OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Lawrence Edward JEFFREY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2638/08(8)
DELIVERED ON:	19 May 2010
DELIVERED AT:	Cairns
HEARING DATE(s):	30 April 2010 & 18 May 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Melinda Zerner

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The *Coroners Act 2003* 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 officials with responsibility for the justice system. These are my findings in relation to the death of Lawrence Edward Jeffrey. 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

After three weeks in hospital Lawrence Edward Jeffrey succumbed to the effects of a large cancerous mass in his right lung on 11 May 2008. He was 63 years of age and had spent the last four and a half years of his life as an inmate at Lotus Glen Correctional Centre (LGCC). During that time he was treated for various chronic medical conditions, though his terminal condition was not diagnosed until shortly before he died.

These findings

- confirm the identity of the deceased, the time, place and medical cause of his death and describe how he died;

- examine the adequacy of the medical treatment provided to the deceased in the months leading up to his transfer to Mareeba Hospital on 20 April 2008; and

- consider whether any changes to procedures or practice at LGCC 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

When Mr Jeffrey died on the evening of 11 May 2008 police at Mareeba station were notified and immediately attended at the hospital. The officer in charge of the Corrective Services Investigation Unit (CSIU) was also notified shortly after the death and assigned Detective Senior Constable Neil Hansen to conduct the coronial investigation.

DSC Hansen seized medical records from Mareeba, Cairns and Townsville Hospitals along with all records pertaining to Mr Jeffrey held at LGCC. He took statements from Mr Jeffrey's next of kin, relevant Corrective Service Officers and treating doctors.

DSC Hansen took a detailed statement from the LGCC acting health service co-ordinator which allowed him to set out a detailed history of Mr Jeffrey's most recent health complaints.

The post-mortem examination of the body of Mr Jeffrey was video-taped and a copy of that recording provided to DSC Hansen.

At the conclusion of his investigation DSC Hansen formed the view that there was no evidence to conclude that any other person had caused or contributed to the medical deterioration of Mr Jeffrey. Insofar as he was able to do so, drawing on the medical evidence collated, he concluded that the standard of medical care afforded to Mr Jeffrey prior to his death was acceptable.

I find that the investigation into this matter was professionally conducted and I thank DSC Hansen for his efforts.

The Inquest

In accordance with the requirement set out in the Act, an inquest was held into the death of Mr Jeffrey. The inquest was held in Cairns on 18 May 2010 during which the investigating officer and an expert medical witness, Dr Don Buchanan, were called as witnesses.

All of the statements, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Counsel assisting submitted that I was unlikely to be assisted by the calling of any further oral evidence.

I determined that the evidence contained in the material tendered and the further evidence provided by way of oral evidence was sufficient to enable me to make the findings required by the Act. I am satisfied that the scope of this evidence was sufficient for me to adequately address those matters which might be appropriately considered under s. 46 of the Act.

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.

Personal and custodial history

Lawrence Edward Jeffrey was born on 20 August 1944. Up until health problems intervened he had spent the majority of his life in gainful employment. This included time working in limestone quarries which, it would appear, left a legacy of lung disease in the form of silicosis. He was married and prior to his divorce in 1982 fathered seven children.

In May 2002 Mr Jeffrey was charged with a number of serious sexual offences. The complainant was his youngest daughter who alleged the offences took place over more than a decade spanning 1972 to 1983. It appears that Mr Jeffrey was remanded in custody at the first mention of these matters and was received at LGCC on 31 May 2002. Four days later he was granted bail and he did not return to custody until 12 December 2003. On that date he was sentenced after being found guilty of, inter alia, three counts of incest. He was sentenced to 14 years imprisonment for the most serious of these counts.

It is clear Mr Jeffrey was suffering from a number of chronic medical conditions by the time of his sentencing in 2003. The effect these were likely to have on his ability to endure imprisonment were considered and taken into account by the sentencing judge. He was given a parole eligibility date of 6 December 2010.

After his imprisonment Mr Jeffrey continued to receive support from his niece Jennifer Hardey, with whom he had developed a close relationship over many years, and her adult son Luke Hardey. Ms Hardey kept in contact with Mr Jeffrey on a daily basis; she was, and remains, very much saddened by his passing.

Medical history

A reception medical history of Mr Jeffrey taken at LGCC on 31 May 2002 includes a lengthy list of chronic conditions. The then 57 year old Mr Jeffrey suffered from a history of allergies, asthma, a history of chest pain, gastric reflux, silicosis and more generally described eye, ear and respiratory problems. He was a long term smoker (and remained so up until his death).

On his return to LGCC in December 2003 Mr Jeffrey's condition and medication was again assessed. Over the course of the following 4 years he received treatment for the conditions set out above as well as sciatic back pain and chronic obstructive airway disease. Mr Jeffrey was prescribed and adhered to a medication regime consisting of Frusemide, Mirtazipine and Tramadol. He received Bricanyl, Ventolin and Seretide multiple times daily via a puffer.

The LGCC medical records for Mr Jeffrey suggest he was not a particularly frequent visitor to the medical centre despite his medical conditions. In February 2008 Mr Jeffrey requested a letter from the VMO setting out his health status as part of an application for "exceptional circumstances" parole he had lodged several weeks earlier. A letter was provided by Dr Temba Dhobha which set out the more serious of Mr Jeffrey's chronic health problems. Dr Dhobha stated that Mr Jeffrey's lung conditions "*whilst stable for now are expected to get worse over the next five years*".

In a draft report dated 4 April 2008 (based in part on an interview with Mr Jeffrey on 19 March 2008) a panel of LGCC officers recommended to the Parole Board that Mr Jeffrey's application for "exceptional circumstances" parole be refused. The panel stated, while noting Mr Jeffrey's condition was expected to deteriorate over the following five years, that it was satisfied his "*health issues and needs were being managed appropriately and within procedural guidelines*".

The panel made particular note of Mr Jeffrey's plans to move to the residence of his niece, Ms Hardey, at Innot Hot Springs should he be released. In that location he would have been isolated from more well resourced medical facilities. When the extreme seriousness of Mr Jeffrey's condition became

evident in early May 2008, the General Manager of LGCC wrote to the Parole Board updating them on his status.

Deterioration of health

On 4 March 2008 Mr Jeffrey attended the medical centre at LGCC complaining of a right lower side chest wheeze and pain, along with a burning sensation, in his right shoulder and back.

No earlier presentation to the medical centre obviously points to (even in hindsight) symptoms related to what we now know was his extensive lung cancer, rather than to his other chronic conditions. On 23 February 2008 Mr Jeffrey had attended the medical centre for Seretide and Ventolin nebulisers. Two days later on 25 February 2008 he attended in relation to diet problems which had been an ongoing matter of concern to him throughout his time in custody.

When he appeared at the medical centre on 4 March 2008, and on presentation over the following weeks, the symptoms complained of by Mr Jeffrey were consistent with his then known chronic conditions, although it is now apparent that they resulted primarily from an undiagnosed metastatic carcinoma of the lung. A call to the VMO resulted in an increase in Mr Jeffrey's Tramadol prescription and by 9 March he reported to nursing staff (who enquired of him on medication rounds) that the pain had reduced. Mr Jeffrey's progress medical notes record a consultation with the VMO on 10 March 2008. The meeting was for the purpose of assessment for the report being prepared in relation to the application for parole. No notation is made in relation to the complaints of 4 March 2008 or similar.

On 13 March Mr Jeffrey presented at the medical centre complaining of a chest infection. He had in fact made a request to see the VMO on a medical request form filled out two days earlier. It is not apparent why he was seen by a nurse instead. It appeared to the nurse on duty that he had congestion in his chest and this was reported by telephone to the VMO. A course of anti-biotics was commenced immediately.

On 17 and 18 March, when seen by medical staff at LGCC, Mr Jeffrey remained unwell. Some weight loss was noted, he was observed to be short of breath on exertion and complained of pain in his right side when coughing. Similar symptoms were noted on 23 March and a Ventolin nebuliser administered. On that day Mr Jeffrey filed a medical request form to see the VMO citing as his reason "*I think my antibiotics ran out to (sic) quick. The chest pain is getting bad again*". This in fact is the only reference to the antibiotics having been administered as they are not noted in Mr Jeffrey's medical chart.

On 24 March 2008 the VMO was called by telephone and ordered that a sputum sample be obtained for bacteriological analysis with a view to then commencing antibiotics. This telephone consultation appears to have been sufficient to satisfy staff at LGCC that Mr Jeffrey's request from a day earlier had been adequately addressed. Mr Jeffrey was provided with a collection

container for a sputum specimen although there is no material on his file indicating that any sample was collected or analysed.

On 6 April Mr Jeffrey again presented to the medical centre with similar symptoms although this time specifically complaining of a build up of yellow phlegm. He was prescribed 2 different oral antibiotics by the VMO and commenced taking these on 8 April 2008.

On 19 April Mr Jeffrey was taken to the medical centre after suffering shortness of breath. An audible wheeze was noted and he was treated with a Ventolin nebuliser. Mr Jeffrey reported feeling better shortly after the nebuliser was given and he returned to his block.

Late the following morning Mr Jeffrey presented at the medical centre with chest pain. He was wheel-chair bound and clearly suffering from respiratory distress. Assessment of his vital signs led staff to call for an ambulance and Mr Jeffrey was transported to Mareeba Hospital.

In her statement to police Ms Hardey complained that Mr Jeffrey's requests to see the VMO were not being adequately addressed by prison staff. Certainly this seems to be supported insofar as the evidence shows the request of 23 March 2008 received no follow up beyond the telephone consultation of the following day.

Hospital treatment

A chest x-ray conducted shortly after arrival at Mareeba Hospital showed an almost complete white out of the right lung. Mr Jeffrey was given intravenous antibiotics, oxygen and regular nebulised Ventolin.

He was transferred to Cairns Base Hospital on 24 April 2008 where another x-ray indicated right sided pneumonia with a mass in the right upper lobe. The mass was associated with pleural effusion and probable superior vena cava (SVC) obstruction. The mass was considered to be cancer as a result of clinical analysis; however, a CT guided needle biopsy was unable to be conducted due to Mr Jeffrey being unable to lie flat without becoming dangerously short of breath. He was treated empirically for pneumonia and transferred to Townsville Hospital for palliative radio therapy.

It had been hoped that radio therapy may alleviate the SVC blockage. However, Mr Jeffrey's condition failed to improve and he refused an offer of palliative chemotherapy. On his request he was transferred back to Mareeba Hospital on 9 May 2008.

A not for resuscitation order was in place and was followed by medical staff at Mareeba Hospital when, on the evening of 11 May 2008, Mr Jeffrey ceased breathing. He was declared deceased by Dr Marcella Seve at 7:05pm.

A report from Dr Phillip Marshall, Staff Physician at Cairns Base Hospital concluded:

“Although a histological diagnosis was never made, the clinical diagnosis was advanced lung cancer, most probably non small cell lung cancer. Given its advanced stage and his poor performance status, the prognosis would have been very grim irrespective of where this gentleman was staying”.

Autopsy results

An external and partial internal autopsy examination was performed on 13 May 2008 by an experienced forensic pathologist, Dr Paul Botterill in the mortuary at Cairns Base Hospital.

He later examined toxicology and histological findings before preparing a detailed report. The toxicology results were consistent with the palliative care being provided to the deceased shortly prior to his death. Histological analysis of the lungs revealed an appearance “consistent with a large cell undifferentiated carcinoma of the lung”.

Dr Botterill examined the chest cavity of the deceased and concluded that it:-

“*…showed extensive cancer involving the right lung and chest wall, squashing and blocking the blood vessels at the top of the heart, with spread around the heart, to the chest lymph nodes and left lung. In addition, honeycomb-like scarring of the remaining lung tissue, an excess of fluid in the lungs, hardening and narrowing of the arteries of the heart and heart muscle scarring consistent with past heart attack were noted.”*

He issued an autopsy certificate listing the cause of death as Metastatic Carcinoma of the lung while noting coronary artery atheroma as a significant underlying condition.

Expert Evidence on custodial medical care

Dr Don Buchanan is an experienced medical practitioner currently attached to the Queensland Health Clinical Forensic Medicine Unit. He examined the police report, custodial medical file and hospital records of the deceased before giving evidence at the inquest.

Dr Buchanan was able to confirm that, by the time he presented to the LGCC medical centre in early March 2008, Mr Jeffrey’s condition was likely to have already been so advanced that it was beyond effective medical treatment. His expertise was sought primarily in relation to the treatment provided to Mr Jeffrey by nurses and VMO’s at LGCC in March and April 2008. Dr Buchanan expressed the view that the medical treatment provided to Mr Jeffrey up until 23 March 2008 at LGCC was adequate and appropriate when considered in the context of his existing chronic health conditions. The only proviso to this being an apparent failure to note the first course of antibiotics in Mr Jeffrey’s medical chart (although I am satisfied he received them).

Dr Buchanan was critical of the failure to facilitate a face to face consultation with a VMO after Mr Jeffrey requested to see a doctor on 23 March 2008. It

would have been reasonable at this time given the relapse of symptoms, he said, for Mr Jeffrey to be examined by a VMO rather than a VMO merely being consulted by telephone. Dr Buchanan expressed the view that even if this had not taken place, a chest x-ray should have been ordered in addition to the sputum test when the VMO was contacted on 24 March 2008.

Even when Mr Jeffrey did see a VMO on 7 April 2008 and two courses of antibiotics were prescribed, no follow up appears to have been conducted. Dr Buchanan took the view that, in light of the fact there had been a relapse after the first course, such re-examination would have been prudent in order to determine whether further investigations were required.

It is to this extent that Dr Buchanan offered the view that the treatment afforded to Mr Jeffrey after 23 March 2008 was not optimal, while acknowledging an extremely limited nexus with the ultimate outcome.

Conclusions

I conclude that Mr Jeffrey died as a result of natural causes and that no third party played any part in that.

Generally, the health care provided to him while he was in custody at the LGCC was adequate. There were however some lapses in the months before he died. I consider Mr Jeffrey should have been examined by a doctor on or about 23 March 2008 or, at least, that an x-ray should have been ordered. I am satisfied that had that occurred it is likely Mr Jeffrey's fatal condition would have been discovered some weeks earlier than it was. I accept that would have made no difference to the outcome. The aggressive cancer which killed him was by that stage almost certainly already well advanced.

I am satisfied that the medical care provided to the deceased by Mareeba, Cairns and Townsville Hospitals was of a high standard given the limited treatment options available.

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 Lawrence Edward Jeffrey

How he died – Mr Jeffrey was transferred from Lotus Glen Correctional Centre to Mareeba Hospital on 20 April 2008 following deterioration of his already poor state of health. After a transfer to Cairns Base Hospital he was diagnosed as suffering from inoperable and untreatable lung cancer. Subsequent palliative radium therapy was

ineffective and he was returned, at his request, to Mareeba Hospital for further palliative care until his death.

Place of death – He died whilst in the custody of the Department of Corrective Services at the Mareeba Hospital in Queensland.

Date of death – He died on 11 May 2008.

Cause of death – He died as a result of metastatic carcinoma of the lung.

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.

For the reasons I have already detailed I have concluded that Mr Jeffrey's death was not caused or contributed to by the actions or omissions of any other person. It is likely that he died from the effects of long term smoking and/or occupational exposure to carcinogens while working in cement quarries as a younger man. It is not necessary that I make a specific finding in that regard.

I am satisfied that insofar as there was some failing on the part of the then Department of Corrective Services to provide adequate health care for Mr Jeffrey in March and April 2008, that it did not cause or contribute to his death.

On 1 July 2008 Queensland Health became the responsible entity for the provision of health care services to prisoners. In the course of investigating numerous deaths in custody I have been provided with evidence relating to the changes to policy and practice in the provision of health care for prisoners implemented since that time. I am satisfied those changes address the origins of the suboptimal health care I have detailed earlier in these findings.

Accordingly, nothing would be served by my making any preventative recommendations.

I close the Inquest.

Michael Barnes
State Coroner
Cairns
19 May 2010