QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Ashley Glenfield Gavenor**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Townsville
FILE NO(s):	COR 2017/4214
DELIVERED ON:	21 November 2019
DELIVERED AT:	Townsville
HEARING DATE(s):	19 & 20 November 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, Indigenous prisoner, chronic disease, bipolar affective disorder, acute cardiac event following physical altercation, refusal of medication, capacity to refuse treatment.

REPRESENTATION:

Counsel Assisting:	Rhiannon Helsen
Queensland Corrective Services:	Amanda Meisenhelter, Crown Law
Townsville Hospital and Health Service:	David Schneidewin, instructed by Corrs Chambers Westgarth

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Introduction

1. Ashley Glenfield Gavenor was 48 years of age when he died in the exercise yard of the secure unit at the Townsville Correctional Centre (TCC) on 19 September 2017. Mr Gavenor was an Indigenous man from Mornington Island who had previously served a number of periods in custody.

2. Mr Gavenor suffered from several significant long-term medical conditions, including diabetes, coronary artery disease, hypertension, and bipolar affective disorder. He was prescribed various medications for those conditions but regularly refused to take them, both in prison and in the community. From July 2017, up until the time of his death, prison records suggest that Mr Gavenor also exhibited behaviour considered to be eccentric by prison officers on a number of occasions. This included chanting and disrobing, which was regarded as out of character.

3. On 19 September 2017, Mr Gavenor was involved in two relatively minor altercations with another prisoner, Michael McKinley. On the second occasion punches were exchanged by both prisoners for about one minute. Mr Gavenor collapsed soon after. Assistance was rendered by fellow prisoners who placed him into the recovery position, and was then continued by Custodial Correctional Officers (CCO). He was initially responsive but semi-conscious. Mr Gavenor deteriorated after medical staff arrived. Despite extensive resuscitation efforts by nursing staff and Queensland Ambulance Service (QAS) officers called to the scene, he was unable to be revived.

The inquest

4. The primary purpose of an inquest is to inform the family and the public about the matters required by s 45 of the *Coroners Act 2003*, including how the person died and what caused the death. An inquest is not an adversarial process in which the coroner makes determinations of civil or criminal liability. Whenever appropriate, a coroner can comment on anything connected with the death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances.

5. At a pre-inquest conference on 19 September 2019 the following issues for the inquest were determined:

    I. The findings required by s.45 (2) of the *Coroners Act 2003;* namely the identity of Mr Gavenor person, when, where and how he died and the cause of his death.

II. Whether the medical care and treatment provided to Mr Gavenor while at the Townsville Correctional Centre was adequate;

III. Whether the response to the altercation involving Mr Gavenor, and his subsequent collapse, by Custodial Correction and Medical Staff, was adequate?

IV. 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.

6. The inquest into Mr Gavenor's death was held at Townsville on 19 and 20 November 2019.

7. As Mr Gavenor was in custody when he died, an inquest was required by the *Coroners Act 2003*. A brief of evidence, which included numerous statements, relevant records, audio and video exhibits, photographs and other materials gathered during the coronial investigation was tendered at the commencement of the inquest. Six witnesses were called to give evidence.

8. I am satisfied that all relevant materials were placed before me to enable the necessary findings to be made. At the conclusion of the evidence helpful written submissions were provided by my counsel assisting, Ms Helsen, which were largely adopted by the representatives of those granted leave to appear.

The evidence

Personal circumstances and correctional history

9. Mr Gavenor was born on Mornington Island in the Gulf of Carpentaria where he resided for most of his life. His temporary address before he entered custody was on Mornington Island, which is the largest of 22 islands that form the Wellesley Islands group.

10. Mr Gavenor was previously in a relationship with Ms Yvette Roughsey. This relationship had been highly volatile, marred by a number of incidents of domestic violence, in which Mr Gavenor had been named as the respondent. Ms Roughsey was also the complainant with respect to a number of outstanding serious violent offences alleged to have been committed against her by Mr Gavenor.

11. Mr Gavenor had an extensive criminal history commencing in 1986 for a wide range of offences, including assault, grievous bodily harm, escape lawful custody, wounding, unlawful use of a motor vehicle, breach of domestic violence orders, property offences and possession of dangerous

drugs.[1] Sentencing remarks from the District Court in 2013 indicate that he had a significant problem with anger and the inability to walk away without resorting to physical violence when he was stressed.

12. At the time of his death, Mr Gavenor was serving his 17th episode in adult custody. On 2 December 2016, he was remanded in custody on charges of rape, assault occasioning bodily harm and a breach of a domestic violence order. On 6 December 2016, he was further remanded on a charge of drug possession and disorderly behaviour.

13. On 9 December 2016, Mr Gavenor was transferred to the TCC, where he remained until his death.

14. From 9 December 2016 until 23 January 2017, Mr Gavenor was accommodated in secure accommodation (first S3, then S4). On 19 January 2017, he was relocated to residential accommodation, where he remained until 14 August 2017.[2] On 18 August 2017, Mr Gavenor was moved to S4, at that time still subject to a safety order, where he remained until his death.[3]

15. The evidence at the inquest indicated that Mr Gavenor was regarded as an elder by fellow Indigenous prisoners and a man with knowledge of traditional healing practices. Fellow prisoners also turned to him to advocate on their behalf in relation to concerns they had with conditions within the prison.

Medical conditions

16. Mr Gavenor's medical records indicate that he suffered from a number of chronic medical conditions including coronary artery disease, high cholesterol, hypertension and Type 2 diabetes. He was prescribed several medications for these conditions while in custody, including aspirin, atenolol (blood pressure lowering agent), atorvastatin (cholesterol lowering agent) and metformin (diabetes drug).[4] The evidence suggested he took no medication while living in the community.

17. Mr Gavenor experienced one episode of chest pain shortly after arriving at TCC. However, this resolved without any ongoing issues. He was appropriately assessed and medicated on that occasion.[5]

18. Up until 9 April 2017, Mr Gavenor was largely compliant with his medications. However, after that date he almost continuously refused to take any medication or was absent at medication rounds.[6] Mr Gavenor claimed that medication conflicted with his spiritual beliefs and at times

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[1] Ex C1.1
[2] Ex D6, pg. 13
[3] Ex D6, pg. 15
[4] Ex B4, [13]
[5] Ex D3, pg. 25
[6] Ex B4, [15]

complained that it made him feel unwell.[7] He was advised and counselled on a number of occasions by medical and nursing staff about the potentially detrimental health consequences of failing to take the medications prescribed.[8] Mr Gavenor continued to refuse, indicating on a number of occasions that he was relying on 'spiritual healing'.[9]

19. As in the wider community, a prisoner cannot be forced to take prescribed medications in the absence of an involuntary treatment order or a forensic order. While encouragement and counselling can be provided by nursing and medical staff, the decision to take medication ultimately rests with the prisoner.

20. When a prisoner at TCC consistently refuses to take medication, their management is discussed and strategies formulated among all stakeholders to ensure a consistent approach.[10] However, CCOs are also not directly advised if a prisoner is refusing to take medications. They may indirectly become aware of this if they are present during the dispensing rounds. While a record of a refusal to take medication is recorded by nursing staff, this information is not disclosed to any of the CCOs.

Custodial Incidents

21. Records from Mr Gavenor's most recent period in custody suggest that his behaviour was largely positive from December 2016 until July 2017. He was employed in the centre laundry during this time where he had been promoted to a higher level. As an elder, he also assisted younger prisoners with cultural issues.

22. There was a noticeable decline in Mr Gavenor's behaviour from July 2017. In July and August 2017, multiple case notes were made about Mr Gavenor's perceived unusual behaviour, which included dancing around the unit, chanting, removing his clothing, and refusing to go to the medical unit when required.[11]

23. On 28 July 2017, Mr Gavenor was escorted to the medical centre after exhibiting abnormal behaviour.[12] The clinical records describe his behaviour as 'bizarre', after he made inappropriate comments to nursing staff and was reportedly clapping and chanting.[13] Nursing staff were unable to effectively engage with him.[14] He was then assessed by the Cultural Liaison Officer and medical staff, who deemed it necessary that he be conveyed to the

[7] Ex B2, [11]; Ex B3 [19]; Ex D3, pg. 25, 27-29
[8] Ex B4
[9] Ex B4, [22]
[10] Ex B5, [15] & [16]
[11] Ex D2, pg. 54-58
[12] IOMS Incident 212626; Ex B1; Ex D3, pg. 29 & 30
[13] Ex B2, [13]
[14] Evidence of Janet Morey provided on 19/11/19

Townsville General Hospital. It was suspected that he may have had a urinary tract infection.[15] A case note from that day states:

> *Mr Gavenor's behaviour has been out of character throughout the day. Gavenor has sang and danced throughout. Gavenor has not got the unit upset and was spoken to by healing elders. Gavenor's behaviour has been acceptable for the Block conditions, except, for removing his clothing on three occasions during the day. Gavenor dressed when directed by Officers but, this was begrudgingly and his tone was argumentative. If Gavenor continues to walk around the unit naked, I will be recommending that he is regressed to the Secure Units.*[16]

24. When he was seen in the Emergency Department at the Townsville Hospital on 28 July 2017, Mr Gavenor was assessed as being not in distress and he was fully oriented in time, place and person. He was assessed as having normal affect with normal thought content and judgement. His medical records include a referral on 29 July 2017 to PMHS. The referral indicated that he *'appears to be psychotic. Past 2 days. Refusing to attend hospital for assessment'.*[17] It was suspected that he was suffering from auditory and visual hallucinations, and was exhibiting inappropriate behaviours. Concern was raised as to whether he was at risk of being harmed by others due to his behaviour.

25. On 30 July 2017, Mr Gavenor was removed as a Laundry Worker.[18]

26. On 5 August 2017, Mr Gavenor was noted to have placed '*three stones in a row spaced apart on the grass, he proceeded to some [sic] kind of dance in front of the stones and then moved back towards the officers station and took all his clothes off and brown eyed the rest of the block'*.[19]

27. On 8 August 2017, Mr Gavenor had a routine Visiting Medical Officer (VMO) appointment with Dr Rafiqur Rahman.[20] He continued to refuse to take his medication, and was once again counselled as to the associated risks. A psychological review was requested.

28. On 11 August 2017, Mr Gavenor was seen by Prison Mental Health Services (PMHS) and referred to Assessment Services.[21] He refused to engage with the service and asked to be removed from the Mental Health Unit, claiming that the Psychologists did not understand 'black magic' in his culture. A referral was made for him to attend the cultural unit.

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[15] Ex B2, [18]
[16] Ex D2, pg. 55 - IOMS case note, 29/07/2017
[17] Ex D3, pg. 73
[18] Ex D2, pg. 55 - IOMS case note, 30/07/2017.
[19] Ex D2, pg. 55 - IOMS case note, 5/08/17.
[20] Ex B4, [22]
[21] Ex D2, pg. 55 - IOMS case note, 11/08/17.

29. On 14 August 2017, Mr Gavenor became verbally abusive towards staff after they asked whether he was willing to attend the medical unit.[22] He stated that he did not wish to have white man's medicine forced upon him. He was described as '*highly agitated and threatening*',[23] and the behaviour was described as being a continuance from last week's 'strange behaviour'. As a result, he was placed on a Safety Order and moved to the Detention Unit (DU) where he was placed under observation.

30. Mr Gavenor underwent a psychiatric review on 14 August 2017. It was concluded that he had a relapse of bipolar affective disorder.[24] Treatment with the antipsychotic drug olanzapine was offered but he refused to take it. A plan was made to hold a multi-disciplinary stakeholder meeting in the future to discuss Mr Gavenor's case.

31. On 18 August 2017, Mr Gavenor was moved from the detention unit to S4 Cell 48. After Mr Gavenor's return to the Secure Unit, a multidisciplinary meeting was convened involving PMHS, Custodial Corrections Supervisor (CCS) Nathan Bucci, Nursing Unit Manager, Denise Shepherd (NUM), Residential Accommodation Manager, Mike Anderson and Cultural Liaison Officer, Drue Ross.

32. The purpose of the meeting was to discuss Mr Gavenor, his medication non-compliance, and aberrant behaviour.[25] CCS Bucci stated that he expected further '*bad episodes*' and, as a result, told other staff in S4.[26] Minutes from the meeting state that, *'Symptoms have settled. QCS/OHS/MH to work together to support to understand mental illness – bipolar, possible involuntary treatment. UPDATE 30.08.18 – Will continue to monitor with needs Indigenous support. VMO medically cleared.*'[27] Details of this meeting were not recorded in Mr Gavenor's Integrated Offender Management System records.

33. On 28 August 2017, Mr Gavenor had a further appointment with Dr Rahman, during which he refused all medications in favour of 'spiritual healing'. He was noted to have poor insight into his situation.

34. A locum VMO at TCC, Dr Oltvolgyi, told the inquest that on admission to prison Mr Gavenor was charted for medications. Although he was not taking his medications in the community, he took them consistently following admission.

35. On 6 September 2017, Mr Gavenor was seen by Dr Oltvolgyi. He continued to refuse all of his medications. However, he appeared calm and considered during the consultation.[28] Dr Oltvolgyi said that the VMO's general role in

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[22] Ex D2, pg. 56 - IOMS Incident 213663
[23] Ex D2, pg. 56
[24] Ex B4, [23]
[25] Ex D6, pg. 15
[26] Ex G1, pg. 15
[27] Ex B5.5, pg. 120
[28] Ex B4, [25]

such circumstances was to explore the reasons for refusal, and assess the patient's state of mind and capacity to ensure that they are competent to refuse medication. Capacity was determined by assessing the patient's awareness of the risk of refusing medications, the alternative options and the risk of no treatment.

36. Similar evidence was given to the inquest by the Nurse Unit Manager at TCC, Denise Stricklen. She said that prisoners refuse to take medications "from time to time". She agreed that prisoners have a right to refuse to take medication. When they did so she would look for an opportunity to have a discussion with the prisoner about the reasons for refusal. She would also use the resources available, including prison psychologists, the Cultural Liaison Officer or the VMO. Where a prisoner consistently refuses to take their medications, their management is referred to a weekly interagency meeting which includes each professional discipline. Ms Stricklen noted that bizarre behaviour within the prison environment was often a matter of perception, and reliance would be placed on medical staff to assess matters such as capacity and competency.

37. Dr Oltvolgyi said that when he first met Mr Gavenor on 11 July 2017 he was very certain that he did not want to take his medications. Dr Oltvolgyi said that Mr Gavenor was rational and personable. He was assessed as having capacity to make the decision to refuse medication.

38. Dr Oltvolgyi noted that although Mr Gavenor had been assessed as having a relapse of bipolar affective disorder on 14 August 2017, when olanzapine was offered, it was determined by the PMHS that an ITO was not required at that time. He said that it appeared that Mr Gavenor may have had fluctuating capacity, and when he saw him on 6 September 2017 he considered that he had diminished capacity.

39. Dr Oltvolgyi said that the recent PMHS assessment that an ITO was not required influenced his determination that there was no immediate risk to Mr Gavenor in refusing medication. Dr Oltvolgyi's focus was not on his mental health but on the risk of the longstanding health conditions such as diabetes. His refusal to take medications for those conditions had little impact on his long term risk.

40. Dr Oltvolgyi said that an ITO would not be sought and would not be granted where someone refused to take medications for chronic medical conditions. He deferred to, and placed reliance on the PMHS to monitor Mr Gavenor's capacity to refuse medications, including olanzapine, on an ongoing basis. He also noted that the PMHS review on 14 August 2017 referred to the risk that olanzapine might cause complications for Mr Gavenor's diabetes. The plan formulated at that time was to persist with voluntary treatment with olanzapine and review at a multi-disciplinary meeting. Another relevant consideration was that there was a risk that Mr Gavenor would lash out if forcibly taken to a mental health unit. Dr Oltvolgyi said that when he saw Mr Gavenor on 6 September 2017, he was satisfied that he was subject to appropriate and ongoing review for all his health needs.

Events of 19 September 2017

41. On 19 September 2017, Mr Gavenor was domiciled in Unit Secure 4. This is a 50 cell unit containing a communal area, eating area, kitchen, laundry, bathroom and exercise yard.

42. At around 10:04 am, Mr Gavenor was cooking a meal in the kitchen area when he was approached by fellow prisoner, Michael McKinley, who was also a unit cleaner. Prisoners Corey Raymond Bray-Prior and Arthur James Murdock saw Mr McKinley heat a cup of coffee, before telling Mr Gavenor to make sure he cleaned up his mess left from preparing his meal.

43. Mr Gavenor is said to have taken issue with this comment before removing his shirt and adopting a fighting stance.[29] Mr McKinley did not engage with Mr Gavenor, and walked from the kitchen to the exercise yard where he started walking laps.

44. Custodial Corrections Officers (CCO) John Willshire and Lachlan Virgo provided verbal directions that both prisoners were to cease and separate. CCO Willshire witnessed Mr McKinley '*physically decline from the fight by stepping back away from Prisoner Gavenor*'.[30] CCTV footage showed Mr Gavenor remove his shirt and advance upon Mr McKinley. No punches were thrown, and the confrontation lasted no more than 20 seconds. CCO Virgo told the inquest that 'shaping up' was common in prison and was often done playfully.

45. It seemed that the situation had resolved as Mr Gavenor proceeded to eat his breakfast. Soon after, Mr Gavenor entered the exercise yard and sat on a bench seat. Mr McKinley approached Mr Gavenor and told him that he did not want to fight. Prisoner Anthony Grentell, who was walking laps with Mr McKinley, heard Mr Gavenor say, '*I can fight too, I'm not scared'.*

46. The CCTV footage depicted Mr Gavenor and Mr McKinley engaged in a conversation before Mr Gavenor stood up from the bench seat. At around 10:03, he removed his shirt and adopted a fighting stance. Mr McKinley backed away before removing his shirt and shaping up to Mr Gavenor. Mr Gavenor and Mr McKinley then exchanged punches before another prisoner approached and told them to stop fighting. The fight briefly stopped before they re-engaged, trading punches once again.

47. After CCO Virgo was advised by another prisoner of the fight, he called a 'Code Yellow' (officer needs assistance) over the prison radio. He requested that additional CCOs attend the location to contain the incident. CCO Patrick Farkas commenced banging on the officers' station window adjacent to the exercise yard in order to gain Mr Gavenor and Mr McKinley's attention, directing them to stop.[31] He recalled seeing Mr Gavenor maintaining a

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[29] Ex B8, [5]
[30] Ex B8, [6]
[31] Ex B5, [7]

fighting stance, with Mr McKinley dropping his hands by his side as he backed away from Mr Gavenor.[32] Both prisoners complied with this direction, with Mr McKinley withdrew to one end of the yard.

48. A short time later, Mr Gavenor collapsed to the ground while standing in the exercise yard, with several inmates coming to his assistance and placing him in the recovery position. According to CCO Farkas, Mr Gavenor took some steps towards Mr McKinley before he collapsed to the ground.[33] He observed a cut to Mr McKinley's face at this time.

49. At 10:06 am, CCO Virgo was alerted to Mr Gavenor's condition. A Code Blue was called at approximately 10:06 am via the prison radio.[34]

50. CCOs Virgo, John Willshire and Anthony Reynolds entered the exercise yard directing inmates to line up against the wall of the yard. CCO Reynolds observed Mr Gavenor attempt to stand on his feet before he collapsed again. Assistance was provided to Mr Gavenor until the medical response team arrived. Mr Gavenor was observed to have blood on his face.[35] CCO Virgo remained with Mr Gavenor, who he observed to be drifting in and out of consciousness and making attempts to stand.[36] CCO Virgo placed him into the recovery position awaiting the arrival of medical assistance.[37] At the inquest CCO Virgo said that Mr Gavenor was making a "snoring noise".

51. Mr McKinley was escorted by correctional officers to the DU where his clothing was seized and secured. Mr Gavenor and Mr McKinley had a long incarceration history, having been domiciled in the same unit on multiple occasions with no adverse events prior to this altercation.

52. TCC Nurses, Janet Morey and Anne Ingwersen responded immediately to the code blue and attended S4 within 3-5 minutes.[38] According to Nurse Morey, Mr Gavenor became unresponsive within three minutes of their arrival at the unit.[39] He was initially semi-conscious, opening his eyes when asked and was observed to be breathing.[40] His condition worsened, and as such, airway management was instigated with bag ventilation and CPR commenced with a defibrillator machine applied. CPR was continued by nursing and correctional staff, including CCOs Virgo, Grant Lowein and Kelly Jewell until they were relieved by Queensland Ambulance Officers (QAS) at 10:32 am.

53. QAS officers continued resuscitation efforts, including intubating Mr Gavenor and using a defibrillator. A bilateral needle was administered for an attempted fluid resuscitation with IV access. After approximately 43

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[32] Ex B5, [8]
[33] Ex B5, [10]
[34] Ex B2, [25]
[35] Ex B7, [30]
[36] Ex B7, [33]
[37] Evidence of Lachlan Virgo provided on 19/11/19
[38] Ex B2, [26]; Ex D3, pg. 34 & 35
[39] Ex B2, [26]
[40] Ex B2, [33]; Evidence of Janet Morey provided on 19/11/19

minutes of resuscitation efforts, Mr Gavenor was declared deceased. A Life Extinct Form was issued at 10:53 am.

54. An interview was conducted by CCO Tim O'Keefe with Mr McKinley following Mr Gavenor's collapse. At that time, Mr McKinley was not aware Mr Gavenor was deceased and participated in the interview voluntarily.

55. Mr McKinley's injuries were noted during the interview as follows:

- Cut above his left eyebrow, which was still bleeding at the time.
- Cut to his bottom lip.
- Scratch to the bottom of his chin.
- Scratch to his right cheek.
- Abrasion to top of his left ear.
- There were no injuries to his hands.

56. During the interview, Mr McKinley described Mr Gavenor as the aggressor during the altercations, which continued even when he repeated clearly that he did not wish to fight.

Police Investigation

57. Investigations were conducted into the circumstances leading to Mr Gavenor's death by the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The QPS investigation was led by Detective Sergeant David Caruana. He submitted a report which was tendered at the inquest. Detective Sergeant Caruana attended TCC with several other CSIU officers.

58. CSIU officers commenced the process of taking statements from correctional staff. They took steps to seize all relevant records and interrogated the TCC Information and Offender Management System (IOMS). Detective Sergeant Caruana made arrangements for statements to be obtained from officials at the prison.

59. Immediately after Mr Gavenor's death, S4 was locked down until the arrival of QPS officers. The initial QPS response was overseen by officers from the Townsville CIB. A crime scene log was commenced at 11:30 am. Scenes of crime officers attended and photographed the unit and Mr Gavenor in situ. A forensic examination of the scene was also undertaken.

60. Detective Sergeant Caruana and other CSIU officers were deployed from Brisbane to Townsville on 20 September 2017 to conduct investigations at TCC.

61. All prisoners in S4 were interviewed with statements obtained from those who witnessed the events that day, as well as CCOs identified as being able to provide relevant information. Mr McKinley was asked to participate in a

further interview with investigators, however, he exercised his right to decline.

62. The CSIU investigation encompassed the management of Mr Gavenor while in custody, criminal responsibility of Mr McKinley, and the incident response, which included the medical treatment he was provided while in custody. Relevant policies were also considered, including applicable Code Yellow and Code Blue. By way of summary, these policies are as follows:

    - On 30 May 2017, ***Incident Response Guidelines -Code Yellow Officer Requires Assistance*** were implemented, the purpose of which was to provide direction to personnel when managing a Code Yellow – Officer Requires Assistance and the responses that are required to aid officers.[41] The first response officer in such a situation is required to raise the alarm, call for assistance stating the location, and direct prisoners to cease activities or actions. A primary response is then provided, which assess and assist the first response officer and medical team with requirements.

    - On 30 May 2017, ***Incident Response Guidelines – Code Blue – Medical Emergency*** were implemented, the purpose of which was to provide direction to personnel when managing a code blue and the response required to aid officers that identify a medical emergency.[42] As is the case with a Code Yellow, the first response officer is required to raise the alarm and call for assistance stating the location as well as clear information as to the nature of the injury/accident. If it is 'clearly evident' that an ambulance is required for a medical emergency, the officer is required to ring 000. First aid is to be maintained until the arrival of the primary response and medical team.

63. The Coronial Report prepared by Detective Sergeant Caruana[43] found that there was no overt act or negligence by Corrective Services staff. A review conducted of the staff response to the incident was found to be in compliance with the incident response guidelines for Code Yellow and Code Blue.[44]

64. It was also concluded that Mr McKinley could not be held criminally responsible for the death of Mr Gavenor. I am satisfied that the CSIU investigation was thoroughly and professionally conducted and that all relevant material was accessed.

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[41] Ex D4
[42] Ex D5
[43] Ex C1
[44] Ex C1, pg. 8

Evidence of CCOs Virgo and Willshire

65. CCOs Virgo and Willshire were called to give evidence during the inquest proceeding. The accounts provided as to Mr Gavenor's behaviour within the unit and the timeline of events on 19 September 2017 were consistent with the written statements each had provided. CCO Virgo described Mr Gavenor as someone who had "good days and bad days" and was often grumpy. He was familiar with him after working in different units within the prison.

66. At the inquest, CCO Virgo said that he knew little about Mr Gavenor's medical history or his refusal to take prescribed medications. Mr Gavenor had told him that he would not take 'white man' medications. He agreed that it would be valuable for a CCO to have access to a prisoner's medical file, for the purpose of facilitating effective management within the unit.[45] This would allow for information as to whether a prisoner was compliant with his medication to be shared. At present, while CCOs may become aware of a prisoner's refusal to take medication incidentally by being present during medical rounds, this information is not directly shared with CCOs. CCO Virgo expressed a similar opinion during his interview with OCI Investigators.[46]

67. CCO Willshire agreed that access to a prisoner's medical records would be valuable. He indicated the issue had been discussed with his colleagues previously.[47] He had limited direct contact with Mr Gavenor prior to the date of his death.

Autopsy results

68. An external and full internal post-mortem examination was performed by experienced pathologist, Professor David Williams, on 20 September 2017.[48] A number of histology and toxicology tests were also undertaken. CCTV footage of the fight between Mr Gavenor and Mr McKinley was viewed by the pathologist.

69. The external examination revealed signs of minor facial trauma, found to be consistent with a violent confrontation in prison. Signs of recent minor trauma associated with resuscitation attempts were also present.

70. The internal examination revealed moderate to severe stenosis of the coronary arteries due to atherosclerosis, which was particularly severe at the junction between the left coronary artery and the origin of the left anterior descending coronary artery.

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[45] Evidence of Lachlan Virgo provided on 19/11/19
[46] Ex G10.1, pg.
[47] Evidence of John Willshire provided on 19/11/19
[48] Ex A2

71. Professor Williams found that the cause of Mr Gavenor's death was coronary atherosclerosis and minor trauma. He noted that the collapse of Mr Gavenor was consistent with a sudden cardiac problem, precipitated by fairly rigorous exercise in an overweight male subsequently found to have substantial coronary artery narrowing.

Clinical Forensic Medical Unit Review

72. Forensic Medical Officer, Dr Ian Home, was asked to consider the circumstances of Mr Gavenor's death, and provide advice on the following matters:

    (i) The appropriateness of the medical care and treatment provided by Offender Health Services.

    (ii) Whether a medical review should be been sought following the altercation; and

    (iii) The adequacy of the response to Mr Gavenor's collapse and the resuscitation efforts by staff.

73. A report detailing Dr Home's opinion in relation to these matters was provided on 25 September 2019.[49] He was not called to give evidence during the inquest.

74. Having considered Mr Gavenor's medical records, Dr Home noted that medications were often declined, and he had indicated a preference for 'cultural healing'. Following repeated unusual behaviours, Mr Gavenor was diagnosed with a relapse of bipolar disorder for which antipsychotic medication was prescribed but refused. Dr Home also considered the circumstances of the altercation and Mr Gavenor's eventual collapse, as well as the care and resuscitation efforts carried out by CCOs, medical staff and QAS.

75. Dr Home concluded that there was no issue with the delivery of health services to Mr Gavenor due to the following factors:[50]

    (i) He had known coronary artery disease on a background of hypertension, high cholesterol and diabetes.

    (ii) There was no documentation to suggest symptomatic heart disease other than a single episode of chest pain reported the day after his admission to the TCC, which resolved without issue.

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[49] Ex H1
[50] Ex H1, pg. 3

(iii) He was often non-compliant with medications stating, among other reasons, they were contrary to his cultural beliefs. It was documented on occasions that he was not concerned that it may shorten his life. While it was acknowledged that this was on a background of a likely relapse of bipolar disorder, medication cannot be forced upon an individual in a prison environment and would have required hospitalisation under a treatment order.

(iv) His sudden collapse from an acute cardiac event could not have been foreseen.

(v) Medical personnel attended as soon as practical and commenced CPR shortly after he became unresponsive. There was no opportunity to arrange for an earlier medical review following his collapse.

76. Dr Home noted that the outcome for individuals who suffer a sudden cardiac arrest remains extremely poor.[51]

Office of the Chief Inspector Investigation Report

77. The Office of the Chief Inspector (OCI), Queensland Corrective Services appointed investigators to examine the incident under the powers conferred by s 294 of the *Corrective Services Act 2006.* A report was subsequently prepared detailing the findings of this investigation.[52]

78. Significantly, the OCI Report noted that it was well known by correctional staff that Mr Gavenor was non-compliant with his medication as he was suspicious of 'white man's medicine'. TCC Cultural Liaison Officer (CLO), Mr Drue Ross, told investigators that he wondered whether Mr Gavenor's erratic behaviour shortly before his death may have been because he was 'spiritually troubled'.

79. TCC Acting Nurse Unit Manager, Ms Carla Vernon, told the OCI investigators of the process by which medications were administered in the secure units. Rounds were undertaken twice daily, at which time nurses were accompanied by officers. In the secure units, there was a secure room in which the nurse is placed together with the medication. The prisoners approach a window to the secure room, one by one. The nurse verifies the prisoner's identity and the medicine is provided to the prisoner. The officers present confirm that the medicine has been consumed. If a prisoner refuses to take their medication, the nurse takes the medication back. Officers are not expressly told if a prisoner does not take their medication, although they may witness this themselves. If there is a basis for communicating non-compliance with PMHS that can occur, however, there is no '*hard and fast rule'*.[53]

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[51] Ex H1, pg. 3
[52] Ex D6
[53] Ex D6, pg. 15

80. Issues identified as a result of the investigation, which may have contributed to the occurrence of the incident, were noted as follows:[54]

- *Lack of shared health information:* issues were identified with obstacles imposed on correctional staff by the limited information they were provided about prisoner's health issues. In this instance for example, correctional staff were unaware of Mr Gavenor's ongoing and largely untreated cardiac issues. Without this knowledge, the officers' ability to effectively care for and manage prisoners may be reduced.

- *Cultural Liaison Issues:* issues were raised as to the lack of indigenous correctional staff at TCC, a lack of understanding by some staff as to the role of the Cultural Liaison Officer and cultural awareness generally, and a lack of support for the liaison officer at TCC following significant cultural events, such as Mr Gavenor's death.

- *Suitability and training of McKinley in his role:* issues as to the training of unit cleaners in matters such as diplomacy, de-escalation of violence or conflict avoidance or resolution were explored, and largely dismissed.

81. While a number of the recommendations made by the Investigators fall outside the scope of this inquest, the following are relevant to the issues that were identified as relevant, given the circumstances of Mr Gavenor's death:

    o *Information sharing with Queensland Health (1):* That QCS generally, and TCC management consider whether information sharing processes between QH and QCS (at the State and Local level), including the current MOU, are such that correctional staff are provided with or able to obtain, as necessary, as much information about prisoners medical conditions as is legally permissible in order to ensure that those staff are fully informed of potential risks to themselves and other prisoners.[55]

    o *Information sharing with Queensland Health (2):* TCC management review whether systems and processes by which information gleaned by supervisors in multi-disciplinary meetings, in particular that which suggest that particular prisoners are at risk of aberrant or erratic behaviour because of untreated MH conditions, is appropriately documented, recorded and shared with those officers responsible for custodial management of those prisoners on a day-to-day basis.[56]

[54] Ex D6, pg. 30 - 32
[55] Ex D6, pg. 32
[56] Ex D6, pg. 32

- *Prisoners who refuse medications:* QCS and TCC management consider whether, and if so what, further action can and should be taken when prisoners with known life-threatening conditions, such as cardiac disease, refuse to take medication, thus making deaths in custody more likely. This should be considered with due reference to a person's right to refuse to take prescribed medication and to the limitations on the circumstances where a person can be required to take a specific medication, such as those specified in the *Mental Health Act 2016.*[57]

- *Case noting:* TCC management reiterate the requirements of the Case Noting/Case Reporting Directive regarding when notes are required to be entered.

- *Cultural issues:* Given the high proportion of Aboriginal and Torres Strait Islander Prisoners at the TCC, the centre should give consideration to the development and implementation of centre-specific strategies for cultural responsiveness and cultural safety in the management of prisoners.[58]

82. In response to the recommendations made, the following actions have been undertaken by TCC and Queensland Corrective Services:[59]

    - *Information sharing with Queensland Health (1):* The current Memorandum of Understanding (MOU) between QCS and Queensland Health as to information sharing is presently under review at a state-wide level.[60] The review is scheduled to be complete by 30 November 2019. On a local level, the General Manager of TCC was to meet with the Nurse Unit Manager to explore opportunities for prisoner health information to be shared with QCS operational managers.[61]

    - *Information sharing with Queensland Health (2):* On 29 May 2019, a communication was sent to all supervisors reiterating the importance of briefing teams of particular risks with regard to the prisoner population. The importance of case notes was also reinforced.[62]

    - *Prisoners who refuse medications:* This recommendation was referred to the Statewide Operations to consider the recommendation given the larger scale implications.[63] It was noted that this was a complex issue with medical and legal

[57] Ex D6, pg. 32 & 33
[58] Ex D6, pg. 34
[59] Ex B17 & Ex under
[60] Ex B12, [7] & [8]
[61] Ex B12, [8]
[62] Ex B17.1
[63] Ex B12, [10]

implications. QCS is continuing to liaise with QH regarding this issue. There was no identified outcome for implementation.[64]

- *Case noting:* The General Manager of TCC emailed all staff reminding them of the importance of accurate and meaningful case noting, as highlighted in the OCI findings. In addition to this move to event based case noting, staff were reminded to record in their notes if a prisoner's activities and behaviours are indicative of some form of medical issue or MH change.

- *Cultural issues:* The Townsville Cultural Liaison team will consult with the Murridhagun Cultural Centre to ensure alignment with the Aboriginal and Torres Strait Islander Reference Group to develop a strategy.[65] A Reconciliation Action Plan has been developed by the Reference Group, which is currently subject to a joint Departmental approval process.

Family Concerns

83. On 12 October 2017, a letter was received from the Mornington Island Community Legal Service on behalf of Mr Gavenor's mother, Ms Gloria Gavenor, identifying specific queries and concerns about her son's death:

    - Details as to what occurred on the days leading up to and on the day of her son's death;
    - The name and background of the person who assaulted her son, including details as to their relationship prior to the assault.
    - Identify of any witnesses to the assault.
    - Who reported her son's death?
    - What – if any – action was taken when Mr Gavenor was found?
    - What are the protocols for TCC when someone is found as her son was, when unconscious?

84. My office provided this letter to Detective Sergeant Caruana for consideration as part of his investigation. I trust that Ms Gavenor's concerns have been adequately answered by the CSIU and OCI investigations, and in these findings. I extend my sincere condolences to her and other members of Mr Gavenor's family.

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[64] Ex B17 [13]
[65] Ex B12, [21]

Findings Required

85. 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 – Ashley Glenfield Gavenor.

How he died - Mr Gavenor died after he collapsed soon after a brief physical altercation with another prisoner within the secure unit of the Townsville Correctional Centre. He sustained minor injuries in that altercation.

Place of death – Townsville Correctional Centre in the State of Queensland.

Date of death – 19 September 2017.

Cause of death – Mr Gavenor died from coronary atherosclerosis and minor trauma.

Conclusions on the issues for inquest

86. It was clear that Mr Gavenor suffered from a number of significant comorbidities, which included coronary artery disease, hypertension and diabetes.

87. Despite being made aware of the risks, Mr Gavenor refused to take any prescribed medication for a number of months prior to his death. It appears that he had also not taken medication while living on Mornington Island.

88. Medical and nursing staff provided advice and counselling to encourage compliance. Mr Gavenor elected not to take medication for reasons including cultural beliefs and adverse side effects. Patterns of unusual behaviour within the unit, coupled with his medication refusal, subsequently gave rise to a diagnosis of the relapse of his bipolar disorder.

89. In the weeks before his death, consideration was given to a consistent approach to managing Mr Gavenor's mental and physical health needs by various disciplines within TCC. This included the possibility of an involuntary treatment order.

90. While I accept that prisoners have the right to refuse medication, questions of capacity may give rise to the need for involuntary treatment in circumstances where the refusal poses an immediate risk to the prisoner or to other persons.

91. Refusal of medications for chronic health conditions such as heart disease and diabetes would not constitute such circumstances. After considering the evidence of Dr Oltvolgyi, the records of the Townsville Hospital and IOMS entries, I conclude that Mr Gavenor's mental and physical health treatment needs had received appropriate consideration in the lead up to his death.

92. A plan was formulated to offer olanzapine on a voluntary basis and then review at a multidisciplinary meeting. It was also evident that Mr Gavenor's mood had stabilised after the diagnosis of a relapse of bipolar affective disorder was made in mid-August 2017. He was recorded in IOMS on several subsequent occasions as being polite and compliant.

93. The multidisciplinary meeting on 30 August 2017 recorded that all stakeholders had agreed to work towards managing Mr Gavenor's bipolar disorder. It was acknowledged that while an ITO may be required in the future, at that time he did not meet the criteria for involuntary treatment. The meeting also recorded that Mr Gavenor's symptoms had settled and further culturally appropriate support was required. The evidence indicated that after 30 August 2017, up until the day of his death, Mr Gavenor experienced general stability of his mood and was unlikely to have met the criteria for an ITO at any stage.

94. I accept the evidence of Dr Home in relation to the medical care and treatment provided to Mr Gavenor while at the TCC, and find that it was appropriate in the circumstances.

95. The response provided following his collapse on 19 September 2017 by CCOs and medical staff, was also adequate, with those attending as soon as was practicable. There was compliance with the relevant Code Yellow and Code Blue policies. CPR was commenced promptly after it was apparent that Mr Gavenor had stopped breathing.

96. I also accept that there was no evidence that QCS officers could have predicted that the altercation between Mr Gavenor and Mr McKinley would occur. They were both Indigenous men who had known each other for many years. They were regarded as friends within the prison and there was no known tension between the two men. I do not consider that the decision to allow association between the two men was inappropriate.

97. The further measures being implemented and considered by the TCC, and QCS Statewide Operations in response to the OCI Report are appropriate. Issues associated with the sharing of information about a prisoner's medical history between medical services and custodial officers and other QCS staff are complex. Ideally this should ideally occur with the informed consent of the prisoner. However, there may be circumstances where the safety of the prisoner or other persons require that information be shared without consent.

98. Based on the evidence at this inquest, in particular Dr Home's advice, it appears that such measures would have been unlikely to have changed the outcome in Mr Gavenor's case, given he suffered an unforeseeable acute cardiac event. It would not have assisted the CCOs to have known of his lengthy cardiac history and other comorbidities in those circumstances.

Comments and recommendations

99. 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. Having regard to the QCS response to the OCI recommendations and the ongoing work on information sharing between QCS and Queensland Health, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future.

100. I close the inquest.

Terry Ryan
State Coroner
Townsville
21 November 2019