CITATION: *Inquest into the death of Paulo Melo* [2008] NTMC 080

TITLE OF COURT:	Coroner's Court
JURISDICTION:	Darwin
FILE NO(s):	D0223/2007
DELIVERED ON:	18 December 2008
DELIVERED AT:	Darwin Magistrates Court
HEARING DATE(s):	21- 24 October, 2008
FINDING OF:	Mr Greg Cavanagh SM
CATCHWORDS:	Motor accident causing severe injury, medical treatment thereof, decision to cease mechanical ventilation consequent on poor prognosis, communication between health professionals and family

REPRESENTATION:

Counsel:

Assisting:	Dr Celia Kemp
Melo Family:	Mr Peter Barr QC
Department of Health and Families	Mr Kelvin Currie

Judgment category classification: B
Judgement ID number: [2008] NTMC 080
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0223/2007

In the matter of an Inquest into the death of

PAULO MELO
ON 20 DECEMBER 2007
AT THE ROYAL DARWIN HOSPITAL

FINDINGS

(18 December 2008)

Mr Greg Cavanagh

1. Mr Paulo Melo was a deeply loved son, brother, uncle and friend. He was only 29 when he died in the Intensive Care Unit at the Royal Darwin Hospital on 20 December 2007. His death was as a result of injuries sustained in a motor vehicle accident and was thus reportable to me pursuant to section 12 of the Coroner's Act. The holding of a public inquest is not mandatory but was held as a matter of my discretion pursuant to section 15 of that Act.

2. Pursuant to section 34 of the Coroners Act, I am required to make the following findings:

> "(1) A coroner investigating –
>
> (a) a death shall, if possible, find –
>
> (i) the identity of the deceased person;
>
> (ii) the time and place of death;
>
> (iii) the cause of death;
>
> (iv) the particulars needed to register the death under the Births, Deaths and Marriages Registration Act;

(v) any relevant circumstances concerning the death."

3. Section 34(2) of the *Act* operates to extend my function as follows:

> "A Coroner may comment on a matter, including public health or safety or the administration of justice, connected with the death or disaster being investigated."

4. Additionally, I may make recommendations pursuant to section 35(1), (2) & (3):

> "(1) A coroner may report to the Attorney-General on a death or disaster investigated by the coroner.
>
> (2) A coroner may make recommendations to the Attorney-General on a matter, including public health or safety or the administration of justice connected with a death or disaster investigated by the coroner.
>
> (3) A coroner shall report to the Commissioner of Police and Director of Public Prosecutions appointed under the Director of Public Prosecutions Act if the coroner believes that a crime may have been committed in connection with a death or disaster investigated by the coroner."

5. This inquest was held from 21-24 October 2008 in the Darwin Magistrates Court. Dr Celia Kemp appeared as Counsel Assisting me. Mr Kelvin Currie was granted leave to appear on behalf of the Department of Health and Families (hereafter 'the Department'). Mr Peter Barr QC was granted leave to appear on behalf of Paulo's family. I heard evidence from Brevet Sergeant Anne Lade, the office in charge of the investigation into Paulo's medical care, Constable 1/C Mark Casey, Jeffery Gillies, Dr Martin Sterba, Dr Brain Spain, Dr Paul Goldrick, Dr Jim Burrow, Dr Nick Vrodos (by videolink from Adelaide), Dr Diane Stephens, Dr David Ernest and Fernanda Isobel Camara. I have before me the medical records of the deceased and a complete brief of evidence.

6. Paulo's family and friends attended throughout the inquest. I mention in particular his mother, Amelia Nunes Melo, his brother, Filipe Nelson Nunes Melo, and his sister, Fernanda Isobel Camara. The inquest went over, in

detail, an extremely traumatic and upsetting period of time for the Melo family and they sat in court throughout.

7. I note also that Drs Goldrick and Stephens attended the inquest once they had given evidence and were free to do so. They too were listening to evidence about an extremely difficult time for them and their unit, and I commend them for choosing to sit through the evidence, regardless.

8. Paulo was injured in a motor vehicle accident that occurred on 5 December 2007 in the Kakadu National Park. He was transferred to the Royal Darwin Hospital and he died there on 20 December 2007. The coronial investigation looked into both the accident and Paulo's hospital admission and I will set out my findings of fact in relation to the accident, and then in relation to his hospital admission separately.

CIRCUMSTANCES OF THE MOTOR VEHICLE ACCIDENT

9. Paulo was born and raised in Darwin. In his late teens he went to Portugal and did a teaching course. He came back to Darwin and worked as a taxi driver and then returned to Portugal and was working as the Director of the Wall Street Institute School of English (the Centro de Ingles Amadora). He had formed a relationship with Ines Fernandez a few years before his death.

10. Paulo and Ines had travelled back to Darwin to visit family, arriving on 2 December 2007. They had planned to stay until 28 December 2007. Early on the morning of 5 December 2007 Paulo and Ines drove to Kakadu in a maroon Toyoto Corolla hatch NT 766 385 which was normally used by Paulo's mother, but was registered to his father.

11. They arrived at the entrance to Kakadu National Park on the Arnhem Highway at about 7 am. They spent the day sightseeing at various locations in the Park and went on the Yellow Waters Cruise from 1:30 pm to 3 pm. They then set off outbound on the Cooinda Access Road. Paulo was driving and Ines was sitting in the front passenger seat.

12. Kevin Lyons was a tour guide working at the Cooinda resort. On Wednesday 5 December 2007 he was conducting maintenance tasks and was driving a work vehicle, a white Toyota Landcruiser NT 794264, back to Cooinda from the Jim Jim Ranger Station, inbound on the Cooinda Access road. The two vehicles collided about 100m inbound from the Warradjan Cultural Centre turn off. The speed limit is signposted at 110 km/h.

13. Kevin states (at p 2 of his statement) *I was travelling on the left side of the road and was travelling at 100 km/h, about 1 km from Cooinda I commenced to negotiate a sweeping left-hand bend. As I entered the bend I saw a maroon coloured sedan approaching from the other direction. I saw that the vehicle was on my side of the road coming straight towards me. I pulled across to the left to try and avoid a collision with the other vehicle. As I pulled over to the left I saw that the other car was also coming further across in my direction. I had just pulled off the bitumen and was on the side of the road when the other vehicle collided with the rear right side of my work car. By this stage I had slowed down considerably and I had done everything I could to avoid a collision. My car rolled over to the left and did a complete roll over, coming back on its wheels.*

14. After the collision Paulo's car came to rest facing towards Cooinda but angled with its' rear wheels on the bitumen and the front wheels in the dirt on the inbound side of the road. Kevin's car continued off the bitumen and rolled at least once, coming to rest about 20 metres from Paulo's car, facing Cooinda although angled back towards the road, and standing upright in bushland about 11 metres off the road.

15. Senior Constable Peter Wiesenekker and Constable Stacey Toneguzzo were the police who attended the accident. They observed that there were skid marks, these were on the side of the road going inbound towards Cooinda and the point of impact was on the edge of the road on the inbound side. After the completion of her investigations Constable Toneguzzo concluded

that *Kevin Lyons, the driver of the Lancruiser, was travelling on the correct side of the road heading inbound to Cooinda on the Cooinda Access Road. The driver, Paulo Melo, of the Corolla was travelling outbound from Cooinda and has at some point travelled over to the incorrect side of the road. Lyons has attempted to veer to the left of the road to avoid the Corolla, but the Corolla followed the same direction, where both vehicles have collided.*

16. Senior Constable Mark Casey, a qualified crash investigator, attended the scene the next day and concluded *the driver of the Landcruiser was not wearing a seatbelt, was travelling at 97 km/h on the correct side of the road and has swerved to the left to avoid the red Corolla. The driver of the red Corolla was wearing a seatbelt and was on the incorrect side of the road and has travelled to the right side of the road, following the Landcruiser off the road.*

17. I am unable to make a finding as to why Paulo's car crossed over to the wrong side of the road. Ines had no memory of the accident. There are many possible explanations for this and no evidence that enables me to prefer one explanation over another.

18. There is one witness who remembers the two cars travelling in the opposite direction to that stated above and the Landcruiser crossing to the wrong side of the road but this is completely inconsistent with the rest of the evidence, including the physical evidence and the evidence as to the likely direction of travel of the two cars, and is also inconsistent with what that witness said directly after the accident and I thus do not rely on it.

19. Both cars were registered. Kevin had a current licence. Paulo had a Portuguese licence. Both vehicles were subsequently inspected by Motor Vehicle Inspectors and found to have been roadworthy at the time of the accident. Paulo and Ines were both wearing seatbelts. Their vehicle did not have airbags. Mr Lyons was not wearing a seatbelt. There were

approximately 100 m of double white lines on the road either side of Warradjan turn-off intersection. The collision occurred on a portion of the roadway where there was a moderate left hand curve in the road (as seen if travelling toward Cooinda). Senior Constable Casey did speed calculations which found that the Landcruiser had been travelling at approximately 97 km/h. The speed of the Corolla was unable to be calculated.

20. There is no evidence that either driver was affected by alcohol. Paulo's family were concerned Kevin wasn't tested until 2:30 am on 6 December 2007. Both Paulo and Kevin were tested only once they arrived at the Royal Darwin Hospital. Kevin had been in a serious roll-over and ended up being transported to the Royal Darwin Hospital for treatment. I would not have expected police to breathalyse him immediately after the accident given those circumstances. There was no evidence at all that Kevin had been drinking, and I note that the evidence in relation to the accident was that Paulo was on the wrong side of the road and that Kevin did everything possible to avoid his car. In my view there is no fault attaching to Kevin in relation to the collision.

PAULO'S CONSCIOUS STATE AFTER THE ACCIDENT

21. Paulo's conscious state after the accident, and the effect of this on prognostic estimates for Paulo, was a matter of concern to his family. I have therefore given careful consideration to this aspect of the evidence.

22. Kevin Lyons saw Paulo shortly after the accident. It seems likely he was the first person to see him. His statement says that Paulo was *slouched over forward with his chin resting on his chest...I could hear him breathing but he didn't say anything or respond to me.* Shaheen Bilwani was driving behind Kevin and stopped when he saw the accident. He says that Paulo *had a deep gash to his right arm and was in and out of consciousness. He occasionally responded to the passenger's request to respond.*

23. John Burrell came across the accident, on the evidence it seems likely that this occurred at the time that Kevin Lyons approached Paulo. He says Paulo was *apparently unconscious.* Cooinda employees arrived shortly after this and their evidence is that Paulo was unconscious at that stage. It is also clear that Paulo was unconscious at about 4 pm when the ambulance arrived.

24. Jeffrey Gillies, the Manager of Cooinda, called the family later that day to tell them what was happening. He had been involved in moving the cars and found a registration in the glove box. He tried to contact police, to give them the details, but the office was closed. The same thing occurred with the medical centre. He then did a directory search and found a phone number and then rang it to let the family know what had happened.

25. Filipe remembers this call. He said he asked Mr Gillies if Paulo and Ines were conscious and Mr Gillies said that they were. Filipe says his father drove down to Jabiru a few weeks later and spoke to Mr Gillies and asked him if Paulo was conscious at the scene and was told that when the ambulance was taking Paulo away he was still awake.

26. Jeffrey Gillies was called to give evidence. He says he may have used the word 'conscious' on the phone, but he can't remember. He says that he was attempting to communicate that Paulo was still alive. He states that at this point of time *it was absolutely clear to me that he had suffered serious injuries and that his condition had not changed since the initial reports of the accident, he was not conscious and I had heard no reports from staff or emergency response team that he had been conscious at any point in time.* He says he never told Mr Melo senior that Paulo was conscious when the ambulance took him away.

27. If Paulo was conscious after the accident it was for a short period immediately after the accident. The only evidence that he was comes from Mr Bilwani. Mr Bilwani's statement is inaccurate on major details, and it is clear that his memory is faulty in relation to the accident, therefore I cannot

put great weight on his evidence. The only other person who saw Paulo immediately after the accident was Kevin. He had just been through a serious rollover and so there are reasons that his recollection may not be accurate. However his detailed recollection of the accident is completely backed up by the evidence subsequently collected. It seems more likely than not that Paulo never regained consciousness after the accident. However in any case the unchallenged evidence from Dr Jim Burrow (p 49 transcript) and Dr Paul Goldrick (p 56 transcript) was that even had Paulo been conscious immediately after the accident for a short period, this would not affect prognostic estimates.

TREATMENT UP TO ADMISSION AT THE ROYAL DARWIN HOSPITAL

28. John Burrell, a tour guide with Travel North, came across the scene and then drove to Warradjan Cultural Centre (which was very close by) to call for help. He called Frank Horat, an employee at Gagadju Cooinda Lodge. Frank immediately called 000 and the call was received by police at 3:16 pm.

29. Various employees of the Gagadju Cooinda Lodge, including Wade Kellie, got first aid kits and set off for the accident. They were only a kilometre away and arrived well before police, ambulance or fire services. RN (Registered Nurse) Jacinta MacCormack was holidaying at the Lodge. She asked if she could be of assistance and went with staff to the scene. They provided first aid to Paulo, including preserving his airway when his breathing began to be obstructed, until the ambulance arrived.

30. The Jabiru clinic were called and two nurses (RN Daniel Horwood and RN Louise Carrington) and a doctor (Dr Tony Ma) set off in an ambulance, arriving at 4 pm. RN Horwood attended Paulo. He was breathing with a low blood pressure (60/40) and a Glasgow Coma Score (GCS) of 3. An oxygen mask was put on his face. The medical team had to wait until the NT Fire and Rescue Service removed the canopy of the car to access the

victim properly. They disconnected the battery (to ensure the car was safe from fire) and, once the medical team had given the go-ahead, then removed both right hand side doors and a full roof fold, and then did a dash roll. They cut Paulo's seat belt.

31. Health staff then removed Paulo. He was given oxygen and fluid, and his blood pressure improved. He remained unconscious and unresponsive. He was taped to a spinal board and taken to the Jabiru Clinic, arriving at about 6:35 pm, and handed over to clinic staff. The Aerial Medical Services Plane had been contacted by RN Horwood when he arrived at the scene, and it was dispatched with a doctor and nurse on board to pick up the deceased from Jabiru. Paulo was intubated, a catheter and arterial line were inserted and he was transferred to the airport for evacuation. He arrived in the Emergency Department at the Royal Darwin Hospital at 9:19 pm.

32. Dr Diane Stephens, the Director of the Intensive Care Unit at the Royal Darwin Hospital, had reviewed the records in relation to Paulo's treatment before he arrived at the hospital and commented on the treatment as follows (p 85)

> *The paramedics and the volunteers out at Kakadu, at Jabiru did a fantastic job. The clinic out at Jabiru, time and time again does a terrific job with the trauma patients that they see out there, and the aeromedical retrieval was prompt and their management was excellent.*

This level of care was provided despite the remoteness of the accident location. I would like to commend all those involved in assisting Paulo.

33. I would also like to commend the Cooinda Gagadju Lodge employees who spent many hours assisting in relation to this accident in every way they could. The evidence was that since this tragic accident, they have been involved in the first response to two other fatalities and, in addition, they regularly assist in the response to less serious accidents. I am very

impressed that they so whole-heartedly commit their time and energy to assisting the victims of remote accidents. I was particularly impressed by the dedication shown by Mr Gillies in his concerted efforts on the evening of 5 December 2007 to contact the Melo family to tell them that their son was in an accident but was alive.

Treatment received at the RDH

34. There were three main issues for this inquest in relation to Paulo's stay in the Intensive Care Unit:

    1. The appropriateness of Paulo's medical care

    2. Paulo's prognosis

    3. The appropriateness of the withdrawal of ventilatory care.

35. I intend to set out the evidence in relation to what happened during Paulo's stay and then set out my findings in relation to each of these issues in turn.

36. I heard evidence from four consultants who had had charge of Paulo's care throughout his admission; Dr Martin Sterba, Dr Brian Spain, Dr Paul Goldrick and Dr Diane Stephens. They were all appropriately qualified and had significant experience. I found them all to be credible and compassionate. I accept the truthfulness of evidence they gave in relation to Paulo's care.

37. I note that their evidence differed at some points from the evidence of Paulo's family as to their recollections of what occurred. I also found Paulo's family to be truthful in their statements, letters, affidavits and evidence before me. I consider the differences are explained by the passage of time, the different vantage points of the parties and the very stressful situation that developed in relation to Paulo's care.

Facts in relation to Paulo's stay in the Intensive Care Unit

38. Paulo was intubated and ventilated when he arrived at the Emergency Department. He was admitted to the Intensive Care Unit (ICU) early on the morning of Thursday 6 December 2007 with a high cervical spinal cord injury (that is injury to the spinal cord in the neck) and brain injury.

39. Dr Martin Sterba was the Intensive Care consultant in charge of Paulo's care on Thursday 6 December 2007 and Friday 7 December 2007. During this time Paulo developed very high intracranial pressure (that is high pressure inside his skull) and although every effort was made to reduce the pressure, it was unable to be reduced. Paulo had been sedated, an appropriate treatment for his condition but a treatment that can mask conscious state, so on 7 December 2007 long acting sedatives were ceased and changed to short acting medication to allow clinical assessment of neurological function.

40. Dr Sterba had a family conference on both days. On the Thursday his notes include *family expressed hope for Paulo's recovery but I have again explained to them how serious the injuries are.* On Friday he spoke again of Paulo's critical condition and notes *I have stated that we are going to support Paulo's vital functions but further deterioration is to be expected.* The family were provided with social work and chaplaincy assistance.

41. Dr Brian Spain, a consultant anaesthetist, was on call on the weekend as the consultant for ICU and thus overall in charge of Paulo's care from 6 pm on Friday 7 December 2007 to 8 am on Monday 10 December 2007. He had a meeting with the family on Saturday 8 December 2007 in which he *outlined the critical nature of Paulo's injuries*; the high cervical cord injury and the severe closed head injury. He told the family that *it is the consensus opinion of all the ICU Specialists that the outlook is bleak with nil chance of useful recovery*. He said he told the family that consideration would be given to withdrawing ventilatory support in a few days. Fernanda Camera remembers being given the impression that withdrawal of treatment was

imminent and that it would occur on the first Monday. Dr Spain's notes state that the family was very distressed and Paulo's father was *angry and threatening* and he wrote that *we understood their distress and we would leave some more time but that it was inappropriate for us to give future hope for a good outcome.*

42. The Orthopaedic team at the Royal Darwin Hospital were also involved in the early stages. The Spinal Unit at the Royal Adelaide Hospital (RAH) was contacted by the orthopaedic registrar for further advice. Dr Wilby, the spinal fellow at RAH reviewed the CT scans and told the orthopaedic registrar on 9 December 2007 that Paulo may have a complete transaction of the cord, and that given his current condition he was not appropriate for transfer to RAH.

43. Dr Paul Goldrick took over care on Monday 10 December 2007. He said he agreed with the other specialists that Paulo's prognosis was extremely poor and his treatment plan was to help the family come to terms with this. He had a meeting that lasted between one and a half and two hours with the family that afternoon. There are lengthy notes taken by Dr Goldrick. He went through Paulo's condition in detail, stating that there was an *infinitesimally small chance of good outcome with respect to both injuries*. He notes *the family are struggling to accept that the situation is so desperat*e.

44. That afternoon Dr Goldrick talked to a specialist the Spinal Unit at the Royal Adelaide Hospital and they said there was no current indication for spinal cord surgery. He was told that it was likely Paulo would need long term ventilation and they agreed that the prognosis was 'appalling'. Dr Goldrick also contacted the duty intensivists at the Intensive Care Unit at the Royal Adelaide Hospital and described the case. They discussed the case with other doctors in the Unit and then contacted Dr Goldrick stating that they agreed with his prognosis and considered that withdrawal of care

was indicated but that given the difficulty the family was having coming to terms with the situation they would given them some more time, in the order of 48 to 72 hours.

45. On 11 December 2007 a MRI of the cervical spine and brain was done. This confirmed transaction of the spinal cord at C5 and showed evidence of brain injury.

46. The next family meeting was on Wednesday 12 December 2007 and Dr Goldrick discussed the scans with the family. He says the meeting went for three hours or longer. He again made detailed notes about this meeting. He reviewed the scans, discussed the likely outcome and talked about the *futility of further extra-ordinary care, especially ventilation* and notes *father and siblings aggressively not accepting this medical opinion* and *father expressed suicidal ideation if ventilator withdrawn.* He states *no consensus reached re withdrawal support*. After that meeting Dr Goldrick contacted the Director of Psychiatry, Dr Rob Parker for advice. Dr Goldrick said he did this because he was concerned about Mr Melo's senior very strong grief reaction which had included elements of hostility and verbal intimidation, and threats about what he would do to himself, and to others, if care was withdrawn. He says Dr Parker agreed with their current plan which was to give the family time to come to their own acceptance of the situation, and to offer them as much evidence as we possibly could. Dr Parker also said that there should be fairly clearly defined parameters for the length of time that discussions would be engaged in, and that at some point a definite point of withdrawal of care would need to be put forward.

47. Dr Goldrick organised for Dr Jim Burrow, the senior neurologist at the Royal Darwin Hospital and a consultant neurosurgeon, Dr Nick Vrodos, to review Paulo and give their opinions in relation to prognosis. He says it was clear that the family was (at p 60)

unaccepting of our opinion and of opinions we'd so far obtained from the Royal Adelaide and from amongst our own specialists. So I offered to engage the expertise that we had in the hospital, but as outside opinions. Because these doctors were not involved in the chain of treatment; they weren't part of the treating team...this was to provide the family with an external reference point that was independent of the intensivist that they'd so far been dealing with at Royal Darwin.

48. Consequently on 13 December 2007 Dr Jim Burrow, conducted a review of Paulo. He told me he considered his role was to give an opinion as to his current neurological state and to offer some prognosis. He talked to Paulo's doctors, looked at his notes, examined him and reviewed the scans and other investigations. He also did an EEG (an electroencephalogram which is placing electrodes on the scalp to record the electrical activity of the brain). His entry in the notes included the following

This man has the combination of a severe closed head injury and severe high cervical cord injury. With respect to the cerebral injury the pre-hospital hypotension and lack of responsiveness now 8 days later indicate a poor prognosis. I suggest an optimistic outcome (cerebral) would be 35% death or 35% severe disability (70%) With respect to his spinal cord function I do not believe he will regain significant recovery – I base this on degree of radiological disruption, prolonged spinal shock, diaphragmatic breathing. At best he would probably be ventilator dependent. Thus overall with the combined injuries I believe his prognosis for any reasonable outcome (ie cognitive + spinal) is extremely low.

49. On Friday 14 December 2007 Dr Nick Vrodos, the Director of Neurosurgery at the Flinders Medical Centre, and a consultant spine and neurosurgeon to the Royal Adelaide Hospital, was in Darwin as part of a regular visit to provide neurosurgical services here, and came to see Paulo. He reviewed

his scans, examined him and attended a meeting with Dr Goldrick and various family members. Dr Vrodos did not make any notes but Dr Goldrick records Dr Vrodos telling the family that Paulo had sustained a transection spinal cord with around a 100% likelihood that he would be quadriplegic and ventilator dependent, and a serious traumatic brain injury with a very high likelihood of moderate to severe permanent brain injury, permanent vegetative state or death. Dr Goldrick notes that Dr Vrodos said that Paulo had a *very very small possibility (about 1%)* of normal brain function.

50. Dr Goldrick noted that he told the family *that we felt withdrawal of care still the most appropriate course of action* and that he *expressed our sadness that such a young life was so badly disrupted.* He documented that the outcome at the end of the meeting was a decision to continue the current level of support over the weekend, treatment would not be escalated, and further discussions would be held on Monday.

51. Fernanda Camara says that during that meeting Dr Vrodos told the family, in response to a question from her father, that the decision to withdraw life support was a very difficult one and he would not switch the life support off. This is consistent with Dr Vrodos' view as expressed in evidence before me. However Dr Vrodos did not make any notes to this effect at the time, and this view does not appear in Dr Goldrick's notes. Dr Vrodos did not clearly recall what he had said, his comment on it was as follows (p 136 transcript):

> Mr Barr QC - - *Did Dr Goldrick, the Intensive Care doctor who was present, ask your opinion as to whether you thought that support should be continued or withdrawn?*
>
> Dr Vrodos - - *I'm not sure, I cannot recall if he asked me specifically but I would say that through the meeting I would not have projected to the family that I would have been in favour of outright withdrawal of support.*

I am unable to determine what precisely was said on this, and am not at all assisted by Dr Vrodos' failure to make any notes. I consider that it is likely that Dr Vrodos said something in passing to indicate that he was not in favour of outright withdrawal of support, as described by Fernanda. I consider it unlikely that he said anything detailed about it, or about timelines, or expressed an alternative management plan. Dr Goldrick was not asked about this during his evidence before me but I am impressed by his detailed note taking and consider it likely, had this been mentioned in any substantial way, that it would have been recorded as part of his notes.

52. Paulo's family did not accept the prognostic information provided throughout Paulo's stay at RDH and were concerned particularly with the inconsistencies between the percentage chances provided by various Doctors as to Paulo's chances of survival. They wanted to obtain an independent opinion on Paulo's prognosis. They began contacting doctors during the week of 10- 14 December 2007 and left messages but were not called back. They requested copies of Paulo's scans on 12 December 2007 and copies were made and were made available on Thursday 13 December 2007.

53. Paulo's family say they requested copies of the medical records. Dr Goldrick does not recall this, there are no notes in relation to this and Dr Stephens says that as head of the unit any such request would have come through her and this did not occur. The request for scans was documented and scans were provided. In any case Paulo's family were unable to find an expert who agreed to provide an opinion during the week of 10-14 December 2007. When they did find an expert, after the matter had progressed to the Supreme Court, a complete copy of the medical records was provided to him. I therefore do not consider it necessary to resolve this conflict in the evidence.

54. Dr Goldrick had been aware the family were trying to obtain another opinion. He said initially he was asked to assist (it seems likely on the

evidence that this was on Wednesday 13 December 2007 as part of the discussion in which he approved the copying of scans) but that he told them that he had got all the opinions he could get. He said he told them he thought it would be very difficult to get another opinion and he said he told them that this couldn't go on indefinitely and should be done by the end of the week.

55. Late on the afternoon of Friday 15 December 2007 Fernanda and Filipe came to see Dr Goldrick saying that they had been trying to obtain the independent opinion and that no one was responding to them. Dr Goldrick told them he thought they would have difficulty finding a specialist over the weekend. He offered to assist them by using hospital processes to send the films to any specialist they found on the following Monday. Dr Goldrick told me (at p 82) that he again told them that it would be difficult to get an opinion and that they may not be successful.

56. No major decisions were made over the weekend. On Monday morning 17 December 2007 a decision was made by Dr Stephens, the unit director, to withdraw ventilation that day. This was made after discussing the matter with Dr Sarah Collins, another intensivist, and Dr Goldrick, who was not on duty that day but talked to Dr Stephens on the phone. Dr Stephens says she considered that as the Head of the Unit, the decision should be hers. Dr Stephen's explained her reasons for this decision (at p 2 of Folio 9)

> *...we had given the family a lot of time to come to the decision themselves and they had steadfastly refused to acknowledge the terrible prognosis and evident poor outcome. I felt that we needed to draw a line and no matter what time we decided on the family were going to struggle with it. I chose to make withdrawal of ventilation that afternoon as we had already continued therapy for a week beyond what all of the staff felt was appropriate for the patient and the family had been given a lot of lead time to come to terms with the situation. I was always prepared to give*

them more time – if they had said we are not quite ready we want another day I would have negotiated that through with them – as we often do with distressed and grieving families. The violent reaction to our even trying to discuss withdrawal of therapy with the family precluded that discussion occurring – they stopped listening after I said we were going to withdraw therapy. As clinicians we could not continue futile therapy any longer and we were in the very difficult situation of having to do what was right for our patient without the family's assent.

57. Paulo's feeds were reduced in anticipation of the extubation. Dr Stephens gave evidence that (at p 91)

The reason that we do that, is to make sure that the stomach is not full of food, because people with severe injuries like Paulo's are at risk of food coming up from the stomach and going down into the lungs, because the protective mechanisms are damaged from the brain injury. And so in order to minimise the risk of food going into the lungs and causing pneumonia, which is often the mode of death for people with head injuries who have a prolonged stay in the ward, we reduce the feeds to minimise the risk.

58. A family meeting was held at 11 am and the family were told that ventilation would be withdrawn at 2 pm that afternoon. Dr Stephens notes, in retrospective notes written at 3:20 pm, that

family meeting this morning to discuss once again withdrawal of mechanical ventilation. Informed family that Paulo's condition was not changed, there has been no improvement in his poor neurological status and that mechanical ventilation would be ceased this afternoon at 2 pm.

She details that Paulo senior is *extremely aggressive and abusive at times...he threatened me and my family directly.*

She states

it is no longer in the best interests of this family to continue mechanical ventilation and it is certainly beyond the time when we should have stopped invasive life support for Paulo's best interests. Further time will not be in anyone's best interests.

59. Dr Stephens formally took over care of Paulo from this point. She says she did this because (p 90 transcript):

as the director of the unit, it was my duty to protect my staff from what we knew was going to be a difficult situation. I am the most experienced intensivist in the team, and it is part of my role to take on those difficult situations, to manage them.

60. Paulo's family strongly disagreed with the decision to withdraw ventilation from Paulo. They were also extremely unhappy about some aspects of the the way the decision was made: the short notice, the failure to allow them extra time to obtain an independent opinion and the absence of Dr Goldrick, whom they had got to know over the previous week.

61. The Melo family obtained an injunction from Justice Riley by phone stopping the withdrawal of care on 17 December 2007 and then the matter was heard before Justice Riley in the Supreme Court on 18 December 2007. Justice Riley made an order that *until further order the Royal Darwin Hospital and treating medical practitioners not withdraw life support systems currently provided to Paul [sic] Melo* and *that until further order the Royal Darwin Hospital and treating medical practitioners provide to Paulo Melo necessary and appropriate medical treatment directed towards preserving his life and promoting his good health and welfare*. The orders were set to expire at 3:30 pm on 19 December 2007 in the absence of an order from the court to the contrary, and the court was adjourned to 2 pm on 19 December 2007. Justice Riley said that he had granted the 24 hours *to enable you to get the additional opinion and place it before whoever the new judge is* (p 6).

62. On 19 December 2007 the matter came on before Justice Mildren. Mr Clift, the lawyer for the family said that a neurosurgeon in Sydney had been located and had proffered an opinion but that opinion was under the caveat that *no definitive opinion could be proffered by him until such time as he has had the opportunity to formally examine in person...Mr Paulo Melo. In the time that has been available to the applicants that has not been possible.* That neurosurgeon was Dr Mobbs and Mr Clift told the court that he had said he could come up *in as little time as 48 hours and perhaps a little longer*. Justice Mildren did not make any further orders and the original orders expired at 3:30 pm on 19 December 2007.

63. The feeding rate was reduced at 10 am on 19 December 2007 in anticipation of the extubation. Paulo was extubated at 4:20 pm on 19 December 2007 and his feeding tube was removed. Dr Stephens decided not to give him fluids overnight; she says his hydration state was good and there is a risk that too much fluid could cause breathing difficulties.

64. On the morning of 20 December 2007 Dr Stephens arrived at work at 7:30 am and spoke to Paulo's parents. She said that Paulo's mother, Amelia, felt strongly that he needed to have fluid, so she put up a small amount of fluid. Dr Stephens asked Paulo's parents *do you think he's suffering at all?*, a question she usually asks families' of dying patients, and that if they thought he was she could give him some morphine through his drip. She says both Paulo's parents said they thought he was suffering and that they wanted the morphine started. After this discussion she started a morphine infusion of 100 mg morphine in 50 mls normal saline at a rate of 5 mls/hr. The notes record this being done at 7:59 am. Paulo Melo died at 9:26 am on 20 December 2007.

Issues for the Inquest in relation to Paulo's stay in the Intensive Care Unit

65. Dr Kemp, the Deputy Coroner, wrote to the Joint Faculty of Intensive Care Medicine to ask for an independent review of the medical records in this

case. The Faculty suggested Dr David Ernest, the Director of Intensive Care at Box Hill Hospital, who was subsequently retained by the Coroner's office as an independent expert. He provided a written report based on the medical records. He was then provided with a full brief of evidence and gave evidence before me at the Inquest. I was greatly assisted by his evidence and I accept both the written report, and his oral evidence before me.

1. Appropriateness of the medical care

66. The evidence is that Paulo received appropriate medical care throughout his time in the Royal Darwin Hospital.

67. Paulo's family had some concerns in relation to the reduction of his feeding in anticipation of the planned withdrawal of ventilatory care, and the decision not to give him fluids for the first night after his extubation. Dr Ernest's unchallenged opinion on this was that *I do not consider that the altered food and fluid regimes on 19 December 2007 caused dehydration or materially hastened the patient's death* and I rely on it to so find.

68. Paulo's family were particularly concerned about the provision of morphine on the morning of his death and whether this was, in fact, what had caused his death. The post-mortem toxicology results showed morphine level of 0.09 mg morphine per Litre, which is within the reported therapeutic range. Both Dr Stephens and Dr Ernest gave evidence that although morphine is a respiratory suppressant, the morphine did not in fact contribute to Paulo's death. I find that the provision of the morphine was reasonable and that it did not contribute to Paulo's death.

69. One of the concerns of Fernanda and Filipe was that they said they had asked for staff to involve them in decisions because they had a better command of English, and in this case Paulo's parents only were involved. None of the treating doctors had any recollection of this request, and there were no notes made in relation to it, although there were in relation to

numerous other requests (such as for no prognostic discussions to take place at the bedside). There was no evidence that Paulo's parents did not understand the discussions on Thursday morning and indeed there is a lot of evidence that Paulo's father was able to clearly express his dissatisfaction in English on multiple occasions, and I consider it entirely appropriate to give treatment based on the consent of the parents.

2. Prognosis

70. The expert opinions in relation to the prognosis take into account a range of factors which include Paulo's lack of consciousness early after the accident, his low blood pressure readings at the scene of the accident, the persistent raised intracranial pressure that developed in hospital, the transaction of his spinal cord at the C5 level, the result of his imaging studies and his persistent unresponsiveness in the hospital.

71. Dr Sterba gave evidence that he considered that there was an 'extremely poor chance for functional recovery'. Dr Spain gave evidence that he considered that the outlook was 'bleak with nil chance of useful recovery'.

72. Dr Burrow gave extremely helpful evidence on this point. In order to assist the inquest he had, in the lead up to the inquest, closely reviewed the raised intracranial pressure readings for Paulo for the 6 days they were carried out and he concluded that death or severe disability is likely to occur in 97% of patients showing such sustained raised intracranial pressure. He broke that down into 80% dead/vegetative state, 17% severe disability. He says that overall, taking into account all the factors, the outcomes was 'very pessimistic'. I particularly thank Dr Burrow for his detailed analysis which was of significant assistance to me.

73. Dr Goldrick gave evidence that Paulo had a high chance of a bad outcome (being death, coma, severe disability) and gave detailed evidence on this point, stating he had relied on the presence of four independent predictors of

a bad outcome, each of which, by themselves, had a predictive percentage rate in the order of 70-80% of a bad outcome.

74. Dr Stephens said that Paulo had the worst combination of injuries and had no reasonable chance of making a meaningful recovery. She gave a statement which read, in part;

> *the objective measures for very poor prognosis include a GCS of 3 (lowest score possible and is associated with an 80% mortality) at the scene with no improvement at all, low blood pressure at the scene (doubles the risk of mortality) with long extrication time (the longer the low blood pressure continues the worse the effect on outcome) and the concomitant high cervical spinal cord injury (the combination of severe brain injury and severe spinal cord injury has a higher mortality than either injury on its own). The expected outcome of severe disability, vegetative state or mortality is therefore about 99%. There is no reasonable expectation of recovery of consciousness given that after 1 week with no sedative medications there has been no objective signs of consciousness.*

75. Dr Vrodos said that Paulo's prognosis was bad, saying that there was a high chance of permanent severe brain injury although he couldn't say that there was no chance of recovery. His statement to the Coroner refers to the *inevitable terrible prognosis as a result of this tragedy*. He said Paulo would have quadriplegia and that he was *quite confident in saying that he would be left with severe brain injuries and more than likely in a vegetated state.*

76. The inquest had before it the written opinion provided by Dr Ralph Mobbs, a Neurosurgeon & Spine Surgeon from NSW, to the Melo family. It stated

> *I have reviewed the comprehensive set of notes supplied to me. Note should be made that I have NOT examined the patient or physically reviewed the radiological investigations. Although I am able to read most*

of the fax that has been supplied – there are some entries that are unreadable.

He then concluded that the potential outcome scenarios were as follows:

Return to Full Independence/Mobility = near 0% chance.

Return to Pre-injury Mentation/Quality of life = near 0% chance.

Likelihood of quadriplegia and ventilatory dependence for survival = near 100% chance.

Likelihood of constant high level nursing care/medical care for survival = near 100% chance.

Likelihood of severe disability or persistent vegetative state = Greater than 98% chance.

77. Dr Ernest said he agreed with the range of estimates given by the various other witnesses and that he considered that Paulo had a high chance of death, persistent vegetative state or severe disability.

78. I there find based on a large number of expert opinions in relation to Paulo's prognosis, that the combination of the high cervical spine injury which resulted in quadriplegia and likely ventilator dependence and the severe brain injury meant that Paulo was very likely to either die, be in a persistent vegetative state or be severely disabled.

79. One of the reasons that the family had difficulties accepting the prognosis was that they observed Paulo responding to them. They describe him responding to a command to 'look at mum' by turning his head towards his mother and his eyes focussing in her direction, trying to talk after the ventilator was removed, responding to questions by blinking his eyes (once for yes and twice for no) in a way that was consistent with what his family

knew of him, opening and closing his eyes when asked, turning his eyes when he heard new voices and rotating his thighs.

80. However there is no evidence from anyone outside the family and friends of Paulo that supports this, that is none of the medical or nursing staff that cared for him saw any evidence of any responsiveness from Paulo. Dr Stephens was asked about the family's observations as described above and stated that these were random reflect movements and that there was no actual responsiveness. She said that it is not unusual for families to believe that things that are random are actually directed, as families desperately want the person to get better. She said when the family believed he was responsive, and told staff, he was examined again each time and it was found that nothing had changed and there was no response. I find that it is likely that Paulo was not responsive.

3. The appropriateness of the decision to withdraw care

81. There are two aspects to this; the overall decision to withdraw care and the decision in relation to the timing, that is when the withdrawal of care was actually to occur.

82. All the ICU specialists who gave evidence before me considered that it was appropriate to withdraw care. Dr Goldrick explained in detail the ethical considerations behind his decision. He said that it had become clear that there was an appalling prognosis and that there was no treatment that could bring Paulo back or benefit him an any way, that is that ongoing treatment was futile. He said that intensive care treatment is burdensome for both patients and family, and even if a patient is unconscious there were still issues in relation to his dignity. He said the question of what Paulo would have wanted was explored with the family during the various discussions and they said that they didn't know. He said there is no obligation for clinicians to continue futile treatment, and that the primary duty of care is to the patient. Usually if there is a difference of opinion between the family

and the clinician then a lot of time and effort is put into resolving this. However in the end if the family want to go in a direction that the clinician thinks is in conflict with the patients right to dignity and their autonomy (that is what the patient would want) it is a very difficult situation. He said in the end his ethical duty to Paulo meant that he should not prolong his care.

83. Dr Stephens similary said that her duty of care was first to the patient *and whilst we try very hard in intensive care – we have very distressed families with patients with injuries and illnesses that you can't survive – we try very hard as part of our duty of care to look after families and to bring them to some resolution as part of that dying process, but in the end, it is the patient who is the primary point of our care…mechanical ventilation is not a natural state of being. It's interfering with a person. It's putting a tube down into their lungs; it's putting them on a machine, and once that treatment is no longer of any benefit to that person, it is our duty of care to stop doing it and to treat the person with dignity, and to allow them to die with dignity and not to impose treatments on them that are futile; that are not going to make any difference to the outcome…it's not ethically right to continue treatment once you believe it's futile* (p 87).

84. Dr Ernest gave evidence that he considered that the decision to withdraw therapy in this case was reasonable (p 147).

85. The only expert evidence that it was not reasonable came from Dr Nick Vrodos, who said that he was not in favour of the ventilator being turned off at the time when he saw Paulo as the family needed time to adjust. He said that he wasn't against Paulo coming off the ventilator per say but that he should have been weaned off the ventilator. He suggested the provision of a tracheostomy (cutting an opening from the outside of the neck to the windpipe) and then Paulo could have been moved to a ward and ventilated there *they would've realised that he could not survive and there would've*

been other opportunities where active treatment could have been withdrawn…almost inevitably he would have developed pneumonia or some other form of infection (p 135). He did not agree that it was unethical to continue to provide futile treatment to Paulo, saying that it was not clear what Paulo's wishes were and there is a duty of care to the family as well, even though the primary duty of care is to the patient. He later said that *I think the issue was perhaps the timing* and said that he thought the family thought that they were being forced. Finally, in answer to a question from Mr Barr, he said that *the only times we would consider turning off [a ventilator] is if they were brain dead or if we were considering the patient for transplantation of organs* (p 138 transcript).

86. Dr Vrodos also made some general comments about the way the ICU unit had dealt with the family, saying that *it could've been dealt with in a more mature and sophisticated, professional way* and *I was uncomfortable with the level of conflict that had been created.*

87. Dr Vrodos was due for a regular visit to Darwin and was called by Dr Goldrick before he came and asked if he could see Paulo. His information about Paulo came from that phone call, from what he was told when he came to the Intensive Care Unit, from reviewing the imaging, and from examining Paulo. He did not review the case notes. He was then in a meeting with Dr Goldrick and Paulo's family for approximately half an hour. He was therefore not aware in any detail of what had happened before his arrival, and in particular of the sustained efforts to engage with the family. He was therefore in no position to comment on the dealings between the ICU and the family, nor to ascribe blame for the level of conflict that he observed. I therefore put no weight on his evidence in relation to the way the ICU unit dealt with the family.

88. It is clear that there was a breakdown in communication between the treating staff and the family. I would expect professional staff to make considerable

efforts to communicate compassionately with a grieving family, and to be able to deal with a degree of hostility as part of the grief reaction. Having heard all the evidence I consider that in this case treating staff did in fact do this. There were multiple, long, meetings with the family, they engaged social work and chaplaincy assistance early and they secured additional expert involvement for the sake of the family. I do not think that the treating staff can be blamed for the breakdown in communication in this instance.

89. Dr Vrodos gave evidence that he considered that the purpose of the consult extended to providing advice on management, rather than being solely for the purpose of assisting with prognosis. This contradicts the evidence of Dr Goldrick. I do not think I need to make a finding either way, however I consider the failure to write any management plan in the notes by Dr Vrodos supports Dr Goldrick's recollection, rather than his own. If Dr Vrodos did indeed form a view that the case should be managed in a way differently than was currently occurring, he should have written this in the medical notes. Dr Vrodos did not write his opinion in relation to the management plan in the notes; Dr Vrodos did not in fact write in the notes at all. This is concerning. It meant that the first time his divergent opinion was clearly expressed was months after the death in his statement to the Coroner, and then at the inquest, obviously far too late to affect Paulo's treatment.

90. Dr Vrodos' views in relation to the withdrawal of care are not consistent with any of the Royal Darwin Hospital intensivists called, nor with those of Dr Ernest, the expert witness. Dr Vrodos' view that the only time he would consider switching off a ventilator is when the patient is brain dead or was being considered for transplant is completely at odds with the evidence as to the general practice in intensive care units. I rely on the opinion of Dr Ernest to find that the decision to withdraw ventilation was reasonable.

91. I have given careful consideration to the timing of the decision. The family were told at 11 am on day 12 of his stay that he would be extubated at 2 pm. At first glance giving the family 3 hours notice of the time the ventilator would actually be withdrawn seems short. Paulo's family also felt that there was a discontinuity with what had occurred on the Friday before.

92. The fact that withdrawal of care was a possible, or indeed, a probable outcome was mentioned from very early on in Paulo' stay. It seems likely that it was first raised on Saturday 8 December 2007 by Dr Spain. Dr Spain describes what he said as follows

> *I outlined that while it was our intention to continue supportive care for the next few days, it was likely that early the following week we would consider withdrawal of life supportive therapies if it remained evidence that these were futile.*

The family were given the impression that this was likely to occur on the Monday 10 December 2007.

93. Mr Barr submitted to me that the issue of withdrawal of care should not have been raised on Saturday 8 December 2007 because the issue *had the potential to poison the relationship between staff of the intensive care unit at the family of Paulo.* Dr Kemp asked Dr Stephens for her comment about whether the issue was raised too early, and she replied (at p 87)

> *We are always open and honest about prognosis, about what we think are the chances of a patient recovering or not recovering. We find its far better for people to know the truth, and we certainly are ...a long way from the days when you kept things from people and you kept things from families in order to protect them, because it doesn't actually do families any good not to know the truth, because the truth is the truth and that was evidence from the 48 hour mark, that this was a non-survivable injury, and we had to work from that point in trying to get the family to understand that.*

I accept Dr Stephens evidence on this point and consider that it was appropriate to raise the possibility of withdrawal of ventilation on the Saturday.

94. Withdrawal of care was consistently mentioned and carefully documented by Dr Goldrick throughout 10-14 December 2007. Fernanda says that when it was raised by Dr Goldrick on Monday 10 December 2007 she was given the impression that it was an imminent decision, that is it was likely to occur within the next day.

95. Thus the evidence is that the withdrawal of ventilation had been mentioned repeatedly from 10 days before Monday 17 December, and the family had been given the impression that it would occur on the Monday, 7 days earlier, and then on the Tuesday, 6 days earlier, and had been told on Friday 14 December that the matter would be raised again on Monday 17 December.

96. Dr Goldrick did not tell the family on the Friday that the ventilator would actually be withdrawn on the following Monday. He said (at p 66)

> *I expected at the beginning of the week, that by the end of the week we would have achieved consensus...but it was a complicated matter and it took a long time and much endeavour on my part and other specialists, to get all the information available; and particularly to get the opinions of the neurologist and the neurosurgeon. And so it wasn't until late Friday evening around 5 or 6 pm that we really finished presenting all the information that we felt we could make available to help them come to terms with what was going on. So by Friday evening, I think we'd all really had a pretty long week, and I wasn't going to sit there at the end of that three hour meeting that I'd just been through with Dr Vrodos and the myself and the family, and say that now we're going to give you a time frame for withdrawal. But we said that this was the issue at hand and that we would meet again on Monday, and that withdrawal of care would almost certainly be the very first thing we'd be talking about on Monday*

morning when the specialists met again and that that was the consensus opinion of all the treating doctors...was that withdrawal of care was the most important thing for Paulo.

97. In light of all of the above I do not consider that the decision made on Monday morning that ventilation would be withdrawn came 'out of the blue' or without adequate preparation.

98. Had the ventilator been withdrawn at 2 pm Monday as planned the family would not have received a report from an independent expert. I have considered whether more time should have been given to enable this. It was certainly appropriate to give the family a reasonable amount of time to obtain such an opinion. It was very difficult for the family to obtain such an opinion due to the remoteness of Darwin and the difficulties in finding a neurosurgeon who had the time and agreed to do it, and the evidence is that they had great difficulty in getting specialists to respond to their calls.

99. There were seven days between the first mention of withdrawal of care, on the third day, and the decision to actually withdraw care, on the 10th day. Dr Goldrick gave evidence the family were made aware that they needed to obtain an independent opinion in a timely fashion and before the end of the preceding week. He was of the opinion that it would be very difficult to get another opinion.

100. I consider that there was a duty to give the family a reasonable amount of time, but given the ethical considerations described above, it would not have been appropriate to wait indefinitely. The primary ethical duty is to the patient. The family was informed very early on that withdrawal of care was an option, and the ICU staff went to considerable effort to get the opinions of a wide range of specialists both internally and externally. I do not consider that the decision to withdraw ventilation on Monday 17 December 2007 was inappropriate and should have been put off solely for the purposes of waiting for another opinion.

101. I note that in the end the family did obtain an independent opinion before the ventilator was withdrawn, although the specialist was not able to examine Paulo, because the family took the matter to the Supreme Court and gained more time. This was the opinion from Dr Mobbs, which entirely supported the prognostic estimates that had already been given to the family.

102. With the benefit of hindsight, and despite the family being on notice that the ventilator would probably be withdrawn, I consider it would have been preferable to give the family more than three hours notice of the actual time. It was clear that this decision was going to be devastating for the family and the three hours notice didn't give the family very much time to deal with it emotionally, or to gather in extra family or friends. I note Dr Stephen's evidence that the time was given would have been subject to negotiation. However, I note that as things turned out, ventilation was not withdrawn on the Monday, and thus there was not in actuality only three hours notice.

OTHER ISSUES

103. Dr Stephens called in security during this week which was something that Paulo's family raised as a matter of concern. Dr Stephens was asked about this and said (at p 93)

Paulo's father was very physically explosive and violent and made quite a lot of threats to myself, my family and there was a degree of anxiety in my mind about the safety of staff and the other patients, and the other patients' families that necessitated a security presence, just to ensure that everything was kept on an even keel and that people were protected in the work they had to do…we had a family of a young boy who was in the unit at the time , who were witness to some of this behaviour and had it directed at them. And it's my job to protect my staff, my patients and my family and I really didn't like doing it but it was necessary because that was the only way that we could control the behaviour.

I consider that the calling in of security was a necessary and prudent decision, in the circumstances.

GENERAL COMMENTS

104. After hearing all the evidence I was impressed with the sustained effort put in by the Consultants at the ICU in relation to their care of Paulo and their efforts to engage with Paulo's family. There was a wide consultation in relation to the appropriate course of action. There were multiple documented long meetings with extensive notes. I consider that the specialists acted out of compassion for Paulo in making the decisions they did, and were very concerned to fulfil their duty of care to their patient.

105. I was also impressed by the sustained effort put in by Paulo's family to fight for what they considered to be the right thing for their severely injured son/brother (although I do not condone threats of violence). It is apparent to me that their actions were because of the love they held for him and their determination to save his life, and now their concern to redress what they see as a significant wrong.

106. The complete divergence of views as to what was the right thing to do for Paulo resulted in a difficult situation for all concerned. It was extremely difficult for Paulo's family who felt they were being thwarted in their efforts to save his life and who were unable to procure a specialist to fly up to Darwin to give them an independent opinion that they hoped would differ from the opinions provided so far. It was extremely difficult for the ICU staff who spent hours trying to explain the prognosis and the reasons for withdrawal of care but were unable to get through, and who throughout Paulo's hospitalisation, but particularly in the last week, had to deal with a great deal of aggression and violence which included threats against their own families.

107. Mr Barr submitted that there is a need for a decision maker that is independent of the treating doctors and the family. He asked me to consider a recommendation to establish a clinical ethics committee comprising liability-protected health professionals, and possibly other persons, with the ability to convene at short notice in urgent situations. He helpfully provided an article from the Medical Journal of Australia (Vol 183 Number 5) by Faunce and Stewart, entitled 'The Messiha and Schiavo cases: third-party ethical and legal interventions in futile case disputes'.

108. I consider that the existence of such a committee would have been of assistance for both the family and the treating doctors in this case, and I therefore make this recommendation. I note that given the small population of the Northern Territory, for the committee to have any independence at all from the treating doctors it would probably need to have interstate members (who would need to be available on short notice by telephone or video conferencing).

FORMAL FINDINGS

109. On the basis of the tendered material and oral evidence at the Inquest I am able to make the following formal findings as required by the *Act*.

(i) The identity of the deceased was Paulo Jorge Nunes Melo. He was born on 10 June 1978 in Darwin.

(ii) The place of death was the Intensive Care Unit at the Royal Darwin Hospital. He died at 9:26 am on 20 December 2007.

(iii) The cause of death was blunt head and neck injuries sustained in an unintentional motor vehicle accident in which the deceased was the driver. The deceased developed bronchopneumonia whilst in hospital which contributed to his death.

(iv) Particulars required to register the death:

1. The deceased was male.

2. The deceased's name was Paulo Jorge Nunes Melo .

3. The deceased was born in Darwin, Australia.

4. The death was reported to the Coroner.

5. The cause of death was confirmed by post-mortem examination and was blunt head and neck injuries sustained in an unintentional motor vehicle accident in which the deceased was the driver. The deceased developed bronchopneumonia whilst in hospital which contributed to his death. The pathologist was Dr Terence John Sinton of the Royal Darwin Hospital.

6. The deceased's mother was Amelia Nunes. The deceased's father was Fernando Goncalves Melo.

7. The deceased was visiting Darwin and was staying with his parents at 57 Rosewood Crescent, Woodleigh Gardens. He lived in Portugal.

8. The deceased was working as the Director of the Wall Street Institute School of English (the Centro de Ingles Amadora).

RECOMMENDATION

110. That the Department of Health and Families consider establishing a clinical ethics committee comprising liability-protected health professionals, and possibly other persons, with the ability to convene at short notice in urgent situations.

Dated this 18th day of December 2008

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GREG CAVANAGH

TERRITORY CORONER