QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Dharam Raj CHETTIAR**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2013/2374
DELIVERED ON:	4 November 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 November 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services	Ms Ulrike Fortescue
West Moreton Health and Hospital Service	Ms Holly Ahern

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The *Coroners Act 2003* provides in ss. 45 and 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 Dharam Raj Chettiar. 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

Dharam Chettiar was an elderly man imprisoned late in life at which time he had an already lengthy history of cardiac disease. While in custody at Wolston Correctional Centre (WCC) he was regularly transported to the Princess Alexandra Hospital (PAH) for treatment.

Despite the efforts of a fellow inmate and medical staff at the PAH, Mr Chettiar was unable to survive the onset of acute heart failure he suffered in the early hours of 4 July 2013.

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 that responsibility; 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 Chettiar was conducted by Detective Senior Constable David Caruana from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). His report was tendered at the inquest.

CSIU officers were notified within an hour of Mr Chettiar's death and promptly attended at the PAH. DSC Caruana arranged for the body to be photographed in situ and ensured that hospital medical records were conveyed to the Queensland Forensic and Scientific Services facility to assist the pathologist performing the subsequent autopsy.

Interviews were conducted with the five prisoners who shared residential block Bravo 12 at WCC with Mr Chettiar. Prison records were seized and photographs taken of relevant areas at WCC.

At the request of counsel assisting, an independent medical practitioner from the Queensland Health Clinical Forensic Medicine Unit, Dr Gary Hall, examined Mr Chettiar's 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 4 November 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from the investigating police officer, Detective Senior Constable Caruana.

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

Dharam Chettiar was born on 18 June 1931 in Fiji and was 82 years of age when he died. On 5 October 2010, at age 79, he was convicted of a number of sex offences involving children and sentenced to 6 years imprisonment. He would have been eligible for parole on 16 September 2013.

After a brief period at the Brisbane Correctional Centre Mr Chettiar was transferred to WCC on 23 December 2010 where he remained until the morning of his death.

Ongoing heart disease

On entering custody Mr Chettiar was noted to have a lengthy history of cardiac disease and this required relatively intensive ongoing monitoring and treatment. This is best illustrated by the evidence that Mr Chettiar was transported to the PAH on 42 occasions during the less than three years he was in custody.

Two significant admissions occurred in March and June 2013. On 26 March 2013 Mr Chettiar presented at the WCC medical centre complaining of chest pain. He was transported by ambulance to PAH where he was treated as an inpatient until 2 April 2013. During that period he was commenced on nicorandil (a potassium channel opener) which relieved his pain. His discharge came after review by a cardiology rehabilitation team.

On 17 June 2013, Mr Chettiar was again admitted to the PAH with a history of two bouts of chest pain earlier in the day. In due course, a discussion was had regarding the need for a further coronary angiography which would help address the risk of myocardial infarct but posed the risk of renal impairment leading to the possibility of dialysis if conducted. Mr Chettiar declined the

procedure and, in discussion with his nephew and hospital staff, put in place an acute resuscitation plan. This plan noted the conditions underpinning it were “end stage coronary artery disease” and “renal failure”. The plan excluded the use of defibrillation, inotropes, intubation, ventilation and intensive care. Mr Chettiar was discharged after putting the plan in place on 25 June 2013.

Events leading to death

At around 1:40am on 4 July 2013 Cameron Stewart, a fellow inmate of Mr Chettiar housed in the same block at WCC, heard the sound of a chair being dragged across the floor. On investigation he found Mr Chettiar lying on the floor of his room, apparently unconscious. After rubbing Mr Chettiar’s chest Mr Stewart noted that he regained consciousness and a medical alarm was raised.

Queensland Ambulance Service records show it was were contacted at 1:55am and attended on Mr Chettiar at 2:12am. He was taken to the PAH where he was reviewed by Dr Walter Hipgrave. The acute resuscitation plan was discussed with Mr Chettiar and his family and his pain was managed with morphine. A chest x-ray confirmed acute pulmonary oedema. Mr Chettiar’s wishes as expressed in the acute resuscitation plan were respected and his condition rapidly deteriorated. He died at 7:10am.

Autopsy results

An external autopsy examination was carried out on 8 July 2013 by an experienced forensic pathologist, Dr Nathan Milne.

A post mortem CT scan was conducted. Samples of blood were taken though not subjected to analysis. Dr Milne examined the WCC and PAH medical records before submitting his report.

Dr Milne noted that nothing in his observations of the body or on CT scan was contrary to what might be expected from his reading of the medical notes. In the report he concluded:

> “*In my opinion, the cause of death is ischaemic cardiomyopathy resulting from coronary atherosclerosis (which had previously been surgically treated). He had well documented ongoing significant heart disease.”*

Dr Milne issued a certificate listing the cause of death as:

> *1(a) Ischaemic cardiomyopathy,* due to or as a consequence of,
> *1(b) Coronary atherosclerosis (previous bypass graft surgery)*.
>
> Other significant conditions:
>
> 2. *Type 2 diabetes mellitus; chronic kidney disease*.

Medical Review

The medical records pertaining to Mr Chettiar were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Gary Hall.

Dr Hall submitted a report which was tendered at the inquest. In that report Dr Hall described the medical management of Mr Chettiar at WCC as:

> "*…good as he could expect (if not better) than if he was living within the greater community."*

Dr Hall considered the medical management of Mr Chettiar during his presentations at PAH in March and June 2013 as "*excellent*". The management of Mr Chettiar when he arrived at PAH on the morning of 4 July 2013 was also considered appropriate.

Dr Hall had no doubts that the advanced resuscitation plan in place had been devised with appropriate explanation and within Mr Chettiar's full capacity to understand the ramifications.

Conclusions

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

I am also satisfied, based on the opinion of Dr Hall, that the medical care provided to Mr Chettiar at WCC and PAH prior to his death 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 Dharam Raj Chettiar.

How he died - Mr Chettiar died while he was in custody as a sentenced prisoner from an acute episode of heart failure which occurred in the context of a lengthy history of appropriately treated cardiac and renal disease.

Place of death – He died at the Princess Alexandra Hospital, Buranda in Queensland.

Date of death – He died on 4 July 2013.

Cause of death – Mr Chettiar died from ischaemic cardiomyopathy which resulted from his 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.

Nothing has arisen on the evidence tendered at this inquest which warrants such comment.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
4 November 2014