



FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 25th day of September 2018 and the 8th day of March 2019, by the Coroner's Court of the said State, constituted of Mark Frederick Johns, State Coroner, into the death of Clinton Neal Peters.

The said Court finds that Clinton Neal Peters aged 40 years, late of 3/4 Edinborough Street, Nairne, South Australia died at the Queen Elizabeth Hospital, 28 Woodville Road, Woodville South, South Australia on the 2nd day of September 2015 as a result of metastatic malignant melanoma. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Mr Clinton Neal Peters was 40 years of age when he died at the Queen Elizabeth Hospital on 2 September 2015. At the time of Mr Peters' death he was detained pursuant to an Inpatient Treatment Order under the Mental Health Act 2009. Mr Peters' death was therefore a death in custody within the meaning of that expression under the Coroners Act 2003 and this Inquest was held as required by section 21(1)(a) of that Act

2. Cause of death

2.1. A pathology review was conducted by Dr Iain McIntyre from Forensic Science South Australia. In his report Dr McIntyre provided the cause of death as metastatic malignant melanoma¹, and I so find.

¹ Exhibit C2a

3. Background and medical history

- 3.1. Mr Peters underwent excision of a lesion from his scalp in September of 2009. This was undertaken by Dr Stephen Cowie, a general practitioner sub-specialising in skin cancer work, at the Redgum Skin Cancer Clinic. That was upon a referral from Mr Peters' general practitioner.
- 3.2. The excised lesion was sent for analysis and it was reported to be a non-cancerous lesion. However, it was an atypical compound nevus which put Mr Peters at a higher risk of developing melanoma at a later stage. He also had a family history of melanoma, which in the context of this disease, raised Mr Peters' risk profile further.
- 3.3. Dr Cowie indicated in his statement² that it was important to monitor Mr Peters' skin for any abnormalities and a reminder was sent out to Mr Peters for a full skin check 12 months after the removal of the lesion, but Mr Peters did not respond.
- 3.4. Mr Peters did however return to the Redgum Clinic on 23 September 2013, some four years later, to reveal a similar lesion had grown back in the same area as the previous lesion. A biopsy of this lesion revealed melanoma, a level four category, with a Breslow thickness of 1.5 mm. That meant that there was approximately a 50% chance of the cancer having metastasised to other parts of the body. Mr Peters was referred to the Melanoma Clinic at the Royal Adelaide Hospital for specialist care. The referral letter was dated 1 October 2013 and is contained within the Redgum Clinic case notes³.
- 3.5. Dr Cowie spoke with Mr Peters on 15 October 2013 and confirmed that he was seeing a doctor at the Royal Adelaide Hospital. CT scans of Mr Peters' neck, chest, abdomen and pelvis were taken and these confirmed the presence of the melanoma and ruled out any metastases at that stage.
- 3.6. On 7 November 2013 Mr Peters underwent surgery to remove the lesion from his scalp as well as two lymph glands from the neck. The operation report contained within the Royal Adelaide Hospital case notes⁴ reveals that the melanoma had a 2cm margin down to the periosteum and the growth was described elsewhere in the notes as the size of a fist. A skin graft was required due to the size of the excised tumour.

² Exhibit C6

³ Exhibit C4

⁴ Exhibit C16

- 3.7. Mr Peters was discharged on 9 November 2013 with a follow-up review at the Melanoma Clinic on 14 November 2013. Mr Peters attended this appointment and the notes reflect that he was required to re-attend in one week for wound care. A further melanoma outpatient's clinic was booked for three months' time.
- 3.8. Mr Peters attended the appointment the following week and again on 28 November 2013 and the graft was noted to be taking well. Mr Peters did not attend the outpatient clinic on 20 February, 13 March or 19 June 2014. From the notes it is clear that the Clinic did attempt to contact Mr Peters, but it is not clear whether contact was made. Mr Peters did attend the clinic on 24 July 2014 for a check-up which was uneventful. He did not attend his scheduled appointment on 30 October 2014.
- 3.9. Mr Peters attended his general practitioner on 3 June 2015 complaining of severe pain. His general practitioner sent him to the Emergency Department of the Queen Elizabeth Hospital⁵ where he was assessed, given analgesia, and sent home. Mr Peters presented himself to the Queen Elizabeth Hospital on 13 June 2015, ten days later, complaining of chest pain and upper-left quadrant pain. He again underwent assessment, this time by the surgical team. A CT was taken of his chest and it was felt he had gastritis as the CT scan did not show any abnormalities.
- 3.10. Mr Peters was discharged after analgesia was given, but two days later on 15 June 2015 Mr Peters returned to his general practitioner who again sent him to the Queen Elizabeth Hospital Emergency Department, albeit reluctantly, as he had been there twice before in a very short period of time. The case notes reflect that there was an element of frustration expressed by Mr Peters and also by the general practitioner.
- 3.11. Mr Peters attended the Queen Elizabeth Hospital and a thorough assessment was conducted noting that he had lost 10kg in weight and there was the discovery of some pulmonary nodules, as well as high levels of lactate dehydrogenase which may indicate liver or muscle damage. The impression of the clinician on this occasion was the presence of metastatic melanoma.

⁵ Exhibit C15

- 3.12. Mr Peters was admitted and started on an analgesia regime with a head and pelvis CT scan ordered and a letter⁶ was written by oncologist Dr Rachel Roberts-Thomson who treated Mr Peters during this admission. The letter stated that the CT scanning revealed extensive malignant disease and the biopsies confirmed that it was the recurrence of the previous melanoma. There is reference to a discussion with Mr Peters to the effect that he now had an incurable disease.
- 3.13. An MRI was undertaken at the Royal Adelaide Hospital during this same admission and that revealed extensive brain metastases. Mr Peters was transferred to the Royal Adelaide Hospital on 22 June 2015 for management of a C6 vertical lytic lesion causing canal compromise and multiple brain metastases. He was considered unsuitable for radiation as he had a certain bacterial strain at the time and it was considered that he would be suitable for a round of palliative chemotherapy.
- 3.14. Mr Peters was discharged on 24 June 2015 into the care of his mother to reside with her for support. On 6 August 2015 Mr Peters attended an outpatient clinic and was admitted to the Queen Elizabeth Hospital medical ward after concern was raised in relation to his level of pain. He was discharged on 18 August 2015 with outpatient chemotherapy to continue.
- 3.15. On 21 August 2015 Mr Peters was visiting his grandmother at her nursing home when he suffered an absence seizure. He was conveyed by ambulance to the Royal Adelaide Hospital and then transferred to the Queen Elizabeth Hospital when it was realised that he had received the majority of his oncology care at that hospital.

4. Inpatient treatment order under the Mental Health Act 2009

- 4.1. During this admission Mr Peters was placed on an Inpatient Treatment Order. On 25 August 2015 the case notes reflect that Mr Peters was unsettled and wandering around the ward in a confused state. Later in the day Mr Peters left the ward without informing staff. He returned, but left again for a period of approximately five hours. He stated that he had been at the pub with his friends. The notes reflect that there was

⁶ Exhibit C12

an increase in his level of agitation and distress, as well as some emerging mania and a high level of pain analgesia was required to keep his pain under control.

- 4.2. On 27 August 2015 Mr Peters expressed a desire to be discharged. The oncology team clearly noted their concern for him due to his cognitive deterioration, which was affecting his reasoning and higher functioning. The notes reflect concern for his capacity to make decisions, his safety and the possibility of self-harm. Dr Roberts-Thomson was also informed and it was agreed that a nursing special would be organised and minimal restraint would be attempted, but detention would occur if required, in part to prevent his discharge, but also to manage his pain and behaviours on the ward.
- 4.3. Mr Peters left the ward later that day and staff attempted to find him without success. The notes reflect that he was found in the cafeteria asleep. He was returned to the ward and a decision was made at that time to detain him under the Mental Health Act 2009.
- 4.4. A Level 1 Inpatient Treatment Order was signed by oncologist Dr Chloe Furst at 1300 hours on 27 August 2015⁷. The order was confirmed by consultant psychiatrist Dr Lawlor at 1600 hours on 27 August 2015. Dr Lawlor's entry in the Queen Elizabeth Hospital case notes reflects his concerns for Mr Peters as:

'Significant personality change due to rapid progression of disease, lacking insight, disorganised thoughts, poor decision making, agitation, manic behaviour and insisting on discharge today.'⁸

- 4.5. The order remained in place until Mr Peters' death. During that time Mr Peters was managed on high levels of analgesia, mood stabilisers and antipsychotic medication. It was clearly a very distressing period for Mr Peters and his family as his health, both physical and mental, declined. Mr Peters died at 0830 hours on 2 September 2015.

5. Conclusion

- 5.1. I find that Mr Peters' detention was appropriate in the circumstances. Mr Peters exhibited high levels of agitation and confusion, particularly when there were periods of breakthrough pain between medical cycles. Mr Peters also required a nursing special right up to the time of his death.

⁷ Exhibit C4

⁸ Exhibit C15

5.2. It was concerning that Mr Peters (who was a known cancer patient who had had a melanoma removed) did not receive a thorough assessment on the two occasions that he was seen at the Queen Elizabeth Hospital in June 2015. However, he was diagnosed with metastatic cancer only a few days later, and it is unlikely that this suboptimal treatment made a difference to Mr Peters' life or his ultimate death.

6. Recommendations

6.1. I have no recommendations to make in this matter

Key Words: Death in Custody; Natural Causes; Inpatient Treatment Order

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 8th day of March, 2019.

State Coroner