



# OFFICE OF THE STATE CORONER

## FINDINGS OF INQUEST

**CITATION:** **Inquest into the death of  
Thomas Gerard McCart**

**TITLE OF COURT:** Coroner's Court

**JURISDICTION:** Brisbane

**FILE NO(s):** COR 2014/3694

**DELIVERED ON:** 19 January 2016

**DELIVERED AT:** Brisbane

**HEARING DATE(s):** 19 January 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

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## Introduction

1. On 17 September 2014, Thomas Gerard McCart, aged 55 years, was transferred from the Arthur Gorrie Correctional Centre (AGCC) and admitted to the Princess Alexandra Hospital (PAH). He was displaying signs of confusion and declining cognition. Tests were conducted which resulted in the finding of a large right frontal brain tumour. He underwent surgery on 25 September 2014, however, his condition continued to decline.
2. On 1 October 2014, Mr McCart became unresponsive. On the afternoon of 5 October 2014 he was transferred to the secure palliative care unit. He was pronounced deceased later that night at 10:30pm.

## The investigation

3. An investigation into the circumstances leading Mr McCart's death was conducted by Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).
4. Upon being notified of Mr McCart's death, the CSIU attended PAH and AGCC and an investigation ensued. Mr McCart's correctional records and his medical files from AGCC, PAH and also prisons in New South Wales were obtained. The investigation was informed by statements from all relevant custodial officers at AGCC and PAH and a statement from his de facto partner, Joy Boyce. These statements were tendered at the inquest.
5. Specialist forensic pathologist, Dr Rohan Samarasinghe, conducted an external autopsy examination, with associated CT scans and a review of records from the PAH. While there was evidence of therapeutic intervention for the brain tumour, no suspicious findings were noted. Dr Samarasinghe recorded the cause of death as:

*1(a) Renal cell carcinoma (brain metastasis).*

6. At the request of the Office of the State Coroner, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr McCart from the PAH and AGCC 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. As he was in custody when he died an inquest into Mr McCart's death was required by the *Coroners Act 2003*. The inquest was held on 19 January 2016. All of the statements, medical records and material gathered during the investigation was tendered in lieu of any oral testimony and submissions were heard from Counsel Assisting.

## **Circumstances of the death**

9. Thomas Gerard McCart was a 55 year old man. He had been on remand since 8 September 2014, after being arrested for disqualified driving, bringing stolen goods into Queensland and offences relating to fraudulent conduct. Those offences related to Mr McCart's de facto partner, Ms Boyce, who resided in New South Wales. Mr McCart was alleged to have stolen a significant sum of money from Ms Boyce.
10. Mr McCart was being held on remand until his next court date on 16 September 2014 at the Richlands Magistrates Court. He was held at watch houses at Warwick, Toowoomba and Richlands before being transferred to the AGCC on 16 September 2014.
11. Upon his reception to the AGCC, he was medically assessed and noted to be confused and disorientated. It was noted that his mental state had deteriorated somewhat over the previous 24 hours. He was recommended for transfer to the PAH secure unit for further medical examination and assessment.
12. Dr Alex Koefman, Senior Neurological Registrar at the PAH was directly involved in Mr McCart's care. Dr Koefman provided a statement to the inquest, which confirmed that Mr McCart underwent an MRI scan on 17 September 2014, which showed a large right frontal tumour. Preparations were then made for surgery. During the interval leading up to surgery Mr McCart suffered a seizure and was subsequently transferred to the ward.
13. On 25 September 2014, Mr McCart underwent surgery for a right frontal craniotomy and resection of the tumour. The surgery was performed by Dr Koefman, who reported the procedure to be uncomplicated. The goal of the surgery was to get a diagnosis and reduce the mass effect of the tumour. Dr Koefman reported that the majority of the tumour was removed. However, residual tumour was deliberately left along the midline as there was adjacent eloquent brain.<sup>1</sup>
14. Post-operatively, Mr McCart was reported to be well with no neurological deficit. He had a post-operative MRI scan which showed gross resection of the tumour with the small medial residual as expected. He underwent normal post craniotomy convalescence on the ward before being transferred back to the PAH secure unit. His condition, despite the uncomplicated surgery, was still considered to be incurable.
15. The Junior House Officer assisting Dr Koefman, Dr Sarah Emmett, confirmed in her statement to the inquest that Mr McCart suffered a seizure a week after the operation. His condition deteriorated significantly after that. The neurological team, in consultation with the medical oncology, radiation oncology and palliative care teams and under the guidance of the Adult

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<sup>1</sup> Brain areas are defined as being eloquent if injuries to these areas would result in deficits in neurological function.

Guardian, made the decision for palliation. Mr McCart was pronounced deceased at 10:30pm on 5 October 2014.

16. Dr Home's report concluded that Mr McCart had a history of right nephrectomy (kidney removal) in August 2013 for asymptomatic renal cell carcinoma. Dr Home explained that this is the most common primary renal neoplasm with the primary treatment for localised disease being either radical (complete) or partial nephrectomy. At the time of the nephrectomy there was no evidence of disease spread and no tumour recurrence was identified when he had a follow-up CT scan in December 2013.
17. Mr McCart had not sought medical investigation of the recent onset headaches he was experiencing before he was arrested. Dr Home said that at the time of his detention, the brain metastasis was advanced and without treatment he would likely have had only weeks to live. Dr Home identified no issues with Mr McCart's care in the lead up to his death. The outcome would have been the same even if his condition had been identified as soon as he was detained.
18. Mr McCart's death was the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

## **Conclusions**

19. I conclude that Mr McCart died from natural causes. I find that none of the correctional officers or inmates at AGCC or PAH secure unit caused or contributed to his death. I am satisfied that Mr McCart was given appropriate medical care by staff at the AGCC and PAH while he was in custody. His death could not have reasonably been prevented.
20. There is no evidence in the records obtained from either Queensland or New South Wales to suggest Mr McCart was suffering from a brain tumour or that he had sought treatment for any symptoms.
21. It is a 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 McCart when measured against this benchmark.

## **Findings required by s. 45**

22. 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. After considering all of the evidence I am able to make the following findings:

**Identity of the deceased** – The deceased person was Thomas Gerard McCart.

<b>How he died -</b>	Mr McCart died at the Princess Alexandra Hospital after he was diagnosed with an incurable renal cell carcinoma that had metastasised to his brain.
<b>Place of death –</b>	He died at the Princess Alexandra Hospital, Ipswich Rd, Woolloongabba Queensland.
<b>Date of death –</b>	He died on 5 October 2014.
<b>Cause of death –</b>	Mr McCart died from natural causes, namely renal cell carcinoma (brain metastasis).

### **Comments and recommendations**

23. The *Coroners Act 2003* enables a coroner to 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 the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan  
State Coroner  
Brisbane  
19 January 2016