CITATION: *Inquest into the death of Daniel Johnson* [2011] NTMC 048

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0127/2010
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HEARING DATE(s):	20 and 21 September 2011
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Death in custody, natural causes, adequacy of custodial medical attention

REPRESENTATION:

Counsel Assisting:	Ms Elisabeth Armitage
Department of Health and Corrections:	Mr Tim Barrett
Dr David Mathison:	Mr Tony Young
Family of the Deceased:	Ms Jodi Truman instructed by NAAJA

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

No. D0127/2010

In the matter of an Inquest into the death of
Daniel Phillips Inging Johnson

ON 11 AUGUST 2010
AT ROYAL DARWIN HOSPITAL

FINDINGS

Mr Greg Cavanagh SM:

Introduction

1. Mr Daniel Johnson, the Deceased, was 33 years old when he died in the Intensive Care Unit of Royal Darwin Hospital on 11 August 2010. The Deceased had developed a colloid cyst in the brain. The cyst obstructed the flow of his cerebrospinal fluid resulting in his seizure and sudden death.

2. At the time of his death, the Deceased was an inmate at the Darwin Correctional Centre. As he died in custody an inquest was mandatory. Pursuant to section 26 (1) (a) of the Coroners Act when considering a death in custody I am further required to investigate and report on the care, supervision and treatment of the Deceased while he was held in custody. Accordingly, although the Deceased died from natural causes, I have considered whether the medical attention provided to him whilst he was imprisoned was appropriate and adequate to his needs.

3. For some time before he died, the Deceased had been complaining of severe headaches. I find that there was a failure to escalate the medical response to his complaints. If the Deceased's headaches had been further medically investigated, particularly if a CT scan had been ordered, it is likely that the colloid cyst would have been detected. Whilst the discovery of the cyst

would not have guaranteed survival, timely medical interventions might have saved this life.

4. The inquest revealed the following further failings with the medical care of the Deceased whilst he was in custody -

4.1 Relevant information concerning the Deceased's repetitive headaches was not fully documented in the Deceased's electronic and hard copy medical files.

4.2 A medical consultation requested by the prison doctor was not booked for the Deceased. The prison doctor therefore missed an opportunity to follow up the severity and extent of the Deceased's headaches.

4.3 The Deceased's medical records were not adequately considered by medical staff during appointments with the Deceased and decisions were made about the Deceased's care based on incomplete information.

4.4 When the Deceased requested further Panadol from the prison officers during the evening before he suffered his fatal seizure, the prison officers failed to consult the on-call nurse.

5. The death was investigated by Detective Sergeant Karl Day. I received into evidence his thorough investigation brief. I also heard evidence from Prison Officers Kevin Ayers, Louis Ventura, Andrew Taylor and Joel McLennan. I received evidence from medical personnel, Ms Katherine Taylor, RN Simon Stafford, Dr David Mathison, Dr Tony Falconer and Dr Nick Vrodos.

6. The Deceased's documented medical history was obtained and formed part of the material available to me during the inquest. It included the Deceased's medical files from the Alice Springs Hospital, the Royal Darwin Hospital, and the Alice Springs and Darwin Correctional Centre records.

7. Pursuant to section 34 of the Coroners 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;

8. 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."

9. 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."

Relevant circumstances surrounding the death

Background

10. The Deceased was born in Tennant Creek on 6 December 1977. As a child the Deceased lived with a foster family in Hermannsburg but maintained

contact with his extended family throughout the Tennant Creek and Alice Springs area. When he died he had a partner, Ms Tanya Turner, and a child Elijah. In spite of difficulties, the Deceased was loved by his family and is sorely missed.

11. As a youth and into his adult life the Deceased came into conflict with the law. He was addicted to petrol sniffing and was an occasional binge drinker.

12. On 24 February 2004 the Deceased was convicted of Manslaughter in the Alice Springs Supreme Court. The Deceased was sentenced to ten years imprisonment with a non-parole period of five years commencing from 1 January 2003.

13. Following his release on parole in 2008, the Deceased worked as a training counsellor with the Central Australian Aboriginal Alcohol Program Unit (CAAAPU). In July 2008, whilst he was employed, the Deceased formed a de-facto relationship with Ms Turner.

14. Unfortunately the relationship was not peaceful and in late 2008 the Deceased assaulted Ms Turner. On 27 January 2009 the Deceased was convicted of aggravated assault. On the same date the Deceased's parole was revoked. The Deceased was due to be released from custody on 27 March 2014.

15. Ms Turner and Elijah kept in contact with the Deceased through correspondence and occasional visits. They last saw the Deceased in April 2010, during an Easter visit at the Alice Springs Correctional Centre.

16. Ms Turner provided investigators with a general description of the Deceased's health before his incarceration. According to Ms Turner, the Deceased suffered from high cholesterol, heartburn, a slow heart-beat, and headaches. Ms Turner said that the Deceased's headaches commenced in 2006 and were irregular. When the Deceased had a headache he would remain in bed or keep the house in darkness.

The Deceased's health and care whilst imprisoned

17. The Deceased commenced his custodial sentence in Alice Springs on 29 December 2008 and received ongoing medical treatment via staff employed by the prison health contractor, SOS International.

18. On 30 December 2008 and again on 8 January 2008, in preparation for his transfer from Alice Springs to Darwin Correctional Centre, the Deceased was medically assessed by a Corrections Transfer Nurse and a doctor. The Deceased complained of heartburn, headaches, anxiety and stress. He was documented as suffering from long standing depression and dyspepsia and was listed on the chronic disease register. His medications, Omeprazole (for gastric ulcers) and Amitryptaline (for depression), were documented. His health status was considered stable and he was considered fit for transfer.

19. On 11 January 2010, the Deceased was transferred from the Alice Springs Correctional Facility to the Darwin Correctional Facility.

20. On 2 February 2010 the Deceased was given his annual health review by a Registered Nurse. No health issues were raised by the Deceased and no indications of ill health were observed.

21. The Deceased was initially placed in K Block in the main prison but was later transferred to the low security Living Skills Unit.

22. Prison officers were permitted to provide Panadol to prisoners. The provision of Panadol was documented in a Panadol Register: a hard copy, manually updated book maintained in each Block of the prison. The Panadol Register was available for medical staff review, but was essentially only checked by medical staff when a request for a top-up supply of Panadol was made by prison officers. Information about prison officers providing Panadol to prisoners was not electronically stored or available to medical personnel when they were working from the prison medical centre.

The first headaches, reported to prison officers

23. On 22 and 23 February, and again on 10 and 15 March 2010, two Panadol tablets were provided to the Deceased following requests made to prison officers. I infer from that, that the Deceased was suffering from headaches on those days.

The second headache episode, reported to Darwin Correctional Centre medical staff

24. On 5 April 2010 the Deceased attended the prison health clinic complaining of a severe headache. On examination by Registered Nurse (RN) Scrivener, the Deceased stated that his headache was better but there was residual pain behind his left eye. RN Scrivener noted that the Deceased denied symptoms of migraine, and that he complained 'he just had a bad headache'. The Deceased was given two Panadeine and encouraged to drink at least two litres of water a day.

25. The Deceased was again assessed by RN Scrivener on 18 April 2010. This was essentially a mental health check requested by the prison intelligence section. During this check-up it is documented that the Deceased stated that he felt 'well within himself'. RN Scrivener noted that the Deceased 'presented appropriately with good eye contact' and she noted no suicidal or self-harm ideation. There is no documented discussion about the Deceased's headaches.

26. However, on 20 April 2010, the Deceased completed an urgent medical request form stating:

> 'I would like to see a doctor cause I've been getting really bad headaches for the last two weeks with blurry visions'.

It is apparent that the Deceased's headache, first reported on 5 April 2010 had not resolved.

27. On 21 April 2010, in response to the Deceased's request, the Deceased was assessed by RN Margaret Campbell-Low. Quite detailed notes of this assessment were recorded on the back of the Deceased hand written medical request form. The form was filed in the Deceased's hard copy medical file. RN Campbell-Low recorded that the Deceased was complaining of headaches over the last two weeks with symptoms consisting of 'sometimes sharp sudden pain, or dull, worse when coughs, pain situated above the left ear'. In addition, the Deceased described seeing 'stars' in the morning and in bright sunlight. The Deceased did not relate this to his headaches. Further, the Deceased stated that he had experienced numbness in the toes of both feet which lasted five (5) minutes. RN Campbell-Low noted that the Deceased was a heavy smoker, was having problems at home and with his partner, and was feeling stressed and anxious.

28. The information obtained from the consultation with RN Campbell-Low was not entered onto the Deceased's electronic medical file because there were problems with the computer system. A reference to the existence of information on the medical request form was recorded on the Deceased's electronic medical file on 14 July 2010.

29. On 23 April 2010 the Deceased saw Dr David Mathison and again complained of extensive headaches. The doctor's medical notes refer to the Deceased's headache as 'global, 2/52 (2 weeks), every day, blurry vision/ 'stars'…headache partly relieved with Panadol'. Dr Mathison noted that the Deceased was worried about a number of personal issues and considered that there was an element of anxiety to his presentation. During the consultation which was reasonably lengthy, Dr Mathison did access RN Scrivener's notes of 21 April 2010.

30. On 30 April 2010 the Deceased was reviewed by Dr Mathison. The Deceased reported that he did not have a headache that day and that he had adjusted his pillow so that it wasn't so high. No other issues were reported

by the Deceased and it appeared to Dr Mathison that the headache episode had resolved.

The third headache episode, reported to Darwin Correctional Centre medical staff

31. On 10 and 11 July 2010 RN Campbell-Low gave the Deceased Paracetamol (two tablets) during her medication rounds. This was recorded electronically in the Deceased's medical file.

32. On 12 July 2010 the Deceased was provided with two Paracetamol during the medication round. The Deceased later attended the Health Clinic and saw RN Thompson. He complained of a migraine and double vision. He said the pain was '10/10' and he reported 'frontal pain, in eyes'. RN Thompson gave him two Aspalgin. The records indicate that RN Thompson spoke to Dr Mathison about the Deceased's headache. Dr Mathison asked to see the Deceased later in the week. However, there is no evidence that any follow up appointment was made and the Deceased did not have a consultation with the doctor.

33. On 17 July 2010 the Deceased was provided with 300mg of Aspirin by RN Grimes documented as for musculoskeletal pain.

A fourth headache episode, reported to prison officers

34. On 26 July 2010 the Deceased requested to see a doctor as he wanted to cease his prescribed medication for depression.

35. On 29 July 2010 the Deceased was provided with two Panadol by Prison Officer (PO) Thrift and later the same day by PO Jennings.

36. On 30 July 2010 the Deceased had an appointment with Dr Mathison arising from his 26 July request. His wish to stop taking the anti-depressant medication was discussed, but there was nothing documented to indicate any follow up discussions about his headaches. In evidence Dr Mathison agreed

that if he had had access to the information in the Panadol Register, it is likely that the history of prison officers providing Panadol would have prompted him to ask the Deceased's about his headaches.

A fifth headache episode, reported to prison officers and medical staff

37. On 4 August 2010 the Deceased was provided two Panadol by PO Hall.

38. On 5 August 2010 the Deceased was provided two Panadol by PO Nuko.

39. On 7 August 2010 the Deceased was provided two Panadol by PO Paltridge and later the same day two Panadol by PO McLean.

40. On 8 August 2010 the Deceased was provided with two Panadol by PO Grosbois and one Aspalgin by RN Campbell.

41. On 9 August 2010 the deceased was provided two Panadol.

42. On 10 August 2010 RN Simon Stafford reviewed the Deceased during medication rounds as he was complaining of headaches. RN Stafford noted that during the consultation the Deceased remained seated with his head in his hands. The Deceased said that he had had a headache since 'last Thursday' (5 August 2010). The Deceased said the headache was sometimes generalised but at other times it was focused in one point. He said that the headaches came and went, and got worse during the day. The Deceased said he took Panadol and that this helped. The Deceased told RN Stafford that he had woken at about 3 o'clock that morning (10/8/2010) and remembered that he had forgotten to take his Neprosol tablet which he normally takes in the evening after dinner. The Deceased said he took his medication but then vomited four times.

43. RN Stafford decided to transfer the Deceased to the prison health clinic for further review and to administer an injection of Maxolon for the vomiting.

44. The Deceased was transferred to the health clinic by prison staff and placed in the Emergency Room for assessment. At approximately 8 am the Deceased reported that his headache had gone however he still felt nauseous. RN Stafford administered 10 mg of Maxolon for the nausea.

45. At approximately 8:30 am RN Stafford returned and checked on the Deceased who advised that his headache had returned. RN Stafford administered two Panadeine and 600mg of Aspirin to the Deceased. A short time later RN Stafford conducted a handover to Dr Mathison. Dr Mathison decided to wait to see how the Deceased went with the medication before assessing him.

46. In evidence RN Stafford told me that he did not check the Deceased's medical records and was therefore unaware of his history of headaches.

47. At 10:00 am the Deceased was reviewed by Dr Mathison. Dr Mathison noted that the Deceased suffered no coordination problems and appeared alert and orientated. However, at 10:30 am, the Deceased was observed vomiting in the toilet. At 11:00 am, an IV Saline 1000 ml drip was commenced by RN Stafford.

48. RN Melanie Buscall records that the Deceased was resting quietly on a trolley on her attendance. On enquiry, the Deceased complained of a dull headache and nausea despite having received the Maxolon. The Deceased was observed to attend the toilet independently and return to the trolley. The Deceased answered all her questions appropriately.

The Deceased is returned to his room but the headache returns

49. After about nine hours in the clinic, the Deceased was observed to improve. Dr Mathison recalled that his eyes brightened. The Deceased was returned to his room.

50. However, at 7:00 pm on 10 August 2010 the Deceased requested and was provided with two Panadol by PO Philby. It appears his headache had returned. This was not reported to the Nurse on Call.

51. At about 11:00 pm the Deceased was observed by fellow inmate Mr Shannon Gurmurdul coughing and vomiting. Mr Gurmurdul also saw the Deceased wake up at around 1:00 am on 11 August 2010 and he was coughing and vomiting again. Mr Gurmurdul asked the Deceased:

> "Are you okay. You want me to tell the officers. Press the button".

But the Deceased said:

> 'It's alright, just coughing that's all".

Mr Gurmurdul told police that he couldn't sleep due to the Deceased coughing but that it eventually stopped and he believed the Deceased had fallen asleep.

52. At about 4:00 am Mr Gurmurdul heard the Deceased fall out of his bed and saw him shaking. Inmates immediately pressed the intercom button and requested help from the prison officers. Officers received the call on the intercom at 4.15 am. Prison Officers Ventura, McLellan and Taylor attended Dormitory 26 and saw the Deceased convulsing and lying on his back in the back right-hand corner of the Dormitory next to his bed. The Deceased was non-responsive to all attempts by the prison officers to wake him.

53. At approximately 4.20 am, RN Stafford was informed that the Deceased was having a fit. RN Stafford confirmed that an ambulance should be called. On completion of the phone call, RN Stafford immediately contacted the Team Leader at the Emergency Department, Royal Darwin Hospital, and informed him that the Deceased's would be arriving. He also provided the Deceased's history from the previous day's attendance at the Health Clinic.

54. The St. John's Ambulance arrived at 4.25 am and departed the scene with the Deceased at 4.56 am.

55. The Deceased arrived at Accident and Emergency at 5.11 am. He was assessed as having a Glascow Coma Score of 3, in other words he was completely unresponsive. He was intubated and underwent immediate CT evaluation of his head. The CT disclosed the presence of acute hydrocephalus secondary to a 14 m x 11 mm mass in the third ventricle. Doctors consultated with the Royal Adelaide Neurosurgical Unit, and then performed emergency surgery in an attempt to reduce the Deceased's intracranial pressure. The Deceased survived the surgery and at 5:59 am, he was admitted to the Intensive Care Unit for ongoing management.

56. At 9:00 am, Dr Susan Winter noted that the Deceased had fixed and dilated pupils. The Intensive Care Unit Director, Dr Dianne Stephens and Dr Winter certified brain death at 7.40 pm on 11 August 2010. The Deceased was maintained on an intubator so that family members could attend and Cardiac Standstill occurred at 2.10 am on 12 August 2010.

The autopsy

57. An autopsy was performed by Dr Terence Sinton on 13 August 2010 which confirmed the existence of a colloid cyst in the ventricular system of the brain.

58. Dr Sinton reported:

> "Development of a colloid cyst deeply in the ventricular system of the brain is rare, and is thought to start early in life. It may grow sufficiently large and be so positioned, as to suddenly and unexpectedly block the normal flow of cerebral spinal fluid around the brain and spinal cord. If such a blockage is not resolved quickly, pressure changes inside the brain (acute hydrocephalus) may acutely and severely damage the brain, with death commonly following shortly thereafter.

> Given the history and autopsy finding, the Deceased died from acute hydrocephalus following sudden and unexpected ventricular blockage in the brain, as a consequence of a longstanding colloid cyst".

59. I accept Dr Sinton's conclusion as to the cause of death and find that the Deceased died from acute hydrocephalus consequential to a colloid cyst. The Deceased died from natural causes.

Issues considered during the inquest

60. In submissions to me, the family of the Deceased have expressed their concern about the lack of escalation in the medical response to the recurring complaints of the Deceased. They reminded me that the Deceased was not at liberty to seek a second medical opinion and was dependent on the care provided by the institution in which he was incarcerated.

61. It is clear from the evidence that while some temporary relief of symptoms was provided to the Deceased, no further investigations were conducted to identify the cause of the Deceased's recurring and severe headaches.

62. I heard evidence and received a report from Dr Nick Vrodos, the Director of Neurosurgery, Flinders Medical Centre. He told me that CT scans are available in Darwin, and that it would be appropriate for a general practitioner to refer someone with a history of headaches for a CT scan. He considered that there were multiple opportunities for that to occur during the ongoing presentations of the Deceased. However, he conceded that his experience and expertise was vastly different from that of the average GP. Dr Vrodos pointed out that the Deceased's condition was very uncommon and many GPs might never see the condition during a lifetime of practice. Further he told me that symptoms associated with the condition, namely headaches, blurred vision and nausea, are globalised symptoms which are non-specific to the condition. I understand this to mean that they are symptoms which might arise from a number of different causes and so not necessarily alert a GP to the need for further investigation.

63. I also received into evidence a report from Dr Stephen Hampton, Clinical Director, Justice Health, NSW. He reviewed the Deceased's medical records. It was his opinion that the Deceased's clinical history was inconsistent, with periods of apparent improvement. He was of the view that the Deceased's symptoms did not indicate that further investigations were required.

64. I consider that decisions about the Deceased's care might have been different if a complete record of the Deceased's headaches had been contained in the Deceased's medical files. It is apparent that critically relevant information concerning the provision of Panadol by prison officers was not considered by treating medical staff because it was not in the medical records. It was only in the hard copy Panadol Registers.

65. I am informed that the practice in the prison concerning Panadol has now changed. Prison officers no longer provide Panadol to inmates. Prisoners can still obtain these analgesics from nurses during twice daily medical rounds if there is a specific indication that the medication is required. Any drugs provided during rounds are recorded in the prisoner's Medications List which forms part of the prisoner's medical records. If there is no specific indication that Panadol is required, then the prisoner must see a doctor before the medication is provided.

66. The effect of this change is twofold. It is now more difficult for prisoners to access Panadol, but if they do, then its provision is recorded in the prisoner's medical records. Accordingly, the medical records should now be more complete.

67. Comprehensive medical records are not the complete answer. Medical records must be accessed and considered at the time of consultation to ensure that the best decisions are made as to a patient's care. I was concerned that on occasions it appeared the Deceased's medical records were not accessed by treating staff. In particular, I note that RN Stafford

was not aware of the Deceased's history of headaches. I heard evidence that the physical medical files were often bulky and a patient's electronic file had to be 'clicked through' on an ad hoc basis in order to access information. Neither the physical nor the electronic records contained any summary page or 'flags' that would alert medical staff to the existence of a patient's recurring or diagnosed conditions.

68. Dr Tony Falconer, Medical Director, International SOS gave evidence and provided a report. He told me that the prison's electronic medical records have been updated with the introduction of a Northern Territory Department of Health system known as PCIS (Patient Care Information System). The new system now allows key diagnoses to be flagged. As a result, potentially critically relevant medical history should now be more readily accessible to medical staff. Hopefully easier accessibility will translate to greater consideration of a patient's history by prison practitioners in the future.

69. A review of the medical records also revealed that on one occasion an appointment for the Deceased was requested by the GP but did not take place. I am told that it is likely human error resulted in the appointment not being made. There were also problems with the computer at that time. However, no systemic error was revealed. In the circumstances I simply note that it is regrettable that an opportunity for further review and assessment of the Deceased was missed.

70. With the benefit of hindsight, it is clear that the Deceased was suffering from significant and recurring headaches and it is likely he would have benefited from a referral for further investigation. However, taking into account the information available to the treating medical staff, their general, non-specialised experience, and the non-specific nature of the Deceased's symptoms, the failure to refer the Deceased is explicable. Whilst there was a failure to escalate the medical response to the Deceased's complaints, in my

view, the evidence falls short of establishing any negligence as to the medical care provided by any person or by the institution.

71. On 10 August 2011, the Deceased was released back to his cell after nine hours of observation in the prison medical clinic. His condition appeared to have improved. However, at 7:00 pm the Deceased was again requesting Panadol from the prison officers. I infer that his headache had returned and he was deteriorating.

72. There is no evidence before me that any member of the medical staff communicated with the prison officers about the Deceased's condition, or what they should do if his headache returned or his condition worsened. In my view, had information been communicated to the prison officers about the Deceased's condition, it is possible that the prison officers would have contacted the on-call nurse. Such contact might have resulted in the Deceased being sent to hospital for further observation. Earlier hospitalisation would not have guaranteed his survival but it might have improved his chances.

73. I appreciate that there are privacy considerations concerning patients' care and illnesses and that medical staff might be cautious about giving information to prison officers about a prisoner's medical condition. However, it would not breach privacy considerations for prison officers to be told to call the on-call nurse if a prisoner's condition changes. In my view guidelines on the use of on-call nurses should be developed to better assist prison officers in the exercise of their discretion in this regard.

Recommendation

74. That Correctional Services develop and implement a policy as to the use of on-call nurses to assist prison officers in the exercise of this discretion.

Formal Findings

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

(i) The identity of the Deceased person was Daniel Phillips Inging Johnson born on 6 December 1977 at Tennant Creek. The Deceased resided at Darwin, in the Northern Territory of Australia.

(ii) The time and place of death was 7.40 pm on 11 August 2010 at Royal Darwin Hospital.

(iii) The cause of death was acute hydrocephalus following ventricular blockage by a colloid cyst .

(iv) Particulars required to register the death:

1. The Deceased was Daniel Phillips Inging Johnson.

2. The Deceased was of Aboriginal descent.

3. The Deceased was unemployed.

4. The cause of death was reported to the coroner.

5. The cause of death was confirmed by post mortem examination carried out by Dr Sinton.

6. The Deceased's mother is Pearl Burke.

Dated this 18th day of November 2011.

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GREG CAVANAGH
TERRITORY CORONER