CITATION: *Inquest into the death of Victor Albert Campbell* [2015] NTMC 002

TITLE OF COURT:	Coroners Court
JURISDICTION:	Alice Springs
FILE NO(s):	A0041/2013
DELIVERED ON:	19 February 2015
DELIVERED AT:	Alice Springs
HEARING DATE(s):	16 and 17 February 2015
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, Alice Springs Correctional Services, natural causes, care and treatment.**

REPRESENTATION:

Counsel:

Assisting:	Jodi Truman
Department of Health and Department of Correctional Services	Greg Macdonald

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

No. A0041/2013

In the matter of an Inquest into the death of
VICTOR ALBERT CAMPBELL
ON 17 AUGUST 2013
AT ALICE SPRINGS HOSPITAL,
ALICE SPRINGS

FINDINGS

Mr Greg Cavanagh SM

Introduction

1. Victor Albert Campbell ("the deceased") was born at Charleville in Queensland on 25 November 1949. On 9 April 2013 Mr Campbell was arrested for serious criminal offences. To protect the identity of the alleged victim I will not outline the nature of those offences but they were offences for which he did not obtain bail. As a result the deceased was remanded in custody at the Alice Springs Correctional Centre ("ASCC") awaiting trial for such offences.

2. Mr Campbell had moved to the Northern Territory from Queensland not long prior to his arrest. He resided with family at the Mount Liebig Community, which lies on the western edge of the greater MacDonnell Ranges, some 325kms west of Alice Springs. Shortly after his arrival there, Mr Campbell disclosed to medical staff at the community clinic that he had emphysema, a visual defect in his right eye, hearing loss, itchy skin with a rash between his shoulder blades and weight loss. He was a heavy smoker. He did not disclose any other significant health issues.

3. Similar issues were noted upon his incarceration at ASCC, however it was during the period of his incarceration that it was ultimately discovered that Mr Campbell was in fact suffering from lung cancer. Investigations were

undertaken and treatment provided but it quickly became apparent that Mr Campbell's cancer was terminal. As a result, on 2 August 2013 Mr Campbell was transferred out of the ASCC and into the care of the Palliative Care Unit at the Alice Springs Hospital ("ASH") where he remained until 17 August 2013. On that day, at approximately 5.00pm, he passed away.

4. Notwithstanding that Mr Campbell 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 *Coroners Act* ("the Act"). As a result, and pursuant to s15(1) of the *Act*, this Inquest is mandatory.

5. Counsel assisting me at this inquest was Ms Jodi Truman. Mr Greg MacDonald was granted leave to appear on behalf of the Department of Health and Department of Correctional Services. The family of the deceased had been notified of the inquest and the nominated representative, Mr Lance Campbell spoke with counsel assisting prior to the inquest. Ultimately he did not seek to give evidence at this inquest. "The Central Australian Aboriginal Legal Aid Service ("CAALAS") was also provided with notice of the inquest but did not seek leave to appear on behalf of the family."

6. A total of five (5) witnesses gave evidence before me, namely Constable ("Const.") Troy Jackwitz, Registered Nurse ("RN") Dorian Dent, Dr Stephen Brady Superintendent ("Supt.") William Yan and Dr Samuel Goodwin.

7. A brief of evidence containing various statements, together with numerous other reports, police documentation, and miscellaneous records were tendered into evidence (exhibit 1). I also received into evidence the original files held by the NTCS (exhibit 2), together with the deceased's medical records from both Queensland and the Northern Territory (exhibit 3). The death was investigated by Const. Jackwitz and I thank him for his assistance.

8. Pursuant to s.34 of the *Act*, I am required to make the following findings if possible:

   (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*"; and

   (v) Any relevant circumstances concerning the death.

9. 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"

10. 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

11. Mr Campbell was born in Charleville, Queensland to Alma Jean Johnson and John Campbell who are both now deceased. As a child his family moved to Mt Isa where Mr Campbell attended school; however he only completed to grade 4 level. From the age of 15 years Mr Campbell became a boxer and used the name "Mick Murphy" before retiring in 1969 at approximately 20 years of age.

12. Following his retirement from boxing, Mr Campbell in fact shot himself in the chest. The bullet passed through his left lung. It is not clear why or how this occurred, but fragments of the bullet remained inside Mr Campbell's chest. Thereafter Mr Campbell went on to gain employment as a stockman and a cattle station manager.

13. On 17 May 1980 Mr Campbell married Nancy Margaret Roissetter in Longreach, Queensland. The couple went on to have five (5) children together. The couple were married for approximately ten (10) years before separating but they did not officially divorce until 2004. During their marriage, Mr Campbell was a regular cigarette smoker and would drink alcohol.

14. In the late 1990's Mr Campbell ceased employment and was placed upon a disability pension after falling from a banana trailer and sustaining a back injury. Thereafter he moved around and would stay with family at different locations until eventually moving to Mount Liebig Community to live with one of his sons and his family in early February 2013.

15. Mr Campbell's Queensland Health medical records note that in early 2011 he had been referred to the Townsville Hospital for investigation of abnormal chest x-ray results. The request was for investigation of potential cancer. Those records make clear that Mr Campbell was reported to be very "nervous" about this and he in fact failed to attend two (2) successive appointments for such investigations to be carried out.

16. The records then note that the next time he was seen was on 13 December 2012 at the Townsville Hospital for chest pain and shortness of breath. A chest x-ray again noted abnormalities in his right lung and reported these were "chronic fibrotic changes". Mr Campbell was again referred for, and underwent, investigations for these abnormalities, however according to the records tendered into evidence there was no diagnosis ever made of lung cancer.

17. As previously referred to, Mr Campbell then moved to the Northern Territory in early February 2013 and resided with one of his sons, and his son's family, at the Mount Liebig Community. On 25 March 2013 Mr Campbell is recorded as attending at the Amunturngu Health Centre which is the local community clinic. He is noted as requesting medication for emphysema and Chronic Obstructive Pulmonary Disease ("COPD"), together with an eye examination and hearing aids. He disclosed to the doctor at the clinic that he had emphysema, a visual defect in his right eye, hearing loss, itchy skin with a rash between his shoulder blades, was a heavy smoker and had been suffering weight loss. The doctor noted that Mr Campbell had a "chronic productive cough" that produced "white sputum". He provided Mr Campbell with medication for his emphysema.

Medical attention following incarceration

18. On 9 April 2013 Mr Campbell was arrested for serious criminal offences and subsequently remanded into custody to the Alice Springs Correctional Centre ("ASCC") on 10 April 2013. Upon his incarceration to the ASCC, Mr Campbell was required, as are all prisoners, to undertake an "Initial

Risk/Needs Assessment" which is conducted by Corrections staff. Upon completion, there is then also an initial assessment conducted by a nurse who enters details of the examination and assessment into the Primary Care Information System ("PCIS"). This also generates an automatic recall for the prisoner to be returned to the clinic the following day for a full consult with a doctor and consideration of whether a personalised care plan is required.

19. This system was in operation and as a result Mr Campbell was seen the following day, i.e. 11 April 2013, by Dr Evan O'Neill. During the course of that attendance, the records indicate that Dr O'Neill noted Mr Campbell's previous medical history as "COPD and ischaemic heart disease". It was also noted that Mr Campbell had a "chronic moist cough". A physical examination was conducted which showed the presence of a "small lump" in Mr Campbell's central abdomen. As a result, Dr O'Neill requested an ultrasound of the lump. Mr Campbell did not attend his first appointment for that ultra sound and it appears this was because the prison was short staffed and unable to facilitate the appointment that day. The ultrasound was not, at that time, however an urgent appointment and with the consent of the medical staff, it eventually took place in May 2013.

20. In the meantime, and during his time in custody, Mr Campbell was seen regularly by clinic staff on medication rounds each day. His next formal attendance at the clinic however was on 20 April 2013 where he was seen by Registered Nurse ("RN") Virginia Lavicka. Mr Campbell complained that he thought he may have "broken a rib" the night before whilst coughing. As a result he was placed on the recall list for review by a doctor. This review occurred on 22 April 2013 by Dr Michael Mbaogu.

21. The records state that Dr Mbaogu noted swelling on the left side of Mr Campbell's chest and associated pain. As a result a chest x-ray was ordered. Those x-rays revealed evidence of the gunshot that Mr Campbell had administered to himself in about 1969. There was evidence of "irregular and calcified pleural thickening, along with fragments of shot". There was also

pleural thickening and multiple old rib fractures with rib abnormalities on the left side. The results indicated a CT scan was required to exclude a "destructive bone lesion".

22. Mr Campbell again returned to the ASCC clinic on 18 May 2013 and was seen by RN Naomi Saunders. He complained of pain in the chest and back and painful "nodes/lumps in xiphoid sternum and under right arm". Contact was made by RN Saunders with the on call doctor and pain relief was ordered together with a referral to see the doctor.

23. On 20 May 2013 Mr Campbell was reviewed by Dr James Ricciardone at the ASCC clinic who noted the following:

    23.1 "3-4cm hard lump noted in lower epigastrium that has suddenly increased in size;

    23.2 Patient states has had significant weight loss recently;

    23.3 2-3cm lump in right axilla".

24. As a result of these findings, referral was made to the ASH for a CT scan. This scan occurred and showed a "14 x 12 mm round ill-defined subcutaneous nodule" (i.e. a growth under the skin) which was irregular. The differential diagnosis at that stage included a necrotic mass or necrotic lymph node. A decision was made for Mr Campbell to return on 28 May 2013 for an ultrasound guided fine-needle aspiration ("FNA") biopsy of this nodule.

25. On 28 May 2013 Mr Campbell also had a CT of his abdomen/pelvis which showed a nodule in the epigastric region. There was also a mass in the left lateral chest wall adjoining the 9th rib and an "indeterminate" nodule on the left adrenal gland. At this stage doctors thought that this was:

> "… an eroding soft tissue necrotic mass in the left lateral chest wall and subcutaneous epigastric nodule, both suspicious for metastases, with an unknown primary".

26. As a result, a further CT scan and chest x-ray were ordered. Results from the FNA biopsy had also showed "atypical cells consistent with tumour". It is clear that at that time cancer was strongly suspected.

27. On 6 June 2013 Mr Campbell was admitted to the ASH for further investigation of metastasis (i.e. spread of cancer from one organ to another) to the lung. Further CT investigation of the chest and upper abdomen showed evidence of:

> "… significant metastatic disease with multiple bony lesions, including several ribs and the T4 vertebral body being involved. There was an epidural component with the spinal mass resulting in some spinal canal narrowing. He had extensive mediastinal and right axillary lymphadenopathy. There was a left adrenal metastasis. There was a large left hilar mass which was suspicious for a primary left lung carcinoma".

28. As a result there was concern that Mr Campbell's spinal cord may become compressed, thus paralysing him. Discussions took place with the spinal team at the Royal Adelaide Hospital ("RAH") and decision was made to refer Mr Campbell to the oncology team at the Royal Darwin Hospital ("RDH"). Mr Campbell was in fact transferred and flown to the RDH on 8 June 2013 for further investigation.

29. Whilst at RDH Mr Campbell received high dose dexamethasone and radiotherapy, which are both used for treating cancer. He also underwent a right axillary (i.e. armpit) FNA biopsy which showed a "poorly differentiated possible adenocarcinoma" with a "possible lung primary". He was seen by the multidisciplinary oncology team who determined that Mr Campbell required a further lymph node biopsy. Mr Campbell was discharged from the RDH and returned to the ASH on 18 June 2013 where he remained until 21 June 2013. During that time he had further biopsies taken from his abdominal wall and his left chest wall mass. He returned to the ASCC on 21 June 2013 with a plan for follow up oncology.

30. According to the records and the evidence of Dr Stephen Brady, on 24 June 2013 Mr Campbell was given a "palliative diagnosis of Metastatic

Adenocarcinoma of the lung". Adenocarcinoma is a type of cancer that forms in mucus-secreting glands. It can occur in many different places of the body, including the lungs. This diagnosis was passed on to the ASCC by the ASH and on 25 June 2013 Mr Campbell was advised of the palliative diagnosis.

31. On 28 June 2013 Mr Campbell attended at the ASH for an appointment with the palliative care and oncology unit to commence a planned course of chemotherapy and radiotherapy that had been prescribed by the oncology team. On that same date, contact was made by Dr Ricciardone with Mr Campbell's lawyers and his family advising them of the diagnosis and palliative care.

32. Given Mr Campbell was terminally ill, there was concern that the ASCC was not the appropriate place for his continued housing and treatment. I received into evidence various emails between senior prison officers outlining these concerns shortly after Mr Campbell returned to the ASCC. It is clear that because Mr Campbell was terminally ill, both ASCC staff and medical staff at the clinic were concerned that the prison may not have been suitable, particularly because he was extremely susceptible to infections.

33. Emails reveal that staff at the clinic preferred that Mr Campbell be placed in "another environment" rather than the prison, "not for survival rate, rather for humane reasons due to his illness". It is clear from those emails that both the ASCC and the medical staff at the clinic were attempting to find a solution, particularly with a view to enabling Mr Campbell to perhaps be placed into hospice care; however it was his status as a prisoner upon remand that was causing difficulties. I note that during this time the Director of Public Prosecutions was also seeking information from the lawyer for Mr Campbell as to whether they would be making application for bail so that he could be released to die at home with family. No such application was ever made.

34. Mr Campbell was then subsequently admitted to the ASH from 11 to 15 July 2013 with increasing pain and a productive cough. He received pain relief and antibiotics during his admission and then returned to the ASCC. On 22 July 2013 he was seen as an outpatient in the oncology clinic at the ASH. On 27 July 2013 he again attended at the ASH with increasing pain and was provided with two (2) doses of oxycodone and then discharged back to the ASCC. From that date until 2 August 2013 Mr Campbell's condition deteriorated even further. He was reviewed each day by the RN at the ASCC clinic. Discussions were held between clinic staff and Corrections staff regarding transfer to the ASH and appropriate management of Mr Campbell who was still a prisoner on remand.

35. On 28 July 2013 it was noted by RN Pauline Wilson of the ASCC clinic that Mr Campbell's condition was deteriorating. A meeting was held on 29 July 2013 between RN Dorian Dent of the ASCC clinic, Supt Yan, Supt Grant Ballantine and Deputy Supt Nicci Bell to discuss Mr Campbell and his condition. It was agreed at that time that the ASCC was "not the proper place" for Mr Campbell and in particular custodial staff were "extremely concerned" that they were "not equipped to handle terminal situations like this" and would not dispense medications. The desire of all was that Mr Campbell be provided appropriate care and agreement was reached to seek that he be provided one of the palliative beds at the ASH.

36. Following that meeting contact was made by the ASCC to the ASH seeking that Mr Campbell be admitted into one of their palliative beds. Further concern arose on 1 August 2013 after medical staff were unable to administer Endone to Mr Campbell as they had been unable to locate any Correctional officers to enter G Block with them. There was also concern that the prisoner that the deceased was sharing a cell with may "stand over" him in order to obtain his dangerous drug medications. Notably, the nurse on duty at the time, RN Julie Tasker, sent an email stating:

> "I have concerns that nursing staff are unable to provide the complex nursing care and subsequent medication requirements that will

become increasingly necessary for this Offender in this correctional setting".

37. On 2 August 2013 Mr Campbell was again taken to the ASH. He was initially seen in the Emergency Department and then referred to the Palliative Care team. His increasing pain was noted together with the difficulties in receiving his medications at night. As a result he was admitted into the ASH on that date for "end of life" care. During this admission he developed further dyspnoea (i.e. shortness of breath) and haemoptysis (i.e. the coughing of blood). He was noted to be cachectic (i.e. losing weight and muscle mass) and had a rapid decline until his ultimate passing on 17 August 2013.

Cause of Death

38. An autopsy was undertaken by Dr Jane Vuletic on 20 August 2013. Her report was tendered into evidence as part of exhibit 1. As counsel assisting indicated at the commencement of the inquest, the cause of Mr Campbell's death was uncontroversial and Dr Vuletic was not required to give evidence before me. Dr Vuletic noted the significant findings at autopsy to include the following:

    (i) "Metastatic cancer in the right lung, myocardium, liver, adrenal glands and ribs.

    (ii) Primary tumour presumed to be at hilum of left lung.

    (iii) Old cerebral contusions".

39. Dr Vuletic expressed her opinion that Mr Campbell died of cancer in the left lung metastatic to the heart, right lung, liver, pancreas and adrenal glands. I accept these findings.

Issues for further consideration

40. Issues raised for consideration during the course of this inquest were as follows:

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

40.2 The nature and standard of the care provided to Mr Campbell during his period of admission at ASH;

40.3 Whether all that could be done to provide an appropriate level of care to Mr Campbell for his terminal illness was in fact done by the relevant Departments involved.

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

41. Mr Campbell had been incarcerated since 10 April 2013. He was assessed by medical staff upon his incarceration and appropriately referred to a doctor for review. That review occurred promptly and in accordance with the automatic recall established on PCIS. There appears to have been some delay in the carrying out of an ultrasound requested by Dr O'Neill on 11 April 2013; however I do not consider that delay contributed to Mr Campbell's death and that there was nothing at that time to indicate any degree of urgency for that ultra sound to take place.

42. In May 2013 when the CT scan was performed, the irregular nodule revealed was already 14 x 12 mm. Various procedure were then carried out which revealed another nodule in the epigastric region, masses in the chest and a nodule in the adrenal gland. Further scans and examinations were conducted thereafter but clearly cancer was strongly suspected. As noted previously by 6 June 2013, less than 2 months after his incarceration, there was significant metastic disease including Mr Campbell's spine, ribs, lungs, lymph nodes and adrenal glands. As I stated during the course of the inquest, Mr Campbell was already "riddled" with cancer.

43. Once his illness was discovered I consider that all reasonable care that could be provided by Corrections staff was provided. There is no evidence to suggest any failure to attend to his needs and in fact the evidence makes clear that prison staff at the ASCC were extremely concerned that they were not able to provide an appropriate level of care for someone as sick as Mr

Campbell in a prison setting. I commend them for taking what was clearly a very humane approach and attempting to do all they could to provide for Mr Campbell in extremely difficult circumstances.

44. I consider the care provided to Mr Campbell during his period of incarceration at ASCC by both the medical staff at the clinic and the ASCC staffs was appropriate and satisfactory. In fact I consider that Mr Campbell received a standard of medical care during his incarceration that he would not otherwise have received in the community, particularly in light of his failures to attend follow up appointments in Queensland in 2011 and 2012.

<u>The nature and standard of the care provided to Mr Campbell during his period of admission at ASH</u>

45. I have already outlined the evidence given before me as to the care provided to Mr Campbell during his various admission to the ASH and then his final admission on 2 August 2013. It is clear to me that considerable effort was made by all members of medical staff at the ASH to initially discover what was wrong with Mr Campbell's health and then to determine whether anything could be done by way of treatment to save his life. Further, that once the diagnosis of cancer was made, it is clear that by that stage only "end of life" care could be provided and this was done.

46. I did raise concern during the course of the evidence as to whether Mr Campbell's final admission into ASH for palliative care in a hospital environment was "sub-optimal". I received evidence from Dr Goodwin as to the number of beds available and occupied during the period 27 July to 2 August 2013 when it was clear that Mr Campbell's condition was deteriorating rapidly. It is clear that on each of those days there were more beds occupied than is formally "authorised" (see exhibit 6).

47. I do consider that, upon the evidence, it would have been optimal for Mr Campbell to have been admitted at least a few days prior to his eventual admission on 2 August 2013 particularly given his clearly deteriorating state and the documented difficulties in providing him palliative care in the

prison environment. However, I note that he was regularly seen by experienced doctors in that time that formed the opinion that he could remain at the ASCC and that was their considered opinion until ultimately it was clear that keeping Mr Campbell in the "community" (which as a prisoner on remand meant the ASCC) was no longer appropriate. At that time staff at the ASH acted promptly and he was then admitted to the ASH for palliative care. I make no criticism whatsoever of the care provided to Mr Campbell at the ASH.

Whether all that could be done to provide an appropriate level of care to Mr Campbell for his terminal illness was in fact done by the relevant Departments involved

48. Providing care for a terminally ill person is difficult in normal circumstances. It is all the more complicated and difficult when that person is a prisoner on remand, awaiting trial and unbeknownst to that person they are already very ill by the time of their incarceration. The contemporaneous records made at the time show exchanges between staff at the ASCC and staff at the prison clinic which reveal that Mr Campbell's care and treatment was extremely important and of real concern to all involved.

49. The myriad of tests, investigations, assessments and consideration of possible treatment plans at the ASH reveals also that again Mr Campbell's care and treatment was also extremely important and of real concern to all involved. I therefore find that all that could be done to provide an appropriate level of care to Mr Campbell for his terminal illness was done by the relevant Departments involved. As a result I have no recommendations to make in relation to this inquest.

Decision

50. 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 Victor Albert Campbell who was born on 25 November 1949 at Charleville in Queensland.

ii. The time and place of death was approximately 5.00pm on 17 August 2013 at the Alice Springs Hospital.

iii. The cause of death was cancer in the left lung metastic to the heart, right lung, liver, pancreas and adrenal glands

iv. Particulars required to register the death:

   a. The deceased’s full name was Victor Albert Campbell.

   b. The deceased was of Aboriginal descent.

   c. The death was reported to the Coroner.

   d. The cause of death was confirmed by post mortem examination carried out by Dr Jane Vuletic on 20 August 2013.

   e. The deceased’s mother was Alma Jean Johnson (deceased) and his father was John Campbell (deceased).

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

Recommendations

51. There are no recommendations arising from this inquest.

Dated this 19th day of February 2015.

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GREG CAVANAGH
TERRITORY CORONER