QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dennis William Childs**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/5500
DELIVERED ON:	15 November 2022
DELIVERED AT:	BRISBANE
HEARING DATE(s):	15 November 2022
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, health care, refusal of treatment by prisoner.

REPRESENTATION:

Counsel Assisting:	Ms Julie Pietzner-Hagan
Queensland Corrective Services:	Ms Vanessa Price
Metro North HHS:	Ms Natalie Mason

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Introduction

1. Dennis Childs was a First Nations man who died at age 64. He was serving a life sentence for murder at the Woodford Correctional Centre (WCC) at the time of his passing on 9 December 2018. He had been convicted of this offence in South Australia in 2007. In 2012 he secured an interstate prison transfer to Queensland on welfare grounds as he wished to be closer to his family.

2. In 2005, while imprisoned in South Australia, Mr Childs was diagnosed with mouth and throat cancer requiring surgery to remove part of his gum and jaw. In 2017, he underwent further mouth and jaw surgery to repair facial disfigurement and to assist in allowing him to chew foods.

3. As well as the history of cancer, Mr Childs' Queensland Prison Health Services Medical Records indicated that he suffered from several other long-term medical conditions, including: [1]

    - Chronic obstructive pulmonary disease (COPD);
    - Congestive cardiac failure;
    - Cirrhosis of the liver; and
    - Hypertension.

4. Queensland Corrective Services records indicate that Mr Childs was involved in six reported medical incidents between 2014 and 2016.[3] On each occasion, he complained of shortness of breath and chest pains resulting in a transfer to hospital. Throughout his imprisonment in Queensland, he made regular visits to the Princess Alexandra Hospital Secure Unit for medical treatment.

5. Mr Childs also suffered from depression and anxiety for which he received psychological treatment while incarcerated.[2]

The investigation

6. Detective Sergeant Stephen Jones and Detective A/Senior Sergeant Jason Kitto from the Corrective Services Investigation Unit (CSIU) were advised of Mr Childs' passing and attended the Caboolture Hospital on 9 December 2018 with a scenes of crimes officer.

7. A direction was subsequently issued for a targeted coronial investigation. This included seeking medical records, interviewing the next of kin about any concerns and obtaining statements from relevant treating medical officers, corrective services officers and fellow prisoners. A comprehensive Coronial Report was prepared and provided to the Coroners Court in December 2019.

8. On 10 December 2018, DS Jones and DSC Tongiatama conducted investigations at Woodford Correctional Centre including a search of Mr Childs' single cell, which had been secured since his removal from the unit. Recorded statements were obtained from four prisoners held in the same unit as Mr Childs who were known to associate with him daily. The prisoners confirmed Mr Childs was in poor health in the lead up to his death.

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[1] Ex A6, pg. 9
[2] ibid

9. DS Jones formed the view that there were no suspicious circumstances surrounding Mr Childs' passing, and he was provided with appropriate care and treatment while incarcerated.

10. Dr Ian Home from the Clinical Forensic Medicine Unit (CFMU) also examined Mr Child's medical records and reported on them for the Coroners Court.

The inquest

11. At the time of his death, Mr Child's was a prisoner in custody under the *Corrective Services Act 2006*. As Mr Child's death was a 'death in custody' an inquest was required by the *Coroners Act 2003*.

12. The inquest was held at Brisbane on 15 November 2022. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence.

13. The issues considered in the inquest were the findings required by s45(2) of the *Coroners Act 2003* and whether Mr Childs' care at the Woodford Correctional Centre and Caboolture Hospital Service was appropriate and adequate.

14. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Social History

15. Mr Childs was born on 29 August 1954 in Adelaide, South Australia. He was one of four children to parents, Alice and Hayden.

16. Mr Childs had a difficult upbringing, having been exposed to emotional and physical abuse from his father. As a child he suffered from a number of health conditions, including asthma and bronchitis. Mr Childs achieved a year 7 education in South Australia, although he was able to complete his School Certificate while in Port Augusta Prison. At age 15, he sustained an injury to his right eye after being shot with a slug gun which also caused minor brain damage. He was employed as a labourer after leaving school.

17. In 1973, Mr Childs married Barbara. They had two children, Dennis and Learna. From 1991 to 1999, he was in a defacto relationship with Anthea, and they shared a child. From 2001 until 2002, Mr Childs' was briefly married to Cheree. Mr Childs' sister Glenda resides in Warner, Queensland and cares for his daughter. I extend my condolences to his family.

18. Mr Childs had a criminal and traffic history in South Australia commencing in 1976, with convictions recorded for various types of offences, including assault, unlawful possession, disqualified driving, domestic violence offences and fraud. He was incarcerated on a number of occasions as a result of these offences.

19. On 1 August 2008, Mr Childs was sentenced to life imprisonment for murder in South Australia.[3] His earliest parole eligibility date was 3 February 2029. He had been in custody for that offence since 4 February 2005.

20. On 8 August 2012, Mr Childs received ministerial approval to transfer his sentence to Queensland to be closer to his daughter and sister. He was received into the Brisbane Correctional Centre on 21 November 2012. He was then accommodated for various periods at the Woodford Correctional Centre, Borallon and the Southern Queensland Correctional Centre.

21. Mr Childs' sister, Glenda, provided a statement outlining his childhood, personal and medical history.[4] With respect to the care provided by Queensland Corrective Services, Glenda believed Mr Childs received appropriate health treatment. She acknowledged that while he was often sick, he would also refuse to go to hospital even when medical staff at the centre requested that he undergo further medical treatment. Glenda did not express any concerns about the circumstances of Mr Childs' passing or his care and treatment while incarcerated in Queensland.

22. Mr Childs had a relatively incident free correctional history, having only been in one altercation with another prisoner at Woodford in September 2018. He had no other reported breaches of discipline, or any acts of violence/threats made against staff or prisoners.

Events leading to the death

23. During the night of 7 December 2018, Mr Childs reported to medical officers that he was experiencing abdominal pain. Following assessment, he refused to attend Caboolture Hospital for further treatment. He claimed he was feeling better and was able to mobilise with minimal pain. Medical records note that, '*despite encouragement patient refused to go to Hospital*'. He was instructed to advise officers if the pain worsened, or new symptoms presented.[5]

24. On 8 December 2018, Mr Childs again told Custodial Corrections Officers that he was suffering severe abdominal pain and a 'Code Blue' was called. He was transported to the medical unit for further assessment, and was subsequently moved to a lower level cell to allow closer monitoring to be carried out by custodial and medical staff.[6] Medical notes indicate that he was provided treatment for constipation.[7]

25. At around 9:30am on 9 December 2018, Nurse Adiodun Bolarinwa asked that Mr Childs be brought to the Medical Centre for review.[8] She noted that he was continuing to complain of constipation despite the laxatives prescribed. He was experiencing ongoing pain and tenderness in his abdomen on palpation. However, it was not grossly distended or bloated. His temperature was normal, and he did not appear jaundiced. Further medication was prescribed to treat constipation and he was scheduled for review later that day. The plan was that

[3] The offence involved setting a man on fire in a hotel car park in January 2005.
[4] Ex B5
[5] Ex D10, pg. 42
[6] Ex B14, [7]; Ex B10, [5]
[7] Ex D10, pg. 43
[8] Ex B1, [13]

he be transferred to the Caboolture Hospital if there was no improvement in his condition.

26. At around 11:30am on 9 December 2018, a 'Code Blue' medical emergency was activated after Mr Childs contacted correctional officers via an in-cell intercom.[9] He appeared to be incoherent, unable to respond to questions and was attempting to put on clothing. He was transported to the Medical Centre where he collapsed with abdominal pain and shortness of breath. He was noted to be sweaty, cold and clammy to the touch.

27. Mr Childs was administered oxygen to prevent respiratory depression. An intravenous saline cannula was also inserted. He was diagnosed by Nurse Bolarinwa as suffering from a suspected bowel obstruction secondary to constipation. Mr Childs was kept warm while an immediate transfer to the Caboolture Hospital was arranged. His airways and vital signs continued to be monitored awaiting the arrival of the Queensland Ambulance Service (QAS). The QAS arrived at the Woodford Correctional Centre at around 11:40am.

28. The QAS Report Form indicates that upon arrival, Mr Childs was complaining of sharp abdominal pain in the context of constipation for four days. He was tachycardiac and hypotensive with an oxygen saturation level of 93% on 4L oxygen.[10]

29. Mr Childs arrived at the Caboolture Hospital Emergency Department at 12:48pm where he was assessed by nursing staff and a senior staff specialist promptly as he appeared critically unwell. Various tests were conducted, including a chest x-ray, CT scan of the abdomen, ECG, blood tests and computer monitoring. He was diagnosed with high grade bowel obstruction with multiple organ failure.[11] Blood tests demonstrated metabolic acidosis, severe acute renal failure and acute hepatic failure.

30. At around 2:00pm on 9 December 2018, Senior Medical Officer, Dr Douglas Feinbloom had a lengthy discussion with Mr Childs about his condition and a possible transfer to the Princess Alexandra Hospital for urgent treatment. He categorically refused to go to the PAH.[12] Dr Feinbloom stated that during this initial assessment, Mr Childs presented 'much better' than his observations and tests indicated. He remained GCS 15, was compliant and did not complain of symptoms apart from nausea and mild to moderate abdominal pain. He did not request any analgesia.

31. Further tests revealed the serious nature of his condition despite his presentation. Further discussions were had with Mr Childs, who reluctantly agreed to remain at the Caboolture Hospital for emergency surgery. He was advised by Dr Feinbloom that without surgery he would certainly die.[13]

[9] Ex B1, [16];
[10] Ex A3, p11
[11] Ex A3, pg. 11; Ex B2, [3]; Ex B4, [4] – [9]; Ex B13, pg. 1
[12] Ex B7, [22]
[13] Ex B7, [22]

32. At around 4:00pm on 9 December, Mr Childs underwent emergency surgery. He was found to have a significant amount of pus, bile and gallstones throughout the abdomen and a perforated gallbladder. During surgery, Mr Childs experienced a continually fast heart rate with low blood pressure and issues associated with blood coagulation. An open cholecystectomy and thorough wash of the abdomen was carried out. Towards the end of the procedure, Mr Childs suffered multiple organ failure before going into cardiac arrest.[14] The Intensive Care Unit Medical Emergency Team responded and despite extensive resuscitation efforts he was unable to be revived. Life extinct was pronounced at 6:27pm.

33. In terms of Mr Childs' poor prognosis, at the time he underwent emergency surgery at the Caboolture Hospital on 9 December 2018, the following comment in the statement provided by Consultant Anaesthetist, Dr Hussey, who assisted with Mr Childs' surgery, is relevant:[15]

> *I have formed the view that this patient was likely suffering both cardiogenic shock (due most likely to ischaemia and acidosis) and septic shock, with multi-organ failure. As such, it was always going to be extremely difficult to rescue this patient, especially with the available resources at Caboolture Hospital. The patient's blood cultures give an idea of how unwell he was: positive cultures from 2 organisms were shown, with the time taken for this 5.0 hours, which is generally considered very fast. At the time I obtained anaesthetic consent, I told the patient he was 'high risk'. I estimate his mortality at 50% or worse. Having re-entered his parameters into the NSQIP website, his estimated mortality was 78%.*

34. Following Mr Childs' passing, the Metro North HHS conducted an internal review. A copy of the review recommendations and identified outcome measures was provided.

Autopsy results

35. On 11 December 2018, an external and full internal post mortem examination was conducted by Pathologist, Dr Li Ma.

36. Evidence of recent acute bile stained peritonitis and ischaemic changes in the small and large bowels were found. Changes in the heart consistent with severe ischaemic heart disease associated with severe coronary atherosclerosis in all three major coronary arteries were observed. Bilateral pleural effusion, which was more severe on the left was noted, with the right lung shrunken and encased in markedly thickened parietal pleura. The liver was also found to be cirrhotic.

37. Microbiology testing of a swab taken from the abdominal cavity grew scant staphylococcus aureus.

38. Peritonitis was found during the post-mortem examination, which appeared to have resulted from the perforation of an inflamed gallbladder secondary to gallstones. It was noted that peritonitis is a severe medical condition, which may lead to shock, acute kidney failure, sepsis, multi-organ failure and death. Admission records suggested Mr Childs was already suffering from sepsis, acute renal failure, acute liver failure with metabolic and electrolyte derangement when he arrived at hospital.

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[14] Ex B13, pg. 2
[15] Ex B8, pg. 4

39. Ischaemic changes in the small and large bowels were also observed post-mortem. This occurs when the blood flow through the major arteries that supply blood to the intestines slows or stops. If untreated, a person can progress to shock, metabolic acidosis, low blood pressure, rapid heart rate and confusion.

40. It was noted that Mr Childs' pre-existing medical conditions, including ischaemic heart disease, liver cirrhosis, COPD and chronic pleural effusion would have contributed to the death by making him more susceptible to the potential complications of the above medical conditions, anaesthetic procedures and surgery.

41. The cause of death was found to be peritonitis, due to or as a consequence of a ruptured gallbladder, due to or as a consequence of gallstones. Other conditions identified were ischaemic heart disease, cirrhosis, chronic obstructive pulmonary disease and chronic pleural effusion.

Review of health care

42. A report from Clinical Forensic Medicine Unit (CFMU) was requested to address the following:

    a. whether the medical treatment provided to Mr Childs at WCC was accurate and appropriate; including whether there was a failure to recognise and respond properly to his deteriorating condition;
    b. whether the changes implemented by WCC since Mr Childs' death sufficiently address any concerns as to his care and treatment; and
    c. whether the medical treatment provided at the Caboolture Hospital was adequate and appropriate.

43. Dr Ian Home provided a report to address the above issues. Dr Home expressed 'significant concerns' with the medical treatment provided at WCC.

44. The nurse at WCC was unable to perform an abdominal examination on Mr Childs when he first complained of it on 8 December 2019, due to what the nurse described as pain and tight abdominal muscles. The pain became worse even with little pressure. Dr Home considered these symptoms were indicative of acute abdomen and warranted a hospital review which did not happen. Dr Home stated that had Mr Childs been taken to hospital and reviewed, the result *"may well have been different"*.[16]

45. Dr Home also expressed concern about the Visiting Medical Officer's (VMO) decision to prescribe morphine despite not knowing what they were treating, but clearly acknowledging the presence of severe pain given the prescription.

46. The VMO was not contacted again after Mr Childs refused to go to hospital, even though it appeared that he denied pain to simply avoid going to the hospital. Dr Home advised that he was aware that prisoners can refuse treatment. However, it was not clear to him if prisoners can refuse transport to a healthcare facility where they can discuss their options with a doctor, which is the process that is followed in the watchhouse setting.

[16] Exhibit B16 at p. 5.

47. Dr Home was also concerned that a Nurse Practitioner (NP) prescribed medication for constipation despite Mr Childs denying being constipated the day prior. According to Dr Home, treatment for constipation should only be considered as a cause for abdominal pain after excluding other potentially more serious conditions. However, the medical notes indicate that Mr Childs was noted to have complained of being constipated to the NP. This was set out in her statement.[17]

48. Based on the information available, Dr Home was of the view that the treatment provided at the Caboolture Hospital was of a 'very high standard'.

49. Dr Home also commented on recommendations flowing from a review of the care provided to Mr Childs by Woodford Corrections Health and the Caboolture Hospital.

50. Dr Home's report was disclosed to Metro North HHS for comment. A statement from Dr Paul, A/Director Medical Services Caboolture, Kilcoy & Woodford Directorate, addressed some of the concerns raised by Dr Home.

51. Dr Paul noted that the escalation of Mr Childs' condition to a VMO on 8 December 2018 was appropriate. Dr Paul advised that medical supervision by VMOs is limited out of hours due to movement restrictions within the WCC. He noted that it may have been considered appropriate for the VMO to prescribe morphine as there was sufficient evidence for the need of a strong pain relief and the potential for deterioration that may be clinically missed in a prison cell environment.

52. Dr Paul advised that it would have been considered good medical practice for the VMO to follow up on Mr Childs after the advice to transfer. However, it is a reasonable expectation that VMO would have been informed that the patient refused transfer since serious pathology could not be reasonably excluded in a prison setting. Dr Paul stated that Mr Childs may have been compelled to go to hospital if a medical emergency was suspected.[18] However, Mr Childs refusal was recorded on file.

53. Dr Paul advised that there have been significant changes to the way nursing care is provided at WCC following Mr Childs' death. Simulation training is being provided to nursing staff to ensure patients presenting with potentially high acuity clinical issues are appropriately managed to avoid such situations occurring again.

54. Alan Thomas has been a clinical nurse at WCC Medical Centre since November 2017. He advised that at the time of Mr Childs' death, there was only one medical centre at the prison. There are now two with registered nurses working 24 hours each day. A VMO, a Senior Medical Officer (SMO) and Nurse Practitioner (NP) provide clinical consultations in the medical centre during business hours and are on call after hours.

[17] Exhibit D10 – Medical records at p.42.
[18] S 21(1) of the *Corrective Services Act 2006* provides *'a prisoner must submit to a medical examination or treatment by a doctor if the doctor considers the prisoner requires medical attention'*.

55. CN Thomas noted that the nurses are employed by Metro North HHS. Nurses abide by MNHHS policies, and follow QCS policies within the prison environment such as obtaining clearance from Master Control before taking a patient to the medical centre. After 6.00pm and prisoners are locked in their cells where they have access to an intercom to speak to Master Control if they feel sick or have been injured.

56. CN Thomas was the nurse who contacted the VMO after reviewing Mr Childs at 1:00am on 8 December 2019. He expressed difficulty in fully assessing Mr Childs' abdomen due to the high level of discomfort Mr Childs expressed when his abdomen was touched.

57. CN Thomas administered morphine as instructed by the VMO and organised the paperwork for Mr Childs to be transferred to Caboolture Hospital, after speaking to the VMO a second time advising that Mr Childs felt better but was still in pain. He also reminded Mr Childs of the VMO's advice about going to the hospital when Mr Childs refused. He tried to encourage Mr Childs to go to the hospital but could do nothing further when Mr Childs refused, and stated he was feeling better. CN Thomas advised since there was no concern for Mr Childs' capacity to make a decision on his health care his wishes were respected.

58. Following Mr Childs death, a *Prison Health Services, Refusal to Accept Treatment Form* now has to be completed where a patient declines to be treated or transferred to hospital.

59. CN Thomas agreed that while QCS staff are able to compel the patient to attend hospital, it is uncommon for health staff to force treatment on a patient who has the capacity to refuse treatment. A patient could also become aggressive if treatment was forced upon them.

60. Dr Rajendra Prakash was the on-call VMO who was contacted by CN Thomas. Dr Prakash has worked as a VMO at WCC since 2006. Dr Prakash prescribed morphine to Mr Childs after the phone discussion with CN Thomas. After being advised of Mr Childs history (cirrhosis of liver, gallstones, right pleural thickening and effusion and chronic abdominal pain) and condition (elevated pulse rate, blood pressure), Dr Prakash believed the working diagnosis was acute abdomen.

61. Acute abdomen is a clinical condition/presentation with sudden onset of abdominal pain that requires urgent attention and management. It is not a definite diagnosis and may be caused by infection, inflammation, vascular occlusion, or obstruction of the peritoneal cavity. Dr Prakash stated that there was difficulty in fully examining Mr Childs' abdomen due to the discomfort he expressed when the nurse touched Mr Childs' abdomen.

62. Dr Prakash advised that morphine was prescribed because early appropriate analgesia decreases suffering and assists in better co-operation of the patient in providing more information, and responds better to examination and reduces discomfort during transfer to the hospital. Dr Prakash was of the view that a simple pain medication was insufficient to treat Mr Childs moderate to severe pain making parenteral morphine the appropriate choice.

63. Dr Prakash advised that opioid analgesia is not a contraindication to management of moderate to severe pain. Dr Prakash referred to a number of evidence-based studies that supported prompt analgesia administration prior to aetiological diagnosis of acute abdominal pain in patients. Pain therapy should no longer be withheld from these patients, and it should be administered prior to diagnosis, after a review of relevant pain characteristics.

64. According to Dr Prakash, Mr Childs required further assessment to confirm the definite diagnosis and management of the diagnosis was only available in a hospital environment and not at WCC. Accordingly, his advice was that Mr Childs should be transferred to hospital if he was still in pain after 30 minutes.

65. I accept that while there were some concerns raised by Dr Home regarding the treatment provided to Mr Childs by Woodford Corrections Health, those concerns have been adequately addressed in the responses provided by the clinicians employed by Metro North HHS. I am also satisfied sufficient measures are now in place to address the concerns.

66. In the Inquest into the death of Jay Maree Harmer I acknowledged the ethical and legal challenges presented by the principle of allowing an adult with capacity to make their own decisions regarding health care in custodial settings. Mr Childs advised that he was feeling better after some morphine early on 8 December 2018. Prior to his emergency surgery on 9 December 2018, his presentation did not match his very serious condition. In those circumstances, the medical staff in the WCC were justified in treating him conservatively and accepting his refusal to go to hospital two days prior to his death.

67. After considering the evidence, including the statements provided by the clinicians who treated Mr Childs directly, I am satisfied that Mr Childs' care at the Woodford Correctional Centre and Caboolture Hospital Service was appropriate and adequate, although some opportunities for improvement emerged after the death.

Findings required by s. 45

68. 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 he came by his death. After considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased –	Dennis William Childs
How he died –	Including periods of remand in custody, Mr Childs had been imprisoned for over 13 years in relation to a murder he committed in Adelaide in 2005. He had significant comorbidities including congestive cardiac failure, cirrhosis and chronic obstructive pulmonary disease. On 8 December 2018, Mr Childs complained of abdominal pain at the Woodford Correctional Centre. He refused a transfer to the Caboolture Hospital for treatment and was given pain medication. On 9 December 2018, Mr Childs was transferred to the Caboolture Hospital where he later died while undergoing emergency surgery.
Place of death –	Caboolture Hospital, Caboolture, Queensland
Date of death–	9 December 2018
Cause of death –	Peritonitis, due to or as a consequence of a ruptured gallbladder, due to or as a consequence of gallstones. Other conditions identified were ischaemic heart disease, cirrhosis, chronic obstructive pulmonary disease and chronic pleural effusion.

69. I close the inquest.

Terry Ryan
State Coroner
BRISBANE