OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of a prisoner**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1811/06(1)
DELIVERED ON:	5 November 2008
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 November 2008
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Inquest – death in custody, natural causes

REPRESENTATION:

Ms Eryn Voevodin	Counsel Assisting
Ms Annie Little	Department of Corrective Services

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The *Coroners Act 2003* (the Act) provides in s45 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 specified officials with responsibility for the justice system. These are my findings in relation to the death of a prisoner. 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

The prisoner was 85 years of age, when he was found dead in his bed at the Princess Alexandra Hospital Secure Unit on 22 June 2006.

These findings

- confirm the identity of the deceased, 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 needs 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 pubic health and safety or the administration of justice.

The Inquest

An inquest was held in Brisbane on 4 November 2008. Eryn Voevodin was appointed to assist me. Leave to appear was granted to the Department of Corrective Services.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigation material suggested that this is a death in custody from natural causes. I determined that the evidence contained in this material was sufficient to enable me to make the findings required by the Act. Counsel Assisting submitted there was no forensic purpose to be served by calling any witnesses to give oral evidence.

One of the prisoners sons were advised of the date of the inquest and the submissions Ms Voevodin intended to make concerning the calling of witnesses. He indicated that he did not wish to attend nor make submissions

in relation to that issue or any other matters. He also advised that he had discussed these proceedings with other family members and none of them was of a different view. Accordingly I accepted Ms Voevodin's submissions and no oral evidence was called.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Background

The prisoner was born on 20 September 1920. He was aged 85 years at the time of his death.

He had 7 children. The relevant factors in relation to the deceased's background can be summarised by review of the judgements of the Court of Appeal and the Supreme Court of Queensland.[1]

Custody

In 1996 the prisoner had returned to Australia from Thailand where he had been living for a number of years teaching at a school for deaf children. During police interviews he admitted that he had frequently gone to Thailand for the purposes of engaging in sexual activity with children and also admitted that in 1993 he had been so diagnosed HIV positive.

On 1 May 1997, when he was 76, the prisoner was sentenced to 9 years imprisonment in respect of sexual offences against children.

On 16 August 2005, he was made subject to an indefinite detention order pursuant to s.13 (5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act 2003.*

The prisoner served his sentence at the Arthur Gorrie Correctional Centre. His corrective services record indicates that he had no breaches or self harm history, but he was listed as having multiple health problems.

Medical issues

As mentioned earlier, the prisoner had been diagnosed as HIV positive since 1993. He was known to the nursing staff of PAH secure unit having been admitted on 26 occasions since the commencement of his incarceration on 30 May 1996.

He was admitted to the PAH Secure unit on 5 June 2006 from Arthur Gorrie Correctional Centre. In the 5 days prior to his admission, he had sustained multiple falls and was complaining of back pain and decreased mobility.

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[1] See Supreme Court of Qld, Court of Appeal, Pincus JA, Shepherdson and White JJ CA No 212 of 1997, 8 August 1997 and Order made by Atkinson J, Supreme Court (Qld) 16 August 2005.

On admission, x-rays performed on the lumbar spine and pelvis showed no evidence of fracture and a CT scan showed age consistent atrophic changes and no infective process of the brain to explain the patient's symptoms.

His haematology and biochemistry were unremarkable.

The prisoner was continued on his anti retroviral medication and physiotherapy was commenced to assist with mobility.

Dr Stuart McDonald (medical director, PAH secure unit) states in his report:

> "*Because of the prisoners age and frailty he was unable to mobilise independently and over the period of his admission he gradually deteriorated to the stage where he became immobile, unresponsive and unable to tolerate oral food, fluids or medication. He was reviewed by the Infectious Diseases Registrar who agreed that a palliative approach to his treatment would be appropriate.*
>
> *The palliative care team reviewed the prisoner on 19.06.06 and noted that he was uncomfortable when turned and they recommended a low dose of Fentanyl subcutaneous infusion by a Grasby pump to improve his comfort.*
>
> *The prisoner continued to deteriorate and at 2140 hours on 22.06.06 he was pronounced dead."*

The death is discovered

At 2020 hours on 22 June 2006, a nurse checked on the prisoner in his room and he was still breathing. However at 2035 hours when she returned to his room on a routine check the prisoners breathing had stopped. Doctors were called to attend. The prisoner was housed in room 7 of the inpatient ward of the PAH secure unit. At the time of his death there were 5 inpatient prisoners., inclusive of the deceased.

At about 2100hours on 22 June 2006, detectives from Corrective Services Investigation unit (CSIU) received a phone call from the operations support manager stating that he had been contacted by PAH secure unit nursing staff and advised that the prisoner had passed away.

A doctor subsequently attended and the prisoner was pronounced life extinct at 2140 hours. The attending doctor advised that there was no suspicious circumstances surrounding the death as according to his medical file he has been admitted to palliative care on 19 June 2006. The death was not unexpected.

The prisoners body was then transferred to the morgue and the scene secured.

CSIU Detectives attended and conducted visual observations indicating no clearly identifiable signs of trauma. Reports were obtained from staff on duty and digital footage of the prisoners room covering the period upto and including the time of death was seized.

The prisoner was formally identified to the police by nursing staff from the PAH secure unit. Further, comparative analysis of a thumbprint confirmed his identity.

Autopsy results

An external autopsy was conducted on 24 June 2006 by Forensic Pathologist, Dr A Ansford.

Based on a review of the PAH medical records, the pathologist determined that he was receiving appropriate prophylactic treatment for his HIV infection. In relation to his recent falling, it was said that appropriate investigations were conducted to exclude intracranial trauma as a possible cause of his deteriorating mental state. He had electrocardiograph evidence of ischaemic heart disease and previous heart attacks.

His final admission was for palliative care only and it was noted there was a "not for resuscitation" entry in his medical records.

The autopsy examination revealed an extremely thin and wasted elderly male (height 180cm, weight 40 kgs) without signs of significant trauma.

In his report the pathologist said:

> *"Taking into account his medical history and his recent steady deterioration in the presence of long term HIV infection in the absence of trauma, I formed the opinion that death was due to extensive weight loss and general deterioration most likely as a result of his HIV infection. His ischaemic heart disease in the form of coronary atherosclerosis may well have contributed."*

Conclusions

I find that Corrective Services staff followed all applicable "death in custody" protocols.

The investigation, coupled with the autopsy, revealed that the prisoner passed away from natural causes with no suspicious circumstances, while receiving inpatient palliative care at the PAH secure unit.

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. I have already dealt with this last aspect of the matter, the manner of the death. As a

result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was a prisoner

Place of death – He died whilst in the custody of the Department of Corrective Services at the Princess Alexandra Hospital Secure Unit at Woolloongabba in Queensland.

Date of death – He died on 22 June 2006.

Cause of death – He died from natural causes namely cachexia due to esophagitis due to HIV infection.

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.

I find that none of the correctional officers or inmates at PAH secure unit caused or contributed to the death and that, under the circumstances, nothing could have been done to save the prisoner, who has passed away expectedly from natural causes. I also find that the prisoner received all appropriate medical treatment while he was in custody.

In those circumstances there is no basis on which I could make any preventative recommendations.

Non publication order

I am concerned that none of the prisoners family should suffer any embarrassment or humiliation on account of the offences he had committed and/or the cause of his death.

Therefore, pursuant to s41(1) of the Act I prohibit the publication of the deceased person's name in any context that would enable him to be identified as the person whose death was the subject of this inquest.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
5 November 2008