QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David Samuel MORRIS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/3970
DELIVERED ON:	11 September 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 September 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Fiona Banwell

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 are my findings in relation to the death of David Samuel Morris. 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

Late on the evening of 19 November 2011 David Morris, 57, experienced a heart attack in his cell at Woodford Correctional Centre ("WCC"). He was located by correctional staff on the floor beside his bed during the second headcount for the night. He displayed no signs of life. Cardio-pulmonary resuscitation was not attempted and he was pronounced deceased at the scene.

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 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 Morris was conducted by Detective Sergeant Stephen Carr from the Queensland Police Service ("QPS") Corrective Services Investigation Unit ("CSIU").

Upon being notified of Mr Morris' death, the CSIU attended WCC and an investigation ensued. Photographs were taken of the scene at WCC. The investigation obtained Mr Morris' correctional records and his medical files from both WCC and PAH. The investigation was informed by statements from all relevant custodial officers at WCC, recorded interviews with fellow prisoners who Mr Morris resided with and a statement from his daughter, Jeanette Keding. These statements were tendered at the inquest.

An external and full internal autopsy examination was conducted by Dr Nadine Forde. Further photographs were taken during this examination.

At the request of the Office of the State Coroner, Dr Les Griffiths from the Queensland Health Clinical Forensic Medicine Unit ("CFMU") examined the medical records for Mr Morris from the PAH and WCC 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 Brisbane on 4 September 2013. All of the statements, records of interview, medical records, photographs 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 only from Detective Sergeant Carr. I agreed that the evidence tendered in addition to the oral evidence of Detective Sergeant Carr was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

David Morris was born in Beaudesert on 27 August 1954 making him 57 years of age when he died. Information provided by his daughter suggests that he had always been a big man and had been a body builder in the early 1970's. Between 1971 and 1998 Mr Morris intermittently appeared in courts in Wynnum and Charleville for a variety of firearm offences, drink driving, stealing and assault occasioning bodily harm.

He had been in a longstanding de facto relationship which broke down around 2002 – 2003. After the breakdown of this relationship he committed a variety of serious offences against his former de facto partner, including assault occasioning bodily harm, multiple burglaries, deprivation of liberty, torture, multiple rapes and other summary offences. On 8 March 2006 he was sentenced for these offences and declared a serious violent offender. Mr Morris was not eligible to apply for parole until 13 October 2013.

Mr Morris' next of kin was his daughter. She had made efforts to visit her father every 6-8 weeks while he was incarcerated.

Medical history

Mr Morris had been undergoing coronary treatment from the Princess Alexandra Hospital ('PAH') since his incarceration in 2006. His background of dilated cardiomyopathy spanned many years.

Mr Morris' last admission at PAH was from 12 – 16 November 2011. The medical records from PAH confirm that this admission was due to dyspnoea and lower limb oedema. The principle diagnosis was new onset atrial fibrillation with rapid ventricular response, congestive cardiac failure, chronic

ischaemic heart disease, hypertension, hyperlipidaemia, nicotine addiction and obesity (Body mass index of 41.5).

It was noted by medical staff that Mr Morris had admitted to not taking some of his medication at times. He was also still smoking, although his intake had reduced from 50g to 30g per day. Medical staff reminded him of the importance of taking all of his prescribed medication when required and the need for him to quit smoking.

He was discharged from PAH on 16 November 2011 with stable observations, he was noted to be comfortable, with a clear chest and he had lost 3kg.

Events leading to death

At approximately 1830hrs on 19 November 2011, Mr Morris proceeded to his cell to go to bed. Mr Morris resided in Residential Unit, RA, cell 2 and had been accommodated there since 28 November 2010. The unit contained 6 cells. Cell 2 was designed to accommodate one inmate, thus Mr Morris being the sole occupant of his cell.

The first headcount commenced at approximately 2025hrs. Corrective Services Officers ('CSO') Lenard Grice and Robert Hay conducted the count of the unit accommodating Mr Morris. CSO Hay checked the cells on the left hand side of the unit (cells 1 – 4) whilst CSO Grice checked the cells on the right hand side (cells 5 – 6). CSO Hay checked Mr Morris' cell and noted that the cell light was off. He directed his torch beam so that it reflected off the ceiling and observed Mr Morris to be lying on the bed, on his side, facing the wall with the bedclothes pulled up to about the middle of his body. CSO Hay observed nothing to cause him any concern about Mr Morris' health or wellbeing.

The second headcount commenced at approximately 2225hrs. CSO Steven Burns inspected Mr Morris' cell by shining his torch through the window of the cell. CSO Burns saw Mr Morris kneeling on the floor and slumped on his bed. He was motionless and did not appear to be breathing. CSO Burns called for assistance from his colleague CSO Donald Rowe who entered the cell and attempted to shake Mr Morris. CSO Rowe noted that the body was cold and appeared to be stiff and unresponsive.

A Code Blue emergency was called and the onsite nurse attended at approximately 2230hrs. Life extinct was declared a short time later. The remaining prisoners in the unit were escorted out and the scene was preserved by corrective services staff until the CSIU arrived at about 0300hrs.

Autopsy results

External and full internal examinations were conducted by forensic pathologist Dr Nadine Forde on 22 November 2011. Dr Forde's findings were peer reviewed by fellow forensic pathologist, Dr Rebecca Williams.

Examination of the heart revealed severe coronary atherosclerosis. The left anterior descending coronary artery showed up to 70% eccentric stenosis

distally. The left circumflex coronary artery showed 10% concentric stenosis. The right coronary artery showed up to 90% eccentric stenosis in the proximal to mid region with possible thrombus present.

Mr Morris was an overweight man with no other significant injuries. The heart was markedly enlarged and the chambers were dilated. There was evidence of coronary atherosclerosis and extensive old scarring indicative of a previous heart attack.

A small aneurysm was identified in a blood vessel supplying the brain but it showed no evidence of rupture and thus was not considered to have contributed to the death.

Toxicology results did not detect any alcohol. Low levels of warfarin, a blood thinning medication, were detected.

Dr Forde opined that coronary atherosclerosis is a common cause of sudden death. Risk factors for its development include smoking, high cholesterol and hypertension, all of which Mr Morris had.

The cause of death was determined as coronary atherosclerosis.

Investigation findings

None of the other inmates at WCC provided information to the investigating officer suggesting foul play or that there was any deficiency or inappropriateness in the treatment received by Mr Morris while in custody.

The examination of Mr Morris' body and his room at WCC revealed no signs of violence.

The CSIU investigation into Mr Morris' death did not lead to any suspicion that his death was anything but natural.

Medical Review

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

Dr Griffiths could not find any areas of concern with respect to the medical treatment provided to Mr Morris by PAH and WCC. In coming to that conclusion, he noted the following:

- The Offender Health Services notes indicated that the return from hospital on 16 November 2011 was uneventful and medication changes which were made during inpatient stay were documented;
- The progress notes from PAH relating to 16 November 2011 made no mention of Mr Morris suffering from any chest pains;
- Mr Morris was reviewed by the cardiology treating team on the day of his discharge and cleared for return to WCC with some medication

changes. Advice was given to Offender Health Services on other aspects relating to his health;
- A follow up appointment with the visiting medical officer was scheduled for 21 November 2011; and
- There was no record of Mr Morris complaining of chest pains after his discharge from PAH.

Conclusions

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

I am satisfied that Mr Morris was given appropriate medical care by staff at PAH and while he was in custody at WCC. His death was sudden and could not have 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 Morris when measured against this benchmark.

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 David Samuel Morris.

How he died - Mr Morris died at Woodford Correctional Centre after suffering a heart attack.

Place of death – He died at Woodford in Queensland.

Date of death – He died on 19 November 2011.

Cause of death – Mr Morris died from natural causes, namely coronary atherosclerosis.

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 Morris was examined by Dr Griffiths. Dr Griffiths found that no person had contributed to Mr Morris' death and that there were no warning signs of the impending heart attack that ought to have been investigated.

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.

Terry Ryan
State Coroner
Brisbane
11 September 2013