OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William Elliot Preston**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1859/07(2)
DELIVERED ON:	12 February 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	13 January 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, emergency access to cells

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Health:	Mr Peter Brockett
Department of Community Safety:	Ms Jane Cromie
GEO Group Australia Pty Ltd:	Ms Donna Callaghan (instructed by Blake Dawson)

Table of contents

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of William Elliot Preston. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

William Elliot Preston, 60, was an inmate of the Arthur Gorrie Correctional Centre (AGCC) when he died on 2 May 2007.

Mr Preston had been in custody at AGCC for 9 days. He had a lengthy history of treatment for a variety of medical conditions including incidents of atypical chest pain. At about 11:30am on 2 May 2007, Mr Preston was seen to collapse in the kitchen area of the W1 Observation Unit at AGCC. He was found to be unconscious. Attempts by prison medical staff to revive him were unsuccessful and when Queensland Ambulance Service (QAS) officers arrived a short time later it was evident he had died.

Because the incident was a "death in custody" within the terms of the Act it was reported to the State Coroner for investigation and inquest.[1]

These findings

- confirm the identity of the deceased, the time, place, circumstances and medical cause of his death;
- consider whether the actions or inactions of any person contributed to his death;
- examine the actions of Corrective Services staff immediately after Mr Preston collapsed on 2 May 2007;
- consider whether the medical treatment afforded at to him while in custody was reasonable and adequate; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

The investigation was conducted by Plain Clothes Senior Constable Bradley Rantall, then of the QPS Corrective Services Investigation Unit.

[1] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

Queensland police were advised of Mr Preston's death at 12:30pm and arrived at the W1 Unit at AGCC at about 1:30pm. They observed the scene to be secured by tape. A Scenes of Crime officer immediately took photographs of the scene. Mr Preston's body had remained in situ and police observed a small amount of blood on a pillow and a small cut to the rear of his head. There was no evidence of other injuries or any signs of a struggle in the immediate area.

Mr Preston's cell and belongings were searched. An industrial bread toaster located close to where Mr Preston had been standing prior to collapse was seized for testing to rule out the possibility of electrocution.

Statements were taken from all Corrective Services officers present when Mr Preston collapsed. All prisoners present in the W1 Unit were interviewed and their statements recorded on audio tape. Closed circuit TV recordings were seized although later inspection showed that they did not capture Mr Preston's collapse. All prison records concerning Mr Preston, including his medical and offender files, were seized. Medical records were obtained from Princess Alexandra Hospital and Royal Adelaide Hospital, and contact was made with two of Mr Preston's children in relation to his medical history.

QAS records were obtained and records concerning Mr Preston's criminal history were inspected to establish the basis for his incarceration.

Mr Preston's body was accompanied by a police officer to the Queensland Forensic Scientific Services (QFSS) morgue and an autopsy examination conducted on the morning of 3 May 2007.

I find that the investigation into this matter was professionally and thoroughly conducted and that all relevant records have been accessed. I thank Senior Constable Rantall for his assistance.

The inquest

An inquest was held in Brisbane on 13 January 2010. Mr Johns was appointed as counsel to assist me. Leave to appear was granted to the Department of Community Safety, Queensland Health and the operator of AGCC, GEO Australia Proprietary Limited.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered.

It was submitted by Mr Johns that the material tendered was such that I would, but for one issue, be in a position to make findings without calling any oral evidence. After opening the inquest I was assisted by the provision of a statement from GEO Australia Pty Ltd which addressed the outstanding area of concern; namely the procedures in place at AGCC to allow access to emergency services personnel. There were no submissions from any other party to the effect that oral evidence should be called. On receiving this further material I determined that the evidence contained in the exhibits was sufficient to enable me to make the findings required by the Act and that there was no

other purpose which would warrant any witnesses being called to give oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal background

Mr Preston was born in Toowoomba on 22 September 1946. In the years leading up to his death he had lived a transient lifestyle moving between hostels and living on the street and with no permanent place of abode. Mr Preston was a carpenter by trade and had been employed on a consistent basis up until several years prior to his death when he fell from a roof and broke both his ankles. The effects of these injuries continued to cause him difficulty up until the time of his death.

Mr Preston was married in 1965 and divorced in 1997 (although it appears he had separated from his wife much earlier). He had seven children from that relationship. The statement from taken by the investigating officer from one of Mr Preston's daughters reveals a significant level of love and concern for him but an understandable resignation to the fact he had no desire to be assisted in relation to his health and lifestyle issues.

Mr Preston had suffered from alcoholism for many years. He had a criminal history extending back to 1961 which appears to relate almost entirely to excessive alcohol use. This, in combination with his advancing years, saw him with a documented medical history of gastro-oesophageal reflux, Barrett's oesophagus, lower urinary tract infection, high blood pressure, near blindness in his left eye and a left side hernia. In addition, he had a history of depression and suicidal ideations. Sadly, he was unwilling to accept medical treatment offered to him in the weeks and months prior to his death.

Mr Preston's children have made it clear that while his death was not unexpected they are of course very much saddened by his passing.

Recent medical history

Records from Royal Adelaide Hospital show that on 21 March 2007 Mr Preston was found in a public toilet heavily intoxicated and covered in vomit.

After initial treatment he was admitted to hospital under South Australian mental health regulations on 28 March 2007. Mr Preston stayed in hospital until 12 April 2007 when he discharged himself against medical advice. During this period of hospitalisation a coronary angiograph revealed atherosclerosis. Mr Preston was advised that by leaving on 12 April 2007 he risked complications of possible haemorrhaging from the cardiac angiograph insertion site. He was also informed of the risk of discharge before seeing a urology consultant. It was explained that he risked potential kidney failure and death.

Mr Preston was also advised to stay in hospital to await a further opinion from a cardiology consultant. He told medical staff in Adelaide that he had 'confidential' family business to attend to in Brisbane. An airfare was arranged for Mr Preston to return to Brisbane and details provided for him to follow up medical treatment. It appears Mr Preston did not pursue any further treatment on his return to Brisbane.

For reasons explained later Mr Preston was arrested in Brisbane on 19 April 2007. His custody index states that he was heavily intoxicated and shortly thereafter complained of chest pains. An ambulance was called and on the advice of QAS staff he was transferred to the PA hospital secure unit. It appears that while there, PA staff accessed medical records concerning Mr Preston's hospitalisation in Adelaide. Mr Preston remained in the PA secure unit until 23 April 2007 during which time he was treated primarily for alcohol withdrawal symptoms. His discharge notes state that he was no longer suffering from chest pains and that an ECG showed 'no acute ischemic changes'. The discharge plan called for 'continued care' with most focus being on ongoing treatment options for Mr Preston's chronic alcoholism.

On reception at AGCC Mr Preston underwent a medical assessment by Dr Sean Pham. Dr Pham noted that Mr Preston was on a number of medications and he made arrangements for these to be continued. These medications were as follows;

- Atenolol – high blood pressure
- Zoton – reflux, stomach and oesophagus
- Fefol – iron deficiency due to alcohol addiction
- Valium – to assist with de-tox from alcohol use
- Thyamine – to assist with malnourishment due to alcohol use

On arrival at AGCC Mr Preston's mental health was also assessed. He made it clear to staff that he was depressed, that he had a history of attempting suicide and that he presently had suicidal thoughts. As a result, Mr Preston was placed in the W1 Secure Observation Unit with a requirement under his interim risk plan to be observed every 15 minutes. Observation records appear to have been diligently filled out with Mr Preston last being observed in the unit block at 11:45am on 2 May 2007 (at which time he was receiving medical treatment subsequent to collapsing).

There is no record of Mr Preston making any complaints in relation to his physical health and, in particular, in relation to suffering chest pains after arrival at AGCC. In addition to the usual channels for accessing medical assistance, Mr Preston had contact with nurses twice daily during the dispensing of his medication.

Basis for imprisonment

Mr Preston was arrested on 22 December 2006 and charged with committing a public nuisance. He was granted bail on that date and entered into an undertaking to reappear at the Brisbane Magistrates Court on 16 January 2007. He failed to appear on that date and a warrant was issued for his arrest.

Mr Preston was arrested pursuant to that warrant on 19 April 2007 and taken to the Brisbane City Watchhouse. He appeared in the Brisbane Magistrates Court on 20 April 2007 and was remanded in custody to reappear on 24 May 2007. Mr Preston was admitted to the secure unit at the PA hospital at 0030 hours on 21 April 2006. He was received at AGCC on 23 April 2007 where he was to remain until his reappearance in court.

Mr Preston collapses

At around 11:30am on 2 May 2007 Mr Preston was in the kitchen area of unit W1. Corrective Service Officer (CSO) Kristy Baker was performing roving duties and observed Mr Preston standing with a cup in his hand. She observed one other prisoner in the kitchen area. CSO Baker saw Mr Preston's legs buckle before he fell to the ground, dropping the cup and hitting the side of his head on the kitchen preparation bench. There was no contact between Mr Preston and the other prisoner during this period. CSO Baker and another CSO attended to Mr Preston. He was unresponsive and they noted some drops of blood to the left side of his head. Other prisoners were moved into the exercise yard while two CSO's commenced CPR with the use of a mouth piece.

In the interim an emergency call had been made to the AGCC medical unit. Two nurses arrived at the unit and took over CPR with the use of an airways bag and oxygen cylinder. A Lifepack machine was attached to Mr Preston and, in accordance with instructions issued by the machine (which are based it's monitoring of Mr Preston's vital signs) a series of electric shocks were given by way of defibrillation.

Queensland Ambulance Service (QAS) records show that they were contacted at 11:41am. Three units responded with the first arriving at the patient at 11:50am. QAS officers noted that Mr Preston was centrally cyanosed (blue in colour and had stopped breathing). QAS staff were informed by AGCC staff that they had been conducting CPR for around 20 minutes. The Lifepack machine by this time indicated that Mr Preston was asystolic and it was agreed between QAS staff and Dr Pham, who had arrived at the scene at about 11:40am that Mr Preston was deceased. Dr Pham signed a life extinct certificate at 12:15pm.

One of the ambulance officers indicated in his statement that their entry into the prison was unduly delayed because "*the prison staff appeared to be more concerned with security than in the preservation of life*". He suggested it took over 15 minutes for the QAS officers to get through security.
Even though this is not consistent with the records quoted above, comment was sought from the prison management in relation to the issue. The general manager of the AGCC provided a statement annexing the policy of Queensland Corrective Services in relation to vehicle access to corrective service facilities which stipulates that "*the general manager of a corrective services facilities must ensure that any emergency services vehicles receive unrestricted access to the facility*". He detailed the implementation of that policy at the AGCC.

He said when an emergency services vehicle is seeking access to the facility all other vehicle access is suspended to give priority to it.

However as the AGCC is a high security centre even emergency services vehicles must pass through a vehicle lock at the front entrance. Once this barrier is cleared the vehicle is escorted by AGCC staff directly to the patient or incident site.

Understandably, the time taken to reach a particular site or patient depends on the location within the centre. On the occasion of Mr Preston's collapse, after passing through the vehicle lock, the ambulance had to pass through four gates which had to be opened, closed and locked individually as the ambulance progressed. When the ambulance vehicle reached the block in which Mr Preston was situated, the ambulance officers had to be given access by remote control room operator.

The general manager expressed the view that the seven minutes that elapsed between the ambulance arriving at the centre and gaining access to Mr Preston was reasonable.

Although it is obvious that such a delay could be fatal in some circumstances, I do not consider it had any bearing in this case and I do not have sufficient information to enable me to suggest that any changes in relation to the procedures are warranted.

The evidence available to me from QAS staff, Dr Pham and all eye witnesses is such that I am able to conclude that the response to Mr Preston's collapse was timely and that all expected measures were taken in an effort to revive him.

Autopsy results

An autopsy examination was carried out on 3 May 2007 by Dr Nathan Milne, an experienced forensic pathologist.

The only signs of recent injury noted by Dr Milne were an abrasion on the right ankle and a curved laceration on the central occipital scalp measuring 20mm. Reflection of the scalp revealed no evidence of a fracture to the skull and no evidence of haemorrhage. Examination of the heart showed severe narrowing of one of its arteries although there was no evidence of old or recent myocardial infarcts. Histology confirmed the gross finding of severe coronary atherosclerosis. Dr Milne states that the atherosclerosis was very likely the cause of Mr Preston's recent incidents of chest pain; that it is a very common cause of sudden death and that it was the cause of death in this case.

Toxicology results are consistent with the medication prescribed to Mr Preston. The autopsy examination and toxicology results are not suggestive of anything suspicious, nor do they point to the involvement of a second party in Mr Preston's death.

Investigation findings

Mr Preston's body was identified by his son Luke Preston on the evening of 2 May 2007. An examination of Mr Preston's cell and the area were Mr Preston's body was found revealed no sign of a struggle or violence of any sort.

Electrical testing of the seized toaster showed it to be working safely.

No other evidence collated was suggestive of anything other than a death by natural causes.

Mr Preston's medication charts show the medications prescribed for him were dispensed to him during his incarceration, other than for some minor irregularities around the day of his death: it does not record him receiving two of the prescribed medications at the usual time of 8:00am on the morning of his death. However, in a recent statement the nurse who administered the medication explained that on the day of Mr Preston's death she was discussing his health issues with the prison's Health Services Manager and realised she had not completed Mr Preston's medications register. She went to address this omission and found officers of the CSIU had already taken possession of the records. She therefore prepared a statement confirming the drugs had been given. Unfortunately that did not find its way into the investigation report.

There were some other anomalies indicating the administering of drugs had not been accurately recorded. I am satisfied that in this case that played no part in Mr Preston's demise but in other circumstances it could negatively impact upon a prisoner's health and/or the investigation of his death. I accept that changes to the recording system and audits of medication charts introduced at the AGCC since Mr Preston's death address these concerns.

Conclusions

I am persuaded Mr Preston died from natural causes and that no other person played any part in his death. I am also satisfied that while in custody he received medical care of an appropriate standard and that no failure of care caused or contributed to his death.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was William Elliot Preston

Place of death – He died at the Arthur Gorrie Correctional Centre, Wacol in Queensland

Date of death – He died on 2 May 2007.

Circumstances and cause of death – Mr Preston died from natural causes, namely coronary artery atherosclerosis, while he was a prisoner at the Arthur Gorrie Correctional Centre.

Comments and recommendations

Section 46, insofar as it is relevant to this matter, provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

I have found that Mr Preston died suddenly of natural causes and that the response to his collapse was timely and appropriate. The health care that he had received while in custody in the weeks before his death was also appropriate. Weaknesses in the system for recording medication administration have been remedied.

In those circumstances there are no preventative recommendations I could usefully make.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
12 February 2010