QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Victor Bertram Vince COURTNEY**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2013/3939
DELIVERED ON:	17 December 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	1 December 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
West Moreton Hospital and Health Service:	Ms Holly Ahern
Department of Justice and Attorney-General (Queensland Corrective Services):	Ms Ulrike Fortescue

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The *Coroners Act 2003* provides in ss. 45 and 47 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 Victor Courtney. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Victor Courtney had been imprisoned for 18 years when, in late 2012, he was diagnosed with lung cancer. After a year of palliative care his condition deteriorated suddenly and he died after being taken to hospital on 2 November 2013. A transfer to the Townsville Correctional Centre had been approved but not implemented at the time of his death.

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 that responsibility;
- examine the adequacy with which applications for transfer and compassionate parole were progressed by Queensland Corrective Services (QCS) staff; 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 Courtney was conducted by Detective Senior Constable Steven Peake from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The report of DSC Peake was tendered at the inquest.

Two officers from CSIU attended the Princess Alexandra Hospital (PAH) soon after being advised of Mr Courtney's death. They arranged for photographs to be taken of his body in the radiography department at the hospital, where his death occurred.

The officers interviewed Dr Robert Giles who told them that Mr Courtney had died from the effects of metastatic lung cancer and, in his view, there were no suspicious circumstances.

CSIU officers obtained statements and records from relevant staff members at PAH. They took possession of all relevant documentation relating to Mr Courtney from Wolston Correctional Centre (WCC) where he had been imprisoned. An interview was conducted with Shane White, a fellow prisoner, who had been assigned as Mr Courtney's carer.

On receipt of the large volume of medical records my Office commissioned a report addressing the adequacy of the care provided to Mr Courtney. This was prepared by Dr Nelle van Buuren of the Clinical Forensic Medicine Unit, Queensland Health. The conclusions of her report are set out later in these findings.

At the request of counsel assisting I issued a direction to QCS to identify the steps taken to progress applications made by Mr Courtney (or members of his family) for a transfer to Townsville and for exceptional circumstances parole.

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 1 December 2014. All statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from the investigating police officer, Detective Senior Constable Steven Peake. Members of Mr Courtney's family were told about the details of the inquest.

I am satisfied that all the material required to make the necessary findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

Victor Bertram Vince Courtney was born in Townsville on 4 April 1969. He was aged 44 years at the time of his death. He had a lengthy criminal history from the age of 14. This involved several periods of imprisonment before his 1995 conviction for murder which resulted in his being sentenced to life imprisonment. He became eligible for parole in January 2006.

Mr Courtney commenced his 1995 sentence in south-east Queensland as a mainstream prisoner. This included periods at the John Oxley Memorial Hospital at Wacol where his psychiatric condition was treated.

In 1996 Mr Courtney was transferred to the Townsville Correctional Centre. However, as he continued to receive treatment at the John Oxley Memorial Hospital he was subsequently returned to south-east Queensland.

He was placed at WCC on 23 December 2009 from Borallan Correctional Centre. At the time of his death Mr Courtney was accommodated in a unit that catered for vulnerable prisoners among the general population. Medical ailments together with his psychiatric condition had significantly limited his general functioning.

Mr Courtney's medical records show that he received frequent medical care for psychiatric and physical conditions, particularly over the last four years of his life. This included in-patient treatment at The Park Centre for Mental Health (The Park) in 2009 and 2013 and transfers on 10 occasions to PAH from September 2010 until his death in November 2013.

Mr Courtney was survived by his sister and mother, among other family members. He maintained a regular telephone contact with his mother while in prison. His family had taken steps to assist in his applications for transfer and parole and would clearly have been saddened by his diagnosis of cancer and subsequent death. I offer them my sincere condolences.

Diagnosis of Cancer and Treatment

In the latter years of his life Mr Courtney suffered from various chronic conditions including cardiovascular disease, atrial fibrillation, hypertension, hyperlipidaemia, hyponatraemia, congestive heart failure, type 2 diabetes, chronic obstructive pulmonary disease, asthma and schizoaffective disorder. Despite his illness, he continued to smoke cigarettes until just before his death.

On 3 November 2011 Mr Courtney was admitted to PAH with a 3 day history of coughing up blood and increasing shortness of breath. Chest x-rays at that time and over the following months showed, in the words of Dr van Buuren, a "*…persistent but variable amount of opification in the right lower lobe (of his lungs)."*

A July 2012 chest x-ray was reported as normal (though on review later in the year it was also considered to show some opification). Mr Courtney was appropriately scheduled for a further chest x-ray in October 2012 but refused to attend. He again refused to attend when a further appointment was made for him later that month.

On 3 November 2012 Mr Courtney was admitted to hospital due to symptomology of his chronic conditions. A chest x-ray was conducted. It indicated a right lower lobe consolidation. A CT scan of his chest and a bronchoscopy confirmed that Mr Courtney had a squamous cell carcinoma which had spread to the lymph nodes. He was advised that the cancer was unlikely to be "curative".

Mr Courtney refused a follow up appointment and later indicated he would only consider treatment if he received parole. A conference was held on 29 November 2012 at PAH to discuss the management of Mr Courtney's lung cancer.

It was determined that further staging investigations had not been possible due to a refusal by Mr Courtney to attend PET scan appointments. The inability to stage the cancer (a pre-requisite for treatment) was attributed to Mr Courtney's "*severe psychiatric disease*". It was also considered that this would "*preclude treatment*".

The concerns relating to Mr Courtney's capacity to give instructions in relation to his treatment ultimately led to the appointment of the Adult Guardian as guardian for Mr Courtney's health care. Mr Terry Hill was appointed as the Adult Guardian's delegate. Mr Hill obtained further information from Mr Courtney's treating doctor at WCC, Dr Hayman from the Inala Indigenous Health Service, and a palliative care consultant, Dr Deuble.

Both doctors considered that Mr Courtney understood his diagnosis of cancer and the nature and effect of refusing treatment, and was competent to make decisions regarding ongoing care and matters such as resuscitation measures. This later formed the basis for a "not for resuscitation" order being put in place via an Acute Resuscitation Plan dated 14 June 2013.

In April 2013, Mr Courtney had increasingly refused to take his anti-psychotic medication and this led to behaviour described as "*elevated and floridly psychotic with prominent grandiose and persecutory delusions and thought disorder."*

Mr Courtney was admitted to The Park from 23 April 2013 until early July 2013. He reportedly responded well to treatment; in particular the more regular taking of his prescribed medication. It was late in this period of treatment that Mr Courtney signed his Acute Resuscitation Plan. After discharge from The Park, Mr Courtney continued to receive palliative care at WCC.

Events leading to death

In August 2013 Mr Courtney applied to the Queensland Parole Board for exceptional circumstances parole. A prisoner may apply for an exceptional circumstances parole order at any time under s176 of the *Corrective Services Act 2006*.

A Parole Board Report was compiled and the application was considered by the Board in early October 2013. On 11 October 2013, the Board asked that QCS facilitate the provision of further medical information. It had indicated that the parole request would only be considered if Mr Courtney was guaranteed release into a palliative care facility in Townsville. At the time of Mr Courtney's death the application had not been reconsidered by the Board.

In September 2013, an informal application had had also been made for Mr Courtney to be transferred to Townsville. Prisoners can be transferred for a range of reasons including medical requirements and advanced care placements.

The basis of the application by members of Mr Courtney's family was that the transfer would allow him to be closer to his aged mother and other family members.

A statement obtained from Mr Peter Shaddock, General Manager, Operational Service Delivery in QCS, noted that at the time of Mr Courtney's death the policy that applied to transfers between prisons was entitled "Procedure – Transfer of Prisoners". This policy has subsequently been replaced by the Custodial Operations Practice Directive – "Interregional Transfer Process".

Mr Shaddock stated that each Correctional Centre has attached to it a Sentence Management Services Unit which deals with transfer requests. The transferring Correctional Centre has primary responsibility for the process and coordinates negotiations between centres, health staff, specialist counsellors and cultural liaison officers

The merits of the application were properly advocated by Charlene Gordon, a Senior Indigenous Mental Health Worker based at The Park. She met QCS staff on 24 September 2013. Evidence tendered at the inquest shows that steps were commenced the following day to investigate whether Mr Courtney could be accommodated in Townsville.

The transfer request appears to have received fresh impetus following letters from Dr Hayman and from Mr Courtney's treating psychiatrist, Dr Tie on 23 October 2013. By this time the Prisoners' Legal Service was also advocating for Mr Courtney, noting that section 4 of the *Corrective Service Regulation* requires an indigenous person to be accommodated as close as possible to the prisoner's family, unless the prisoner does not want to be accommodated at that location.

Doctors Hayman and Tie strongly recommended a transfer to Townsville and offered the opinion that Mr Courtney's complex physical and psychiatric conditions could be catered for there.

The material before the General Manager of the Townsville Correctional Centre on 31 October 2013 indicated that Mr Courtney had less than a month to live. The General Manager indicated that he was not comfortable about accepting Mr Courtney "but would do so if required".

On 1 November 2013, eight days after receipt of these letters, the transfer to Townsville had been approved and steps taken to arrange transport. It does not seem Mr Courtney was notified that day and, due to the events of the following day, it is not clear that he was ever notified of the decision.

Mr White, a fellow prisoner who was assigned to care for Mr Courtney, told investigators that during October 2013, Mr Courtney had become increasingly unsteady on his feet. On the morning of 2 November 2012, Mr Courtney had an unobserved fall which resulted in a laceration to his forehead. Mr White took him to the medical centre where the laceration was treated by a nurse.

Although he initially appeared to have avoided any other effects, after around 15 minutes Mr Courtney refused to take his prescribed morphine and then developed slurred speech. He was transported to PAH and assessed in the Accident and Emergency Department at 1:40pm. Mr Courtney was sent for a chest x-ray and, while waiting in the x-ray department at 5:30pm his condition deteriorated suddenly with increasing respiratory distress. He died at 5:44pm.

Medical Review

Dr Nelle van Buuren examined the extensive medical documentation relating to Mr Courtney and submitted a report which was tendered at the inquest.

Dr van Buuren considered the overall response by health care providers at WCC in relation to Mr Courtney's many chronic health problems and found that he was "…*provided with medications, investigations and appropriate specialist consultations commensurate with a non-custodial environment*".

Dr van Buuren noted that at times appropriate medical care was not possible due to Mr Courtney's refusal to engage. She stated that, "…*this was manifested as refusal to attend planned specialist appointments and investigations, self-discharging from hospital against medical advice and refusing to take prescribed medications particularly anti-psychotics*."

In her report Dr Van Buuren considered the difficulty faced by practitioners in assessing Mr Courtney's competence to make decisions and ultimately concluded that:

> "*The WCC and the PAH appropriately provided and coordinated management of Mr Courtney's chronic medical problems including his lung cancer.*
>
> *The medical practitioners involved in his care were respectful of his decision to refuse treatment and resuscitation, but more importantly they considered and ensured his competence to make those decisions."*

Dr van Buuren noted that Mr Courtney had undergone six chest x-rays from late 2011 to July 2012. The radiological reports identified that during the course of these x-rays there had been progression in "*middle lobe collapse/consolidation (air space opification)…."* In the view of Dr van Buuren it was not then evident that these changes could be attributed to carcinoma, though that possibility could not be excluded. It is clear for this reason that further x-rays were necessary.

As noted above, arrangements were made for Mr Courtney to receive further x-rays in October 2012 but he refused to attend the appointment on both occasions. Although it was not until his return to hospital in November 2012 that the diagnosis of cancer was confirmed I am satisfied that adequate steps were taken for follow up examination. It is almost certain that the minor delay

caused by Mr Courtney refusing to attend the October 2012 appointments made no difference to the outcome.

Autopsy results

An external autopsy examination was carried out on 5 November 2013 by an experienced forensic pathologist, Dr Alex Olumbe.

A CT Scan was conducted on the body and samples of blood were taken. Dr Olumbe examined Mr Courtney's medical records before submitting his autopsy report to my Office.

The CT scan revealed multiple indications of the advanced carcinoma which had been diagnosed before Mr Courtney's death. It showed extensive consolidation of the lungs with multiple nodules in the left and right lung, and cavitation in the right lower lobe. The abdomen contained extensive metastatic nodules in the liver.

Dr Olumbe noted that Mr Courtney's condition had progressed rapidly "*…with a distant metastasis into the liver, hence poor prognosis"*.

Dr Olumbe issued a certificate listing the cause of death as:

> *1(a) End stage non-small cell lung carcinoma.*
>
> Other significant conditions:
>
> 2. *Chronic obstructive pulmonary disease, atrial fibrillation.*

Conclusions

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

I am also satisfied that the medical care provided to Mr Courtney at WCC and PAH prior to his death was adequate and appropriate.

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 Victor Bertram Vince Courtney.

How he died - Mr Courtney died from the effects of lung cancer which had spread to his liver. This occurred while he was incarcerated at

Wolston Correctional Centre and being treated for his illness there and at the Princess Alexandra Hospital.

Place of death – He died at the Princess Alexandra Hospital, Buranda in Queensland.

Date of death – He died on 2 November 2013.

Cause of death – Mr Courtney died from end stage non-small cell lung carcinoma.

Comments and recommendations

Section 46 of the *Coroners Act 2003*, 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.

I have outlined the interactions between Mr Courtney, his family, QCS and Queensland Health staff relating to requests that he be transferred to Townsville. This was against a background of Mr Courtney having applied for an exceptional circumstances parole order.

It is clear that the transfer request was ultimately approved, albeit reluctantly on the part of the General Manager of Townsville Correctional Centre, on 1 November 2013. Arrangements for the transfer were being made at that time.

I find that the transfer request was given appropriate consideration under the policies in place at the time and was treated with sufficient urgency, given the issues involved in responding to Mr Courtney's complex physical and mental health needs at the Townsville Correctional Centre.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
17 December 2014