CITATION: *Inquest into the death of Peter Alexander Clarke (Senior)* [2014] NTMC 004	
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0031/2012
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HEARING DATE(s):	15 - 17 October 2013
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, serving prisoner, terminal illness, care and treatment thereof.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Department of Corrections	Kelvin Currie
International SOS Pty Ltd	Tass Liveris
Next of Kin	John Rowe

Judgment category classification:	A
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IN THE CORONER'S COURT
AT ALICE SPRINGS IN THE
NORTHERN TERRITORY
OF AUSTRALIA

No. A0031/2012

In the matter of an Inquest into the death of
PETER ALEXANDER CLARKE (SNR)
ON 3 APRIL 2012
AT ALICE SPRINGS HOSPITAL,
ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Peter Alexander Clarke was born in Alice Springs on 24 August 1956. On 20 May 2009, following an appeal to the Court of Criminal Appeal, Mr Clarke received a sentence of five years imprisonment for various drug offences. That sentence carried with it a non-parole period of two years and six months and was backdated to 12 November 2008.

2. On 29 February 2012 Mr Clarke was deemed suitable by the Parole Board of the Northern Territory to be released upon conditional release parole. The Chairman of the Parole Board authorised the date of release to be 26 March 2012. Mr Clarke was provided notice of this decision by way of correspondence dated 5 March 2012.

3. On 19 March 2012 Mr Clarke was admitted to the Alice Springs Hospital ("ASH") initially for treatment associated with pneumonia. Unfortunately, his condition deteriorated quickly following his admission and he was transferred to the Intensive Care Unit ("ICU"). Shortly after being transferred to the ICU it was discovered that Mr Clarke had masses upon his lungs which were strongly suspected of being malignant lesions, ie: cancer.

4. On 3 April 2012 Mr Clarke died as a consequence of bronchopneumonia complicating metastatic carcinoma of the right lung. The effect of these was compounded by longstanding emphysema, coronary atherosclerosis and chronic pancreatitis.

5. Notwithstanding that Mr Clarke died at the ASH, he was at the time of his death, in custody of the Northern Territory Department of Correctional Services ("NTCS"). Accordingly I find that this was a death in custody pursuant to section 12 of the *Coroner's Act* ("the Act"). As a result, and pursuant to s15(1) of the Act, this Inquest is mandatory.

6. Counsel assisting me at this Inquest was Ms Jodi Truman. Mr Kelvin Currie was granted leave to appear on behalf of the Department of Health and Department of Correctional Services. Mr Tass Liveris was granted leave to appear for International SOS Pty Ltd. Mr John Rowe was granted leave to appear for the family of Mr Clarke.

7. It is also noted that a large number of extended family members and friends were in attendance at this Inquest. I thank them for the respect that they showed during the course of this hearing.

The Conduct of this Inquest

8. A total of eleven (11) witnesses gave evidence before me. Those persons were:

    8.1 Detective Senior Constable Brett Wilson, the Officer in charge of the Coronial Investigation.

    8.2 Senior Constable Bruce Hosking, who was previously employed as the Coroner's Constable in Alice Springs.

    8.3 Prison Officer ("PO") Bridget Davey.

    8.4 Registered Nurse ("RN") Sarah Wyatt.

8.5 RN Kristen Flint.

8.6 Dr Gordon Goodwin.

8.7 Dr Rajendra Goud.

8.8 Associate Professor Graeme Maguire.

8.9 PO Grant Ballantine.

8.10 Ms Louise Blacker.

8.11 Dr Terence Sinton.

8.12 Additionally, various members of the family of the deceased also addressed me with their concerns.

9. A brief of evidence containing 37 statutory declarations and numerous other reports, police documentation, and records were tendered into evidence ("exhibit 1"). I also received into evidence the original files held by the NTCS, ASH, the Northern Territory Parole Board and Community Corrections in relation to Mr Clarke. The death was investigated by Detective Senior Constable Brett Wilson who prepared a thorough investigation brief and I thank him for his assistance.

Formal Findings

10. Pursuant to s.34 of the Act, I am required to make the following findings:

"(1) A Coroner investigating:

a. A death shall, if possible, find:

(i) The identity of the deceased person.

(ii) The time and place of death.

(iii) The cause of death.

(iv) Particulars required to register the death under the *Births Deaths and Marriages Registration Act*"

11. I note that section 34(2) of the Act also provides that I may comment on a matter including public health or safety connected with the death being investigated. Additionally, I may make recommendations pursuant to section 35 as follows:

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

12. Additionally, where there has been a death in custody, section 26 of the Act provides as follows:

> "(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. Must 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 the 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 must make such recommendations with respect to the prevention of future deaths in similar circumstances as the Coroner considers to be relevant"

Background

13. As previously referred to, Mr Clarke had been incarcerated since 12 November 2008. During his time in custody he was seen regularly by staff at the medical clinic located at the Alice Springs Correctional Centre ("ASCC"). In fact Mr Clarke was seen twice per day on medical rounds in order to receive his medication for diabetes and chronic pain. At the relevant time, the clinic was operated by International SOS Pty Ltd. This is no longer the case.

14. On 29 June 2011 Mr Clarke was referred by the ASCC clinic to the ASH. He was admitted for treatment for pneumonia and discharged on 2 July 2011, returning to ASCC. I received evidence that during this admission there were no signs evident that Mr Clarke was suffering from cancer, nor were there any concerns held for him in this regard.

15. On Thursday 15 March 2012 Mr Clarke presented to the ASCC clinic and spoke with RN Sally Wyatt. He complained of pain in his upper lungs/chest when coughing, and cold sweats. RN Wyatt examined Mr Clarke and referred him to the clinic doctor, Dr Gordon Goodwin. Dr Goodwin gave evidence that upon examination Mr Clarke reported to him that he was experiencing chest and mid back pain for a few days prior and had a "minor cough". Mr Clarke also stated that the pain he was experiencing felt similar to the pain he had felt when he suffered pneumonia in June 2011.

16. Dr Goodwin stated that he conducted a careful examination of Mr Clarke and that he found Mr Clarke was in no distress, was not particularly unwell, his vital signs were normal and he did not have a fever. Examination of his chest and lungs were normal and there was no sign of any lung infection. As a result, Dr Goodwin formed the opinion that Mr Clarke's pain was musculo-skeletal and associated with a minor viral illness. He provided him with medication however advised Mr Clarke that if his condition did not improve within one - two days he should return to the clinic for review.

17. Mr Clarke continued to receive his medication on rounds twice per day thereafter and there is no record of him complaining about his condition until the early morning of 19 March 2012. I received evidence that Mr Clarke was a heavy smoker of tobacco and is recorded in the ASH file as reporting his own smoking history as "25 per day all my life".

18. On 19 March 2012 Mr Clarke communicated with prison staff at about 5.30 am that he was unwell and was suffering continued pain. PO Bridget Davey spoke with Mr Clarke and contact was also made with RN Wyatt who was on call that morning for the clinic. RN Wyatt stated she asked PO Davey to confirm with Mr Clarke whether his condition was such that he could wait until clinic staff commenced at 7.00 am. PO Davey gave evidence that Mr Clarke said he was willing to wait. PO Davey gave evidence that she personally saw Mr Clarke at that time and he was standing upright, communicating and was in fact rolling himself a cigarette.

19. RN Kristen Flint was the first person to commence duty at the medical clinic that day. She had received a text message from RN Wyatt advising her of the need to see Mr Clarke when she commenced duty and did so shortly after 7.00 am. RN Flint took a full set of vital signs including blood pressure, heart rate, temperature, respiratory rate and blood glucose level. Mr Clarke's vital signs were not abnormal and did not raise any alarms,

however he continued to complain of pain which was worse on deep breathing and coughing.

20. RN Flint listened to Mr Clarke's chest and on examination found he had clear breath sounds but that there was decreased air entry on the right lower base of his lung. As a result RN Flint referred Mr Clarke for examination to Dr Goodwin. Mr Clarke stated that he was content to wait in his cell for Dr Goodwin to arrive and Mr Clarke was provided with pain medication, his usual morning medications and returned to his cell.

21. Dr Goodwin saw Mr Clarke later that afternoon and recalled that at that time Mr Clarke appeared substantially worse from when he had seen him on 15 March 2012. Dr Goodwin noted that Mr Clarke remained "afebrile", i.e. he did not have a fever. His vital signs were satisfactory, but he found signs of a pulmonary infection in Mr Clarke's lungs and decided that he required urgent review at hospital.

22. An ambulance was called at 3.47 pm and arrived at the ASCC at 4.04 pm. Mr Clarke was conscious and taken by the ambulance to the ASH, arriving at approximately 4.40 pm. Mr Clarke was accompanied by a prison officer in the ambulance and at the ASH.

Events at the hospital

23. Mr Clarke was initially assessed in the Emergency Department ("ED"). He was assessed as suffering from severe pneumonia and was admitted for treatment to one of the wards. He was conscious during this time. Unfortunately, despite treatment, Mr Clarke's condition did not improve and at 11.00 am on 20 March 2012 he was transferred to the Intensive Care Unit ("ICU"). Mr Clarke was still conscious at the time of his transfer to ICU and remained accompanied by a prison officer.

24. Dr Rajendra Goud is an ICU specialist and was one of the consultants responsible for the care of Mr Clarke during his time in ICU. Dr Goud

assessed Mr Clarke when he was first transferred to ICU. Mr Clarke was placed upon a non-invasive ventilator to assist with respiratory failure and a number of blood tests and x-rays were undertaken, which are part of the routine tests undertaken when a patient is transferred to ICU. Mr Clarke remained conscious.

25. Mr Clarke's condition deteriorated again however and he was sedated into a medically induced coma and intubated. This occurred just prior to midnight on 20 March 2012.

26. An echocardiogram was then undertaken on 22 March 2012 which revealed two masses on Mr Clarke's heart. It was suspected that these masses were either a thrombus (or blood clot) or an infection known as Infective Endocarditis. As a result Mr Clarke was placed upon broad spectrum antibiotics to attempt to deal with the possible infection and referral was made to specialist cardiologists.

27. Despite continued treatment with antibiotics, Mr Clarke's condition was not improving and on 23 March 2012 a computerised tomography ("CT") scan was conducted of his chest and brain. The CT scan revealed a mass in his lung and a mass in his abdomen in the adrenal gland. Dr Goud suspected a malignant lesion, or what is commonly referred to as cancer. It was also suspected that the masses previously seen on his heart were a metastasis (or spread) from the likely cancer in his lung.

28. It is clear from the evidence of Dr Goud and the ASH file that Mr Clarke's circumstances were discussed and considered by a number of consultants and specialists both within and outside the ASH. It was determined however that Mr Clarke's condition was too critical to enable any biopsy to be conducted to confirm the suspected diagnosis of cancer and that he was not suitable for surgical therapy or chemotherapy.

29. Due to Mr Clarke's condition and the size of the masses found, a decision was made to attempt to stabilise his condition and deal with his infection in the hope that once the infection improved, attempts could then be made to try and find out what type of cancer existed and whether any treatment was possible. Dr Goud stated that Mr Clarke's prognosis at this time was extremely poor and this was explained to the family on 24 March 2012. Agreement was reached with the family that there wold be no escalation in treatment if Mr Clarke's condition deteriorated further.

30. With a view to attempting to identify the precise nature of the infection and determine if anything further could be done to assist Mr Clarke, the ICU called upon the assistance of Associate Professor Graeme Maguire to carry out a bronchoscopy. This is a procedure directly examining the bronchi, or upper airways. That procedure was carried out on 26 March 2012 at which time bronchial washings, or samples, were taken of fluid from the bronchi. These were sent to a laboratory to determine whether there were any particular organisms that were present that could be treated and thus improve Mr Clarke's condition.

31. Both Dr Goud and Professor Maguire gave evidence that the initial results from those bronchial washings came back on 27 March 2012 and were negative for any relevant infections, but also negative for cancer. Professor Maguire stated that such results were not unusual and being able to detect the cancer or infection was dependent upon its location. Despite these initial results, it was still the strong suspicion of those involved in Mr Clarke's care that the masses found on Mr Clarke's lungs were cancerous.

32. Around this time, Mr Clarke's condition started to stabilise and he needed less ventilation support. Given that the consensus was Mr Clarke was suffering an advanced cancer, a decision was made to reduce his sedation, attempt to bring him out of his medically induced coma and extubate him early so that he could spend time with, and speak to, his family. The ASH

notes make clear that Dr Goud explained to the family that it was likely that upon extubation Mr Clarke would deteriorate. On 30 March 2012 Mr Clarke was extubated. When he regained consciousness he was able to speak with family and was responsive.

33. Unfortunately however on 2 April 2012 his condition deteriorated once again and he began to suffer worsening respiratory distress. Dr Goud undertook a further family meeting on that day and advised that escalating treatment was not going to change the outcome, Mr Clarke was suffering, and his underlying lung condition was beyond cure. Dr Goud recommended palliative care. This was agreed to by those family members present. Dr Goud raised with the family the option of having a subsequent autopsy, but it was declined at that time.

34. On 3 April 2012 at 6.10 am Mr Clarke passed away at the Alice Springs Hospital.

Cause of Death

35. An autopsy was undertaken by Dr Terence Sinton on 17 April 2012. His report was tendered into evidence as part of exhibit 1 and Dr Sinton also gave evidence before me. Dr Sinton noted within his report that the purpose of his autopsy was to "further define the nature of the primary malignancy", i.e. the cancer. Unfortunately however, "because of post mortem necrosis, further diagnostic differentiation of the tumour type could not be made".

36. Despite this inability to differentiate the type of cancer that Mr Clarke was suffering, I do not consider that this prevents me from making a finding as to the cause of Mr Clarke's death. In accordance with the findings made at autopsy, I find that Mr Clarke died as a consequence of bronchopneumonia complicating a metastatic carcinoma of the right lung. The effect of these was compounded by longstanding emphysema, coronary atherosclerosis and chronic pancreatitis.

37. I note that an issue arose during the course of the Inquest as to the potential relevance of a finding of Mycobacterium Avium Complex or MAC. This was raised by counsel for the family very shortly prior to the commencement of this Inquest. As a result, I investigated this finding during the course of the hearing, there was the very clear evidence from all medical practitioners involved that it was not relevant to Mr Clarke's death. Professor Maguire is a respiratory specialist and I consider his evidence to have been particularly relevant and helpful on this issue. Professor Maguire made clear that the positive result for MAC received some weeks *after* Mr Clarke's death was not relevant to his cause of death, and in his opinion was an unlikely contributor to Mr Clarke's cause of death.

38. Professor Maguire stated that MAC was "a ubiquitous bug", i.e. found everywhere, and that in fact it was likely that each and every one of us has been exposed to such a "bug" at some stage in our lives. As Professor Maguire put it (transcript page 94):

> "As I was saying, MAC is a ubiquitous organism. It's everywhere. Showerheads, water supplies, I'm sure most of us would have been exposed to MAC sometime in the last few weeks".

39. He stated quite plainly that for some people, exposure causes no problems whatsoever, in others the germ will "colonise" in the body, but still cause no particular difficulties, however in those with chronic lung disease and other conditions, MAC can cause infection.

40. Professor Maguire stated that despite his extensive knowledge and experience of MAC, he did not see anything in the materials that he was provided concerning Mr Clarke that MAC may be involved. As stated by Professor Maguire (at transcript page 92):

> "It's hard to be definite in clinical medicine but this would be one of those cases where I'd say this **definitely** didn't look like MAC infection". (my emphasis)

41. Although there was eventually a finding of MAC being present, Professor Maguire noted that there were in fact two tests conducted (transcript page 93):

> "So we - there are two tests we ask for when we're looking for MAC and other bacteria, which we call mycobacterium, and one is where we stain the specimen, looking for, actually, the bugs and we didn't see those bugs when we specifically stained that bronchial washing and that's the result we get back within 48 hours and so that's called an AFB stain or acid-fast bacilli stain. The - the bug itself, we then actually culture the specimen, where we put it on a plate and we put it in a warm place and we wait to see whether these bugs grow. These mycobacterium, of which MAC belongs to, can take anywhere between two and 12 weeks to actually grow up and in this case the specimen actually showed that there was this bacteria, MAC, present after about two weeks".

42. Professor Maguire was asked whether at the time of his review he formed the opinion that Mr Clarke was colonised with MAC and he stated as follows (transcript page 93):

> "This gentleman indicated **no evidence** of actually active infection with MAC. The fact that we isolated it at bronchoscopy would therefore suggest that he was simply colonised. The bacteria was there but causing no problems". (my emphasis)

43. In terms of when Mr Clarke may have been colonised with the bacteria, the following exchange took place (transcript page 93):

> "With that in mind, is it possible that he could have had MAC prior to even entering into gaol, his period of incarceration?---Certainly he - that - that MAC could have been present in his lungs for several years".

44. As to the question of whether the vegetations (or masses) seen on Mr Clarke's heart were potentially MAC, Professor Maguire stated (transcript page 94):

> "Certainly I have never seen, nor have I seen reported, a case of mass lesions in the heart being secondary to MAC. The other thing of note is I believe that the post mortem was delayed and the specimens were

not optimal. When we've undertaken work with other mycobacterium, usually they will actually stain and be present even two weeks after sitting at room temperature. So the fact that there were no - none of these bacteria actually seen in the post mortem would also support that this wasn't MAC."

45. I therefore do not consider the finding of MAC as relevant at all in relation to the death of Mr Clarke.

Issues for further consideration

46. Other issues were also raised for consideration upon the evidence. These are as follows:

46.1 The nature and standard of the care provided to Mr Clarke during his period of incarceration at ASCC;

46.2 Whether that care had any impact upon Mr Clarke's subsequent death;

46.3 The nature of the custody and control of Mr Clarke by ASCC staff during Mr Clarke's admission at ASH; and

46.4 The circumstances surrounding the initial failure to have this matter recorded as a death in custody and investigated accordingly.

<u>The nature and standard of the care provided to Mr Clarke during his period of incarceration at ASCC</u>

47. Mr Clarke had been incarcerated since 12 November 2008. He was seen on a regular basis by staff at the medical clinic at the ASCC and he received twice daily medication to deal with his pre-existing medical conditions, particularly diabetes and chronic pain.

48. RN Wyatt gave evidence that she recalled Mr Clarke well and that he was a person that if he had any concerns in relation to his health he would raise them with the medical staff, who would then see him accordingly. RN

Wyatt stated that she did not think Mr Clarke was a malingerer, nor had she ever heard any other member of the medical staff describe him as such and she always considered that Mr Clarke's complaints (whenever made) were taken seriously. I accept this evidence.

49. Mr Clarke was a heavy smoker and on his own reporting had been so all of his life. It is described variously in the files tendered before me as between 25 to 40 cigarettes per day. I note that Mr Clarke was spoken to by clinic staff about his smoking but despite the very clear, very public and very well-known evidence of the dangers of such a pastime, he continued to smoke, and to do so heavily.

50. Even if Mr Clarke did not himself complain of any issues he may have been experiencing with his health, I accept the evidence of RN Wyatt that in her experience if she or any other member of the staff at the clinic had seen a prisoner appearing unwell on their rounds, even if they did not approach staff, an inquiry would be made as to whether that prisoner required any assistance and medical staff would ask to see them.

51. The complaint made by Mr Clarke on 15 March 2012 was pain on coughing, being short of breath and cold sweats. He referred to his previous pneumonia but did not link his complaints at that time to being similar to that illness. Mr Clarke was appropriately examined and did not have a fever, thus it was determined that there was no underlying infection. I accept the evidence of Dr Goodwin that he believed it more likely than not that Mr Clarke was suffering from a viral illness and treated him accordingly. I also accept his evidence that he told Mr Clarke to return if he did not improve in the next day or so.

52. Mr Clarke does not appear on any of the evidence to have complained to anyone again about his condition until the early morning of 19 March 2012. This is despite the evidence of Dr Goodwin that he told Mr Clarke to make contact with the clinic staff if his condition did not improve in one - two

days. When he complained on 19 March 2012, prison staff attended to him promptly and made prompt contact with the clinic staff. Given it was just over an hour away from the nurse coming on duty, Mr Clarke was asked if his condition was such that he could wait until the nurse arrived or if he needed to go to hospital straight away. I accept the evidence that Mr Clarke said he could wait.

53. When RN Flint commenced her duties I accept her evidence that she saw Mr Clarke very shortly after 7.00 am, conducted an examination of him and appropriately referred him to Dr Goodwin. There was some issue in relation to the urgency that was placed upon that referral to Dr Goodwin. RN Flint maintains that she requested Dr Goodwin see Mr Clarke urgently, however Dr Goodwin maintains that he was not so advised. The progress notes relating to Mr Clarke from the clinic records for that day do not support a finding that RN Flint requested that Dr Goodwin see Mr Clarke urgently, however I do not doubt RN Flint when she states that she was concerned about Mr Clarke's condition. Likewise I do not doubt that Dr Goodwin was also concerned.

54. Given the already advanced nature of Mr Clarke's condition, I do not consider that the time period that passed between when he was seen by RN Flint and when he was seen by Dr Goodwin on 19 March 2012 made any significant difference to his condition, nor the outcome.

55. I accept that when Dr Goodwin saw Mr Clarke on 19 March 2012 he conducted a careful examination of him and concluded that Mr Clarke required urgent review at the ASH. Dr Goodwin acted accordingly and I consider the care provided to Mr Clarke during his period of incarceration at ASCC was appropriate and satisfactory.

Whether that care had any impact upon Mr Clarke's subsequent death

56. It is unfortunate that Mr Clarke's underlying cancer was not discovered earlier. Clearly the earlier a cancer is detected, the better the prognosis. However, I received evidence from Dr Goud that there was nothing he saw in Mr Clarke's records, or was told by Mr Clarke directly, or observed during any of his examinations of Mr Clarke, which indicated to him that his cancer should have been detected earlier.

57. I also acknowledge that Mr Clarke had been admitted to ASH for pneumonia on or about 29 June 2011, however I accept Dr Goud's evidence that having perused the chest x-rays taken at that time, there was no suggestion of cancer at the time of that admission in the x-rays.

58. I accept that there were a number of symptoms that *could* have alerted medical staff to the possibility of cancer. However it is also clear on the evidence that such symptoms were non-specific and were consistent with risk factors for a number of other medical conditions, not simply cancer. The fact remains that when Mr Clarke became sick at the ASCC, he was sent to the ASH promptly. Even then it took a few days before the specialists and consultants at the ASH were able to infer that Mr Clarke was suffering from cancer. I do not consider that evidence as suggestive of there being any failure in the treatment and care provided to Mr Clarke during his period of incarceration, nor an indicator that his cancer should have or could have been discovered earlier.

59. As I have stated in many Inquests, to deal with the question of whether a particular condition could have or should have been discovered earlier, and thus perhaps avoided the subsequent death of a person, it is necessary to deal with what material the doctors had available to them ***prior*** to the diagnosis. In this matter I accept the evidence of Dr Goodwin, and also where relevant Dr Goud, that there was nothing in the earlier presentations

of Mr Clarke that would have supported a reasonable basis for a diagnosis of cancer earlier than what occurred.

60. In this case I also accept the evidence of Dr Sinton and Dr Goud that it was more likely than not that Mr Clarke suffered from an aggressive cancer and one which was likely to have developed quite quickly in the last three to five months of his life. The rapidity therefore of this cancer, together with its aggressiveness, meant that by the time it was discovered it was already too late for Mr Clarke.

The nature of the custody and control of Mr Clarke by ASCC staff during Mr Clarke's admission at ASH

61. When Mr Clarke was first admitted to ASH he was under the custody and control of the ASCC and in fact had a guard present with him. I received evidence that there were prison officers in attendance guarding Mr Clarke until approximately 4.00 pm on 21 March 2012. On that date custody of Mr Clarke was in fact transferred to the ASH in accordance with a written agreement between ASH and ASCC. That written agreement was tendered in evidence before me (see exhibit 12).

62. I received evidence that it was not the transfer of custody that caused concern to the family of the deceased, but the fact that for a period of Mr Clarke's admission at ASH he was shackled to his bed by his leg. The statement given before me in particular by Ms Kylie Hampton, and also the evidence received from other family members, made clear just how distressing it was to the family to see the deceased shackled to the bed at a time when he was seriously unwell.

63. On this issue I received evidence that the use of restraints and the arrangements for the escort of prisoners to ASH was carried out in accordance with the *Prisons (Correctional Services) Act* and the Standard Operating Procedures ("SOP") and Directives issued pursuant to that

legislation. I received a copy of the relevant SOP's and Directives (see exhibit 10).

64. I find on the evidence that upon his admission to ASH, Mr Clarke was shackled by his leg to the bed and that this shackle was only removed for the purposes of medical treatment and/or to go to the bathroom. This is in accordance with usual practice. I also find however that on 20 March 2012 at about 9.30 pm PO Peter King was requested by medical staff to remove the leg shackle as Mr Clarke was about to be placed into a medically induced coma. I find that at that time the shackle was removed and that it was not placed upon Mr Clarke again after that time.

65. Whilst there is no doubt that seeing a sick loved one shackled to a bed is confronting and upsetting, it is also clear that there are good reasons for the existence of such restraints and for senior prison officers to hold the responsibility for exercising the discretion in relation to their removal pursuant to the relevant provisions of the Act, the SOP's and/or the Directives.

66. I accept that standing in the stead of the family members, I too would have been extremely distressed upon seeing a clearly ill loved one shackled to their hospital bed. However it is clear that there is a need in certain circumstances for restraints to be used and that for the decision to remove those restraints to rest with a senior prison officer, rather than simply any officer. The capacity for junior officers to be the victim of manipulation that may affect their judgement in relation to the exercise of their powers is real. I consider therefore that the discretion in relation to their removal should remain with those officers of senior rank as is presently the case. However, the "SOP", in my view, might be revisited to consider all the implications when dealing with not just a sick prisoner but with a terminally ill prisoner (as was the case here).

67. Counsel for the family submitted that clause 7.1 of the SOP 9.15 was unlawful given the specific provisions of section 74 of the *Prisons (Correctional Services) Act*. I do not accept that submission. As submitted on behalf of the Department, clause 7.1 of the SOP is to provide a "minimum standard" for officers when dealing with the custody of a prisoner moved to a hospital. The provisions of that SOP make clear that it is subject to the discretion of a Deputy Superintendent or Officer in Charge of the ASCC which complies with section 60 of the Act.

<u>The circumstances surrounding the initial failure to have this matter recorded as a death in custody and investigated accordingly</u>

68. Mr Clarke passed away at 6.10 am on 3 April 2012. At around 9.30 am that morning, Dr Goud telephoned Senior Constable Bruce Hosking and notified him of the death. Senior Constable Hosking was the Coroner's Constable in Alice Springs at that time. Senior Constable Hosking was already at the ASH and attended upon ICU to read the file and determine whether this was a death in custody.

69. Senior Constable Hosking gave evidence that when he read the ASH file he noted the contents of the letter dated 21 March 2012 which was the written agreement transferring care from ASCC to ASH. As a result of the contents of that letter, but in particular the second last paragraph he formed the opinion that this was not a death in custody. That paragraph read as follows:

> "If, prior to 26 March, the prisoner is given medical clearance for discharge from the Hospital, the prison will need to be contacted to enable collection from the Hospital for return to the prison. It is to be noted that all custodial requirements will expire at midnight on the night of the 25 March, this being completion of his custodial sentence".

70. Determination however of whether a death is a death in custody does not finally rest with the constable and contact was therefore made with my

Office. That also occurred on 3 April 2012. When the contents of the letter dated 21 March 2012 were provided, it was determined that this was not a death in custody. That was an error.

71. It is clear that, shortly after the passing of Mr Clarke on 3 April 2012, this error caused confusion and upset to the family given the different messages they were receiving as to whether this was, or was not, a death in custody. It is unfortunate that any further upset was caused, however it is clear having heard and received all of the evidence, that the initial failure to have this matter recorded as a death in custody and investigated accordingly was not unreasonable given the information that was to hand at the relevant time.

72. Equally, whilst that error occurred initially, it is clear that at all times the Department of Corrections considered this to be a death in custody and their records were kept accordingly. An autopsy was also conducted on 17 April 2012 and Dr Sinton was clear in his evidence that whilst the autopsy came to him under different circumstances, the autopsy itself was conducted in exactly the same way as any other "death in custody" autopsy.

73. In addition, upon receipt of all the relevant information, the death was accepted as a "death in custody" and it was investigated accordingly.

Concerns of the family

74. During the course of this Inquest, counsel for the family also alerted me to the fact that the family were concerned that Mr Clarke had not been granted parole earlier than on 29 February 2012. As indicated during the course of the Inquest, I do not consider it part of my powers to attempt to effectively "go behind" the decision making power of the Parole Board and to attempt to discern why the Board exercised its discretion in the manner in which it did.

75. It is clear however that despite the belief of certain family members that Mr Clarke was refused parole previously because he had not undertaken certain

courses which were not available to him at the gaol, this belief was incorrect. Both the Community Corrections file and the Parole Board file were tendered in evidence before me (exhibits 5 and 6). The contents of those files make clear that there were a *number* of matters highlighted by Community Corrections in their reports to the Board that were asked to be considered by the Board in determining whether to grant parole.

76. Attendance at relevant courses was just *one* of those matters and equally it was made clear that Mr Clarke's non-attendance was through "no fault" of his own. It is clear therefore that other matters were relied upon as part of the exercise of the discretion of the Board to grant parole, not simply courses.

77. I accept that it is unfortunate that Mr Clarke was not granted parole earlier so that he may have been able to be free to spend his last days with his family. However it is clear that no one knew of the existence of Mr Clarke's cancer before it was too late, and by then the terms of the parole order had already been stipulated which included a residential condition, which Mr Clarke would have been in breach of had the Board not revoked his parole to ascertain what his condition was.

78. Another matter that was raised by counsel for the family, and upon which I received two (2) letters from Mr Rowe after the closing of the evidence, is the possibility of having an x-ray machine at the ASCC to assist medical staff, like Dr Goodwin, to make a proper diagnosis of prisoners during their incarceration. In this regard Mr Rowe submitted as follows (transcript page 132):

> "The problem realistically is with the fact that he's placed into an environment with a practice of some 500 mainly ill patients, that he has to get around and his best with them. He is there with severely under resourced conditions. He is confronting daily people with high incidence of possible lung disease. And in a practice such as that you would think he would have an x-ray machine as being a very important factor enabling him to properly diagnose.

> He's running a practice that normally you'd have two or three doctors running, with a number of nurses, more than two, to properly provide the standard of care that he would be entitled to; all the prisoners would be entitled to."

79. Mr Rowe's letter did outline certain matters as to the cost of provision of an x-ray machine and made submissions concerning the benefits of such a machine being located at the ASCC. I note that the correspondence also makes clear that the staff at the ASCC were "open and frank" and "acknowledged the benefits of having an onsite x-ray facility and is working through the concept".

Findings

80. On the basis of the tendered material and oral evidence received at this Inquest I am able to make the following formal findings:

i. The identity of the deceased person was Peter Alexander Clarke (Senior) born 24 August 1956 in Alice Springs in the Northern Territory of Australia.

ii. The time and place of death was approximately 6.10 am on 3 April 2012 at the Alice Springs Hospital.

iii. The cause of death was bronchopneumonia complicating metastatic carcinoma of the right lung.

iv. Particulars required to register the death:

a. The deceased was a male.

b. The deceased's name was Peter Alexander Clarke (Senior).

c. The deceased was of Aboriginal descent.

d. The death was reported to the Coroner.

e. A post mortem examination was carried out by Dr Terence Sinton who investigated and discussed the possible causes of death on 17 April 2012.

f. The deceased's mother was Thelma Clarke (deceased) and his father was Keith Joseph Clarke (deceased).

g. At the time of his death, the deceased was a sentenced prisoner incarcerated at the Alice Springs Correctional Centre in the Northern Territory of Australia.

81. On all of the evidence received, I have the following recommendations.

1. The Department of Corrections review and consider all of the guidelines for restraint of ill prisoners within hospital environments with special reference to those prisoners who are terminally ill.

2. The Department of Corrections review and consider the desirability of increasing resources within the medical clinic in Alice Springs Correctional Centre especially in light of the chronic medical issues prevalent within the prison population.

Dated this 13th day of February 2014.

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GREG CAVANAGH
TERRITORY CORONER