelled to Indonesia regularly and lived there for extended periods of time. He retired from full time employment in 2004 but continued to work part-time as an Indonesian teacher until his incarceration.

11. On 8 October 2007 the Deceased was convicted of offences relating to the possession of child pornography, and acts of indecency on a person under 16 years while outside Australia. He was sentenced to a period of 8 years imprisonment with a non-parole period of 5 years. He was to be eligible for release from custody on 21 August 2012. He was, therefore, in custody when he died.

12. Whilst in custody, the Deceased's physical condition deteriorated. In December 2007 he was diagnosed with hypertension. In March 2008 he was

admitted into the Royal Darwin Hospital and was diagnosed with severe triple vessel disease. He was advised to have surgical revascularisation. Although the Deceased was aware of the risk of further cardiac events, he refused surgery. He consented only to medical therapy and was discharged from hospital into the care of the medical officer at Berrimah Correctional Services.

13. The Deceased had short admissions into hospital on 8 April 2008 for chest pain and on 14 July 2008 for shortness of breath. He also saw specialists in the outpatient department as required. In August 2008 the Deceased was advised by his treating Cardiologist that he had only a 50% chance of surviving 5 years without surgery.However, the Deceased continued to decline surgery for his coronary condition. He continued to be provided with medical treatment as prescribed by his specialists.

14. On and from April 2008 the deceased completed numerous Notices of Direction pursuant to the *Natural Death Act* ("Advanced Care Directives"). He repeatedly directed that he did not consent to intubation, cannulation, defibrillation, or the administration of medication. He gave consent to chest compressions and EAR (expired air resuscitation). His last Advanced Care Directive was dated 16 October 2009.

15. On 16 October 2009 the Deceased was admitted into the Royal Darwin Hospital suffering from severe abdominal pain. He was diagnosed with acute appendicitis and he consented to an appendectomy. The surgery was performed by Dr Edward Yeboah and Mr Sabu Thomas using a McBurney incision. The surgery was "technically difficult"[1]. The appendix had perforated, it had released purulent peritoneal fluid into the abdominal cavity, and it was adhered to the ileum (small intestine). The appendix was removed and serosal tears of the ileum were repaired. The surgical site was

[1] Statutory Declaration of Dr David Read, Director of Trauma Surgery and A/Director of General Suregry, RDH, dated 24 September 2010.

washed, suctioned and closed. No other part of the abdomen was explored by instrument or hand and the sigmoid colon was not viewed.

16. The Deceased was returned to the ward for post-operative care. He did not recover as quickly as anticipated and on 21 October 2009 he was diagnosed with an "acute abdomen". It was determined that the Deceased required further surgery to look for and fix the cause of his deterioration. The Deceased was lucid and oriented, and again verbally consented to the recommended surgical and related procedures.

17. Doctors Arun David and Richard Bradbury performed a midline laparotomy. They found:

    (i) That the appendectomy stump and site was well healed,

    (ii) A perforation of the ileum,

    (iii) A transection of the sigmoid colon which was leaking faeculent material.

18. The ileum and sigmoid colon were resected and an ileostomy and colostomy were formed. The abdominal cavity was cleaned and a vacuum assisted closure ("VAC") dressing was applied.

19. The Deceased consented to further surgery on 26 October 2010. This operation was a "re-look" laparotomy, performed by Dr Luke Anthony. Purulent intra-abdominal fluid was evident and the site of the colostomy was necrotic. The site and wound were cleaned and the colostomy was revised.

20. As a result of the persistent faeculent contamination the Deceased developed intra-abdominal sepsis and was advised that further surgeries would be required before his abdominal wound could be closed. However, the Deceased declined any further investigation, surgical intervention, or resuscitation. The Deceased was psychiatrically assessed and found fit to consent to "no further active treatment". I note that his decision to decline

further treatment was consistent with his pre-admission Advanced Care Directives.

21. According to his wishes, the Deceased was transferred to the Palliative Care Unit on 31 October 2009. He was bed-bound but remained lucid until 27 November 2009.Throughout this period he maintained his decision not to receive any further treatment for his condition. The Deceased continued to receive pain relief, wound care and pastoral care until his death on 30 November 2009.

22. The cause of the post-appendectomy abdominal complications was examined in this inquest because there was some evidence that the complications might have arisen from "a medical procedure that went wrong", and because Doctors David and Bradbury had been unable to identify a cause of the complications.

23. I was also concerned that Dr David's Operation Record dated 22 October 2009 ("the operation record"), appeared to have been altered. Some words concerning the damage to the ileum and sigmoid colon were obliterated. Other words appeared to have been added in a different pen, namely:

    (i) Concerning the sigmoid colon *"-clearly old injury-",* and

    (ii) At the top of page 2 *"Findings discussed with Mr Bade(consultant on call). Is happy with plan. To go ahead with procedure as planned. (See below)".*

24. Dr David gave evidence via video link from London. He told me that he completed the operation record shortly after the surgery had taken place and that the amendments were made at the same time the record was completed. He could not enlighten me about what had been changed or why, but maintained that the record was accurate. I was not completely satisfied by Dr David's evidence. He admitted to me that he had been concerned that the appendectomy might have caused the unusual complications that he was

called on to correct. It is, therefore, possible that Dr David amended the operation record out of a misguided concern to protect the hospital and his fellow surgeons from potential criticism. If these were indeed his motivations, the evidence called in this inquest proved them to be unwarranted.

25. Dr David Read, Director of Trauma Surgery and A/Director of General Surgery, was asked to review the medical records and provide an opinion in this inquest. During the course of his evidence he was shown the operation record and the changes that had been made to it. Dr Read's curiosity was sparked and he attempted to discern what lay below the obliterations. He could not assist. Dr Read expressed the opinion that the obliteration of some words and the addition of others resulted in a hospital record that lacked transparency. He considered that the way the alterations were made was inappropriate, unprofessional, and not in accordance with proper records maintenance. I agree with Dr Read's opinion.

26. It is fortunate that ultimately nothing turns on this altered record and I do not consider it necessary to make any further recommendation or comment about it. My concerns about transparency in the maintenance of the hospitals records are now well known to both Dr Read and Dr Sarah Watson, Director of Medical Services, who attended the inquest as an observer for Royal Darwin Hospital. I appreciated the interest she showed in the proceedings.

27. I am satisfied by other evidence received in this inquest that the appendectomy was performed competently and without negligence. Dr Yeboah and Dr Thomas both gave evidence that the colon was not transected during the appendectomy. I accept their evidence and find it to be completely consistent with the opinions provided by Dr Sinton and Dr Read.

28. Dr Sinton, Forensic Pathologist, gave evidence that the Deceased's severe longstanding coronary artery disease is likely to have resulted in obstructed blood flow to his abdominal cavity. On autopsy Dr Sinton observed

extensive abdominal necrosis, indicative of obstructed blood supply. Dr Sinton considered it most unlikely that the sigmoid colon, which lies to the left of the abdomen, was transected during surgery on the appendix, which lies to the right. He considered it much more likely that the perforation and transection of the bowel occurred as a natural consequence of the tissue necrosis.

29. Dr Read reviewed the medical file. It was his opinion that the likely cause of the bowel perforations was ischaemia due to the Deceased's generally poor cardiovascular state.

30. It is clear to me from the evidence produced at this inquest that the Deceased was chronically ill from severe triple vessel coronary disease and his death was due to the natural course and consequences of his condition.

31. I find that the Deceased's received competent and appropriate surgical treatment at Royal Darwin Hospital. There was no evidence of any negligence on the part of any surgeon. The doctors and nursing staff at the Palliative Care Unit provided appropriate and compassionate care during the terminal stages of the Deceased's condition.

32. I am satisfied that the Deceased was provided with adequate and suitable care in accordance with his Advanced Care Directives whilst at the Berrimah Correctional Centre.

33. I do not make any recommendations arising out of this death in custody.

Dated this 29th day of October 2010.

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GREG CAVANAGH
TERRITORY CORONER