OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David Robert PETERSEN**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 306/07(0)
DELIVERED ON:	16 September 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	26 March 2010, 31 May – 04 June 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Adequacy of medical treatment, ruptured spleen, referral to Medical Board

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Dr Gary Martin:	Mr Geoffrey Diehm SC (instructed by Flower & Hart Lawyers)
Mr Darryl Waters & Department of Community Safety:	Ms Melinda Zerner

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So far as is relevant to this case, the *Coroners Act 2003* provides in s45 that a coroner's written findings must be given to the family of the person who died and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of David Robert Petersen. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

When he died, David Petersen was a 35 year old man with a significant history of chronic illness, but none of recent trauma. He fell ill on the evening of 23 January 2007. The following day, together with his mother, he saw his general practitioner, Dr Gary Martin. Dr Martin made a non-specific diagnosis of pleurodynia; referred Mr Petersen for a chest x-ray and prescribed some pain-killing medication.

Thirteen hours later, at Beaudesert Hospital, Mr Petersen was pronounced dead. A post mortem examination revealed a large tear in his spleen and more than four litres of blood in his abdominal cavity.

These findings

- confirm the identity of the deceased man, and determine how he died and the time, place and medical cause of his death;

- critique the adequacy of the care given to Mr Petersen by his doctor, the QAS paramedics and the staff of the Beaudesert Hospital; and

- consider whether the conduct of any of those involved in Mr Petersen's care should be referred to the Medical Board of Australia or the DPP for consideration of disciplinary action or a criminal prosecution.

The Investigation

The initial QPS investigation was conducted by Detective Senior Constable Scott Furlong. This concluded with a report to the Beenleigh Coroner deeming the death non-suspicious. He postulated that the injuries to Mr Petersen's spleen may have been caused by his being struck with a cricket ball. The Beenleigh Coroner did not consider this or any other aspect of the death required investigation and finalised the matter with a finding as to the medical cause of death but no finding as to the cause of the fatal injury or the adequacy of the medical care provided to the deceased.

I considered this inadequate and reopened the investigation. Detective Senior Constable Darren Ward of Beaudesert CIB conducted further enquiries in relation to the suggestion Mr Petersen had been struck with a cricket ball in the days leading to his death. After establishing there was little basis for this theory other avenues were explored.

Detailed statements were taken from Mr Petersen's parents along with other relevant witnesses. Statements were sought and later obtained from the QAS officers involved and from Dr Martin. Hospital and ambulance records were seized.

On 7 March 2009 a search warrant was executed at the medical centre. Forensic analysis of computer hard drives was conducted and records relating to Mr Petersen obtained.

Independent medical reports were then obtained from practitioners with relevant specialist qualifications and experience.

Counsel for Dr Martin submitted valuable evidence was lost by the failure to obtain statements from staff at Dr Martin's surgery, the x-ray clinic where Mr Petersen had an image taken and the pharmacy where he had a prescription filled on the day before his death. I agree some of those staff members *may* have been able to give evidence about Mr Petersen's visible symptoms had they been interviewed soon after the death. However, as detailed earlier, the investigation initially focussed on the possibility the fatal injuries were caused during a cricket match. His parents' statements detailing concerns about Dr Martin's care were not taken until June 2008 and Dr Martin's statement was not provided until August 2008, some 18 months after the death. By that stage it is unlikely clinic staff or shop assistants who saw Mr Petersen briefly in January 2007 would have had much to offer.

The evidence

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

Social history

David Robert Petersen was born on 29 December 1971; the elder of two children of Carol and Michael Petersen.

He was raised and went to school in Brisbane before moving with his family to the Gold Coast when he was 17. This move, in part, resulted from David having become involved in illicit drug use and his parents hope that moving would reduce his associating with other drug users and criminals.

It seems this hope was borne out because his parents report by 1994 David had ceased abusing drugs. He established a successful landscaping business and in later years assisted his parents with their muffler repair business. Unfortunately he was forced to gradually reduce his involvement in active employment as a result of his increasingly severe chronic health conditions.

David moved with his family to Boyland, near Canungra, in October 2005. He gradually began to make friends in the community, joining the local cricket club and becoming a well known and popular face at the Canungra Hotel. This

was in contrast to preceding years during which he had been more socially isolated.

It is clear from the material collated by investigators and the evidence given by his mother that, by the time of his death, David was widely known and liked in the local community.

It is also clear he was dearly loved and supported by his close family. I offer them my sincere condolences for their sad loss.

Medical history

At the age of 12 David Petersen suffered kidney problems and underwent surgery for a urinary tract bypass.

When he was 25 blood tests revealed Mr Petersen to have Hepatitis C and Ross River Fever. Shortly afterwards he was diagnosed with cirrhosis of the liver. Mr Petersen received some treatment for these conditions but was not consistent in taking medication or seeking medical advice or treatment. His mother became concerned that he was becoming increasingly socially isolated, that his alcohol consumption was increasing and that these were combining to negatively impact upon his physical and emotional well-being.

Records show he started to see Dr Gary Martin, a general practitioner practicing at Arundel, in August 2004. At that time Dr Martin noted him to be a heavy consumer of alcohol, cigarettes and, less frequently, marijuana. Over the following years Dr Martin would diagnose and treat Mr Petersen for hemochromatosis, depression, hypertension and chronic obstructive pulmonary disease/chronic bronchitis along with his existing conditions.

The evidence from Mr Petersen's parents pointed to a man who was self-conscious and discreet in relation to his ill-health; an exception being a tendency to show others when he had sustained bruises (to which he was susceptible) from being hit with a cricket ball.

Prior to the consultation on the day before his death, Mr Petersen had last seen Dr Martin on 12 December 2006. On that occasion, as on many other occasions, Dr Martin issued a pathology referral for a series of blood tests to assist with the monitoring of the hemochromatosis.

Events prior to 24 January 2007

In the course of conducting his inquiries, the initial police investigator, Detective Senior Constable Furlong, was provided with information by another local police officer suggesting a link may exist between Mr Petersen's death and his having been struck by a ball while batting during a cricket match some days earlier.

This aspect of the matter was investigated more fully by Detective Sergeant Ward who later assumed primary responsibility for the investigation. He spoke to the captain of Mr Petersen's cricket team which had most recently played on Saturday 20 January 2008. It is clear Mr Petersen did not bat on that day

and there was never a suggestion he had otherwise been struck with the ball or been in any way injured during the match. On the basis of this evidence and the absence of any complaint from Mr Petersen to his parents that evening, I am satisfied there is no link between the cricket match and Mr Petersen's death.

There is no evidence of Mr Petersen complaining of illness that might now be attributed to his death at any time prior to the evening of 23 January 2007.

On that evening, Mr Petersen's parents arrived home to find he had begun preparing dinner. As had been the case on the previous evening, Mr Petersen and his father spent some time planting trees and landscaping their yard in preparation for a social event to take place on the coming Friday. This involved the moving of trees too large for Mr Petersen's father, Michael, to move on his own. Mr David Petersen, a large man, was able to do so by putting his arms around the base and lifting them by himself.

At dinner that evening Mr Petersen ate very little of his dinner and complained of an upset stomach. He mentioned his breath had been "*taken away*" on opening a bag of potting mix. No further complaint was made that evening but it appears Mr Petersen was ill enough that his father was not at all surprised when called the following day to assist in taking him to the doctor.

24 January 2007

As was usual practice, Mr Petersen's parents told him they were leaving for work early on 24 January 2007. Not unusually, they got no response from Mr Petersen who remained in his bedroom.

Early in the afternoon, Mr Petersen rang his mother and told her he wasn't feeling well. In her statement to police Mrs Petersen claimed to recall her son complaining of a burning, ripping sensation in his upper chest; his heart feeling like it was jumping out of his chest and excessive sweating that was making him clammy.

Mrs Petersen telephoned the Arundel Plaza Medical Centre and made an appointment for her son to see Dr Martin at 3.30pm. It seems this phone call occurred at 1:21pm and the appointment was made by a receptionist at the centre named Kim Tempany. Mrs Petersen says when she made the appointment she indicated its urgency but also noted they would use the opportunity to get the results of Mr Petersen's recent blood test.

Mr Petersen's father went to their home to collect his son and then drove to Mrs Petersen's workplace to collect her. They then dropped Mr Peterson senior back to work and Mrs Petersen took David to Arundel Plaza.

Mrs Petersen says during the car ride she noticed her son to look very ill. She says he was "*dripping with sweat*", shaking and holding his stomach with one hand while the other tightly gripped the support handle on the interior of the vehicle. He asked her to be careful over bumps or around corners because this was aggravating his symptoms.

She says on approaching the medical centre Mr Petersen vomited into an ice cream container that had been placed in the vehicle for that purpose.

At the medical centre Mrs Petersen entered to tell the receptionist they had arrived while Mr Petersen "*insisted*" on having a cigarette outside the front door. The exact sequence of events is unclear but it seems Mr Petersen was unable to finish his cigarette and, although Mrs Petersen does not say so in her statement to police, there is other evidence both she and Mr Petersen briefly took a seat in the waiting room.

Consultation with Dr Martin

One of the issues considered by this inquest is the adequacy of the treatment provided to Mr Petersen by Dr Martin on the day before his death. Unfortunately, I consider neither of the surviving witnesses, Mrs Petersen or Dr Martin, is reliable.

Mrs Petersen's evidence at the inquest varied significantly from that contained in her statement and her evidence on other matters was contradicted by reliable witnesses such as the paramedics. She also gave inconsistent answers when giving evidence. I conclude she has allowed information she gained after her son's sad death to influence what she believes she heard and saw on the day before his death. I also suspect she is unwilling to accept the primary cause of the disease that led to her son's death was his protracted abuse of alcohol and illicit drugs. While this would be hard for any parent to accept, it does not justify her attempts to lay all the blame for the death on Dr Martin.

Dr Martin, when confronted with overwhelming evidence, admitted his statement contained falsehoods and he was caught out making misleading changes to the computerised medical charts. He also gave a demonstrably false account of the circumstances under which the officer who investigated this matter executed a warrant on his surgery, although I accept that was because of his deeply flawed memory rather than an attempt to initially mislead the court. Indeed, he admitted in his statement he could not even remember whether Mrs Petersen was present during the crucial consultation. His counsel made the quite proper concession I would need reliable corroboration before accepting Dr Martin's evidence.

I have therefore sought to identify what is most likely to have occurred and what I can find independent corroboration for.

Mrs Petersen gave inconsistent evidence about what happened when she and her son arrived at the surgery. Her evidence that David remained outside to have a cigarette raises doubts about how sick he might have felt but an accurate assessment would need to take into account his level of addiction. This makes it more difficult for me to find he was manifesting symptoms of severe illness as I accept that the reception staff are likely to have offered some assistance were he as obviously ill as his mother contends. However, it seems likely Mr Petersen sat in the waiting area, at least briefly.

Mrs Petersen says she was told by the receptionist they could go in to the consultation room but the receptionist and Dr Martin insist the doctor came to the waiting area to indicate he was ready to see the next patient. I think this version is more likely.

Mrs Petersen says when she and her son entered the consultation room Dr Martin was facing his computer and seemed to be reviewing Mr Petersen's blood test results. Dr Martin agrees he did review the results but claims it was later in the consultation. It seems likely the doctor assumed Mr Peterson was there to receive the results and in my view it is likely he was looking at them when the patient and his mother followed him in.

She says Dr Martin first addressed Mr Petersen in relation to his blood test results saying words to the effect they had gone "*from the black into the red"* and this was not good. Dr Martin denies saying this although he acknowledges such terminology would have been apposite, as pathology results outside the acceptable range do in fact print out red (although they are monochrome on the screen). Dr Martin agrees the results relating to Mr Petersen's iron levels had in fact gone from a reading within the acceptable range to a reading outside the acceptable range over the course of his last two blood tests. I conclude Mrs Petersen has accurately recalled this part of the conversation.

Mrs Petersen says Dr Martin began to speak about programs he suggested David undertake. He also stressed the need for David to return soon for another "bleed" – a reference to the treatment required for hemochromatosis.

Mrs Petersen says it was not until she pointed out to Dr Martin that Mr Petersen was here for other reasons that Dr Martin asked what was wrong. Indeed, Dr Martin agrees he did not notice anything unusual about Mr Petersen's appearance.

On his mother's account, Mr Petersen asked whether it was possible for his "…*liver or some organ to rip open or blow out inside of me?*" He spoke of his heart beating quickly, profuse sweating (noting it to be different than when he had Ross River fever) and shaking. He told Dr Martin at 2:00am that morning he had woken "…*in a foetal position and the bed was wet from sweat. I was shivering and my kidney area was sore. It felt like someone had kicked me.*"

Dr Martin continued to listen to Mr Petersen's account without responding. Mr Petersen began to offer possible explanations, such as the pain being the result of spicy food, or gardening. In her statement to police, Mrs Petersen says that as he did this Mr Petersen was pointing to the top section of his stomach, just under the sternum. Dr Martin explained at the inquest he had a "*90 second rule*" whereby it is his practice to allow the patient at least 90 seconds to explain, uninterrupted, why they are there to see him. I accept Dr Martin was told of this episode in terms similar to that described by Mrs Petersen.

Mrs Petersen says Mr Petersen told Dr Martin that earlier that day he had gone to the toilet and passed black blood. Mrs Petersen said that Dr Martin picked up the cord of his telephone and asked "*What, this black?*" Mr Petersen replied in the affirmative.

Dr Martin says Mr Petersen offered a history he had not heard before; namely frequent hematemesis and passing of blood per rectum. Dr Martin understood Mr Petersen's account to be that these symptoms had been experienced for years. He did not ask Mr Petersen when they had last been experienced.

Dr Martin denies being told by Mr Petersen he had passed black blood. However, he confirmed he routinely uses his stethoscope (not his telephone cord) to check with patients as to the colour of the blood which makes Mrs Petersen's account more likely in my view. Dr Martin states he did not do this on 24 January 2007. He says had he been told such a thing he would have recorded "*melena"* on the consultation notes rather than "*PR haemorrhage*" which refers to fresh or red blood. However, Mrs Petersen's account is also supported by the fact a similar history was given to Dr Chan at the Beaudesert Hospital. Counsel for Dr Martin submitted the reference in the Beaudesert Hospital notes to "*one episode of black motion 2/7 ago"* somehow makes it less likely Dr Martin was told of it. I disagree. It is easy to imagine when David was clearly close to death, mistakes in communication could occur when strangers were taking a history from his parents. I conclude Dr Martin was told Mr Petersen had recently passed black blood per rectum.

Mrs Petersen says after being told the patient was suffering chest pain, Dr Martin stood up and placed his stethoscope on Mr Petersen's upper back at points near his left and right shoulders. She says this was done without lifting Mr Petersen's shirt. This differs from what she apparently told police a couple of days after the death. A supplementary form 1 completed then recites her claiming "*the doctor has lifted up the shirt of the deceased and conducted a visual examination of his torso and listened to his chest sounds with a stethoscope."* This more accords with the doctor's account. He says he lifted Mr Petersen's shirt, and conducted a chest examination by auscultating points on Mr Petersen's back with his stethoscope. I accept that. However, at the inquest he gave evidence for the first time that in the process of turning Mr Petersen around for this procedure he felt several points around the renal area, looking for any sign of tenderness. He says he detected none and the chest examination was clear. Dr Martin agrees he did not conduct any examination of Mr Petersen's abdomen and I find his recent claim he palpated the renal area unconvincing.

Mrs Petersen says Dr Martin then advised that David had pleurisy and he would make out a referral for a chest x-ray and a prescription for medication.
Dr Martin agreed the diagnosis of pleurodynia mentioned in the notes amounted to a description of the pain complained of rather than a diagnosis as to cause. He accepts he may have advised Mr Petersen he had pleurisy. He agrees he referred Mr Petersen for a chest x-ray and told him to telephone the following day to discuss the result.

Mrs Petersen says Mr Petersen then told of his vomiting during the course of that day. Soon after, he told Dr Martin he again felt like vomiting. Dr Martin told Mr Petersen to go to the treatment room which is separate from Dr Martin's consultation room. According to Mrs Petersen she then said to Dr Martin that Mr Petersen had been having difficulty with his hearing and asked if he could address that problem "*while we're here".* She says Dr Martin was quite attentive to this complaint and after an inspection advised Mr Petersen to book into the Australia Fair hearing clinic the following week. Dr Martin denies any conversation about Mr Petersen's hearing and indeed it is difficult to understand why, if David was as sick as his mother alleges, she was concerned about his hearing. I conclude this didn't happen.

Dr Martin has no recollection of Mr Petersen needing to vomit during the consultation, nor any recollection of being given a history of recent vomiting. I believe he is mistaken in relation to that; his prescribing Maxolon was in my view most likely done to address this concern. I accept at no time during the consultation did any of them go to the treatment room. I consider Dr Petersen's version is more likely because there was no reason for the move to another room. It is likely Mr Petersen was moved to a treatment area within the consultation room so he could vomit.

Dr Martin prescribed the medications Codalgin and Maxolon. He says he prescribed the first because it is the strongest analgesic "*before you start to get into real narcotics*". He denies Maxolon was prescribed in response to a complaint of nausea and/or vomiting. Rather, Dr Martin says this was prescribed as it has the effect of increasing the speed at which the Codalgin is absorbed and therefore becomes effective. None of the specialists consulted accept this drug would be used for this purpose.

Mrs Petersen says she asked Dr Martin if she should take her son to the Gold Coast Hospital. She says he replied "*I could send you to the Gold Coast Hospital, but why waste their time. All they are going to do is monitor David for two or three hours and then send him home*." Mrs Petersen says she reminded Dr Martin they lived an hour from the hospital and expressed her belief Beaudesert Hospital was a "lock down" hospital. Dr Martin re-iterated his advice to get the chest x-ray; take the medication and that Mr Petersen would be alright once it "kicked in".

Mrs Petersen says they returned with Dr Martin to his room. There he wrote up the prescriptions and x-ray referral while Mr Petersen remained in the treatment room. She again raised the question of taking Mr Petersen to hospital noting they "*live a long way out*".

She says Dr Martin told her "…*if it comes to that call an ambulance and they'll take you to whatever hospital is available".* Mr Petersen had joined them by this time and expressed his desire not to go to hospital if he didn't have to. As they left, Mr Petersen made an appointment for the following Tuesday with the receptionist.

On 12 October 2007 a request for Mr Petersen's medical records was sent to Arundel Plaza Medical Centre by the Beenleigh Coroner. Dr Martin attended to this request personally and sent back what he termed a "*complete medical history"*. Therein was recorded the following in regards to the consultation on 24 January 2007:

> *Severe [L] sided renal pain*
> *Woke him from sleep*
> *Assocd. dyspnoea*
> *Now distressed with chest pain*
> *Also PR hemorrhage freq. hematemesis for YEARS!!*
> *OE: CHEST clear*
> *Pitting odema*
>
> ***Reason for contact:***
> *Pleurodynia*
> ***Actions:***
> *Discussed situation with patient*
> *Recommended hospital admission*
> *Patient refused admission*

As a result of a request from my office, and after obtaining legal advice, Dr Martin provided a statement concerning his treatment of Mr Peterson. Six paragraphs dealt with the consultation on the day before Mr Petersen's death. In paragraph 17 of his statement Dr Martin claimed:

> "*In view of the symptoms that Mr Petersen had complained of, I recommended that he be admitted to the Gold Coast Hospital for treatment. He refused."*

This statement is consistent with the entry in the notes for that day which are set out above.

A forensic analysis of Dr Martin's hard drive showed retrospective additions had been made to Mr Petersen's medical notes. These included the phrase: "*Recommended hospital admission. Patient refused admission*". They also included the following additions to Mr Petersen's "social history":

> "***DRUG ABUSE***
> *Used marijuana/IV drugs*
> *Shared needles >>>> HEPATITIS C*
> *Heavy smoker*
> ***ALCOHOLIC***"

At the inquest Dr Martin provided a further statement acknowledging he had made these changes while preparing the records to be sent to the Beenleigh Coroner. In that statement he also acknowledged paragraph 17 of his original statement was incorrect; that in fact what had occurred is:

> *“At the conclusion of Mr David Petersen’s consultation with me on 24 January 2007 I told him that if his condition got any worse that he should go to hospital. He said that he did not want to go to hospital”.*

Dr Martin says his failure to acknowledge in the original statement and in the notes that his advice had been conditional on Mr Petersen’s condition worsening was an oversight. I do not accept that. I conclude the alteration of the notes and the false assertion in the statement, were attempts to deliberately mislead the court.

In her evidence, one of two receptionists on duty that day, Leanne Johnson, recalled that, after the consultation, Dr Martin asked her to organise a referral to the Gold Coast Hospital. Dr Martin confirmed this did not occur.

In the circumstances, I accept Mrs Petersen’s account of her asking for her son to be referred to hospital and the doctor refusing is more likely to be accurate. I also accept however that Mr Petersen expressed an unwillingness to go to hospital and Dr Martin told him and his mother to call an ambulance if his illness worsened.

Mrs Petersen believes it should have been obvious to the doctor that her son was in severe pain. Her evidence was that his whole body was shaking; he was perspiring heavily; his knuckles were white; and he had both hands around his stomach. It is difficult to reach a conclusion on the extent to which Mr Petersen looked unwell; in particular the extent to which he was shaking and sweating. It is likely Mrs Petersen was more sensitive to changes in her son’s demeanour and pallor, particularly in the context of him complaining of being in pain. A degree of increased sweating and an apparent unsteadiness were not so obvious to other observers. I have also concluded Mrs Petersen deliberately exaggerated the extent of her son’s symptoms because she resents Dr Martin not insisting he go to hospital.

Conversely, Dr Martin’s attempt to fraudulently alter the records suggests he was aware David Petersen’s symptoms were more severe than those records or his statement indicates and his deceptions suggest a consciousness of guilt that provides support for Mrs Petersen’s version of her son’s presentation.

Having regard to the expert evidence as to the likely inflammation of his spleen at this time, it is more likely than not Mr Petersen was exhibiting signs of distress that should have prompted further investigation.

Dr Martin acknowledges no blood pressure, pulse or temperature readings were taken during the consultation.

Both witnesses agree Mr Petersen was told to organise an appointment for the following Tuesday.

Evening of 24 January 2007

Mrs Petersen took David straight to the Gold Coast Imaging Centre to have the x-ray taken. She recalls during this trip, and in the waiting room of the

imaging centre, he was still shaking, holding his stomach and appeared to be in a lot of pain.

After emerging from his appointment, Mrs Petersen recalls her son looked pale and complained it felt like his legs were about to give way. The x-ray process had required him to hold his breath which he said was extremely painful on his upper stomach.

At this point Mrs Petersen says she asked Mr Petersen to let her take him to hospital or at least to another doctor. She says he became increasingly annoyed as she continued with this suggestion, insisting he would start to get better after taking the medication prescribed to him by Dr Martin.

On arrival at the Nerang Centro shopping centre Mrs Petersen left Mr Petersen in the vehicle and went into the pharmacy where she had the prescription filled. She says he was too sick to get out of the car.

The two then travelled to the workplace of Michael Petersen. Mr Petersen junior got out of the car at this point and both Michael and Carol Petersen recall him being in great difficulty. They both recall seeing him struggling to support himself with his chin resting on the top of the open car door. Michael Petersen, with some urgency, assisted him onto a seat inside the shop. Mrs Petersen again asked Mr Petersen to let her take him to hospital but again, sounding frustrated, he refused. In the context of having recently been asked to treat him more like an adult, Mrs Petersen says she desisted from pushing this point further notwithstanding how ill Mr Petersen appeared.

The three family members then travelled home, though on the way Mr Petersen asked that they call in at the Canungra Hotel to purchase some beer. This appears odd behaviour if one accepts Mrs Petersen's evidence in relation to the apparent severity of Mr Petersen's condition. It is, though, consistent with her contention Mr Petersen was confident his condition would improve with medication. It is also appropriate to acknowledge the compelling evidence of Mr Petersen's alcohol dependency.

On arrival at their property Mr Petersen vomited on the driveway before going inside. He went to his room where he was unable to lie down but found the pain more bearable while sitting on his bed.

Mrs Petersen then called the Arundel Plaza Medical Centre. She did this from the other end of the house so that Mr Petersen did not hear her. On asking to speak to Dr Martin she was put on hold and then advised by a female member of staff that he had "*taken an early mark*". Telephone records show this call was made at 6:23pm. On the basis of Dr Martin's patient sheet for that day; and on the evidence from both he and Leanne Johnson that he rarely if ever left straight after his last patient, it is likely he was in fact still at the surgery when Mrs Petersen rang. Mrs Petersen says she was advised by the female member of staff that David should "*take another lot of tablets and call an ambulance later on if he got any worse*".

Mr Petersen did not eat anything that evening and continued to look very ill. His parents say during the evening he asked them to hold his rib cage while he vomited so as to provide some comfort. He complained of "*everything feeling tight*" in his rib cage. Mrs Petersen says she again at this point said "*let's go to the hospital*" but Mr Petersen said to "*just wait, I'll be right in a couple of hours*".

At the inquest Mrs Petersen says she went to bed knowing Mr Petersen was still in pain but with a hope the tablets would work and everything would be better by the morning. She says she made sure Mr Petersen had a phone with him and took her own phone to bed with her so he could contact her if needed.

She says at around 1.00am her phone rang. She found him on the floor in his room. He told her he tried to go to the toilet but his legs had given way. Mrs Petersen says he was shaking all over and his voice was stressed. In keeping with his clear reluctance to attend hospital, even now Mrs Petersen apparently felt unable to immediately call an ambulance without first getting Mr Petersen's approval to do so, saying to him: '*I'm going to have to call an ambulance*" to which he replied "*Yes Mum, I know*".

QAS arrival

Queensland Ambulance Service (QAS) call centre records show they received a call to attend the Petersen residence at 1:09am on 25 January. Paramedic Daryl Waters arrived at 1:22am to find Mr Petersen breathing rapidly, appearing anxious and pale in colour. Mr Petersen told him he had woken up breathless and "*couldn't shake it*"; he had been feeling unwell for 24 hours and had suffered a similar, less severe, episode the previous evening which had passed quickly.

Mr Waters took a brief history from Mr Petersen. He told the inquest it was his usual practice to seek a history from the patient rather than a friend or relative. Mr Petersen told him he had a pain while pointing to his epigastric area. He rated this pain 8 out of 10 in terms of severity. He also told Mr Waters he was feeling nauseous. Mr Waters was informed of the consultation with Dr Martin and was shown the medication prescribed.

Mr Waters does not recall being told anything about black faeces or loss of blood from the rectum and is sure he would have recorded such details. He was also sure he did not suggest the pain Mr Petersen was then complaining of was coming from his spleen, as was later suggested by Mrs Petersen. He conceded he might have been advised of a history of sweating and shaking without necessarily recording such details but could not remember being told of them.

Mr Waters felt Mr Petersen's abdominal area and did not note any guarding or distension. Ambulance records show a pulse rate of 160 and a blood pressure of 160/100.

Another paramedic, Leisa Tocknell arrived at 1:28am. Mr Waters asked her to get a stretcher from his vehicle. While she was doing this he assisted Mr Petersen to walk into the lounge room where they would be able to better manoeuvre the stretcher. As they approached the lounge Mr Petersen was noted to be staring into space and began to fall. Mr Waters had to support his weight and guide him onto a chair.

Ms Tocknell recalls that during her initial observations of Mr Petersen, he indicated he did not wish to go to the hospital and it was necessary for Mr Waters to convince him it was essential.

On her return to the house Ms Tocknell found Mr Petersen to be on a chair in the lounge and looking stiff. Mr Waters advised her he thought Mr Petersen was suffering from a dystonic reaction to Maxolon. Ms Tocknell had seen such reactions previously and thought Mr Petersen's symptoms looked very similar.

The recollections of Mr and Mrs Petersen accord approximately with the more significant events as recounted by the paramedics. Where their versions differ from that of Mr Waters, I conclude his version should be preferred. Mr Petersen's parents were undoubtedly and understandably distressed by his severe deterioration and it is probable this impacted upon their ability to accurately recount all of the details.

Mr Petersen was loaded into the ambulance at 1:47am and the paramedics set off with a view to take him to the Gold Coast Hospital. On notifying ambulance communications the paramedics were advised an intensive care paramedic, Rachel Latimer, lived nearby and arrangements were made for her to rendezvous with the ambulance and assess Mr Petersen. Ms Latimer made a brief assessment of Mr Petersen, agreed with the diagnosis of a dystonic reaction and told the paramedics to take him to Beaudesert Hospital where Benztropine could be administered.

I accept the view of one of the independent experts who gave evidence, Dr Anthony Brown that, in the circumstances, this was not an unreasonable diagnosis. Similarly, I accept the decision to go to Beaudesert rather than the more distant Gold Coast was wise.

At 2:00am when the ambulance was still some distance from Beaudesert, Mr Petersen suffered a sudden loss of consciousness, brachycardia and an un-recordable blood pressure. Mr Waters commenced manual ventilation and CPR. Within one minute of CPR commencing Mr Petersen regained consciousness and was able to communicate.

Beaudesert Hospital was advised of pending admission and its circumstances. The ambulance arrived there at 2:11am. At that stage Mr Petersen still had a blood pressure of 130/100 and a Glascow Coma Scale (GCS) level of 7.

Treatment at Beaudesert Hospital

At Beaudesert Hospital Mr Petersen was initially examined by Dr Kah Wait Chan and then, from 2:30am onwards, by the on call senior medical officer, Dr Heidiliza Cayari. Shortly after his arrival Mr Petersen went into cardiac arrest on several occasions. When Dr Cayari arrived Mr Petersen was noted to have a GCS reading of 3, blood pressure of 130/105 and signs of brachycardia.

Mr and Mrs Petersen were able to see the doctors attending to Mr Petersen. They recall a nurse asking them for a medical history of their son. I accept that Dr Chan also attended on them for this purpose although they do not recall speaking to him. Dr Chan made note of a history of "*vomiting*" and "*1 episode of black motion 2/7 ago*".

At 2:40am Mr Petersen was intubated, resuscitation medication was commenced and he was given adrenaline and atropine when he continued to have 'runs of ventricular fibrillation'. An ICU helicopter crew were called and arrived at the hospital at 4:15am. At this stage Mr Petersen had suffered intermittent arrest with ventricular fibrillation a number of times. He was resuscitated for a further 15 minutes after the arrival of the helicopter crew. After discussion with Mr Petersen's parents those attempts ceased and he was declared dead at 4:30am.

The autopsy

An external and full internal autopsy examination was performed on 27 January by Dr Alex Olumbe.

The examination revealed:-

> "…*massive intra-abdominal blood and blood clot measuring up to 4100ml that was associated with a ruptured (burst) subcapsular haematoma in the spleen."*

Dr Olumbe also noted:-

> *"…bruising in the adjacent abdominal wall which is an indication that the haematoma that preceded the rupture is a consequence of a traumatic episode that occurred a few days earlier."*

Dr Olumbe postulated the following chronology:-

> *"The presence of the subcapsular haematoma in the spleen is an indication that there was internal bleeding in the spleen which had occurred a few days after the traumatic event. However, the final event that led to the collection of blood in the abdominal cavity following the capsular rupture/burst might be due to the build up in pressure within the subcapsular haematoma or be precipitated by another incident of trauma, even if it is minor."*

Other significant findings at autopsy included advanced liver cirrhosis and dilated cardiomyopathy. Toxicological examination of bodily fluids did not reveal any findings of note.

In his autopsy report of 15 May 2007 Dr Olumbe suggested the cause of death was:

1. *(a) Intra-abdominal haemorrhage, due to or as a consequence of:*
   (b) ruptured spleen.

He listed as an underlying contributory factor:

2. *Liver cirrhosis, dilated cardiomyopathy.*

Expert medical evidence

The weight of medical opinion is that Mr Petersen was suffering from a subcapsular haematoma in the spleen during the day or days prior to seeing Dr Martin on 24 January 2007. The chronic conditions suffered by Mr Petersen left his spleen more susceptible to this. At autopsy Dr Olumbe found bruising on the adjacent abdominal wall which he attributed to a traumatic episode which occurred a "*few days*" earlier. He postulated the build up of blood then may have been sufficient of its own to lead to a rupture. Alternatively a further, albeit minor, trauma may have caused the rupture.

Dr Brown provided literature pointing to the possibility of such haematomas developing without there having been any obvious trauma to the body - a "spontaneous" or "pathologic" rupture – although it acknowledged such occurrences are rare.

The experts were unable to pinpoint when the haematoma is likely to have burst and haemorrhaging into the abdominal cavity began. Dr Woodruff favoured a rupture late afternoon or evening of 24 January. However, he could not rule out the possibility that by the time Mr Petersen saw Dr Martin some seepage of fluid into the abdominal cavity had begun. Dr Brown suggested this was in fact likely.

The size of the rupture found at autopsy is indicative of a catastrophic event in the spleen sometime prior to death (although as Dr Woodruff noted, once a tear has begun, even very slight movement can result in such a catastrophic outcome). It would have led very quickly to the build up of the majority of blood found at autopsy.

It is now known only emergency surgical intervention could have saved Mr Petersen and by the time he arrived at Beaudesert Hospital even that is unlikely to have been successful.

Section 45 findings

A Coroner is required to determine, as far as is possible, who the deceased was, how he came by his death, when and where he died, and what caused the death. In this case I make the following findings:

Identity	The deceased person was David Robert Petersen
How he died	Mr Petersen died as a result of a subcapsular haematoma in the spleen of unknown origin going undetected and untreated until it ruptured leading to exsanguination
Place of death	He died at the Beaudesert Hospital in Queensland
Date of death	Mr Petersen died on 25 January 2007
Cause of death	He died from intra-abdominal haemorrhage caused by a ruptured spleen

Section 46 recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future. That requires the coroner to consider whether the death under investigation was preventable and/or whether other deaths could be avoided in future if changes are made to relevant policies or procedures.

In my view this death occurred because of the aberrant behaviour of individuals that is not amenable to a systemic, preventative response. Accordingly there are no recommendations or comment I could usefully make.

Referral pursuant to s48

Section 48(2) of the Coroners Act requires a coroner who, as a result of information obtained while investigating a death, "*reasonably suspects a person has committed an offence*" to give the information to the appropriate prosecuting authority.

Subsection (4) of the same section authorises a coroner who reasonably believes information gathered while investigating a death might cause a professional disciplinary body to inquire into the conduct of a relevant professional to give the information to that body.

In my view those provisions require me to consider whether the medical care given to Mr Petersen was of an appropriate standard and if not, whether it was such that it should be referred to the DPP or the Medical Board of Australia for consideration of a prosecution or disciplinary action respectively. I also need to consider whether the provision of inaccurate information by Dr Martin should be referred to those authorities.

Adequacy of medical treatment

Dr Martin

In considering the adequacy of the medical treatment given to Mr Petersen I was greatly assisted by the evidence of a number of experts.

Dr Stephen Rashford is the medical director of the QAS, and a specialist in emergency medicine. When he provided his report to the court he was unaware of the falsity of the claim by Dr Martin that he had recommended Mr Petersen be admitted to hospital. Based only on the account of the QAS paramedics, Beaudesert Hospital records and the consultation notes from Arundel Plaza Medical Centre, he formed a view that the "*correct*" course of action in relation to Mr Petersen's presentation was he be told to go to hospital. At the inquest he made it clear he could not see how it might be considered reasonable for a general practitioner to have treated Mr Petersen as an outpatient in the circumstances as disclosed in the medical notes.

Dr Anthony Brown, a senior staff specialist for the Department of Emergency Medicine at the Royal Brisbane and Women's Hospital was firmly of the view Dr Martin should have referred Mr Petersen to hospital when he saw him on the afternoon before his death.

The co-morbidities arising from his existing chronic conditions were such that, in Dr Brown's view, it would have been very difficult if not impossible for a GP to adequately deal with the situation. Even on Dr Martin's version, his examination did not come near the degree of thoroughness envisaged by Dr Brown as being necessary if there was any prospect of treating Mr Petersen as a day patient.

He said in his report in summary;

> *I have multiple, profound and serious concerns about the care, or lack of it, provided by Dr G Martin on the afternoon of 24/01/07.*
>
> *Dr Martin failed to examine Mr Petersen properly, failing to recognise in general how sick he was, and in particular failing to measure vital signs or examine the abdomen…*
>
> *Dr Martin failed to make a relevant diagnosis, or appropriate differential diagnosis.*
>
> *Dr Martin failed to arrange immediate referral hospital, and failed to adequately explain the urgent need to go to hospital….*

Dr E W Ringrose is an experienced consultant physician. He saw some scope for Mr Petersen being treated as a day patient if the version of events given by Dr Martin was accepted. He would though have required Mr Petersen's attendance the following day for a further examination. His report also makes it clear an abdominal examination should have been conducted notwithstanding the prospect such examination might not necessarily reveal

the presence of an underlying problem. He agreed with the proposition that it would be necessary for a doctor conducting an adequate examination of Mr Petersen to ask when he last vomited blood and when he last passed rectal blood having been told of these symptoms.

He was strongly of the view had Mr Petersen told Dr Martin he had passed black blood; as I have found he did, referral to hospital was the only reasonable course of action. While Dr Martin disputes he was told Mr Petersen had passed black blood as distinct from frank, red blood, he agrees he did not investigate the causes of that, in any event.

When considering the criticisms of these experts it is necessary to ensure the standards which might be expected of a tertiary hospital emergency medicine specialist are not applied to a general practitioner. I am satisfied appropriate caution was applied in this regard.

The oral evidence of Dr Hoskins, the director of the Clinical Forensic Medicine Unit and an experienced GP, was more supportive of Dr Martin, notwithstanding that in his report Dr Hoskins stated complete agreement with the opinions expressed by Dr Brown. Dr Hoskins saw scope for a general practitioner to treat Mr Petersen as a day patient if the presentation was as described by Dr Martin. His opinion in this regard extended to a scenario where other symptoms such as vomiting and profuse sweating were present.

Dr Hoskins was the only one of the expert witnesses who had heard of Maxolon being used for the purpose prescribed by Dr Martin rather than as a medication to prevent nausea and vomiting.

The preponderance of expert evidence is that, even on the facts Dr Martin acknowledges as being known to him on 24 January 2007, his examination of Mr Petersen was inadequate in the following ways:

- There was no measuring or recording of any vital signs;
- There was a failure to palpate the abdomen;
- No enquiry was made as to the most recent vomiting or passing of blood;
- No physical examination to confirm the colour of the rectal blood was undertaken;
- There was a failure to refer for a CT scan or similar imaging of the abdomen; and
- No adequate diagnosis or differential diagnosis of the cause of the symptoms was made.

The weight of expert evidence is that the only reasonable course of action for a doctor in Dr Martin's position was to refer Mr Petersen to hospital. Of course Mr Petersen may well have refused that advice. If he did, the advice should have been carefully recorded.

I am of the view Dr Martin had become frustrated with Mr Petersen's failure to comply with his recommendations to reduce his drinking and smoking and to

lose weight. He seems to have come to the view that as Mr Petersen was not taking reasonable steps to care for his health his obligation to exercise the appropriate standard of care was obviated.

I therefore consider there is a significant body of evidence which could lead a criminal court or a disciplinary body to conclude Dr Martin failed to provide Mr Petersen with an adequate standard of care.

There are a number of provisions in the Criminal Code under which a health care practitioner can be held criminally responsible for the death of a patient. All require proof of a causal connection between the doctor's action or inaction and the death.

Therefore, when determining whether I should refer his conduct to the DPP for consideration of a prosecution I need to have regard to whether the arguably substandard care Dr Martin provided caused or significantly contributed to the death.

Dr Woodruff is the director of vascular surgery at the Princess Alexandra Hospital. He provided a report and gave evidence that had Mr Petersen gone to hospital and received prompt treatment, his chance of surviving the emergency surgery that would have been indicated was *"closer to 50/50 than 99%".* The comparison to 99% was a reference to an assessment made in Dr Brown's initial report. Upon reflection he accepted Dr Woodruff's assessment, as do I.

That means that if Mr Petersen had gone to hospital and he had been operated on promptly it is more likely than not, he would have survived. However, before Dr Martin can be held criminally liable for the failure of that to occur, the Crown would need to convince a jury beyond reasonable doubt that had he recommended admission, David Petersen would have accepted and acted in accordance with that advice. In this case I am not satisfied that would have occurred. Indeed the doctor did tell the patient and his mother that if his condition deteriorated an ambulance should be called. They did not do that until some 9 hours after seeing Dr Martin, even though according to his mother, David continued to deteriorate all afternoon and evening. This was not his mother's fault – she was urging her son to allow her to take him to hospital from soon after they left Dr Martin's surgery. Of course, that was his right, but it is not reasonable to then seek to hold someone else criminally responsible. David Petersen's disinclination to go to hospital is graphically demonstrated by statements to that effect to the paramedics who came to his house even when he was just a few hours from death.

Further, there is considerable doubt as to whether the "work up" that would have been necessary before surgery was undertaken would have occurred as quickly as would have been necessary to save his life, had Mr Petersen been admitted to the Southport Hospital late on the afternoon of 24 January.

Accordingly, it is not appropriate I refer the information concerning Dr Martin's treatment of Mr Petersen to the DPP.

QAS

I accept the opinions of Dr Brown and Dr Rashford that the treatment afforded to Mr Petersen by the paramedics was adequate and appropriate in the circumstances.

Beaudesert Hospital

I accept the evidence of Dr Brown that the treatment provided to Mr Petersen by staff at Beaudesert Hospital was of very high quality.

The provision of false information

I also need to consider whether the provision of false information to the court by Dr Martin should be referred to the DPP.

I am of the view Dr Martin sought to deliberately mislead the court by fraudulently altering the computerised medical record of the consultation on 24 January to make it appear he had recommended Mr Petersen be admitted to hospital. I surmise that when he became aware of the on-going coronial investigation, he read the record of the symptoms that had been noted, observed the absence of any meaningful diagnosis in circumstances where the death of the patient occurred so soon after the consultation, and became concerned his conduct would not withstand scrutiny. He continued this attempt to mislead when he made a false claim to the same effect in his statement to the court.

I have considered referring this conduct to the DPP but having regard to the high standard of proof required for a criminal prosecution and the availability of what in my mind is a more appropriate remedy I have decided to refrain from doing so.

Referral to the Medical Board

As of 1 July 2010 the Medical Board of Australia is the body appointed to consider complaints and notifications about the conduct of medical practitioners in Queensland.

The *Health Practitioner National Law Act 2009* (Qld) sets out the grounds on which voluntary notification can be made to the Board in section 144. So far as may be relevant to this case that section provides:

> *(1) A voluntary notification about a registered health practitioner may be made to the National Agency on any of the following grounds—*
>
> *(a) that the practitioner's professional conduct is, or may be, of a lesser standard than that which might reasonably be expected of the practitioner by the public or the practitioner's professional peers;*
>
> *(b) that the knowledge, skill or judgment possessed, or care exercised by, the practitioner in the practice of the practitioner's health profession is, or may be, below the standard reasonably expected;*

(c) that the practitioner is not, or may not be, a suitable person to hold registration in the health profession, including, for example, that the practitioner is not a fit and proper person to be registered in the profession;

The Act confers powers on the Board to investigate and commence disciplinary proceedings as a result of a notification.

I am of the view the apparent failure of Dr Martin to provide an adequate standard of medical care to Mr Petersen on 24 January 2007 could provide a basis for a voluntary notification under either or all of the grounds detailed above.

I also consider the Board could conclude Dr Martin's deliberate and repeated attempts to mislead the court indicate he is not a fit and proper person to be registered.

Accordingly I intend referring the material gathered during these proceedings to the Board for its consideration.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
16 September 2010