DISTRICT COURT OF QUEENSLAND

CITATION:	*Lockwood v Barnes* [2011] QDC 84
PARTIES:	**SHERRIE ANNE LOCKWOOD (ALSO KNOWN AS LYNWOOD)** (Applicant) **v** **MICHAEL BARNES (STATE CORONER OF QUEENSLAND)** (Respondent)
FILE NO/S:	1582 of 2010
DIVISION:	Civil
PROCEEDING:	Originating Application
ORIGINATING COURT:	District Court
DELIVERED ON:	3 June 2011
DELIVERED AT:	Brisbane
HEARING DATE:	27 May 2011
JUDGE:	Dorney, QC DCJ
ORDER:	**1. That the application be dismissed.**
CATCHWORDS:	Inquest – application to District Court for Order – "public interest" – whether views of family (or community) alone sufficient *Coroners Act* 2003, ss 3(d), 27, 28(2), 30(6), 30(8), 45(2) and 46(1) *Gentner v Barnes* [2009] QDC 307 *O'Sullivan v Farrer* (1989) 168 CLR 210
COUNSEL:	J Ashcroft for the applicant L Byrnes for the respondent M Hickey for the Attorney-General of Queensland as amicus curiae
SOLICITORS:	Coastal Law and Conveyancing for the applicant Crown Law for the respondent

Introduction

[1] Cherish Rose Van Brugh was born on 22 February 2007. She died on 9 July 2008 at Russell Island. She was then 16 months old. This was a tragic death of an indigenous infant. Hopefully, now, this kind of outcome can be prevented in the future.

[2] The mother of Cherish is the present applicant, Sherrie Anne Lockwood. She seeks, by an Originating Application, an order pursuant to s 30(8) of the *Coroners Act* 2003 that an inquest be held into the death of Cherish, in circumstances where the State Coroner has refused to hold an inquest.

[3] The proceeding came on before me for hearing on 27 May 2011. The respondent appeared, but sought leave to withdraw on the basis that the respondent intended to abide the order of the court (save as making submissions, if any, on costs). That leave was granted. The Attorney-General of Queensland sought leave to appear as *amicus curiae*. That leave was also granted.

[4] The supporting material was contained in two affidavits of Carlo Bianchino (the applicant's solicitor) and the affidavit of the applicant. It was intimated on the applicant's behalf during oral submissions that it was intended to call the applicant to give, orally, further evidence. When I enquired as to the nature of that evidence, it was stated that the applicant now remembered that there was a cannula placed in her child's arm – when earlier admitted to the Paediatric Emergency Department at the Mater Children's Hospital – in the paediatric emergency ward, on 7 July 2008. That intimation was never pressed, possibly for reasons which I will canvass later.

[5] Written submissions were given to the Court on behalf of the applicant and on behalf of the Attorney-General.

Background

[6] On 7 July 2008, the Queensland Ambulance Service, attending to treat a sibling of Cherish for chickenpox, observed that she was dehydrated and, so, arranged for her to be transferred by boat and ambulance from Russell Island to the Mater.

[7] Cherish was seen by Dr Colleen Poole. From her clinical examination, Dr Poole thought Cherish might have right lower lobe pneumonia. Although an x-ray, reviewed by a radiologist, did not show any consolidation or pneumonia, since Dr Poole still heard a decreased air entry, she decided to treat her with the antibiotic "Amoxicillin". Dr Poole, on review, an hour later, noted that Cherish appeared to be happier. Thereafter she was discharged at 1.15 am on 8 July 2008 with instructions for the applicant to continue with Amoxicillin and Hydrolyte, and to treat her fever with pain medication. After waiting until dawn for boat transport, the family returned to Russell Island.

[8] For most of the rest of that day Cherish slept. She did not eat very much; but she was given two bottles of the Hydrolyte and water mix. The applicant thought her daughter's temperature was a little high, but otherwise she indicated that she was fine.

[9] At around at 2.00 am on 9 July 2008 Cherish awoke. The applicant gave her a bottle of milk but she, subsequently, vomited. At 5.50 am the applicant noticed Cherish had a temperature, was really sleepy and had no energy. The applicant took her to the shower. While showering Cherish, the applicant noticed a discolouration to her right foot and ankle which was purple in colour. The applicant thought that it looked like a bruise.

[10] Cherish's father called an ambulance. Upon arrival, the ambulance officers noted a rash, and checked Cherish's heart rate and blood pressure. Her heart rate went down from 220 bpm to 40 bpm in a short period of time, which led to CPR being commenced. Cherish could not be revived and was pronounced dead at 8.25 am.

[11] On 10 July 2008, an autopsy was performed on Cherish. The autopsy report, dated 5 January 2009 and conducted by Dr Williams, a pathologist, stated that the cause of death was "staphylococcus aureus sepsis". On the same day a "Form 1– Report of Death to a Coroner" was received by the Coroners Court.

[12] Three specialist medical reports have now been obtained by the Coroner's Office. Two were reports of Dr Don Buchanan, a Forensic Medical Officer with the Clinical Forensic Medical Unit in Queensland Health. The first was dated 9 February 2009. The second was dated 16 November 2009 and followed upon a request made from the Office of the State Coroner for a further report which specifically sought that Dr Buchanan review a statement made by Dr Colleen Poole dated 6 June 2009 and provide a formal response to a report of Dr Michael Whitby dated 6 May 2009 (who was, among other accredited specialties, registered in the State of Queensland in the specialities of Internal Medicine, Infectious Diseases and Pathology (Medical Microbiology). He held the position of Director, Infection Management Services (Southern Queensland), based at Princess Alexandra Hospital, Brisbane and Director, Centre for Health Care Related Infection Surveillance Prevention, Brisbane. He was also an Associate Professor of Medicine, University of Queensland and Visiting Associate Professor, School of Public Health and Community Medicine, University of New South Wales. With respect to paediatric experience, he stated that although he did not practice as a Paediatric Infectious Diseases Physician, he has done so in the past and did, on occasions, treat infectious diseases in children. Even so, he confined his opinion to areas that were common to both paediatric and adult infectious diseases and also encompassed by the speciality of medical microbiology. Dr Buchanan was also requested to consider whether the measures that the Mater had put in place in response to deficiencies identified were "sufficient".

[13] It is clear that Dr Buchanan was critical of the original treatment given at the Mater Hospital. It is also clear that he was, unsurprisingly, sympathetic to the applicant's case, within the confines of giving his objective medical views.

[14] Concerning the direct medical issues raised, Dr Buchanan reached the following conclusions in his second report.

[15] First, concerning Dr Poole, after noting that the applicant was advised to treat Cherish's fever with Panadol or Neurofen and advised that Dr Poole would be happy to see Cherish again if her mother had any concerns, it was observed that, while not documented in her medical notes, Dr Poole did re-examine Cherish an hour after the initial consultation and found her to be better, with her heart rate and breathing rate decreased. He noted that the details of such a decrease were not stated and there were no medical or nursing notes provided that documented such observations.

[16] Secondly, with respect to Dr Whitby's report, Dr Buchanan advised that he considered this specialist, whom he had recommended as the person to be engaged, had addressed Dr Buchanan's areas of concern regarding the treatment of the pneumonia. Dr Whitby had considered the diagnosis of right lower lobe pneumonia was an appropriate diagnosis in the circumstances because, even in the indigenous population, pneumococcus is the most common cause of bacteria (which is sensitive to penicillin). Therefore, a penicillin such as oral Amoxicillin was the appropriate treatment. He also noted Dr Whitby's consideration of the prevalence of non-multi

resistant MRSA (methicillin resistant staphylococcus aureus) is high in indigenous communities but that, since it has spread into the general community, the fact that the patient was an aboriginal child did not of itself mean that this organism should have been suspected, particularly without any preceding history of skin or soft tissue infections either in the patient or close contacts. Dr Whitby judged that the illness did not seem to warrant intravenous antibiotic therapy.

[17] Thirdly, as for the prospect of what might have happened if Cherish had been admitted as an in-patient, Dr Whitby considered that she would have been given a penicillin antibiotic initially and that, since Cherish did not rapidly deteriorate soon after she was sent home, if she had remained in hospital, it might have been some hours before antibiotic therapy was altered by hospital staff to cover the community acquired MRSA. In addition, when Cherish's condition did deteriorate, it suggested a rapid progression of the infection and, as such, it was entirely possible that this would have occurred in any event even if appropriate antibiotics had been commenced.

[18] Fourthly, as for the Root Cause Analysis (RCA) conducted by the staff of the Mater, the Hospital itself, in a letter of 2 June 2009, detailed the extent to which the RCA recommendations had been implemented by that institution. It was Dr Buchanan's opinion that it was sufficient to state that, collectively, the implementation of wide-ranging and appropriate measures addressed the deficiencies identified. In particular, action had been taken to expand the Clinical Practice Guidelines to highlight the increased susceptibility of indigenous children to certain infections, including the issuing of guidelines by the Infectious Diseases Paediatric Infection Service. It was Dr Buchanan's conclusion concerning the RCA, and its implementation, that these measures together have adequately addressed the formulation and documentation of discharge plans and appropriately involved the parents in the process.

[19] Finally, with respect to the suggestion that a further opinion be obtained, from a paediatric emergency physician, Dr Buchanan concluded that he was not sure how this would further assist.

[20] Besides the various medical reports obtained, there was a report from Queensland Ambulance, statements from Nurses Oliver and Ayers, reports from and medical records of the Mater Hospital, and a detailed eight page statement from the applicant who expressed the view that, after discharge from the Mater Hospital, Cherish seemed fine, she was sleeping and, in holding her, she seemed fine. There were also printouts obtained from computer records of both the Police and Ambulance.

Applicable Principles

[21] Section 30(6) of the *Coroners Act* states that, if the State Coroner refuses an application to hold an inquest, the person may apply to the District Court. Without going into the details here about how the application came to be made to the State Coroner, that is the applicable provision. By s 30(8) the District Court may order that an inquest be held if satisfied it is in the "public interest" to hold the inquest.

[22] Since it has not been suggested by the applicant that the Coroner was required, pursuant to s 27 of the *Coroners Act,* to hold an inquest, it is to s 28 that the next consideration is directed. Given that this is a reportable death, s 28(2) provides that, in deciding whether it is in the public interest to hold an inquest, the Coroner may consider both the extent to which drawing attention to the circumstances of a death may prevent deaths in similar circumstances happening in the future and any

guidelines issued by the State Coroner about issues that may be relevant to the decision: see paragraphs (a) and (b). Although Guideline 8.1 was raised in a document, "Outline of Argument", contained in a List of Documents filed 22 July 2010, it neither was tendered in full nor was it further referred to in the later written and oral submissions of the applicant. With respect to the "views" of the family or other significant members of the community, the quotation states that an inquest should be held where those views are "*such* that an inquest *is likely to assist* maintaining public confidence in the administration of justice" (emphasis added).

[23] The object of the Act, as stated in s 3 of the *Coroners Act,* relevantly, by paragraph (d), is to, amongst other aspects, help to prevent deaths from similar causes happening in the future by allowing coroners at inquests to comment on matters connected with deaths, including matters related to public health or safety, or the administration of justice.

[24] The only case that appears to have considered these provisions is the decision of Robertson DCJ in *Gentner v Barnes* [2009] QDC 307. Robertson DCJ limited his investigation to material that was in the State Coroner's file. Nevertheless, he stated that he was not convinced that the wording in the then s 30(7) of the *Coroners Act* meant that the Court will only consider circumstances in existence at the time the request is made. I have permitted reference to be made to a recent affidavit of the applicant sworn 24 May 2011. I am of the view that, since the application is not for a review of any administrative decision (bringing into operation the various grounds upon which judicial review of administrative acts is based) and since the application is not an appeal from the decision of the State Coroner, the District Court is able to look at all material as it exists at the date the application is heard, subject to issues as to relevancy, weight, appropriate notice and, perhaps, an adjournment of the hearing of the application.

[25] With respect to the conclusions reached by Robertson DCJ, I agree that the relief sought should be granted rarely or sparingly, and that regard should be had to the specialist nature of the Office of the State Coroner, including resourcing issues. I also agree that the phrase "in the public interest" involves a discretionary value judgment of the kind identified in *O'Sullivan v Farrer* (1989) 168 CLR 210 in the judgment of Mason CJ, Brennan, Dawson and Gauldron JJ, at 216. But I do not agree that – while it is unnecessary to conclude that the decision of the State Coroner is erroneous – it is sufficient for an application to succeed that the views of the family of the deceased, or the local community, are such that an inquest is likely to assist to maintain public confidence in the administration of justice, unless one reads into the term "such" an unexpressed qualifier such as "in all the relevant circumstances". All these matters are discussed in paragraph [38] of *Gentner*. The last expressed conclusion was said to be in addition, or as an alternative, to establishing such uncertainty or conflict of evidence so as to justify the use of judicial forensic processes. I agree that the "views" of relevant persons are a factor to be brought into account and that such things as uncertainty or conflict in evidence are factors which will also affect the decision to be made. But it can only be that such views are to be taken in the context of the factual matrix of the circumstances of the death and of the investigation of it (if any) – in which uncertainty and conflict might play a part – to determine whether the touchstone of "public interest" has been triggered. It is only then that a decision can be made whether the views satisfy the required likelihood. Of course, in *Gentner*, the uncertainty and conflict of evidence, given the range and extent of it, when taken with the impact on public confidence (particularly having regard to the extent to which the views of the family

were taken into account), justified the use of the procedures available for holding an inquest.

Specific Issues raised by applicant

[26] The first substantive matter raised is that "closer hospital care available" was not utilised. It is difficult to see, in circumstances where Cherish was admitted to the Paediatric Emergency Department of a major children's hospital in Brisbane such as the Mater, that there needs to be any further investigation of that non-utilisation on 7 July 2008.

[27] The next matter is criticism of the content of the statement by Ms Debbie Ayers, a clinical nurse on duty at the Mater at the relevant time. While it is obvious there is some inadequacy in the documentation provided by this person, there is absolutely no basis presented to this court which suggests that the accuracy of Ms Ayers' recollection of the salient events "is somewhat questionable". As with many other matters raised, the applicant's counsel merely threw the issues into the air without any focussed enquiry on why it should lead to an order being made in the public interest. This is illustrated by the other criticism of Ms Ayers with respect to her determination that Cherish did not require "urgent treatment". It is not clear at all that there is any medical evidence that suggests that, on the facts known and on the systems then in place at the Mater, it is established that she did require urgent treatment. As for the criticism of what Ms Ayers did with the information provided by the ambulance officer, while it is true that there was no diagnostic printout as to Cherish's temperature, it becomes irrelevant whether or not Ms Ayers entered that temperature into the computer system or whether there was a computer system error which "lost" the information. This is in light of the steps now taken by the Mater following the RCA, and the knowledge, reviewed by Dr Buchanan, that Dr Poole in fact had about such things. That knowledge included that fact that Dr Poole recollects Cherish's "fever" to have been 39.2 degrees Celsius. That itself is consistent with Nurse Ayres' recollection that the Ambulance Office told her it was "about 39 degrees". Earlier recordings by the Queensland Ambulance officers were lower.

[28] The next matter raised concerns the isolation of Cherish. She was so isolated due to her potential earlier exposure to chickenpox. Although it is clear from the documentation that she was dehydrated at the time, the criticism that she was not placed in a position which promoted constant monitoring does not suggest that she was not properly re-hydrated and does not suggest that the RCA has failed to address the classification of a patient such as her (which is the subject of the criticism).

[29] The next matter to be dealt with is the statement made by a relevant police officer and its "inconsistency" with the report of Dr Williams, the pathologist, and in particular, the observation by the police that Cherish was wearing a "(clean) disposable nappy" in contrast to a urine soaked disposable nappy that was observed during the autopsy. But this in no way suggests that the relevant advice as to hydration was not given by Dr Poole or not understood and followed by Cherish's mother. Again, when it was inquired of counsel for the applicant as to whether there was any suggestion of error or inadequacy shown by any medical practitioner, particularly resulting from any suggestion to the contrary by a paediatric specialist, arising from these "conflicts", the response was simply that these raised issues of conflict and inconsistent recordings. Since there is no evidence which in any way

suggests that any of the medical opinions expressed are, even slightly, erroneous or that any conflicts, where the evidence relied upon is cogent, would have any effect on the conclusions so far reached by the medical specialists, is difficult to see how mere conflicts as those generate the requirement for the satisfaction of "public interest", either alone or with other matters canvassed.

[30] A similar problem attends upon the non-reporting of lesions on Cherish's body by Dr Williams in his autopsy report (i.e. that no lesions were seen during the post-mortem examination). It is therefore highly unlikely that those "crusted skin lesions" noted while the clinical examination was performed by Dr Poole in the search for evidence of chickenpox are relevant to any potential misdiagnosis, particularly where any sign had totally disappeared such a short time later. In any event, yet again nothing is suggested which in any way indicates that the medical opinions reached are not correct or that identified further investigations still need to be done.

[31] With respect to the matter of there being no opinion sought from an experienced paediatrician, although Dr Williams, the pathologist, mentioned in his autopsy report dated 5 January 2009 that he recommended that an opinion be sought from an experienced paediatrician, Dr Buchanan's comment – which has been in no way contradicted by any evidence, much less by a process of deductive reasoning to the effect – was that he was not sure how this would further assist. This is quite understandable in light of the medical qualifications of Dr Whitby and in light of the implementation of the RCA after review by the Mater staff.

[32] The criticisms about the absence of any, or any adequate, follow-up with the parents and family have been acknowledged by the Mater and are the subject of the RCA.

[33] As to the criticisms of Queensland Ambulance, particularly as to responses on 7 July 2008, again it has not been suggested in any way that the resources available could have been used in any better way. The mere failure to activate the MDT on arrival at the scene on each attendance, with the result that there was no "on-scene time" recorded in the "Mobile Data Network", does not of itself demonstrate any deficiency in the actual response taken. In any event, that criticism is made concerning the time before Cherish was taken to the Mater Paediatric Emergency Department. As for the response of the various authorities on 9 July 2008, the initial criticism is of a failure to press the MTD on arrival. But again its relevance has not been demonstrated, when the approximate time can be easily determined. As for the response being "only" a code 2B, with a response time of some 30 minutes, there has been nothing suggested that the responses, including that by those responsible for the operation of the helicopter, led to any outcome which is materially different from what would have inevitably occurred if all resources available had been appropriately applied. Furthermore, there is nothing to suggest that there are concerns about how such emergencies are reported and prioritised, in the absence of any criticism from anybody with knowledge of those responses that they were other than reasonable in the circumstances. After all, the "000" call was made at 06:53:56 hrs, the paramedic was dispatched at 06:57:35 hrs, he was "enroute" at 07:03:27 hrs and he arrived some time prior to 07:11:00 hrs. Further, the helicopter's "availability" was requested at 07:33:02 hrs and it was dispatched at 07:39:21 hrs.

[34] With respect to what would have occurred if Cherish had remained in hospital and been monitored, there is nothing to suggest that the conclusion by Dr Whitby – analysed above – is not correct. The additional evidence intimated to be led, orally, from the applicant was that she observed that a cannula was inserted into her daughter's arm. The question that I posed to the applicant's counsel was that,

should I accept that as being true, what consequence would it have on the conclusions reached in the medical opinions so far available? He was unable to indicate anything other than the fact concerned hydration and that an experienced paediatric specialist "might" be able to throw some further light on the matter. Given the evidence so far canvassed, it does not appear to me that these are sound reasons for determining that the State Coroner should be ordered to conduct an inquest, noting that, incidentally, resourcing issues must be involved. With respect to Dr Poole's qualifications, even if she was not a paediatric registrar, there is nothing which has been suggested, in light of the analysis by Dr Buchanan of all the medical reports obtained, which indicates that, given the lack of appropriate procedures at the time (as since implemented by the Mater), a paediatric registrar would have reached any different conclusion. This is particularly where Dr Poole, despite the negative opinion given by a radiologist about the implications of the x-ray, did make the correct diagnosis of pneumonia and took action which is not the subject of any specific criticism, given the circumstances which prevailed. Additionally, no analysis has been proffered of her actual experience to show that she was in any way an inadequate person to be given the responsibility she undertook.

[35] Finally, it was submitted that besides the uncertainty or conflict – which I have just dealt with – the views of Cherish's mother and those of the Russell Island indigenous community more generally should be the reason that an inquest should be ordered. As to the basis being that it is likely to assist the family to understand what happened to Cherish, that is, on the present evidence, extremely unlikely considering that the five obligatory findings (if possible) to be made by a Coroner as set out in s 45(2) of the *Coroners Act* are known. Further, as to s 46(1) of the *Coroner's Act*, the "review" of the final implementation of the RCA by Dr Buchanan obviates any need for further comment concerning either public health or safety or ways to prevent deaths from happening "in similar circumstances" in the future. As for the acceptance of such views as indicating that an inquest is likely to assist to maintain public confidence in the judicial process and the administration of justice, it is, as I have remarked earlier, quite obviously a significant factor if there were to be other factors which, taken together with such views, went to establishing the relevant satisfaction that the "public interest" would be served by ordering an inquest: but there are not.

[36] In all circumstances of this application, I am not satisfied that it is in the public interests for an inquest to be held.

Orders

[37] In consequence of the conclusions which I have reached, I order that the application be dismissed. Given the circumstances of this case, I do not intend to make any orders as to costs, although I will consider, orally, any application made, when these reasons are published, to address the issue further.