QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert John GERHARDT**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/1524
DELIVERED ON:	19 December 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	3 July 2012; 13 August 201
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Melinda Zerner
Queensland Health:	Mr Kevin Parrot

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The *Coroners Act 2003* provides in s. 45 that when an inquest is held 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 officials with responsibility over any areas the subject of recommendations. These are my findings in relation to the death of Robert John Gerhardt. 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

Robert Gerhardt had been in custody for more than four years when he was diagnosed in late 2010 with advanced lung cancer. Over the following months he received ongoing treatment and then palliative care at both Wolston Correctional Centre (WCC) and the Princess Alexandra Hospital Secure Unit (PAHSU). He died at PAHSU on the afternoon of 6 May 2011 only hours after receiving a grant of parole on compassionate grounds.

Mr Gerhardt began suffering symptoms, now known to be related to his cancer, in early September 2010. A chest x-ray taken at PAHSU later that month revealed a density that was not further investigated by medical staff until Mr Gerhardt presented again almost two months later. It is now clear this x-ray revealed the cancerous growth from which Mr Gerhardt subsequently died.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care needs adequately discharged those responsibilities; and
- 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.

Jurisdiction

Mr Gerhardt had been in the custody of Queensland Corrective Services since he was transported to the Arthur Gorrie Correctional Centre (AGCC) on 27 October 2006. At that time he was on remand for alleged offences of which he would later be convicted. He was sentenced to 11 years imprisonment for the most serious of those charges. Mr Gerhardt was not eligible for parole under this sentence until 2015.

On 22 March 2011 Mr Gerhardt made an application to the Parole Board for exceptional circumstances parole on the basis of his terminal cancer. The Parole Board is required to assess such requests within a six month period. On 3 May 2011 Dr Stuart McDonald, Director of the PAHSU advised the

Parole Board that Mr Gerhardt was expected to die within one to two days. On the morning of 6 May 2011 the parole board was convened and a decision made to grant parole to Mr Gerhardt under exceptional circumstances. The parole contained a number of conditions, including:

> *That the prisoner is to be accommodated at either a hospital or palliative care facility and in the event of the prisoner leaving such facility it will be considered a breach of his order.*

The effect of another condition was that the hospital or palliative care facility in which Mr Gerhardt was accommodated would have to be approved by the Board or a corrective services officer (CSO).

The request was made, in effect, so that Mr Gerhardt could be transported out of the Secure Unit at the PAH and into a bed in the public section of the hospital. This would allow his family members unrestricted visits.

The Act at s. 9 defines *custody* to mean:

> *…detention, whether or not by a police officer, under –*
> *(a) an arrest; or*
> *(b) the authority of a court order; or*
> *(c) the authority of an Act of the State….*

The condition restricting Mr Gerhardt to a hospital or palliative care facility does not constitute 'detention'. The order was given effect about an hour before Mr Gerhardt died.

Accordingly, an inquest is not mandatory as Mr Gerhardt was not in custody when he died. However, as the death occurred such a short time after he was granted parole, and as the factors leading to the death occurred while he was in custody, I consider the convening of an inquest is consistent with the policy of the Act.

The investigation

An investigation into the circumstances leading to the death of Mr Gerhardt was conducted by Plain Clothes Senior Constable (PCSC) David Caruana from the QPS Corrective Services Investigation Unit (CSIU).

After receiving notification of Mr Gerhardt's death investigators from the CSIU attended the PAH. They questioned the four other prisoners present in the PAHSU. The investigators also obtained a statement from the registered nurse who was present at the time of Mr Gerhardt's death. A scenes of crime officer attended the public section of the hospital and took a number of photographs of the body of Mr Gerhardt in situ.

PCSC Caruana attended the WCC and seized all relevant records relating to Mr Gerhardt. He later obtained Mr Gerhard's medical file from the PAHSU.

Counsel assisting obtained an independent evaluation of the medical care afforded to Mr Gerhard at the WCC and the PAHSU. This report was prepared by Dr Robert Hoskins, then Director of the Clinical and Forensic Medicine Unit (CFMU) of Queensland Health. It raised concerns about one aspect of the care given to Mr Gerhardt at PAHSU. The PAH was given an opportunity to respond. Dr Hoskins' report also identified an incident in February 2011 at WCC in which Mr Gerhardt was apparently unable to obtain adequate pain relief on request. At the instigation of counsel assisting further details relating to this incident were obtained and relevant documents tendered.

I am satisfied the investigation was thoroughly and professionally conducted and all relevant material was ultimately accessed.

The Inquest

A pre-inquest conference was held on 3 July 2012. Mr Johns was appointed as counsel assisting and leave to appear was granted to Queensland Corrective Services and Queensland Health.

An inquest was held in Brisbane on 13 August 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigating officer gave evidence, as did a senior medical officer from the emergency department at PAH.

The evidence

Personal circumstances and custodial history

Robert John Gerhardt was born on 12 December 1966 and was 44 years of age at the time of his death. On 19 December 2007 he was convicted of a number of sexual offences including rape, indecent treatment of a child under 12 of lineal descent and maintaining an unlawful relationship with a child. He was sentenced to 11 years imprisonment.

After spending more than a year on remand at the AGCC Mr Gerhardt was transferred to the WCC on 24 March 2008.

Early symptoms and treatment

In his examination of Mr Gerhardt's medical history, Dr Hoskins found nothing of concern in relation to the medical treatment provided by staff at the AGCC or the WCC up until 10 September 2010. Prior to that there was nothing in the medical notes that would indicate the presence of the cancer that led to Mr Gerhardt's death or that any investigation into the possibility of cancer should have been initiated.

Between 10 September and 28 September 2010 Mr Gerhardt was treated for symptoms of coughing, excess production of phlegm and fatigue. These symptoms had begun as early as 23 August 2010 and were treated on the

basis they were likely linked to his long-standing asthma. Dr Hoskins considered the treatment provided by medical staff at the WCC during this period was:-

> *…appropriate quantitatively and qualitatively in the first instance. A similar presentation in general practice may have led to a slightly earlier hospital referral but could have taken this long and nothing turns on this in any event.*

Initial examination at PAHSU

On 28 September 2010 Mr Gerhardt was taken to the emergency department at the PAH for evaluation. He had a chest x-ray which was reported by a junior doctor as 'clear'. The image was then examined by the radiology registrar, Dr Cameron Napper. He provided a report which stated:-

> *A density appearing to originate within the mediastinum adjacent to the aortic arch and pulmonary trunk indents the left upper lobe medially. No previous imaging is available for comparison, and a CT could be performed to exclude a mediastinal lesion….*

It appears nothing was done to follow-up these findings.

Diagnosis of cancer

Mr Gerhardt was returned to the WCC later on 28 September 2010. His cough and wheeze persisted despite treatment for his asthma and he began to suffer rib pain on 29 October 2010.

Mr Gerhardt was reviewed by a visiting medical officer (VMO) on 1 November 2010. Blood tests were taken and a review was arranged for three weeks time. In the opinion of Dr Hoskins nothing in the blood test results warranted an earlier appointment being made.

In the interim, arrangements were made for Mr Gerhardt to be transferred to the PAHSU on 21 November 2010 for an Ear, Nose & Throat outpatient review in regards to his hoarse voice. This led to Mr Gerhardt's transfer on 22 November 2010 to the PAH emergency department where the examining medical practitioner, Dr Eric Chou, conducted an extensive examination and noted a chest x-ray taken that day showed an increase in the size of the mass initially identified by the radiology registrar on 28 September. This led to Mr Gerhardt being diagnosed with cancer. Chemotherapy was offered despite the low prospects of any benefit. Mr Gerhardt underwent chemotherapy treatment until April 2011 although, as expected, it failed to halt the effects of the cancer to any significant degree.

Ongoing treatment and palliative care

The medical records show Mr Gerhardt was receiving strong painkillers as early as 6 December 2010 and by early March 2011 he had lost around 15%

of his body weight. In his report, Dr Hoskins drew attention to an entry in Mr Gerhardt's WCC medical records on 25 February 2011 which reads:-

> *Offender complained of chest pain, refused oxygen and requested morphine. Offender was declined and requested for Panadol which was given*.

Dr Hoskins noted that as little as four weeks later Mr Gerhardt's condition had deteriorated such that he needed a wheelchair when travelling to the medical centre and that his pain was, by then, inadequately controlled by the strong painkillers OxyContin and Endone.

On 10 April 2011 Mr Gerhardt signed a form refusing any further chemotherapy treatment and from that time was provided with palliative care. He was referred by a VMO back to the PAHSU on 27 April 2011 because it was apparent by that time that his *pain was poorly controlled* by the facilities and medication available at the WCC.

On 3 May 2011 Mr Gerhardt's condition had deteriorated significantly and the Director of the PAHSU, Dr Stuart McDonald, wrote to the Parole Board. Dr McDonald told them Mr Gerhardt was dying and he would now be unable to leave hospital. Dr McDonald asked that the application be assessed urgently. As detailed earlier, the application for special circumstances parole was considered by the Board on the morning of 6 May 2011 and approved.

At 12:30pm on 6 May 2011, Mr Gerhardt was transferred to a ward in the public section of PAH. By this time he was unresponsive to speech and touch and appeared to be showing no signs of pain. One hour later, registered nurse Amanda Clarke discovered Mr Gerhardt deceased. Unfortunately it seems the move to the public section of the hospital was not communicated to Mr Gerhardt's parents who had arrived at the PAHSU and waited there while enquiries were made as to his whereabouts. By the time they arrived at their son's bedside he had already died.

Dr Vaishnavi Deepikanath attended and documented Mr Gerhardt's death in his medical record at 1:45pm. A formal life extinct certificate was issued at 7:10pm by Dr Danny Pinjuh.

Autopsy results

An external autopsy examination was carried out on 9 May 2011 by an experienced forensic pathologist, Dr Nathan Milne.

Samples were taken for toxicological testing and revealed only the presence of drugs administered at the PAHSU at appropriate therapeutic levels.

Dr Milne had access to all medical records relating to Mr Gerhardt. After considering these, the toxicological results and his own observations, Dr Milne issued a certificate listing the cause of death as:

> *1(a) Metastatic small cell neuroendocrine carcinoma of lung*

Investigation findings

None of the other inmates at WCC provided information to the investigating officers suggestive of any deficiency or inappropriateness with regard to the treatment received by Mr Gerhardt while in custody.

The examination of Mr Gerhardt's room at the PAHSU and in the public ward at the PAH revealed no signs of violence or foul play.

The investigating officer, PCSC Caruana, told the inquest that the CSIU investigation into Mr Gerhardt's death did not lead to any suspicion that the death was unnatural.

Conclusions

I conclude Mr Gerhardt died from natural causes. I find none of the correctional officers or inmates at WCC caused or contributed to his death.

I am satisfied Mr Gerhardt was given adequate medical treatment at the WCC in the lead up to his diagnosis of lung cancer. I accept his treatment at the WCC subsequent to the diagnosis of cancer was predominantly adequate although, as detailed below, I am concerned that in February 2011, a prisoner with such an obvious source of potentially severe pain was unable to access stronger medication than Panadol.

I accept the conclusion of Dr Hoskins, that if the chest x-ray taken at the PAH emergency department on 28 September 2010 had not been incorrectly assessed as being 'clear', Mr Gerhardt would most likely have been seen by a more senior doctor in that department. It is likely this would have led to an earlier diagnosis of the cancer. I also accept the conclusion of Dr Hoskins that this error and the subsequent failure to take any further action as a result of the findings of the radiology registrar on 28 September 2010 until nearly two months later was most unlikely to have influenced the outcome for Mr Gerhardt – that is, even had the cancer been diagnosed on 28 September, it would not have been able to have been successfully treated.

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 he came by his death. As a result of considering all of the material contained in the exhibits and the oral evidence given at the inquest, I am able to make the following findings.

Identity of the deceased – The deceased person was Robert John Gerhardt.

How he died - Mr Gerhardt died from natural causes at Princess Alexandra Hospital, shortly after being granted parole.

Place of death – He died at Buranda in Queensland.

Date of death – He died on 6 May 2011.

Cause of death – Mr Gerhardt died from metastatic small cell neuroendocrine carcinoma of lung.

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.

There are two issues which arise from the facts of this case which warrant further comment:

- The absence of further investigation following Mr Gerhardt's examination at PAH on 28 September 2010; and
- His inability to obtain stronger pain relief medication than Panadol following his request to medical staff at WCC on 25 February 2011.

Failure to diagnose earlier

The inquest received a statement from Dr James Collier, Staff Specialist at the PAH. It also heard oral evidence from Dr Andrew Staib of that hospital. Both addressed the sequence of events regarding the medical care provided to Mr Gerhardt on 28 September 2010.

Mr Gerhardt presented to PAH on the evening of 28 September 2010. Because he arrived after hours he was taken to the emergency department rather than the secure unit. He presented with an exacerbation of asthma and at 7:12pm an x-ray was taken to exclude pneumonia. That x-ray was initially examined by an intern who did not detect the mass in Mr Gerhardt's lung.

The PAH acknowledged that the abnormality evident in the x-ray was not noted nor followed up by any emergency department staff member. Evidence was given that the process for reviewing radiology current as at the time of Mr Gerhard's presentation on 28 September 2010 was:

1. The treating team will initially review the x-ray film once it becomes available. This would include a review of that film by a member of staff more senior than an intern; and
2. A standard practice of staff from radiology alerting emergency department staff by telephone for unexpected findings requiring urgent attention.

The inquest heard that the PAH is cognisant of the propensity for the problem that arose in Mr Gerhardt's case to be repeated. I was advised that two systems are currently being considered to catch cases where abnormal radiology findings have not been appreciated by treating teams and the patient has been discharged prior to the receipt of the radiology report. One proposal is for a senior member of the emergency department to manually

examine all finalised radiology reports received each day and cross-reference them with the patient's attendance record. An alternate is a possible electronic solution based on the radiology PACS system currently in place. Where abnormal findings have been missed by the treating team, the new system would result in the patient, their GP, or in the case of prisoners, staff at the correctional facility being notified of the abnormality with a recommendation for follow-up treatment.

As senior staff at the PAH are aware of the issue and have taken steps to address it, no further comment by me is necessary.

Adequacy of Pain Relief at WCC

The nurse who gave Mr Gerhardt Panadol on 25 February 2011 after he had requested morphine was Olufunmilola Peters. She supplied a statement after the concerns of Dr Hoskins were raised. She notes that morphine is not a drug which can be administered by nursing staff without approval from a doctor. Nurse Peters says she was mindful of Mr Gerhardt's pain management and offered him oxygen but this was refused. There is no reference to oxygen in the notes made in Mr Gerhardt's progress notes for this date.

Queensland Health provided the inquest with two policy documents relating to the administration of medication to prisoners. The first is a procedure manual for the provision, supply and administration of pharmaceuticals. The second is a guideline relating to pain management. Both were issued by Offender Health Services. These confirm the position of Nurse Peters that she was in no position to administer morphine herself. The issue therefore is whether Mr Gerhardt's request should have been referred to a doctor. The medical records for Mr Gerhardt reflect an appropriate level of responsiveness to previous requests for medical attention. It was also possible for Mr Gerhardt to have approached nursing staff following the ingestion of Panadol to advise them it was not providing sufficient pain relief. If there had been a further decision at that time by nursing staff not to explore the provision of stronger pain relief I would have been critical. There is no evidence Mr Gerhardt did indicate the Panadol was having an inadequate effect. In the circumstances I am not inclined to make any criticism. I also accept that the policy documents in place at the time were appropriate and set out a pathway for the provision of stronger pain relief in a clinical assessment had it been deemed appropriate.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
19 December 2012