QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert George QUARTERMAIN**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/1890
DELIVERED ON:	11 September 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	28 August 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Fiona Banwell
Central Queensland Hospital and Health Service	Ms Anna-Maria Lofaro (Minter Ellison Lawyers)

The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Robert George Quartermain. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Late on the evening of 6 June 2011 Robert Quartermain, 67, experienced breathing difficulties in his cell at Capricornia Correctional Centre ("CCC"). Despite assistance from fellow prisoners, CCC nursing staff and Queensland Ambulance Service ("QAS") paramedics he went into cardiac arrest. He was able to be revived, albeit to an unstable state, but after arriving at Rockhampton Base Hospital ("RBH") in the early hours of 7 June 2011 his condition deteriorated and he died later that day.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care adequately discharged those responsibilities; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

An investigation into the circumstances leading to the death of Mr Quartermain was conducted by Detective Senior Constable Steven Peake from the Queensland Police Service ("QPS") Corrective Services Investigation Unit ("CSIU").

A Rockhampton general duties officer attended RBH and made preliminary enquiries. A QPS scenes of crime officer also attended and conducted an external examination of the body. He observed no signs of trauma and proceeded to take a series of photographs. Medical records from RBH were seized and lodged with the body at the Rockhampton morgue. There, two days later, an external and partial internal autopsy examination was conducted by Dr Nigel Buxton. Further photographs were taken during this examination.

CSIU staff, including DSC Peake, travelled to Rockhampton on 8 June 2011 and made inquiries at CCC. Statements were obtained from all correctional staff and prisoners who had been in contact with the deceased in the lead up to the medical emergency two nights prior. A statement was obtained from one of the QAS paramedics who attended CCC. QAS data relating to the dispatch of two units to CCC was also obtained.

DSC Peake sought statements from some of the medical personnel who treated Mr Quartermain during the period after he arrived at RBH but prior to death. These were tendered at the inquest.

At the request of counsel assisting, Dr Don Buchanan from the Queensland Health Clinical Forensic Medicine Unit ("CFMU") examined the medical records for Mr Quartermain from RBH and CCC and reported on them.

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

The Inquest

An inquest was held in Brisbane on 28 August 2013.. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Mr Johns, proposed that all evidence be tendered and that oral evidence be heard only from Detective Senior Constable Peake. I agreed that the evidence tendered in addition to the oral evidence of Detective Senior Constable Peake was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

Robert Quartermain was born in Sydney on 24 June 1943 making him 67 years of age when he died. There is little information available about Mr Quartermain's personal circumstances but certainly by 1985 he appears to have settled in central Queensland. Between 1985 and 2006 Mr Quartermain intermittently appeared in courts in Rockhampton and Mackay for a variety of public order offences and assaults. This resulted in four separate periods of imprisonment before, in March 2006, he was convicted of manslaughter as a result of an incident on 8 October 2004.

Mr Quartermain was subsequently sentenced to 8 years imprisonment. With time already served, he was due for release on 8 October 2012. In the period leading to his death Mr Quartermain was accommodated in a low security section of CCC.

A QPS subject profile tendered at the inquest lists "next-of-kin" details for a person identified by Mr Quartermain as his sister. The age of the entry is unclear and, in any event, only lists the address of a motel in Mackay by way of contact. This is the only link to any identifiable family or friends Mr

Quartermain may have had. The investigating officer examined the records seized from CCC which showed Mr Quartermain had never received a visit or a phone call while in custody. Interviews with other prisoners revealed only a vague account of Mr Quartermain having once been married for a number of weeks many years ago but otherwise indicated that he had "*no one on the outside*".

Medical history

Mr Quartermain's medical history included chronic obstructive pulmonary disease ("COPD"), a lengthy history of smoking, alcohol abuse, stomach ulcers, high cholesterol and a previous myocardial infarction. He was prescribed medication aimed at lowering his cholesterol and treating his COPD and stomach ulcers.

In July 2005 Mr Quartermain was transferred to RBH where he was found to have a chest infection. After 5 days in hospital he was returned to CCC where he recovered fully. In February 2006 Mr Quartermain complained of shortness of breath on exertion. He was found to be anaemic and tests conducted at RBH showed this was likely caused by stomach ulcers. These were treated and the symptoms abated. He had colonoscopies in 2006, 2008 and 2009 but his presentations to the medical centre at CCC were otherwise for low level "general practice" issues.

The clinical notes of a regular check-up in July 2010 at CCC reveal normal blood results (including cholesterol levels), satisfactory blood pressure and no abnormal heart sounds. His last presentation prior to death was on 7 April 2011 at which time he complained of back pain and a CT scan was ordered.

At no time since his imprisonment at CCC in 2004 had Mr Quartermain complained of chest pains or any other symptoms considered as having a cardiac origin.

Events leading to death

At 11:10pm on 6 June 2011 a prisoner housed in the same block as Mr Quartermain used the prison intercom system to alert corrections staff that Mr Quartermain was having trouble breathing. That prisoner had been alerted by Mr Quartermain's cries for help from within his cell. Other prisoners in the block had placed Mr Quartermain in the recovery position while they waited for help.

It was apparent to the first two officers on the scene, Custodial Corrections Officers (CCO's) Jorgensen and Clark that Mr Quartermain was having great difficulty breathing. CCO Jorgensen called a "Code Blue" medical emergency over his radio. When a vehicle pulled up at the block (coincidentally it seems) the officers were surprised to see it did not contain any medical staff. CCO Clark called the medical centre and was advised by Nurse Carol Jones that she had not heard the Code Blue. She immediately requested that an ambulance be called and then made her way to the block housing Mr Quartermain. CCO Clark called "000" and, after some difficulty communicating the circumstances to the operator, requested an ambulance. QAS records

show that this call was received at 11.24pm, almost 15 minutes after Mr Quartermain's fellow prisoners had sought help.

Nurse Jones applied oxygen therapy and this seemed to initially assist Mr Quartermain to maintain his breathing albeit with continued difficulty. The first QAS paramedics arrived at 11.42pm and this coincided with the cessation of Mr Quartermain's breathing. Intensive and lengthy resuscitation attempts with the injection of adrenaline eventually revived Mr Quartermain though he never regained consciousness. He remained unstable throughout the transfer to RBH where he arrived at 1:17am.

It was immediately apparent to the Intensive Care Registrar on duty that Mr Quartermain was unlikely to survive given the significant 'down time', hypoxic damage and, by then, "*global multi-organ dysfunction*". Mr Quartermain received inotropes (to maintain blood pressure) and morphine over the following hours. At approximately 10:00am ICU staff advised custodial officers that the deceased would not survive. As there was no recorded next of kin, the Adult Guardian was consulted and consent granted for withdrawal of therapy. Active treatment was subsequently withdrawn

He continued breathing with the assistance of a ventilator but at 4:08pm his cardiac monitor displayed asystole and a life extinct certificate was issued at 4:35pm.

Autopsy results

An external and internal (chest cavity only) autopsy examination was carried out on 9 June 2011 by an experienced forensic pathologist, Dr Nigel Buxton.

Samples were taken for toxicological testing and no illicit drugs or alcohol were detected. Other toxicological results were in keeping with Mr Quartermain's prescribed medication.

Dr Buxton had access to the medical records relating to Mr Quartermain from CCC and Rockhampton Base Hospital. After considering these, the toxicological results and his observations at autopsy, Dr Buxton issued a certificate listing the cause of death as:

> *1(a) Myocardial infarction*

Dr Buxton considered the infarction to have been of approximately two days duration. He also made the following observation:

> "*Review of the correctional centre medical chart shows no presentation with acute chest pain, indigestion or other harbingers of impending myocardial infarction within the previous 8 months."*

And later:

> "*Having had an opportunity to review the medical charts I see no prodromal evidence of impending infarction or other heart disease.*

There is indication of old myocardial infarction from which the patient has made a full recovery."

Investigation findings

None of the other inmates at CCC provided information to the investigating officers suggesting foul play or that there was any deficiency or inappropriateness in the treatment received by Mr Quartermain while in custody.

The examination of Mr Quartermain's body and his room at CCC revealed no signs of violence.

The CSIU investigation into Mr Quartermain's death did not lead to any suspicion that his death was anything but natural.

Medical Review

The medical records pertaining to Mr Quartermain were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Don Buchanan.

He considered the treatment provided to Mr Evans at CCC and RBH was reasonable and appropriate. He noted that:

"*His heart attack two days previously may well have been silent, in that he suffered no pain, or at least symptoms not severe enough for him to seek medical attention."*

In relation to the timing of an ambulance being called subsequent to Mr Quartermain's collapse he stated:

"The response by correctional and nursing staff to his acute breathing difficulties was timely and appropriate, with the only issue being that the nurse had not initially heard the Code Blue. She was nevertheless contacted soon after, and this did not affect the outcome.

Conclusions

I conclude that Mr Quartermain died from natural causes. I find that none of the correctional officers or inmates at CCC caused or contributed to his death.

I am satisfied that Mr Quartermain was given appropriate medical care by staff at Rockhampton Base Hospital and while he was in custody at CCC. Insofar as there was any undesirable delay in his being attended to by ambulance staff, it is clear that this had no affect on the outcome.

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

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Robert George Quartermain.

How he died - Mr Quartermain died at Rockhampton Base Hospital after earlier suffering a heart attack while he was in custody at Capricornia Correctional Centre.

Place of death – He died at Rockhampton in Queensland.

Date of death – He died on 7 June 2011.

Cause of death – Mr Quartermain died from natural causes, namely acute myocardial infarction.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

In this matter the adequacy of the medical care afforded to Mr Quartermain was examined by both Dr Buxton and Dr Buchanan. Both independent reviewers found that no person had contributed to Mr Quartermain's death and that there were no warning signs of the impending infarction that ought to have been investigated. The delay in an ambulance being called, while undesirable, did not affect the outcome. The delay arose from events peculiar to this incident rather than as a result of a systemic problem.

In the circumstances I accept the submissions of counsel assisting and lawyers for the Central Queensland Hospital and Health Service that there are no comments or recommendations to be made that would likely assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
11 September 2013