CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Terence Neil Burgess**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	2017/3494
DELIVERED ON:	6 December 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	6 December 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes.
REPRESENTATION:	
Counsel Assisting:	Ms Martina Parry
Queensland Corrective Services:	Ms Taylor Mobbs
Princess Alexandra Hospital:	Ms Fiona Banwell

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Introduction

1. Terence Burgess was a 50 year old man who was incarcerated at the Southern Queensland Correctional Centre (SQCC). At the time of his death on 11 August 2017, Mr Burgess was an inpatient at the Princess Alexandra Hospital Secure Unit (PAHSU).

2. Mr Burgess had served five years of his sentence.[1] He was sentenced to 13 years imprisonment on 5 April 2012 in the District Court at Mackay for a range of very serious sexual offences. Mr Burgess was declared a serious violent offender.[2] The earliest date he could have applied for parole was in late 2022, after he had served 80% of his sentence. He had no previous criminal history.

3. Mr Burgess suffered from cardiac disease before he was imprisoned. He had at least three known myocardial infarctions in 2002, 2012 and 2013.[3] During his imprisonment, Mr Burgess received regular coronary care and treatment including numerous hospital admissions following the exacerbation of symptoms. The 2012 and 2013 events were associated with percutaneous coronary intervention with stenting of the right coronary and left circumflex arteries.[4]

4. On 11 August 2017, Mr Burgess died as a result of ischaemic and valvular heart disease (severe aortic stenosis),[5] while in the PAHSU, having suffered myocardial infarctions following the cessation of his prescription medication.[6]

5. In the lead up to his death Mr Burgess had declined invasive investigations or surgical intervention for his heart disease including aortic valve surgery, angiograms or stenting procedures. He requested comfort care only in so far as accepting medical management and medication for symptom control.[7]

The investigation

6. The Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) investigated the circumstances leading to Mr Burgess' death.

7. At approximately 4:00pm on 11 August 2017, the CSIU was notified of Mr Burgess' death. Detective Sergeant David Caruana and Senior Constable Jacob Andriolo attended the PAH and commenced their investigation. Information and witness statements' were obtained from

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[1] Exhibit C2 – Death in Custody Report
[2] Exhibit C2 – Death in Custody Report
[3] Exhibit H1 – Clinical Forensic Medical Unit Report
[4] Exhibit B1 – Statement of Dr Ian Scott
[5] Exhibit A5 – Autopsy Report
[6] Exhibit E3 – Princess Alexandra Hospital medical record and notes
[7] Exhibit E3 – Princess Alexandra Hospital medical record and notes

medical practitioners involved in the provision of care to Mr Burgess along with his medical records. Photographs of the scene and of Mr Burgess were also taken.

8. Mr Burgess' son informed investigators that he had no concerns about his father's treatment in prison.

9. CCTV footage, taken 30 minutes prior and 30 minutes following Mr Burgess' collapse was also reviewed. This showed Mr Burgess getting out of bed and taking a shower. He was seen to dry himself with a towel, sit to dry his feet and then collapse in the shower recess. A brief time later, Dr Ravindnath Balasubramaniam attended to review Mr Burgess and found him unresponsive. Other staff attended to assist and Mr Burgess was lifted from the floor and placed on the bed in his room.[8]

10. Senior Constable Andriolo provided a report, along with information about the circumstances of the death and statements and medical records. Senior Constable Andriolo reported he did not identify any issues and or concerns indicating the death was suspicious. He further determined there were no deliberate acts or omissions or errors of judgement contributing to Mr Burgess' death. He concluded Mr Burgess' death and the circumstances of his death were non suspicious.[9]

11. An external autopsy examination with associated CT scans and toxicology testing was conducted by Forensic Pathologist, Dr Christopher Day. The cause of death, based on a review of the medical records, external post-mortem examination and associated testing including CT scanning, was identified as ischaemic and valvular heart disease (severe aortic stenosis).

12. At the request of the Coroners Court, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the statements as well as the medical records for Mr Burgess from SQCC and the PAH and reported on them.

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

The Inquest

14. Although Mr Burgess' death was from natural causes, as he was in custody when he died, an inquest into the death was required by the *Coroners Act 2003*. The inquest was held on 6 December 2019. All of the statements, medical records and material gathered during the investigation were tendered. Counsel Assisting proceeded immediately to make submissions in lieu of any oral testimony. I was satisfied that I

[8] Exhibit A1
[9] Exhibit C2 – Death in Custody Report

sufficient material before me to make the necessary findings under the *Coroners Act 2003.*

The Evidence

Medical history

15. Mr Burgess was born on 22 August 1966 in Mackay, Queensland.[10] Mr Burgess had a significant medical history which included severe aortic stenosis (hardening and narrowing of the heart valve), mild to moderate mitral regurgitation, ischaemic cardiomyopathy (with severely dilated moderately hypertrophic left ventricular with moderate to severely impaired systolic function) ejection fraction of 30-35 per cent.

16. Mr Burgess had previously undergone angioplasty with stent insertion into the right coronary and left circumflex arteries. Mr Burgess also suffered hypertension, hyperlipidaemia, and breathlessness due to emphysema or chronic bronchitis. He also received nasal prong oxygen intermittently and took prescribed medication for his heart condition as well as fentanyl patches.[11]

17. On 25 July 2017, Mr Burgess was transferred from the SQCC to the Emergency Department of the PAH having experienced acute exacerbation of shortness of breath. Mr Burgess underwent medical review including a chest x-ray to exclude pulmonary oedema, and was medically managed with oxygen and medication. After he was advised surgery for his worsening heart condition would be optimal, Mr Burgess declined any further investigations and or surgery and asked to return to SQCC the same day.[12]

18. On 28 July 2017, Mr Burgess was again admitted to the PAH with worsening shortness of breath and crushing central chest pain following his refusal to take prescription medications. Blood tests revealed an elevated troponin level (sensitive marker of heart muscle damage) indicating Mr Burgess had experienced a further myocardial infarction.

19. Despite these findings and further recommendations for surgery, Mr Burgess declined any invasive management or surgical intervention and elected treatment by medication only. Mr Burgess agreed to recommence his usual prescription medications along with anticoagulation, through a heparin infusion and ticagrelaor (anti-platelet agent). Mr Burgess was transferred to the PAHSU for ongoing medical management. [13]

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[10] Exhibit A1

[11] Exhibit A5 – Autopsy Report and Exhibit H1 – Clinical Forensic Medical Unit Report

[12] Exhibit E3 – Princess Alexandra Hospital medical record and notes and Exhibit H1 - Clinical Forensic Medical Unit Report

[13] Exhibit E3 – Princess Alexandra Hospital medical record and notes and Exhibit H1 - Clinical Forensic Medical Unit Report

20. The heparin infusion was replaced twice daily with Clexane injections. As a consequence of the blood thinning medication, Mr Burgess experienced nose bleeds which were controlled by the insertion of nasal packs.[14]

21. The further damage sustained to Mr Burgess' already weakened heart resulted in severe congestive cardiac failure. The subsequent fluid overload was managed with intravenous frusemide (diuretic) infusion, administered over the following 7 days. Mr Burgess was advised of his very poor prognosis without surgical intervention.[15] Despite the exacerbation of symptoms, Mr Burgess remained resolute in his refusal of any invasive intervention or escalation of treatment.

22. On 7 August 2017, Mr Burgess experienced sudden onset crushing chest pain, shortness of breath, nausea and dizziness. Investigations revealed he had suffered a further myocardial infarction, evidenced by troponin elevation. He was managed with intravenous infusion of heparin over a period of 48 hours and a continuous fentanyl infusion was commenced for pain relief. [16]

23. Mr Burgess again declined any invasive management or surgical intervention including the recommendation for intervention with angioplasty/stenting. He confirmed he did not want to be resuscitated in the event of cardiorespiratory arrest, but was content to continue with medications.[17]

24. On 9 August 2017, the PAH palliative care team reviewed Mr Burgess for the purpose of optimising his pain relief and to provide symptom management. Mr Burgess was assisted to document his wishes, subsequently completing an Acute Resuscitation Plan (ARP) in the event of acute deterioration. The ARP reflected Mr Burgess' request for comfort cares and he expressly declined the provision of intervention/treatment of all resuscitation efforts including intubation, ventilation, defibrillation, angiograms, blood tests, fluids and or antibiotics.[18]

25. Review of the PAH records disclose many medical practitioners' notations of discussions with Mr Burgess about his poor prognosis, and the worsening of symptoms or death as likely to result from his refusal of treatment. There was agreement that Mr Burgess had capacity to refuse medical treatment.

26. On 10 August 2017, Mr Burgess' pain and dyspnoea were recorded as under control. Although he had asked that he be returned to the SQCC,

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[14] Exhibit H1 – Clinical Forensic Medical Unit Report
[15] Exhibit E3 – Princess Alexandra Hospital medical record and notes
[16] Exhibit E3 – Princess Alexandra Hospital medical record and notes and Exhibit H1 – Clinical Forensic Medical Unit Report
[17] Exhibit B1 – Statement of Dr Ian Scott
[18] Exhibit B2 – Statement of Dr Ravindnath Balasubramamiam

he remained in the PAH as he was being treated for constipation which was yet to resolve.

Events of 11 August 2017

27. Registered Nurse, Eva Sianjaya was employed at the PAH and commenced work at 6:00am on the morning of 11 August 2017. Ms Sianjaya along with fellow registered nurses Shirley Nicholson and Benjamin Gibson (also rostered on the morning shift) were advised of Mr Burgess' ARP at the beside handover between 6:00am and 6:30am. Ms Sianjaya stated she reviewed the ARP and subsequently understood resuscitation was not to be performed on Mr Burgess in the event of cardiac arrest.[19]

28. Between 7:00am and 7:25am on 11 August 2017, Mr Burgess was medically reviewed, provided with his regular medication and also prescribed additional agents to assist with constipation.[20] Mr Burgess was monitored hourly during his admission. Reduced observation frequency was due to his palliative care status. He was on closed monitoring by visual site observation and CCTV footage.[21]

29. Ms Sianjaya and Mr Nicholson checked on Mr Burgess several times through CCTV footage between 7:25am and 9:00am. At 9:00am Ms Sianjaya completed a visual check of Mr Burgess and at 9:30am he was provided with morning tea.

30. At 10:30am Mr Burgess made a telephone call and spoke with family members. He was observed to be alert, orientated and independent with mobility.

31. At 1:40pm, Mr Burgess was provided with afternoon tea and his regular medications. At 2:40pm he notified staff his constipation had resolved. The supervising medical practitioner was notified of Mr Burgess' status and it was confirmed Mr Burgess could be discharged back to the SQCC.[22]

32. At approximately 3:30pm, Dr Balasubranamiam attended on Mr Burgess and found him unresponsive on the floor. Dr Balasubranamiam immediately checked Mr Burgess' but found no pulse. Mr Burgess' breathing was agonal initially then subsequently ceased. His pupils then fixed and dilated. Dr Balasubranamiam determined Mr Burgess' to have experienced a cardiac arrest. After considering his wish not to be resuscitated, he did not attempt to revive him. Dr Balasubranamiam alerted staff for assistance and Mr Burgess was moved from the floor to his bed. Dr Balasubranamiam then examined Mr Burgess and declared him deceased at 3:40pm.

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[19] Exhibit B3 – Statement of Eva Sianjaya
[20] Exhibit H1 – Clinical Forensic Medical Unit Report
[21] Exhibit B1 – Dr Ian Scott and Exhibit B3 – Statement of Eva Sianjaya
[22] Exhibit B3 – Statement of Eva Sianjaya

Autopsy

33. On 15 August 2017 Dr Christopher Day, Forensic Pathologist performed an external examination of Mr Burgess. A number of toxicology and histology tests were conducted. A CT scan was also undertaken.

34. The post mortem CT scans revealed degenerative calcification of the coronary arteries and aortic valve, consistent with coronary artery and valvular heart disease. Fluid within the chest cavities was also identified, consistent with heart failure.

35. Dr Day's external post mortem examination identified fluid overload of the lower limbs, also consistent with congestive cardiac failure. Scattered bruises of the upper and limbs, likely as a consequence of blood thinning medications. No significant recent injures were identified as having caused or contributed to death.

36. Toxicology samples of antemortem blood collected from Mr Burgess showed numerous prescription medications including a relaxant, anti-psychotic, analgesic, anti-depressant, anti-nausea drugs and synthetic opioid consistent with medical treatment. The anti-depressant drug mirtazapine was however detected within greater than therapeutic range. No alcohol was detected.

37. Dr Day concluded that the degree of Mr Burgess' heart disease was of such severity that sudden collapse and death could have occurred at any time.

38. The cause of death, based on Dr Day's review of the QPS investigation material, Mr Burgess' medical history, external post-mortem examination and associated testing, was ischaemic and valvular heart disease (severe aortic stenosis). Other significant conditions included hypertension and hyperlipidaemia.

Clinical Forensic Medicine Unit Review

39. At the request of the Coroners Court, Dr Ian Home of the Clinical Forensic Medicine Unit conducted a review of Mr Burgess' care, including the appropriateness of the medical treatment provided to him in the 12 months prior to his death and while at the PAH from 25 July 2017 to 11 August 2017.

40. In his report of 29 May 2019, Dr Home confirmed Mr Burgess' medical history including but not limited to ischaemic cardiomyopathy, severe aortic stenosis and previous myocardial infarctions. He also identified

Mr Burgess "experienced chest pains on an almost daily basis along with dyspnoea (shortness of breath) on minimal exertion".[23]

41. Dr Home advised that aortic stenosis is the most common form of valvular heart disease which involves abnormal narrowing of the aortic value through which blood passes from the left ventricle of the heat to the aorta. Symptoms are non-specific and occur as a result of impaired cardiac function (heart failure) and include fatigue, dyspnoea (particularly on exertion), angina, palpitations and syncope. Dr Home noted that severe aortic stenosis has a poor prognosis with medical management alone and carries a high risk of sudden cardiac death. Further, for patients with symptomatic severe aortic stenosis, akin to Mr Burgess' circumstances, the annual incidence of sudden death increases to 8 to 34 percent. Dr Home clarified the risk of sudden death is reduced by valve replacement surgery.

42. Dr Home confirmed that Mr Burgess died as a consequence of ischaemic and valvular heart disease. Dr Home noted, Mr Burgess "was adamant he did not want any invasive treatment including aortic valve replacement surgery or further angioplasty, despite numerous discussions with doctors advising him his condition was treatable. As a result, his management was restricted to pharmacological therapies".

43. Dr Home gave the following opinion in respect of the treatment provided to Mr Burgess':

> *"Despite being provided appropriate medication Mr Burgess experienced ongoing symptomatic disease with a further myocardial infarction experienced four days prior to his death. On 11 August 2017, whilst still in hospital, Mr Burgess suddenly collapsed and was not resuscitated in keeping with his wishes. Sudden cardiac death is a well-recognised complication of symptomatic severe aortic stenosis. I therefore see no reason to be critical of the care provided in this case".*

44. As to Dr Home's review of the antemortem toxicology results and elevated mirtazapine levels found in Mr Burgess' system, he noted the daily prescribed 60mg of mirtazapine was the upper limit of therapeutic range. Dr Home explained some individuals are poor metabolisers of mirtazapine and measuring drug levels is not routinely performed.

45. Dr Home's review of Mr Burgess' medical records did not identify any obvious signs or symptoms directly attributed to the accumulation of mirtazapine. Dr Home opined, "whilst cardiac disorders including chest pain, myocardial infarction and arrhythmia have been reported as rare associations with mirtazapine, Mr Burgess' cardiac issues can be more readily explained by his underlying cardiac disease".[24]

[23] Exhibit H1 – Clinical Forensic Medical Unit Report
[24] Exhibit H1 – Clinical Forensic Medical Unit Report

Conclusions

46. Mr Burgess' death was the subject of a police investigation. I have considered the conclusions of that investigation, and I accept that the death was from natural causes with no suspicious circumstances associated with it.

47. I also consider that none of the correctional officers or other staff involved in his care at SQCC caused or contributed to his death. I am satisfied that Mr Burgess was given appropriate medical care by staff at SQCC and the PAH while he was admitted there. His death could not have reasonably been prevented.

48. It is a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest, including Dr Home's review, established the adequacy of the medical care provided to Mr Burgess when measured against this benchmark.

49. The circumstance of Mr Burgess' death do not call for any comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.

Findings Required by s. 45

50. 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 Mr Burgess – Terence Neil Burgess

How he died - Mr Burgess died at the Princess Alexandra Hospital after being transferred from the Southern Queensland Correctional Centre following the exacerbation of symptoms of his underlying heart disease, and suffering a myocardial infarction following the cessation of his regular prescription medication. He suffered a further myocardial infarction and declined any invasive investigations or surgical intervention and elected not to be resuscitated in the event of deterioration. Mr Burgess signed an acute resuscitation plan confirming his wish for comfort cares. He was transferred to palliative care and received treatment for symptom management only. On the date of his death he was cleared for a transfer back to the Southern

Queensland Correctional Centre. However, he was found collapsed in his room at the Princess Alexandra Hospital. He was not resuscitated in accordance with his express wishes.

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

Date of death – 11 August 2017

Cause of death – Mr Burgess died from ischaemic and valvular heart disease (severe aortic stenosis). Other significant conditions were hypertension and hyperlipidaemia

51. I close the inquest, and extend my condolences to Mr Burgess' family.

Terry Ryan
State Coroner
Brisbane
6 December 2019