CITATION: *Inquest into the death of Clive Henry Impu* [2001] NTMC 72

TITLE OF COURT: Coroner's Court

JURISDICTION: Alice Springs

FILE NO(s): A0005/2001

DELIVERED ON: 19 October 2001

DELIVERED AT: Alice Springs Court House

HEARING DATE(s): 3 & 4 September 2001

FINDING OF: Mr G Cavanagh SM

CATCHWORDS:

CORONIAL – INQUEST, ischaemic heart disease, prevalence in Aboriginal persons, fail to diagnose.

REPRESENTATION:

Counsel:

Assisting: Mr Stewart Brown

Solicitors:

Family: Stewart O'Connell

Dr Morrison: Terry Reilly

Congress Medical Assoc: Katrina Budrikis

Judgment category classification: B

Judgement ID number: [2001] NTMC 72

Number of paragraphs: 126

Number of pages: 34

IN THE CORONERS COURT
AT ALICE SPRINGS IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. A0005/2001

In the matter of an Inquest into the death of

CLIVE HENRY IMPU
ON 26 JANUARY 2001
AT ACCIDENT & EMERGENCY SECTION OF THE ALICE SPRINGS HOSPITAL, ALICE SPRINGS IN THE NORTHERN TERRITORY

FINDINGS

(Delivered 19th October 2001)

Mr GREG CAVANAGH:

1. Clive Henry Impu ("the deceased") died in the Accident and Emergency Section of the Alice Springs Hospital at 1.51 pm on the 26th of January 2001. The cause of his death was from coronary thrombosis as a result of coronary atherosclerosis.

2. In layman's terms this means that the deceased had coronary artery disease. That is to stay the arteries supplying blood to his heart had been narrowed by the deposit of fat on the artery walls. This damaged the muscle of his heart and as a result it failed as a pump.

3. At the time of his death the deceased was twenty-five years of age. He had not been previously diagnosed as suffering from coronary heart disease. His death was both sudden and unexpected.

4. Section 12(1) of the *Coroners Act* ("the Act") defines a "reportable death" to mean a death that:

> "appears to have been unexpected, unnatural or violent, or to have resulted directly or indirectly from an accident or injury".

5. For reasons that appear in the body of these Findings, the death fell within the ambit of that definition and this Inquest is held as a matter of discretion pursuant to section 15(2) of the Act.

6. Section 34(1) of the Act details the matters that an investigating Coroner is required to find during the course of an Inquest into a death. That section provides:

> "(1) A coroner investigating –
>
> 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;*
>
> (v) any relevant circumstances concerning the death."

7. 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."

8. The Public Inquest in this matter was held at Alice Springs Magistrates Court on the 3rd and 4th of September 2001. Counsel assisting me was the Deputy Coroner, Mr Stewart Brown. Mr Stewart O'Connell of the Central Australian Aboriginal Legal Aid Service sought leave to appear on behalf of

the family of the deceased. Mr Terry Reilly of Morgan Buckley, Solicitors sought leave to appear on behalf of Dr Noel Morrison. Ms Katrina Budrikis of Budrikis McNamara, Solicitors sought leave to appear on behalf of the Central Australian Aboriginal Congress ("Congress"). I granted leave to each of them pursuant to section 40 (3) of the Act.

9. The senior next of kin of the deceased is his wife Ms Rosario Young. She was a witness before the Inquest. A short time after she had given her evidence she left the courtroom where the Inquest was being conducted. I appreciate that the proceedings were extremely traumatic for her and I respect her decision to leave.

10. Nine witnesses were called to give evidence during the Inquest. These witnesses comprised Ms Rosario Young, the wife of the deceased who was with him on the day he died; Dr Noel Morrison, a doctor at Congress who saw the deceased shortly before he died; Sister Patricia Anne Strazzari, a registered nurse at the Alice Spring Hospital who was on duty at the Accident and Emergency Section of the Hospital at the time the deceased died; Sister Tracey Dianne Harker, who was the Acting Nursing Services Co-ordinator at the time; Mr Craig Douglas Garraway, the Deputy Regional Manager of St John's Ambulance in Alice Springs; Dr John Boffa, the Public Health Medical Officer at Congress; Ms Tracey Roman, an administration officer at Congress; Dr Tatjana Janusic, the Medical Officer Co-oridinator at Congress.

11. I also received evidence from Dr Samuel Russell Heard, a medical practitioner and university lecturer who currently is employed as a senior lecturer in General Medical Practice at Flinders University. Dr Heard provided expert evidence regarding general medical practices in the Northern Territory.

12. In addition to the evidence of these witnesses some seventeen statements from other witnesses were admitted into evidence.

13. There was also tendered into evidence a number of records relating to the health and antecedents of the deceased. These records included his medical records at the Alice Springs Hospital and the Central Australian Aboriginal Congress.

CORONER'S FORMAL FINDINGS

14. Pursuant to section 34 of the Act I find as a result of the evidence adduced at the Public Inquest the following:

(a) The identity of the deceased is Clive Henry Impu, a male who was born at Alice Springs Hospital in the Northern Territory of Australia on the 8th of February 1975.

(b) The time and place of his death was at the Accident and Emergency Section of the Alice Springs Hospital at 1.51 pm on the 26th of January 2001.

(c) The cause of his death was coronary thrombosis resulting from coronary atherosclerosis.

(d) The particulars required to register the death are:

1. The deceased was a male;
2. The deceased was an Aboriginal Australian;
3. The cause of death that was reported to the Coroner was heart failure;
4. A post mortem examination was carried out and the cause of death was coronary thrombosis as a result of coronary atherosclerosis;

5. The pathologist viewed the body after death;

6. The pathologist was Dr Michael Zillman of the Royal Darwin Hospital;

7. The father of the deceased is Clive Henry Impu;

8. The mother of the deceased is Raelene Bloomfield;

9. The deceased lived at 116 Kurrajong Drive, Alice Springs at the time of his death;

10. The deceased was employed as a labourer at the time of his death;

15. The deceased was married to Rosario Young according to Aboriginal custom and was the father of three children, Bruce Impu born the 19th of September 1994, Norman Impu born the 17th of July 1996 and Raelene Impu born the 5th of October 1999.

RELEVANT CIRCUMSTANCES SURROUNDING THE DEATH

The background of the Deceased

16. The deceased was a Western Arrente man. He was born in Alice Springs Hospital on the 8th of February 1975. He grew up at Haasts Bluff, Hermannsburg and Alice Springs. He attended school at Hermannsburg and Haasts Bluff and later attended High School at Yirara College in Alice Springs and Kormilda College in Darwin. By all accounts the deceased was a gifted footballer. At times he played for the Federals team in Alice Springs and for community teams at Hermannsburg and Haasts Bluff.

17. He married Rosario Young at Santa Teresa in 1992 and was the father of three children: Bruce born in 1994, Norman born in 1996 and Raelene born in 1999.

18. He worked from time to time as a stockman and fencer at Santa Teresa and Undurana Outstation. He also worked as an interpreter at the Alice Springs Hospital. He joined the Aboriginal Liaison Team at the Hospital at some time in the mid 1990's. He was able to speak Western Arrente, Eastern Arrente and some Luritja and Pitjantjatjara as well as English. His duties were to assist Aboriginal patients to complete forms and to interpret for them in the setting of the Hospital. However he was not formally qualified to be an interpreter and did not hold any accreditations as such.

19. Dr John Boffa saw the deceased at Congress on the 2nd of March 2000. Dr Boffa has extensive experience of examining Aboriginal patients from Central Australia in a clinical setting. He described the deceased as speaking "quite good English". Ms Young gave evidence that she and the deceased and their respective families spoke both Western and Eastern Arrente at home.

20. As I have already indicated the deceased's wife, Ms Rosario Young gave evidence before me; I found her to be an intelligent and perceptive person. She told me that she went to school at Santa Teresa. It was clear to me that her formal education was rudimentary. She was asked many questions by counsel regarding her husband's death. She gave her answers to the questions in English although she had available to her an interpreter who was fluent in her (Ms Young's) mother tongue, Eastern Arrente as well as English. Ms Young could clearly understand English however she did not give her answers with any degree of fluency or confidence. It was obvious to me that English was very much her second language. It was also clear to me that she could in no way be described as a sophisticated or assertive person, certainly not in any professional dealing she may have had with a

tertiary educated European person. For want of a better expression I would describe her as a "traditionally orientated Aboriginal person".

21. On the evidence before me I find that the deceased was likely to have been a person of similar disposition.

The Deceased's Medical History

22. Dr Michael Zillman, a forensic pathologist, performed an autopsy on the deceased on The 30th of January 2001. In the comments section of his report Dr Zillman wrote as follows:

> "1. The cause of death was coronary atherosclerosis (ie. fatty narrowing of the coronary arteries which supply blood to the heart), which resulted in coronary thrombosis (ie. the formation of a blood clot in the coronary artery) and consequent damage to heart muscle, with failure of the heart as a pump.
>
> 2. The presence of scarring of the heart muscle (ie. myocardial fibrosis) is consistent with the effect of long-standing coronary artery disease."

23. In the light of Dr Zillman's finding and with the benefit of hindsight coupled with a close examination of the deceased's medical records it is apparent that the deceased was showing the symptoms of coronary artery disease in the months prior to his death.

24. Unfortunately his disease was not diagnosed despite the fact that he consulted several medical practitioners at both Congress and the Alice Springs Hospital in the several months before his death. Nor did he undergo a number of comparatively simple diagnostic tests, which may have had the effect of revealing his condition. These tests include a measurement of his blood cholesterol and an exercise electrocardiogram.

25. Coronary artery disease in the comparatively young can be hard to detect because it is unusual and unexpected. It is easy to misdiagnose. It is however more prevalent amongst Aboriginal people, a topic to which I will return in more detail later in these findings.

26. On the 2nd of March 2000 the deceased went to Congress and saw first a health worker and then Dr Boffa. He complained to the health worker of "pain and a crushing sensation on the left of his chest and of finding it difficult to breathe". His blood pressure and an ECG that was taken at the time did not give cause for concern.

27. However the complaint of left-sided crushing chest pain is a classic indication of ischaemic heart disease. When Dr Boffa saw the deceased after the health worker had finished taking this history, the deceased's pain was apparently no longer present. However, Dr Boffa queried whether the pain was ischaemic in origin and ordered the deceased to have a fasting cholesterol test and an exercise ECG. These tests would have possibly resolved the query one way or the other. Sadly neither test was performed. Dr Boffa also referred the deceased to a specialist clinic for a further opinion. Again this consultation did not eventuate.

28. It now seems certain that as early as March of 2000 the deceased was showing symptoms of the disease that would lead to his death.

29. The fact of this consultation in March of 2000 was recorded in the deceased's notes at Congress to which I have had access. There was a systemic failure at Congress in respect of its failure to follow up the deceased in respect of both his non-attendance at the specialist clinic and to undergo the two diagnostic tests. Again matters that will receive further scrutiny at a later stage in these findings.

30. At 6.08 pm on the evening of the 15th of August 2000 the deceased went to the Accident and Emergency Section of the Alice Springs Hospital. The note from the deceased's hospital record indicates that on this occasion he complained of:

> "right sided chest pain on and off for the past few days since playing football. He thinks it could be due to an unnoticed injury during play."

31. It is not unknown for the pain resulting from ischaemic heart disease to present atypically on the right side of the chest. Again, with the benefit of hindsight, it is telling that the deceased could not point to a specific incident on the football field that had resulted in what he considered to be an injury, which caused his chest pain. He was diagnosed with muscular pain.

32. At 2.48 pm on the afternoon of the 3rd of December 2000 the deceased again came to Accident and Emergency and complained of pain in what is described in his notes as the right axilla or the area of the armpit or under the shoulder. He said that the pain had come on a few days before after he had been throwing rocks at ducks but had gone away. There was no pain on his presentation to the doctor.

33. After an examination of the deceased, this too was diagnosed as a musculo-skeletal problem and *brufen* and *indocid*, both anti-inflammatory drugs were prescribed. However the Accident & Emergency doctor sent a discharge summary to Congress and it was placed on the deceased's medical file there.

34. Later that month on the 30th of December 2000 The deceased again went to Accident and Emergency. He went twice on the same day. Firstly at 5.24 pm in the afternoon and then again that evening at 9.19 pm.

35. On the first occasion he complained of a headache and vomiting. His blood pressure was found to be slightly elevated at 120/90. He was diagnosed as having a tension headache and given aspirin.

36. On the second occasion he complained of what was described as "epigastric pain" in the notes. He was given *gastrogel,* which is a gastric antacid medication. Later he complained of muscular soreness in his right arm and on the right side of his chest. His chest was tender to the touch. Otherwise he looked well. Apparently the deceased asked for more anti inflammatories and was given *indoethacin,* which is another anti inflammatory drug. A diagnosis of musculoskeletal pain was made.

37. It is most likely that all these incidence of chest pain related to ischaemic heart disease. However the history of the deceased as can be gleaned from his medical record demonstrates the grave difficulties associated with making a diagnosis of coronary artery disease in his particular case. He was very young. When he presented the pain of which complained was intermittent and had passed. He linked it to activities that suggested a muscular injury. Above all he looked reassuringly well to all the medical practitioners who saw him. But in my view it is important to note that he was medically examined on each occasion and a diagnosis was made.

The Nature of Congress

38. The Congress Clinic is a general medical practice. It is situated in Gap Road, Alice Springs, a short distance from the Alice Springs Hospital. It has clinic hours. At the time of the deceased's death those hours were from 9.00 am until 8.00 pm during weekdays and on weekends and public holidays from 9.00 am until 12.30 pm. It is not the function of Congress to operate a twenty four-hour emergency service equivalent to that offered at the Alice Springs Hospital. Congress does have a limited after hours service but it is not one designed to deal with serious medical emergencies. In the

case of such emergencies, if contacted, Congress doctors will either refer the patient concerned to the Accident and Emergency Section at the Alice Springs Hospital or call an ambulance for that patient.

39. Congress keeps two types of records in respect of its patients. Firstly there is a computerised system referred to as the Communicare System. This is a basic system for collecting patient data and other statistics that is used in the main for the purpose of gaining government funding. It records the patient's name and basic details of why the patient has come to Congress. Secondly a comprehensive paper record is kept in an individual file of all the patient's consultations and other dealings with Congress. Both systems give the patient a common reference number. The paper files are kept numerically and it is the responsibility of the reception staff to locate and replace the files in an area behind the reception desk at Congress. Doctors requiring a file complete a form, which they hand to a member of the reception staff, who then locate it. Some but not all of the doctors at Congress are capable of locating patient files themselves. Patient files are forbidden to leave the premises of Congress.

40. Congress keeps a wide range of drugs on its premises, which are available to the medical practitioners and other health professionals employed by Congress to dispense to patients. No prescriptions are generally written but it is expected that a note will be made on the patient's medical file of the type of drug dispensed.

The background of Dr Morrison

41. Dr Morrison obtained his medical qualifications in 1975 from the University of New South Wales. He has been a general medical practitioner for well over twenty years, practising mainly in rural areas of Australia, particularly Lismore, New South Wales. He is a Fellow of the Australian College of Rural and Remote Medicine. He has a particular interest in the treatment

and diagnosis of cardiac problems within general practice. I find that he is an experienced general medical practitioner.

The events of 26 January 2001

42. The 26th of January 2001 was a public holiday. It was Australia Day. Accordingly Congress was open from 8.30 am until 12.30 pm. Working that day at the clinic were Tracey Roman, who was the receptionist, Alicia Ross who was the health worker on duty, Syd Strangway who was driving the Congress bus that morning and Dr Noel Morrison, who was the doctor on duty.

43. Dr Tatjana Janusic, the Medical Officer Co-ordinator was not working that day but dropped into the clinic around 11.30 am to do some work on a computer. The morning was described by each of the people working at Congress that morning as being "averagely" busy. Certainly in terms of the workload there was nothing exceptional about the day.

44. The deceased had been at Haasts Bluff to take part in some ceremonial activities. He had left for Haasts Bluff earlier in the week on Monday the 22nd of January. He returned to his home situated at 116 Kurrajong Drive, Alice Springs at about 10.00 am on the 26th of January. Two friends dropped him off in a car. When he first got home he seemed to be in good health and as a result Ms Young took the family car and visited some relatives who lived nearby.

45. When she returned she found the deceased sitting on the floor in the bedroom. He did not look well and was holding his arm across his chest, something that he had done previously when complaining of pain in his chest. Ms Young was concerned and decided that she would ring Congress.

46. She made the call to Congress at sometime most probably between midday and 12.30 pm. It was at any rate around the time the staff was preparing to close after the morning's clinic. The call was answered initially by Ms Roman. She cannot remember the exact nature of the conversation other than the person said she wanted to speak to a doctor and as a result she put the person through to Dr Morrison.

47. It is not surprising that Ms Roman has no particularly strong recollection of the telephone call. She gave evidence to me that she and her fellow workers have been strictly schooled to respect patient confidentiality. As a result they do not vet in coming calls or attempt to ascertain in any great detail why the person calling wishes to speak to a doctor.

48. Both Ms Young and Dr Morrison do recall the content of the conversation although their recollections differ markedly. Ms Young gave the following evidence of the conversation (page 14):

> "All right. And you rang up Congress. What happened when you rang up Congress?---Asked them if I – asked them if they was closed first. And I asked them if I could talk with the doctor. So I asked that doctor if he could check my husband out because he was in pain, was having a lot of chest pains.
>
> So you said about the chest pain?---Yep.
>
> Did you say what his name was? You don't have to say what his name but did you tell the doctor?---Yeah, I told the doctor what his name was.
>
> If they had said at Congress that they were closing up or they were closed, would you have gone somewhere else?---Yep."

49. Dr Morrison gave this evidence of the content of the conversation (page 45):

> "So it was after 12 o'clock. And to whom did you speak?---Um, I spoke to the partner of Mr Impu.
>
> Did she say who she was?---No. she didn't.

> Did she identify the deceased person?---Yes.
>
> So you knew the name?---Yes.
>
> What was the nature of the phone call?---She said words to the effect that Clive Impu has a muscle problem. That he's been getting tablets from the Alice Springs Hospital, could I provide him with more such tablets.
>
> So --- ?---And I gathered she meant anti-inflammatory tablets.
>
> Well you gathered that? Is that now the effect of your evidence that you inferred that she wanted the anti-inflammatories?---Yes.
>
> And it – that her husband was suffering. Was it chest pain?---No.
>
> What sort of pain?---Um, a pain in the right shoulder and she ---
>
> This is on the telephone?---Yes.
>
> So she said ---?---In the right shoulder area.
>
> All right?---Hang on, yeah, I think she said it on the telephone. I know she did when I spoke to her."

50. Ms Young in her evidence was adamant that she did not ask Dr Morrison to stay behind at Congress so that the deceased could get some tablets from him. She said this when cross-examined on the subject (page 26):

> "When you rang the woman at – sorry, you rang Congress and a lady answered. Did you – when you spoke to the doctor did you ask him to stay behind so that you could get some tablets?---No."

51. I accept the submission of counsel for Dr Morrison that to some extent the evidence of Ms Young is "coloured by her grief and obvious resentment". It would be extraordinary if it were not given the circumstances of her husband's death.

52. However I find it unlikely that she would use an expression such as "anti-inflammatories" although she may well have indicated that her husband had received some form of medication from the Alice Springs Hospital. I find however that she did indicate to Dr Morrison that her husband was

experiencing pain. What other reason could she have had for ringing Congress in the first place? This is particularly so given her evidence (page 25) that her husband had some tablets remaining that had been given to him by the Hospital. I find on the balance of probabilities that the content of the conversation between Ms Young and Dr Morrison was that the deceased was experiencing some pain; had previously received medication from a source other than Congress; but had consulted doctors at Congress on past occasions. It may well be that Ms Young indicated to Dr Morrison her husband's belief, erroneous as it turned out, that the pain was attributable to an old football injury. This after all was what he had said to other doctors at the Alice Springs Hospital in the past.

53. However the most important factor flowing from the conversation was that Dr Morrison agreed to see the deceased at Congress prior to Congress closing for the day and that he understood that the deceased was in some pain.

54. As I have indicated Dr Janusic was present at Congress for the latter part of the morning. She was aware in a vague sense of a telephone conversation between Dr Morrison and someone who was requesting medication. Her evidence was as follows:

> "Do you remember having a discussion with Dr Morrison about him seeing a particular patient?---I don't remember the details, but we did talk.
>
> Do you remember what the nature of the conversation was?---Um, there was a phone call from a wife requesting to come and get some medication – if they could pick up medication for her husband. And I can't remember the details of what happened after, but I would have said that they should come in and be seen.
>
> When you said they should come in and be seen, what did you mean by that, when you said that to Dr Morrison, that they, the people that made the enquiry, should be seen ?---That refers to being seen as in a consultation, being assessed.

That was your understanding?---Yes.

And that was what you indicated should occur?---Yes."

55. A central issue for me to determine in this inquest is the nature of the consultation that subsequently took place between the deceased and Ms Young on the one hand and Dr Morrison on the other. From that determination must follow findings regarding the nature of the duty of care owed by Dr Morrison to the deceased and whether he breached that duty of care. It is relevant to note that Dr Morrison had not treated or examined the deceased on any previous occasion.

56. In his report dated 6 May 2001, which was tendered before me, Dr Heard succinctly stated the issue:

> "The issue seems to me to have been, did Mr Impu present late at the clinic and ask for tablets or did he present as a worried man with his wife who had a major problem with chest pain?"

57. Once again Ms Young and Dr Morrison have differing accounts of what occurred. Before turning to the divergences between the two accounts, it is necessary to place the consultation in context.

58. Subsequent to the deceased attending Congress on 26 January the deceased collapsed at his home at 116 Kurrajong Drive, Alice Springs at some time shortly before 1.13 pm. Ambulance records indicate that the ambulance was called to that address at 1.13 pm arriving there at 1.20 pm. The deceased was unconscious at the time the ambulance arrived. He was taken to the Alice Springs Hospital arriving there at 1.34 pm. However unfortunately he never regained consciousness and died at 1.51 pm.

59. The autopsy report of Dr Zillman indicated that the deceased's lungs were in state of pulmonary oedema at the time of his death. A condition that was confirmed by subsequent histological examination. This finding indicates that the deceased's heart was failing to pump properly in the hours before

his death. As a result his lungs filled with fluid. It was a condition that most probably had been in existence for several hours before his collapse, certainly at the time he saw Dr Morrison. The evidence of Dr Heard at Inquest is confirmatory of this.

60. I find therefore at the time the deceased met with Dr Morrison at Congress at sometime after 12.30 pm on the 26th of January 2001, he was more likely than not already in a state of heart failure.

61. Both Dr Morrison and Ms Young agree that the consultation between the deceased and Dr Morrison took place in a consultation room rather than in the public waiting area or at the reception counter at Congress. This fact together with the fact that both the deceased and Ms Young attended at Congress together are in my view more indicative of it being a medical consultation rather than a routine request for a repeat of medication. If it was the latter why did it take place in a consultation room and why were both the deceased and Ms Young present? Surely if it was routine there was no necessity for both to attend. Ms Young, as the person who had requested the medication on the telephone, could have collected it alone on behalf of her husband. Dr Heard in his evidence (Transcript P161) indicated that when two parties attended at the doctor together the expectation was that it was usually a more serious matter, especially when it was an Aboriginal husband and wife attending together. It also flies in the face of the recollection of Dr Janusic, who says she urged a consultation.

62. It is also clear that Dr Morrison requested that Ms Roman obtain the medical file of the deceased. It was Congress policy that if any medication was prescribed that a note should be made of it on the file of the patient concerned.

63. The deceased has a relative with the same name as he does. However this relative is considerably older than the deceased. Ms Roman discovered this fact when she accessed the communicare system at the request of Dr

Morrison. The effect of Ms Roman's evidence is that when this became known, Dr Morrison requested that she get the file of the older of the two patients with the name of Clive Impu. In so doing she, through no fault of her own, obtained the wrong file. As a result at the time Dr Morrison saw the deceased he did not have access to his medical notes.

64. Ms Young gave the following evidence about the meeting in the consulting room between herself and the deceased on the one hand and Dr Morrison on the other (Transcript P16 – 17):

> "What did Kwementyaye tell the doctor, as best you can remember?---He told the doctor about that chest pain and that – he said tingling in both arms and numbness.
>
> So the tingling in both his arms and the numbness and about the chest pain?---Yeah.
>
> Did he do anything when he said this?---He was showing – pointing that where it was.
>
> And did the doctor ask him what sort of pain or how bad it was?---Yep.
>
> The doctor did ask, did he?---Yeah.
>
> Did he do anything after that?---No.
>
> Like touch? You know, sometimes a doctor pushes your chest or asks to take your shirt off?---No.
>
> What happened after that?---The doctor opened that file and said, 'The only time you was here was with the flu.'
>
> Yes. What did Kwementyaye say about that?---He said, 'You must have got the wrong file. Must have been my old man's file.'
>
> And did Kwementyaye say anything about the football or hurting himself in the football?---Yeah he told that doctor he thought it was a stretched muscle and the doctor said it would have healed up by now.
>
> Did Kwementyaye mention anything about tablets and medicines?---Yeah, he told that doctor about them white pills. He's been saying that tablet helped him a bit. That's what he said to the doctor.

When you rang up and spoke to the doctor did you say anything about tablets to him?---No.

What about when you got to Congress, did you say anything about tablets to anybody at Congress?---No.

How long were you with the doctor for?---Not that long. He just sat in that chair and looked at him, 'You might have arthritis but you're too young to have arthritis.' And then he got up and he went to the little pharmacy at Congress and he got a box of tablets and he said it was for arthritis. Told him to take it. And then we went home after that."

65. Both Ms Young and Dr Morrison are in agreement that Dr Morrison did not physically examine the deceased or take any measurements or his pulse or blood pressure or temperature or make any other observations of him by means of a stethoscope or other instrument.

66. Dr Morrison's gave his account of the meeting as follows (page 50 – 52):

"All right. Now in the consulting room, and I appreciate it's now some 8 months or so later, do you remember how the meeting between you and the deceased and Ms Young began; who initiated the conversation?---Um, no I don't. Both people spoke to me. And I asked Mr Impu to point to the site of the pain. And he pointed to the right armpit and shoulder area.

So you asked him to point to the area of the pain?---Yes. And then either he or she sort of said that it was due to a football injury that occurred at the end of the football season the previous year.

The previous year?---Yeah.

Do you follow the football?---No.

Do you know when the football season ends in Alice Springs?---Um, in Alice Springs I don't. I know that in normal States it's at the start of summer.

All right. Did it surprise you a person complaining of a muscular type injury some 3 or 4 months after it could have been inflicted?---Slightly, so I made the suggestion that he could see somebody like a chiropractor.

> As a general practitioner your job is to be empathetic and get people's stories from them?---That's right....
>
> Do you think that what occurred in your consulting room or consulting cubicle became a consultation?---No, I don't. Well they were under the – Medicare's definition of a consultation it would be, a brief attendance. …
>
> So the deceased man indicated that he was having some pain. He indicated and area?---Yes. Yes, he sort of indicated and said that he'd been having it for – ever since the football, the end of the football season.
>
> Did you think at that stage that you ought to palpate his shoulder or move it around or have a look?---No, I didn't.
>
> Why not?---Because I was complying with the request for medication and they said they'd already been seen several times for the same problem at the hospital."

67. It is common ground that at the conclusion of the meeting between the deceased and Dr Morrison, Dr Morrison went to the Congress pharmacy and obtained a box of *celebrex,* a common and popular anti inflammatory medication and gave it to the deceased. It is also common ground that the meeting was brief and that Dr Morrison did not examine the deceased. The deceased was also given a sling.

68. Dr Morrison's position has always been that he was routinely answering a request for medication from the deceased. As such his meeting with the deceased and Ms Young did not require a more detailed examination of the deceased than that which he was afforded on the 26th of January 2001.

69. For a number of reasons which I will now enumerate I do not accept in its entirety the evidence of Dr Morrison in respect of what took place.

70. It seems clear to me that when the deceased attended on Dr Morrison that he had the expectation that he would be examined. This after all was his experience of each of his other past attendances at both Congress and the Alice Springs Hospital when he had seen a doctor and complained of pain.

71. When the deceased attended on Dr Morrison, on Dr Morrison's evidence there was the beginning of an examination, albeit a cursory one by the Doctor of the deceased. Dr Morrison asked the deceased where the pain was and the deceased indicated by pointing.

72. In my view this does support the contention that Dr Morrison did at least start on the process of making some sort of assessment of the deceased which in the normal run of medical practice should have ended in diagnosis. This to my mind supports the evidence of Ms Young that the deceased did indicate to Dr Morrison that he had had previous medication for the pain and that this had seemed to help him. To my mind such a statement is akin to patient history and is not in my view analogous to a request for repeat medication.

73. I also accept that the deceased indicated to Dr Morrison that he (Dr Morrison) had the wrong patient file when the consultation began. The evidence of Ms Young was that Dr Morrison said to the deceased that there was no mention of any previous pain in the file and only a reference to the flu. A contention that can only support the position that the deceased knew that Dr Morrison had the file of his older relative and was concerned by it. It cannot be an invention. A person seeking only a repeat of previous medication would not have been concerned by this omission. His concern would only be to get the medication. It seems clear to me that the deceased wished Dr Morrison to understand his past history and in so doing reach a concluded diagnosis.

74. Dr Heard in his evidence spoke of situations in general practice where medication might be prescribed after only the most superficial sort of examination (page 160):

> "Is it good general practice to prescribe any medication to a patient the doctor has not seen on a prior occasion?---The terms you've put it I would say it's fine, as long as you seen them adequately.

> Well it's – that's on – so if that's occurred it would require a consultation?---Yes.
>
> So you haven't seen the patient before, there would be a consultation, regardless of what medication it was?---I think there would always be a consultation of some sort. I do think very occasionally there would be a very superficial one, when, perhaps, a traveller came in with their box of tablets, blood pressure tablets, or something at the last minute, saying they were going to Katherine or something and could they please have some more. I mean I might just check their blood pressure and give it to them, out the door, if they're late on a Saturday morning.
>
> So there'd be some assessment?---Some assessment."

75. To my mind that was not the scenario here. The deceased did not in my view present to Dr Morrison with a clearly accepted diagnosis in his mind – like the traveller with his box of blood pressure tablets – he was expecting to be examined and a further diagnosis made. He had no such empty carton. He was complaining of pain and indicated that to Dr Morrison. That being the case and Dr Morrison having agreed to see him, Dr Morrison was in my view obliged to conduct a more thorough examination of the deceased than he did.

76. I also find that the deceased had in any event still have ample supplies of the medication that he had received from the hospital at his home.

77. As Dr Morrison said it his own evidence it is the duty of general medical practitioners to be empathetic with the patients that consult them. In other words to obtain as best and as skilfully as they can the patient's history. This is especially so in the setting of an Aboriginal Health Clinic, where the vast majority of patients are again, for want of a better phrase, "traditionally orientated".

78. The examination that the deceased received from Dr Morrison on the 26th of January 2001 was cursory and in the circumstances inadequate.

79. In his evidence to me (Transcript P57) he said that if he had had the correct file on the day in question that he would have asked the deceased several more questions.

80. It was the evidence of both Dr Boffa (Transcript P109) and Dr Janusic (Transcript P140) that in the absence of a patient's file or in a situation where the doctor is unfamiliar with the patient that the doctor concerned asks more rather than less questions and is more meticulous in his examination. This would seem to me to be rudimentary medicine. The essence of general practice is to go through a process to reach a diagnosis. That process entails the taking of a history and appropriate examination. Medication is prescribed when a diagnosis has been made.

81. Dr Heard in his evidence (Transcript P161) indicated that greater caution should also be exercised in respect of Aboriginal patients because of the higher prevalence of serious disease amongst them, even in young patients. The emphasis is always on the clinician actually ascertaining what is going on with the patient.

82. In this case a physical examination of the deceased was clearly warranted. Dr Boffa (Transcript P114) would have sprung the deceased's ribs and taken a blood pressure. Dr Heard (Transcript P165) would have listened to the deceased's chest. However the common thread with all the doctors concerned is that they would have taken a more thorough history from the deceased and seen where this led.

83. The tragedy of this particular case is that the deceased appeared to Dr Morrison (Transcript P54): "to be a particularly fit, muscular, healthy young man in no sign of distress at all". In this belief he was sadly mistaken. The news of the deceased's death was a cause of great shock and distress to Dr Morrison. To my mind the depth of this shock explains to some extent but not all, the subsequent behaviour of Dr Morrison in respect of the matter.

84. Dr Morrison learnt of the deceased's collapse at around 1.35 pm, around about an hour after he had seen the deceased. At this stage I have no doubt that Dr Morrison began to question in his own mind the adequacy of his consultation and examination of the deceased, an examination which I have found to have been inadequate in the circumstances. I suspect that at this time Dr Morrison too realised that what had occurred was inadequate and very poor general medical practice.

85. Furthermore, after observing Dr Morrison giving evidence, I am compelled to the view that Dr Morrison was less than frank with the Court. I found him to be disingenuous and evasive. His final couple of answers in the foregoing quoted exchange are simply not believable (Transcript P87):

> "Just on that topic, you knew on the 29th that this matter was reportable death to the Coroner, didn't you?---Yes.
>
> Because there was no death certificate?---Yes.
>
> Issued by you?---Yes, I think that's right.
>
> Furthermore, you knew that there was a probability of a coronial inquest by and on the 29th, didn't you?---Um, I didn't really know what was on the cards. All I knew was I – that I should make more detailed notes.
>
> And that's because it was a reportable death to the Coroner for investigation purposes by the Coroner; didn't you?---Um, well as I said, I didn't know what it involved.
>
> Look, doctor, you've treated a man, or at least seen, for medical purposes, a man on a particular day, who has died an hour after leaving you?---Yes.
>
> You know it's a reportable death to the Coroner?---Yes.
>
> And knowing that, plus other things, including, it might be said, incomplete notes of the 26th?---Mmm.
>
> You revisit the file on the 29th and take original medical records from that file, destroy them and replace them with something else. Can

> you understand that that concerns me, as the Territory Coroner, a medical practitioner doing that?---Um, I can now.
>
> And what is the concern you can now understand?---Um, that you and other people have said that I shouldn't.
>
> Yes, and why do you think we've said that you shouldn't?---I don't know."

86. In my view, much of his evidence was a reconstruction of events to minimise what he knew to have been his inadequate examination of the deceased in the light of what subsequently occurred and in the light of the deceased's complaints of pain to him. Dr Morrison went to some lengths to indicate that the deceased's complaint to him was one of "shoulder pain" rather than "chest pain".

87. As I have indicated Dr Morrison learnt of the deceased's collapse at about 1.35 pm. He was telephoned from the Alice Springs Hospital by Sister Harker. Sister Harker was part of the resuscitation team at the hospital and she wished to have as much of the deceased's medical history as was possible. It is clear that she made a note of her conversation with Dr Morrison and that that note made its way onto the deceased's Alice Springs Hospital file. The note was as follows:

> "I 12.30 – Anti Inflamatory drugs
>
> Celebrex
>
> pain R breast R axilla
>
> football injury since last "

88. To my mind it is telling that the note indicates pain in the right breast as well as the axilla.

Events Following the Deceased's Consultation with Dr Morrison

89. Following his consultation with Dr Morrison the deceased returned to his home at 116 Kurrajong Drive, Alice Springs. Ms Young was driving. She drove straight home without deviation. It takes about eight minutes to drive the journey. On arriving at home the deceased told Ms Young to put a mattress down on the floor in the house so that he could lie down on it. Ms Young left the deceased in the car while she went to do this. Whilst she was away the deceased collapsed in the car.

90. As soon as this happened Ms Young called St John Ambulance. Ambulance records indicate that the call was received at 1.13 pm, a crew was despatched at 1.14 pm and that the ambulance arrived at the house at 1.20 pm. On arrival the ambulance officers found the deceased to be unconscious and his breathing to be shallow. He had a weak bracchial pulse. A short time later the deceased stopped breathing and went into a state of cardiac arrest. Because of the seriousness of the deceased's condition, the ambulance officers concerned, Peter Wilson and Adele Major called for paramedic backup.

91. Craig Douglas Garraway, a paramedic and the deputy regional manager of St John's Ambulance lived close by and arrived at the scene at 1.23 pm. Mr Garraway found the deceased to be in full arrest that is there was no pulse and the deceased was not breathing. As a result Cardiac Pulmonary Resuscitation ("CPR") was commenced at this time.

92. The deceased was put onto a stretcher and loaded into the ambulance and taken to the Accident and Emergency Section of the Alice Springs Hospital. The ambulance left the house at 1.28 pm and arrived there at 1.34 pm. During the trip to the hospital the ambulance crew continued with CPR. The ambulance concerned carried advance life support equipment and a defibrillator, a devise that applies electrical shocks to the heart that are

calculated to reinvigorate the heart in the event that it stops beating. Monitors within the ambulance indicated that the deceased was in asystole during the six minute journey from his home to the hospital. This indicates that his heart was not beating at all and that it was producing no electrical energy.

93. The evidence of Mr Garroway was that he was authorised by St John's protocols to perform a low-level defibrillation in appropriate circumstances. By low-level defibrillation electrical shocks of 200 jules on three occasions is meant. On the day in question the defibrillator was not working and accordingly the deceased could not be defibrillated in the ambulance.

94. The deceased was however defibrillated at the Alice Springs Hospital on a number of occasions starting at 1.41 pm. He was also administered adrenaline and atropine and CPR was continued. The hospital's monitoring of the deceased showed that he remained in asystole from the time of his arrival. Unfortunately it was not possible for him to be revived and the resuscitation attempts were ceased at 1.51 pm.

95. As I have indicated Dr Morrison learnt of the deceased's collapse very soon after it had occurred. The Alice Springs Coroner's Constable, Constable Hosking, informed him of the deceased's death later that afternoon. At this time Constable Hosking asked Dr Morrison whether he would be in a position to issue a death certificate in respect of the deceased. Dr Morrison indicated to Constable Hosking that he would not be able to do so.

96. Dr Morrison arranged to attend at the Alice Springs Hospital so that he could be better appraised of what had happened. I accept that Dr Morrison was deeply shocked by what had occurred. Dr Morrison did not make any notes in respect of his consultation with the deceased contemporaneous with the consultation. Later that afternoon at sometime after 2.00 pm and before he attended at the hospital he wrote notes in respect of what had happened.

97. The evidence is uncontroverted that these initial notes were duly filed on the deceased's Congress medical file where both Dr Boffa and Dr Janusic later saw it. However Dr Morrison at a later stage removed his initial notes from the file and destroyed them. This is a matter of great concern to me.

98. The explanation for his behaviour provided by Dr Morrison was that on the Monday following the deceased's death he spoke to Dr Janusic regarding the matter. She recommended that he make a more comprehensive note of what had occurred. This he did in fact do on the 29th of January 2001 but nonetheless he dated the subsequent note the 26th of January 2001. I note there is nothing in writing to indicate at all that these notes were made on 29th January 2001. In those circumstances his evidence was that he believed that the initial note was now superfluous and could thus be discarded. In his evidence Dr Morrison told me that he did not believe that what he did in those circumstances was either inappropriate or wrong.

99. As I have stated I do not accept his evidence in this regard. All of the medical practitioners who gave evidence before me emphasised the sacrosanct nature of medical records. Dr Boffa said (page 133) that: "…in my experience I've never seen it happen before." Dr Janusic said (page 142) that: "…it's not normal practice and makes the person look bad if they remove it. You shouldn't do it."

100. Dr Heard gave evidence in respect of patient notes as follows (Transcript P157):

> "What would your view be of a situation where a note was made in respect of a meeting between a doctor and patient and it became part of the patient's medical record, and the note was subsequently removed?---Well I think at an undergraduate level, from my experience, every medical student would be taught that that was inappropriate behaviour. And certainly at a postgraduate level, again ---
>
> THE CORONER: Can I just take this part because it is really quite concerning me? You have a doctor who attends in consultation with

a patient and his wife. The man dies within an hour, of natural causes, of leaving that consulting room. A doctor has made contemporaneous notes. They're placed on the hospital – on the file. That same doctor, knowing it is a reportable death to the Coroner, being warned of a probable inquest, the following Monday he takes those notes and destroys them, original medical record notes, replaces them with other notes. What's your opinion, as lecturer in general practice to doctors, of that kind of behaviour?---Well I would think everybody would be taught never to do that.

And why?---Because I guess, we appreciate that if somebody does it – it makes you seem guilty of something.

But more than that, isn't it the case that the best evidence of what occurred at that consultation is in the original notes made at the time?---Yes, I think – well I would encourage somebody, if something very unexpected happened to perhaps make fuller notes in addition to those, but never to remove the original notes.

It's just not good medical practice, is it?---I think it's bad practice."

101. Dr Boffa said of the note (Transcript P113):

"Now you saw a note that Dr Morrison apparently wrote on the day he saw this man. Do you remember the content of this note?---I remember looking at it and thinking it was very brief and being somewhat annoyed at the fact that there was no diagnosis. So it was a very brief note, basically explaining information he'd been given over the phone, describing symptoms. No examination. No diagnosis. And then a medication prescribed.

So you were somewhat annoyed?---Yeah, I mean it wasn't what I'd hoped to see."

102. From this answer I take it that Dr Boffa thought that the original note reflected some shortcomings in Dr Morrison's examination of the deceased, that is the note reflected the prescription of a medication without first an examination being done and a diagnosis made.

103. In all these circumstances it seems to me extraordinary that Dr Morrison should subsequently remove the note and substitute for it another more

extensive note, which nonetheless was dated the 26 January 2001 although it was actually written some three days later.

104. In these circumstances the only inference I can draw from this behaviour is that Dr Morrison wished to minimise any adverse criticism he might subsequently receive for his inadequate examination of the deceased and his failure to make a diagnosis. A situation that was reflected in the original note, certainly in the interpretation of it by his medical colleague, Dr Boffa. In my view Dr Morrison is to be criticised for his behaviour in respect of the notes which at best can be described as thoughtless and cavalier and at worst deceptive. In my view, it was unprofessional behaviour.

OTHER ISSUES AND RECOMMENDATIONS

The Failure of the Ambulance Defibrillator

105. It was unfortunate that the defibrillator in the ambulance failed to work. However given that the deceased was in asystole at the time he was loaded into the ambulance I find that the unavailability of low level defibrillation is unlikely to have made any difference to the ultimate outcome in respect of the deceased.

The Failure of the Deceased to Undergo an Exercise ECG and Attend the Specialist Clinic and undergo Fasting Cholesterol Test

106. One of the tragedies of this particular matter is that in March of 2000 an opportunity arose to address the possibility that the deceased had ischaemic heart disease. Neither the deceased nor his medical advisers were able to take that opportunity.

107. In March of 2000 Dr Boffa wanted the deceased to be examined by a specialist. Apparently the deceased was also well motivated at that time to have such an examination. The specialist consultation never eventuated.

Why it did not eventuate seems to have been as a result of a succession of unfortunate errors.

108. The specialist clinic was cancelled. The fact of the cancellation was noted on the wrong file, once again the file of Mr Impu Senior and accordingly it was not possible to follow up with the deceased the reason he had not attended the clinic and for a subsequent appointment to be made for him. This error was unfortunate but in my view not of such magnitude as to render Congress itself liable for any particular criticism. It can not now be determined why the deceased himself did not follow up with the specialist appointment himself. Most likely it can be attributed to his lack of sophistication in medical matters and his lack of knowledge of the dangers of ischaemic heart disease.

109. It was at the specialist clinic that an exercise electrocardiogram (“ECG”) would most likely have been ordered. This is a procedure where a patient’s heart is subjected to stress through exercise to see if ischaemic heart disease is present. A doctor has to be present because of the risk of the patient concerned developing acute ischaemic pain whilst exercising. General Practitioners in Alice Springs are not able to order exercise ECG’s only specialists can. I accept that this would appear to be something of a bottleneck in the diagnosis of ischaemic heart disease.

110. In his evidence Dr Boffa told me that such procedures are not in themselves expensive but they do require doctor time to conduct for the reason I have already provided.

111. Dr Heard told me that in his view it would be worthwhile if general practitioners could order exercise ECG’s directly without the intervention of a specialist first.

112. I accept the evidence of both Dr Heard and Dr Boffa in this regard and recommend that steps be taken by Territory Health Services to allow general

medical practitioners in Alice Springs to order exercise ECG's directly without the requirement for their patients to see a specialist first.

113. I accept Dr Boffa's evidence that steps have been taken by Congress to make it easier for their patients to have measurements of their cholesterol levels taken after the necessary period of fasting.

114. As with all diagnostic tests there is always some onus on the patient to follow through with the necessary attendance to have the required test done.

Orientation of Medical Practitioners working in Central Australia

115. Dr Boffa told me in his evidence that statistics indicate that the leading cause of overall death amongst Aboriginal people both nationally and in the Northern Territory is ischaemic heart disease. In both men and women it is the second highest cause of premature death in the Northern Territory. (It is a sad indictment that the leading cause of premature death amongst men in the Northern Territory is motor vehicle accident and amongst women is homicide.)

116. Yet although there is a high rate of death from ischaemic heart disease the level of diagnosis remains low. Dr Boffa told me that of the approximately 10,000 patients known to Congress only about 100 or so have been diagnosed as suffering from ischaemic heart disease.

117. The other issue which is particularly germane when considering the provision of medical services to Aboriginal people is that generally they are more likely to develop chronic disease at an earlier age than non-Aboriginal members of the community.

118. The development of ischaemic heart disease by Aboriginal people in their twenties, as this present case demonstrates, cannot in any way be regarded as aberrant. Nonetheless Dr Boffa indicated to me in his evidence that it was his experience that some doctors who came into Aboriginal health from

elsewhere would hardly consider ischaemic heart disease in a young patient, even an Aboriginal one.

119. Anything that has the potential to alert medical practitioners to the greater prevalence of ischaemic heart disease amongst Aboriginal patients must have value and must, one would think, lead to a greater level of diagnosis.

120. For that reason I adopt the submission of Ms Budrikis, counsel for Congress and recommend that all medical practitioners in Central Australia undergo a specific orientation in respect of the greater prevalence of chronic disease amongst Aboriginal people than in the wider population, including the prevalence of ischaemic heart disease as soon as possible after commencement of medical practice.

CONCLUSION

121. When the deceased presented at Congress on the 26th of January 2001 he was entitled to be medically examined, and he should have been medically examined. With the benefit of a great deal of hindsight it is now possible to ascertain that when he arrived at Congress he was seriously ill. It is clear that he was not suffering from a comparatively trivial musculo-skeletal problem but rather a life threatening ischaemic heart disease.

122. For the reasons that I have already provided the examination afforded to him by Dr Morrison was inadequate and Dr Morrison is to be criticised for that. I pause to note that my findings in relation to Dr Morrison have been duly considered having regard to the ramifications they may have on his professional life, and also having regard to the satisfactions I am to have in relation to the evidence (Briginshaw.v.Briginshaw (1938) 60 CLR.336).

123. Whether a more thorough examination of the deceased and the taking of a more exhaustive history from him would have made his death less likely to have occurred cannot now be ascertained. It is however likely that a more thorough examination and taking of history from the deceased would have

made a correct diagnosis more likely. As events ultimately unfolded, the only course that would have been likely to have prolonged the deceased's life would have been for him to have gone directly to the Alice Springs Hospital from Congress.

124. Given how he presented at Congress on the 26th of January 2001, even with a thorough and comprehensive medical examination, it is highly possible that the deceased would have been allowed to go home first before being urged to make his own way to the hospital. Given the results of Dr Zillman's autopsy examination, which shows that the deceased had long standing coronary artery disease, I accept that the deceased was living to a large extent on borrowed time in the event that his illness was not diagnosed. I accept that the factors, which trigger arrhythmia in those patients suffering coronary artery disease, are sporadic and unpredictable.

125. It can only be speculation that dissatisfaction and unhappiness at his treatment from Dr Morrison, or the mere stress from going to the doctor's surgery, triggered the arrhythmia that resulted in the deceased's fatal cardiac arrest. It is impossible to know the instant "trigger".

126. The sadness of this particular case is that a number of skilled and caring medical practitioners at both the Alice Springs Hospital and at Congress, through no fault of their own and through no failure of diligence on their part, were unable to diagnose the deceased's illness, notwithstanding their medical examination of the deceased during the last year of his life.

Dated this 19th day of October 2001.

____

GREG CAVANAGH
TERRITORY CORONER