QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Scott Hambly**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/5635
DELIVERED ON:	4 May 2021
DELIVERED AT:	Brisbane
HEARING DATE(s):	4 May 2021
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, life prisoner lost to follow-up.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lio Willie
Queensland Corrective Services:	Ms Megan Lincez
West Moreton Health:	Ms Prudence Fairlie, Legal Counsel

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Introduction

1. Scott Hambly was aged 38 years when he died at the Wolston Correctional Centre (WCC). He was serving a sentence of life imprisonment for murder. On 17 December 2018, he was found unresponsive in his cell. Resuscitation efforts were unsuccessful, and he was declared life extinct at 3.21pm that day.

The investigation

2. Senior Constable McGregor of the Corrective Services Investigation Unit (CSIU) carried out the investigation into the circumstances surrounding Mr Hambly's death. A Coronial Report was provided with various annexures, including witness statements and incident logs.

3. Police went to the WCC after being notified of the death. A targeted direction for investigation was issued by the State Coroner. Mr Hambly's correctional records and his medical files from WCC were obtained.

4. The investigation was informed by statements from the relevant custodial correctional officers, medical and nursing staff, and fellow prisoners at WCC. These statements were tendered at the inquest. A statement was also obtained from Mr Hambly's mother.

5. Dr Ian Home from the Clinical Forensic Medicine Unit (CFMU) also examined Mr Hambly's medical records and reported on them for the Coroners Court.

6. The CSIU investigation concluded that Mr Hambly died from natural causes, and that he was provided with adequate medical care in prison. It also found that there were no suspicious circumstances associated with the death. I am satisfied that the CSIU investigation was professionally conducted and that all relevant material was accessed.

The inquest

7. At the time of his death, Mr Hambly was a prisoner in custody under the *Corrective Services Act 2003*. Mr Hambly's death was a 'death in custody' and an inquest was required by the *Coroners Act 2003*. The inquest was held on 4 May 2021. All statements, medical records and material gathered during the investigation into Mr Hambly's death were tendered.

The evidence

Personal and medical history

8. Mr Hambly's mother, Patricia Hambly, had visited him every fortnight following his incarceration in 2003. Ms Hambly advised that she was not aware of the details of her son's medical history and that he would not normally share concerns with her.[1] The autopsy report detailed a family medical history of heart disease. Notably, Mr Hambly had a sister with Parkinson's disease, a sister who died from a heart attack at age 50, and a sister who survived a heart attack at age 40. His father also died following a heart attack at age 69 years.[2]

[1] Ex B2.
[2] Ex A4.

9. Ms Hambly recalled that her son would sometimes hold his chest during visits. When she visited Mr Hambly in early December 2018, he kept holding his chest. She suggested he see a doctor, but he assured her that he was alright.

10. Given Ms Hambly's frequent visits over the years, she became quite friendly with WCC staff. She had no concerns with her son's treatment while incarcerated at WCC.

11. Mr Hambly had a criminal history that consisted primarily of property offending, disorderly public behaviour, and breaches of community based orders. He was convicted on 27 July 2006 for the April 1997 murder of a 79 year old man at Keperra. Mr Hambly was sentenced to life imprisonment, having been in custody since 24 April 2003.[3]

12. On 28 May 2003, Mr Hambly was transferred from Arthur Gorrie Correctional Centre to WCC and was classified as a protection prisoner.[4]

13. Mr Hambly suffered an acquired brain injury at the age of 15 years after he was struck by a car while he was riding a bicycle. He was in a coma for a period following this accident. He then experienced biblical delusions and attributed the commission of the offence of murder as being commanded by God.[5]

14. Mr Hambly was first diagnosed with reactive psychosis in 1998 and received treatment; and in 2002 he was thought to have a psychotic illness with a differential diagnosis of schizophrenia.[6] Mr Hambly received treatment for his psychosis and was admitted to hospital a number of times throughout his period in custody.

15. In November 2014, Mr Hambly displayed grandiose/ religious delusions and was diagnosed with schizophrenia. He was subsequently admitted to The Park, Centre for Mental Health (The Park), High Secure Inpatient Service for psychiatric review.[7]

16. In January 2015, during his admission to The Park it was discovered that Mr Hambly had mild systolic dysfunction, a left ventricular ejection fraction of 43%, and mild diastolic dysfunction. As a result, he was referred to the Outpatient Cardiology Clinic at Ipswich Hospital for further investigation. He was first seen on 2 April 2015 and diagnosed with Mild LV dysfunction. He was commenced on an ACE inhibitor and Beta Blocker. Mr Hambly attended for a second Outpatient Cardiology Clinic review on 4 June 2015. The outcome of that attendance was for him to continue the prescribed medication, and an update was written to his treating Consultant Psychiatrist.[8]

17. On 16 July 2015, Mr Hambly was discharged from The Park and returned to WCC. He did not attend the next two scheduled Outpatient Cardiology Clinic appointments at Ipswich Hospital and was subsequently removed from the clinic. The reason cited being "unable to be contacted". Subsequently, Mr Hambly was not seen by cardiology services again.[9]

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[3] Ex C1; Ex E.
[4] Ex A6.
[5] Ex E, Vol 1, pg.11.
[6] Ex E, pg. 29, 174.
[7] Root Cause Analysis Report.
[8] Root Cause Analysis Report.
[9] Root Cause Analysis Report.

18. Mr Hambly also had epilepsy. It appears that he had two generalised seizures, one as a teenager and one in 2017. Investigations in 2017 had shown a normal brain on the CT scan. An MRI scan showed early features of left medial temporal sclerosis and changes in the right thalamus possibly due to the previous brain injury. An EEG had shown a potential epileptic focus in the left temporal lobe.[10]

19. Mr Hambly was prescribed the following daily medications:

    - Bisoprolol and perindopril for heart disease
    - Sodium valproate for epilepsy
    - Pantoprazole for reflux type symptoms
    - Quetiapine and aripiprazole, which were antipsychotic medications.[11]

20. On the day of his death, Mr Hambly had taken bisoprolol, perindopril, pantoprazole, sodium valproate and quetiapine.

Events Leading up to the Death

21. Mr Hambly was housed in Unit 5B with six other prisoners. The unit had a shared common room and kitchen area. The other prisoners in his unit were aware that he took *"*heavy psych meds*"* and it was not uncommon for Mr Hambly to be "passed out".

22. On 17 December 2018, Mr Hambly was seen by Custodial Correctional Officers (CCO) at approximately 7.00 am during morning muster. After muster he returned to his cell and went to sleep. Other prisoners who were in the unit at the time heard Mr Hambly snoring heavily during the morning and muttering in his sleep. A fellow prisoner, Mr Kirby, went into Mr Hambly's cell at least twice to check on him and rolled him onto his side.

23. Mr Kirby tried to wake Mr Hambly for the 10.30am muster but could not rouse him and advised CCOs he was asleep in his cell. Officers checked on him and after seeing that he was sleeping and snoring, did not attempt to wake him.[12]

24. At the 1.30pm muster Mr Hambly did not stand at the front of his cell door, as was required. CCO Savery asked Mr Kirby what was wrong with him and it was explained that Mr Hambly was on "heavy medication". CCO Savery went into Mr Hambly's cell and saw him in bed, snoring loudly and decided not to wake him. There was no concern for Mr Hambly's health at that time.[13]

25. At approximately 2.30pm, prisoner Kajewski went into Mr Hambly's cell to get his medical card to collect his medication. He saw that Mr Hambly was lying on his side and he did not appear to be breathing. When Mr Kajewski got closer and saw that Mr Hambly was pale in the face and not breathing, he yelled out to the unit "Scotty's not

[10] Ex A4 – Medical history summary contained in the Autopsy Report.
[11] Ex A4; Ex E1.
[12] Ex B7.
[13] Ex B11.

breathing".[14] Mr Kirby commenced CPR[15] while another prisoner went to advise the CCOs.

26. CCOs Rea and Savery ran to Mr Hambly's cell and observed Mr Hambly was blue and not breathing. They called a *Code Blue* emergency at 2.34pm and called for another CCO to bring a bag valve mask from the office. CCO Rea said that he had initiated CPR using a Laerdal face mask, but this was not effective. The other CCO took office keys and went to retrieve the bag valve mask and CCOs took over CPR efforts.[16]

27. A statement from Correctional Supervisor Warwick confirmed that CCOs from cluster 2 attended the scene and observed cluster 1 CCOs having difficulty performing CPR with a small Laerdal face mask. They subsequently retrieved a bag valve mask from the cluster 2 office to assist.[17] The correctional supervisor indicated that QCS policy requires that *staff trained in first aid who are responding to a medical emergency must provide first aid only after appropriate measures are taken to ensure their safety and prevent contamination including by blood or other body fluids*.

28. Registered nurses (RN) responded to the *Code Blue* and found Mr Hambly on his bed, with a fixed gaze and unresponsive. CCOs continued CPR while the RNs attached the automated external defibrillator (AED). As the AED advised "no shock", CPR was continued.[18]

29. At 2.40pm QAS were requested to attend Code 1, urgent assistance. Mr Hambly was moved to the ground to allow CPR efforts to continue. An IV was inserted and fluids and medication were administered.

30. At 2.58pm QAS arrived on scene and requested Mr Hambly be moved from his cell floor to the common room where there was more room. Resuscitation efforts continued without success, and Mr Hambly was declared life extinct at 3.21pm.[19]

Autopsy Results

31. An external and full internal post-mortem examination[20] was performed by Dr Nathan Milne on 20 December 2018 at Queensland Health Forensic and Scientific Services.[21]

32. A CT scan showed changes in the lungs of uncertain cause. The internal examination showed that the heart was of normal size, but the left and right ventricles were mildly dilated. Histology of the heart showed non-specific changes consistent with dilated cardiomyopathy. There was no evidence of an old or recent heart attack. Sections of the lungs showed widespread bronchopneumonia. As in at least one area this was associated with aspirated foreign material, the bronchopneumonia was most likely the result of aspiration. The liver showed changes related to Hepatitis C but was not cirrhotic.

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[14] Ex B5.
[15] Ex B7.
[16] Ex B1.
[17] Ex D11.
[18] Ex B3.
[19] Ex A2; Ex D6.
[20] To the extent necessary to determine the cause of death.
[21] Ex A4.

33. Dr Milne concluded that the cause of death was acute aspiration pneumonia. It was well-established on microscopic examination and would have taken several hours to develop. Aspiration could have occurred after he had been seen at muster at 7.00am and before he was noted to be snoring at about 10.30am. The snoring was consistent with him having aspirated and having a reduced level of consciousness.

34. Dr Milne considered that the cause of aspiration was uncertain. It was possible that Mr Hambly had an epileptic seizure as he had a clinical history of rare generalised seizures. The lack of any brain abnormalities on neuropathology did not exclude there having been epilepsy or a recent seizure.

35. Dr Milne noted that another possible cause of aspiration was an abnormal heart rhythm (arrythmia) developing as a complication of dilated cardiomyopathy. There were multiple potential causes for this including alcohol misuse, previous infections, inherited genetic abnormalities and morbid obesity. In some instances, an underlying cause cannot be identified. Individuals with this condition are at increased risk of cardiac arrythmias and progressive cardiac failure. Arrhythmias can cause impaired consciousness and aspiration.

36. Epilepsy and dilated cardiomyopathy were considered by Dr Milne to be other significant conditions in relation to death. Coronary atherosclerosis was also significant. The degree of narrowing of the arteries was moderate, and less than that typically causing significant symptoms. However, in the context of acute aspiration pneumonia and dilated cardiomyopathy, it could have contributed to the death.

Investigation Findings

37. After Mr Hambly's death was investigated by the Queensland Police Service Corrective Services Investigation Unit (CSIU). A Coronial Report was prepared by Senior Constable McGregor.[22]

38. The investigating officer was satisfied that adequate care was provided to Mr Hambly and there were no suspicious circumstances in relation to his death.

39. It was Senior Constable McGregor's opinion that the correctional officers, medical staff and several of the other prisoners who were present when Mr Hambly suffered the medical episode that resulted in his death had tried valiantly to save his life and should be commended for their efforts.

Root Cause Analysis

40. The WMHHS finalised a Root Cause Analysis (RCA) in February 2020 in response to Mr Hambly's death.[23] Several issues were identified during the review, including loss of follow-up to cardiology services, clinical handover and fragmented information systems.

41. As noted above, after Mr Hambly was discharged from The Park and returned to WCC he failed to attend subsequent cardiology clinic appointments and was removed from the clinic because he was "unable to be contacted".

[22] Ex A1; A6.

[23] Root Cause Analysis Report.

42. It was established that the appointment letters were sent to The Park. The process upon receipt of letters was that the patient opened it in front of staff. However, the letter remained the property of the patient and was not placed in the patient's medical record unless the patient handed it to staff. If a patient was no longer an inpatient at the facility, the mail would be forwarded to the last recorded address. In this case, it should to have been forwarded to WCC. The RCA concluded that Mr Hambly and Prison Health Service (PHS) staff were unaware of the appointment as there was no documentation or evidence that the appointment letter had been received.

43. During his admission to The Park, Mr Hambly was recorded as a Category 1 patient for the cardiology clinic on 25 March 2017. At the time the system for Category 1 patients who failed to attend, did not accept a new appointment or could not be contacted was that a medical officer or nurse was required to call the patient. However, on 17 April 2017 he was changed to a Category 2. There was no documentation to explain the reason for this change.

44. It was also unclear why the reason "unable to be contacted" was used upon closure to the cardiology service. The RCA team acknowledged that The Park and the cardiology clinic were both facilities within the West Moreton Health Service, and the cardiology clinic could have made a phone call to The Park to confirm if Mr Hambly was still an inpatient. Further, a letter was addressed to Mr Hambly's treating psychiatrist which should have been placed on his medical record.

45. It was the responsibility of clinicians and administration officers to ensure that Mr Hambly's contact details were kept up to date with the cardiology clinic, given they were aware he was a patient at The Park and would have been aware he was a prisoner.

46. It was noted by the treating psychiatric team on Mr Hambly's paper medical record at The Park that he needed ongoing cardiology follow-up. A review of his PHS medical records did not indicate that he was seen by a nurse on his arrival back to WCC. Documentation also indicated that Mr Hambly's monthly medication was scheduled into the clinic paper diary. However, there was no evidence an appointment was made for him to see the VMO as requested in the discharge summary.

47. The RCA team discovered three different Consultant Psychiatrists noted that "*cardiology follow-up was arranged"* in their clinical reports. However, they were seemingly unaware he was already removed from the clinic and it was apparent that no discussions were had with the PMHS Case Manager that Mr Hambly was required to attend the cardiology clinic or be seen by the VMO.

48. It was clear that Mr Hambly was lost to follow-up for cardiology review. The RCA team concluded that there were multiple complex systems across multiple locations and specialist teams which contributed to that. Given the passage of time, it was acknowledged that a number of systems and process changes have occurred that have mitigated the risks from that period of time, including an amended outpatient referral system / electronic portal at the Ipswich Hospital where the cardiology clinic was based.

49. However, the PHS had a lack of access to current integrated electronic records and they also lacked their own electronic system which remains a current patient safety risk. The RCA team stated that there are already actions occurring to address these major causal factors. Subsequently no further recommendations were made.

CFMU Review

50. Dr Ian Home of the Clinical Forensic Medicine Unit conducted a review of the medical treatment provided to Mr Hambly while he was in custody.[24] Dr Home noted that Mr Hambly was 'lost to follow-up' after failing to attend two scheduled cardiology appointments that were not effectively redirected from The Park to WCC. The purpose of those appointments was a further review to assess progress and consider additional testing.

51. Dr Home noted that while regular contact with Prison Mental Health continued upon his return to WCC on 16 July 2015, Mr Hambly never underwent a thorough medical assessment. It was not until 22 October 2016 that any substantive physical assessment was documented by a nurse practitioner. The first review by a visiting medical officer occurred on 6 June 2017, almost two years after his return from The Park. No detailed systems review was undertaken, although Mr Hambly had epilepsy and a heart condition requiring prescription medication.

52. Dr Home noted that the cardiology appointment letters sent to The Park should have been directed to WCC. Notwithstanding, he said that the need for cardiology follow-up should still have been identified at some point. The medical discharge summary from The Park to WCC said that arrangements needed to be made for a follow-up cardiology appointment. This did not occur.

53. Reviews by a consultant psychiatrist in July and October 2015 also noted the need for cardiology follow-up. Those were not actioned, and three subsequent reviews incorrectly indicated that cardiology follow-up had been arranged. Even though medication was prescribed and dispensed at WCC there had been no regular monitoring, such as blood pressure surveillance, and Mr Hambly had not undergone a thorough review for at least four years.

54. With respect to events on the day of his death, Dr Home considered that it was difficult to know whether Mr Hambly's loud snoring should have alerted those present to the fact that he was exhibiting signs of airway compromise. His fellow prisoners had reported that it was normal for him to snore loudly.

55. Dr Home indicated that the cause of the aspiration pneumonia remained unclear and that sudden unexpected death in epilepsy remained a possibility. The other possibility presented by Dr Milne was an arrhythmia as a complication of dilative cardiomyopathy, the cause of which was not identified. Dr Home noted that opportunities to investigate ischaemic heart disease as a possible cause were missed when Mr Hambly was lost to follow-up.

56. Dr Home concluded that appropriate medical care at WCC should have identified the need for further cardiology review. However, the magnitude of Mr Hambly's loss to follow-up remained uncertain as there was no conclusive evidence that ongoing review by cardiology would have prevented his death. He said that individuals with cardiomyopathy can develop arrhythmias, and sudden death can occur at any stage of the disease, even with optimal treatment.

[24] Ex B16.

57. Another possible contributing factor for the aspiration event identified by Dr Home was the potential risk of aspiration caused by antipsychotic medication that may have caused increased sedation. However, there was also no clear evidence of this. Mr Hambly's last medication change on 6 November 2018 saw a reduction in the night-time dose of quetiapine.

58. While Dr Home considered that Mr Hambly was well managed from a psychiatric standpoint, he essentially had no general medical care for his epilepsy and dilative cardiomyopathy at WCC despite the continued prescription of medications for those conditions from 2015.

59. Dr Home said that those medications were appropriate at the time and there was no indication additional treatment would have been required. While it was possible that Mr Hambly was stable and no changes would have been made that could have altered the outcome, the absence of regular reviews was a missed opportunity to identify health issues and optimise his care.

60. Dr Home concluded that the continued fragmentation of medical record systems between health and custodial facilities, combined with the absence of reliable chronic health surveillance within the prison system mentioned in the RCA Report, means inmates remained at risk. In the absence of coordinated health care, appointments may be missed, known diseases poorly managed and new conditions not identified in a timely manner.

West Moreton Health response

61. West Moreton Health provided a further response in relation to the provision of care to Mr Hambly, include the issues identified by Dr Home, in December 2020.

62. The response noted that West Moreton Health provides health services within corrective services consistent with a primary health care model of care. The standard of care expected is commensurate with that available in the community/ general practitioner setting. Services are provided by visiting medical officers employed on a part-time basis. Ideally, service provision includes annual reviews for those consumers with identified cardiology pathology. In the absence of an electronic medical record, the recall system is operated from an Excel spreadsheet.

63. West Moreton Health acknowledged and noted the concerns raised by Dr Home about Mr Hambly being lost to follow-up. It also noted that Dr Home concluded there was no evidence that ongoing cardiology review would have prevented the death or changed the outcome. Notwithstanding, West Moreton Health has implemented changes to improve the way these issues are managed to prevent similar events from occurring.

64. West Moreton Health's response indicated that after Mr Hambly was transferred from The Park to WCC in July 2015 a discharge summary was provided to WCC. As Mr Hambly was back in custody any further cardiology review was to be a arranged and undertaken at the Princess Alexandra Hospital (PAH).

65. With respect to epilepsy, Mr Hambly had previously presented to the PAH following an unwitnessed seizure at WCC. An EEG had identified potential epileptiform focus on the left temporal region. Mr Hambly was reviewed by neurology outpatients at the PAH in September 2016. He was commenced on valproate twice daily with recommended slow up titration in 2017, which was actioned by PHS.

66. There were no focal neurological signs on examination. There were no further neurology reviews are no further seizures were reported. He was further reviewed in January 2018 and was scheduled for further review at the PAH in January 2019.

67. The West Moreton Health response also identified several actions that have been taken since the death of Mr Hambly. The response noted that Mr Hambly would be more vigourously managed today considering the improvements that have been implemented.

68. In March 2018, the PHS appointed a nurse practitioner / nurse navigator model for chronic disease management funded through the Office of the Chief Nursing and Midwifery Officer. This role aims to identify patients with chronic health conditions and assists them through their healthcare journey by monitoring their health condition and escalating when required. Consumers can self-refer or are referred by nursing staff at each prison. The nurse practitioner also reviews investigation results, monitors blood pressure, arranges blood tests, identifies abnormal results and determines further investigations or medications required, alongside the Medical Officer.

69. In addition, the development of a specific nurse navigator role in 2020 allows for more regular and thorough monitoring and reviews of consumers with chronic conditions. Cardiovascular risk assessment is undertaken at the time of initial assessment and when consumers are symptomatic are set out in the RACGP guideline for CVD risk assessments. As Mr Hambly had known left ventricular failure he would fit into this category. Mr Hambly would now be placed on the Medical Officer / nurse practitioner clinic list for review of his medications and the need for cardiac follow-up.

70. In addition, a Clinical Nurse Consultant role was created in 2020 within the PHS as an interface between the PHS and PMHS to ensure that concerns raised about prisoners are actioned appropriately and in a timely manner. The role also assists with coordination of follow-up reviews so that prisoners are not lost to follow-up, as in Mr Hambly's case.

71. A "vulnerable person's list" was commenced in 2020 due to the Covid pandemic and will continue. This list is for prisoners identified with high risk and high healthcare needs and is based on both the consumer's clinical history and clinical presentation. The list is reviewed weekly by the Clinical Nurse Consultant. Mr Hambly would today be considered a vulnerable person and included in the list because of his epilepsy and cardiac disease.

72. Updated Triage Guidelines for referring to the Nurse Practitioner and to the Medical Officer came into effect in March 2019 and have been developed to ensure prisoners are appropriately followed up for certain medical conditions within a set time frame. Mr Hambly would now have been seen within 14-28 days for medication review and investigations.

73. An updated rebooking system has been implemented which is a spreadsheet managed by Clinical Nurse Consultants at each facility. This allows consumers to be reviewed in a timely manner in the identification of prisoners who miss appointments to ensure they are followed up and be booked to be reviewed as soon as practicable.

74. A Management of Medical Transfer and Returns procedure was developed in 2020 to facilitate continuation of patient care regarding transfer of care to hospital and following

transfer back from hospital to a correctional facility following an external medical appointment.

75. West Moreton Health confirmed that correctional facilities do not operate using an Electronic Medical Records Management system. A project is underway under the auspices of the Office for Prisoner Health and Well-Being to develop this capacity. This will assist with information sharing of consumer health issues across all prison health services, Prison Mental Health Service, general practitioners, and other health service providers. Read only access for IemR and CIMHA records has also been provided to nursing staff, enabling faster access to discharge summaries from the PAH including for mental health admissions and other specialist medical appointments.

76. The West Moreton Health response also highlighted improved governance in relation to information exchange between the PHS and the PMHS, as well as the Ipswich Hospital Outpatient's Department and PHS.

Conclusions

77. Mr Hambly had a heart condition that was identified in 2015 as needing follow-up with the Ipswich Hospital cardiology clinic as an outpatient. He was lost to the referral system and removed from the clinic's list. In retrospect, it is difficult to understand how Mr Hambly was not followed up as he was a prisoner serving a life sentence.

78. At the same time, there is no indication that Mr Hambly attended the WCC medical centre with any complaints related to his heart or breathing. Even if the cardiology clinic reviews were conducted when they should have been, it was reasonable to expect that Mr Hambly might have attended to seek medical attention if he felt regular chest pain.

79. Mr Hambly's mother stated he did not complain of or disclose any health concerns or treatments with her. Other prisoners in Mr Hambly's unit were also unaware of any health conditions, other than his treatment for psychosis. Mr Kirby noted that Mr Hambly's health had deteriorated over his years in custody.

80. Based on Dr Home's opinion, I am satisfied that Mr Hambly was given appropriate medical care by staff at The Park. Although he was lost to follow-up at WCC, there is insufficient evidence to conclude that his death could have been prevented.

Findings required by s. 45

81. 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 the material, I make the following findings:

Identity of the deceased – Scott Hambly

How he died – In July 2006, Mr Hambly was sentenced to life in prison for a murder he committed in 1997. In November 2014, he was transferred to The Park, Centre for Mental Health for psychiatric review.

In January 2015, during his admission to The Park he was referred to the Outpatient Cardiology Clinic at Ipswich Hospital for investigations.

On 16 July 2015, Mr Hambly was discharged from The Park and returned to Wolston Correctional Centre. He did not attend the next two scheduled outpatient Cardiology Clinic appointments at Ipswich Hospital and was lost to follow-up.

He died in December 2018 from aspiration pneumonia. It was not clear that follow-up for his cardiac conditions would have prevented his death.

Place of death – Wolston Correctional Centre, Wacol Station Road Wacol, QLD 4076 AUSTRALIA

Date of death– 17 December 2018

Cause of death – Aspiration pneumonia.

Other significant conditions were epilepsy, dilated cardiomyopathy and coronary atherosclerosis.

Comments and recommendations

82. 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.

83. The RCA that was conducted identified a range of actions to address the major causal factors identified. The comprehensive supplementary response provided by West Moreton Health in December 2020 identified a range of strategies that highlight improved communication and clinical handover to ensure that prisoners are not lost to follow-up, and to prevent a breakdown in communication between service providers including outpatient departments, hospitals, doctors, the PHS and the Prison Mental Health Service.

84. Given the measures already taken by West Moreton Health in response to the death, there is no basis on which I could make any useful preventative recommendations.

85. I extend my condolences to Mr Hambly's family and close the inquest.

Terry Ryan
State Coroner
BRISBANE