QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Frank Leslie Burrows**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2016/4929
DELIVERED ON:	5 December 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	5 December 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Ms Rene Jurkov
Queensland Corrective Services:	Ms Nikola Core
Townsville HHS, Prison Health Service:	Alice Robertson, Corrs Chambers Westgarth

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Introduction

1. At the time of his death on 23 November 2016, Frank Burrows was 58 years of age. He had been convicted of murder on 25 July 1988. Mr Burrows absconded while on leave of absence in 1995 and committed a further murder in April 1996. He was sentenced to a further term of life imprisonment on 27 August 1998. He was in custody at the Townsville Correctional Centre (TCC) before being transferred to the Townsville Hospital's Intensive Care Unit where he died.

2. Mr Burrows had an extensive medical history including morbid obesity, minor lymphadenopathy of the neck and chest, severe microcytic anaemia, rectal bleeding, dyslipidaemia and internal haemorrhoids. He had been largely wheelchair bound for several years prior to his death.

The investigation

3. Detective Senior Constable McGregor from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) led the investigation into the circumstances leading to Mr Burrows' death.

4. Upon being notified of Mr Burrows' death, an officer from the Stuart Police Station attended at the Townsville Hospital. Members of the CSIU travelled to Townsville on 24 November 2016 to continue the investigation. Mr Burrows' correctional records and his medical files from TCC and the Townsville Hospital were obtained.

5. The investigation was informed by statements from the relevant custodial correctional officers, nursing staff and custodial staff at TCC and medical staff at the Townsville Hospital. These statements were tendered at the inquest.

6. At the request of the Coroners Court, Dr Gary Hall from the Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Burrows from TCC and the Townsville Hospital and reported on them.

7. The CSIU investigation concluded that Mr Burrows died as a result of natural causes, and that he was provided with adequate medical care at TCC. It also found that there were no suspicious circumstances associated with the death. I am satisfied that the CSIU investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The inquest

8. As Mr Burrows died while in custody an inquest was required by s 27 of the Coroners *Act 2003*. All the statements, records of interview, medical records, photographs and materials gathered during the investigations were tendered at the inquest.

The evidence

Personal history

9. Mr Burrows was born in Bulolo, Papua New Guinea, where his parents worked in the timber industry. He had two older brothers with whom he had little contact during his childhood and no contact in his adult life. He moved to Australia when he was 6 years of age and subsequently lived in North Queensland.

10. Mr Burrows had a daughter, who was born on 7 January 1988. On 11 January 1988, four days after the birth of his daughter, Mr Burrows killed his partner's six year old son who he was caring for while his partner was in hospital following the birth of their daughter. Apart from leaves of absence, Mr Burrows spent the next 28 years in custody.

Incarceration history

11. Mr Burrows had a criminal history dating back to late 1974, when he was convicted of drug possession at 16 years of age. His history predominantly involved drug offences, with three further convictions in 1978, 1981 and 1983.

12. On 25 July 1988, Mr Burrows was sentenced to life imprisonment. His appeal from that conviction was dismissed.

13. From 24 December 1994 to 2 September 1995, Mr Burrows had approved unescorted leaves of absence. During the final leave of absence, Mr Burrows absconded. He committed a second murder in April 1996 and was sentenced to a further term of life imprisonment on 27 August 1998.

14. Mr Burrows had lodged a parole application dated 13 July 2016 which had not been determined prior to his death.

Medical history

15. Mr Burrows was morbidly obese and wheelchair bound. His daughter attributed his back pain to "some sort of slipped disk",[1] however there is no medical record of that diagnosis. He had a carer for two years prior to his death and was noted by Dr Kault, Visiting Medical Officer, to have been gaining weight since 2011. His weight increased from 82kg[2] to 118.5 kg in five years. By 6 October 2016, Dr Kault had determined that the painkillers associated with his back pain would only be continued if he lost one kilogram per month, in the interests of his health.

16. Mr Burrows had a history of urinary difficulty associated with thickened bladder, bladder diverticulae and stones. He had rectal bleeding intermittently with internal haemorrhoids. He also had a history of smoking and dust inhalation from working in dusty environments, with episodes of bronchitis.

[1] Exhibit B9 - Statement of Amy RIGBY, para 3.
[2] Exhibit B5 - Statement of Dr David Kault, para 9.1, 14 – 17.

17. In 2013, he had complained of throat soreness and was referred to Townsville Hospital ENT Outpatients where the results of a CT scan revealed enlarged mediastinal and paratracheal lymph nodes, with a further CT scan revealing multiple mediastinal and hilar chest lymph nodes. On review at the respiratory clinic, Mr Burrows was found to have small lung opacity with the lymph nodes not likely associated with it. Mr Burrows attended a check-up after eight months, with his results showing no change in pattern. This was not considered to be a progressive disease.

18. In early 2016, Mr Burrows underwent an upper GI Endoscopy and Colonoscopy, the results of which were normal.

Events leading up to the death

19. On 6 October 2016, Dr Kault saw Mr Burrows at the TCC medical unit where Mr Burrows presented with nausea, intermittent fevers and excessive thirst. Blood tests were ordered on past abnormal results including anaemia, diabetes and increased inflammatory markers.

20. On 20 October 2016, Mr Burrows was recalled to the TCC medical unit due to very high inflammatory markers detected on his blood analysis. Dr Kault referred Mr Burrows to the General Medical/Rheumatology Clinic at the Townsville Hospital seeking a specialist review and advice regarding his management. Mr Burrows was assigned a category 2 status for an appointment on the rheumatology waiting list.

21. On 7 November 2016, Mr Burrows presented to the TCC medical unit as having diarrhoea, chills, sweats and vomiting. While Dr Kault discussed immediate hospitalisation, Mr Burrows declined.

22. Three days later on 10 November 2016, Mr Burrows attended the medication parade where he was spoken to by a nurse about the need to investigate his symptoms. After Mr Burrows agreed, he was transferred to the Townsville Hospital for assessment. Dr Kault wrote a letter to accompany Mr Burrows to the hospital, detailing his review of 7 November 2016, and his opinion on urgent assessment of his inflammatory/rheumatoid exacerbation.

23. On attending the Townsville Hospital Emergency Department, Mr Burrows was noted to have had a febrile illness for two weeks with fevers, sweats, shaking and diarrhoea. His vital signs were normal, with slightly low blood counts and a ‘misty mesentery’ on a CT scan which was deemed non-specific.

24. He was returned to TCC in the early hours of 11 November 2016 with his discharge summary reading a “possible post-viral autoimmune phenomenon”[3] and a recommendation to expedite the rheumatology review.

[3] Exhibit B5.4 – DK4 – Discharge Summary.

25. On 12 November 2016, Mr Burrows was noted by nursing staff on the medication round at TCC to be 'grey' and struggling for breath. A transfer to the nursing clinic was delayed for some 45 minutes due to an operational lockdown and Mr Burrows became hypotensive and tachycardic. The Queensland Ambulance Service was called and he was transferred back to Townsville Hospital Emergency Department.

26. Upon readmission, Mr Burrows had blood tests showing low blood counts and hypotensivity, but similar liver function to his earlier admission on 10 November 2016 and without fever. He was monitored by the medical team and was noted to be febrile and hypotensive later that afternoon. He was started on empirical antibiotics and fluid bolus with blood cultures taken.

27. A medical review on 13 November 2016 noted Mr Burrows' history, low blood counts on all three lines and raised CRP (non-specific inflammatory marker). A multidisciplinary medical review was arranged including haematology, infectious diseases, gastroenterology and cardiology. Cardiology reviewed Mr Burrows on the same day and arranged an echocardiogram. The gastroenterology registrar reviewed Mr Burrows on 15 November 2016 and opined that the underlying cause may be infectious, with a differential diagnosis of lymphoma. Several infectious disease tests and iron studies were ordered. The echocardiogram revealed normal cardiac function.

28. On 14 November 2016, Dr Kault sent an email to the Senior Staff specialist[4] expressing his concern about Mr Burrows discharge on 10 November and re-admittance on 12 November. Dr Brown replied on 16 November 2016, stating that the assessment undertaken was reasonable.

29. At approximately 7:30pm on 16 November 2016 Dr Yu, the haematology registrar, attended Mr Burrows for review. At this time, Mr Burrows was acutely unwell with drowsiness, dyspnoea (shortness of breath), mild fever, worsening liver function and very high ferritin count (iron protein). Dr Yu noted in the medical records that Mr Burrows possibly had lymphoma, with a differential diagnosis including infective, rheumatological or solid organ malignancy with metastases.[5]

30. At 9:48pm that same day, an MET call was made for hypotension. Mr Burrows was transferred to the ICU where he was intubated and ventilated. From the medical records, it appears the hypotension was secondary to sepsis; however, his microbiology was negative.

31. On 17 November 2019, Dr Yu had discussions with the consultant physician and haematologist (Dr Cowtan and Dr Morris respectively) and Haemophagocytic Lymphohistiocytosis (HLH) was suggested as a possible diagnosis with a possibility of underlying lymphoma. A bone marrow trephine biopsy was arranged for tissue diagnosis on 18 November 2016.

[4] Exhibit B5.5 – DK5 – Email to Dr Richard Brown.
[5] Exhibit B4 – Statement of Dr Emma Hothersall, para 11.

32. The bone marrow trephine on 18 November 2016 confirmed the diagnosis of HLH. Mr Burrows' steroids were changed to anti-inflammatories (dexamethasone) and etoposide (chemotherapy) to treat his underlying lymphoma was withheld due to his health. His condition worsened; he was ventilator dependant, on dialysis and failed to wake off sedation, suggesting cerebral dysfunction. His liver function was continuing to deteriorate and there was concern for coagulopathy and disseminated intravascular dysfunction.

33. On 21 November 2016, Dr Hothersall took over Mr Burrows' care, and found him in multi-organ failure with a poor prognosis. He continued to require dialysis and remained grossly fluid overloaded. An MRI was undertaken to ascertain whether there was inflammation of the brain. An early verbal report had suggested the possibility of meningeal infiltration, but this was not contained in the formal report.

34. On 23 November 2016, Mr Burrows' daughter was contacted and agreed to follow a palliative pathway for his care. Mr Burrows' daughter explained that Mr Burrows would not wish to be kept alive if he were dependant on carers[6] and that she was happy for pain relief to be commenced.

35. A morphine infusion commenced as Mr Burrows was also grimacing and tachypnoeic (rapid breathing). An Advanced Resuscitation Plan (ARP) was agreed upon with Mr Burrows' daughter and CPR was agreed to be withheld.

36. Mr Burrows was extubated at 6:15pm and declared deceased at 10:28pm.

Autopsy report

37. On 25 November 2016 Professor David Williams conducted an autopsy consisting of an external and full internal examination of the body, toxicology, microbiology and histology investigations.[7]

38. The internal examination of the head and central nervous system showed no abnormalities. The lungs and cardiovascular system were largely normal but for reddened lymph nodes in the hilar areas and enlarged lymph nodes around the aorta. The liver was pale yellow with frequent enlarged lymph nodes at the porta hepatis. The right kidney had a 25mm white lesion with the appearance of a lymphoma deposit.

39. Histology showed numerous white blood cells in the epicardial fat of the heart muscle. There were clusters of white cells in the walls of the bile ducts, portal tracts, and infiltrating neoplastic (cancerous) white blood cells within the kidneys.

40. On consideration of the above and Mr Burrows' medical history, Professor Williams concluded that the pre-death diagnosis of Haemophagocytic lymphohistiocytosis was correct, and that the condition mimics sepsis. He said that this was a very rare condition.

[6] Exhibit B4 – Statement of Dr Emma HOTHERSAL, page 9.
[7] Exhibit A6.

41. The cause of death was given as Haemophagocytic lymphohistiocytosis, due to or as a consequence of T-cell lymphoma (nasal type).

Clinical Forensic Medicine Unit Review

42. At the request of my office, Senior Forensic Medical Officer, Dr Gary Hall, provided advice as to the treatment of Mr Burrows in both TCC and Townsville Hospital.

43. Dr Hall agreed with the cause of death given at autopsy and noted that there were three occasions where it might be argued there may have been an opportunity to intervene to prevent Mr Burrows' death.

i) The enlarged mediastinal lymph nodes found on 17 July 2013

Dr Hall noted that the enlarged hilar and mediastinal nodes may well have indicated the presence of lymphoma. However, to diagnose the condition would require an open procedure to access the nodes, located close to major chest vessels. That was a high-risk operation, and the alternative of surveillance with CT scanning was a more logical option given that there was no evidence of progression and the history of dust exposure.[8]

While regular surveillance with CT scanning (yearly) was an option, there was no indication that the thoracic nodes had increased dramatically in size at the time of his diagnosis, and regular checks would not have affected the outcome.

ii) No admittance to hospital on 10 November 2016

Mr Burrows presented to Townsville Hospital with somewhat vague, non-specific symptoms with unremarkable vital signs and a mild reduction across all three blood lines. Dr Hall considered that Mr Burrows did not present as constitutionally unwell and his discharge back to prison by Dr Brown was not unreasonable at the time.

When Dr Kault expressed dissatisfaction with the discharge when Mr Burrows became acutely unwell, Dr Brown reviewed his medical notes and spoke with treating staff, opining that the decision to discharge was reasonable in the circumstances. Dr Hall agreed with Dr Brown's assessment and found that there was no opportunity for earlier intervention on 10 November 2016 on both Townsville Hospital and TCC's part.

iii) Haematological intervention earlier than 16 November 2016

Dr Hall reiterated that the treating team had recommended reviews from several specialist teams on 13 November 2016, gastroenterology on 15 November and haematology on 16 November. It was the haematology review that had made the possible diagnosis of HLH through the ferratin test.

[8] Exhibit F1 – CFMU Report, Page 11.

While Dr Hall indicated that a ferratin test is a matter of routine in iron studies, had a haematology review been conducted, and the ferratin test ordered earlier, it is arguable that HLH may have been diagnosed earlier.

Dr Hall did not believe a diagnosis would have been made by 14 November 2016. At 14 November 2016, Mr Burrows' liver function tests were reasonable and it would have been acceptable to commence etoposide. However, it was doubtful the outcome would have changed considering his rapid deterioration.

Family concerns

44. In a statement to police, Mr Burrows' daughter stated that she was "concerned and worried"[9] that perhaps Queensland Corrective Services did not take action soon enough for her father, and wondered if there was some sort of treatment that Mr Burrows could have been given "years ago" that would have prevented his death.

45. Dr Kault addressed Mr Burrows' pain management and continual admissions for respiratory and gastroenterology reviews during his incarceration.[10] Given Dr Hall's conclusions relating to his medical treatment and the rare and sudden nature of HLH, it is unlikely that any treatment could have been provided earlier to prevent his death.

CONCLUSIONS

46. Mr Burrows died from a very rare and rapidly progressing syndrome called Haemophagocytic lymphohistiocytosis that develops from excessive immune activation which is triggered by infection or malignancy (commonly blood cancers).

47. Diagnosis is made generally on clinical grounds with five of seven factors being required.[11] The triggering condition for Mr Burrows was an aggressive and disseminated malignancy (active lymphoma in chest). [12] However, treatment of underlying conditions is usually engaged when appropriate after initial management of the HLH.[13] This is of little relevance as Mr Burrows' health declined too rapidly for treatment of his lymphoma with etoposide.

48. In respect of whether the care provided to Mr Burrows at TCC was adequate, Dr Hall noted that there was no opportunity for the medical and nursing staff at the TCC to intervene earlier than they did.[14] The TCC could not have provided a diagnosis of HLH and Mr Burrows' enlarged lymph nodes were not progressing in a way that would indicate lymphoma.

[9] Exhibit A7 – Police Report, para 7.11.
[10] Exhibit B5 – Statement of Dr David Kault
[11] See Exhibit B7 – Statement of Dr Edward MORRIS
[12] Ibid, para 11
[13] Exhibit F1 – CFMU Report, page 10.
[14] Ibid, page 11.

49. Dr Hall noted that Dr Kault was thorough and persistent in his referrals to the Townsville Hospital. The nurses were observant and were the driving force behind Mr Burrows' admission to hospital on 12 November 2016. Dr Hall had no concerns with the management of Mr Burrows at the TCC. I accept those conclusions.

50. Dr Hall was impressed by the comprehensive examination and consideration of Mr Burrows' history by the medical teams at the Townsville Hospital, and noted that they were thorough, timely and appropriate. I also agree that there were no concerns with the treatment provided to Mr Burrows at the Townsville Hospital.

51. Dr Hall addressed each opportunity that may have presented to intervene to prevent Mr Burrows' death. As Dr Hall noted, there were only 11 days between his admission to the Emergency Department and his death. While there may have been opportunities to diagnose Mr Burrows marginally sooner than 17 November 2016, the decisions made did not affect the outcome.

Findings required by s. 45

52. 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 evidence I am able to make the following findings:

Identity of Mr Burrows – Frank Leslie Burrows.

How he died – Mr Burrows had been imprisoned for over 28 years. He had a history of arthritis, chronic back pain and was confined to a wheelchair. He was referred to the Townsville Hospital for rheumatology review in October 2016. He was admitted to the Townsville Hospital on 10 November 2016 and discharged back to the Townsville Correctional Centre. He was returned to the Townsville Hospital on 12 November 2016 and a diagnosis of Haemophagocytic lymphohistiocytosis was made on 16 November 2016. Later that day, he became acutely unwell and he failed to respond to treatments in the Intensive Care Unit that would have allowed him to safely receive chemotherapy. He continued to deteriorate and was provided with end of life care after consultation with his family.

Place of death – Townsville Hospital 100 Angus Smith Drive Townsville, Queensland.

Date of death– 23 November 2016.

Cause of death – Haemophagocytic lymphohistiocytosis, due to or as a consequence of T-cell lymphoma (nasal type).

53. I close the inquest, and extend my condolences to Mr Burrows' family.

Terry Ryan
State Coroner
BRISBANE
5 December 2019