QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Harold James CARPENTER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2014/1827
DELIVERED ON:	29 January 2015
DELIVERED AT:	Townsville
HEARING DATE(s):	6 January 2015; 28 January 2015
FINDINGS OF:	Magistrate John Lock, Deputy State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Mr D Robinson i/b Office of General Counsel
Townsville Hospital & Health Service	Mr C Fitzpatrick i/b Corrs Chambers Westgarth

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Introduction

On 28 April 2014 Harold James Carpenter was experiencing hip and leg pain in addition to shortness of breath. At the time Mr Carpenter was a prisoner at Townsville Correctional Centre (TCC) and he was transferred later that day from his cell to the Townsville Hospital (TTH). He remained at TTH until his death in the Palliative Care Unit in the early hours of 24 May 2014. Mr Carpenter's partner, Ms Esson was present at the time of his death.

All Deaths in Custody require a thorough investigation into the circumstances leading up to death and the holding of an inquest is mandatory. As well, Mr Carpenter's partner, Ms Esson expressed some concerns regarding the deterioration in his health in the months prior to his death, which were also considered.

The issues determined at a pre-inquest hearing and to be contained in these findings were:

- 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

An investigation into the circumstances leading to the death of Mr Carpenter was conducted by Detective Senior Constable Marcelle Sannazzaro from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

Upon being notified of Mr Carpenter's death, the CSIU attended TTH and TCC and an investigation ensued. The investigation obtained Mr Carpenter's correctional records and his medical files from both TCC and TTH. The investigation was informed by statements from all relevant custodial officers at TCC and medical personnel at TTH, as well as a statement from his partner, Biancha Esson. These statements were tendered at the inquest.

An external autopsy examination with associated histological and toxicological testing was conducted by Professor David Williams. Photographs were taken during this examination.

At the request of the Office of the State Coroner, Dr Adam Griffin, Director of the Queensland Health Clinical Forensic Medicine Unit ("CFMU") examined the medical records for Mr Carpenter from the TTH and TCC and reported on them.

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 Townsville on 28 January 2015. All of the statements, medical records, and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Miss Cooper, proposed that all evidence be tendered and that oral evidence be heard from Detective Senior Constable Sannazzaro, Dr Adam Griffin and Dr Dharampal Anand. The evidence tendered in addition to the oral evidence of these witnesses is sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

Harold James Carpenter (also known as Robert Wayne McMahon) was born on 23 April 1948 making him 66 years of age when he died. Information obtained during the investigation confirmed that Mr Carpenter came from an abusive family background and was physically and sexually assaulted by family members during his childhood. It seems that throughout his life Mr Carpenter had disruptive relationships with women. He was the father of two children, Warwick Aitken whom he had limited contact with, and a daughter whom he had not had contact with for many years. He worked as a truck driver and in the construction industry.

Mr Carpenter had an extensive criminal history dating back to his early teenage years. This history includes crimes against property, assault against persons, sexual offences, drug offences, motor vehicle offences and possession of weapons. At the time of his death, he was serving a 20 year term of imprisonment for rape. This was his third period of imprisonment for rape, having previously served periods of incarceration in both New South Wales and South Australia in the 1970's.

On 22 September 2008, Mr Carpenter was placed on a continuing detention order pursuant to section 13(5)(a) of the *Dangerous Prisoners (Sexual Offenders) Act 2003*. This was confirmed at a periodic review on 3 December 2012. He remained on this order at the time of his death. He was transferred to TCC on 8 May 2013 so as to facilitate his participation in a program relevant to his continuing detention order. At the time of his death he was also awaiting extradition to New South Wales for some outstanding charges and to serve the remainder of a sentence for which he had breached his parole.

Mr Carpenter's partner at the time of his death was Biancha Esson. They had met in 1998 whilst Mr Carpenter was incarcerated at the Borallon Correctional Centre. In 2003, they had applied to Queensland Corrective Services to be married, however, this was declined. Ms Esson had consistent contact with Mr Carpenter during his final period of incarceration, and was with Mr Carpenter when he died on 24 May 2014.

Ms Esson has expressed concerns regarding the conduct of the program he was involved and the stress and frustration this caused. Although it appears Mr Carpenter was regarded as a compliant prisoner in many respects, his history makes it inevitable that any release in the near future, whether he completed the program or not, was highly unlikely.

Medical history

Mr Carpenter's well documented medical history dates back to at least 2002, and includes:

- Ischaemic heart disease (in the form of previous myocardial infarction, ongoing angina and acute coronary syndrome);
- Chronic Obstructive Pulmonary Disease (emphysema);
- Hepatitis C;
- Hypertension;
- Lung nodule (possible cancer);
- Weight loss (Dr Griffin stated this was suggestive of a malignancy somewhere. In 2013 Mr Carpenter had declined an examination to investigate his weight loss and possible cancer);
- Possible previous tuberculosis; and
- Hyperlipidaemia.

Mr Carpenter was on a variety of medications for the treatment of these conditions, including various inhalers, cholesterol lowering medication and blood pressure medication. It is evident Mr Carpenter's co-morbidities were no doubt contributed to by lifestyle decisions in his earlier life, which included heavy alcohol use as well as use of cannabis and amphetamines. This is likely to have resulted in his contracting Hepatitis C as well as impacting on other body organs. It was documented he was also a heavy smoker and continued his use in prison. A past and continued habit of smoking is well known to be associated with the increase of disease to the lungs and heart

Events leading to death

At midday on 28 April 2014 Mr Carpenter was referred to the TTH as he was noted to have increased shortness of breath, chest pain from four days earlier, he appeared to be clammy and reported 10/10 pain in his hips. He reported feeling like he had a fever and had also experienced 'sweats' over the previous few days.

His observations in the emergency department were normal. The attending doctor ordered an X-ray and ultrasound of the right hip and blood tests. The ultrasound confirmed an effusion (fluid collection) in the hip joint. The blood tests confirmed a raised white count supporting an infection of some sort. As

such, Mr Carpenter was referred to the orthopaedic ward as it was presumed he had a problem with his hip joint. When tests revealed the source of the symptoms was not bone related, his care was transferred to Dr Dharampal Anand, a general physician. Dr Anand provided a statement and gave evidence at the inquest.

On 30 April, blood culture and urine culture was returned with a positive result, indicating that bacteria was present in the bloodstream. A review of Mr Carpenter's bone scan indicated the right kidney might be a source for the infection. His diagnosis was subsequently thought to be pyelonephritis (an infection of the kidney) that had spread to the bloodstream. On 1 May, Mr Carpenter was seen by the Infectious Disease doctors. An ultrasound of the heart was conducted but did not show a potential source for the infection.

Mr Carpenter became progressively more unwell, with low blood pressure noted. He was considered for admission to the Intensive Care Unit and assessed by Intensive Care doctors and an urologist. On 3 May, an abdominal CT scan was conducted and identified a soft tissue mass, thought to be an aneurysm of the iliac artery blocking the drainage of the kidney. A vascular surgeon was consulted. A further CT scan was then conducted, with Mr Carpenter's consent, which supported a diagnosis of an aneurysm in the iliac artery on the right hand side that was blocking the kidney from draining properly. An angiogram was subsequently conducted and a stent device inserted on 4 May by the vascular surgeon.

Mr Carpenter continued to have poor kidney function. It was then decided that it was necessary to have the obstruction in the right kidney removed to improve his kidney function – this procedure was performed by an interventional radiologist on 6 May 2014. The procedure was successful.

On 7 May, Mr Carpenter was seen by renal physicians. They considered the cause of his ongoing kidney impairment to be multifactorial, but primarily related to damage to the kidney as a response to the widespread infection.

On 8 May, Mr Carpenter suffered an episode of chest pain, and a myocardial infarction was considered likely.

On 9 May, Mr Carpenter underwent further assessment by medical specialists to try and determine whether the infection was located in or around the aneurysm, within the kidney or another location. The infection in the back muscle was also considered to be very close to the aneurysm, and there was concern about this proximity when considering any surgical intervention.

The overall view was that Mr Carpenter was not responding completely to the antibiotic regime on its own and that surgical intervention would be required to take away the collection of the infection in the back muscle near the aneurysm. Mr Carpenter decided that he did not want further surgery. As such, his medical management became more aggressive.

Over the next six days, Mr Carpenter showed signs of stabilising and seemed he was responding to the more aggressive treatment. However, on 14 May, he became unwell again with nausea, light headedness and vomiting. There was blood present in the vomit. His observations otherwise appeared normal. On 15 May, he suffered a further episode of chest pain that was relieved with a single anginine. The kidney function impairment was thought to be the likely cause of the pain. However, there were a further three reported episodes of this pain over the next 12 hours.

On 16 May, Mr Carpenter was assessed by cardiology doctors and an echocardiogram was performed. He subsequently developed high fevers and again was generally unwell. Antibiotic therapy was changed to a broader spectrum antibiotic. On 17 May he started to suffer nose bleeds and his blood thinning medication was withheld on orders by Dr Anand, which seemed to help. He then became incontinent and suffered a further episode of chest pain. In consultation with microbiologists, a decision was made to further broaden the spectrum of antibiotic cover.

Mr Carpenter continued to have episodes of chest pain and serious nose bleeds. He subsequently accidentally removed his nephrostomy tube and did not want it replaced. Dr Anand stated the tube was grossly infected and there was no plan to resite the tube. Dr Anand documented that Mr Carpenter was generally looking unwell, with evidence of ongoing anaemia. He refused further blood transfusions and nasal packing for his nose bleeds, but consented to continued antibiotic therapy and other oral medications.

In light of his worsening clinical condition and multi organ involvement on the background of significant pre-existing co-morbidities, Mr Carpenter spoke to doctors, nurses and social workers with respect to his ongoing management. He clearly communicated a desire to cease further intervention. He was noted to be cognitively intact and capable of decision making. On 21 May, medical staff documented Mr Carpenter's wishes to cease further intervention and to receive comfort measures only. This second discussion took place with Mr Carpenter, his partner Ms Esson and in the presence of a prison officer and medical staff that he wanted comfort measures only. Dr Anand considered this to be a reasonable course of action. These discussions were well documented in the medical records. A referral to the Palliative Care Unit was made on 22 May. Oxycodone and Midazolam were prescribed to maintain his comfort.

Mr Carpenter continued to be observed over the next couple of days. At 0335 hours on 24 May 2014, nurses noted that Mr Carpenter had ceased breathing and that no signs of life were apparent. This was subsequently confirmed by a doctor and life declared extinct at 0353 hours.

Autopsy results

Given the clear clinical history an external only autopsy examination was considered necessary. This was conducted by forensic pathologist Professor David Williams on 26 May 2014.

Toxicology results revealed a number of mind altering drugs and pain relief medication but all the drugs present were in therapeutic levels and there were no drugs of abuse.

Prof Williams opined that the death was due to natural causes. There was no evidence of foul play.

The cause of death was determined as coronary atherosclerosis, with emphysema listed as a secondary cause.

Investigation findings

There was no information provided to the investigating officer suggesting foul play or that there was any deficiency or inappropriateness in the treatment received by Mr Carpenter while in custody.

The examination of Mr Carpenter's body at TTH revealed no signs of violence.

The CSIU investigation into Mr Carpenter's death did not lead to any suspicion that his death was anything but natural. Mr Carpenter had been suffering from long-term illnesses and he had opted for palliative care, which had been well documented. TCC had followed all appropriate protocols prior to and after his death.

Medical Review

The medical records pertaining to Mr Carpenter were sent by the Office of the State Coroner to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Adam Griffin.

Dr Griffin provided a comprehensive report. He could not find any areas of concern with respect to the medical treatment provided to Mr Carpenter by TCC and TTH. In coming to that conclusion, he noted the following:

- The diagnosis of the aneurysm was made some 5 days after admission. This was completely unsurprising given the symptomology and focus of these symptoms to his hips. The delay in diagnosing the aneurysm is explained by the rarity of the condition, the lack of localising signs and the lack of a severe systemic reaction to what would be considered a significant physiological challenge.
- Mr Carpenter did have Hepatitis C and a possible lung malignancy. Both conditions would predispose him to a diminished immune response and increased risk of generalised infection.
- Aneurysms can occur due to vascular disease, and Mr Carpenter was known to have significant coronary vascular disease.
- The care and assessment at TCC, in terms of documentation, comprehensiveness of assessment, investigations, referral and institution of appropriate therapy, was excellent and stood out in comparison to Mr Carpenter's care at other correctional facilities. His comments about other facilities were focussed on a paucity of recording the outcomes of some of his presentations for high blood pressure as distinct from the care provided.

- The documentation in the medical record at TTH is clear in identifying Mr Carpenter as being cognitively intact and able to make decisions. When Mr Carpenter declined further surgery he was provided with maximal alternative treatment of a high standard.
- The decision to cease further intervention was not made out of character – he had previously declined investigation of his potential lung malignancy, expressed a desire to not know if he had cancer, and declined screening for his liver disease. He had refused previous treatment and intervention.
- Overall, the documentation and care at TTH was at a standard not dramatically different from what General Practitioners would practice in the community. Dr Griffin stated his treatment as a prisoner did not differ to what he would expect of a person in the community. He stated there were excellent care and diagnostic skills evident and good patient focussed care.

Concerns of Ms Esson

Ms Esson has expressed a number of concerns regarding Mr Carpenter's initial placement in an air-conditioned cell when he first arrived at TCC. It is evident such a placement was problematic for him given the extent of his emphysema (a matter referred to in the 2008 Supreme Court decision ordering his indefinite detention.) Ms Esson states it took 8 months and many representations on her part to have this changed. She considers this initial placement contributed significantly to the deterioration in his health. Ms Esson has advised she has no concerns with respect to the care provided to Mr Carpenter when he presented to TTH.

In response to these concerns Ms Winter, the Acting General Manager of TCC, confirms he was not moved to non air-conditioned premises until 24 December 2013. A number of reasons for this were advanced. Accepting those reasons may be valid, it does appear his request was lost somewhat in the process and could have been dealt with some months earlier. The medical records at TCC note Mr Carpenter raised this matter at a medical presentation on 10 December, although respiratory issues were often a feature of his medical presentations.

It should be noted however that Mr Carpenter's presentation to TTH occurred in the context of symptomology not connected with his emphysema but ultimately was diagnosed as a blockage to the right kidney due to an aneurysm of the right iliac artery. From there his condition deteriorated in the face of multiple co-morbidities including principally his coronary artery disease, as well as possible malignancy and his depleted lungs.

Conclusions

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

I am satisfied that Mr Carpenter was given appropriate and excellent medical care by staff at TTH and while he was in custody at TCC. His death could not have reasonably been prevented.

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 Carpenter when measured against this benchmark.

Findings required by s45

The *Coroners Act 2003* provides in s47 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 findings in relation to the death of Harold James Carpenter will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

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 Harold James Carpenter.

How he died - Mr Carpenter died at the Townsville Hospital after a month long complex admission relating to complications from a blockage to the right kidney, consequent sepsis, multiple heart attacks on a background of his longstanding ischaemic heart disease and emphysema.

Place of death – He died at Townsville in Queensland.

Date of death – He died on 24 May 2014.

Cause of death – Mr Carpenter died from natural causes, namely coronary atherosclerosis and emphysema.

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.

In this matter the adequacy of the medical care afforded to Mr Carpenter was examined by Dr Griffin. Dr Griffin provided no concerns that any person had

contributed to Mr Carpenter's death. He ultimately concluded that the care and treatment provided to Mr Carpenter by TCC and TTH was of an excellent and appropriate standard.

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.

I close the inquest.

John Lock
Deputy State Coroner
Townsville
29 January 2015