QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Craig Steven LINGWOOD**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/1562
DELIVERED ON:	24 January 2014
DELIVERED AT:	Brisbane
HEARING DATES:	28 August 2013 and 12 November 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, recognition of melanoma, management of urgent referrals to external providers, follow-up care

REPRESENTATION:

Counsel Assisting:	Mr Peter De Waard
Queensland Corrective Services (incorporating Capricornia Correctional Centre and its health employees prior to 1 July 2008):	Ms Jennifer Rosengren (instructed by the Department of Justice and Attorney-General)
Central Queensland Hospital and Health Service (incorporating Rockhampton Base Hospital employees and Capricornia Correctional Centre health employees from July 2008):	Ms Julie Farr (instructed by Minter Ellison Lawyers)

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The *Coroners Act 2003* provides in s. 47 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 officials with responsibility for the justice system. These are my findings in relation to the death of Craig Steven Lingwood. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Mr Craig Lingwood was 45 years of age at the time of his death on 10 May 2011. He died from complications arising from a metastatic melanoma.

Mr Lingwood had been in custody since 2001. For the six years prior to his death, he was an inmate at the Capricornia Correctional Centre (CCC) in Rockhampton.

The purpose of the inquest was to:

- confirm the identity of the deceased person, when, where and how he died and what caused his death

- determine the adequacy of the health care provided to the deceased by the Capricornia Correctional Centre and Rockhampton Base Hospital between 23 August 2006 and 10 May 2011

- consider whether any changes to procedures or policies 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

Shortly after Mr Lingwood's death on 10 May 2011 at 5:00pm, Constables Anthony Stratton and Jessica McLaren from the Queensland Police Service (QPS) attended the Palliative Care Ward of the Rockhampton Base Hospital (RBH) and commenced a preliminary investigation. Scenes of Crime officer Sergeant Harding took a series of photographs of the deceased and the scene.

After the preliminary investigation, the deceased was conveyed to the hospital mortuary and the QPS Corrective Services Investigation Unit was notified of his death. Plain Clothes Senior Constable David Caruana and Detective Sergeant Myke Anderson attended the Capricornia Correctional Centre the following day to commence their investigation.

During the investigation, the police officers took statements from custodial corrections officers, prisoners from Mr Lingwood's unit, his treating doctor and nurse prior to his death, and his next of kin. They were also present during the autopsy and Scenes of Crime Officer Carrick took a series of photographs of the autopsy.

Senior Constable Caruana concluded there were no suspicious circumstances surrounding Mr Lingwood's death. He did, however, identify that there had been a significant delay in the removal of the melanoma from Mr Lingwood's back but he was unable to determine whether earlier intervention may have prevented Mr Lingwood's death.

As a result of this issue raised within the police investigation report, the State Coroner referred the matter to the Clinical Forensic Medical Unit (CFMU) for review. The CFMU report by Dr Adam Griffin, Forensic Medical Officer and State Director, was then forwarded to Dr Perry Wilson, a Cutaneous Oncologist, for an expert report.

The CFMU report and expert report were tendered at the inquest.

The inquest

Following a pre-inquest conference on 28 August 2013, an inquest was held in Brisbane on 12 November 2013. All of the statements, records of interview, medical records, expert reports and photographs gathered during the investigation were tendered at the inquest.

Oral testimony was also provided by Dr Perry Wilson (Cutaneous Oncologist, Toowoomba), Dr Arthur Ewart (General Physician at the RBH), Dr Wendy Christie (former Visiting Medical Officer (VMO) of the CCC, Ms Michele Gardner (Executive Director, Division of Sub Acute & Community Services, Central Queensland Hospital and Health Service (CQHHS), Rockhampton), and Ms Paula May (General Manager of the CCC).

Counsel assisting, Mr Peter De Waard, proposed that no further oral evidence be heard subject to objection from any other party. I agreed that the evidence tendered, together with the oral evidence received was sufficient for me to make the requisite findings.

The evidence

Mr Lingwood's medical records indicate that he had a background medical history of high blood pressure, severe headaches, a clot to the lung, intermittent rhythm disturbance to the heart, and Hepatitis C.

Mr Lingwood's first complaint to his next of kin regarding his mole

Mr Lingwood's mother, who resided in Coffs Harbour, and sister, who resided at the time in Brisbane, were in regular phone contact with Mr Lingwood while he was incarcerated. They would also regularly visit him at the prison in Rockhampton together.

During one of their visits in 2005 or 2006, Mr Lingwood mentioned a mole on his back and complained to them that the mole was itchy, red and bleeding intermittently. His sister was a nurse and his mother was a retired nurse. His sister looked at the mole and thought that it appeared to be suspicious and she was concerned it could have been a cancer. Both his mother and sister told him to go and see the prison doctor.

Mr Lingwood's first check up by the prison doctor (Dr Cave)

Mr Lingwood first saw the prison doctor (VMO), Dr Frank Cave, about his mole on 23 August 2006. Dr Cave was a doctor with many years experience, and was the only VMO on staff.

Dr Cave's entry in Mr Lingwood's prison medical record reads: '*8mm mole on back for 8mm punch'*. One dimension only is described. No description is given of the mole's location or appearance.

Dr Wilson explained in oral evidence that an 8mm mole, in the absence of any other notable features, is not unusual.

It is unknown whether Mr Lingwood informed Dr Cave that his mole was itchy, red and bleeding. These details do not appear in Dr Cave's notes in Mr Lingwood's prison medical record. Dr Cave died on 10 July 2008. It is also unknown whether Mr Lingwood's initial complaint to his mother or sister about his mole took place before or after his initial appointment with Dr Cave.

Although Dr Cave's notes indicate an intention to punch biopsy the mole, there is no record of when he intended to do this. It does not appear, however, that Dr Cave ever performed a punch biopsy and there is no evidence of the mole subsequently being examined histologically at his request.

Mr Lingwood's second check up by the prison doctor (Dr Cave)

In the period following Mr Lingwood's first check up with Dr Cave on 23 August 2006, he complained numerous times about his mole to his sister and mother. In their witness statements, they said that every time they visited Mr Lingwood, they would tell him to go and see the doctor again.

On 18 December 2006, Mr Lingwood saw Dr Cave about his mole again. Dr Cave's entry in Mr Lingwood's prison medical records reads: '*mole (23/08/06) still 8mm*'. Only one dimension is described again. No description is given of the mole's location or appearance.

It is unknown whether Mr Lingwood was at that time experiencing the same symptoms he had earlier complained about to his sister and mother. It is again unknown what level of detail Mr Lingwood gave to Dr Cave regarding his concerns during his second visit as Dr Cave did not make any notes about this aspect.

Mr Lingwood's sister recalls that during one of her phone calls with Mr Lingwood, he mentioned he had gone to see the doctor about his mole but the doctor told him there was nothing to worry about. Mr Lingwood said the doctor drew a picture of the mole and showed it to him and stated it had not changed.

It is assumed that this phone call took place after Mr Lingwood's second check up with Dr Cave and that Dr Cave was therefore under the impression at the time that there was no need to biopsy the mole as it had not changed.

Nothing is mentioned in Dr Cave's notes about why he decided not to biopsy the mole.

Mr Lingwood's check up by an external doctor (Dr Ewart)

Over a year later, on 6 February 2008, Mr Lingwood was referred by Dr Cave to the Skin Clinic at the RBH for review of a rash on his neck.

The RBH Skin Clinic was a clinic run by Dr Arthur Ewart and another doctor. It was not a general dermatology clinic because it was limited mainly to review of patients with skin rashes. The RBH also operated a separate Lesion Clinic run by a surgical team for patients with skin lesions.

Despite this, Dr Ewart observed what appeared to be a black mole on Mr Lingwood's left shoulder blade when reviewing his neck rash. The appearance of the mole was such that he immediately suspected melanoma requiring urgent removal. He recorded in the Progress Notes in Mr Lingwood's hospital medical records:

> *Also we noticed a probable melanoma over medial L [left] scapula*
>
> - *[approximately] 8 x 6mm (not measured exactly) black variable pigment Raised, itchy he says.*
>
> - *Dr. Cave Refer Lesion Clinic*

Dr Ewart's urgent referral of Mr Lingwood to the Lesion Clinic

Dr Ewart says that he did not biopsy the lesion because in cases of suspected melanoma it was his understanding that it was better to leave the lesion alone so as not to disturb it and to treat melanoma with a wide excision. He was not qualified to perform a wide excision, nor was this a procedure that was ordinarily performed at the Skin Clinic. That is why he referred Mr Lingwood to the Lesion Clinic for further management.

Dr Ewart completed a Queensland Health 'Consultation Referral and Request Form' referring Mr Lingwood to the Lesion Clinic. He ticked the 'urgent' box in the form.

Dr Ewart recalls that he completed the referral form in front of Mr Lingwood and he specifically recalls informing him about his observations of what he thought was a melanoma on his shoulder blade. He informed Mr Lingwood that the mole needed to be urgently removed, and that he was referring him to the Lesion Clinic for further management.

Dr Ewart explained that in the usual course, referral forms were given to nurses at the Skin Clinic or, if there was no nurse immediately available, the referral form was placed on a table outside the consultation room for later collection by a nurse. There were no secretarial services at the Clinic. The nurses who assisted at the Skin Clinic performed administrative duties, including in relation to referrals.

Dr Ewart does not recall what specifically happened to Mr Lingwood's referral form. Because this case was urgent in his mind, he believes he would have given the referral form directly to a nurse and advised the nurse it was urgent.

It is not known what became of Mr Lingwood's referral form. However, there was clearly some form of systemic breakdown because Mr Lingwood never attended an appointment with the Lesion Clinic as a result.

Follow up by Dr Ewart

It was Dr Ewart's usual practice to always write a letter back to the doctor who had referred the patient to the Skin Clinic. If there was time at the end of Clinic, he would dictate letters then. Otherwise, he would take the relevant patient records to his office on the medical ward and dictate letters the following day or early the following week when he was next at the RBH.

Dr Ewart does not specifically recall when he dictated the letter to Dr Cave but he thinks it may have been after the clinic session because the letter had not been returned to him for signing before he went on leave for a month on 28 February 2008.

The letter sent to Dr Cave under Dr Ewart's signature block is dated 14 February 2008 and marked 'dictated but not signed'. The relevant section of his letter read as follows:

> Incidentally we noticed a mole on his back which stood out from all the rest. This was about 8 x 6mm with some irregular colour and irregular outline and Mr Lingwood stated that it had become itchy' I have requested urgent referral to the Lesion Clinic and would be very grateful if you could follow this up. It would be dreadful if the referral got lost in the system. Perhaps he might be able to get the lesion excised at the prison medical centre?

Dr Ewart, in oral evidence, explained that he suggested that Dr Cave could perform the excision himself because he believed Dr Cave was a very experienced practitioner and would have been among the general practitioners able to perform minor surgery of this nature.

Dr Ewart also explained that the reason he expressed concern in his letter to Dr Cave that Mr Lingwood's referral could get lost in the system is because, although he had not had a failed referral before, he was aware that patients sometimes did not receive notification of their appointments from the outpatient office. He knew this because he sometimes telephoned patients who had failed to attend his clinics and many would say they had not received the appointment notification.

Although Dr Ewart had a concern that Mr Lingwood's referral could be lost, he did not follow it up in any way. This is not unusual and is not considered to be unreasonable in the circumstances.

Dr Ewart has explained that part of the reason for not following up is that the letter he dictated was never actually signed by him because he was away on

leave, so he did not receive an obvious prompt to check up on the appointment.

Dr Ewart also stated that in his mind, having written a referral to the Lesion Clinic, sent a letter back to Dr Cave as the referring doctor at the CCC and personally informing Mr Lingwood that he needed urgent treatment, he felt that he had taken adequate precautions to ensure Mr Lingwood was appropriately managed. From his point of view, he no longer had continuing care of the patient.

Dr Ewart conceded, with the benefit of hindsight, that it was possible for him to check if Mr Lingwood had been given an appointment at the Lesion Clinic by asking a nurse to access the Hospital Based Corporate Information System (HBCIS). He could have also called Mr Lingwood back to the hospital for a further appointment. However, he did not feel there was any basis to do so as the problem for which Mr Lingwood had been referred to him was seemingly resolved. He could also have asked to call Mr Lingwood's records back to his clinic to determine if Mr Lingwood had been seen by the Lesion Clinic, but at the time he felt that there was no need to do so.

I accept that it must also be borne in mind that Dr Ewart was an extremely busy practitioner in a large regional hospital, responsible for three separate clinics in different speciality areas. It would simply not be possible for him to personally follow up every urgent referral he made.

No follow up by prison medical service

The prison doctor who replaced Dr Cave, Dr Wendy Christie, explained in oral evidence that the usual system for processing incoming correspondence at the prison medical centre was for VMO to place their initials on correspondence as having read it and to instruct the nurses if further action needed to be taken. However, there was no formal process in place at the prison and Dr Christie was unsure as to whether Dr Cave had adopted this practice.

There are no initials or notations on the copy of Dr Ewart's letter, which was filed on Mr Lingwood's prison medical record, nor are there any entries in Mr Lingwood's prison medical progress notes to indicate whether Dr Cave or any other prison medical staff member actually read the letter. It would appear that the referral was filed in Mr Lingwood's prison medical record without being actioned.

It is unknown when Dr Ewart's letter was filed on Mr Lingwood's medical record. In oral evidence, Dr Christie remembered seeing the letter on Mr Lingwood's medical record when she first consulted with him on 19 September 2008. This means that the letter must have been filed between 14 February 2008 (the date of the dictated letter) and 19 September 2008.

It is unknown who filed Dr Ewart's letter to Dr Cave on Mr Lingwood's prison medical record and why no action was taken.

Identification of suspicious lesion during hospital admission

On 17 April 2008, Mr Lingwood was admitted to the RBH following an episode of chest pain. While the emergency staff responsible for his treatment were focussed on his acute presentation, they also specifically noted on the discharge form which was addressed to the 'doctor of the correctional centre', that Mr Lingwood had a suspicious mole awaiting removal.

It is not possible on the available evidence to say whether there was a booking in place for Mr Lingwood at the hospital's Lesion Clinic as at 17 April 2008, or whether the hospital staff took any action to check whether he actually had a booking.

Mr Lingwood's discharge letter from the hospital dated 17 April 2008 was received by the prison medical service because it was filed in his prison medical records. It is unknown when this was received because there is no date stamp, initial or notation on the letter itself.

On 17 April 2008, there is an entry in Mr Lingwood's prison medical progress notes by a registered nurse suggesting that he was reviewed that day by the prison nurse upon discharge from the hospital. However, there is no mention in the nurse's notes about the hospital's discharge summary regarding Mr Lingwood's mole requiring excision.

It would appear that Dr Cave acknowledged receipt of Mr Lingwood's discharge summary letter from the RBH in his entry in Mr Lingwood's progress notes the next day on 18 April 2008 but he did not refer to the hospital's discharge summary regarding Mr Lingwood's pigmented lesion requiring excision.

However, even if Dr Cave did receive the discharge letter, it is noted that the letter related principally to the treatment of chest pain. The reference to the mole in the letter is brief and indicates that the mole was awaiting removal. The clear inference in the letter was that arrangements had already been made at the hospital for this to occur.

Request by Mr Lingwood for a further appointment with a prison doctor

During a prison visit by Mr Lingwood's mother and sister in July 2008, he advised them that the usual prison doctor, Dr Cave, had left and was replaced with a female doctor. They told him to go and see her regarding his mole as soon as he could.

On 4 August 2008, Mr Lingwood submitted a 'Medical Request Form' to see the prison doctor. In the reason for the request section, he stated:

> I have a mole on my back when I was at the hospital 8 months ago the doctor put in a form and said it should come straight off and I haven't heard anything since so could I please see the doctor. Thank you.

The CCC nurse recorded as the outcome on the request form that Mr Lingwood was to be placed on the next VMO Clinic. Mr Lingwood did not see a prison doctor until six weeks later. The reasons for this delay are unknown.

Mr Lingwood's check up with a new prison doctor (Dr Christie)

Mr Lingwood saw a new prison doctor, Dr Christie, on 19 September 2008. Dr Christie was employed after Dr Cave had passed away.

Dr Christie described the lesion on Mr Lingwood's back in his medical notes as a 'nodular melanoma' and '10mm - 11mm'.

Dr Christie had worked for four years in a skin cancer clinic and was very aware of the urgency of diagnosis and definitive treatment of melanomas. She performed a punch biopsy and subsequently reported it as a melanoma.

In an e-mail to my office dated 31 July 2013, in response to questions from counsel assisting, Dr Christie outlined her reasons for performing a punch biopsy at that time, rather than an excision. They include: poor lighting, the range of instruments available, lack of facilities to control haemostasis and overbooked clinics.

Dr Christie stated that a biopsy takes three to five minutes compared to an excision, which could take 20 minutes or more. She went ahead with the biopsy, knowing it would not compromise Mr Lingwood's condition and would expedite his surgical management.

Dr Christie was concerned that if she did not perform a punch biopsy and instead re-referred Mr Lingwood to the Outpatients Department, he would again have an undue wait as a new referral. If he had a definite diagnosis of melanoma, he would be prioritised for surgery.

Dr Christie also considered that should she do a total excision and not achieve adequate margins, Mr Lingwood would need to be recalled for definitive surgery. She did not believe it was justified to do a wide excision without a histological diagnosis, given the risks and possible wound complications.

Excision of mole

Dr Christie conscientiously ensured that appropriate action was taken in relation to Mr Lingwood's melanoma. She sought out the results from the punch biopsy during her next visit to the prison. She then telephoned the surgical registrar at the RBH to seek an early appointment for Mr Lingwood, which was given within a day or so after her call.

Dr Christie visited the RBH while the surgical clinic was being conducted and asked to attend while Mr Lingwood was being seen. She discussed the case with the surgeon, Dr Renton-Power, who saw Mr Lingwood. Dr Renton-Power listed Mr Lingwood as an urgent excision and asked the Registrar to give him an early appointment.

A wide excision of Mr Lingwood's mole was performed at the RBH Lesion Clinic on 24 October 2008, over two years after he first saw Dr Cave. A pathological diagnosis was used to stage Mr Lingwood's tumour and it was determined that he had a Stage IIa tumour. Mr Lingwood subsequently underwent a barrage of further tests to identify if any lesions had spread elsewhere. No further lesions were identified.

Follow up care

After the conclusion of a series of tests by the surgical team at the RBH, Mr Lingwood's hospital progress notes indicate that he was discharged from the hospital into the care of the prison medical centre on 13 July 2009.

On 13 July 2009, an entry in Mr Lingwood's prison medical record progress notes indicates that he was reviewed by a prison nurse, following his discharge from the RBH. The notes say that Mr Lingwood had informed the nurse that he had received the results of his MRI and CT scans and that there was no malignancy detected.

On 20 July 2009, Dr K. Rao, Consultant Surgeon at the RBH, wrote a letter addressed to the 'Visiting Medical Officer', after a review of Mr Lingwood. Dr Rao advised that the MRI of Mr Lingwood's brain had come back as quite normal with no evidence of melanoma metastases. Dr Rao advised that Mr Lingwood had been discharged into the VMO's care but Dr Rao would be happy to see him again should he develop any further problems. Dr Rao's letter was filed in Mr Lingwood's prison medical record and initialled.

It does not appear that upon discharge from the RBH, any follow up plan was put in place by the nurse who reviewed Mr Lingwood that day or the staff member who initialled Dr Rao's letter, which followed soon after. There is no record of Mr Lingwood having any reviews with a doctor at either the prison or the RBH following his discharge from the RBH on 13 July 2009 until a year later, on 13 July 2010.

It was important that Mr Lingwood receive regular check ups to increase the chances of detecting a melanoma recurrence or formation of a second primary lesion, in order for appropriate action to be taken as quickly as possible.

The Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand published by the National Health and Medical Research Council in association with the Australian Cancer Network on 31 October 2008 (Guidelines) were applicable at the time.

After a melanoma is excised from a patient, the Guidelines recommend that follow-ups occur at three-monthly or four-monthly intervals for five years and yearly thereafter (all with ultrasound examination of regional nodes) for patients with stage II and stage III disease. Mr Lingwood had a stage II disease.

The recommendations in the Guidelines are based on the observation that about 80% of melanoma recurrences develop in the first three years. The Guidelines note that there is a lack of valid prospective studies of the efficacy of routine follow up. No study has demonstrated an improvement in survival due to intense routine surveillance. The Guidelines note that the reasons for the lack of valid prospective randomised trials assessing the value of routine follow up are numerous, but foremost among them may be patient reluctance to accept a 50% risk of being assigned to the arm not receiving ultrasound or other follow up.

Excision of lump

In July 2010, Mr Lingwood telephoned his sister and said a new lump had appeared in his back at the end of his scar on the left side. She advised him to see the prison doctor.

After requesting an appointment to see a prison doctor, Mr Lingwood was able to see Dr Moore on 13 July 2010. Dr Moore confirmed that there was a mass on Mr Lingwood's shoulder blade at the lateral end of the excisional scar relating to the original melanoma. A biopsy was taken of the mass and proved to be a metastatic melanoma.

Mr Lingwood was again referred to the Lesion Clinic at the RBH for another excision.

On 23 September 2010, Mr Lingwood's lump was excised at the Lesion Clinic. The wound took some months to heal and the healing process was complicated by infection and likely local recurrence of melanoma.

Spread of cancer

Just over three months later, in January 2011, Mr Lingwood was suffering from hip pain and it was discovered that his cancer had spread to his right femur. He was also coughing up blood and it was identified that this was most likely caused by cancer in his lung.

Mr Lingwood subsequently underwent surgery at the RBH to prevent his femur from fracturing. Mr Lingwood was then referred to the Royal Brisbane and Women's Hospital for radiation therapy. After his pain management could be managed, Mr Lingwood was returned from Brisbane to prison on 31 March 2011.

Five weeks into Mr Lingwood's return to prison, on 8 May 2011, prison staff were concerned about him because he was refusing to take his medication. Mr Lingwood later started complaining about difficulty breathing and a decision was made to transfer him to the RBH.

Mr Lingwood was admitted to the RBH under the palliative care team for pain management. He deteriorated rapidly over the course of the next two days and died on 10 May 2011 at approximately 5:00pm.

Autopsy results

An external autopsy and review of the deceased's hospital clinical chart was carried out on 12 May 2011 by a forensic pathologist, Dr Nigel Buxton. He issued an Autopsy Report on the same day.

Dr Buxton noted that nodular malignant melanoma is a serious condition and prognosis is related to tumour thickness. Mr Lingwood had presented with recurrence and metastases within two years of the primary diagnosis, which reflected the aggressiveness of this particular tumour.

Dr Buxton noted that there was nothing in the deceased's clinical chart that indicated that the clinical progression was anything but in line with the diagnosis. The external examination found no evidence of trauma to Mr Lingwood that may have hastened his demise.

Dr Buxton did not have access to Mr Lingwood's prison medical records at the time of autopsy. He commented that a review of the prison records may reveal whether or not Mr Lingwood presented prior to 2008 with concern about a pigmented lesion on his back. Dr Buxton noted that an earlier diagnosis may have changed the outcome.

Dr Buxton concluded that the cause of death was:

> *1(a) Metastatic malignant melanoma*.

Analysis of the evidence

Would an earlier biopsy or excision of the mole have improved Mr Lingwood's prognosis?

Although there is no histology available prior to the excision of Mr Lingwood's mole in 2008, it is known that Mr Lingwood was complaining to his mother and sister that his mole was red, itchy and bleeding intermittently in 2006.

Dr Wilson's report indicates that a mole that is itching and bleeding intermittently would be highly suspicious of an ulcerated melanoma if it was a melanocytic lesion. The mere fact that a melanoma was bleeding intermittently would indicate it was not an in situ melanoma, and it would very unlikely be a thin melanoma. There is therefore an implication that this was associated with a malignant melanoma, rather than a benign mole.

If Mr Lingwood's mole was bleeding in 2006, Dr Wilson surmised that it was already quite an advanced melanoma with a friable surface, which frequently ulcerated and would likely be associated with an already poorer prognosis. However, Dr Wilson stressed that earlier intervention (i.e. biopsy or wide excision), either in 2006 or earlier in 2008, may have improved Mr Lingwood's prognosis and may have averted his death from melanoma. He stated that there is no doubt that the best prognostic outcome for treating melanoma is derived by the earliest intervention once a melanoma is diagnosed.

I accept Dr Wilson's opinion that earlier intervention could have improved Mr Lingwood's prognosis.

Should Dr Cave have intervened earlier?

The key points in time that Dr Cave may have had an opportunity to conduct a punch biopsy or excision of Mr Lingwood's mole himself or to arrange for someone else to perform the procedure include:

- 23 August 2006 - during Mr Lingwood's first consultation with him
- 18 December 2006 – during Mr Lingwood's second consultation with him
- upon receipt of Dr Ewart's dictated letter dated 14 February 2008 (if he in fact received it).

Dr Cave may also have had an opportunity to confirm whether Mr Lingwood had obtained an appointment with the RBH Lesion Clinic after Dr Ewart's urgent referral:

- upon receipt of Dr Ewart's dictated letter dated 14 February 2008 (if he in fact received it)
- upon receipt of Mr Lingwood's discharge letter from the RBH on 18 April 2008 (if he in fact received it).

I have, however, accepted the submission by Queensland Corrective Services (QCS) and resisted the inclination retrospectively to find fault in Dr Cave's management of Mr Lingwood's mole, by devising chains of causation involving risks which were not reasonably regarded as significant at the time Dr Cave was involved in Mr Lingwood's medical care.

This is particularly important in circumstances where the relevant examinations by Dr Cave took place a number of years ago, Dr Cave and Mr Lingwood have both since passed away and there is very limited evidence regarding the information provided by Mr Lingwood and the presentation of the mole at these examinations.

The processing methods utilised by the prison medical service at the time for incoming correspondence also make it impossible to determine whether Dr Cave read Dr Ewart's letter or Mr Lingwood's hospital discharge letter.

Would earlier review after the excision of the mole have improved Mr Lingwood's prognosis?

From 13 July 2009 onwards, there was no follow up or review plan in place to check on Mr Lingwood for local recurrences or new melanomas. This was contrary to the Guidelines applicable at the time and despite him being in a high-risk category and having already had a melanoma excised.

In oral evidence, Dr Wilson, Dr Christie and Ms Gardner agreed that follow up in the circumstances should usually be done by both the hospital and prison in consultation with each other. However, in this case, after Dr Rao's letter to the

prison VMO dated 20 July 2009, the RBH surgical team had very clearly handed back the continuing care of Mr Lingwood to the prison medical service.

In oral evidence, Dr Wilson confirmed that there was no difference in mortality rates following excision of Stage II melanoma between patients who were followed up in accordance with the Guidelines and those who were not. However, this is due to the lack of empirical data which is unlikely to ever be obtained due to the practical limitations of running such studies.

CQHHS submitted that adherence to the Guidelines simply ensures that any melanoma recurrence is diagnosed and treated at an earlier stage and that there is no difference in mortality rates following excision of Stage IIA melanoma as between patients who were followed up in accordance with the Guidelines and those who were not.

While I accept what Dr Wilson said about mortality rates, this was in the context of a lack of empirical data. The Guidelines explain the reasons why practically such data is unlikely to ever be obtained. Importantly, Dr Wilson also said that there is no doubt that the best prognostic outcome for treating melanoma is derived by the earliest intervention once a melanoma is diagnosed.

It is self evident, that the more regular the follow-up appointments after an excision of a primary melanoma, the more likely that a recurrence of melanoma or new melanoma will be identified. Earlier identification enables earlier intervention. Earlier intervention improves prognostic outcomes. I therefore do not accept the submission for CQHHS to the effect that more regular follow up reviews do not increase the chances of a better outcome for patients.

There is, however, insufficient evidence in this case to determine whether Mr Lingwood's outcome would have actually been improved, had the prison medical service followed the Guidelines.

I accept counsel assisting's submission that no blame should be attributed to any individual for not putting in place a follow up plan for Mr Lingwood at the prison. It would appear that this failure arose due to a deficiency in the policies and procedures in place at the time, rather than individual fault.

Adequacy of the policies and procedures in place at the prison prior to Mr Lingwood's death

Between 2006 and 1 July 2008, health services within the prison were under the management of QCS. From 1 July 2008 to June 2012, responsibility was transferred to Queensland Health, Offender Health Service, Division of the Chief Health Officer. Then in July 2012, this was transferred to CQHHS, Division of Subacute and Community Services.

Ms Michele Gardner, Executive Director, Division of Subacute and Community Services, CQHHS, provided a statement dated 13 September

2013 outlining the applicable policies and procedures for health services at the prison from July 2008 onwards. She also gave oral evidence at the inquest.

It was not possible to obtain information about the policies and procedures in place prior to July 2008 because QCS did not have any records. QCS advised that any such records would have been handed over to Queensland Health and then to CQHHS. However, CQHHS advised that it did not have those records.

Encouragement of prisoners to undertake regular skin cancer checks

Prior to Mr Lingwood's death, there does not appear to have been any specific policies or procedures in place to encourage prisoners to have regular skin cancer checks.

Prisoners, as with non-prisoners, were encouraged to have regular skin cancer checks through health promotion information relating to skin care. This information was provided to prisoners through various methods, including poster displays and information sheets at the prison health service.

I find this to have been adequate in the circumstances at the time.

Examination, measurement, monitoring and recording of moles

Prior to Mr Lingwood's death, a full skin examination of all new prisoners was supposed to be conducted as part of the reception process into the prison. However, this was not routinely complied with and did not occur in Mr Lingwood's case.

Management of prisoners complaining of moles occurred on an ad hoc basis when they accessed the prison health service. Prisoners were then generally managed in accordance with the 'Clinical Practice Guidelines for the Management of Melanoma in Australia and New Zealand'. Ms Gardner has advised that this resource was available online and a hard copy kept at the prison's health service.

The inconsistent skin examinations of prisoners upon reception was less than ideal. Had such an examination occurred in Mr Lingwood's case, it may have assisted Dr Cave and other medical practitioners to conduct a better examination and diagnosis later down the track. However, I find that the system was adequate in the circumstances at the time and it cannot be said that this deficiency in any way contributed to Mr Lingwood's death.

Monitoring and tracking of referrals to external service providers

Prior to Mr Lingwood's death, prisoner appointments were managed on an ad hoc basis by medical officers at the prison's health service.

Between July 2008 and June 2012 there was no specific follow up policy or procedure in place for referrals to external service providers. It is assumed that the situation was no different in 2006 and 2007.

Due to information technology infrastructure requirements at the prison, there was no electronic access to the HBCIS from the medical centre at CCC. HBCIS is an electronic administration system adopted by Queensland Health for capturing and managing patient and administrative data, including: patient demographic information; admissions and discharges; referral and wait list management for both specialist outpatients and elective surgery, appointment management, elective admissions management, medical record tracking, and financial reporting.

I find that the lack of specific follow up policies and procedures in place for referrals to external service providers prior to Mr Lingwood's death was inadequate. Had a process been in place prior to Mr Lingwood's death, his referral to the Lesion Clinic for excision of a suspected melanoma may not have fallen through the cracks. This may have resulted in his melanoma being excised more quickly and his chances of survival increasing.

Adequacy of the policies and procedures in place at the Rockhampton Base Hospital at the time

Follow up after urgent referral of a prisoner

Prior to Mr Lingwood's death, there were no specific policies or procedures at the RBH to ensure prisoners who were given urgent referrals for conditions of a life threatening nature, actually received their intended appointments.

While Dr Ewart may have followed 'conventional guidelines' in relation to referral and continuity of care of patients, this system clearly failed in Mr Lingwood's case. I find, however, that the responsibility for the system failure in Mr Lingwood's case should rest with the prison, rather than the hospital in the circumstances.

Adequacy of the policies and procedures in place at the prison now

Examination, measurement, monitoring and recording of moles

Ms Gardner advised that a policy and procedure was implemented in March 2011 at the prison to ensure that full skin examinations are now routinely conducted upon reception for all prisoners.

Beyond reception, a prisoner with an issue such a problematic mole may still access the prison's health service by lodging a 'Medical Request Form'. This process was formalised in July 2011. The form was revised in 2012 to allow a prisoner to provide greater specificity about the nature of the health issue or service requested, so that appropriate urgency can be given to certain requests. In oral evidence, Ms Gardner assured the court that there was now a system in place to ensure that nursing staff who process Medical Request Forms submitted by prisoners consult with VMOs when appropriate.

In July 2010, a process was also introduced for photographs to be taken (with consent) for wound management or mole/skin condition monitoring. The

photographs are kept electronically and are available for review by the prison's health service staff.

I find that these improvements to the system adequately address prior deficiencies.

Monitoring and tracking of referrals to external service providers

Ms Gardner has advised that as a direct result of Mr Lingwood's death, CQHHS:

- implemented a work instruction on 17 September 2013 to formalise the current referral process within the prison

- conducted a review of the work instruction to confirm specialist referral management process and follow up is being conducted in accordance with the work instruction

- is currently formalising prisoner wait list management processes in the form of a work instruction

- implemented an Outpatient Service Implementation Standard in November 2010 relating to communication with prisoners and referral management. A staff User Manual is currently being drafted to reflect this Standard.

Ms Gardner also assured the court that under the new system, if a prisoner is discharged from hospital after having a melanoma excised, they will be reviewed by prison medical staff to determine what follow up and review appointments they require and a plan would be put in place.

There are also negotiations with QCS to enable access to Queensland Health IT clinical system applications at a state wide level. There is a current collaboration occurring with QCS and West Moreton Hospital & Health Service as a pilot site. Ms Gardner advised that she is continuing to work with senior members of QCS to overcome these issues with a view to HBCIS access being achieved in early 2014.

I find that the new policies and procedures implemented (and currently being developed and implemented) by the prison health service since Mr Lingwood's death in relation to monitoring and tracking of referrals to external service providers are adequate in the circumstances.

Adequacy of the policies and procedures in place at Rockhampton Base Hospital now

The Outpatient Service Implementation Standard implemented in November 2010 is directed to communications with patients from QCS. Referral management is also covered.

I find that the changes are appropriate in the circumstances.

Findings

I make the following findings, based on the totality of the evidence:

- earlier intervention (i.e. a biopsy or wide excision of Mr Lingwood's mole), either in 2006 or earlier in 2008, may have improved Mr Lingwood's prognosis and may have averted his death from melanoma

- it is not possible to say if any blame should be attributed to Dr Cave for failing to take earlier action because of the lack of detail in his notes and his death prior to Mr Lingwood's death and this inquest

- the policies and procedures in place at the CCC for the monitoring and tracking of medical referrals of prisoners to external service providers were inadequate prior to Mr Lingwood's death. Earlier intervention generally improves a person's prognosis. However, it is impossible to say with any level of certainty whether earlier intervention would have averted Mr Lingwood's death from melanoma in this case

- from 13 July 2009, a follow-up or review plan should have been put in place by the CCC's medical service to ensure that Mr Lingwood received a check up every three to four months in accordance with the relevant Guidelines. Adherence to the Guidelines may have resulted in earlier detection of Mr Lingwood's metastatic melanoma. Earlier detection should have resulted in earlier intervention. Earlier intervention may have improved his prognosis. However, it is impossible to say with any level of certainty whether the CCC medical service's failure to follow the Guidelines actually contributed to Mr Lingwood's death in this case

- the health care provided by the CCC was inadequate in terms of the apparent failure to follow up Dr Ewart's urgent referral of Mr Lingwood to the RBH Lesion Clinic for excision of his suspected melanoma; and failure to put in place a follow up or review plan once Mr Lingwood's primary melanoma was excised and he was discharged back into the care of the prison

- the improvements made to the relevant policies and procedures applicable at the CCC and RBH since Mr Lingwood's death appear to have adequately addressed any deficiencies identified by this case.

Findings required by s. 45

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.

I therefore make the following findings:

Identity of the deceased – The deceased person was Craig Steven Lingwood.

How he died – Mr Lingwood first complained to his next of kin in 2005 or 2006 that a mole on his back was red, itchy and bleeding. He saw the prison doctor, Dr Frank Cave, on 23 August 2006 and 18 December 2006. Dr Cave appeared to have assessed the mole as benign. On 6 February 2008, Dr Arthur Ewart, from the Rockhampton Base Hospital Skin Clinic, determined that the mole was a suspected melanoma. He referred Mr Lingwood to the hospital's Lesion Clinic for an urgent excision and wrote to Dr Cave advising him of this. On 4 August 2008, Mr Lingwood asked to see the prison Visiting Medical Officer after not hearing anything regarding Dr Ewart's urgent referral to the Lesion Clinic in February 2008. Mr Lingwood saw a new prison doctor, Dr Wendy Christie, on 19 September 2008. Dr Christie performed a punch biopsy and confirmed melanoma. She arranged for an urgent wide excision, which was finally performed on 24 October 2008 at the Rockhampton Base Hospital. After further tests were conducted it was determined that Mr Lingwood had a stage IIa tumour but the cancer had not spread. Follow up and review post-operation was managed by the Rockhampton Base Hospital's surgical outpatients department up until Mr Lingwood was discharged into the care of the prison medical service on 13 July 2009. In July 2010, Mr Lingwood noticed a lump adjacent to the original excision scar on his back. He saw a prison doctor, Dr Moore, on 13 July 2010. Mr Lingwood's lump was excised on 23 September 2010 at the Rockhampton Base Hospital. It was determined that Mr Lingwood had metastatic malignant melanoma and he received treatment for his condition until his death on 10 May 2011.

Place of death – Mr Lingwood died at Rockhampton in Queensland.

Date of death – Mr Lingwood died on 10 May 2011.

Cause of death – Mr Lingwood died from metastatic malignant melanoma.

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.

Given the measures already taken by QCS and CQHHS in response to this incident, there is no basis on which I could make any useful preventative recommendations.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
24 January 2014