CITATION: *Inquest into the death of Krista Louise Lloyd* [2016] NTLC 025

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0063/2015
DELIVERED ON:	17 October 2016
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HEARING DATE(s):	12 October 2016
FINDING OF:	Judge Greg Cavanagh
CATCHWORDS:	**Delay in provision of autopsy report, delay in Coronial Investigation**

REPRESENTATION:

Counsel Assisting:	Kelvin Currie
Counsel for Police:	Jodi Truman
Counsel for Health:	Stephanie Williams

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

No. D0063/2015

In the matter of an Inquest into the death of

KRISTA LOUISE LLOYD
ON 1 MAY 2015
AT ROYAL DARWIN HOSPITAL

FINDINGS

Judge Greg Cavanagh

Introduction

1. Krista Louise Lloyd (the deceased) was born on 23 April 1979 in Darwin to Sandra Eileen Williams and Ian Trevor Lloyd. She grew up in Western Australia.

2. On 13 August 2000 while in Perth the deceased gave birth to a daughter, Caitlyn LeCerf.

3. In 2002 she entered a relationship with Adrian Baxter while in Western Australia. In 2008 they moved with Caitlyn to Eva Valley near Batchelor in the Northern Territory. She worked at Woolworths at Coolalinga.

4. The deceased and Adrian had a son, Allan Baxter. He was born in the Royal Darwin Hospital on 30 May 2010.

5. In 2012 the deceased and Adrian separated. She moved into Batchelor with the two children. Thereafter, there were some acrimonious struggles in relation to the residency of the children.

6. She had ceased working at Woolworths and obtained work from time to time at a retirement village and also cleaned houses. At the time of her death she was unemployed. Her medical notes indicate that she smoked heavily and drank alcohol regularly.

7. In February 2015 the deceased entered a casual relationship with Curt. They did not live together. He lived in Winnellie. But he would visit from time to time.

8. On 6 February 2015 the deceased went to the Batchelor Clinic for a pap smear. While there she mentioned that about a week before she had chest pain that radiated up to her neck and jaw and her arms felt heavy. She said it lasted for about 5-10 minutes.

9. The doctor thought it was probably gastritis. But an ECG was conducted and showed a poor "r" wave progression. The doctor referred Krista to NT Cardiac for a stress test. She told a friend that she had something wrong with her heart and had bad chest pains and had to go to hospital for chest scans.

10. On Thursday 30 April 2015 Krista visited with friends at Darwin River during the day. They socialised and drank beer. That same day Curt had travelled to Batchelor to stay with Krista until Sunday.

11. Krista and her friends got back to Batchelor at about 4.00pm. After picking up a carton of Carlton Dry stubbies they socialised at a friend's house a short distance from Krista's residence. Krista sent a text to Curt suggesting he come to her friend's house for a beer. He did so.

12. When he got there he found them all in good spirits. Krista, Curt and Allan left together at about 9.00pm. They went to bed at about 10.00pm.

13. At 8.00am the next morning Krista got up to get Allan ready for school. At about 8.30am Allan came into the bedroom and told Curt his mother was spewing. Shortly after he said that his mother was not talking.

14. Curt got up and found her sitting in the middle of the couch. She was slouched to one side. She was blue around the lips and her eyes were half

open. She was unresponsive. Curt blew into her mouth and heard a gurgling sound as her lungs filled with air.

15. He telephoned his friend Vaughan who lived around the corner and asked him to help. Curt drove to his residence to pick him up. He said he would have been gone two minutes. When they got back Curt continued CPR and Vaughan called "000". The call was made at 8.41am. Vaughan told the operator that Krista was unconscious, not breathing and blue. The operator put the call from Vaughan through to the Batchelor Clinic but it was not answering. He told the operator he would drive around to the Clinic.

16. St John Ambulance managed to contact the Clinic. When Vaughan got there the staff were just leaving on their way to Krista's house. The Clinic staff arrived shortly after and put Krista onto the floor and continued CPR.

17. Police arrived at 8.51am. An ambulance with a doctor on board was dispatched to the scene and the clinic staff spoke to an Emergency Department consultant at about 9.00am. Careflight was also tasked to the scene and the Clinic Staff kept in contact with the Careflight consultant.

18. By 9.00am Krista had occasional spontaneous breathing and her heart rhythm had gone from asystole to flipping in and out of ventricular fibrillation. They provided adrenaline (six doses) and defibrillator shocks (15 in total). By 9.30am Krista was breathing spontaneously.

19. The ambulance arrived at 9.40am and the Careflight helicopter arrived at 10.16am. The doctor assessed her as having a Glasgow Coma Score of 5, unrecordable blood pressure, a heart rate of 100 beats per minute and oxygen saturations of 49%. It was thought that she had experienced a massive aspiration into her lungs.

20. She was intubated, commenced on an adrenaline infusion and evacuated to the Royal Darwin Hospital. She arrived at 12.50pm. She was admitted to the Intensive Care Unit and placed on a ventilator and Continuous Veno-Venous

Hemofiltration (CVVH) as well as Inotropes. However despite full support she developed worsening acidaemia, hypoxia and bradycardia. She was declared deceased at 6.24pm on that same day, 1 May 2015.

21. The ICU summary prepared after her death noted that she had suffered an "out of hospital cardiac arrest".

22. Initially Police thought that Krista might have suffered a drug overdose. A crime scene was declared and a search conducted. No hard drugs were found.

The Autopsy

23. An autopsy was performed by Dr John Rutherford. His Provisional Cause of Death (PCOD) was expressed as, "Pending further investigations".

24. He had found the anterior descending branch of the left coronary artery was blocked by greater than 90%. The atherosclerosis was concentric and soft with no calcification.

25. The results of the toxicology were received on 8 July 2015. There was no alcohol detected and the only drug was morphine. It was said to be at therapeutic levels. The notes from Careflight indicate that Morphine was provided to Krista from 11.00am.

26. The results of the histology were returned on 21 July 2015. Of that Dr Rutherford indicted in a statement prepared for the inquest:

> "The histology slides returned to our laboratory and I reviewed them several times in the early months of 2016, being puzzled by the combination of observations on the heart (the intensity of the myocardial contraction bands), coronary artery (the exuberance of the fibro proliferative reaction) and lung (the Broncho centric granulomatosis). I sought advice from an international expert in the field of cardiac pathology."

27. However, after consideration Dr Rutherford concluded:

"(a) the lung condition was highly unlikely to be causative or contributory to death and, therefore, for coronial and registration of death purposes, could be sidelined a cause of death even though its exact nature was undetermined; and

(b) although the case was demographically unusual it did, in the end, represent a case of ordinary coronary artery atherosclerosis."

28. In February and May 2016 specific enquiry was made of the mortuary as to when the autopsy report would be available.

29. On 9 June 2016 Dr Rutherford signed off on the autopsy report. He stated:

> "I am satisfied that death was from myocardial infarction as a consequence of severe focal coronary artery atherosclerosis."

Police Coronial Investigation

30. Within five days of Krista's death Police had obtained the relevant medical records and a statement from Curt Williams.

31. Unaware that the toxicology results were available, the Police sought further statements between 14 September and 7 October 2015 primarily based on the suspicion that she had suffered a drug overdose.

32. The reason Police were unaware was that they did not upload "unsigned and uncertified" toxicology reports to their system. Relying on the signed original copy in this case proved problematic as it was not released from the mortuary for another three months. The toxicology report was received by Police on 12 October 2015.

33. In light of the recognition that in waiting for the original they are relying on other fallible systems, Police have now changed that practice and accept the electronic version in non-suspicious deaths.

34. From the date of the receipt of the toxicology report the police investigator did little more than seek information as to when the autopsy report would be available.

35. After the autopsy report was provided however, there was a further ten weeks until the Police investigation file was provided to the Coroner's Office. That was in spite of a memo on 15 June 2016 from the Sergeant of Coronial Investigation Unit requesting that the file be completed and provided "ASAP".

36. That memo was sent because since at least February the family had been seeking that the matter be finalised. Those entreaties were becoming more urgent by April and by June the Coroner's Office was receiving regular telephone calls desperate for the matter to be completed.

37. In the period after the autopsy report became available no further investigation occurred. A draft memo was prepared by the investigator on 17 June 2016. The investigator prepared his statement on 20 June 2016 and uploaded photos on 21 June 2016. However by that time he had been moved to a different position and so he sent the file and draft memo to a fellow officer at the Police Station from which he had moved. At that time he thought that the only remaining tasks were to proof-read the memo, sign it and submit the file.

38. However for various administrative reasons the file did not arrive at the Coroner's Office until the afternoon of 24 August 2016. That was after the matter came to the attention of Commander Hollamby. He arranged for the file to be delivered that same day. Had that not happened the file would have been sent to a Superintendent to check and approve before making its way to the Coroner's Office. I am grateful for the intervention of Commander Hollamby.

Issues

39. The issues that arise are:

39.1 The failure of the death investigation process to fulfil the expectations of the family for a conclusion within a reasonable time; and

39.2 The unresponsiveness of the system to the family's frequent requests for the matter to be finalised.

Department of Health

40. As is the case in Queensland, New South Wales and Tasmania the Department of Health in the Northern Territory is responsible for providing forensic pathology services to Police and the Coroner. It is a manifestly important and essential public service. The manner of its operation (and particularly delay) can adversely affect criminal investigations and (as in this case) the ability of families to deal with their loved one's estate and obtain closure.

41. Delays have been increasing for some years. In the 14 years preceding 13 January 2015 the Forensic Pathology Unit at the Royal Darwin Hospital was staffed by only one Forensic Pathologist, Dr Terence Sinton. The Department was unsuccessful in recruiting another part-time Forensic Pathologist and a backlog of reports developed.

42. On 13 January 2015 Dr John Rutherford was employed and Dr Sinton, who had in mind retirement, agreed to help out by working part time for another two years.

43. However for various reasons that did not relieve the backlog. That backlog is the reason for the inability of the system to respond to the many requests by investigating Police and the needs of grieving families.

44. The Department of Health indicated that they are now increasing the staffing of the unit to two fulltime forensic pathologists. A new forensic pathologist is envisaged to commence in January of 2017. I am told that the Department will continue to maintain the second position. The Department state they

"hope that will assist in improving the turn-around times for autopsy reports".

45. Some of the difficulties in recruiting and the delays may also relate to the problems experienced with the mortuary facilities and equipment. This has been an ongoing problem.

46. In 2006 a cause of death could not be provided by the forensic pathologist because there was no equipment to allow for autopsy of an obese male (death of Stuart Jordan). Due to those issues I was assured by the CEO of the Department of Health, Dr Ashbridge that he had ordered a review of the mortuary facilities to establish what was needed to bring the facilities up to a "contemporary standard". He said:

> "it is anticipated that consequent upon that review, the mortuary facilities within the Territory can be upgraded over the next three years".

47. One of the recommendations made in the findings pursuant to that death was:

> "That the Department of Health upgrade the mortuary facilities within the Territory over the next three years (that is, the upgrade will be completed by June 2010) to bring them up to a contemporary standard."

48. In 2013 during the inquest into the death of Kevin Taylor, Lena Yali and Gregory McNamara I heard of the distress caused to the family around the poor viewing area and non-existent grieving facilities and counselling resources at the mortuary.

49. The mortuary facilities are not of a contemporary standard. The evidence provided by the Department of Health is that the mortuary facilities are 40 years old. They are based on 50 year old design.

50. The Department said those problems were being remedied:

> "the Department of Health capital expenditure proposal is being developed, to redesign and bring up to standard the on-site grieving, mortuary and body storage facilities".

Police

51. The Northern Territory Police undertake investigations on behalf of the Coroner into all reportable deaths.

52. Acting Assistant Commissioner Vanderlaan gave evidence at the inquest and provided on behalf of Police sincere apologies to the family for the length of time the investigation took to get to the Coroner's Office.

53. She indicated that in her experience delay is usually the result of there being an outstanding autopsy report. However, she indicated that there was a recognition that many files could be submitted without the autopsy report and that a review of the General Order would be undertaken to focus on streamlining the process.

54. Acting Assistant Commissioner Vanderlaan then stated,

> "With any death, it is the desire of the Northern Territory Police to attempt to reduce distress to families following the death of a loved one as much as possible. To this end, endeavours will continue to be made to ensure that coronial investigations are conducted and finalised in as timely a fashion as possible in all circumstances."

55. I am encouraged by the evidence of Acting Assistant Commissioner Vanderlaan and the attitude of the Northern Territory Police.

56. I commend both the Police and the Department of Health on their careful preparation for the inquest and the presentation of evidence.

Findings

57. 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;

(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*;

58. I find as follows:

(i) The identity of the deceased was Krista Louise Lloyd born 23 April 1979 in Darwin, Northern Territory.

(ii) The time of death was 6.24pm on 1 May 2015. The place of death was the Royal Darwin Hospital.

(iii) The cause of death was myocardial infarction as a consequence of severe focal coronary artery atherosclerosis.

(iv) The particulars required to register the death:

1. The deceased was Krista Louise Lloyd.

2. The deceased was of Caucasian descent.

3. The deceased was unemployed at the time of her death.

4. The death was reported to the coroner by the Royal Darwin Hospital.

5. The cause of death was confirmed by post mortem examination carried out by Forensic Pathologist, Dr John Rutherford.

6. The deceased's mother was Sandra Eileen Williams and her father was Ian Trevor Lloyd.

Recommendations

59. I **recommend** that the Northern Territory Police do all things necessary to successfully ensure that coronial investigations are conducted and finalised in as timely a fashion as possible in all circumstances.

60. I **recommend** that the Department of Health apply their best efforts to successfully ensure that there are a minimum of two forensic pathologists employed in the Forensic Pathology Unit.

61. I **recommend** that the Department of Health do all that is necessary to successfully bring to a contemporary standard the on-site grieving, mortuary and body storage facilities.

Dated this 17th day of October 2016.

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JUDGE GREG CAVANAGH
TERRITORY CORONER