CITATION: *An inquest into the death of Corey Paddy* [2000] NTMC 44

TITLE OF COURT:	Coroners Court
JURISDICTION:	Coronial
FILE NO:	9913563 71/99
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DELIVERED AT:	Darwin
HEARING DATE(s):	8,9 August 2000
JUDGMENT OF:	Greg Cavanagh SM

CATCHWORDS:

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REPRESENTATION:

Counsel:

Assisting	Elizabeth Morris
Territory Health:	Sally Sievers
Family:	David Dalrymple

Solicitors:

Territory Health:	Cridlands
Family:	Dalrymple & Associates

Judgment category classification:	B
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IN THE CORONERS COURT
AT KATHERINE AND DARWIN
IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. 9913563

In the Matter of an Inquest into the death of

COREY PADDY

FINDINGS

Cavanagh SM:

Nature and Scope of the Inquest

1. Corey Paddy was born on the 23rd of September 1973 in Darwin, and at the time of his death, was residing at the Katherine Hospital. Prior to hospitalisation, he resided at Bulla Community near Timber Creek. He was married with children. The deceased died on the 14th of June 1999 in the Katherine Hospital at approximately 1020hrs.

2. A "reportable death" under the Coroners Act is a death that appears to have been unexpected, unnatural or violent or to have resulted, directly or indirectly, from an accident or injury.

3. The death is such a "reportable death" which is required to be investigated by the Coroner pursuant to s14 (2) of the Act. The Inquest was held as a matter of my discretion.

4. The Act also contains my powers in relation to findings and comments as a result of this Inquest. These include:

> **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.*

And

> **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.

Formal Findings

a) The identity of the deceased person

The deceased was Corey Paddy. He is recorded on his birth certificate as Gorey, with no surname. His Aboriginal name was Nganitjpuru. He was born on the 23rd of September 1973 at Darwin, Northern Territory. He normally resided at Bulla Community.

b) The time and place death

The deceased died on the 14th of June 1999 in the Katherine Hospital at approximately 1020hrs.

c) The cause of death

The cause of death was positional asphyxia in a man with extensive old hypoxic brain damage, acute chest infection and concurrent morphine therapy.

d) The particulars needed to register the death under the *Births, Deaths and Marriages Registration Act*:

i) The deceased was a male.

ii) The deceased had resided all his life in Australia

iii) The deceased was of Australian Aboriginal origin.

iv) The deceased was not employed.

v) The deceased was not retired.

vi) The deceased was a pensioner.

vii) The deceased was married.

viii) The deceased had children.

ix) The father of the deceased was Jack Keller Bidjura Bigura.

x) The mother of the deceased is Jenny Ngoria Bangamun, also known as Jenny Paddy.

5. The Inquest commenced on the 8th of August 2000 in Katherine, and continued in Darwin on the 9th of August 2000. Ms Elizabeth Morris appeared as counsel assisting. Ms Sally Sievers sought and obtained leave to appear for Territory Health, and Mr David Dalrymple sought and obtained leave to appear on behalf of the deceased's family.

SUMMARY OF THE EVIDENCE

6. The witnesses called in the Inquest were

Tuesday 8 August 2000

1. Vivean Carol Boalar
2. Nicola Thea Fullerton
3. Margaret Anne Walton
4. Helen Mizen

Wednesday 9 August 2000

5. Timothy James Semple
6. Patricia Watson
7. Howard Desmond Flavell

8. Richard Byron Collins

9. Brett Allan Thompson

The exhibits tendered included:

1. Coronial Brief of Evidence
2. Medical Files from Katherine Hospital
3. Medical Files from Darwin Hospital
4. Adult Guardianship File
5. Report of Dr Peter Vuillermin
6. Statutory Declaration of Jenny Paddy
7. Statutory Declaration of Bernadette Morrison
8. Statutory Declaration of Marie Hughes

7. The evidence showed that on the 17th of April 1998 the deceased was the driver of a car that hit a tree. He was admitted to the Royal Darwin Hospital via the Katherine Hospital with a posterior dislocation of his right hip. On the 22nd of April 1998 he had a right hip arthrotomy and washout and removal of bony fragments. Subsequent to his anaesthetic he suffered post operative hypoxic brain injury. It has not been the intention of this Inquest to put forward and consider evidence as to the cause of that injury, but rather to present and consider evidence on the circumstances of the deceased's care as a person with hypoxic brain injury, and whether those circumstances contributed to his death.

8. The evidence also showed that painfully and sadly, the quality of life that the deceased was enduring was very low indeed. His

medical records show that other complications were osteomyelitis, heteroptopic bone formation and MRSA infections. He had lower lip trauma and ulceration due to biting with multiple healing abrasion on limbs and torso. He was often distressed and agitated, vocalising sounds with severe facial truncal and limb dystonic posturing. He appeared to be in pain on hip movement. He bit his finger tips and finger nails resulting in significant trauma. Medical staff were unable to fully communicate with the deceased. He fell from his bed on at least four recorded occasions. He was permanently bedridden.

9. The deceased was assessed at the Julia Farr Centre in South Australia, where he remained from the 8th of September 1998 to the 14th of October 1998. Testing there found that he was unable to follow commands or actively participate in activities and they were unable to assess his level of cognitive awareness. He was transferred to Katherine Hospital as it was thought (and properly so) that it was in his interests to be near family and country.

Circumstances surrounding the death

10. On the 14th of June 1999 the deceased was a patient at the Katherine Hospital. Ms Vivean Boalar was a cleaner at the hospital at that time. She went into the deceased's room, which he had to himself, at 10 minutes to 10.00am. Another cleaner, Ms Anne-Marie Bennett was in the bathroom of the room. Ms Boalar noticed that she could not see the deceased's face, as he was lying shortways across the bed, and his face was under the side cushions. His head was tipped back. She looked at the deceased, and then immediately fetched assistance.

11. Ms Boalar does not remember the bed having side pads on it. However from the other evidence presented I find that rails and side pads were in place at the time of the deceased's death.

12. Nurse Fullerton showered and cared for the deceased that day. She recalls the time as being 10.15am when she went into the deceased's room and the cleaners pointed out the deceased. She took the bolster off the deceased's face, and then called for the sister in charge the shift, Patricia Watson, for assistance. Nurse Fullerton noticed that deceased's head was "sort of back, but not like really extended back", and his mouth was open. Both nurses straightened the deceased in the bed, and a doctor arrived shortly after.

13. Nurse Watson gave evidence that the deceased was straight across the bed with his legs twisted back. The deceased's neck was balancing on the edge of the mattress and his head was back and chin extended. A bolster cushion was across his mouth and torso. She said "there's no way it was obstructing his breathing." (T- 91) Her opinion was that the deceased was dead when they found him. In her opinion resuscitation was going to be futile. Nurse Watson gave evidence of having cared for the deceased that morning, giving him morphine at 9.15am. She noted that prior to the morphine he had been agitated.

Decision to resuscitate

14. Dr Vuillermin attended and also determined that it was inappropriate to attempt resuscitation. The Doctor's supervisor, Dr Brett Thompson then attended and came to the same conclusion. Dr Thompson in his evidence to the Coroner stated

> We had someone who was profoundly injured, who's had an unknown period of hypoxia and because of that I felt, you know, that we were – if we were successful in resuscitating him, he in fact would be – that's even a worse compromise than we was already. ….I think given any situation likely in a hospital where we followed someone who's, who's been in arrest for an unwitnessed period of time, particularly with a condition that is serious, sometime resuscitative attempts are not commenced. But no value judgment there of the worth or otherwise of his life.
>
> The Coroner: Are you saying, Doctor, that it was a medical decision? ---A medical decision, yes.
>
> And made in pursuance of your oath and based upon your training and experience?---Yes, I am.
>
> Thank you.---and the initial decision had been made by other parties and I just – guess I came along and condoned that decision. (T-117)

15. I find the decision not to attempt resuscitation was an appropriate one.

Management and care of the deceased

16. There is no doubt from the evidence that nursing the deceased was a difficult and challenging role. Nurse Fullerton says

> He used to get quite upset when you touched him or tried to do anything for him. He'd try and push you away with the arm that he could move. He'd cry out. More so if you were trying to, you know, reposition him or clean him up and he used to sweat quite heavily as well, so you know, bed changes and things had to be done because he'd be wet. And he used to get quite upset when you tried to do these things for him…..He'd cry out. He'd try and push you away with his arm and just – just sort of appeared really upset. (T-18)

17. Margaret Walton also gave evidence. She is an experience nurse who has been nursing since 1968. It was part of her duties to do a nursing care plan for the deceased.

18. She gave evidence of the problems the deceased had with his bed, and the extent to which the Hospital tried to solve those problems. They tried padded rails and bumpers. They nursed him on the floor for a while, but it was difficult for nursing staff due to backache. They considered and dismissed the idea of a bed with high sides all round. They elevated the bed to try and prevent the onset of pneumonia.

19. She thought that the deceased sweated a lot from pain. Despite his state of health he appeared to her to be a very strong man still, and used to wedge a foot into the side of the bed rails and push himself around. She did not see that he necessarily became calmer outside on the verandah.

20. The evidence also disclosed that shortly prior to the deceased's death, he was found to have maggots in one ear. Nurse Walton considers that it was "unfortunate" but not poor nursing. She claims that because of his chronic ear infections the site would have been inspected regularly by nurses.

21. It was also a concern that he would end up with a pillow on his face, thereby leading to suffocation. The softer pillows were removed for that reason.

22. When asked about the level of nursing care Katherine Hospital was providing, Nurse Walton answered thus:

> Do you think he was a patient who required a greater level of nursing care than Katherine Hospital was providing, ie one to one nursing care?---He – he did

> require a lot of nursing care and every – every moment he was awake, somebody basically was with him. You couldn't leave him. If we were too busy to look after him, I used to call the orderlies down to sit with him, until we were --- (T-43)

23. Nurse Walton also gave evidence that on average there would be 22 to 24 patients in the ward. The ward was divided into two sides and that a team of two nurses would take each side. There would usually be a nurse in charge. On the deceased's side of the ward, the maximum number of patients was 12. However she felt that competent experienced nurses should be able to handle that number, even when a patient was requiring a high level of care.

24. Nurse Watson did not feel that the deceased needed a full time carer, although she regarded herself as giving one to one type nursing. She says the deceased was left on his own, but was checked frequently. Nurse Walton stated that "every moment he was awake, somebody basically was with him. You couldn't leave him. If we were too busy to look after him, I used to call the orderlies down to sit with him…" (T – 43)

25. It is clear from the evidence of the nursing staff involved with the care of the deceased that he was a challenging patient with high level needs. It is also clear that his distress and situation was felt with sympathy by the nurses who gave evidence at the Inquest.

26. Their evidence regarding the level of care however, is not supported by the observations of the deceased's mother, who has sworn a statutory declaration which has been tendered in evidence. She states that

a) I never saw any plastic coverings over the side of my son's bed when I visited him at the Katherine Hospital.

b) The last time I visited him was Friday 11/6/99, which was the Friday of the Barunga Festival weekend. I visited him on that occasion together with Regina.

c) My son had some of his own clothing together with some of his other property in a suitcase which was held at the Jack Roney Ward. During the time that my son was in Katherine Hospital I never say him wearing any of his own clothing, and I only ever saw him wearing a big nappy.

d) I also can't remember ever seeing him with a sheet over him, even though it was quite cool in the air-conditioned ward, especially when the dry season came.

e) On no occasion when I visited my son in the Hospital did I ever see him sweating.

f) There were times when I went to visit my son when I found him completely alone, either in the ward or outside in the verandah area at the entrance to Jack Roney ward.

27. Due to the nature of the care required by all patients in the ward, it would have been impossible for the deceased to be watched 24 hours a day. His bed placement was such that it was visible from the nurse's station, however if the ward was busy, then the nurse's attention must have been diverted to other matters at times. A statement from Elaine Watts indicates a time when the deceased was on the verandah, and appeared uncomfortable. She does not recall a nurse being present, and she mentioned the deceased to nursing staff, but did not see him being attended to. She also had concerns that he was not well clothed during her visits to the hospital.

28. His health care plan involved a balance between various factors, such as attempting to be close to family, home and cultural ties, and providing expert up to date medical attention, as well as

attempting to ensure a safe environment. Dr Flavell mentioned these difficulties in his evidence as to the deceased's placement at Julia Farr. "Katherine Hospital would be a far more appropriate setting for someone like Corey from a remote community to be managed…" (T-101)

29. A few days prior to his death, the evidence disclosed that the deceased had a flyblown infested ear with live maggots. This is despite evidence that the deceased received daily bathing and washing from nursing staff. The deceased, by some witnesses' accounts appeared to be happier outside on the verandah. As he was not able to disrupt flies from his infected ear, one can suppose that that is where the maggot infestation occurred. Sanitation would be greater in a controlled environment, (such as his air-conditioned hospital room) but at the cost of the deceased's enjoyment of an open-air facility. However the infestation is of significant concern to me, when considering the level of care that the deceased received.

30. In my view the shift nurses and orderlies did their best to care for the deceased (at the same time caring for all the other patients on the ward). However I find that the standard of care the deceased received was just or barely adequate in the circumstances of his condition. That it was just or barely adequate is explainable, but not excusable, by the very difficult nature of the deceased's presentation as a patient.

31. Katherine Hospital is a small country hospital, and the staff did their best, however more resources ought to have been provided in order for the provision of better care to the deceased.

32. Attempts were made by hospital staff to involve the deceased's family in his care. This involvement is certainly desirable and was the recommendation of Dr Flavell. However it is also clear that there was a breakdown in communication between family members and health providers. Family members did not attend an arranged meeting until some six hours after it was scheduled on the 6th of May 1999. The Katherine Hospital employed an Aboriginal Liaison Officer, Ms Bernadette Morrison, who knew the family of the deceased. Ms Morrison had contact with family members at various times, but issues were not raised with her about the deceased's care. It is clear the Hospital had made some attempts to involve the family in the deceased's treatment. It is not clear why these attempts were largely unsuccessful.

Level of medication

33. Dr Tim Semple, Staff Specialist at the Pain Unit Royal Adelaide Hospital provided a report to Ms Sievers which has been tendered. In it he states

> Throughout the notes, it is apparent that from the time of his hypoxic injury through to the time of his death Mr Paddy exhibited frequent episodes of agitation and distress. Review of nursing commentary for the last month of his life suggest that this occurred on most days. It appears that the perception of those people treating this man was that some of these episodes of clear distress were caused by pain and required treatment for pain relief.

34. He concludes that is was appropriate to prescribe morphine for these conditions, and that increased dosages had occurred relatively slowly and without apparent adverse effect over many months.

> The reported high blood Morphine level of 0.12 mgs/litre is consistent with the therapeutic level in the setting of doses utilised for Mr Paddy. Whilst this blood level would possible be lethal in an individual without previous exposure to Morphine, I believe this is unlikely the circumstances of Mr Paddy.

35. Nursing staff indicated that the deceased did settle after medication, and appeared less distressed. Dr Flavell gave evidence that his preference would be to minimise the amount of narcotic, but that if someone is obviously in distress, that has to be managed.

36. I find that the deceased was in pain. Whilst the deceased's mother, during her visits, did not notice that the deceased was in pain, the evidence from the medical records and the nursing staff is overwhelming. Dr Flavell comments that there was evidence of pathology present that in an able bodied person would have led to significant amounts of pain. (T-104)

37. I also find that the level of opiate prescription was escalating, but was appropriate, necessary and reasonable, and that it was a factor in a combined set of circumstances that led to the death of the deceased. I concur with the submissions for Counsel for Territory Health Services, who refuted the allegation that medication for sedation was given to make dealing with the deceased easier for nursing staff.

38. Counsel for the family has suggested that family members should have been consulted as to the extent of pain the deceased was suffering and as to the subsequent increase in medication to control that pain. This is something which should have occurred over the time the deceased was in hospital in discussion between family and hospital staff. However, the day to day management

needs of the deceased's condition needed to be met by the professional staff charged with that care. Not all decisions, including the increase of medication, could be immediately advised to family members.

Pneumonia

39. That the deceased had pneumonia is of course, cause for concern, although not unusual. Doctor Flavell gave evidence that people with the degree of disability of the deceased seem to be much more prone to pneumonia and respiratory complications. (T-101) Nursing staff attempted to address this by propping the head of the bed the deceased was using. The deceased's temperature was taken the day before death, and he did not exhibit signs of fever. Pneumonia can onset very quickly.

40. Upon postmortem examination, it was found that the deceased was suffering from broncho-lovular pneumonia. Initially the Forensic Pathologist, Dr Collins, ascribed this condition as a greater contributing factor to the death of the deceased than other factors. However, after consideration of the evidence, including listening to the evidence of Nurse Watson, the doctor placed slightly lesser weight on the contribution of the pneumonia. The pneumonia was not a "particularly florid infection", and was unlikely to have caused death by itself.

Deliberate self-harm

41. There has been some question raised as to whether or not the deceased's actions on the 14th of June could be a deliberate attempt to suffocate himself or cause self harm. He had harmed

himself previously, through biting his fingers and his lip. He was also known to pull out his feeding tube.

42. When asked about capacity for self harm, Dr Flavell answered

> I think that's an extremely difficult question to answer. I mean, I think we're dealing with someone that although I understand he spoke English beforehand, that his – obviously his native tongue was an Aboriginal language as I understand it, and in terms of really being accurately able to assess someone both from a language and cultural perspective, it's extremely difficult for someone like myself. I gained the impression at times that Corey had some understand of English, but I mean, I really wasn't very clear about that and that ws only in a very limited sense……there was a question that was raised as to whether Corey was depressed and I guess to be depressed you have to have some insight into you circumstance and I really fell hopelessly unqualified to comment from a cultural perspective and from a language perspective as to whether Corey was depressed. I mean, I guess it's possible and very, very difficult to know in the circumstances. (T –102)

43. There is insufficient evidence to show that the deceased intended to end his own life.

Dated this 31st of October 2000

Greg Cavanagh

Territory Coroner