QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Andrew John Joseph EMERTON**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR/2012/418
DELIVERED ON:	24September 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	11 September 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mrs Rhiannon Helsen
Department of Community Safety – Queensland Corrective Services:	Ms Fiona Banwell
Wide Bay Hospital and Health Service:	Ms Stephanie Gallagher (Corrs Chambers Westgarth Lawyers)

Table of Contents

The *Coroners Act 2003* provides in s.47 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 Andrew John Joseph Emerton. 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

Shortly after 5:00 pm on 2 February 2012, Mr Andrew Emerton, aged 43, made a call from the intercom of his cell at the Maryborough Correctional Centre to custodial corrections officers ('CCO') stating that he was short of breath and needed help. CCOs initiated a code blue (medical emergency) via the radio system before attending his cell. Mr Emerton was observed to be lying on his bed naked and was stating that he could not breathe. He was rolled onto his side into the recovery position, whilst being instructed to take deep breaths. Within a few moments, Mr Emerton stopped breathing. CPR was immediately commenced and continued until nursing staff arrived some three minutes later. At this time, the Queensland Ambulance Service ('QAS') was called. Despite extensive resuscitation attempts by the custodial officers, nursing staff and the QAS officers, Mr Emerton was unable to be revived. Life extinct was declared at 6:12 pm.

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 Emerton was conducted by Plain Clothes Senior Constable ('PCSC') Libor Joch from the Corrective Services Investigation Unit ('CSIU').

Initially, a Constable from the Maryborough Police station attended the scene with scenes of crime officers. Photographs of the scene and Mr Emerton in situ were taken. No signs of violence were noted upon the body of the

deceased. Medical treatment tubing utilised by medical staff remained attached to the deceased. No physical exhibits, aside from the deceased's medical chart, were seized at this time. Officers from the Maryborough District Child Protection Investigation Unit also attended the scene. Mr Emerton was subsequently transported to the Maryborough Mortuary.

On 3 February 2012, CSIU staff, including PCSC Joch, attended the Maryborough Correctional Centre, taking carriage of the investigation. During the course of the investigation, statements were obtained from all of the relevant CCOs, inmates, nursing staff and QAS officers who attended to assist Mr Emerton. These were tendered at the inquest. Medical records, CCTV footage, audio exhibits and photographs were also obtained. A coronial report detailing the investigation was subsequently submitted to my office and tendered at the inquest.

On 8 February 2012, a full internal and external post-mortem examination was conducted by Pathologist, Dr Rebecca Williams. Further photographs were taken during this examination.

In addition to the CSIU investigation, an enquiry was also conducted by appointed inspectors from the Office of the Chief Inspector. A report detailing the findings and recommendations of the inspectors was subsequently provided and tendered during the inquest.

At the request of the Office of the State Coroner, Dr Don Buchanan from the Queensland Health Clinical Forensic Medicine Unit ('CFMU') examined the medical records for Mr Emerton 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 11 September 2013. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigating officer, PCSC Joch gave evidence and Counsel Assisting, Mrs Helsen, proposed that no further oral evidence be heard subject to objection from any other party. I agreed that the evidence tendered, in addition to the oral evidence of PCSC Joch, was sufficient for me to make the requisite findings.

The evidence

Criminal history

Andrew John Joseph Emerton was born on 29 May 1968, making him 43 years of age at the time of his death. He had an extensive Queensland criminal history, commencing in 1987 when he was 19 years of age. He had

previous convictions for a range of offences, including possession of a dangerous drug, production of a dangerous drug, assault occasioning bodily harm, stealing, breaches of the *Bail Act*, fraud and various property offences. In total, he had ten episodes with the Department of Corrective Services and was first incarcerated in April 1992.

At the time of Mr Emerton's death, he had no outstanding criminal charges.

Details of incarceration at time of death

On 13 October 2011, Mr Emerton was arrested and transported to the Southport Watch House where he was charged with 16 offences, including numerous burglary, unlawful use of motor vehicle, stealing and fraud related offences. At the time of Mr Emerton's placement at the Watch House, he stated that he had no know medical conditions, however, was a heroin addict. He indicated he had used heroin two hours prior to his arrest.

On 14 October 2011, Mr Emerton was sentenced in the Magistrates Court at Southport for numerous burglary, unlawful use of motor vehicle, stealing and fraud related offences. He was sentenced to two years imprisonment and given a parole release date of 14 June 2012. All terms of imprisonment were ordered to be served concurrently.

On 17 October 2011, Mr Emerton also pled guilty to two further burglary offences and one charge of fraud. He was sentenced to two years imprisonment and given a parole release date of 14 June 2012.

On 19 October 2011, Mr Emerton was transported to the Brisbane Correctional Centre, Wacol.

On 24 November 2011, Mr Emerton was transferred to the Maryborough Correctional Centre. He was initially placed into Secure 7 Unit before being moved to Secure 9 Unit on 6 December 2011.

On 16 December 2011, Mr Emerton received placement in the residential unit and was transferred to V010 Cell 3.

Mr Emerton was reported to be a compliant and co-operative prisoner. He had no major incidents during his stay at the Maryborough Correctional Centre.

Mr Emerton's medical history

Corrective Service Medical records for Mr Emerton indicate that he had a significant substance abuse history, which included the prolonged use of alcohol, amphetamines, heroin and prescription medication. In a Parole Board Report dated 12 March 2008, Mr Emerton indicated that he had used drugs for 25 years and had been dependent on amphetamines for 10 years.

Records also confirm that whilst in custody, Mr Emerton had regularly been prescribed anti-psychotic medication to treat auditory hallucinations thought to be due to schizophrenia or a drug induced psychosis.

Records from Mr Emerton's incarceration at the Arthur Gorrie Correctional Centre in August 2007 suggest that he was prescribed a high dose of the anti-psychotic drug, Quetiapine, to treat auditory hallucinations. In view of the dose, blood tests were obtained and an ECG was ordered. Mr Emerton refused the ECG, however, the blood tests showed his lipids (cholesterol and triglyceride) were elevated. It was thought that the Quetiapine may be causing this, so it was decided that the dose would be gradually reduced. Mr Emerton indicated at this time that he was not keen to embark on a low fat diet. Repeat lipid tests confirmed his elevated cholesterol and triglyceride. As such, on 29 August 2008, Mr Emerton was commenced on lipid lowering medication, Atorvastatin.

A test performed on 9 December 2008, showed Mr Emerton's cholesterol had decreased but his triglyceride had increased. He was therefore commenced on another lipid lowering drug, Lopid to address this condition. On 5 January 2009, he presented with symptoms of stomach reflux, so was commenced on Losec, a proton pump inhibitor.

Mr Emerton was discharged from the Arthur Gorrie Correctional Centre on 17 June 2009.

On 10 March 2010, Mr Emerton returned to the Arthur Gorrie Correctional Centre, at which time he was prescribed Losec (20 mg), Lipitor (20 mg), Lopid (600 mg twice a day) and Quetiapine (900 mg).

Mr Emerton was transferred to the Brisbane Correctional Centre on 16 August 2010. He was prescribed Quetiapine (600 mg), Losec (20 mg) and Diazepam (15 mg). On 23 August, he was recommenced on his lipid lowering medication, Lipitor (20 mg) and Lipidil (145 mg). His dose of Quetiapine was increased to 900 mg.

Mr Emerton was subsequently transferred to the Woodford Correctional Centre on 12 October 2010. During this time, his dose of Quetiapine was reduced to 25 mg. He was subsequently discharged on 9 May 2011, with seven days supply of medication.

Mr Emerton was received at the Brisbane Correctional Centre on 19 October 2011. He was assessed by health personnel who noted that he was on a Valium withdrawal regime. He was prescribed Losec (20 mg). There is no evidence that Mr Emerton requested any lipid lowering medication. On 4 November 2011, Mr Emerton was prescribed Quetiapine (100 mg) to be taken in the evening to treat auditory hallucinations.

During his admission to the Maryborough Correctional Centre on 24 November 2011, Mr Emerton was assessed by health personnel. He told staff that he had a mental health problem and wished to have his dosage of Quetiapine increased from 100 mg to 200 mg. He was still smoking at the time. His blood pressure was normal at 130/80. Mr Emerton also indicated that he was undergoing drug withdrawal due to his previous use of heroin. He had been prescribed Valium (10 mg), Losec (20 mg) and Thiamine (100 mg).

Induction records for the Maryborough Correctional Centre suggest that his only known medical conditions upon admission were Hepatitis C and possible Schizophrenia concerns.

On 6 December 2011, Mr Emerton was assessed by the prison medical officer at the Maryborough Correctional Centre. He complained that he was not sleeping and was hearing auditory hallucinations. His dosage of Quetiapine was increased to 150 mg.

There is no record during any of Mr Emerton's periods of incarceration to suggest that he ever presented to a Corrective Services medical centre with cardiac pain.

Sequence of events on day of Mr Emerton's death

At the time of Mr Emerton's death he was domiciled at the residential unit V010 Cell 3 of the Maryborough Correctional centre.

Mr Emerton was observed by custodial officers and fellow prisoners to regularly engage in vigorous exercise. He would often conduct exercise sessions twice a day regardless of the weather conditions.

On 2 February 2012, Mr Emerton exercised in the morning with fellow prisoner, Mr Matthew Bugajna. According to Mr Bugajna, nothing out of the ordinary occurred during the workout, although Mr Emerton did complain of suffering from pain in his left forearm.

Later that afternoon, Mr Emerton undertook another exercise session in an area located behind the custodial officer's station with fellow inmate, Mr Samuel Gallaher. According to Mr Gallaher, Mr Emerton exercised "*really hard*". At around 5:00 pm, Mr Emerton indicated that he needed a break and returned to his cell. CCTV footage shows Mr Emerton returning to his Cell at 5:11 pm.

After returning to his cell, Mr Emerton showered. He left his clothing in the middle of the common area prior to taking a shower. At 5:15 pm, Mr Emerton returned to his cell. He subsequently made a call on the intercom via the "Jacques" system to custodial officers stating that he was short of breath and needed assistance. Mr Emerton's call was answered by CCO Zoe Morgan, who initiated a Code Blue (medical emergency) via the radio system. According to CCO Morgan, Mr Emerton's call was received at around 5:20 pm.

CCO John Arndt along with Acting Supervisor CCO Rose Cockfield, who had been in the residential cluster office, were the first officers to attend upon Mr Emerton. CCTV footage shows the officers entering his Cell at 5:19 pm. CCO Arndt observed Mr Emerton in Cell 3 lying on the bed naked. Mr Emerton told CCO Arndt that he could not breathe. CCO Arndt placed Mr Emerton into the recovery position on his side and instructed him to take deep breaths. Mr Emerton complied. Within a few moments, Mr Emerton convulsed, vomited and stopped breathing. CCO Arndt turned him onto his back and commenced

CPR, which he continued until nursing staff arrived. CCO Andrew Cross and CCO Timothy Ryan also attended Mr Emerton's cell. CCO Cross directed CCO Gavin Earl to keep a timeline of events.

At 5:23 pm, Nurses Denise Young and Julie Tasker arrived at Cell 3 and took over resuscitation attempts. At this time, CCO Morgan contacted Acting Centre Supervisor ('ACS'), Mr Shannon Richards and asked him to contact the QAS to request assistance immediately. ACS Richards subsequently called QAS.

At 5:27 pm, QAS officers Natalie Creighton-Jay and Anthony Crompton were dispatched to attend the Maryborough Correctional Centre.

At 5:30 pm, an oxygen bottle and defibrillator were delivered to the Cell for use by nursing staff during resuscitation attempts. When the Automated External Defibrillator was applied to Mr Emerton no shock was indicated.

At 5:44 pm, QAS officers arrived at the scene. As the Cell was too small for the equipment and personnel, Mr Emerton was moved to the common area with the assistance of nursing staff and the CCOs. Once Mr Emerton was positioned on the floor, CPR was resumed. QAS officer Creighton-Jay observed Mr Emerton to be unresponsive with no pulse or cardiac electrical activity whilst being monitored through the paddles of the defibrillator. QAS officers noted that Mr Emerton's airway was severely compromised with vomit. This was cleared by QAS officer Crompton before an endo-tracheal tube was inserted. A cannula was placed into Mr Emerton's external jugular vein allowing Adrenaline and Sodium Bicarbonate to be administered.

At 5:56 pm, a second QAS crew arrived at the Maryborough Correctional Centre.

Despite extensive resuscitation measures, Mr Emerton was unable to be revived. Mr Emerton had continued to be asystole and was unresponsive to all medication, ventilation and CPR. He was declared deceased by QAS officer Crompton at 6:12 pm.

CCTV footage from a camera located inside the unit confirms the events as outlined above. The footage confirms that no other person entered the Cell or was involved in Mr Emerton's death.

At 6:35 pm, General Manager, Mr Trevor Craig and Deputy General Manager, Mr Peter Drage embarked together from their homes to the Maryborough Correctional Centre. En route they co-ordinated with ACS Richards a variety of activity in response to the incident, and directed that the following occur:

- That the crime scene be preserved;
- That clothing from the other prisoners in Unit 1C be collected and secured (although this was not undertaken);

- That guards be posted outside the Unit;
- That the compliance manager and Intel staff be called to the Maryborough Correctional Centre; and
- That psychologists be called to the Maryborough Correctional Centre to assist prisoners.

At 6:50 pm, police from the CSIU were notified of Mr Emerton's death.

At 7:12 pm, a lock away was called. The other prisoners from Mr Emerton's Cell were found alternative accommodation. They were also offered counselling by the Maryborough Correctional Centre psychological services.

At 7:46 pm, Constable Andrew White of the Maryborough Police Station attended the Maryborough Correctional Centre with scenes of crime officers. Photographs of the scene and Mr Emerton in situ were taken.

At 9:08 pm, ACS Richards directed a head count be undertaken, which was completed at 10:45 pm.

After a short address by the General Manager, all remaining staff involved in the incident attended a critical incident debrief with PPC Worldwide before being allowed to leave the Maryborough Correctional Centre.

Despite attempts, contact was unable to be made with Mr Emerton's next of kin until the following morning.

Autopsy results

An external and full internal post-mortem examination was performed by Dr Rebecca Williams on 8 February 2012. A number of histology and toxicology tests were also undertaken.

The external post-mortem examination showed a man with signs of recent medical intervention. One minor injury was observed on his left shin, which was not considered to be related to his death.

The internal post-mortem examination revealed areas of severe narrowing in all of the major arteries to the heart (Coronary Atherosclerosis). Histological examination confirmed severe atherosclerosis.

Serological tests were reactive for Hepatitis C. Toxicological tests were also performed on port-mortem blood and urine samples. Quetiapine was identified in the blood at a concentration below the usual therapeutic range.

The cause of Mr Emerton's death was found to be Coronary Atherosclerosis. Dr Williams noted that this condition was a common cause of sudden unexpected death. Major risk factors include cigarette smoking, high blood pressure, high cholesterol and diabetes. The terminal event in Mr Emerton's case was most likely an abnormal heart rhythm precipitated by the impaired

blood supply to the heart. Intense physical activity may have placed added strain on his already encumbered heart function.

Investigation findings

Following a thorough investigation, PCSC Joch concluded that Mr Emerton's death was not preventable and there were no suspicious circumstances. Furthermore, he did not identify any concerns with the response and attempts made to revive Mr Emerton by the CCOs, Nursing staff and QAS officers. He noted that the CCOs responded appropriately, calling a Code Blue and directing a number of officers in response to the distress call. These officers attended Mr Emerton within less than a minute. When officers arrived, Mr Emerton was still conscious and breathing. Soon after he went into a seizure and stopped breathing. The CCOs immediately commenced CPR and within three minutes the nurses from the medical unit arrived. At this time, a request for an ambulance was made. At 5:43 pm, the ambulance arrived at the scene and took over resuscitation attempts. Despite all efforts, resuscitation was not successful and Mr Emerton was declared deceased.

Investigation by the Office of the Chief Inspector

Pursuant to s.294 of the *Corrective Services Act 2006,* the Office of the Chief Inspector also conducted an investigation into Mr Emerton's death. Mr David Crothers, Inspector, Office of the Chief Inspector and Mr Matthew Hickey, Barrister at Law, were appointed to investigate. A report detailing the findings of the investigation was provided in June 2012 and was tendered during the inquest.

The terms of reference for the investigation included the following matters:

- How, when and where the incident occurred and the circumstances surrounding the occurrence;
- The custodial management of Mr Emerton leading up to his death;
- The timeliness and effectiveness of centre staff and centre management in responding to the incident, including whether or not appropriate contingency plans were in place and were implemented immediately following the incident; and
- Whether there was any intelligence or other information in existence prior to the incident which might have indicated that the incident was likely to have occurred.

Following the investigation into Mr Emerton's death, the appointed inspectors found that there were policies, procedures and practices in places for the supervision of Mr Emerton, and that those had been effectively implemented and complied with, having regard to the assessment and ongoing management of Mr Emerton. Furthermore, it was noted that the response of officers to Mr Emerton's medical emergency was appropriate, timely and professional. The appointed inspectors found that the Maryborough

Correctional Centre resources were appropriately deployed and staff at the centre had attempted to preserve Mr Emerton's life. There was no intelligence or other information which might have indicated that the incident was likely to occur.

Nonetheless, the appointed inspectors made a number of findings following their review, which included:

(a) That the assessment and management of Mr Emerton was appropriate in the circumstances.

(b) While the timeliness and effectiveness of centre management and staff in responding to the incident was appropriate, there is scope for improved practices in relation to:

(i) Awareness of and compliance with Code Blue contingency checklists;

(ii) Participating in and attendance at operational debriefs; and

(iii) Crime scene preservation, especially as regards the separation of prisoners, searching them and collecting their clothing in the wake of an incident.

As a consequence of these findings, the appointed inspectors made the following recommendations (although it was noted that none of these recommendations would have had an effect on Mr Emerton's outcome):

(c) Recommendation 1 – *in respect of Code Blues,* that the Maryborough Correctional Centre remind its staff about the existence of the Code Blue contingency checklist;

(d) Recommendation 2 – *in respect of operational debriefs,* that the Maryborough Correctional Centre make a more concerted effort to ensure staff members directly or indirectly involved in incidents, especially those fundamentally involved, directly participate in operational debriefs as a part of a group operational debrief, rather than individually after the event, in circumstances where those persons are not rostered to work on the date of any proposed operational debrief; and

(e) Recommendation 3 – *in respect of crime scene preservation,* that the Maryborough Correctional Centre reminds its staff about the importance of maintaining a crime scene and preserving evidence, especially as regards the separation of witnesses to prevent collusion and the collection and preservation of prisoners clothing and other personal effects.

All of these recommendations have since been implemented by the Maryborough Correctional Centre, as outlined in the statement of the General Manager, Mr Trevor Craig, which was tendered during the inquest.

Medical Review

The available medical records pertaining to Mr Emerton were sent to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Don Buchanan.

In a report dated 18 March 2013, Dr Buchanan confirms that the low concentration of Quetiapine found during the post-mortem examination would not have contributed to Mr Emerton's death.

Dr Buchanan notes that Mr Emerton had a long history of drug abuse, which may have been responsible for the auditory hallucinations he had experienced episodically. The few presentations he had made to the prison health staff were for psychiatric reasons and nothing in the records suggests that he had presented for a condition that could have been cardiac in origin. Nonetheless, Mr Emerton was suffering from narrowing of the coronary arteries, which caused cardiac arrest following a bout of vigorous exercise. The cardiac arrest was asystole, which was treated appropriately with CPR and adrenaline for over 50 minutes. Resuscitation attempts ceased only when it was clear that further treatment was futile.

In Dr Buchanan's opinion, the response by the CCOs, health staff and ambulance officers was timely, reasonable and appropriate in the circumstances.

On 7 August 2013, after receiving further medical records pertaining to Mr Emerton from the West Moreton Offender Health Service, Dr Buchanan was asked to conduct a further review of the material.

In a report dated 8 August 2013, Dr Buchanan notes that upon being received at the Brisbane Correctional Centre on 19 October 2011, Mr Emerton did not request lipid lowering medication, which he had previously been prescribed upon his discharge from the Woodford Correctional Centre on 9 May 2011. In the three months prior to his death whilst he was incarcerated at the Maryborough Correctional Centre, Mr Emerton was not provided with this medication. Nonetheless, Dr Buchanan is of the view that this gap in his lipid lowering therapy would have been unlikely to have a significant impact on Mr Emerton's eventual outcome.

Conclusions

I conclude that Mr Emerton died from natural causes. I find that none of the correctional officers or inmates at the Maryborough Correctional Centre caused or contributed to his death.

The circumstances surrounding Mr Emerton's death have been thoroughly and professionally investigated by the CSIU. The conclusions reached by PCSC Joch in the Coronial Report tendered at the inquest are appropriate. Clearly, Mr Emerton's death was not preventable. The CCOs and nursing staff responded appropriately to Mr Emerton's distress call and acted incredibly quickly. Efforts to resuscitate Mr Emerton were initiated promptly by the CCOs and continued until being taken over by the QAS officers. Despite the efforts of the CCOs, nursing staff and the QAS officers, Mr Emerton was not able to be revived. The post-mortem examination revealed that Mr Emerton died as a result of Coronary Atherosclerosis, which is a condition known to cause sudden, unexpected death.

I am satisfied that Mr Emerton was given appropriate medical care by staff at the Maryborough Correctional Centre. 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 Emerton 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 Andrew John Joseph Emerton. He was a prisoner at the Maryborough Correctional Centre.

How he died - Mr Emerton was unable to be revived after experiencing difficulty breathing and falling unconscious.

Place of death – He died at the Maryborough Correctional Centre.

Date of death – He died on 2 February 2012.

Cause of death – Mr Emerton died suddenly as a result of 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 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
24 September 2013