QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Francis Ronald Llewelyn Collins**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2015/3243
DELIVERED ON:	23 January 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	23 January 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes
REPRESENTATION:	
Counsel Assisting:	Daniel Bartlett
Queensland Corrective Services:	Kendall Dixon, Department of Justice and Attorney-General

Introduction

1. Mr Collins was sentenced in Cairns in May 2007 to a term of 11 years imprisonment. At that time he was aged 77 years. In August 2007, he was transferred from Maryborough Correctional Centre to Wolston Correctional Centre (WCC). This was to facilitate frequent trips to the Princess Alexandra Hospital (PAH) for medical treatment. Mr Collins had a variety of medical issues at the time he was sentenced, including diabetes, hypertension, high cholesterol and vascular disease.

2. On 16 August 2015, Mr Collins was transferred to the PAH for treatment of a blister that was not healing. He was admitted, and over the ensuing days his condition deteriorated and Mr Collins stated he wished only for comfort measures. His breathing became more laboured, and an oxygen mask was applied, which Mr Collins resisted. He was also offered pain relief, which he declined. A short time later, nursing staff checked Mr Collins for vital signs, but none were detected. Mr Collins was declared deceased at 7:45pm on 20 August 2015.

The investigation

3. An investigation into the circumstances leading to the death of Mr Collins was conducted by Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

4. Upon being notified of Mr Collins' death, the CSIU attended WCC and the PAH. Mr Collins' correctional records and his medical files from the PAH and WCC were obtained. The investigation was informed by statements from the relevant custodial correctional officers, and clinical staff and treating doctors at the PAH. Interviews were also conducted with other prisoners at the WCC, including the prisoner allocated to care for Mr Collins. These statements and interviews were tendered at the inquest.

5. A full internal autopsy examination was conducted by forensic pathologist, Dr Phillip Storey. At the request of the Coroners Court of Queensland, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the statements as well as the medical records for Mr Collins from the PAH and WCC and reported on them.

6. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

7. As Mr Collins was in custody when he died, an inquest into his death was required by the Coroners *Act 2003.* The inquest was held on 23 January 2018. All of the statements, medical records and material gathered during the investigation were tendered and Counsel Assisting proceeded immediately to submissions in lieu of any oral testimony being heard.

8. Mr Collins next of kin were notified of the inquest. The Coroners Court was advised that they did not wish to attend the inquest and that they "did not have any concerns or any issues surrounding Francis's death."

Circumstances of the death

9. Francis Ronald Llewlyn Collins was 85 years of age at the time of his death. On 31 May 2007 he was convicted of historical offences relating to the indecent treatment of children. He had no previous criminal history. He was sentenced to 11 years imprisonment, and initially served this at the Maryborough Correctional Centre. He was eligible for parole from 7 December 2011, but his application for parole had been refused.

10. On his reception to prison, Mr Collins' medical history included the following conditions:

    - Hypertension;
    - Type 2 diabetes mellitus;
    - Peripheral vascular disease (PVD; hardening and narrowing of blood vessels to the body, particularly the lower limbs);
    - Foot ulcers due to a combination of diabetes and poor blood supply to the feet;
    - Gastro-oesophageal reflux disease (GORD; gastric reflux);
    - Right total hip replacement;
    - Excision of multiple skin cancers.

11. It was noted that Mr Collins also had a persistent, non-productive cough that had been present for approximately 20 years. As noted above, Mr Collins was transferred from the Maryborough Correctional Centre to WCC in August 2007 to facilitate transfers to the PAH to deal with his multiple co-morbidities.

12. On 7 August 2015, Mr Collins presented to the WCC medical centre with a blister on his right big toe. Fluid was drained by nursing staff with immediate relief noted. On 14 August 2015, Mr Collins was reviewed and the blister was noted to look and feel better.

13. On 15 August 2015, Mr Collins presented to the medical centre with shortness of breath and a one week history of a productive cough. On examination he had crackles in all lung fields and a wheeze on exhalation. He was given Ventolin, and transferred to the PAH emergency department. On examination there, he did not appear to be in respiratory distress, and was prescribed oral antibiotics for a possible lower respiratory tract infection. Of note, the blister on Mr Collins' right foot was also noted to have no infective features. He was discharged back to WCC.

14. On 16 August 2015, Mr Collins re-presented to the WCC medical centre reporting significant pain in his right foot. He was transferred back to the PAH for further review. The blister was described as now being a necrotic (dead tissue present) diabetic foot ulcer. A chest X-ray was also performed, and demonstrated partial right middle lobe atelectasis (reduced aeration due to collapse of lung tissue) and consolidation consistent with pneumonia.

15. Mr Collins was subsequently admitted to the PAH secure unit under the care of the General Medical Team for treatment and investigation of an acute exacerbation of his chronic cough. A statement from Dr Kyle White, who was part of this treating team, was tendered at the inquest.[1]

16. Investigations carried out at the PAH included the following:

- A chest CT scan demonstrated right lower lobe atelectasis and an unusual pattern of partial left upper lobe obstruction although an underlying lesion was not visualised;
- Lung function tests revealed moderate obstructive airways disease (a chronic inflammatory lung disease that causes obstructed airflow from the lungs);
- An echocardiogram revealed moderate calcific aortic stenosis (hardening and narrowing of the heart valve) and pulmonary hypertension (elevated blood pressure in the arteries of the lungs).

17. By 19 August 2015, Mr Collins' shortness of breath, cough and foot ulcer appeared to have improved. However, he remained wheezy and breathless when mobilising. A repeat chest X-ray revealed progressive atelectasis involving the left lung base. During his clinical work up, Mr Collins was found to have low iron levels, which was deemed to be a possible contributor to his dyspnoea.

18. Soon after midday on 19 August 2015, Mr Collins was commenced on an intravenous iron infusion. At 4:50pm that afternoon, he became acutely short of breath and the rapid response team had to be activated. The iron infusion was ceased, and he was treated with aggressive symptomatic management for a suspected anaphylactoid reaction.

[1] Exhibit B6.

19. Following this treatment, Mr Collins' shortness of breath returned to baseline levels. An immunologist agreed that his symptoms were likely the result of an anaphylactoid reaction to components within the iron infusion. However, confirmation of an anaphylactoid reaction was inconclusive.

20. On 20 August 2015, Mr Collins was stable. He indicated to medical staff that his condition was similar to how felt before he was admitted to hospital. Statements from his medical team, registered nurses Dahyun Kang and Alecia Mott, were tendered at the inquest.[2]

21. Later on 20 August 2015, his respiratory rate increased due to presumed mucous plugging (thick, tenacious secretions blocking the airways). A review was requested by a physiotherapist and a respiratory physician. A repeat chest X-ray showed persistent left lower lobe volume loss along with development of minor atelectasis at the base of the right lung. Following a further episode of decreased oxygen saturations, an Acute Resuscitation Plan was completed. This indicated that Mr Collins did not want any invasive measures, and wished to be kept comfortable in the event his condition deteriorated further.

22. Despite attempts to clear the secretions blocking his airways, Mr Collins' condition continued to decline with type 1 respiratory failure. The possibility of a pulmonary embolus was considered, and Mr Collins was commenced on enoxaparin (blood thinner). Mr Collins was not deemed a suitable candidate for any non-invasive forms of ventilation. Supplemental oxygen was increased, however Mr Collins failed to improve. He was pronounced deceased at 7:45pm on 20 August 2015.

23. The post-mortem examination carried out by Dr Storey[3] revealed shallow skin ulceration in varying states of healing to the inner right big toe, the lateral aspect of both heels, the left anterior thigh and lateral calf; none of which appeared to be infected. There was a thick tenacious mucus plug within the main airway of the left lower lobe of the lungs, causing complete obstruction of the airway. The remaining bronchi contained thick white material. Bloodstained watery fluid was seen in both lung cavities and was thought to reflect heart failure.

24. Mr Collins heart was enlarged with widespread calcified atherosclerosis evident in the heart and aorta.

[2] Exhibits B2; B4.
[3] Exhibit A6.

25. Dr Home assisted the inquest by reviewing the available medical records, witness statements, and the autopsy report completed by Dr Storey. He provided a detailed report which was tendered at the inquest.[4] Dr Home confirmed that Mr Collins died due to respiratory failure as a consequence of chronic obstructive pulmonary disease (COPD). Changes following emphysema were seen at autopsy. Dr Home explained that most patients with emphysema also have a degree of chronic bronchitis, which produces a chronic cough, something which Mr Collins had experienced for some twenty years.

26. Dr Home explained that sufferers of COPD often experience rapid onset exacerbations of their symptoms in response to chest infections and other factors. Dr Home confirmed that Mr Collins' assessment on 15 August 2015, and subsequent return to WCC, was appropriate in the circumstances, particularly given the subsequent report of the chest x-ray performed that day, which indicated no signs of a chest infection.

27. Dr Home confirmed that the care provided in the following days was also appropriate. He explained that Mr Collins had emphysema with focal consolidation as well as mucous plugging obstructing the airways. All these factors would have contributed to inadequate gas exchange in an individual with reduced functional reserves. Despite antibiotics, steroids, multiple inhaled medications to open the airways, as well as regular chest physiotherapy, the mucous was unable to be cleared from Mr Collins' airways. As a result of this, he developed worsening type 1 respiratory failure, and subsequently passed away.

28. Although accepting that it was not a direct contributor to the death, Dr Home raised the apparent anaphylactoid reaction during the iron infusion involving iron polymaltose. He explained that while such reactions are considered rare and typically occur within the first few minutes of commencing an infusion. Dr Home raised that the PAH might wish to review the decision to stock this particular type of compound, and consider other safer alternatives.

29. Having regard to Dr Home's concern regarding the iron infusion, and Dr Storey having listed the iron infusion as a significant condition relating to the cause of death, I requested a response from the PAH. A letter from the Director of Clinical Pharmacology, Dr Peter Pillans,[5] noted that haematologists seldom give iron infusions to inpatients, and that the most are administered on an outpatient basis using a different iron preparation. Dr Pillans indicated that iron polymaltose was almost exclusively used for inpatients at the PAH, and no adverse reactions had been no recorded. He

[4] Exhibit B7.
[5] Exhibit B8.

noted that while anaphylactoid reactions to iron infusions are well known, they are rare.

Conclusions

30. Mr Collins' death was the subject of an investigation by the QPS Corrective Services Investigation Unit. That investigation has been considered by me. I accept that the death was from natural causes with no suspicious circumstances associated with it.

31. I find that none of the correctional officers involved in his care caused or contributed to his death. I am satisfied that Mr Collins was given appropriate medical care by staff at WCC and the PAH whilst he was admitted there. His death could not have reasonably been prevented.

32. It is a recognised principle that the health care provided to prisoners should be of no 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 Collins when measured against this benchmark.

33. I am satisfied that the concerns raised by Dr Home were adequately addressed by the PAH.

Findings required

34. 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. After considering all of the evidence I am able to make the following findings:

Identity of the deceased – The deceased person was Francis Ronald Llewelyn Collins.

How he died - Mr Collins died after developing emphysema with focal consolidation as well as mucous plugging obstructing his airways. These factors contributed to inadequate gas exchange in an individual with reduced functional reserves. Despite antibiotics, steroids, multiple inhaled medications to open the airways, as well as regular chest physiotherapy, the mucous was unable to be cleared from Mr Collins' airways. He consequently developed worsening type 1 respiratory failure.

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

Date of death – He died on 20 August 2015.

Cause of death – Mr Collins died from respiratory failure, due to, or as a consequence of, chronic obstructive pulmonary disease. Other significant conditions were coronary atherosclerosis, diffuse vasculopathy, recent hypersensitivity reaction to iron infusion and recent respiratory tract infection.

Comments and recommendations

35. The *Coroners Act 2003* enables a coroner to 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.

36. In the circumstances, I accept that there are no comments or recommendations that I could make that would assist in preventing similar deaths in future.

37. I close the inquest.

Terry Ryan
State Coroner
Brisbane
23 January 2018