CITATION: *Inquest into the death of Freddie Peterson* [2006] NTMC 080.

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Alice Springs
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DELIVERED AT:	Alice Springs
HEARING DATE(s):	27, 28, 29 June 2006
FINDING OF:	Greg Cavanagh SM
CATCHWORDS:	Death in Custody, Natural Causes Care and supervision of deceased in custody

REPRESENTATION:

Counsel:

Assisting:	Ms Helen Roberts
NT Correctional Services:	Ms Penny Turner
Dr Chris Wake (Corrections Medical Services)	Mr Roger Bennett

Judgment category classification:	A
Judgement ID number:	[2006] NTMC 080
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0052/2005

In the matter of an Inquest into the death of
FREDDIE PETERSON
ON 24 JULY 2005
AT ALICE SPRINGS HOSPITAL

FINDINGS

(Delivered 2 October 2006)

Mr Greg Cavanagh SM:

INTRODUCTION

1. Freddie Peterson, the deceased, was an Aboriginal man born on 13 October 1974 in Alice Springs in the Northern Territory. He was originally from Papunya and he usually lived there. He died on 24 July 2005 in the Alice Springs hospital after a month-long illness. At the time of his death, he was a person detained in custody at Alice Springs Correctional Centre and therefore he was a person in custody within the meaning of the *Coroners Act* and the holding of this inquest was mandatory.

2. Pursuant to section 34 of the *Coroners Act*, I am required to 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;"

3. In addition, as this is a death in custody, section 26 of the *Coroners Act* applies. That section provides:

   "(1) Where a coroner holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody, the coroner –

> (a) shall investigate and report on the care, supervision and treatment of the person while being held in custody or caused or contributed to by injuries sustained while being held in custody; and
>
> (b) may investigate and report on a matter connected with public health or safety or the administration of justice that is relevant to the death.
>
> (2) A coroner who holds an inquest into the death of a person held in custody or caused or contributed to by injuries sustained while being held in custody shall make such recommendations with respect to the prevention of future deaths in similar circumstances as the coroner considers to be relevant."

4. Ms Helen Roberts appeared as counsel assisting me in this inquest. Ms Penny Turner of the Solicitor for the Northern Territory sought and was granted leave to appear on behalf of Northern Territory Correctional Services. Mr Bennett of counsel sought and obtained leave to appear to represent the interests of Dr Chris Wake. The sister and brother of the deceased attended the inquest. They had sought some advice from the Central Australian Aboriginal Legal Aid Service, which had been provided with a copy of the brief from my Office. The sister had been advised that she did not qualify for Legal Aid due to her income (she is the principal of a community primary school). In any event, the family were able to discuss the matter with counsel assisting the Inquest and will be provided with a copy of these findings. I welcomed them to the Inquest and acknowledge their respect of the process.

5. The issues in this matter were ultimately not complex. An investigation was undertaken into the circumstances of the death by First Class Constable Barrie Bahnert and the brief containing statements from relevant witnesses was tendered (Exhibit 2). In addition, two prison officers and three medical practitioners were called to give evidence before me about the circumstances of the deceased's illness and the response to his illness by Correctional Services. I have found no criticism of that service with respect to their

dealings with this deceased prisoner, nor have I found it necessary to make any formal recommendations concerning this death.

FORMAL FINDINGS

6. Pursuant to section 34(1) of the *Coroners Act*, I find:

   (a) the identity of the deceased person is Freddie Peterson born on 13 October 1974 in Alice Springs;

   (b) the time and place of death was 9:20pm on 24 July 2005 at Alice Springs hospital;

   (c) the cause of death was diffuse alveolar damage, a complication of bacterial endocarditis;

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

      (i) the deceased was a male person of Aboriginal origin;

      (ii) the death was reported to a coroner on 24 July 2005;

      (iii) the cause of death was as stated above;

      (iv) an autopsy was carried out by Dr Terrence Sinton on 28 July 2005;

      (v) the deceased's usual residence was Papunya in the Northern Territory;

      (vi) his mother's name was Punata Nabarula Kawindji;

      (vii) the deceased had no usual occupation.

CIRCUMSTANCES

7. The deceased was a 30 year old Aboriginal man from Papunya. He had spent some time over his adult life in short to medium periods of custody at the Alice Springs Correctional Centre, primarily for offences relating to driving and stealing. He had a problem with alcohol, which was apparently the source of his offending behaviour, and also resulted in poor health. He had

Type 2 diabetes, chronic pancreatitis, and was often malnourished or underweight. On 19 January 2005 he was sentenced to a total of nine months imprisonment at the Alice Springs Correctional Centre, commencing 14 January 2005.

8. At that time, medical care and treatment to prisoners at Alice Springs Correctional Centre was provided by Corrections Medical Services (the principal of which is Dr Christopher Wake), by a means of contract between that company and Northern Territory Correctional Services. Upon admission to the prison, the deceased underwent an appropriate medical 'reception'. That included various tests, one of which recorded a high blood sugar level. He was seen by Dr Chris Wake on 20 January and was prescribed Ranatidine for gastrointestinal problems (related to chronic alcohol abuse).

9. Dr Wake had treated the deceased previously due to his regular periods of custody in Alice Springs goal. On 20th January, as with other admissions, he was "quite grog sick". At that time Dr Wake treated him only for his gastritis. He explained (at transcript p 27):

> "I specifically did not treat his diabetic condition, even though his sugar was moderately raised, because the use of the drug Metformin, which is the standard diabetic drug we use in this situation, can tip a sick man over into being very acutely sick, in hospital care, so I made a positive decision not to treat him at that time. Because he had an admission late the year before, November, I think, he was automatically put down for a full diabetic review at that time, this is in January, which was to occur in February some time … and that, in my mind, was the elected time to consider whether or not we would treat his diabetes."

10. The deceased was housed at the Cottages, the low security section of the prison, housing about 80 prisoners in total. Those prisoners were involved in work parties, both in and outside the prison. The deceased worked in a group that did general gardening and cleaning work within the prison grounds. He was generally a quiet prisoner who did not make complaints.

11. The deceased saw Dr Wake again on 4th February, explaining that his gastrointestinal symptoms had resolved, and so the Ranatidine was ceased. He next saw Dr Szabo for his scheduled diabetes review on 18 February 2005. Dr Wake explained that it is better to delay this review until a few weeks after a prisoner has been admitted, as after a few weeks without alcohol and with regular meals, their general health is usually much better. The evidence before me was that due to the prevalence of diabetes among Aboriginal prisoners, there was a systematic approach to review and care of such patients.

12. Dr Szabo practises principally in Victoria, but has spent periods of locum work at Alice Springs Correctional Centre over the past few years. When he gave evidence before me, he did not have a specific recollection of the consultation with the deceased, but was able to rely on the medical notes, his interview with police shortly after the death, and his usual practice. The notes are brief, and state: *doesn't want diabetic meds. Will cease*.

13. Dr Szabo explained that his normal procedure with a prisoner reluctant to take medication would be to find out why, and then try to educate the patient as to why the medication was required and the consequences of not taking it. In the case of Type 2 diabetes, the medical consequences of not taking the medication was an increased risk of diabetic complications which include blindness, heart disease, strokes, leg ulcer, peripheral vascular disease and so on.

14. However, as both Dr Wake and Dr Szabo explained, because patients with diabetes do not feel sick, it is common for such patients to be reluctant to take medication. Dr Szabo said (transcript 19):

> "…because people with diabetes feel well. They don't feel as though they are sick. And unless someone's got a very very good grasp of what it means to have a high risk of a future illness, people don't feel the need to be taking a tablet..."

15. I accept Dr Szabo's evidence that he would have followed his general practice in this case and explained the risks to the deceased, in an effort to ensure that the deceased was making an informed decision not to take the medication. This is consistent with Dr Wake's knowledge of the deceased, whom he knew very well. Dr Wake said (transcript 31):

> "What, in your experience, was his general approach to medical care and medical matters? - When he was sick he would take medication. He couldn't be prevailed upon or forced to take medication ... he was an experienced prisoner....if he felt sick, he would take medication, and if he didn't feel sick he wouldn't."

16. On the morning of 24 June 2005, a group of prisoners presented to Prisoner Officer Baxter and said to him "Peterson is not very well, he's in pain". PO Baxter went to the dormitory immediately and said in evidence that he could see just by talking and looking at the deceased that he was "very sick". The deceased said "I can't move my legs boss". Prison Officer Fisher contacted the medical centre. Two Officers carried the deceased from his bed to the medical centre. From there, an ambulance was called and the deceased was transferred to Alice Springs hospital.

17. The deceased advised hospital staff that his pain had been present for about one week. Certainly this may have been the case. However, I also accept from the oral and documentary evidence, that the complaint on the morning of 24 June was the first complaint the deceased had made to a prison officer, or any medical staff at the prison, that he was unwell. Furthermore, I find that during this period it was not obvious to anyone that the deceased was as unwell as he turned out to be.

18. Dr Brady, head of the Department of Medicine at Alice Springs goal hospital, was involved in the clinical care of the deceased once he was admitted. The deceased presented from the prison on the morning of 24 June, with the initial complaint of leftsided pain, reportedly present for one week. He had a fever, high pulse rate and high blood sugar level. A number of investigations were performed. Ultimately (that same day) a diagnosis of

bacterial endocarditis was considered to be most likely and a number of antibiotics were commenced. Bacterial endocarditis is a bacterial infection of one of the heart valves. It follows an abnormality of the heart valve (either congenital or as result of rheumatic heart disease) and circulating bacteria in the bloodstream.

19. Dr Brady in his evidence stated (transcript p.23) quote:

> "Doctor, you're the head of the Department of Medicine at Alice Springs Hospital?
> ---Yes.
>
> You had a role in the clinical care of the deceased, Freddie Peterson, who died on |24 July 2005 at Alice Springs Hospital?---I did.
>
> You've provided the Coroner with a three page report and then a subsequent short statement with respect to various medical issues surrounding his care?---I did.
>
> THE CORONER: Is that in the brief?
>
> MS ROBERTS: It is, at number 10, your Honour.
>
> THE CORONER: Thank you. He was a very sick man, Doctor?---He was a very sick man when he came in, so I looked after him very briefly from when he arrived from the prison, saw him that afternoon when he was transferred to the Intensive Care Unit and then went down to Adelaide the next morning, so that was limited, my sort of involvement in his care. But when he arrived he was, yeah, extremely ill."

And p.23 & 24:

> "MS ROBERTS: Dr Brady, you've also had the opportunity to have a look at the autopsy report related to this matter?---Yes I have.
>
> If you could assist us by explaining, first of all, what bacterial endocarditis is?---Okay. Bacterial endocarditis is a bacterial infection, endocarditis refers to the valves in the heart, so it's a bacterial infection of one of the heart valves. So it usually occurs when patients have a bacteraemia, ie, that means they have got bacteria going around in their bloodstream, they lodge on the heart valves and in about three-quarters of the cases this is because the heart valve is abnormal in some way, either because of rheumatic

heart disease or of a congenital abnormality. And this means that there's

abnormal turbulent flow around the valve so that bacteria are much more likely to lodge there, and then the bacteria start growing. And when they grow they form what's called vegetations on the valves, which are growths of bacteria, and those vegetations are exposed to ongoing blood flow and often break off and send bacteria all round the body, and so you can get little focuses of infections disseminated throughout the body, including in the brain, and you can get what are called mycotic aneurysms, where you get the bacteria growing in the walls of the blood vessels in the brain and these are likely to bleed."

20. The forensic pathologist (Dr Sinton) opined in his Autopsy Report (p.8 & 9):

> "3. A possible sequence of events leading to his death, based on the autopsy findings above, might be as outlined below.
>
> (i) It remains a strong possibility that, prior to his sudden onset of illness in June 2005, he had pre-existing heart valve disease, possibly from previous rheumatic carditis. It is also a likely possibility that he had oral inflammatory disease at the same time, as a consequence of chronic poor dental and oral hygiene.
>
> (ii) The combination of the two factors in (i) above is known to produce the condition called bacterial endocarditis, this being bacterial inflammatory disease of one or more heart valves. By the nature of the function of the heart valves, bacterial endocarditis may cause physical damage to affected valves, leading eventually to heart failure.
>
> (iii) Another well recognised complication of bacterial endocarditis is the development of "vegetations" on the affected heart valves. Acutely, these vegetations consist of bacterial colonies, and fibrin from the resulting inflammation. They can vary in size, and are very fragile and friable. They were seen in this man's heart on imaging studies in the Royal Adelaide Hospital. Classically, these infected vegetations, or parts thereof, may break away from the heart valve, pass into the blood stream, and impact as emboli in widely separate parts of the body. The clinical results of this embolisation (ie blood vessel blockage) depend in part on where precisely these fragments impact, but in this particular case, there was evidence of recent infarction of his spleen and both

kidneys, as well as localised abscess formation in his brain.

(iv) The passage of bacterially infected emboli may result clinically in acute septicaemia, a condition also noted in this man's medical history.

(v) The gangrene of his left foot was likely to have been caused by blood clot formation in his left leg, possibly secondary to acute septicaemia, although he reportedly underwent an operation for the removal of this blood clot in Royal Adelaide Hospital.

4. The use of antibiotics in this man's treatment just prior to his death was likely to have modified the subsequent pathological findings at autopsy, notably the damage to the mitral valve in his heart.

5. The severe pancreatic damage was likely to have arisen from events other than the bacterial endocarditis, in particular chronic alcohol toxicity, but would have acutely compounded the effects of the endocarditis.

6. Given the history and autopsy findings, he died from diffuse alveolar damage consequent on bacterial endocarditis, the effects of these conditions compounded by associated damage to the heart, brain, liver, spleen, kidneys, and pancreas."

21. The bacteria was staphylococcal aureus, a bacteria commonly found on the skin and in the nose (more commonly in diabetics than people without diabetes). Untreated diabetes carries with it an increased risk of infection. For that reason, the decision not to recommence the deceased's diabetes medication was explored with the witnesses in this inquest. I find that decision was made by the deceased, and that the risk of doing so was appropriately explained to him. Further, there is no evidence that the failure to take the medication made a direct contribution to his death, or even, in fact an indirect contribution. Certainly his general state of poor health would have contributed. However, I accept Dr Wake's opinion, that overall, this man (as with many others) was probably healthier after a few months in custody than when he was at liberty, given the routine of food, no alcohol, and accessible medical care. I note that the deceased was a low security

prisoner who worked outdoors, and therefore generally presented as well enough to work on a daily basis.

22. At the time the deceased was admitted to hospital he was extremely unwell. He had evidence of infection in several places in his brain, and absent blood flow to the legs due to the vegetations. Although all emergency and other medical treatment was provided to the deceased (including transfer to Royal Adelaide hospital for cardiac and neurological consultations) there was ultimately nothing that could be done for him. This was explained to family members. He died at Alice Springs hospital under palliative care on 24 July 2005.

23. The deceased was a very sickly man and a chronic alcoholic with diabetes, chronic pancreatitis, chronic hepatitis and coronary atherosclerosis. Simply put his body was unable to resist the infection which spread to his heart and killed him.

CONCLUSION

24. I am satisfied on the basis of the investigation and the evidence I have heard at this inquest that the care, supervision and treatment of the deceased prisoner was appropriate, and that he died from natural causes. There was no want of care by authorities that contributed in any way to his unfortunate death. I have no recommendations to make in relation to this death.

Dated this 2nd day of October 2006.

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GREG CAVANAGH

TERRITORY CORONER