QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Gregory Bert Smallwood**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2014/4395
DELIVERED ON:	28 July 2016
DELIVERED AT:	Townsville
HEARING DATE(s):	27 July 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Ulrike Fortescue

Table of Contents

Introduction

1. In the early hours of 28 November 2014, Gregory Bert Smallwood suffered a heart attack in his residential cell at the Lotus Glen Correctional Centre (LGCC). He had been incarcerated for almost 18 months. During this time his weight had increased to over 140 kilograms. Although cardio-pulmonary resuscitation was attempted by nursing staff and continued by paramedics, Mr Smallwood was pronounced deceased at the scene.

2. 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

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

4. Upon being notified of Mr Smallwood's death, the CSIU attended LGCC and an investigation ensued. The scene was initially secured by officers from the Mareeba CIB. The investigators obtained Mr Smallwood's correctional records and his medical files from LGCC. Statements from all relevant custodial officers at LGCC, fellow inmates and relevant medical personnel, as well as a statement from Mr Smallwood's brother, Darryl Smallwood, informed the investigation. These statements were tendered at the inquest.

5. A full internal autopsy examination with associated histological and toxicological testing was conducted by experienced forensic pathologist, Professor David Williams. Photographs were taken during this examination.

6. At the request of the Coroners Court, Dr Ian Home of the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined Mr Smallwood's medical records from the LGCC and reported on them.

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

The Inquest

8. An inquest was held in Townsville on 27 July 2016. All of the statements, medical records, and materials gathered during the investigation were tendered at the inquest.

9. Counsel Assisting, Miss Cooper, proposed that all evidence be tendered and that oral evidence be heard from Detective Sergeant Seery, and John Roberts and Timothy Cheney from LGCC. The evidence tendered in addition to the oral evidence of these witnesses was sufficient for me to make the requisite findings under s45 of the *Coroners Act 2003*.

The evidence

Personal circumstances and correctional history

10. Gregory Bert Smallwood was born on 21 March 1961, making him 53 years of age when he died. Information obtained during the investigation confirmed that Mr Smallwood was one of eight children. He grew up in Townsville, Ayr and Gregory, and attended school up to year 10. After leaving school, he spent most of his working life as a labourer. He had used drugs from an early age, and was described as using "anything and everything."

11. Mr Smallwood had an extensive criminal history dating back to 1978. His offending began at a relatively low level and related to alcohol and drug use. In 1996 he was charged with attempted murder, but convicted of assault occasioning bodily harm. As a result he served his first period of imprisonment. On 11 April 2013, Mr Smallwood was sentenced in the Cairns District Court to 6 years imprisonment for multiple sexual offences.

12. The nature of these offences led to Mr Smallwood's estrangement from his family. His brother, Darryl Smallwood, provided me with a statement on behalf of the family, and he attended the inquest along with his mother, Margaret. I extend my condolences to Mr Smallwood's family.

Medical history

13. Mr Smallwood had an extensive medical history at the time of his incarceration in April 2013, including:
    - morbid obesity;
    - hypertension;
    - diabetes;
    - chronic obstructive pulmonary disease (COPD);
    - schizophrenia; and
    - a history of substance abuse including methamphetamines and cannabis.

His medications at the time of incarceration were:

- clozapine (antipsychotic);
- sertraline (antidepressant);

- benztropine (to reduce excess saliva); and
- metformin (used in the treatment of non-insulin dependent diabetes);
- perindopril (anti-hypertensive);
- Ventolin and seretide inhalers (to treat COPD).

14. Mr Smallwood was medically reviewed on a number of occasions during his final period of incarceration. His usual treating doctor was Dr Margaret Purcell, who routinely attended LGCC from the Mareeba Hospital. Dr Purcell provided a statement to the inquest detailing the extent of her treatment of Mr Smallwood. Mr Smallwood was also under the care of the Prison Mental Health Service in relation to his schizophrenia.

15. As at 19 April 2013, Mr Smallwood was noted to weigh 108 kilograms. He had normal observations, with his blood pressure, pulse rate and oxygen saturations all within normal limits. In May 2013, a follow up appointment was attended and Mr Smallwood's smoking habit was discussed. Dr Purcell strongly recommended that he quit smoking, and he was prescribed Champix to assist with withdrawal symptoms.

16. By July 2013, Mr Smallwood was still smoking up between 15 – 30 cigarettes a day. He was not taking the Champix. He was also on a waiting list for a nicotine patch program. By his next appointment date on 13 September 2013, Mr Smallwood had gone 26 days without smoking. He complained of some lower back pain and was given Panadol and Celebrex to manage the pain.

17. On 3 January 2014, Dr Purcell attended on Mr Smallwood after he had complained of shortness of breath, especially at night. An ECG was conducted, which returned normal results. Dr Purcell also arranged for further investigations to be conducted, including spirometry, a chest x-ray and an echocardiogram. Mr Smallwood denied any chest pain. His vital signs were essentially normal, though Dr Purcell noted Mr Smallwood's weight was increasing.

18. At a review appointment on 16 January 2014 Dr Purcell noted from the chest x-ray that Mr Smallwood had a likely old, crush fracture. Dr Purcell was also able to make a diagnosis of COPD from the x-ray. On 20 January 2014, the results of spirometry testing were available, and showed mild restriction. That is, Mr Smallwood's lung capacity was reduced, but the lung function was adequate.

19. By the end of January 2014, Mr Smallwood was complaining of worsening back pain, and a CT scan of his spine was ordered. He was trialled on morphine for the pain, with good results. That CT scan showed extensive osteoarthritis and possible spinal stenosis at multiple levels. He was referred for orthopaedic review.

20. On 10 February 2014, Mr Smallwood reported that his back pain had improved markedly and he was very happy with his current management. His shortness of breath symptoms had also improved. Dr Purcell still

required him to undergo an echocardiogram. By March 2014, that process had occurred and the results showed no abnormalities. The combined effect of all of the investigations ordered by Dr Purcell on 3 January 2014 was that Mr Smallwood's heart was functioning normally with a normal sinus rhythm. While the lung function was reduced, it was functioning adequately and the shortness of breath symptoms had resolved.

21. From this point in time onwards, Dr Purcell's focus changed to Mr Smallwood's weight gain and his smoking. By the end of April 2014, his weight had increased to 129.1 kilograms. His vital signs remained at satisfactory levels. Dr Purcell confirmed that, in around May 2014, smoking was banned in the LGCC, so this resolved Mr Smallwood's smoking issue.

22. However, by August 2014, Mr Smallwood's weight had increased to 141 kilograms. His diet was discussed, and he was told limit carbohydrates. He was also advised to exercise and mobilise more. He had not experienced any further episodes of shortness of breath.

23. On 16 September 2014, the QAS was called for Mr Smallwood after an exacerbation of his COPD. He was seen urgently at the LGCC medical centre with symptoms including shortness of breath and increased work in breathing. He was then transferred to the Mareeba Hospital and diagnosed with a chest infection. He was admitted for two nights and treated with intravenous antibiotics and kept under observation. The day after his discharge, Dr Purcell examined Mr Smallwood, particularly his chest. It was noted to be clear.

24. Dr Purcell considered that Mr Smallwood recovered from this episode and did not require any further admissions to the medical centre or transfers to hospital.

25. The last time Dr Purcell reviewed Mr Smallwood was on 24 November 2014, four days prior to his death. He had complained of cramping in his legs, and wanted to resume taking morphine. His weight was discussed and Mr Smallwood advised that he was eating significantly less than usual. Dr Purcell prescribed morphine, which was reflected in the toxicology results at autopsy.

Events leading to death

26. At the time of his death, Mr Smallwood was accommodated in Residential 2D, Cell 3. This unit comprises six cells, with the opening for the electronic security door under the control of Master Control in LGCC. The internal doors are not secured during the night shift. The prisoners close their cell doors during the hours of darkness. Each cell has its own intercom, and the Master Control Room Operator answers the intercom system in the first instance.

27. At 3:05am on 28 November 2014, Custodial Correctional Officer (CCO) Elisha Harris was receiving a handover to take control of the Master Control Room. During the handover, at 3:06am, CCO Harris received an intercom

call from Mr Smallwood's cell. CCO Harris answered and said "what's up mate?" Mr Smallwood responded, "I can't breathe, can't breathe."

28. CCO Harris provided a statement to the inquest. In that statement, she recalled that Mr Smallwood sounded like he was in total distress and was having extreme trouble breathing. She immediately called a Code Blue (medical emergency) and first officer response to Mr Smallwood's cell. CCO Harris recalled receiving immediate confirmation of the Code Blue from residential patrols as well as the registered nurses on shift.

29. At 3:09am, CCO Harris recalled opening the doors to Residential 2D as requested by CCO John Brown, CCO Patrick Campbell, CCO Patricia Ferguson and CCO Glen Spires. Each of these officers provided statements to the inquest. Those statements confirm that, upon entering Mr Smallwood's cell, the CCOs noticed Mr Smallwood on his back on his bed. CCO Campbell moved Mr Smallwood's arm to see if he would respond, and his head moved as a result. CCO Ferguson remembered seeing Mr Smallwood's mouth move, and he appeared to exhale. There were no other signs of life. As Mr Smallwood was being placed in the recovery position two registered nurses arrived and commenced CPR.

30. The registered nurses in attendance by 3:10am were Trevor Hicks and Bridgetta Makoti, who provided statements to the inquest. The evidence they provided was fairly consistent. They said the call for the Code Blue was received shortly after 3:00am, and that they acted in accordance with the protocol in relation to a medical emergency by equipping themselves with gloves and proceeding immediately to the scene for assessment.

31. CCO Harris recalled receiving prompt information that Mr Smallwood was not responding or breathing upon entry. At 3:15am, the Queensland Ambulance Service (QAS) was asked to attend. At 3:18am a call was made for the crash cart, which contained various emergency medical equipment like a defibrillator and oxygen tank.

32. Nurses Hicks and Makoti both confirmed in their statements that it is the responsibility of the correctional staff to retrieve the crash cart. CCOs Spires and Ferguson obtained the crash cart from the Detention Unit. The location of the crash cart is a matter I deal with in more detail later in these findings. Nurse Makoti had also made a call to a doctor from the Mareeba Hospital to advise of the situation. The advice from the doctor was to continue the CPR management as had already been employed.

33. At 3:34am paramedics from the QAS arrived on the scene, and CPR management was transferred to them. The defibrillator was also transferred to the QAS issued device, and no shockable rhythms were detected. Adrenaline was administered on three occasions, and an IV inserted in his right hand. No signs of life returned at any stage, and Mr Smallwood was declared deceased at the scene at 4:11am.

Autopsy results

34. Forensic pathologist Professor David Williams conducted a full internal examination on 1 December 2014.

35. Toxicology results revealed therapeutic amounts of the opiate Morphine and its metabolite. There was also a slightly high but therapeutic amount of the antidepressant Sertraline and its metabolite. There was a therapeutic concentration of the anti-psychotic Clozapine.

36. Professor Williams confirmed the presence of ischaemic heart disease, chronic obstructive airways disease and a degree of active bronchiectasis. He opined that Mr Smallwood's death was due his natural disease, and that he could have died at any time. There was no evidence of foul play.

37. The formal cause of death was confirmed as:

    1(a) Coronary atherosclerosis
    2 Chronic obstructive pulmonary disease
    Chronic cholecystitis

Investigation findings

38. There was no information provided to the investigating officer suggesting suspicious circumstances or that there was any deficiency in the treatment received by Mr Smallwood while in custody.

39. The examination of Mr Smallwood's body at LGCC revealed no signs of violence.

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

Medical Review

41. The medical records pertaining to Mr Smallwood were sent by the Coroners Court to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Ian Home.

42. Dr Home was not critical with respect to the medical treatment provided to Mr Smallwood at LGCC. In coming to that conclusion, he noted the following:
    - During his incarceration at LGCC, Mr Smallwood had progressively gained weight from 108kg to 144kg, despite regular advice from doctors about diet and exercise;
    - There is no legitimate way for correctional facilities to force prisoners to exercise or lose weight;
    - Given Mr Smallwood's smoking history, morbid obesity, diabetes, overeating and inactivity, the presence of severe coronary atherosclerosis man was not unexpected; and

- There were no indications prior to Mr Smallwood's death that he was experiencing any acute cardiac symptoms, such as chest pain or worsening exertional dyspnoea (shortness of breath).

43. Dr Home noted that there was a 13-minute delay between the initial Code Blue call and the arrival of the emergency crash cart. Dr Home pointed out that a defibrillator is the only treatment proven to restore normal heart rhythm, and it should be administered as quickly as possible. Dr Home opined that although this delay was unlikely to alter the outcome with Mr Smallwood, querying the location of the crash cart at LGCC was appropriate.

44. I subsequently investigated the availability of the crash cart at the inquest. In that regard, I heard evidence from Mr John Roberts, Deputy General Manager of LGCC and Mr Timothy Cheney, Acting Correctional Supervisor at LGCC.

45. Mr Cheney provided evidence that he was rostered on shift when Mr Smallwood passed away. He recalled the timing of the Code Blue, and that the most time effective route for him to attend at the cell, from his office in the gatehouse, was to go through a series of security measures including 4 x security doors, 4 x security gates and 1 x mantrap-hostage device. Master Control was responsible for the control of those gates.

46. Mr Cheney also confirmed the standard operating procedure for the unscheduled opening of a cell at night requires a number of officers and a supervisor to be present before entering a cell to ensure the safety of all officers involved. A copy of that procedure was tendered at the inquest, and confirmed a minimum of two officers were required to be in attendance prior to a cell door being opened. As there were a number of unsecured cells in Mr Smallwood's unit, it was necessary to have more than two officers attend.

47. Mr Cheney recalled that as he made his way to the entrance of the residential compound, registered nurses Hicks and Makoti were about 20 metres behind him. He arrived at the incident shortly before the nurses did. The nurses immediately took over resuscitation efforts, and Mr Cheney dispatched CCOs Ferguson and Spires to retrieve the crash cart from the Detention Unit. The CCOs had gone to the scene from the officers' mess, where they were co-located on the night shift. He explained that the Detention Unit was approximately 300m away with 8 security doors and gates along the route. He considered that it was the closest medical cart to Residential 2 as it was in the adjacent building.

48. Mr Cheney noted that a medical cart was also located in the Medical Centre but no CCOs were rostered to work in that centre on this shift as there were no inmates in the Centre. This meant that CCOs would have to travel to the "key press" to obtain a key for that centre before retrieving a crash cart.

49. At 3:18am, CCOs Ferguson and Spires arrived with the medical cart, but due to the nature, weight and size of the cart it was not considered feasible

to have the cart lifted to the top landing via the stairs to the incident site. The nurses ended up asking for the requisite medical supplies and apparatus to be brought up the stairs for their use, and it was delivered to them as requested.

50. Mr Roberts provided more general information about the layout of the LGCC, the number of medical crash carts at the prison and where those crash carts are located. Mr Roberts' evidence was that the location of crash carts had been negotiated with Queensland Health following difficulties experienced in passing through air locks and security doors during Code Blue incidents in the past. He also confirmed that following Mr Smallwood's death, negotiations were underway with Queensland Health to place a further crash cart in closer proximity to the residential units at LGCC. He said that while Code Blues were a regular occurrence within the prison, the crash cart usually arrives at an incident before the medical staff.

51. Mr Roberts confirmed that it is the responsibility of the correctional officers to obtain the crash cart in the event of a Code Blue. He also provided a copy of the Local Action Plan in place at the LGCC, which confirmed that in the event of a Code Blue, the primary response officers are to attend and collect a medical crash cart from the Detention Unit, the Secure South Store room, or the Medical Centre. The Local Action Plan was tendered at the inquest.

52. Mr Roberts also confirmed that, on this occasion, the medical crash cart was obtained from the Detention Unit at the northern side of the secure centre within the Secure North Precinct. Mr Roberts marked the route taken by CCOs Spires and Ferguson on a map, which was tendered at the inquest. He confirmed the distance the CCOs had to travel was some 400m, a distance which involved 4 x electronic doors and 4 x electronic gates.

53. There was another medical cart located in the Medical Centre, about 336m away and through 4 x doors and 2 x electronic gates. As noted above, although CCO Ferguson was rostered on as the night Medical Observations Officer at the Medical Centre at the relevant time there were no patients in the Centre and he was located in the officers' mess. When CCO Ferguson attended initially to the Code Blue, it was unknown whether the crash cart would be required.

54. Ultimately, I accept the submission of Counsel Assisting that there was little difference between the distance from Residential 2 to the Medical Centre crash cart and the Detention Unit crash cart. I also accept that there is no way of knowing whether a crash cart will be required until an initial assessment of the patient is conducted. I also accept that it was impractical in the circumstances to retrieve the cart from the Medical Centre as the relevant CCOs did not have a key to that centre.

55. I accept the submission of Counsel Assisting that Mr Smallwood was a morbidly obese man who had severe natural disease and, in the opinion of Professor Williams, could have died at any time. The nurses had access to Mr Smallwood's cell within four minutes of Mr Smallwood's complaint over the intercom but he was already unresponsive upon their arrival (aside from some potential movement of his head and mouth). CPR was commenced immediately. Dr Home's opinion in this regard was that the delay was unlikely to have altered the outcome.

56. Overall, I am satisfied that there is no evidence to suggest that earlier use of a defibrillator would have ultimately changed the outcome in this case. There is no evidence that retrieving the crash cart from the Detention Unit, as opposed to the Medical Centre, contributed in any way to Mr Smallwood being unable to be revived.

Conclusions

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

58. I am satisfied that Mr Smallwood was given appropriate medical care while he was in custody at LGCC. His death could not have reasonably been prevented.

59. 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 Smallwood when measured against this benchmark.

Findings required by s. 45

60. 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 evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Gregory Bert Smallwood.

How he died - Mr Smallwood died in his cell at the Lotus Glen Correctional Centre after longstanding ischaemic heart disease and chronic obstructive airways disease.

Place of death – He died at the Lotus Glen Correctional Centre, Chettle Road, Arriga in Queensland.

Date of death – He died on 28 November 2014.

Cause of death – Mr Smallwood died from natural causes, namely coronary atherosclerosis, chronic obstructive airways disease and chronic cholecystitis.

Comments and recommendations

61. 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.

62. In this matter the adequacy of the medical care afforded to Mr Smallwood was examined by Dr Home. Dr Home provided no concerns that any person had contributed to Mr Smallwood's death. He ultimately concluded that the care and treatment provided to Mr Smallwood by LGCC was appropriate.

63. I commend the efforts of QCS and Queensland Health in reviewing the availability of medical crash carts within LGCC to ensure they are in reasonable proximity to all units within the centre.

64. In the circumstances I accept the submission of Counsel Assisting that there are no comments or recommendations to be made that would likely assist in preventing similar deaths in future.

65. I close the inquest.

Terry Ryan
State Coroner
Townsville
28 July 2016