OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Elles John PONT**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2749/07 (6)
DELIVERED ON:	27 January 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	21 August 2009 & 15 September 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Health:	Mr Kevin Parrott, Crown Law
Department of Communities:	Mrs Elizabeth Gullo

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The *Coroners Act 2003* provides in s45 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 Elles John Pont. 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

On 15 June 2007, Elles John Pont, 69, was standing outside his cell at the Wolston Correctional Centre (WCC), when he suffered severe chest pain. He was taken to Princess Alexandra Hospital where his condition continued to deteriorate. Despite attempts to revive him he died later that afternoon.

These findings

- confirm the identity of the deceased person, 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 needs 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 pubic health and safety or the administration of justice.

The investigation

Mr Pont's death was reported to the Corrective Services Investigation Unit (CSIU) and an investigation was carried out by Detective Sergeant Craig Hickling.

Detective Sergeant Pascoe of the CSIU attended Mr Pont's cell on 15 June 2007 to carry out an examination and to have it photographed.

An examination of Mr Pont's body was carried out at the PA Hospital and photographs were taken. A representative of the CSIU then attended the autopsy examination where further photographs were taken.

Interviews were carried out with the first response Corrective Service Officers and nursing staff. Dr McNeil of the PA Hospital was interviewed and Mr Pont's medical records were obtained.

A report was obtained from the QAS exhibiting all relevant paperwork generated by their involvement in the matter.

On 16 June 2007 all prisoners in unit S7 at Wolston were interviewed regarding their knowledge of the incident.

CCTV recordings, movement registers, incident reports and vehicle movement registers relevant to the incident were seized from Wolston Correctional Centre. Mr Pont's professional management file, detention file and medical file were also seized.

The investigation was thorough and professionally conducted. It failed to look into an apparent anomaly concerning the medication provided to Mr Pont at the prison but that has been addressed by those assisting me. I thank Detective Sergeant Hickling for his efforts.

The Inquest

An inquest was held in Brisbane on 15 September 2009. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the Department of Corrective Services.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Two witnesses were called to give evidence.

A copy of the police investigation report was provided to Mr Pont's brother and sister prior to the inquest and both were advised of the date of the inquest.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Background

Mr Pont was born in Brisbane on 24 May 1938. He is survived by his brother Athol Pont and his sister Patricia Somer.

Mr Pont's date of birth was the subject of some conjecture in the evidence tendered at inquest. His date of birth is alternately recorded as 4 June 1937 and 24 May 1938 and 24 May 1939. As a result Sgt Hickling obtained and produced a copy of Mr Pont's birth certificate which allows me to be satisfied that he was born on 24 May 1938 and was 69 years of age at the time of his death.

Custody

Mr Pont had a significant criminal history predominantly consisting of sex offences against children. His latest period of imprisonment was not his first.

Mr Pont was sentenced on 11 July 2002 to a period of 8 years imprisonment after being convicted on two counts of rape. Subsequent cumulative sentences imposed as a result of convictions for historical offences of

indecent treatment of children increased the maximum period to be served to a period of 12 years. His full term discharge date would have been 10 July 2014.

Mr Pont had spent the majority of his time in custody at Arthur Gorrie and Capricornia Correctional Centre. On his request Mr Pont was transferred to WCC on 28 March 2007.

Medical issues

At the commencement of his most recent sentence in July 2002 Mr Pont underwent a medical check-up at which time a medical history was taken. He reported no previous cardiac problems. At that time he was suffering from depression, hypertension and asthma.

In June 2003 Mr Pont was diagnosed with high cholesterol and note was again made in his prison medical file of high blood pressure.

On arrival at WCC Mr Pont was again medically assessed. The notations of it refer only to an inability to work due to "*sore back and allergies".*

The progress notes do, however, contain a blood pressure reading taken just prior to his transfer which is notably high. In any case, he continued taking the same prescribed medication on arrival at the WCC as he had previously. This consisted of daily doses of Aspirin (100mg), Lipitor (40mg) and Lisodur (20mg). Mr Pont's medical file does not indicate any incidents or reports of chest pain suffered while in custody.

On 6 June 2007, Piroxicam, a common arthritis treatment, was prescribed by a visiting medical officer, Dr Ronie Acabado.

Dr Acabado gave evidence that he attended WCC in a locum capacity, usually on a weekly basis during the course of 2007. He did not have a specific recollection of Mr Pont. After reviewing Mr Pont's records he was able to confirm that he had prescribed Piroxicam for the treatment of Mr Pont's arthritis.

Dr Acabado agreed with the contention that Piroxicam is a drug requiring follow up consultation. He was adamant that he would have advised Mr Pont of the need to return to see a doctor over the course of the next few weeks. He was sure that this would have been noted and was not able to say why no such record was on Mr Pont's medical file. He stated that such notations would be made in the progress notes of the prisoner's file which were, in his experience, almost always affixed to the file.

Counsel assisting detected the medication documentation on Mr Pont's prison medical file, showed no record of him having been given his medication at any time after 6 June 2007 until his death on 15 June. This aspect of the matter is dealt with later in these findings.

Mr Pont's collapse and immediate treatment

Mr Pont was the only occupant of cell 37 in secure unit S7 of the WCC. Cell 37 is located on the top landing of the unit.

Around 12:30pm on 15 June 2007 prisoner's mail was distributed and Corrective Services Officer (CSO) Michael Petrovic recalls giving Mr Pont his mail at this time. He noticed nothing unusual about Mr Pont.

At 12:45pm CSO's had their attention drawn to Mr Pont by other prisoners. CSO Terence Walker went to where he was standing, outside his cell, bent over and supporting himself on the railing on the outside of the catwalk. Mr Pont was being attended to by two other prisoners. He was clearly in pain and was having difficulty speaking. An urgent call was made for medical staff and Mr Pont was carried into his cell and placed on his bed in the recovery position. Vomit was observed in the toilet bowl and on the floor of the cell.

Two nurses, Leonie Cutelli and Marie Griffiths arrived within a few minutes. They noticed Mr Pont was by this time sweating, groaning, having difficulty breathing and turning blue. He was administered oxygen and morphine and a nitro lingual spray placed under his tongue.

Transfer to Princess Alexandra Hospital

Shortly after the arrival of the nurses the Queensland Ambulance Service (QAS) were called and arrived at 1:10pm. Mr Pont's condition had deteriorated by this time to the point that he appeared unconscious. He was given further oxygen and transferred to an ambulance at 1:20pm.

An initial assessment made by QAS personnel was that Mr Pont had suffered an acute myocardial infarction. The ambulance arrived at the PA Hospital at 1:58pm.

Treatment at hospital and events surrounding his death

On arrival at hospital Mr Pont was conscious, however in the following minutes his condition deteriorated. At 2:12pm adrenaline was administered. At 2:18pm, Midazolon and further adrenaline was administered. At 2:30pm Vecaronium and yet further adrenaline was given to Mr Pont. These had little effect and at 2:33pm CPR was commenced. This was unsuccessful and life was pronounced extinct at 2:45pm by Dr Isoardi.

Mr Pont's body was transported to the morgue later that evening. Fingerprints of the body were taken and confirmed by a QPS expert fingerprint analyst as being identical to those recorded for Mr Pont on police records.

Autopsy results

An autopsy examination was carried out on 18 June 2007 by an experienced forensic pathologist Dr Olumbe. After considering histology results he stated in his report:

> *Autopsy revealed acute myocardial infarction (death of heart muscle) of hours to days duration that is consequent to severe coronary atherosclerosis. There was also scarring of the heart muscle which is an indication of previous heart attack/s. These findings are sufficient to account for the sudden unexpected death.*

During autopsy Dr Olumbe noted fractures to Mr Pont's ribs and breastbone as well as a tear to his spleen. In relation to this he states:

> *The chest injuries including breastbone/rib fractures and a small collection of blood in the abdominal cavity due to a tear of the spleen and parenchymal lacerations of the liver are consequence to resuscitation efforts and in my opinion did not contribute to his death.*

He concludes:

> *There is no evidence of any other pre-existing natural disease which may have contributed to death*.

As a result Dr Olumbe issued a certificate listing the cause of death as:

1(a) Acute myocardial Infarct, *due to or as a consequence of,*

1(b) Coronary atherosclerosis

Investigation findings

The search of Mr Pont's cell found a small quantity of blood smeared on the edge of the bed, however, Detective Sergeant Pascoe who conducted the search concluded there were no signs of a physical altercation.

No information was obtained from other prisoners that was inconsistent with Mr Pont having suffered anything other than a medical problem on 15 June 2007.

No signs of trauma were noted on the body of the deceased other than that which could be linked to medical treatment.

Medication records

The apparent failure to administer Mr Pont's medication in the last nine days of his life led to a suspicion this may have contributed to his death.

At the inquest the WCC nurse manager, Marie Griffiths explained the medication sheets found in Mr Pont's medical file would not have been the ones on which drugs given during the period in question would have been recorded. Rather, when another drug was added to the prisoner's ongoing drug order on 6 June, a new dose medication signing sheet would have been generated and kept in a folder containing the current sheets for all other prisoners. The superseded sheet would be filed in the prisoner's medical chart.

The new, current dose signing sheet should have been sent for filing after Mr Pont died. She speculated that Mr Pont's file may have been seized by intelligence officers prior to the sheet finding its way onto the file. Ms Griffith's explanation is plausible. I accept there was another medication sheet for Mr Pont being used at the time of his death and the absence of notations on the medication sheet in his medical file does not indicate he received no medication for the last nine days of his life.

A review of the toxicology results confirms this. It was clear the level of the cholesterol lowering agent Lipitor in Mr Pont's blood was indicative of recent ingestion and was at a level, in the view of Dr Griffin, the deputy director of the clinical forensic medicine unit, "appropriate for the usual dose". The level of salicylic acid, a by-product of aspirin, also pointed strongly to ongoing ingestion over the course of the days preceding Mr Pont's death, although it could not be said whether aspirin had been ingested on the morning of his death.

I am satisfied Pont continued to be provided with this prescribed medication in the days leading to his death. The extent of the forensic resources and investigation necessary to establish this very important issue highlights the importance of record keeping and the necessity for all documents relating to a deceased prisoner to be diligently collated as soon as possible after death.

Conclusions

I find that after Mr Pont collapsed Corrective Services staff followed medical emergency protocols. An internal review of staff reaction to the situation was carried out at the direction of WCC management as a matter of course. I agree with their conclusions that staff acted quickly and appropriately to the emergency. Corrective Services staff and QAS paramedics did all within their power to provide assistance and resuscitation to Mr Pont. Treatment was carried out in an appropriately timely manner.

A comprehensive police investigation was conducted. It revealed Mr Pont passed away relatively suddenly after having suffered an acute myocardial infarction while standing near his cell.

The autopsy report of Dr Olumbe provides sufficient evidence to find that the death was sudden and unexpected. There is no suggestion therefore that medical staff at Capricornia or WCC should have conducted themselves any differently in their ongoing treatment of Mr Pont.

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 how, when, where 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 in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Elles John Pont

How he died –	Mr Pont died of natural causes while a prisoner at the Wolston Correctional Centre.
Place of death –	He died at the Princess Alexandra Hospital in Brisbane.
Date of death –	Mr Pont died on 15 June 2007.
Cause of death –	He died from natural causes, namely acute myocardial infarct due to or as a consequence 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.

I have found that none of the correctional officers or inmates at WCC caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr Pont, who passed away suddenly and unexpectedly from natural causes.

In those circumstances there is no basis on which I could make any preventative recommendations.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
27 January 2010