OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Tony William Gates**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2685/2010
DELIVERED ON:	19 April 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 April 2012
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – Death in custody, adequacy of medical care at Wolston Correctional Centre

REPRESENTATION:

Counsel Assisting	Ms Emily Cooper, Office of the State Coroner
Dept of Community Safety	Ms Melinda Zerner of Counsel

Introduction

1. Tony William Gates was born on the 24 January 1968. He died overnight between the 5 and 6 August 2010 in Cell 2, Unit R2-D, at the Wolston Correctional Centre at Wacol in Queensland. He was 42 years of age at the time of his death.

2. Usually Mr Gates worked as a forklift driver, but at the time of his death, he was being detained in custody, serving a five year term of imprisonment. The period of incarceration commenced on the 13 March 2009 when he was sentenced by the District Court. His death was mandatorily reportable to the State Coroner, irrespective of the circumstances or cause of his death.[1]

3. Section 27 of the *Coroners Act 2003* states:

4. The coroner investigating a death must hold an inquest if –
   (1) the coroner considers the death is –
      i. a death in custody.

5. I accept the evidence before this inquest that Mr Gates' death was a death in custody. In accordance with the requirements of the Coroners Act, this inquest has reviewed the circumstances leading to the death to enable findings to be made determining –
   - who the deceased person is;
   - how the person died;
   - when the person died;
   - where the person died, and whether this was in Queensland; and
   - what caused the person to die.[2]

6. Investigations were undertaken at the direction of the coroner by the Specialist Corrective Services Investigation Unit as part of the Queensland Police Service. The report of Detective Sergeant Beattie was tendered to this inquest and he gave oral evidence.

7. Statements from correctional officers, medical personnel, police officers, the next of kin and former prisoners have been tendered, together with photos and other exhibits including an independent medical review arranged by the coroner's office.

8. Upon the report of the death, the deceased man was identified as Tony William Gates by a supervisor at the Wolston Correctional Centre. Ian Fairweather had known Mr Gates for a period of one year prior to his death. I accept that identification.

9. Mr Gates' next of kin is his mother, Elaine Gates. She was informed of her son's death and provided her statement on the 17 February 2011. In relation to her son's previous medical history, she recalled his habit of sucking on antacids such as Quick-Eze or Rennie's throughout his

[1] Section 10, *Coroners Act 2003*
[2] Section 45, *Coroners Act 2003*

adult life due to apparent indigestion or heartburn. She was unaware he had pursued medical review or advice or treatment for these symptoms. She stated her son was a heavy smoker and she was also aware he used illicit drugs over many years. She was aware of some cardiac history in the family. The last time she saw her son was when he was incarcerated around Easter 2007.

Events leading to the discovery of Mr Gates' demise

10. The precise timing of events leading to the discovery that Tony Gates had died in his cell is uncertain. However, variation in the records is only to a minor extent on the night of 5 August 2010 and the early hours of 6 August 2010. Mr Gates occupied Cell 2 in the upstairs residential 2-D unit. There were five other inmates in that unit.

11. In broad terms, inmates were locked into their residential unit between 18:20 and 18:40 on the evening of 5 August 2010. The first head count of the evening occurred around 20:10 over approximately 25 minutes. The procedure involved a Correctional Services Officer looking into each cell through the perspex window and, with the aid of a torch, 'sighting' each prisoner to ascertain apparent wellness. Obviously the extent of examination and the level of information regarding an inmate's wellbeing gathered by such an observation is limited, but must be balanced by considerations of not unduly disturbing the inmates overnight as well as considerations of security.

12. Nothing of concern was observed or recorded by the officers during the first head count after lockdown.

13. A second head count was recorded to commence at about 22:15 and was completed within about 16 minutes with no concerns noted or recorded.

14. The third head count of the evening commenced shortly after midnight and a code blue, declaring a medical emergency, was recorded some time between eight and 13 minutes after midnight.

15. Correctional Services Officer Aron Mason shone his torch into Mr Gates' cell and noted his bed was not occupied. This was not a cause for immediate concern and he proceeded to the communal bathroom area and checked that area before returning to Mr Gates' cell. It was then he observed Mr Gates lying naked on the cell floor. The cell door was closed but not locked. There was no response from Mr Gates to verbal prompts and Officer Mason alerted his colleagues before entering the cell. A nudge of his foot did not elicit a response. He observed Mr Gates' feet were blue.

16. The supervising officer, Ian Fairweather entered the cell and he checked for a pulse. There was none. A code blue had been called by Officer Blom and within a very short time, Registered Nurse Diane Tapsell attended upon Mr Gates in the cell.

17. She checked for a carotid pulse, and rechecked with a stethoscope for any sign of inspiration or expiration. There was none. She observed his pupils were fixed and dilated and she declared him deceased. There were no signs of injury on Mr Gates' body but there were signs of post mortem lividity.

18. The response to the discovery of Mr Gates lying unresponsive in his cell was prompt and appropriate. A code blue emergency was called as soon as it was clear Mr Gates was unresponsive. I accept the evidence from nurse Tapsell that her assessment accurately concluded he was deceased and efforts at resuscitation were futile.

Events leading up to Mr Gates' death

19. Nicholas Fursey was a friend of Tony Gates. They first met in 2003 outside prison and their friendship continued when they both found themselves in custody at Wolston Correctional Centre in 2007.

20. They both worked in the sandblasting and paint shop section of the prison over about a one year period. They were in separate residential units but socialised within the prison, sharing 'brews' of coffee. Anthony Murphy was another close friend of Mr Gates during his period at Wolston.

21. Together, the three men had constructed a makeshift bench press at the sandblasting/paint shop worksite. Two sandbags were secured to a mop handle and they constructed a bench from milk crates. Mr Fursey's statement in February 2011 said the weight was 50kg. His oral evidence was that each sandbag was 40kg. Whatever the precise weight was, it was common ground that Mr Gates had only recently resumed some training in a period of between five and 10 days prior to his death, as recalled by both Mr Fursey and Mr Murphy.

22. According to Mr Murphy's statement, Mr Gates was motivated to improve his fitness as he was hopeful of gaining parole and being reunited with his son. He was clearly pushing himself with the bench press and he also worked out his arms and legs, walked and used the stairs. He had a limitation due to a shoulder problem.

23. Nicholas Fursey recalled it was about four days prior to his death when Mr Gates first complained of chest pain. He recalled Mr Gates describing being 'tight in the chest' and experiencing pain down his legs. Mr Fursey reassured him it was because they had just trained and it was to be expected they would experience some muscle fatigue. He also reminded Tony he had not been training for a long period before resuming physical exercise.

24. On the evening of 4 August 2010, Mr Fursey recalled Mr Gates telling him he had chest pain again. Mr Fursey chastised him for 'scoffing down his food' as he thought he had indigestion.

25. The next day, on 5 August, Mr Fursey did not recall Mr Gates mentioning chest pain. Mr Gates worked that day, but Mr Fursey had the day off.

26. Later that day, Mr Fursey recalled Mr Gates complaining of chest pain and pain down his leg. They discussed it and essentially agreed it was due to training. Mr Fursey recalled Mr Gates had a visit with his partner, Eileen Arneil. He recalled she was a registered nurse.

27. Mr Fursey recalled Mr Gates telling him she had made a limited assessment of his complaint of pain, noting pain on the left-hand side of his chest and down both lateral rib cage areas. He recalled they had agreed it was probably muscular but she had told him to go and see the nurse.

28. Mr Gates had a second visit with his partner Eileen that day, the second in the company of Mr Gates' brother, Jason Gates. Ms Arneil did not recall Mr Gates making any complaint of pain during this second visit during which Mr Gates' brother was doing most of the talking.

29. Mr Fursey saw Mr Gates queue to speak with the nurse who was dispensing medication on request at the 'pill parade'. He recalls Mr Gates attending with the nurse for perhaps three minutes before being dismissed.

30. He conceded he did not know what Mr Gates had said to the nurse and he could not overhear any conversation.

31. Mr Gates' other friend, Anthony Murphy provided a detailed statement to Detective Sergeant Beattie in February 2011. He also confirmed Mr Gates attended the pill parade to see the nurse after complaints of pain following physical exercise. He said Mr Gates explained the pain was up under his right arm and Mr Murphy could not work out how this could occur as he did not think Mr Gates had performed much 'back' work. He did not hear the conversation with the nurse but believed Mr Gates was given Brufen medication and sent back to the unit.

32. The inquest heard evidence from Registered Nurse Te Maro. I accept she was a qualified and experienced nurse and gave evidence to the best of her recollection. She could not recall Mr Gates attending at the pill parade on 5 August 2010. On review of the record, she confirmed Mr Gates was not receiving any regular medication which explained why it was unlikely she would have an independent recollection of him as an inmate.

33. Nor could she recall anyone attending the pill parade with a complaint of chest pain. In her evidence she stated had there been such a complaint, she would have examined the inmate, checked his pulse, asked questions regarding the onset of pain, checked his pallor, whether he was clammy and the severity of the pain. If it were an emergency situation, she would have called a 'code blue'.

34. Nor could she recall any inmate attending the pill parade complaining of muscle pain necessitating the issue of either Panadol or Brufen. However, she conceded it was a very common presentation at pill parade for inmates who frequently complained of muscular pain after physical training.

35. Her account of whether or not she would record a request for medication was somewhat unsatisfactory. Initially she was uncertain whether she would record such an event, later she stated she would make a record.

36. However, the context was these events occurred at a time when responsibility for the delivery of health services to prisoners transferred from Corrective Services to Queensland Health via the Offenders Health Services.

37. She confirmed her recollection of the recordkeeping was by use of an A4 spiral bound notepad. This was consistent with the evidence of Detective Sergeant Beattie who inspected the pill record document in March 2011. He could not identify an individual page dated 5 August 2010. He noted there were records which were undated but he could not find the name of Mr Gates entered in the pill record. I accept his evidence. I note that subsequently this document has apparently been archived and is no longer able to be produced.

38. I also note there was no evidence that Mr Gates completed a medical request form requesting to be seen at the medical centre in relation to a complaint of pain in the days immediately prior to his death. He had used this procedure on many other occasions during his incarceration to access medical care.

39. Registered Nurse Te Maro also acknowledged she had been shown a photograph of Mr Gates in the course of the investigations following his death. She conceded after seeing the photograph she could recall him as an inmate but denied this was due to having seen him at pill parade.

40. I accept Registered Nurse Te Maro's evidence overall, subject to my remarks with respect to recordkeeping at the pill parade.

Intercom

41. I accept the evidence presented to the inquest that there was an operational intercom accessible to each inmate in the residential unit occupied by Mr Gates. Intercoms were checked on a weekly basis. I accept there is no evidence this intercom was activated by Mr Gates seeking medical assistance overnight on 5/6 of August 2010.

Medical Review

42. The coroner's office arranged for independent review of the medical treatment provided to Mr Gates. This was undertaken by Dr Ian Mahoney of the Clinical Forensic Medicine Unit. A review of the complete record indicated there was no evidence of any previous

presentation by Mr Gates which included any reference to a complaint of chest pain.

43. The last entry of his attendance at the medical unit whilst incarcerated was on 8 June 2010. His presentation was for an infected boil. His previous attendance was for an ankle injury in March 2010. Prior to that, he attended for a sore throat in August 2009.

44. The most recent blood pressure recording was made in August 2009. Blood pressure was recorded at 134/76 which was within the normal range. A fasting lipid test was undertaken in August 2008 and found to be normal.

45. There was a previous incident when Mr Gates complained of shortness of breath whilst in the watch house at Brisbane in April 2007. He was taken to the Princess Alexandra Hospital and assessed. A diagnosis of panic attack was made.

46. During 2007 and again in 2008 there were two recorded occasions when Mr Gates attended due to pain following exercise. The first occasion was in December 2007 when he complained of right shoulder pain after doing push ups. He was advised to rest and given anti-inflammatory medication. The second occasion was in January 2008 when he again complained of pain after exercise, this time in his neck. He was given Panadol and Brufen.

47. I accept Dr Mahoney's evidence that the medical care provided to Mr Gates whilst incarcerated at Wolston Correctional Centre was satisfactory and appropriate.

48. I accept Dr Mahoney's conclusion that there was -

    (1) No history of Mr Gates suffering from cardiac disease.
    (2) No history of Mr Gates complaining of chest pain.
    (3) No issue arising with respect to emergency care on 5/6 August 2010 as it was clearly evident Mr Gates was already deceased at the time he was discovered. The issue of resuscitation was therefore not relevant.

49. I also accept Dr Mahoney's view that the registered nurse's interpretation of Mr Gates' complaint of chest pain was likely provided in the context of recent physical exertion and thus not referred for medical review.

Autopsy

50. Autopsy examination was performed on Mr Gates' body on 9 August 2010 by the pathologist, Dr Beng Ong. He confirmed there were no signs of recent injury. His examination noted Mr Gates had a body mass index of 30. Internal examination confirmed significant atherosclerosis affecting all the major coronary arteries with the exception of the left main coronary artery. In particular, the most severe occlusion was noted in the right coronary artery. There was only pin

point residual lumen enabling the flow of blood to the heart. There was corresponding early infarction noted involving the area supplied by the right coronary artery.

51. Dr Ong was able to observe microscopic evidence of subendocardial infarction in the posterior left ventricle with extension into the septum.

52. Dr Ong concluded Mr Gates died due to an acute myocardial infarction resulting from coronary atherosclerosis. I accept these findings of the medical cause of his death.

53. After consideration of all the evidence, and with the advantage of hindsight available to a coroner, it is likely the chest pain complained of by Mr Gates was due to heart disease. However, this symptom occurred in the context of recent challenging physical exertion as well as a long history of heartburn and indigestion. It is understandable that Mr Gates and others, including his friends and, most probably the registered nurse on the pill parade, underestimated the potential of a serious health problem.

Findings pursuant to section 45 of the Coroners Act

54. The identity of the deceased is Tony William Gates who was born on 24 January 1968.

55. He died between 10:36pm on 5 August 2010 and 12:10am on 6 August 2010.

56. He died in Cell 2 of Unit R2-D in the Wolston Correctional Centre at Wacol, in Queensland.

57. He died due to acute myocardial infarction after recently resuming strenuous physical exercise which caused him to experience chest pain as well as pain in his legs and lateral pain. Although this was reported to other inmates and a registered nurse at pill parade, it is most likely he reported it in the context of recent physical exertion, and it was therefore attributed to a muscular cause.

58. Mr Gates died due to acute myocardial infarction caused by extensive underlying undiagnosed coronary atherosclerosis.

Conclusion and comments

59. I accept Mr Gates received adequate medical care at Wolston Correctional Centre despite his sudden, unexpected death at the relatively young age of 42.

60. I accept, on balance, Mr Gates told a registered nurse at pill parade that he was experiencing pain after recent physical exertion. It is likely he referred to arm, chest and leg pain but the context of the symptoms was recent resumption of strenuous exercise.

61. I accept it is in this context that no record exists of the administration of pain relief to Mr Gates, which I find most likely did occur. I conclude it was in theses circumstances that no referral was made to the medical centre.

62. It is only in hindsight that the significance of the report of pain can be appreciated. I note the nurse indicated had she assessed an inmate as making a report of a focal complaint of chest pain, she would have immediately assessed the situation. In a medical emergency she would have called a code blue response and initiated immediate treatment. Otherwise she would have arranged review by the medical centre.

63. It was of some concern that the registered nurse on pill parade expressed frustration about the documentation process stipulated by Offenders Health Services. On my understanding of her evidence, the issue of any pain relief is now supposed to be documented, and referred for approval to the medical centre. The registered nurse said her experience in attempting to comply with this process was it was unworkable and unable to be complied with, within the time constraints of prison scheduling.

64. I consider this is a matter that should be reviewed by Offender Health Services.

65. I also consider Corrective Services should review their arrangements for supervision within the worksites at Wolston Correctional Centre. The inmates had created their own physical training equipment and environment in an apparently unsupervised place or period of time within the prison. In Mr Gates' case, it is possible this unsupervised unusual physical exertion may have triggered the fatal event. It of course must be understood the level of undetected coronary atherosclerosis was the primary cause of his death and many people in the broader community suffer similar sudden deaths. His death could have occurred at any time.

66. In making these comments, I do not consider in all of the circumstances that Mr Gates' death was preventable.

The inquest is now closed.

Chris Clements
Acting State Coroner
19 April 2012