CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Darrin Edward Paddon**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2015/1014
DELIVERED ON:	28 February 2017
DELIVERED AT:	Brisbane
HEARING DATE(s):	28 February 2017
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Kendall Dixon
Metro South Hospital and Health Service:	Ms Fiona Banwell
West Moreton Hospital and Health Service:	Mr Aaron Suthers

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Introduction

1. On 11 March 2015, Darrin Edward Paddon, aged 51 years, was transferred from the Wolston Correctional Centre (WCC) and admitted to the Princess Alexandra Hospital Secure Unit (PAH) after undergoing routine haemodialysis. He was admitted to undergo investigations into ongoing gastrointestinal bleeding and pancytopenia.[1] Over the following days, his condition continued to decline, resulting in four 'code blues' being called.

2. On 16 March 2015, when the third code blue was called, Mr Paddon had been undergoing a planned echocardiogram. He had become hypotensive during the procedure, resulting in the code blue. Shortly afterwards, he suffered a further episode of hypotension, which progressed to a pulseless electrical arrest. He was resuscitated but remained unresponsive. In consultation with his mother, it was decided to direct his care towards comfort measures. He was pronounced deceased later that day.

The investigation

3. Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted an investigation into the circumstances leading to Mr Paddon's death.

4. After being notified of Mr Paddon's death, the CSIU attended PAH and WCC and an investigation ensued. Mr Paddon's correctional records and his medical files from WCC and PAH were obtained. The investigation was informed by statements from the Nurse Unit Manager at WCC, his treating nephrologist at the PAH and a statement from his mother, Barbara Stevenson. These statements were tendered at the inquest.

5. An external autopsy examination with associated CT scans and toxicology testing was conducted by Dr Beng Ong. At the request of the Coroners Court of Queensland, Dr Gary Hall from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Paddon from the PAH and WCC, and reported on them. The post mortem CT scan showed extensive calcification of coronary arteries due to atherosclerosis. There was also calcification of the aortic valve in keeping with known aortic valve disease. Only one kidney was present.[2]

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

The inquest

7. As Mr Paddon was in custody when he died, an inquest into his death was required by the *Coroners Act 2003*. The inquest was held on 28 February 2017. All of the statements, medical records and material gathered during the investigation were tendered and oral evidence heard only from Detective

[1] Blood cell deficiency
[2] Mr Paddon had a congenital condition resulting in the absence of one kidney.

Sergeant Seery. Counsel Assisting proceeded to submissions after the conclusion of the evidence.

Background

8. Darrin Edward Paddon was a 51 year old man. Mr Paddon's mother reported that he had intellectual disabilities and struggled to read and write. He left school and commenced offending as a teenager. He was placed at the Sir Leslie Wilson Youth Hospital at an early age. Mr Paddon's mother maintained contact with him during his time in custody and expressed no concerns about the treatment he received.[3] He is survived by his parents and two of his three siblings.

9. On 24 March 1998, Mr Paddon was convicted of murder and incarcerated at WCC. He was released on parole on 24 March 2011. However, he subsequently breached parole after committing a break and enter offence in 2012. He was then returned to WCC and remained there until his death.

Circumstances of the death

10. Dr Nicole Isbel provided a statement to assist the inquest, in her capacity as Mr Paddon's treating nephrologist at the PAH.[4] Dr Isbel confirmed that Mr Paddon had a background of end stage renal disease in the lead up to his death. He had commenced haemodialysis in 2003. He had a range of other comorbidities:

    - Hepatitis C infection complicated by cirrhosis;
    - Recurrent sepsis events requiring protracted antibiotic therapy;
    - Endocarditis involving calcified stenotic aortic valve with severe aortic regurgitation; not amenable to surgery due to recurrent sepsis;
    - Pancytopaenia; and
    - Rapidly progressive cardiac decompensation.

11. Lorraine Reid also provided a statement to assist the inquest, in her capacity as the Nurse Unit Manager at WCC.[5] Ms Reid explained that Mr Paddon was, on occasion, non-compliant with treatment and occasionally refused to keep appointments for dialysis. Ms Reid recorded an incident which involved Mr Paddon being discharged from the PAH to WCC in February 2015, without a discharge summary from the PAH. This resulted in Mr Paddon receiving an extra three days of aspirin, although the hospital had ceased it due to gastrointestinal bleeding.

12. In the material tendered at the inquest I was provided with a clinical incident review report in relation to this incident. After reviewing that report, I am satisfied that the matter has been appropriately addressed. I am also satisfied that this incident ultimately had no connection with Mr Paddon's death in March 2015.

13. It is clear from the medical records that Mr Paddon regularly attended at the PAH for the management of his multiple comorbidities. It can be observed that early in 2015, the frequency of Mr Paddon's transfers to the PAH had escalated.

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[3] Exhibit B3.
[4] Exhibit B1.
[5] Exhibit B2.

14. On 8 March 2015, Mr Paddon was admitted to the PAH with a syncopal episode, where he became dizzy and was witnessed to lose consciousness. A chest x-ray revealed interstitial oedema. He underwent his usual haemodialysis and a blood transfusion. He also complained of a number of nose bleeds and black stools (suggestive of gastrointestinal bleeding) in recent days. It was arranged that he return to the PAH on 11 March 2015 for an endoscopy to investigate the blood loss.

15. On 11 March 2015, Mr Paddon was admitted to the PAH for investigation of recent black bowel motions and pancytopenia. The gastroscopy showed the presence of oesophageal varices, some evidence of old blood staining the stomach and portal hypertensive gastropathy. His haemoglobin was very low (66), his white cell count was low (1.9) and his platelet count was also low (95).

16. Early in the morning on 13 March 2015, Mr Paddon was pacing in his cell at the PAH secure unit complaining of chest pain and headache. An ECG was performed. Later that day, it was noted by medical staff that Mr Paddon had reduced blood pressure, his haemoglobin was down to 60, and there were new changes on the ECG suggestive of heart ischaemia. A further blood transfusion was ordered. At 1330 hours, a code blue was called after Mr Paddon was found unresponsive, thought to be due to his low blood pressure. He was successfully resuscitated.

17. Early in the morning on 14 March 2015, a further code blue was called when Mr Paddon was again found unresponsive and making a gurgling sound. He was again successfully resuscitated. Further ST segment and T wave changes were noted on an ECG, suggesting a cardiac event. At 1500 hours, a cardiology registrar documented that the heart attack was thought to have occurred due to the gastrointestinal bleeding.

18. At 1535 hours, a further code blue was called after Mr Paddon was found unconscious. A rectal examination revealed no blood loss, however a further ECG showed inferolateral T wave inversions, suggesting further cardiac ischaemia. The presence of melaena and pancytopenia precluded treatment with anticoagulant medication.

19. On 16 March 2015, at 1625 hours, a further code blue was called due to bradycardia (slow pulse) and low blood pressure (67/45). Mr Paddon was resuscitated with medication to increase the heart rate and adrenaline. Spontaneous circulation returned, however, he remained unresponsive. In discussions with his mother, it was decided that care would be directed towards keeping Mr Paddon comfortable. He passed away at 1730 hours after these measures were put in place.

Clinical Review

20. Dr Hall assisted the inquest by reviewing the available medical records.[6] Dr Hall confirmed that over the last 12-14 months of his life, Mr Paddon had developed complications of the hepatitis C virus, by way of infection and cirrhosis,

[6] Exhibit B4.

bacteraemia and subsequent cardiac issues. These all culminated in his death, which was ultimately due to myocardial infarction.

21. Dr Hall confirmed that Mr Paddon's multiple medical conditions severely affected his medical management. There was a significant interplay between each which made definitive treatment, collectively, extremely risky. If any condition was focused on separately, complications were likely to destabilise his other comorbidities. Ultimately, he could only have been effectively treated by renal transplant and major cardiac surgery. I accept that such surgery was not a reasonable option having regard to the wide spectrum of conditions he suffered.

22. Over the last three months of his life, Mr Paddon was deteriorating in health, predominantly due to cardiac decompensation, with his other comorbidities *simmering in the background complicating his management.* While Dr Hall expressed some concerns surrounding the end stage cardiac and emergency management provided to Mr Paddon, he did not consider that these would have altered the outcome as there were limited treatment options at this time. Dr Hall had no significant concerns with the overall medical care provided at the PAH and WCC. This opinion is extracted from his report as follows:

> *Despite these concerns I believe the medical management offered to Mr Paddon by PAH treating doctors, including PAHSU, as well as his medical carers at WCC was appropriate and of a standard that a community patient might expect to receive in a public hospital in Queensland and in a community general practice setting. His mother, Mrs Stevenson, indicated to the Coroner in her statement that she was relieved that he was in prison as she believed her son would receive appropriate medical care in that environment. Having reviewed the medical documentation from WCC and from PAH I can reassure her that she was correct in her beliefs*.[7]

23. Mr Paddon's death was also the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes. There were no suspicious circumstances.

Conclusions

24. I conclude that Mr Paddon died from natural causes. I find that none of the correctional officers or inmates at WCC caused or contributed to his death. I am satisfied that Mr Paddon was given appropriate medical care by staff at the WCC and PAH while he was in custody. His death could not have reasonably been prevented.

25. It is a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Paddon when measured against this benchmark.

[7] Exhibit B4, page 23.

Findings required

26. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all of the evidence I am able to make the following findings:

Identity of the deceased – The deceased person was Darrin Edward Paddon.

How he died - Mr Paddon died in custody after a lengthy term of imprisonment. He had been imprisoned for most of his adult life. He died from natural causes after an extensive history of significant cardiac and kidney disease which had multiple causes. The nature of his multiple medical conditions precluded definitive treatment.

Place of death – He died at the Princess Alexandra Hospital Secure Unit, Ipswich Rd, Woolloongabba Queensland.

Date of death – He died on 16 March 2015.

Cause of death – Mr Paddon died from acute myocardial infarction, due to or as a consequence of, coronary atherosclerosis. Other significant conditions included bleeding oesophageal varices due to liver cirrhosis, end-stage renal failure and aortic valvular disease.

Comments and recommendations

27. The *Coroners Act 2003* enables a coroner to 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. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
28 February 2017