CITATION: *Inquest into the death of Damien Hughes* [2013] NTMC 022

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0174/2012
DELIVERED ON:	30 September 2013
DELIVERED AT:	Darwin
HEARING DATE(s):	2 September 2013
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	**Death in Custody, natural causes**

REPRESENTATION:

Counsel Assisting:	Mr Mark Thomas
Counsel for Correctional Services:	Mr Ray Murphy
Counsel for the family of the Deceased:	Mr Matthew Fawkner

Judgment category classification:	A
Judgement ID number:	[2013] NTMC 022
Number of paragraphs:	41
Number of pages:	13

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

No. D0174/2011

In the matter of an Inquest into the death of

DAMIEN HUGHES
ON 26 SEPTEMBER 2011
AT HOSPICE – ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. On 30 November 2010 the deceased, Mr Damien Hughes was sentenced in the Supreme Court of the Northern Territory of Australia for the offence of manslaughter. He received a sentence of imprisonment that was comprised of a head sentence of seven years and two months and a non-parole period of three years and seven months. The sentence was backdated to the time that he went into custody for the offence that he had committed, which was 16 May, 2009. His release date to parole, which was subject to the approval of the parole authorities, was 16 December 2012.

2. Notwithstanding that Mr Hughes died in the Hospice of Royal Darwin Hospital "(RDH)", he was at the time of his death in the custody of the Northern Territory Department of Correctional Services. Accordingly, I find that this was a death in custody, pursuant to section 12 of the *Coroner's Act*. Section 15 of that *Act* requires that this inquest be held.

3. Mr Mark Thomas appeared as Counsel Assisting me in this Inquest and Mr Ray Murphy appeared for the Northern Territory Department of Corrections. Mr Matt Fawkner appeared for the mother of the deceased who was present throughout the Inquest.

4. Mr Hughes's death was investigated by Detective Senior Constable Josh McDonald who has since left the Northern Territory Police Force to join the Queensland Police Force. Police officer Tanja Ward replaced him in this matter. I received into evidence the brief that was compiled by Detective McDonald. In addition, I heard evidence from Ms June Woods, Dr Paull Botterill, Ms Joanna Rositano, Dr Mohamudally and Dr Michael Lowe.

5. Pursuant to section 34 of the *Coroners Act* ("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;
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> (ii) the time and place of death;
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> (iii) the cause of death;
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> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

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

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

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

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.

(3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

8. Where there has been a death in custody, pursuant to section 26(1) and (2) of the Act a coroner:

"(1) Must investigate and report on the care, supervision, and treatment of the person being held in custody; and

(2) May investigate or report on a matter connected with public health or safety or the administration of justice that is relevant to the death."

Background

9. On 23 April of 2012 Berrimah Prison medical officer, Dr Robyn Walker referred Mr Hughes to RDH's emergency Department for treatment. Mr Hughes had provided to Dr Walker a two week history of an expanding lump over his sternum. On 26 April 2012 a CT scan revealed that Mr Hughes had a tumour in the mediastinum (the central compartment of the thoracic cavity) that had eaten through the front of the sternum and was causing a lump there. Dr Michael Lowe, Consultant physician at RDH, who was one of the doctors treating Mr Hughes was of the opinion that he had cancer and that it was probably incurable.

10. On 27 April 2012 pathology results and a biopsy confirmed that the mass in Mr Hughes's chest wall was cancer, specifically adenocarcinoma.

11. On 3 May 2012 Mr Hughes's condition was discussed by a multi-disciplinary medical team. The findings of this team were that the cancer was incurable and that neither the chest wall mass nor the left lung mass could be surgically removed. The primary cancer was thought to have originated in the left lung. Further tests were to be conducted. Initially

radiotherapy followed by chemotherapy was to be administered to Mr Hughes.

12. Subsequent to this point Mr Hughes went back and forth from the hospital to Berrimah detention centre.

13. On 11 May 2012 Mr Hughes's doctors explained to him that the cancer was incurable and that the treatment was palliative, that is, it would not cure the cancer. A "Do not Attempt Resuscitation Order" was put in place with Mr Hughes's consent.

14. On 21 August 2012 Mr Hughes was readmitted to RDH with acute pain. He was admitted to the Hospice the RDH hospital and remained there until his death.

15. Prison authorities granted him a leave of absence from the Darwin Correctional Centre at Berrimah pursuant to section 63(d) of the *Prisons (Correctional Services) Act* for the purpose of Mr Hughes receiving end of life treatment. This meant that Mr Hughes no longer needed to be accompanied by a prison officer. However, he remained in lawful custody of the Northern Territory Department of Correctional Services.

16. On 26 September 2012 Mr Hughes entered the terminal phase of his illness. He died at 4.55pm on this day in the presence of his uncle.

17. The condition directly leading to death was bronchopneumonia, which was caused by Metastatic lung cancer.

18. Mr Hughes was of Aboriginal descent and was 28 years old at the time of his death. Mr Hughes had smoked cigarettes on a regular basis since his youth.

Relevant circumstances surrounding the death

Background of Mr Hughes

19. Mr Hughes was born in Katherine on 11 March 1984. He had one brother and one sister. His sister passed away in 2011. He attended school in Katherine; he liked school and enjoyed basketball in particular. He left school at the end of year 10. He later met a young woman and married her in the traditional Aboriginal way. His wife gave birth to a young child. On 15 May 2009 Mr Hughes killed his wife and it is in respect of this crime that he received the sentence of imprisonment that he was serving at the time of his death.

The nature of Mr Hughes's cancer

20. I have received evidence in this inquest from Dr Michael Lowe, an experienced physician who was a senior doctor involved in the treatment of Mr Hughes. He has stated to this Inquest that the cancer that Mr Hughes had that ultimately killed him was rapidly growing and aggressive. Secondly, the incidence of this cancer, adenocarcinoma of the lung, for persons aged 28 years of age is extremely rare. Dr Lowe referred to a graph from the Australian Institute of Health and Welfare, which stated that only 15 men aged less than 40 were diagnosed with this sort of lung cancer throughout the whole of Australia in the year 2007. This is important as there had been a question raised during this Inquest on behalf of the family of the deceased as to whether the cancer could have been diagnosed earlier, and if so, the life of Mr Hughes might have been prolonged.

Could Mr Hughes have been diagnosed with cancer earlier, such that his life could be prolonged?

21. To deal with this question it is necessary to deal with what material the Doctors had available to them prior to Mr Hughes's diagnosis of cancer on 27 April 2012. Firstly, I note that Dr Lowe, whose evidence I accept

entirely, was able to review the prison medical notes on the patient care information system as well as the hospital records. Dr Lowe noted that Mr Hughes had entered the prison without tuberculosis but at some point he had a positive Mantoux test, which meant that he had been exposed to tuberculosis. This would appear to have occurred in the prison. He then came under the care of the tuberculosis team whose treatment of him ceased on 26 October 2011. Dr Lowe observed that an X ray had been conducted in December 2010 of Mr Hughes's lungs, which indicated that the later site of the cancerous tumour was normal.

22. Dr Lowe then added that the medical notes revealed that Mr Hughes had, as at September 2011, a painful right shoulder. Dr Lowe observed that the medical notes stated that there was no history of injury or any apparent cause. The notes said that it had been painful for several weeks. It appears that the initial consultation in this regard was on 7 September 2011; he was seen again by a Doctor on 12 September 2011 when it was found at that point to be no longer painful.

23. Dr Lowe also noted that Mr Hughes had seen medical staff in September 2011 in relation to knee pain, for which he was required to do a series of exercises. There was follow up consultation with physiotherapists in November 2011 in relation to this matter. His last physiotherapy appointment was on 22 November 2011.

24. Dr Lowe then referred in evidence to a sore throat and cough that Mr Hughes stated that he had in February 2012, which had persisted for a couple of months with some lethargy. Dr Lowe observed that the medical notes indicated that he was examined and his chest was clear.

25. Dr Lowe observed that in February 2012 Mr Hughes complained of pain to his left shoulder, which had occurred on an intermittent basis, with pain radiating down to the costochondral junction at the front and down to the muscles at the back. Dr Lowe noted that the medical notes revealed that the

treating Doctor (Doctor Walker), who was a member of the prison medical staff, was looking at the question of rotator cuff tear. She prescribed analgesics and physiotherapy. On 21 February 2012 an ultrasound was ordered of the left shoulder. Some delay appeared to have occurred here before the ultrasound was performed. In any event on the 2 April Mr Hughes was again seen in the prison medical clinic. It was again noted that the pain was intermittent and that it had started again in that week when lifting something heavy. Swelling was noted to the left shoulder and to the chest. The ultrasound was noted as having been done, however, the report that specified the results had not been completed.

26. On 23 April 2012 Mr Hughes was referred to the emergency department of RDH for new swelling to the chest. He then had an X ray that showed a mass in the left lung with involvement of the mediastinum. On the same day he had a ultrasound. He was returned to the prison and called back the following day for a CAT scan. He was then admitted under the care of Dr Lowe.

27. Dr Lowe was asked about the appearance of a hoarse voice at around this time. He responded by stating that this would be suggestive of laryngitis or something similar to that.

28. Mr Thomas asked Dr Lowe whether the cancer could have been diagnosed earlier than what it was. Dr Lowe replied by observing that the pain in the left and right shoulder would be suggestive of a diagnosis of a musculo-skeletal problem. He noted however that the swelling in the chest did not quite fit with that diagnosis, however it was also significant that he had swelling in his shoulder and that it was likely that he had injured his arm. Dr Lowe stated that the swelling in the chest consisted of the lymph nodes eroding through the sternum, which meant that the cancer was very advanced at that stage. Dr Lowe stated that in fact it would be already too

late to cure it at that point as a consequence of how advanced it was and how quickly it was moving.

29. Therefore, Dr Lowe expressed the opinion in his evidence that there was no reasonable basis for a diagnosis of lung cancer earlier than what occurred. In relation to the swelling in the chest that was observed on 2 April 2012 Dr Lowe specifically stated that a diagnosis of a musculo-skeletal injury would be much more likely given the swelling in the left shoulder. Dr Lowe noted in this regard that this specific cancer was very rare in men of Mr Hughes's age, whereas musculo-skeletal injuries, especially for young men, were very common.

30. After Mr Thomas concluded questioning Dr Lowe, neither Mr Fawkner nor Mr Murphy asked questions of him.

31. I am satisfied after hearing Dr Lowe's evidence that there was no reasonable basis for a diagnosis of cancer of any meaningful time prior to when it occurred in this case. By meaningful I note that Dr Lowe in his written statement to this Inquest referred to there being at most a few days delay in the diagnosis. However, Dr Lowe has stated that in his opinion it would have made no difference to the outcome. I agree with him. The rarity of the cancer in men of Mr Hughes's age, coupled with the commonality of musculo-skeletal injuries meant that it was understandable that the cancer was not identified until 27 April 2012. The rapidity of the cancer combined with its aggressiveness meant that in the case of Mr Hughes it was too late. The doctors involved in treating Mr Hughes cannot be criticised for this.

Mr Hughes's medical treatment after the diagnosis of cancer

32. Considerable medical attention was devoted to Mr Hughes after he was diagnosed with cancer. It is not necessary to go through this in detail suffice to say that it is important to observe that soon after Mr Hughes's diagnosis with cancer, a multi-disciplinary meeting of medical staff took place on 3

May 2012 that determined how best to treat Mr Hughes in the circumstances. No criticism can be made of the treatment that followed. I note that the Doctors had to walk a difficult tightrope between dealing with the problem of clotting through the administration of anti-coagulants, which if applied in excess or at the wrong time, could produce excessive bleeding. Nevertheless, it was apparent that the medical treatment from 3 May 2012 onwards was purely of a palliative nature.

33. Dr Mohamudally was Mr Hughes's palliative care Doctor. She was an impressive witness. She was thorough and attentive and clearly did everything that she could as a Doctor to alleviate the suffering that Mr Hughes was no doubt experiencing in the last month or so of his life. I was particularly impressed by the fact that she made the effort to see Mr Hughes's mother at her home near Katherine just prior to the death of Mr Hughes.

34. I note that the post mortem results reveal that six legally prescribed drugs were identified in Mr Hughes's blood at the time of the post mortem, which was conducted by Dr Sinton on 28 September 2012. Ms Rositano, the toxicologist, gave evidence in relation to the toxicology results. Of the six legally prescribed drugs Ms Rositano stated that all quantities of each drug were within therapeutic range, with one exception. This drug was hydromorphone, which is a semi-synthetic narcotic analgesic that is prescribed for the treatment of moderate to severe pain. Approximately 0.2mg (per litre) of this drug was detected. Ms Rositano stated in her formal written statement for this Inquest that blood plasma concentrations greater than 0.1mg/litre of plasma may be toxic. This matter was specifically addressed by Mr Thomas who asked Ms Rositano, Dr Mohamudally and Dr Botterill about this. Dr Sinton also addressed this matter in a email to his statement that forms part of the brief. The net effect of this body of evidence is the opinion, which I accept, that tolerance to a drug such as hydromorphone can build up in a person as a consequence of continual

administration of this or similar drugs. In this case, it could well be understood that Mr Hughes had built up a tolerance to hydromorphone given his prolonged ingestion of this and similar drugs under the care of his Doctors. Furthermore, the Doctors added that in the context of significant pain occurring as death approaches, toxicity levels cannot be stated with any precision and would be professionally balanced with the pain level experienced by the patient. Therefore, the 0.1mg/litre estimate, would appear to be a rough guide and nothing more. I so find. Finally, Dr Mohamudally stated in her evidence that Mr Hughes experienced terminal agitation delirium at a point very close to his death, which is something that she says occurs in about 88% of people in the last 72 hours of life. Dr Mohamudally said that she was doing all that she could to reduce the pain to ensure Mr Hughes had a comfortable death. I accept this evidence. No criticism can be made of her or of the other medical staff involved in Mr Hughes's palliative care in terms of the nature and dosages of the drugs administered to Mr Hughes.

The Post Mortem

35. Dr Sinton conducted the autopsy on 28 September 2012. His key findings were as follows:

> (i) "Advanced lung cancer (non small cell carcinoma) which had spread directly in the chest to involve the upper part of the left lung, the upper airways in the chest, the upper part of the sternum (breast bone), and ribs on the left side of the chest. In addition, there was a constricting tumour around the superior vena cava (which is the large vein in the upper part of the chest, through which blood from the head, upper trunk and arms are returned to the heart).
>
> (ii) A microscopic deposit of tumour in the brain.
>
> (iii) As a consequence of the cancer, partial blocking of venous (blood flow in the veins) blood flow from the left arm, with resulting oedematous swelling of the arm (lymphedema).

(iv) Widespread bronchial pneumonia in both lungs.

The condition leading directly to death was bronchopneumonia. This was caused by metastatic cancer that had originated in the left lung and spread widely to the chest and into the brain."

36. Dr Botterill, a very experienced pathologist, gave evidence in this Inquest in the absence of Dr Sinton. He adhered to the findings of Dr Sinton in his report. I accept Dr Sinton and Dr Botterill's opinions that Mr Hughes died as a result of bronchopneumonia that was caused by cancer that had originated in the left lung.

Findings

37. Mr Hughes died at the Hospice of the RDH whilst serving a prison sentence. The cause of his death was bronchopneumonia, which was caused by lung cancer, specifically adeneocarcinoma. This type of lung cancer in a man of 28 is extremely rare. The cancer was aggressive and rapidly moving. At the time that his probable diagnosis of lung cancer was made (23 April 2012) his treating Doctor thought that it was probable incurable. On 27 April 2012 this diagnosis was confirmed and on 3 May 2012 the prognosis was confirmed. There was, regrettably, no basis for a diagnosis of Mr Hughes's cancer to have occurred earlier than what in fact occurred, other than a couple of days, which would have made no difference to the result given the rapid movement and lethal quality of the cancer. Mr Hughes was a regular smoker of cigarettes since his youth. Whilst the doctors did not refer to it the connection between tobacco smoking and lung cancer is so well known in Australia as to be otiose.

Formal Findings

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

(i) The identity of the deceased was Damien Hughes born 11 March 1984 formerly of Katherine.

(ii) The time and place of death was 4.55pm on 26 September, 2012 at Royal Darwin Hospital's Hospice, in Tiwi, Darwin.

(iii) The cause of death was bronchopneumonia that was caused by metastatic lung cancer.

(iv) Particulars required to register the death:

1. The deceased was Damien Hughes

2. Mr Hughes was of Aboriginal descent

3. The cause of death was reported to the Coroner

4. The cause of death was confirmed by post mortem examination carried out by Dr Sinton on 28 September, 2012

5. Mr Hughes's parents are Ms June Woods and Mr Colin Hughes.

39. At the time of his death Mr Hughes was a prisoner under the authority of the Northern Territory Department of Correctional Services who had, pursuant to section 63(d) of the *Prisons (Correctional Services) Act*, permitted Mr Hughes to be at the RDH Hospice without supervision as a consequence of the seriousness of his medical condition, which meant that his death was imminent.

40. On all the Inquest evidence, I have no criticisms to make of the care, supervision and treatment of the deceased by custodial authorities.

Recommendation

41. As this was a death in custody I must make recommendations with respect to the prevention of future deaths in similar circumstances.

42. Given that no criticism is made of the medical care that Mr Hughes received as a prisoner both before and after his diagnosis of lung cancer the sole recommendation that I make addresses the reality that the death of Mr Hughes at such a young age serves as a timely reminder of the dangers

inherent in cigarette smoking. I commend all efforts made to publicise through community educational programmes, particularly in Aboriginal communities, the inherent dangers of cigarette smoking.

Dated this 30th day of September 2013.

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GREG CAVANAGH
TERRITORY CORONER