OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Fay CRAMB**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2965/08(9)
DELIVERED ON:	07 May 2010
DELIVERED AT:	Townsville
HEARING DATE(s):	5 March 2010, 04-06 May 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: death in custody, provision of health care to impaired patients, end of life decisions by prisoners

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Health:	Mr Geoffrey Diehm SC (instructed by TressCox Lawyers)
Sisters Inside:	Ms Catherine Cuthbert & Ms Debbie Kilroy
Department of Community Safety:	Mr Michael Nicolson
QPS Commissioner:	Mr Liam Burrow (QPS Solicitors Office)

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The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Fay Cramb. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Fay Cramb had spent more than twenty years as an inmate in Queensland prisons when, on the early evening of 27 May 2008, she died at Townsville Hospital. She had narrowly avoided this fate three weeks earlier when undergoing emergency surgery and subsequent treatment in the Townsville Hospital Intensive Care Unit (ICU).

By 27 May 2008 Ms Cramb had improved to the extent that she had been transferred to a medical ward after mechanical ventilation had been withdrawn. She had a tracheotomy in place. After complaining about a build up of secretions early that evening, nurses attempted to clear her airway by the use of suctioning equipment. A fault with the operation of that equipment delayed this process; Ms Cramb began to turn blue and a medical emergency team was called. They found her unconscious and not breathing. Ms Cramb's wish not to be resuscitated in such circumstances was respected and she died within minutes.

These findings:-

- confirm the identity of the deceased, describe how she died and establish the time, place and medical cause of her death;

- examine the events leading up to her arrival at Townsville Hospital on 5 May 2008 and consider the adequacy of the medical care provided to Ms Cramb while she was in custody;

- consider the adequacy of the care provided to Ms Cramb at the Townsville Hospital during her last admission; and in particular, determine the validity of assertions that her medical care was influenced by police officers' desire to interview her in relation to unsolved criminal offences;

- consider whether staff at Townsville Hospital gave adequate and timely regard to the deceased's wishes in relation to resuscitation and the withdrawal of life sustaining measures as expressed via her next of kin;

- examine the events immediately preceding the rapid deterioration and death of the deceased on the early evening of 27 May 2008;

- consider the adequacy of the policy and procedures governing the recording and notification of next-of-kin details for prisoners when they are transferred to hospital;

- consider the procedures in place to assist prisoners in the making and implementing of 'end of life' health care decisions; and

- consider whether any changes to procedures or equipment could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Ms Cramb's death was reported to the Corrective Services Investigation Unit (CSIU) shortly after her death. A member of that unit, Detective Senior Constable Grant Linwood, had been forewarned of her imminent demise and was on stand-by. He conducted an investigation into the circumstances surrounding the death and later compiled a detailed coronial report.

Initial investigations at Townsville Hospital were conducted by officers from the Townsville Criminal Investigation Branch. On 29 May 2008, Senior Constable Linwood attended Townsville Correctional Centre (TCC) to seize records relating to the deceased and to conduct an inspection of her cell. He later attended Townsville Hospital Morgue and observed Dr Williams conduct an autopsy examination.

Statements were obtained from some medical staff who had attended to the deceased at both TCC and Townsville Hospital. Other statements were later provided to the Office of the State Coroner pursuant to directions requiring their production. Senior Constable Linwood seized the medical records relating to the deceased from Townsville Hospital and obtained a copy of the security log maintained by Custodial Corrections Officers (CCO's) during the deceased's stay in hospital.

Senior Constable Linwood took statements from all relevant CCO's, corrections supervisors, Queensland Ambulance Service personnel and from Ms Stephanie Gunton who was the deceased's nominated next-of-kin.

At the conclusion of his investigation Senior Constable Linwood formed the view that there was no evidence to conclude that any other person had caused or contributed to the medical deterioration of Ms Cramb at Townsville Hospital. The concerns raised by Ms Gunton regarding the care afforded to the deceased at Townsville Hospital were referred to the Office of the State Coroner for further consideration and investigation.

Senior Constable Linwood expressed frustration and concern about the tardy response of some of the Queensland Health employees to his repeated requests for statements. I share his concerns. This is not an isolated incident: it is an on-going problem. I appreciate public hospital employees are very busy, but in my view they need to pay greater heed to their obligation to assist those responsible for investigating the deaths of their patients. The Coroners Act contains provisions that enable coroners to compel the production of information and statements. The police officers attached to the Office of the

State Coroner are liaising with QPS investigators to ensure they are aware of their right to resort to these powers when undertaking coronial investigations.

I find that the investigation into this matter was professionally conducted and I thank Senior Constable Linwood for his efforts.

No investigation into the death of Ms Cramb was carried out by the Department of Community Safety; the *Corrective Services Act* 2000 making it clear that there is no requirement to instigate such a process when a QPS investigation has already commenced. No investigation, analysis or other mechanism of review was instigated at Townsville Hospital. This is more surprising having regard to the temporal connections between the death and an equipment failure.

The Inquest

Ms Cramb's death was a death in custody and in accordance with the requirements of the Act an inquest was held over three days in Townsville commencing on 4 May 2010. Leave to appear was granted to Queensland Health, the Department of Community Safety and the QPS.

At the pre-inquest conference on 5 March 2010 leave to appear was granted to a specialist prisoner welfare and advocacy group, Sisters Inside, pursuant to s. 36(2) of the Act. I accepted their submission that issues other than those originally identified by counsel assisting should be inquired into and the inquest benefited from material supplied by Sisters Inside and their submission on preventative recommendations.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The inquest heard oral evidence from Ms Cramb's nominated next-of-kin, Stephanie Gunton. Evidence was also taken from three nurses involved in Ms Cramb's treatment in the hour prior to her death, from Dr Emma Hothersall who treated Ms Cramb in the Townsville Hospital intensive care unit and from Professor David Williams who conducted the autopsy examination. Independent medical expert evidence was heard in relation to the quality of the care afforded to Ms Cramb in the period just prior to her death.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Social history

Fay Cramb was born on 2 August 1943 and on the available evidence appeared to have endured an abusive childhood. Court documents show that in 1959, at the age of 15, she was registered as a neglected child and committed to the care of the state until the age of 18. There is also reference to her being the victim of severe childhood sexual assaults.

The second half of her life was to be defined by her dysfunctional relationship with Barry Watts whom she married and later divorced. In November 1987, she and Watts abducted, raped and murdered a 12 year old girl near Noosa. The horrific nature of the crimes resulted in a degree of notoriety in the prison system as well as in the wider community.

She was sentenced to life imprisonment on 20 October 1988.

It has long been suspected by QPS homicide detectives that Ms Cramb had knowledge of the circumstances of other deaths for which Mr Watts is believed to be responsible. She had been questioned with little success in April 2007 in relation to the 1987 disappearance from Carseldine of a young woman, Helen Feeney. It appears she did little to dissuade investigators from their suspicions as shortly after being questioned Ms Cramb advised TCC staff that she had significant information to pass on in relation to Ms Feeney's disappearance. Subsequent questioning in May 2007 by both the current and original investigator into Ms Feeney's disappearance failed to result in any useful information being given.

Custodial and medical history

Ms Cramb served her sentence in Brisbane and Townsville. She was held at TCC for the last three years of her life.

Extensive records show that Ms Cramb suffered from a number of chronic medical conditions. She had long standing type II diabetes and emphysema. She was obese throughout her prison life, weighing more than 100kg in May 2008.

Ms Cramb was 44 when she was imprisoned and it was accepted at the inquest that she was not healthy at this time; suffering even then from emphysema and obesity. The extensive prison medical records show her to have been hospitalised in Townsville on a number of occasions between 1993 and 2008. Those records reflect a concern over many years in relation to her weight and the receipt of advice on matters such as diet. They also consistently record her next-of-kin as being Stephanie Gunton (who gave evidence at the inquest and will be discussed later in these findings).

I have given careful consideration to the evidence relating to the long standing health problems suffered by Ms Cramb. I have considered this in the context of the very useful evidence submitted by Sisters Inside concerning health outcomes for prisoners (and in particular women in prison). While it is likely Ms Cramb's death can be linked to her poor long term health, her obesity in particular, I am not persuaded this could justify an extensive investigation of health care for women at TCC in a general sense.

Ms Janet Smith, a nurse in charge of offender health services at TCC provided the court with a broad outline of the approach taken to prisoner health concerns. I accept, on the basis of this information and from information obtained from other recent inquests that the takeover of offender

health services by Queensland Health in July 2008 has resulted in improved practice and procedure in the provision of health care to prisoners. I am, though, mindful of the well established evidence concerning poor health outcomes for long term prisoners which can not be reconciled with the principle of 'equivalence'.[1]

During the course of the inquest Ms Smith had an opportunity to more thoroughly examine Ms Cramb's custodial health files. Those records show that Ms Cramb was not on insulin for her type II diabetes but that the condition was managed by oral medication. They show that 'Hb A1C' testing to monitor the extent and seriousness of her condition was carried out on a regular basis from at least 2005 until the date of her death. These tests were arranged by visiting medical officers (VMO) to TCC. Ms Cramb's medication regime was often changed in response to the results of this testing.

Ms Cramb's pre-existing health conditions and the absence of specific evidence in relation to any deficiencies in her care mean that this is not a suitable case for a more extensive examination of that issue.

Events of 3 May 2008

At 2:23pm on 3 May 2008 staff at TCC called the Queensland Ambulance Service (QAS) to attend to Ms Cramb. She had been unwell since that morning and transferred to the prison medical unit for staff to observe her condition throughout the day. QAS officers arrived around 20 minutes after the call to find Ms Cramb short of breath and clammy. They made an initial assessment of early onset acute pulmonary oedema.

Ms Cramb was transported to the emergency department at Townsville Hospital where she was kept under observation for a number of hours. Her condition improved and she was considered sufficiently well to be transferred back to TCC later that evening. Adjustments were made to the level of some of her medication and advice given for the VMO to refer Ms Cramb for a sleep study in order to better assess the extent of her obstructive sleep apnoea.

Events of 5 May 2008 – TCC

Two days later Ms Cramb again reported to TCC staff that she was feeling unwell and was having difficulty breathing. She was attended to by medical staff and placed on oxygen. QAS was called at 2:30pm and arrived at 2:44pm to find Ms Cramb suffering nausea, dizziness, shortness of breath and chest pain.

QAS officers treated Ms Cramb at TCC and transported her to Townsville Hospital, arriving there at 4:04pm. The time taken from arrival at TCC to arrival at Townsville Hospital appears to have resulted from the need to stabilise Ms Cramb, but may also have been contributed to by a delay caused by a difficulty in identifying staff available to provide an escort to the hospital.

[1] The long established principle that prisoners should be afforded health care of an (at least) equivalent standard to those in the general community.

John Harrison, then the General Manager of TCC, gave evidence at the inquest and stated that after Ms Cramb was transferred to hospital attempts were made by either himself or his staff to contact Ms Stephanie Gunton. She was listed as Ms Cramb's 'primary contact' on prison records. He says that these attempts were unsuccessful.

Second admission to Townsville Hospital

On arrival at Townsville Hospital, Ms Cramb was attended to by Dr Kumar Gunawardane, a senior consultant cardiologist. He diagnosed Ms Cramb as suffering from an acute atrio-ventricular block. This is a disturbance of the electrical conduction from the upper part of the heart to the lower part, causing them to pump disjunctively rather than in the usual co-ordinated manner. Dr Gunawardane considered he needed to insert a temporary pacing wire into Ms Cramb's heart to stabilise its rhythm.

Ms Cramb was unconscious and so unable to consent to this treatment. The proposed intervention might have been categorised as emergency, life preserving treatment which a medical practitioner is entitled to undertake without a substituted decision maker's consent. Notwithstanding this a registrar assisting Dr Gunawardane called the TCC at 6.00pm and spoke to a nurse to try and get the contact details of Ms Cramb's next of kin. This information was apparently not readily available but the nurse undertook to have a senior officer call the hospital to discuss the matter. The chart records that the insertion of the pacing wire proceeded between 6.18 and 6.32pm. The assisting registrar recorded he spoke with the TCC Custodial Services Manager, Mr John Harrison, at some time after 6.45pm who, according to the chart, was "*happy with the treatment*" that had been provided.

Mr Harrison recalls that he spoke to either a doctor or a member of the prison staff shortly before Ms Cramb underwent the planned procedure. In any event he understood that Ms Cramb's treating doctor was trying to obtain consent for the procedure. He says that he again tried to contact Ms Gunton but, as with earlier in the afternoon, was unsuccessful. Mr Harrison's evidence was that he then travelled to Townsville Hospital and in fact arrived just prior to the planned procedure. He recalls that the operating doctor spoke to him briefly, stating that he had decided to go ahead with the procedure without obtaining consent due to the urgency of the circumstances.

Mr Harrison is sure that he was not asked for his consent in relation to the procedure at this time or at any later time in relation to ongoing treatment. He understood that he was not in a position to give such consent. If the issue of consent had not been resolved by the decision of medical staff to proceed on an emergency basis, and he could still not get in contact with Ms Gunton, he would have consulted with departmental lawyers as to what steps to then take.

During the procedure Ms Cramb began to show signs of respiratory distress. A medical emergency team (MET) was called but despite the use of

inotropes[2], diuretics and a CPAP machine to assist with her breathing, Ms Cramb's condition continued to deteriorate and she developed respiratory failure and acute renal failure. She was transferred to the ICU and later that evening was placed on mechanical ventilation and renal dialysis. She was diagnosed as suffering from multiple organ failure and was receiving drug therapy for her heart, lung and kidney functions.

Treatment in ICU

The director of Intensive Care medicine at Townsville Hospital, Dr Geoffrey Gordon, described Ms Cramb as being in a '*parlous*' state from 5 May 2008 until 9 May 2008. On that date the hospital staff was successful in weaning Ms Cramb off a reliance on the inotropes and sedating medication was ceased.

At the inquest Dr Emma Hothersall, an ICU consultant doctor who treated Ms Cramb at length on 5 May 2008 and on subsequent occasions, gave an insight into Ms Cramb's condition on 7 May 2008. She stated that by that date Ms Cramb was still reliant on mechanical ventilation and that without it survival would have been impossible.

On 11 May 2008 a tracheostomy was fitted to Ms Cramb, ostensibly to provide comfort by alleviating the need for an endo-tracheal tube.

On 13 May 2008 Ms Cramb was noted as being conscious and able to understand commands. Her lung function, though, remained marginal and it was considered premature to wean her from ventilation. She remained on kidney dialysis and was treated with antibiotics over the next few days for suspected pneumonia.

Dr Gordon stated that as at 21 May 2008 it was considered that Ms Cramb was showing ongoing slow improvement. On that date ventilation and dialysis were ceased and by the following day she was noted as being able to lift her legs.

Ms Cramb was discharged from the ICU on 25 May 2008, but due to a shortage of available beds, was not transferred to Medical 3 Ward until 2pm the following day.

Involvement of NoK

Ms Stephanie Gunton was a religious sister conducting prison ministry when she met Ms Cramb at Boggo Road Gaol in 1988. Ms Cramb requested that Ms Gunton continue to visit her even after Ms Gunton's decision to leave the sisterhood. The relationship slowly developed from one of ministry and pastoral support to one of friendship. Ms Gunton told the inquest that from their initial meetings, Ms Cramb had acknowledged her involvement in the crimes for which she was imprisoned and expressed her deep regret and remorse for them. On that basis Ms Gunton felt able to maintain a pastoral relationship with Ms Cramb.

[2] Drugs to support the contractile function of the heart

In 2000, Ms Cramb asked Ms Gunton to act as her sponsor[3] and next-of-kin. Aware that Ms Cramb was estranged from her children and other relatives, Ms Gunton agreed. However, Ms Gunton says she was not aware whether prison authorities recognised her as Ms Cramb's next-of-kin until she was contacted on the afternoon of 6 May 2008 by the Assistant General Manager of TCC, Louise Kneeshaw.

Ms Kneeshaw contacted Ms Gunton to inform her of Ms Cramb's hospitalisation and critical condition. When contacted, Ms Gunton was in Cairns en route to Cape York. She abandoned those plans and immediately flew to Townsville, arriving at 7:30pm. She hired a car and drove to Townsville Hospital. In a statement provided to police on 18 February 2009, and again at the inquest, Ms Gunton says she spoke to a female registrar shortly after her arrival. Ms Gunton says she was advised that Ms Cramb had been placed in an induced coma due to a life-threatening episode. The stress of the urgent trip to Townsville on an otherwise already busy day coupled with having to confront the seriousness of her friend's severe illness meant that Ms Gunton was understandably very upset by this time.

Ms Gunton says she had been told by Ms Cramb on a number of occasions that she dreaded a prolonged and compromised terminal decline: she "*did not want to end up a veggie"'* or find herself in a situation where it was necessary for her to be cared for by other prisoners she suspected would not treat her with any respect.

At the inquest, Ms Gunton specifically recalled the first time they had discussed this issue and understood Ms Cramb's wishes to be unambiguous. The instructions were certainly sufficiently clear to Ms Gunton to cause her on 6 May 2008 to ask the female registrar she met at the Townsville Hospital to take Ms Cramb off all life supports so that she could "*die with dignity".*

Ms Gunton says the registrar, who she could not identify other than to say she was female and possibly English, refused to act on this advice because she claimed she had been told Ms Cramb was to be kept alive until she could be brought out of the coma and questioned about outstanding crimes alleged to involve herself or Barry Watts. In her statement Ms Gunton said the registrar said; "*We were told from 'above' that we were to keep her alive until she could be brought out of a coma and asked about other outstanding crimes that she and Barry were involved in."* When she gave evidence, Ms Gunton gave slightly different accounts of this conversation but she remained adamant that the clear thrust of the comments were as reported by her.

Ms Gunton says she was too upset on the evening to press the point further.

The notes made in Ms Cramb's medical chart first make reference to Ms Gunton under an entry dated 7 May 2008. No time is noted. I am satisfied this entry in fact refers to events on the evening of 6 May 2008.

[3] In the context of Ms Cramb considering an application for parole

An exhaustive search has failed to identify any female registrar who recalls conversing with Ms Gunton on that evening. The medical chart notes Ms Gunton was spoken to by a male consultant, Dr Scott Simpson and that she "*approached doctors herself*" when she was not satisfied with information provided by nursing staff. The entry is broadly consistent with Ms Gunton's memories of the events of the evening of 6 May in that they make specific reference to her demands that a "*NFR*" order be made and her concerns about providing a phone number to clerical staff lest it be leaked to the media.

Dr Emma Hothersall is an ICU consultant who was on duty in the Townsville Hospital ICU during the day on 7 May 2008. She had treated Ms Cramb at length through the night of 5 May 2008; effectively keeping her alive when the prospects of survival looked extremely grim, and stayed with her in the ICU until relieved the following morning. She gave evidence at the inquest and I found her to be a most impressive witness. Dr Hothersall made a lengthy, retrospective entry in Ms Cramb's medical chart at 4:50pm on 7 May 2008.

That entry cogently sets out her interaction with Ms Gunton under the heading '*Retrospective documentation of events which occurred earlier in the day and recent developments regarding Fay's prison escorts and her next of kin'*. Dr Hothersall notes that there was "*initial confusion"* about who was next-of-kin before it became clear as a result of discussions with TCC senior officers that Ms Gunton was to be recognised as such. The notes stress that Ms Gunton, and not the TCC General Manager or TCC guards at the hospital, is the only person entitled to full disclosure and involvement in clinical decision making. The entry sets out Ms Cramb's wish not to be artificially kept alive or actively resuscitated and explicitly states that Ms Cramb is therefore "*Not for CPR*". Dr Hothersall was confident she explained to Ms Gunton that this was the position that had been arrived at as a result of their discussion of Ms Cramb's wishes and her serious illness.

Dr Hothersall explained at the inquest that when she arrived at work on 7 May 2008 she received a verbal briefing on the handover of Ms Cramb. She was told of Ms Gunton's arrival at the hospital the previous evening and it became apparent that the identity of the next-of-kin for Ms Gunton needed to be urgently addressed. Dr Hothersall gave instructions for a meeting to be held later that morning between herself, senior Townsville Hospital administrators, the hospital press office and the General Manager of TCC, John Harrison. As well as clarifying the status of Ms Gunton, that meeting addressed concerns relating to zealousness of the corrections officers guarding Ms Cramb and the problems being caused by, what Dr Hothersall felt was the excessive number of calls from media and police regarding Ms Cramb's status.

After setting out Ms Cramb's current medical status, Dr Hothersall noted in Ms Cramb's medical records a purported agreement with Ms Gunton:

> '*…it was decided therefore and discussion with Stephany (sic) that if she deteriorates we will <u>not</u> escalate therapy and if her condition does not improve we should consider ceasing active therapy and switching to a palliative approach. At present the plan is as follows:*

- *Not for CPR*
- *Continue active therapy but not escalate once inotropes are reduced'*

Dr Hothersall noted her agreement to contact Ms Gunton with any changes in Ms Cramb's status.

In her evidence at the inquest Dr Hothersall was adamant that she had made it very clear to Ms Gunton on 7 May 2008 that Ms Cramb was to be considered as "not for CPR". She says that over the course of the following 2½ weeks she had several other conversations with Ms Gunton and that in most, if not all, of them it was re-iterated that it was well known to all staff in the ICU that Ms Cramb was not for resuscitation if she suffered a cardiac or respiratory arrest.

Dr Hothersall made it clear that the treatment plan discussed on 7 May 2008 was one devised by herself but that Ms Gunton had expressed no objection to it. Dr Hothersall was sure that she would have made it clear that the plan included the continuation of mechanical ventilation and dialysis.

When Dr Hothersall's notes were put to Ms Gunton she acknowledged that she had been given information regarding the proposed treatment plan for Ms Cramb and that she understood it to include continued *"active therapy*". She denied that she was ever told that a "*Not for CPR*" or *"NFR"* order had been put in place until 25 May 2008, when she was called by Dr Hothersall on that specific issue.

An entry on 11 May 2008 makes reference to a conversation between Dr Danielle Howe and Ms Gunton in relation to the "*Risks v benefits*" of the insertion of a tracheostomy. A statement was obtained from Dr Howe during the course of the inquest re-iterating that such a conversation took place. In her evidence at the inquest Ms Gunton was adamant that she had never had such a conversation and had not become aware of the insertion of a tracheostomy until she was contacted by the hospital on 25 May 2008.

It is impossible to reconcile the two versions and I am inexorably drawn to accepting the evidence of Dr Hothersall and Dr Howe.

Unfortunately it does not seem that the efforts of Dr Hothersall to ensure Ms Gunton's next-of-kin status was recognised were entirely successful. A nursing entry can be found on 17 May 2008 noting a refusal to provide information over the phone to a "relative" of Ms Cramb. Ms Gunton's evidence was that she continued to have difficulties obtaining information on some occasions due to unwillingness to accept her identity over the phone.

On 25 May 2008 Dr Hothersall made contact with Ms Gunton to have her sign a form then being used in the wards (but not ICU) at the hospital which made it explicit that Ms Cramb was not to be resuscitated. I accept Dr Hothersall's explanation that this was done only to avoid confusion while Ms Cramb was transferred to a medical ward and that Ms Gunton had been told many times since 7 May 2008 that such an arrangement was already in place.

Medical 3 Ward

Ms Cramb was transferred to Medical 3 Ward on 26 May 2008. Her medical records indicate she had steadily improved over the preceding three weeks but was still very ill.

Dr Gunawardane, who had fitted the pacemaker to Ms Cramb on 5 May 2008, conducted a ward round at 4.00pm on 27 May 2008. On 5 May 2008 he had thought it unlikely Ms Cramb would survive but by the time of his round on 27 May he noted her condition was stable and she was "*no longer acutely unwell".* Notwithstanding, he did expect her to remain in hospital for a number of months while recovering.

Ms Cramb still had a tracheostomy in place. The part of the tracheostomy tube which extends into the patient's airway is accompanied by a cuff or balloon. This is expanded once the tube is inserted into the trachea to form a barrier which prevents fluids such as regurgitated material or other secretions from flowing into the lungs. This creates a necessity on occasion for secretions building up above the cuff to be suctioned. It is also necessary on occasion to suction secretions that can build up below the tracheostomy tube.

A closed ventilation suction system (also called an in-line suction system) was being used on Ms Cramb for the latter purpose. This device is used by feeding it through the tracheostomy site and some way into the tracheostomy tubing or even further into the trachea itself if necessary. A second device known as a Yankeur sucker was used to remove secretions from above the cuff via insertion through Ms Cramb's mouth.

Common to both devices is a secretions canister which is attached to the suction port on the wall of the ward. Suction tubing then extends from the secretions canister resulting in an open end to which either of the suction devices mentioned above can be attached. Once the in line suction system is attached, it is operated by the nurse pressing a blue button that releases a valve and allows the suction coming from the wall port, via the secretions canister, to flow through the entire system.

Shortly after 5:30pm Nurses Rebecca Furlong and Rebecca Holman attended on Ms Cramb in order to administer medication via an inhaler handheld delivery system (puffer) and to attend to pressure area care. Neither nurse had recently cared for a patient with an in-line suction system. It appears that Nurse Furlong had the more recent experience (around 6 months earlier) but was sufficiently unsure as to its use that at the start of her shift, having learned that the system was being used on Ms Cramb, she commendably sought a quick refresher on its operation from one of the other nurses.

After administering the puffer and turning Ms Cramb on her side, Nurse Furlong heard Ms Cramb cough and so the nurse asked whether there were secretions in her mouth. Ms Cramb nodded, so Nurse Furlong decided to use the Yankeur sucker to remove the build up. This required her to first remove the in-line suction system from the end of the suction tubing. As she did this the ribbed plastic nozzle from the in-line system that is inserted into the

suction tubing snapped off rendering the in line tubing useless. It was immediately clear to her that she would need to obtain a new in-line suction system and a new piece of suction tubing.

Nurse Furlong left the room to obtain this equipment which was located nearby. She also took this opportunity to flag the attention of clinical nurse Alison Coe in order that she might assist with the reattachment of the new equipment. These two nurses returned to the room where Nurse Coe says she observed Ms Cramb to be relaxed and showing no signs of distress.

Nurses Furlong and Holman say that by the time the new equipment had been obtained Ms Cramb was in fact coughing in a manner (and creating a sound) that led them to believe she needed secretions removed from below the tracheostomy. As a result, the new tubing was attached along with the new in-line suction system (rather than the Yankeur system as originally planned). It was inserted but no secretions could be seen being sucked into the tubing as would have been expected if there was a build up of secretions. A check of the system by Nurse Coe revealed the suction tubing to have been directly and incorrectly attached to a point on the wall of the ward rather than to the secretions canister. This was corrected but still no secretions were seen being suctioned into the tubing. A further systematic check took place by which time Nurses Coe and Furlong were confident the system was working correctly.

At this point Nurse Furlong noted that Ms Cramb was changing colour in a way that led her to believe she was becoming cyanosed – her lips were turning blue, suggesting poor circulation. Nurse Holman also noticed this and commented on it. Ms Cramb was placed on her back and Nurse Coe says she used the phone next to her to call for a Medical Emergency Team (MET). Continued suctioning attempts were made with little success but for a very small amount of blood stained secretions eventually making their way into the tubing.

It appears that from the time Ms Cramb was first asked about secretions in her mouth until the time she was noted as ‘turning blue’ a period of 2-5 minutes had passed.

Response to the medical emergency

All evidence points to an appropriately rapid response by hospital personnel to the MET call. Nurse Furlong recalls that Ms Cramb was ‘bagged’ in order to provide manual ventilation although Nurse Coe suggests that she stopped this process given it was futile in circumstances where a tracheostomy was in place. Dr Suruliraj, a registrar in the ICU, arrived to find Ms Cramb with a heart rate of 25 beats per minute, fixed and dilated pupils and no spontaneous respiratory effort.

The team quickly became aware of the NFR order. They agreed no attempts should be made to resuscitate Ms Cramb in accordance with the notation in her record to this effect. She was administered morphine and Midazolam before going into asystole and cardiac arrest a short time later. She was declared deceased at 6:15pm.

Autopsy results

An autopsy examination was performed on 29 May 2008 by an experienced forensic pathologist, Professor David Williams.

He later examined toxicology and histological findings before preparing a detailed report. The toxicology results were unremarkable. Histological analysis of the coronary arteries revealed recent haemorrhage into atheromateous plaque. Professor Williams explained that this is a process that causes pressure on pre-existing fatty deposits in the artery, thus narrowing an already small lumen. At the inquest he stated it was likely Ms Cramb's death followed within a few minutes of this event.

The examination revealed no signs suggestive of a struggle or violence and no evidence was indicative of the involvement of another person in the death. Professor Williams stated at the inquest that he found no evidence consistent with Ms Cramb's airway being blocked in the immediate lead up to her death.

Professor Williams issued a certificate following the autopsy examination listing the cause of death as:

1.(a) Haemorrhage into atheromatous plaque, due to, or as a consequence of
(b) Coronary atherosclerosis

2. Emphysema
Cirrhosis

Expert evidence on cause of death

The issue of Ms Cramb's cause of death was explored further with Dr Bowler, the Director of Medicine at the Mater Adult Hospital in Brisbane. He discussed the possibility that a blockage in Ms Cramb's airway which was somehow removed by either resuscitation attempts or suction, may have caused sufficient strain in the circumstances of Ms Cramb's parlous medical state that it led to the cardiac pathology described by Professor Williams. He agreed that this possibility was made less likely if one accepted the evidence of the nurses that no secretions of any substance were ever suctioned. We also now know no resuscitation was attempted.

He agreed at the inquest that as an alternative hypothesis, it was possible Ms Cramb's cardiac pathology may have led to symptoms that the nurses mistook for signs of a blocked airway. Importantly he was entirely supportive of the accuracy of the cause of death determined by Professor Williams. He pointed out that the most likely point where a blockage would occur is at the end of the tracheostomy tube; which, as he noted, is also the most accessible point for the suctioning device used by the nurses. He also acknowledged that if a blockage in the airway was causally involved in the death more evidence in the pathology of the lungs would have been expected.

Quality of health

Dr Bowler was also asked to review the medical records from Townsville Hospital along with relevant parts of the police report and to comment on the quality of the health care provided to Ms Cramb. He expressed the view that the quality of care afforded to Ms Cramb in the ICU at Townsville Hospital and in the medical ward subsequently was as good as any that would be provided in Australia. He was also highly complimentary of the nurses who were with Ms Cramb immediately before her death and said they did everything they could to respond to the challenges presented by the equipment failure. I unreservedly accept his assessment in all respects.

Interference "from above"

I found no evidence to support Ms Gunton's claim she was told Ms Cramb was to be kept alive on orders from "*above,"* motivated by a desire to have her further questioned by police. Nor is there any evidence that any decisions regarding Ms Cramb's health care or treatment were influenced by any criminal investigation priorities.

All female doctors on duty in the Townsville Hospital ICU around the relevant time have been approached and specifically deny that any such comment was made. Those that gave evidence were understandably indignant that it might be suggested that they would be amenable to such pressure.

The treating doctors and the police agree that police made inquiries about Ms Cramb's condition and when she might be capable of being interviewed but the officers did not seek to in any way influence decisions about Ms Cramb's treatment.

Statements were obtained from various police officers with interests in speaking to Ms Cramb at the relevant time. The QPS Northern Region Crime Co-ordinator at the time, Detective Inspector Warren Webber was responsible for obtaining and disseminating information to those police officers in relation to Ms Cramb's health status and, in particular, if she was, or would be, in a position to be interviewed. He tasked Detective Sergeant Timothy Byrnes of the Townsville CIB to make inquiries with the hospital in this regard. Other evidence before the inquest indicates that Inspector Webber also sought and obtained updates on Ms Cramb's medical status from staff at TCC.

Sergeant Byrnes attended Townsville Hospital on 6 May 2008 and spoke to Dr Kate Matthews (now Dr Kate Sharpe). He told Dr Matthews that police were interested in speaking to Ms Cramb if and when she regained a sufficient level of health. Dr Matthews advised that there was only a "50-50" chance of Ms Cramb surviving and that even if she did, she would not be leaving hospital for weeks. Sgt Byrnes left a business card with the corrective service officers guarding Ms Cramb with a request to be notified should her condition suddenly improve.

The suggestion that Ms Cramb was being kept alive for the purpose implicit in the statement that Ms Gunton says was made is not consistent with the clear

notations in Ms Cramb's medical notes from 7 May 2008 onwards that she was not to be resuscitated.

The evidence from medical practitioners at Townsville Hospital made it clear that such a request or directive was unheard of in their experience and, in any case, it would be ignored. After considering all of the evidence tendered and hearing from Dr Hothersall, I am confident that had there been any attempt to influence the course of Ms Cramb's clinical treatment by police, it would have been met, properly, with an indignant refusal and complaint.

Conclusions

- Although I ruled the question of the management of health care in the female prisoner population generally was beyond the scope of this inquest, some evidence was received in relation to the long term management of Ms Cramb's chronic health complaints. As a result I conclude that reasonable attempts were made to assist her in this regard. She regularly attended on VMOs, had numerous hospital admissions, was assisted with special diets and given access to pharmacotherapy as prescribed. Her prison employment and accommodation were changed to better suit her medical condition. I have no basis to conclude that Ms Cramb's health care would have been better provided for had she not been a prisoner.

- As is evidenced by the opinion of Dr Bowler quoted above, Ms Cramb's acute health care needs were expertly attended to by the staff of the Townsville Hospital when she suffered a medical emergency on 5 May 2008 and thereafter her critical care was well managed up until her death.

- The equipment failure that occurred immediately prior to her death did not cause or contribute to her death which was as a result of a haemorrhage into atheromateous plaque precipitated by long standing atherosclerosis.

- The doctors and nurses who responded to the medical emergency when Ms Cramb arrested on 27 May acted appropriately when they gave effect to the NFR order recorded in her chart.

- There is no evidence to support the claim a member of the hospital staff told Ms Cramb's next-of-kin that she had instructions "*from above*" to manage her health care in a way that might facilitate criminal investigations. Nor is there any evidence that any such considerations played any part in Ms Cramb's health care.

- Apart from initial difficulties in contacting and verifying the authority of Ms Cramb's next of kin (issues I will deal with later in these findings) decisions concerning the withholding of life sustaining measures were appropriately negotiated, recorded and acted upon.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how she came by her death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Fay Cramb

How she died - Despite receiving an appropriate standard of health care, Ms Cramb died from natural causes three weeks after an emergency cardiac procedure, while she was a prisoner in the care of the then Department of Corrective Services.

Place of death – She died at the Townsville Hospital in Queensland.

Date of death – Ms Cramb died on 27 May 2008.

Cause of death – She died as a result of a haemorrhage into atheromateous plaque, consequent upon atherosclerosis.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The issues that are raised by the circumstances of this case which warrant considerations from that perspective are:-

- Consent for treatment by prisoners.
- “End of life decisions” by prisoners.
- Communication between prisons and hospitals.

I am satisfied that once Dr Hothersall again became involved in the treatment of Ms Cramb on 7 May 2008, and thereafter, appropriate regard was given to Ms Cramb’s wish not to be resuscitated.

More problematic is the treatment of Ms Cramb on 5 May 2008. Analysis of this treatment requires me to briefly set out the statutory regime in Queensland governing decision making and substituted consent for health care procedures where the person, the subject of the procedure, has impaired capacity.

As a starting point, it is clear a competent adult may refuse treatment even if that is likely to result in his/her death.[4] Normally, to undertake health procedures that involve touching, cutting and other invasive applications of force would be unlawful unless consented to by the patient and would expose the person doing them to civil liability and/or criminal prosecution. These prohibitions are buttressed by the *Guardian and Administration Act 2000* which creates an offence of carrying out health care without consent.[5]

However, in order to enable health care to be provided in emergency situations when the patient's consent can not be sought because he or she is unconscious, while ensuring as far as possible the patient's wishes are respected, the *Powers of Attorney Act 1998* (PAA) and the *Guardian and Administration Act 2000* (GAA) create a legal framework to regulate the administering of emergency treatment and the withholding of life sustaining measures.[6]

Those acts together set out a scheme whereby a substitute decision maker is identified to make decisions for an adult with impaired capacity. This includes decisions regarding the withdrawal or withholding of life sustaining measures.[7]

The GAA authorises the undertaking of urgent health care without the patient's consent in s63. In summary, it authorises a health provider to give treatment without consent if he or she reasonably considers the procedure should be carried out urgently to meet imminent risks to the patient's life, provided the patient has not indicated in an advance health directive that he or she does not wish to receive the treatment and this is known to the health provider. If a health provider undertakes a procedure without consent by relying on this provision, the health provider must certify in the patient's clinical records the various things enabling the health care to be carried out.

The legislation provides if an adult lacks the capacity to make a decision concerning the withdrawing of a life sustaining measure, the hierarchy of alternative decision makers created by the Act is activated.[8] If the highest in the hierarchy of potential decision makers is not apposite or available, the next potential decision maker needs to be consulted. First resort is to an advance health care directive. If none exists but the Guardianship and Administration Tribunal has appointed a guardian, that persons can make decisions on such matters. Next, a person appointed under an enduring power of attorney is to be consulted. If none of these three mechanisms are apposite decisions will fall to a "*statutory health attorney*", a term defined in

[4] *Re B(Adult: Refusal of treatment)* [2002] 2 All ER449
[5] s79
[6] The law concerning the withdrawal or withholding of life sustaining measures is usefully summarised and analysed in a comprehensive and thoughtful issues paper, "*Rethinking life sustaining measures: Questions for Queensland*" by Dr Ben White and Associate Professor Lindy Wilmot, February 2005, QUT.
[7] Howard, Michelle, *Principles for substituted Decision-making about withdrawal or withholding life-sustaining measures in Queensland: A case for legislative reform* [2006] QUTLJJ 11
[8] GAA s66

the PAA.[9] That Act creates a priority list with the statutory health attorney being the first person on the list who is "*readily available and culturally appropriate"* to make the decision.

So far as is relevant to this matter, the list provides in paragraph (c)

> *a person who is 18 years or more and who is a close friend or relation of the adult and is not a paid carer for the adult.*

Applying that regime to the facts of this case it seems clear that soon after Ms Cramb arrived at Townsville Hospital on the afternoon of 5 May 2008 she lost consciousness and had "impaired capacity" within the terms of the Act.

It became clear that a pacemaker needed to be inserted. The medical staff made contact with TCC to enquire about consent for the procedure. When that was not readily available, the doctors caring for her concluded that urgent intervention was necessary to preserve her life. They had no basis for believing she had an advance health directive which might override their right to provide such emergency care. They did however fail to record the basis on which they proceeded in this manner.

Ms Gunton was clearly Ms Cramb's statutory health attorney and therefore the appropriate person under the statutory regime to act as the substitute decision maker concerning the withholding or withdrawing of life sustaining measures. But her power to determine such matters was limited by s66A which provides that a statutory health attorney's consent to the withholding or withdrawal of a life-sustaining measure can not operate unless the health provider reasonably considers the commencement or continuation of the measure would be inconsistent with good medical practice.

In this case Dr Hothersall carefully considered Ms Cramb's condition and prognosis before agreeing that "active" intervention should not be re-escalated once it was withdrawn if she again deteriorated. Consistent with her professional oath, the doctor was clearly concerned to give Ms Cramb every opportunity and assistance to recover, while respecting her right to die peacefully if those efforts failed.

That means any delay in contacting Ms Gunton had no impact on the course of treatment provided to Ms Cramb.

However, if it was indeed Ms Cramb's wish that she should not be involuntarily provided with emergency care or invasive procedures to sustain her life should she collapse, then those wishes were frustrated by her not having in place an advance health directive which could have prohibited emergency intervention and the provision of life sustaining measures.

[9] PAA section 63

Health care directives for prisoners

The inquest was provided with evidence demonstrating the poorer health outcomes for prisoners as compared to the general populace. It was also acknowledged in the statement of Mr Scott Collins, General Manager Custodial Operations, Department of Community Safety that the Department has noticed the increasing complexity of dealing with health services for aged and chronically ill prisoners.

Prisoners are by their very circumstances more isolated from friends and family members than other members of the community.

They are likely to be less educated and literate.

They are less likely to have an on-going therapeutic alliance with a health care provider. In my experience, much of the medical care in prisons is provided by transient VMOs or locums and prisoners move between correctional facilities.

These factors combine to increase the likelihood of the legislative substituted decision making processes being needed by the members of a cohort who are less likely to have taken steps to avail themselves of the mechanism that could best serve their needs: an advance health care directive (AHCD).

This is graphically demonstrated by Fay Cramb. She had numerous chronic health complaints, a fervent wish not to have her life prolonged if she was compromised and her primary contact was an experienced nurse. Yet she did not have an AHCD in place and she underwent treatment she is likely to have declined had she been in a position to have been asked.

The submission that prisoners should not be treated differently from the general population ignores the significant and relevantly different characteristics of that demographic. I am aware that many nursing homes, for instance, routinely inquire of their residents whether they wish to make such arrangements because of their special circumstances.

I accept Queensland Health's submission that it would not be appropriate to suggest to all prisoners that they should consider creating an AHCD. But that doesn't mean that they should not facilitate the creation and periodic review of such instruments with any of their inmates.

I am grateful for a body of information provided to me by Sisters Inside which identifies the 'end of life' decision making process for prisoners to be an area which has been researched in some detail; especially for prisoners in the United States. That material demonstrates the problems identified by Queensland Health are not insurmountable.

Recommendation 1 – Facilitate AHCD

I recommend that as the primary provider of health care to the prison population, Offender Health Services facilitate the creation and periodic review of advance health care directives for prisoners reasonably in need of such a mechanism.

Consent for medical treatment

The Department of Corrective Services (as it then was) had in place in 2008 a policy to regulate the obtaining of informed consent from prisoners before providing them with medical treatment.[10] The assuming of responsibility for offender health care by Queensland Health in July 2008 resulted in a more detailed consent policy which was tendered at the inquest.

The policy sets out at section 2.1 the sources from where consent for medical procedures may be obtained when the prisoner's capacity is impaired. It is not consistent with the legislative regime set out in the GAA and PAA in that it does not provide for reference to the prisoner's statutory health attorney. To that extent it needs to be amended.

Recommendation 2 – Consent to treatment policy

I recommend Offender Health Services review its Consent to Treatment policy to ensure it aligns with the substituted decision making regime set out in the GAA and PAA.

Recording and disseminating prisoner's contacts

Neither of the improvements suggested above will benefit prisoners if the relevant information is not disseminated appropriately. In this case it seems advice of Ms Cramb's next-of-kin did not go with her from the prison to the hospital. The doctors wishing to institute treatment were forced to ring around in an effort to identify and contact the relevant person. They asked the prison officers guarding her to no avail.

Counsel for the Department of Community Safety suggested the problem was coincidental to this case and in any event, communication of such information will be made easier by the transfer of responsibility of prisoner health care to Queensland Health.

I accept that I have no evidence of this being a wide-spread or systemic problem. It may be Ms Gunton's understandable sensitivity about being publicly known as Ms Cramb's next-of-kin caused that information to be less easily accessed. I will therefore refrain from making any recommendations about this issue. I trust the two departments will avoid the potential for confusion that conflicting definitions of "next-of-kin" and "primary contract person" presents.

I close the Inquest.

Michael Barnes
State Coroner
Townsville
7 May 2010

[10] Notwithstanding the legislative power under the *Corrective Service Act 2000* (Qld) to require the examination and treatment of prisoners against their will; a power the policy acknowledged ought to be narrowly construed.