QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Rex Harold**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2009/1490
DELIVERED ON:	28 September 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 August 2012
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – death in custody; natural causes
REPRESENTATION:	
Counsel Assisting:	Ms Emily Cooper, instructed by the Office of the State Coroner
Aboriginal & Torres Strait Islander Legal Service:	Mr Rory Downey
Department of Community Safety:	Ms Elizabeth Gullo

INTRODUCTION

1. Rex Harold was born on 2 March 1950 in Normanton, Queensland. He was a member of the *Gkuthaarn* people who hold traditional lands in the Normanton area together with *Kukatj*, *Kurtijar* and *Kokoberrin* peoples. Mr Harold never married or had any children of his own, but he was very close to his nephews and nieces and other members of his extended family. Mr Harold was very fit and active when he was a young man, and he participated in many different sports including, soccer, cricket, swimming, running, baseball (rounders), camping and hiking.

2. As a young man he was an all-round sportsman, as well as a keen horseman. He worked as a stockman on cattle stations around the Normanton region.

3. Mr Harold left the Normanton region in the 1970s, and his nephew explained that he lost contact with his immediate family members for many years. It is believed he worked as a miner during some of this period.

4. Mr Harold returned to Northern Queensland and by this time he was suffering from a number of physical and mental health issues. He was under the control of the Adult Guardian before he passed away, and he spent many years in mental health units and residential care facilities in the Cairns and Townsville area.

5. He died on 23 July 2009 at Townsville Hospital in Townsville. He was aged 59 years at the time of his death. His death was mandatorily reportable to the State Coroner as he was serving a term of imprisonment at the time of his death.[1] An inquest was convened after investigation of his death was completed in accordance with the requirements of section 27(1)(a)(i) of *Coroners Act 2003*.[2]

6. Mr Harold's most recent period of incarceration was at the Townsville Correctional Centre where he was imprisoned on 28 April 2009. He had been transferred there from the Mt Isa police watch house where he had spent nine days in custody.[3]

7. Mr Harold's family was informed of his death and he was identified by his sister. The Aboriginal and Torres Strait Islander Legal Service has assisted in representing the family in the inquest which was commenced in Brisbane

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[1] Section 7 (3) (b)
Duty to report deaths
(3) The person must immediately report the death to—
(a) if the death happened in the course of or as a result of police operations—the State Coroner or the Deputy State Coroner; or
(b) if the death is a death in custody—the State Coroner or Deputy State Coroner;

[2] Section 27
When inquest must be held
(1) The coroner investigating a death must hold an inquest if—
(a) the coroner considers the death is—
(i) a death in custody;

[3] Exhibit C 2

on 13 August 2012 with a pre-inquest hearing. The investigation had previously been provided to the family's legal representative and to the legal representatives for Community Safety. At the pre-inquest hearing it was agreed there was no necessity for witnesses to be called to give oral evidence.

EVENTS LEADING TO MR HAROLD'S DEATH

8. On 19 July 2009 Mr Harold was ordered to be transferred to the Townsville Hospital from the jail for medical assessment and x–ray. At about 1530 that afternoon a prison officer reported to the clinical nurse on duty that Mr Harold was refusing meals and appeared unwell. He was then reviewed at the medical centre where he appeared lethargic. An audible wheeze was heard and his temperature was elevated.

9. The nurse was concerned as there was no visiting medical officer attending that day and she therefore arranged his transfer to the Townsville Hospital. After assessment in the emergency department he was admitted under the care of general physician Dr Tara Cowtan. She reviewed Mr Harold after he was first seen by her registrar. The medical history taken at admission was recorded as follows:

    (a) he had been unwell for a few days,
    (b) he was increasingly lethargic over the last few days,
    (c) he had an audible wheeze,
    (d) he had a productive cough,
    (e) there was increased shortness of breath,
    (f) weight loss over previous few months,
    (g) loss of appetite.

10. Mr Harold was known to have a significant medical history which was documented on the final discharge summary as follows:

    (a) chronic obstructive airways disease
    (b) a change in the structure and function of the right ventricle of his heart due to respiratory disorder (cor pulmonale)
    (c) schizophrenia
    (d) alcohol induced brain injury
    (e) diabetes mellitus type two
    (f) a smoker
    (g) possible malignancy, with elevated calcium on arrival at hospital, associated with weight loss, decreased appetite

7. A chest x-ray showed a right sided basal consolidation of the lung, extending into the upper lobe leading to an initial diagnosis of pneumonia. Antibiotics were commenced in the emergency department. Other tests revealed an elevated troponin level indicating strain on the heart and a possible myocardial infarction. He had a high level of calcium, was in acute renal failure and had a worsening liver function.

8. He was assessed as being very unwell and it was suspected there was an underlying malignancy. Treatment was commenced to address the

immediate health problems of his lungs, heart, liver and kidneys and investigations were commenced. A scan showed possible spread of cancer into his bones.

9. On 21 July there were signs of some positive response to antibiotic treatment but he still required significant levels of oxygen support. He was reviewed by the cardiology team and a recommendation was made for a CT pulmonary angiogram.

10. The next day the registrar reviewed Mr Harold in the morning after the physiotherapist reported his breathing was worsening. Antibiotics were reviewed and changed to cover a broader spectrum of organisms that may be causing the underlying infection. Diuretics were also ordered to address possible congestive heart failure.

11. Dr Cowtan reviewed him around midday when he was more comfortable but there were still signs of congestive heart failure. He was not well enough to undergo the planned CT scan.

12. During the afternoon of 22 July 2009 Mr Harold was extremely drowsy. Attempts to assist his respiratory function via a mask were unsuccessful as he could not tolerate the mask. Dr Cowtan reached the opinion it was futile given all of Mr Harold's co-morbidities and state of health to continue with medical interventions. By this stage Mr Harold was unresponsive to indicate his own wishes. A portable chest x-ray was performed at the bedside. This confirmed worsening of his pneumonia. The doctor requested the Aboriginal Liaison Office to contact the prison to obtain details of family as it was likely Mr Harold would die quite soon.

13. Dr Cowtan met with Mr Harold's sister and another female family member at the hospital. Agreement was reached that no further life saving interventions would assist her brother and no attempts at resuscitation were appropriate. Discussions were also held with the Adult Guardian who had been appointed on behalf of Mr Harold.[4]

14. Dr Cowtan obtained a medical review and second opinion with respect to Mr Harold's condition. This opinion agreed with her conclusion that it was not appropriate for Mr Harold to be treated in intensive care as this would not resolve his underlying significant chronic medical conditions. Accordingly the Adult Guardian provided verbal consent to the proposed treatment decisions late on the afternoon of 22 July 2009.

15. Mr Harold was cared for and reviewed during the night by nursing staff. He was declared deceased at about 0210 on 23 July 2009.

AUTOPSY

16. On 24 July 2009 professor David Williams performed a full autopsy with consent of the family. The left lung showed extensive emphysema and the

[4] Exhibit E1, page 5

right lung was widely infiltrated with necrotic carcinoma which had spread to the lymph nodes and liver.[5]

17. He concluded Mr Harold died due to disseminated carcinoma, due to right lung carcinoma. Underlying chronic obstructive airways disease and coronary atherosclerosis contributed to Mr Harold's death.

18. I accept the pathologist's findings with respect to the cause of death and that the death was due to natural causes.

PERSONAL HISTORY, MEDICAL HISTORY AND TREATMENT

19. Mr Harold suffered from poor health over a number of years from about the early 1980's. In particular he suffered from mental health problems and health problems associated with heavy alcohol and smoking addictions. Due to the severity of his mental health problems he was required to be treated during various periods pursuant to the Mental Health Act. In 1987 he was diagnosed with paranoid schizophrenia requiring long periods of hospitalisation at Mossman Hall, Baillie Henderson Hospital, Cairns Mental Health Unit and Townsville Mental Health Unit. In July 2005 he was ordered to be detained in Townsville Medium Secure Mental Health Unit under a forensic order.[6] After admission he was diagnosed with dementia, type two diabetes, and chronic obstructive airways disease.

20. In February 2006 he was placed under an Involuntary Treatment Order pursuant to the Mental Health Act.[7] By October that year he was released into the community into supervised nursing home care still subject to the Mental Health Order. In April 2007 he was re-admitted to hospital, under the continuing order, this time into the Cairns Mental Health Unit. It was during this admission that a possible diagnosis of chronic lung disease known as sarcoidosis was made.[8]

21. The Adult Guardian was appointed in November 2007 to assist Mr Harold with respect to accommodation and services particularly involving Disability Services Queensland. In December 2007 Mr Harold was transferred from Cairns to the Townsville Secure Mental Health Unit. In April 2008 the Involuntary Treatment Order was changed to community based care and Mr Harold was transferred with the consent of the Adult Guardian to aged care nursing home accommodation in Normanton. The Involuntary Treatment Order was revoked in July 2008, but unfortunately Mr Harold had difficulty complying with medication and behaviour expectations in the nursing home environment. He left the nursing home and moved between family members' and hostel accommodation. This led to a period during which he was often homeless and then came into contact with police leading to his arrest and being taken into custody at the Mount Isa Watch House, and then on to the Townsville Correctional Centre after he was remanded in custody by a court in April 2009.

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[5] Exhibit A2, page 2
[6] Exhibit B2.7
[7] Exhibit B2.6
[8] Exhbit B1.1

22. His medical care was managed in prison from May 2009 until his death in July 2009. It was identified that he was non compliant with respect to satisfactorily managing his sugar diabetes disease. Psychiatric review also established Mr Harold's mental state was such that it was unlikely he would be fit for trial. There was difficulty in establishing a suitable long-term safe environment to meet Mr Harold's particular physical and psychiatric needs, particularly against the background of aggressive and disruptive behaviour which had ended previous accommodation arrangements in the community in the past.

23. In June 2009 he was reviewed in the medical centre due to a chesty cough. He also had symptoms of shoulder and back pain. Antibiotics and an anti inflammatory were prescribed. By 7 July he was becoming lethargic and refusing food and medication, leading to his transfer to hospital on 20 July 2009.

ADEQUACY AND APPROPRIATENESS OF MEDICAL TREATMENT

24. The Queensland Police Service Corrective Service Investigation Unit reviewed all the history and circumstances of Mr Harold's death in custody.[9] I am satisfied with their investigation which concluded that Mr Harold died due to natural causes and did not raise any concerns of suspicious circumstances.

25. In addition I directed a review of medical care provided to Mr Harold in periods of incarceration due to imprisonment or detention under Mental Health Orders. Professor Bob Hoskins of the Clinical Forensic Medicine Unit reviewed the records and provided expert opinion on Mr Harold's medical history and the medical care provided.

26. The main issue of contention raised by Dr Hoskins was the possible diagnosis in 2007 of sarcoidosis. He considered this was insufficiently investigated and thus failed to establish that Mr Harold was, in fact suffering from cancer. However, he was unable to say that an earlier diagnosis might have changed the ultimate outcome or timing of his death.

27. Otherwise, Dr Hoskins considered Mr Harold's care with respect to both his physical and mental heath illnesses was at least satisfactory and, at the end of his life in 2009, of the highest standard. He also considered the Townsville Hospital had appropriately considered and communicated with family members as well as the Adult Guardian.

28. An incidental issue raised by Dr Hoskins was the voluminous nature of the medical record and the difficulty this would present to treating staff in different facilities to access and appropriately review and inform them of Mr Harold's medical history.

29. Dr Patrick O'Neill, who is the Director of Medical Services at Cairns Base Hospital reviewed the records and considered the issue of possible misdiagnosis of sarcoidosis raised by Dr Hoskins. [10] Dr O'Neill noted Mr

[9] Exhibit B2.6
[10] Exhibit F5

Harold was a patient for about three months in 2007. He was admitted due to an incidence of violence and the primary focus of care was management of his complex psychiatric illness of schizophrenia and alcohol related brain injury as well as type two diabetes and seizures. Dr O'Neill stated there was no record of respiratory problems to any extent.

30. On 6 July 2007 he was reviewed by a registrar who noted history of 20 cigarettes per day for 30 years. At the time there was a productive cough, crepitations and a wheeze. This was interpreted as an exacerbation of chronic obstructive airways disease which was treated accordingly. A chest x-ray showed bilateral hilar lymphadenopathy lung disease which suggested sarcoidosis.

31. A respiratory physician reviewed Mr Harold on 30 August 2007. Consideration of other diagnoses included interstitial pulmonary fibrosis, or pneumonoconiosis, particularly as Mr Harold previously worked as an underground miner. The physician considered the diagnosis of sarcoidosis as unlikely according to Dr O'Neill's review of the medical record. A bronchoscopy and lung biopsy were considered but not pursued because of difficulties with consent as well as consideration that symptomology was minimal.

32. Another exacerbation of chronic obstructive airway disease occurred in September 2007 and was treated and settled with routine therapy.

33. Dr O'Neill noted Mr Harold died in July 2009 from disseminated small cell anaplastic carcinoma emanating from his right lung. He disagreed with Dr Hoskins' interpretation that the disease was present in 2007. Dr O'Neill noted this form of cancer is very aggressive and unlikely to have been survived for the period between 2007 and 2009. There was a long background history of smoking as well as underground mining to explain the presence of the diagnosed and suitably managed chronic obstructive airways disease. His symptomology in 2007 was not sufficient to pursue further at that time.

34. It is considered that treatment of lung conditions in 2007 was sufficient in the context of the level of symptoms demonstrated at the time and Mr Harold's positive response to treatment when exacerbation of his diagnosed pulmonary obstructive disease process occurred in the Cairns hospital.

35. A review was also undertaken by Dr William Kingswell, the A/Executive Director of the Mental Health and Other Drugs Directorate. The review included the issue of care of patients under mental health care who had other co-morbidities. Improvements have been initiated state wide to ensure compliance with standardised medical physical examinations, metabolic monitoring, and follow up at set intervals both in hospital and in the community, as well as concentration on physical findings and proposed care upon both transfer and discharge documentation.

36. State-wide web based information support systems within the mental health area have also commenced since 2008 to ensure conformity of data

collection. As well, Queensland Health has a protocol to assist staff in the recognition of a deteriorating patient to respond appropriately. This is applicable within the holistic care of a patient primarily under care due to a mental health diagnosis.

37. Another concern expressed by Dr Hoskins was the volume and complexity of a patient‘s medical history, such as Mr Harold. He suggested initiation of a one page summary of critical information to assist a treating team to review and consider if new symptoms appear. Practices vary from hospital to hospital. He suggested a particular software product to display all relevant information in an accessible coherent summary.

38. The suggestion was considered by Dr Jillan Farmer, the Medical Director of the Patient Safety and Quality Improvement Centre in Queensland Health[11]. She acknowledged the difficulty with paper based records across the state. She described the initiative of a new electronic system which will progressively replace the paper record and improve access and integration. The particular system is called The Viewer and commenced in 2011 across the State of Queensland.

39. This is supplemented by a Commonwealth system called the Personally Controlled Electronic Health Record which commenced in 2012. With a patient’s consent a longitudinal summary record of a patient’s medical history can be recorded.

40. There remains the problem that neither system is compulsory. The regional based health care delivery may continue to reduce the likelihood of conformity with a particular system state-wide.

FINDINGS

41. In accordance with the requirements of section 45 of the Coroners Act 2003 I find:

    (a) The identity of the deceased was Rex Harold who was born on 2 March 1950.

    (b) The date on which Mr Harold died was 23 July 2009.

    (c) Mr Harold died at the Townsville Base Hospital, on Angus Smith Drive, at Douglas in Queensland 4814.

    (d) Mr Harold died whilst in custody. He had been transferred to the Townsville Hospital for medical treatment after being unwell for a few days and appearing lethargic and declining food and medication. He had multiple co-morbidities including diabetes, chronic obstructive lung disease against a background of thirty years smoking, as well as schizophrenia and alcohol acquired brain injury. The combination of physical and mental heath issues over a long period of time and the frequency and length of time during which Mr Harold was incarcerated, either due to mental health laws or court sanction made for a very

[11] Exhibit G1

complex presentation for treating doctors to consider. A malignancy was suspected but had not been diagnosed at the time he was last admitted to hospital. He was too unwell to confirm a diagnosis. He was treated for pneumonia and cared for palliatively until his death on 23 July 2009. After his death, it was confirmed he died due to an aggressive form of lung cancer which had disseminated through his body and was not amenable to treatment. It is unknown whether an earlier diagnosis could have changed the outcome.

(e) Mr Harold's death was caused by disseminated carcinoma due to right lung carcinoma. Underlying chronic obstructive airway disease and coronary atherosclerosis contributed to his death.

CORONER'S COMMENTS

42. When an inquest is held a coroner may consider whether or not it is appropriate to make comments connected to the death oif the deceased person relating to:

(a) public health and safety;
(b) the administration of justice; or
(c) ways to prevent deaths form occurring in similar circumstances in the future.[12]

43. Dr Hoskins' review of Mr Harold's medical care was the primary basis for considering several issues which have been previously detailed. On the basis of the thoughtful and detailed review of Dr Hoskins and the considered responses made by Doctors O'Neill, Kingswell, Fisher and Farmer, I am satisfied there is no need for coronial comment in this inquest.

44. I thank all who have participated in this inquest into the death of Rex Harold. He died due to natural causes after many years of declining physical and mental health during which he spent long periods in custody.[13] He will be sadly missed by his family.

Christine Clements
Deputy State Coroner
28 September 2012

[12] Section 46 Coroners Act 2003
[13] Page 12-13 of Counsel Assisting submissions