QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Desmond Arthur SIMS**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR
DELIVERED ON:	6 December 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 August 2013; 3 September 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Fiona Banwell
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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 Desmond Arthur Sims. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Desmond Sims was 62 years of age when on 26 January 2011, having been a prisoner for nearly six years, he died at the Princess Alexandra Hospital Secure Unit (PAHSU). His premature death had been expected since at least July 2010 when Mr Sims was informed of his diagnosis of advanced lung cancer. He subsequently refused further examination or treatment for the cancer and received palliative care at Wolston Correctional Centre (WCC) and PAHSU until his death.

Initially, less clear was whether Mr Sims had also been notified of this diagnosis when it was first made by staff at the Princess Alexandra Hospital (PAH) in February 2009. After being sent for an oncology scan, which confirmed the diagnosis, Mr Sims was *lost to follow up* for the ensuing 15 months.

While the evidence at inquest suggested that there were discussions with Mr Sims about his diagnosis and/or treatment options in February 2009, not all of these were recorded.

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
- 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 Sims was conducted by Detective Senior Sergeant Walker from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). She provided a report to my office and this was tendered at the inquest.

Another CSIU officer, DS Anderson attended PAHSU on the day of Mr Sims' death. He inspected the body, arranged for photographs to be taken and seized relevant medical records.

After a requirement was issued by my office, statements were provided by medical staff at the PAHSU who had treated Mr Sims during his final admission. The PAH also provided a statement under the hand of the then locum respiratory and sleep consultant. This addressed the history of Mr Sims' treatment at the hospital. It properly noted that Mr Sims had been *lost to follow up* after his lung cancer was diagnosed in 2009 though did not provide any further explanation as to why this occurred.

Prison records relating to Mr Sims were seized and statements taken from corrective services staff who had been involved in transporting and guarding Mr Sims in his final days.

The CSIU investigation into Mr Sims' death did not lead to any suspicion that his death was anything other than natural.

At the request of counsel assisting, Dr Don Buchanan, an independent medical practitioner from the Queensland Health Clinical Forensic Medicine Unit, examined Mr Sims' medical records from WCC and PAH and reported on them. His findings are detailed below.

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 3 September 2013. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Helpful written submissions were received from each of the represented parties.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

Desmond Sims was born in Brisbane on 28 February 1948 and was 62 years of age when he died. A difficult upbringing was followed by two lengthy relationships, each of which saw him father three children.

A conviction for indecent dealing with a girl under 14 years of age in 1978 was unfortunately a precursor to further sexual offences against young girls in the early 1980s and again between 2002 and 2004. On 9 September 2005 Mr Sims was convicted of multiple serious sexual offences involving five separate children, including ten counts of indecent treatment of children under 12 years of age. He received a total head sentence of 12 years with a recommendation that he be considered for parole after five years.

Taking into account time already served, Mr Sims first became eligible for parole on 11 February 2010 while his full time discharge date was 10 February 2017. An application for special circumstances parole was prepared by a doctor at PAHSU on 24 January 2011 but had not reached the Parole Board by the time of Mr Sims' death two days later.

Mr Sims was moved to WCC on 21 October 2005 and remained there until his final transfer to PAHSU three days before his death. Mr Sims had become estranged from his family following his imprisonment and the nominated 'next-of-kin' on WCC records was found to have died some years earlier when police attempted to make contact after Mr Sims' death.

Diagnosis of cancer and initial treatment

Although a long term smoker, Mr Sims' medical history was unremarkable until 4 January 2009 when he suffered an episode of central chest pain. He was transported urgently to PAH where a CT scan was conducted to check for pulmonary embolus. The scan found no pulmonary embolus but incidentally revealed a large tumour mass in the lower lobe of the left lung. Fluid surrounding that lung was thought likely to be associated with the mass and it was evident that lymph nodes were also affected.

The medical opinion was that Mr Sims almost certainly had a primary lung cancer that had spread to nearby left sided intra-thoracic lymph glands. Clinical notes from the PAH indicate that Professor Marwick discussed the possible diagnosis of lung cancer with Mr Sims on 6 January 2009, together with the need for follow up by the respiratory team. Professor Marwick recorded that Mr Sims was 'aware and understands' and that all his questions were answered.

The cardiology unit at PAH diagnosed Mr Sims with coronary artery disease albeit they did not consider the chest pain he had suffered was cardiac in origin. Testing showed poor respiratory function and it was decided that Mr Sims should undergo a bronchoscopy and positron emission tomography (PET) scan.

The bronchoscopy took place on 19 January 2009 after Mr Sims signed documentation acknowledging that the procedure was to investigate a *lung mass*. On 5 February 2009 Mr Sims was seen as an outpatient at PAH by Dr Joanna Jones. Dr Jones noted the results of the bronchoscopy, which showed a narrowing of the lower lobe of the left lung due to compression from the tumour mass. It was noted that cytology from cells collected during the procedure were abnormal which was indicative of small-cell lung carcinoma (lung cancer). The notes from this consultation indicate that Dr Jones spoke with the respiratory consultant, Dr Luke Garske. Dr Garske advised that the PET scan should to be conducted so that appropriate treatment options could be determined. There are no notes as to whether the results of the bronchoscopy or the reason for the PET scan were discussed with Mr Sims.

Dr Jones gave evidence at the inquest and, consistent with her earlier statement, told the court that on 5 February 2009 she would have informed Mr

Sims, after discussion with Dr Garske, that he had been diagnosed with lung cancer. Dr Garske told the court that, on the basis of the information available on 5 February 2009, he also would have told Mr Sims there was a 99/100 probability that he had lung cancer. Both told the court that they would not normally make a specific note of having informed the patient of their diagnosis. I accept the submission by counsel for MSHHS that this was a reasonable practice with the recorded fact of such a serious diagnosis, in the ordinary course, being sufficient record of the patient's awareness of it.

Intended follow up

Dr Jones' recorded the intended treatment plan for Mr Sims in his file. This was to consist of a PET scan and a follow up appointment at PAH on 19 February 2009. A request was appropriately sent to the Royal Brisbane and Women's Hospital (RBWH) via fax for Mr Sims to be booked into that facility for the PET scan. The PAH did not have a PET facility at that time.

The usual practice in the PAHSU was for the only nurse on duty, in this case clinical nurse Margaret Cullen, to read the doctor's notes and to book a follow up appointment where one was indicated. Nurse Cullen told the court that she did this by filling out a loose pre-printed form with the new appointment date. This was then collected by an administrative officer who would enter the details into a spreadsheet. This spreadsheet allowed PAHSU staff to check on a daily basis which prisoners had appointments the next day. This was important because, for obvious security reasons, it was only the day before the appointment that the corrections facility housing the patient would be notified. Transport would then be arranged for the prisoner to be taken to PAHSU the following day.

The appointment Dr Jones had requested for 19 February 2009 in relation to Mr Sims was never correctly entered into the relevant spreadsheet. I can readily see how such an oversight might be made in a busy hospital setting dealing with a high volume of patients. It is not clear (and now unable to be determined) if Nurse Cullen filled out the loose leaf form detailing the 19 February appointment. If she did, it seems that an administrative officer entered the appointment details incorrectly into the spreadsheet. This was the primary mechanism by which the PAHSU was to ensure security patients were adequately followed up in relation to their treatment. Whatever the undoubtedly innocent explanation, the breakdown of this process is the primary systemic reason Mr Sims was not seen by PAH staff on 19 February 2009 and, ultimately, not for another 15 months.

Unfortunately, the RBWH scheduled the PET scan for 19 February 2009, notwithstanding that they had information on the referral form from the PAH which indicated that there was to be a follow up appointment at PAH on that day. There is no indication that staff at RBWH made contact with the PAH to advise of the potential conflict. The PET scan took place and although the scan itself is dated 23 February 2009, the attaching notes purport to have been 'transcribed' early on the afternoon of 19 February 2009; the scheduled date.

The inquest heard that the usual practice at this time was for a hard copy of the PET scan to be sent to Dr Garske. There is no record of this occurring. A copy of images from the PET (though not the associated report) was first made available electronically to the PAH on 20 February 2009. There was nothing associated with this electronic transfer though that would, as a matter of course, prompt Dr Jones, Dr Garske or any other staff member to review Mr Sims treatment plan. An electronic copy of the written report analysing the PET images was not transferred to the PAH until 13 May 2010 – more than a year later and likely prompted by Mr Sims' reengagement with hospital staff at that time.

The PET scan demonstrated the mass in the lower lobe of the left lung was most likely the primary tumour and had spread to the glands. Dr Garske frankly acknowledged at the inquest that the receipt of a hard copy PET scan was not meant to act as a mechanism to prompt him or other staff to book an appointment with the patient. He did state though, and I accept, that if the PET scan had been sent to him in the usual manner, that it may well have prompted him to enquire into the status of Mr Sims' ongoing treatment.

Return to PAH in 2010

A medical note from a visiting doctor at WCC on 11 March 2010 refers to Mr Sims' history of a *lesion in lung*. This consultation related to treatment for a cough with chest pain. A diagnosis of upper respiratory tract infection was treated with antibiotics.

Mr Sims again presented to the WCC medical centre on 6 May 2010 with an audible wheeze and productive cough. He was seen by a doctor the next day and referred to PAH immediately, where he was admitted and underwent a chest x-ray and received intravenous antibiotics. There is no indication that this WCC doctor was aware of the significant left lung tumour mass initially observed more than a year earlier.

At PAH Mr Sims was noted to be a difficult historian but it is clear that his cancer and the various treatment options were discussed with him prior to his discharge on 10 May 2010. Mr Sims told medical staff at PAH that he did not want any further scans or chemotherapy, although he was content with being further reviewed as an outpatient.

On 24 May 2010 a visiting medical officer at WCC discussed with Mr Sims his various treatment options. Mr Sims again made it clear that he did not want any further investigations conducted in relation to his lung cancer. Another consultation in a similar vein took place at PAH on 15 July 2010. The notes from that consultation indicate that Mr Sims was not interested in radiation therapy or chemotherapy, even if the tumour may be curable.

Events leading to death

Over the following months Mr Sims continued to be seen at WCC and PAH as his health declined. In October 2010 Mr Sims consented to a chest x-ray on the basis that it may reveal fluid around his lungs that might then be drained to alleviate his worsening shortness of breath. In the event, it did not show

any fluid but Mr Sims had indicated he would have consented to the invasive procedure required to drain the fluid if it was likely to assist him.

On 23 January 2011 Mr Sims was admitted to PAHSU with end stage lung cancer. He agreed to be treated for the high calcium levels caused by prescribed narcotics but stated he did not want chemotherapy or radiation. He did not wish to be resuscitated in the event of cardiac arrest. Curiously, the notes of the consultation on this date indicate that Mr Sims seemed surprised by the seriousness of his prognosis at this time. There may have been various reasons for this and it is not inherently inconsistent with his having received an adequate explanation of his condition and prognosis. I accept that he did receive such explanations in both 2009 and 2010.

Mr Sims continued to receive palliative care until 11:58am on 26 January 2010 when nursing staff found that he was not breathing and was unresponsive. He was declared deceased at 12:23pm

Autopsy results

An external autopsy examination was carried out on 28 January 2011 by an experienced forensic pathologist, Dr Alex Olumbe.

A post mortem CT scan was conducted. A specialist radiologist consultant examined this scan and found it to be consistent with extensive cancer of the lung with metastases to the liver and pelvis. It also showed extensive calcification of the coronary arteries, severe emphysema and bronchiectasis.

Dr Olumbe had access to the medical records relating to Mr Sims from WCC and PAH. After considering these, the CT scan and his observations at autopsy, Dr Olumbe issued a certificate listing the cause of death as:

> *"1(a) Non-small cell lung carcinoma with metastases*
>
> Other significant conditions:
>
> 2. *Ischaemic heart disease, coronary atherosclerosis, emphysema, bronchiectasis."*

Medical Review

The medical records pertaining to Mr Sims were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Don Buchanan. He noted the one glaring deficiency in the medical treatment afforded to Mr Sims, namely, the failure to follow up his 2009 diagnosis of cancer with any further properly documented consultation.

Dr Buchanan concluded:

> *It is regrettable and unsatisfactory that a patient diagnosed with a stage IIIa non small cell lung carcinoma is lost to follow up for 15 months. The progressive nature of such a cancer means*

that, for patients willing to undergo treatment, the possibility of cure or extended survival diminishes with time.

This was uncontested by any party at the inquest.

Conclusions

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

I have addressed the roles of staff at PAH and RBWH in the events of February 2009 and found that a breakdown in the appointment booking process at PAHSU led to Mr Sims being *lost to follow up*. As discussed below, this loss to follow up could only have occurred in combination with the unusual circumstance of Mr Sims himself not making any enquiries as to the results of his PET scan or his treatment more generally.

It was submitted by counsel for MSHHS that I should also attribute some accountability for the failure to book a follow up consultation at PAH to the Queensland Health staff based at WCC. When cross examined by counsel for MSHHS, Dr Buchanan stated that he would not have expected nursing staff at WCC to have been aware of Mr Sims' diagnosis of cancer from the material and records available to them. It may have been desirable for the nursing staff at WCC to have been sufficiently proactive that they questioned the lack of follow up treatment. However, I do not consider the evidence is sufficient to warrant criticism of the nursing staff at WCC, particularly given Mr Sims presentation at the WCC and his reluctance to engage in treatment.

I find that Mr Sims was aware of his diagnosis of cancer in February 2009 and that it is very unlikely (consistent with his position in 2010), that he would have consented to the available treatment of radiation and chemotherapy.

I find that, outside the failures to formally arrange follow up which I have addressed, that the medical care provided to Mr Sims by staff at PAH and WCC was adequate and appropriate.

Findings required by s. 45

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 Desmond Arthur Sims.

How he died - Mr Sims died as a result of cancer which originated in his lung and spread to other parts of his body.

Place of death – He died at Buranda in Queensland.

Date of death – He died on 26 January 2011.

Cause of death – Mr Sims died from natural causes, namely non-small cell lung carcinoma with metastases.

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 case I have considered the following factors in deciding whether any preventative recommendations might be made:

- Subsequent to Mr Sims' death a PET scanner has been installed at PAH so patients are no longer required to travel to the RBWH.

- The evidence of Dr Garske and Nurse Cullen indicated that no similar incident has occurred in relation to a prisoner being treated at PAH. I am not aware of any similar incident occurring in connection with coronial investigations into deaths of prisoners who receive treatment through the PAHSU.

- The fact it took 15 months for Mr Sims to be seen at PAH after the PET scan was, in large part, a function of his own failure (or just as likely, disinterest) in making enquiries about the status of his treatment.

These matters in combination mean that a similar set of circumstances is most unlikely to arise in future. On that basis I do not consider that there are any recommendations I can usefully make about the management of prisoners at PAHSU.

One area that does warrant attention is the adequacy of communication between health staff at PAHSU and, in this case, WCC. The inquest heard that, despite being employed by Queensland Health at that time (and now by the local health and hospital service) the email and information technology accounts of medical staff based in prisons were linked to the Department of Community Safety and not the Queensland Health intranet. The result is that recording and data collection processes for inmate health matters are paper based, and some email may be lost if incorrectly addressed. Access to the Queensland Health intranet would provide for improved transfer of information between hospitals and prisons.

Health staff working in prisons are also disadvantaged in that they do not have access to a range of electronic clinical resources available to similar employees in community settings. The inquest heard from the nursing director for WMHHS, which employs the medical staff at WCC, Ms Laura Dyer. She stated that significant progress had been made since the death of Mr Sims to

address these problems but that further technical and funding challenges remained.

I am satisfied from Ms Dyer's evidence that these are being addressed appropriately. Although I do not consider that a specific recommendation is necessary, I endorse the efforts of officers from Queensland Health and Queensland Corrective Services in facilitating the resolution of these impediments to information sharing.

I note the repeated attention given by the Office of the State Coroner, in prison related inquests, to the importance of health staff in prisons having adequate information and resources, including the capacity to access relevant patient records.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
6 December 2013