QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Lenard John Casey**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Normanton
FILE NO(s):	COR 2851/04(1)
DELIVERED ON:	10 August2006
DELIVERED AT:	Normanton
HEARING DATE(s):	21 July 2006 & 09-10 August 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	**Coroners inquest, death in custody, natural causes**

REPRESENTATION:

Counsel Assisting:	Mr Mark Plunkett
Plain Clothes Senior Constable Billi-Jo McGregor, Constable Luke Tulacz, Constable Brett Hughes & Constable Lee Fortune:	Mr Adrian Braithwaite
Queensland Police Service Commissioner:	Mr Wayne Kelly

Findings of the Inquest into the death of Lenard John Casey

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The *Coroners Act 2003* provides in s.45 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 organizations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system including the Attorney-General and the Minister for Police and Corrective Services. These are my finding in relation to the death of Lenard John Casey. They will be distributed in accordance with the requirements of the Act.

Introduction

At about 1:00 pm on Friday 19 November 2004, Lenard Casey was arrested on a charge of unlawfully wounding of his partner. As he was being charged at the Normanton police watch house he complained of chest pains and was taken by ambulance to the Normanton Hospital.

Shortly after midnight that evening, an attempt was made to transport Mr Casey by aircraft to the Mount Isa Hospital. However, as result of his behavior the pilot refused to transport him and Mr Casey was returned to the Normanton hospital where he died about an hour later.

These findings explain how that happened and consider whether any changes to police policies or practices concerning the restrain of ill and sedation used by the Royal Flying Doctor Service could reduce the likelihood of deaths occurring in similar circumstances in the future.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

As at the time of his death Mr Casey was under arrest and detained, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible he/she is required to find:-

- whether a death in fact happened;
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly

[1] See s10

[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state coroner or deputy state coroner. Section 27 requires an inquest be held in relation to all deaths in custody

establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will say something about the general nature of inquests however.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations statements that a person is or maybe guilty of an offence or is or may be civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s. 37 of the Act provides that the court "*may inform itself in any way it considers appropriate."* That doesn't mean that any and every piece of information however unreliable will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

On Saturday 20 November 2004 the death was reported to my office pursuant to s. 7(3) of the Act.

On the same day the Queensland Police Service Assistant Commissioner, Northern Region was notified of the death. As a result Acting Inspector Anderson with Scenes of Crime Officer Brock was dispatched to Normanton from Mt Isa. On arrival Acting Inspector Anderson supervised the investigation into the death. Later that afternoon Inspector Holihan from the Ethical Standards Command also arrived and assisted with the overview of the investigation.

Tape recorded interviews were conducted with all police officers who had been in contact with the deceased in the 12 hours prior to his death. Prior to the arrival of the police the hospital room had already been cleaned, but was nevertheless photographed.

As can be readily appreciated whenever a death is connected with police action it is essential that the matter be thoroughly investigated to allay any suspicions that inappropriate action by the officers may have contributed to the death. It is also desirable that the general public be fully apprised of the circumstances of the death so that they can be assured that the actions of the officers has been appropriately scrutinised. The police officers involved also have a right to have an independent assessment made of their actions so that there can in future be no suggestion that there has been any “cover up.”

I am satisfied that this matter has been thoroughly and professionally investigated in that all relevant sources of information were accessed.

The Inquest

A pre-inquest conference was held in Brisbane on 21 July 2006. Mr Plunkett was appointed counsel assisting. Leave to appear was granted to four of the police officers involved in the detention of Mr Casey and the Commissioner of the Queensland Police Service. The family of Mr Casey were not legally represented, but counsel assisting liaised extensively with the older brother of Mr Casey before and throughout the hearing.

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[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., “Inquest Law” in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[10] (1990) 65 ALJR 167 at 168

A list of witnesses was settled and the issues to be examined during the inquest was agreed upon.

The inquest then proceeded on 9 and 10 August 2006. Seventeen witnesses gave evidence and 60 exhibits were tendered.

The Evidence

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

Background

Lenard Casey was an Aboriginal man who was born on 14 June 1965 at Normanton. He lived all of his life in the Gulf region where he worked on a number of cattle properties as a ringer. In his early days he was a noted horseman but regrettably in later years alcohol abuse dominated his life. He was just 39 years of age when he passed away.

From when he was 13 years of age Mr Casey was convicted of numerous offences such as breaking and entering, stealing, unlawful use of motor vehicles, willful damage and assault. His offending was regular and prolific. Most offences were committed in Normanton or Mt Isa. He served numerous periods of imprisonment. The deceased was a chronic alcohol abuser. According to his brother the deceased was drunk almost every day. He was also a heavy smoker.

Mr Casey's medical history

The deceased's family have an extensive history of heart disease. The deceased was one of ten children. His father died of a heart attack. Three of his six brothers died from coronary heart disease, two at 40 years of age and another at 55 years of age. All of his surviving siblings have heart disease and are on medication.

In his late teens, the deceased presented to the Normanton hospital suffering chronic alcohol abuse.

In February March, May, June, July, August and September 1984 he was admitted to Normanton Hospital for alcohol abuse.

In October 1987 he was again admitted to Normanton hospital for alcohol abuse.

In January 1988 he was admitted to the Normanton hospital after fitting. He was non-compliant and dislodged his cannula cap. He was discharged after a few days of treatment.

In October 1988 he was again admitted for the effects of alcoholism. In November 1988 he was admitted following fits. But after sleeping well, he walked out of hospital refusing to see the doctor and refusing to sign out.

In April 1992 he was admitted for alcohol withdrawal and absconded after half an hour.

In May 1995 he present at the Normanton Hospital with chest pain saying he had been punched in the chest in a fight.

In early February 1997, he was admitted to hospital after fitting. He was obviously intoxicated and admitted to "*drinking everything as well as smoking a joint."* He soon absented himself and went home.

Later in February 1997 he was admitted to the hospital with a fractured jaw following a fight. After a few days he pulled out IV tubes, signed himself out and walked away.

On two occasions in March 1997 he was taken to Normanton hospital with acute chronic alcohol intoxication.

The first occasion followed seizures suffered in the police watch house. The ambulance was called and he was taken to the hospital and kept over night. Ignoring medical advice he discharged himself and walked home.

On the second occasion, he had been brought to the hospital by the Minister of the Christian Centre. That night he had gone to the church and after asking for a sandwich appeared to take some tablets. He discharged himself before being seen by a doctor.

In April 1997 he was admitted to Normanton hospital after severe vomiting but discharged himself after six hours. In November 1997, he reported to Normanton Hospital suffering from a seizure, reportedly from another drug overdose in an apparent attempt at suicide after overdosing on tablets after attending at the pastor's house that evening. He was also diagnosed with acute alcohol intoxication. On this occasion he was less than well behaved at the hospital, pulling out medication tubes and refusing to take medication. He absconded from the ward saying that he was going to the bank. After returning he was flown out by Royal Flying Doctor Service to Mount Isa Base Hospital for further treatment.

In March and April of 2001 he was taken by ambulance to Normanton Hospital for alcohol withdrawal fits. He walked out after a few hours without receiving treatment.

In February 2002 the ambulance brought him to the Normanton Hospital following visual and auditory hallucinations.

In April 2002 he was admitted for alcohol seizures but after a few hours was seen walking away down the hospital drive way. Again later that month he was seen at the hospital for hallucinations.

In March 2003 he was admitted to the Normanton Hospital complaining of chest pains.

Later in March 2003 he was admitted for alcoholic fits.

On 30 November 2003 at the Townsville Hospital, he was diagnosed with severe two vessel coronary artery disease and offered surgery but he declined.

In May 2004 at Townsville Hospital, the cardiologists, following angiograms assessed the state of his heart disease and again offered surgery but Lenny declined as he was worried about the risks involved. At this time he was in prison and was due to return to Normanton where he wanted to think about surgery and reconsider his decision.

On 25 August 2004 he was admitted to Normanton Hospital for heart problems and transferred to Mount Isa and then to Townsville.

On 23 October 2004 he presented at the Normanton Hospital with angina. He was flown by RFDS from Normanton to Mount Isa following a cardiac arrest. He was sent to Townsville where he discharged himself untreated.

On 30 October 2004 Mr Casey was admitted to the Normanton Hospital with chest pains. On this occasion he removed his cannula.

On 10 November 2004 he was brought to the Normanton Hospital complaining of chest pains following a fight. After two hours he self-discharged and left his medication behind.

Mr Casey's heart condition was well known to his relatives, the police and the general community in Normanton. He was also known not to take his medication. He drank heavily and smoked cigarettes despite being told by numerous people including his brother who has managed to "kick" these habits, that they exacerbated his heart disease.

It was against this background of persistent, serious and long standing ill health that the following events unfolded. I have set it out in detail to dispel the inclination to assume that Mr Casey may not have had access to appropriate health care.

His final arrest

On 18 November 2004 both Mr Casey and his partner Helen Williams drank heavily all day. That night he stabbed her in the back.

The next morning, at about 10.00, the police were advised of the offences when the ambulance attended to provide treatment for Ms Williams. Constable Luke Tulcaz went to premises at 32 Philip Street Normanton. When he saw the extent of Ms William's injuries and ascertained her willingness to make a complaint he called Plain Clothes Senior Constable Billie-Jo McGregor to assist with the investigation.

Mr Casey was not at those premises but later in the day, police went to a house in the same street where Mr Casey and Ms Williams usually lived and located him drinking with a number of others in the front yard. He was arrested for doing grievous bodily harm to Ms Williams and for breaching a domestic violence order that prohibited him from assaulting her. He appeared to be intoxicated but seemed in good spirits and didn't resist the efforts of police to take him to the police station.

At the police station, Constable Tulacz began to fill out the watch house register which records personal details of those charged including their answers to a series of health related questions. It records that Mr Casey reported that he had a history of heart disease. It also recorded that he consumed more than 6 alcoholic drinks a day.

At this stage, Senior Constable McGregor was also in the process of commencing an interview with Mr Casey in connection with the stabbing of Ms Williams. He was warned that he need not answer questions but before the interview proceeded much further, in response to Mr Casey saying he will die if put in a cell, and that he had chest pains, Senior Constable McGregor can be heard to acknowledge that they will need to get an ambulance. Constable Tulacz's call was received at the local ambulance station at 1.27pm.

While this was happening Mr Casey's condition seemed to worsen in that his eyes were seen to roll back in his head, so that even though the ambulance had just been called, Senior Constable McGregor asked that another call be made and she assisted Mr Casey lie on some cushions she put on the floor.

The ambulance arrived within a couple of minutes. The para-medic, Scott Warriner, saw the deceased on his side in the recovery position. He appeared to be conscious but would not answer any questions. Oxygen therapy, cardiac monitoring and a check for vital signs was undertaken. Mr Casey was then placed on a stretcher and loaded into the ambulance with Constable Tulacz driving while the Mr Warriner attended to Mr Casey in the back.

Senior Constable McGregor remained at the station and finished the paper work. She contacted Aboriginal Legal Aid and arrangements were made for the matter to be mentioned in the Magistrates Court at 4:00 pm where there was no application made for bail. The deceased was remanded in custody on all charges to the Magistrates Court at Mount Isa as the police anticipated that Mr Casey would be medically evacuated as had happened on numerous previous occasions when he had been hospitalized.

Admission to hospital

At about 1.50 pm the ambulance and its occupants arrived at the Normanton Hospital and Mr Casey was taken to the emergency room and handed into the care of Dr Michelle Jagga.

Mr Casey refused to speak to her about his condition and was quite agitated. When asked about the pain he pointed to his chest. Dr Jagga placed an

intravenous cannula in each of his arms and undertook the examinations usually conducted when angina was involved. An ECG showed old ischemic changes. Oxygen was applied and monitors placed. He was given an aspirin, a GTN tablet and 80 milligrams of Clexane.

After the initial examination, Mr Casey was placed in a secure room that had a perspex panel in the wall that enabled the officers who were detailed to guard him to observe him from the hallway.

A short time later he fell asleep and was stable.

Dr Jagga called Dr Neil at the Mount Isa Base Hospital and was advised to administer intravenous fluids to reduce the effects of the alcohol Mr Casey had consumed earlier.

Arrangements were made for the deceased to the transported by air by the Royal Flying Doctor Service (RFDS) to Mount Isa Hospital but they had a number of other patients needing emergency transportation. As Mr Casey seemed stable, it was agreed he could wait till midnight when a plane and medical crew returning from Townsville would collect him.

Dr Jagga saw the deceased at about 5:00 pm when he was eating and coherent. At 7.45 pm Dr Jagga saw the deceased again and he seemed fine. This was confirmed by a stable ECG reading undertaken at that time.

Constable Tulacz guarded the deceased until relieved by Constable Brett Hughes at 9.45 pm.

At about 10:00 pm the deceased complained to Dr Jagga of shortness of breath and chest pains. He was agitated and scared. He was administered 2.5 milligrams of morphine which did not relieve his chest pain.

Attempt to fly to Mount Isa

At 11.30 pm Mr Warriner was asked to convey Mr Casey from the Normanton Hospital to the Normanton Airport. Around this time Clinical Nurse Katherine Stock arrived on duty to assist with the transfer.

Nurse Stock said Mr Casey was settled and calm until he was handcuffed by Constable Hughes in preparation for leaving the hospital, at which stage the deceased started to hyper-ventilate and become unsettled and aggressive in his manner. The nursing staff, Sergeant David Rutherford, and Constable Hughes helped the deceased into the ambulance. He was not complaining of any chest pain at this stage.

Nurse Stock said the deceased's un-settled behavior continued on the drive out to the airport. He repeatedly asked Constable Hughes to remove the handcuffs and became abusive when this demand was not met. Constable Fortune and Sergeant Rutherford followed in a police vehicle.

The ambulance arrived at the airport at 11.58 pm. At 12:06 am on 20

November the RFDS Beech Craft 200 super king aircraft, flown by Bruce Evan Waller, touched down at Normanton airport. Also on board were Dr Francisco Munoz and Nurse Suzanne McDonald. Nurse Stock gave to the medical team, documents recording the drugs Mr Casey had been given at the hospital and the print outs of his ECG tests.

The deceased was taken to the steps of the aircraft and helped up the steps by Sgt Rutherford and Constable Fortune. The aircraft door was closed and these two officers then left to attend to a disturbance in the town. There assumption that the medivac would then proceed smoothly was proven to be overly optimistic.

Upon being placed on the “aero sleep”, a bunk built into the plane and used for transporting sick or injured passengers, the nurse and police officer began to secure Mr Casey with a seat belt across his thighs and a four point harness over his shoulders and across his chest.

Mr Casey violently resisted these efforts. He was throwing himself around on the stretcher, rolling for side to side. He grabbed a support strap above his head and tried to lift himself off the stretcher. Dr Munoz says that at one stage Mr Casey seemed to be trying to break the window in the aircraft by smashing his handcuffs against it and he banged his head against the sides of the plane. At another point he managed to get his legs free of their restraint and was kicking out.

The nurse says Mr Casey’s actions prevented her from undertaking the monitoring of blood oxygen saturation, pulse rate and blood pressure that would usually be done.

He asked Dr Munoz to direct the police officer to remove the handcuffs but the doctor tried to explain to Mr Casey that he had no authority to do that. In evidence Dr Munoz said he considered there was no medical reason the handcuffs should have been removed and that for the safety of those on board he considered it imperative that they remain on.

Mr Casey continued to be very agitated and aggressive and was not responding positively to the efforts of the Constable Hughes to physically restrain him or the entreaties of the medical personnel to clam down. Dr Munoz therefore considered resort to pharmacological agents was appropriate. He first administered 5 mg of Diazepam via the IV cannula that the hospital had put in place. This relatively fast acting sedative seemed to have no effect on Mr Casey’s behavior and so another 5mg was administered.

Diazepam possesses anxiolytic, anticonvulsant, sedative, skeletal muscle relaxant and amnesic properties. This makes it a useful drug for treating anxiety, insomnia, seizures, alcohol withdrawal, and muscle spasms. An independent emergency medicine specialist, who gave evidence, Associate Professor Tony Brown, confirmed that the drug and the dosage were appropriate for the circumstances.

There was still no improvement in Mr Casey’s behavior and the pilot

expressed concerns about the safety of flying with him in such an agitated state but agreed to allow the medical staff continue with their efforts to subdue Mr Casey.

When the double dose of Diazepam did not calm him, Mr Casey was given two, 5mg injections of Haloperidol, an antipsychotic with sedative properties. Haloperidol is a conventional butyrophenone antipsychotic drug. It is used in the control of the symptoms of hyperactivity, aggression and acute mania. The medical literature suggests that the use of this drug can cause complication in patients with cardiac instability. However, Associate Professor Brown who reviewed Mr Casey's medical charts said that there was no contraindication for its use in this case nor any evidence that it negatively impacted upon Mr Casey's condition.

The deceased was perspiring profusely and the inside of the aircraft was becoming quite hot, so the pilot re-opened the stair door. At some stage the deceased managed to unfasten his safety harness and attempted to get up. The nurse said she was not happy with the situation. The pilot was concerned that if the deceased did get up during flight the stretcher was close to the air stair door.

Accordingly, the pilot in consultation with the medical crew made the decision on the grounds of air safety to decline to transport Mr Casey. This was a decision made in accordance with standard air safety policy and I consider it was quite appropriate in the circumstances. It meant that Mr Casey would not get access to more expert medical assistance but I am confident that he was aware of that and indeed intentionally engaged in conduct he knew would result in him not being removed from Normanton.

Sergeant Rutherford, Constable Fortune and Mr Warriner assisted the deceased down the steps of the aircraft. Mr Warriner observed that the Mr Casey was perspiring a lot and appeared to be hyperventilating and agitated. Mr Casey was by this stage covered in a lather of perspiration and was foaming at the mouth.

Mr Casey taken back to the hospital

Mr Casey was placed back into the ambulance and at 12.50am departed the airport for the hospital. At 12:55am the ambulance arrived at the hospital. He was removed from the ambulance and placed back in room 4. He remained handcuffed.

Dr Munoz telephoned the hospital soon after the RFDS plane took off and told Nurse Coutis of the medication Mr Casey had been given as a precaution against over sedating. This caused Doctor Michelle Jagga to tell the nursing staff not to administer any more medication to Mr Casey.

Mr Casey continued to be non-compliant. Nurse Annette Fury and Nurse Evelyn Coutis gave evidence that he attempted to strike at hospital staff and declined treatment. He moved around the room and at one stage was seen trying to grab a clinical monitor. Constable Hughes therefore removed the

handcuff from Mr Casey's right hand and attached it to a side rail of the bed. A short time later he asked to go to the toilet. Mr Warriner and Constable Hughes assisted him to the toilet but he was unable to move his bowels and was escorted back to his bed. When he returned to room 4, Mr Casey continued acting aggressively and irrationally. He asked Mr Warriner to go to the toilet again but this request was refused.

The patient threw himself around violently from the bed onto the floor. As a precaution items and furniture were removed to prevent him from injuring himself. At nurse Stock's initiative a mattress was placed on the floor for the deceased.

The final collapse

Everyone then left the room in the hope that if Mr Casey was left alone, he might settle. Constables Hughes and Fortune continued to observe him from the hallway. Soon after he was left alone, Mr Casey was seen to get up off the mattress on the floor and sit on the bed frame. He then lay down on it. At about 1.23am Constable Fortune became concerned that Mr Casey was not breathing. He alerted Constable Hughes to this but that officer did not initially agree. However, upon further insistence from Constable Fortune, the officers entered the room and confirmed that Mr Casey was not breathing and had only a very weak pulse. They immediately, removed the handcuffs and summoned the nurses.

The nurse who responded examined Mr Casey and noted his pupils to be fixed and dilated. She called Dr Jagga who had gone home. The hospital staff with the assistance of Constable Hughes immediately commenced cardiopulmonary resuscitation. While this was occurring the ambulance officer returned and also assisted.

Mr Casey was ventilated with a resuscitator bag and geudal airway that enabled pure oxygen to be administered to him. At no time was a normal heart rhythm restored.

Dr Jagga then arrived. She says that she ascertained that Mr Casey had no pulse and was not breathing. She intubated him by inserting an endo-tracheal tube. Adrenaline and Atropine were administered in an attempt to stimulate his heart. None of these actions caused any improvement in Mr Casey's condition and at 1.45 am Dr Jagga declared life extinct.

The autopsy results

On 23 November 2004 an experienced forensic pathologist, Dr Beng Ong conducted an autopsy examination of Mr Casey's body at the John Tonge Centre in Brisbane.

He found very significant atherosclerosis in the coronary arteries. The right coronary artery showed at least 2 foci of significant atherosclerosis with 75% eccentric occlusion at the mid-front of the right ventricle and at the right border. The left anterior descending artery showed a thrombus occluding

almost the entire lumen at its commencement and several segmental atherosclerosis of almost 75% occlusion distally including the intermediate branch. The circumflex showed significant atherosclerosis (90%) for about 1.5cm at its proximal aspect.

The thrombus found in the left anterior descending artery is a clot of blood that forms when plaque ruptures from the walls of the artery. The precise mechanism is not well understood but it usually requires an acute event in a chronic setting. In this case the chronic context was Mr Casey's long standing and well documented heart disease. The acute event could be any trauma, stress or exertion such as could have occurred as a result of the anxiety and violent struggle Mr Casey had been involved in during the 12 hours preceding his death.

Toxicological results taken during the autopsy examination were unremarkable. It showed only presence of therapeutic drugs (morphine, lignocaine and diazepam). There was a low level of alcohol present.

Associate Professor Brown gave evidence that Mr Casey was in the highest risk category for a cardiac arrest. The factors that led him to this conclusion were; Mr Casey was Aboriginal, a male, he had a history of three heart attacks, he smoked cigarettes, he drank heavily and he did not take his heart medication. These characteristics made it almost certain in Dr Brown's view, that Mr Casey would suffer a fatal heart attack unless he underwent surgery and made life style changes.

As we know Mr Casey did neither of these things.

It was also discovered at autopsy that the distal end of the endo-tracheal tube was located in the esophagus. In this position no oxygen passed through the tube could enter the lungs. However, Dr Brown discounted the possibility of this having played any part in Mr Casey's death on the basis that by the time he was intubated, Mr Casey was almost certainly already dead or so near death that there was no chance that he could be revived. He noted that Mr Casey was found not breathing with only a very slight pulse and fixed pupils at about 1.23am and was not intubated until after 1.40. I accept his assessment that if the tube was misplaced it played no part in the death. I say "if" because it is impossible to exclude the possibility that in the numerous moves the body underwent between the place of death and the place of the autopsy, it was dislodged from the trachea and fell back into the esophagus.

Findings required by s45

I am required to find, as far as is possible, who the deceased was, when and where he died, what caused the death and how he came by his death. I have already dealt with this last issue, the manner and circumstances of the death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses I am able to make the following findings in relation to the other aspects of the death.

Identity of the deceased – The deceased person was Lenard John Casey.

Place of death – He died at at the Normanton Hospital in Queensland.

Date of death – Mr Casey died on 20 November 2004.

Cause of death – He died from coronary thrombosis caused by coronary atherosclerosis.

Concerns, comments and recommendations

Section 46, in so far as is it relevant to this matter, provides that a coroner may comment on anything connected with the death investigated at the inquest that relates to:-

(a) public health or safety; or

(b) the administration of justice; or

(c) ways to prevent deaths from happening in similar circumstances in the future.

This inquest has considered a number of aspects of the management of Mr Casey from this perspective.

The handcuffing of the prisoner/patient

In particular it looked at whether the handcuffing of Mr Casey was appropriate considering his grave illness. It is obviously undesirable for seriously sick people to be restrained in this way. The problem for the police is that the deceased was both a patient and a prisoner. He had a long criminal history and been accused of a serious crime of violence. On arrival at the hospital he was non compliant and had made a fist to Dr Jagga and was agitated. The hand cuffing was to ensure the security of the prisoner and the safety of the medical and flight staff for the transfer to Mount Isa. I accept there was a need to Mr Casey and I accept Dr Brown's view that this restraint in no way compromised the care of Mr Casey or exacerbated his condition.

Therefore, no other comment or recommendation from me is warranted in relation to this aspect of then matter.

Sedating a coronary care patient

I also investigated whether the administration of sedatives to Mr Casey when he was known to be suffering from severe heart disease was appropriate. Again, I accept the evidence of Dr Brown that the risk of using the drugs in question were very slight and that there is no evidence that an adverse reaction eventuated.

Contact between Mr Casey and his family

Mr Casey's older brother Hector says that during the late afternoon or early evening of 18 August, he went to the hospital to see Mr Casey having been told that he had been arrested and transferred to the hospital by ambulance. He says the officer guarding Mr Casey would not allow this to happen. None of the officers who were at various times at the hospital can remember this occurring but none of them denied that it may have happened. I have no reason not to accept Mr Hector Casey's evidence on this point. Sergeant Rutherford was the most experienced officer of those involved in watching Mr Casey at the hospital, although he was only there briefly. He gave evidence that he believes that he would have acceded to the request had it been made to him. He considers it appropriate from humanitarian and utilitarian perspectives to allow such contact. I agree with his assessment in this regard and consider that the more junior officer, who it seems took a different view, made an error of judgment.

Aboriginal Health

A full inquiry into Aboriginal health is beyond the scope of the inquest. Apart from questioning some relevant witnesses involved in the death about the more general issues concerning alcohol abuse and health in Queensland communities, reliance is placed on an updated literature survey on Aboriginal health issues.[11]

There can be little doubt that alcohol abuse and other life style factors brought about to the death of the deceased.

In Australia cardiovascular disease claims more than 50,000 lives and affects more than 3.6 million people per year. But it is Indigenous Australians who suffer to a greater degree than non-indigenous people from this illness resulting in death from cardiovascular disease.

Aboriginal Australians are up to 2.6 times more likely to die from cardiovascular disease than the rest of the population.[12]

The medical literature is replete with reference to the very poor state of

[11] see Justice T Fitzgerald QC (Chair), *Cape York Justice Study* (CYJS), November 2001 (further, as regards alcohol abuse and policing on Aboriginal communities); Queensland Government (DATSIP), *Making Choices About Community Governance*, Green Paper, *Review of Indigenous Community Governance*, March 2003 at 10-15; Queensland Government (DLGPSR), *Community Governance Improvement Strategy*, December 2004;

[12] Cardiovascular disease (CVD), Australian Indigenous HealthInfoNet, June 2006; Nutrition in Aboriginal and Torres Strait Islander Peoples: an information paper, National Health and Medical Research Council (NHMRC), May 2006, Rheumatic Heart Disease Registers, Australian Government Department of Health and Ageing, March 2006; Rheumatic heart disease: all but forgotten in Australia except among Aboriginal and Torres Strait Islander people, Australian Institute of Health and Welfare, August, 2004; Heart, Stroke and Vascular Diseases: Australian Facts 2004, Australian Institute of Health and Welfare, May 2004; Aboriginal and Torres Strait Islander Program, National Heart Foundation of Australia, January 2003, Aboriginal Vascular Health Program, NSW Department of Health

Aboriginal health.[13] It is an indisputable medical fact that Aboriginal people have higher rates of ill health than any other group in Australia. Indigenous people have a shorter life expectancy - around 18 to 19 years less than non-indigenous people. The average life span is 57 years for an Aboriginal male and 62 years for an Aboriginal female. The most common causes of death is coronary heart disease which is more than double that of the non-indigenous population.[14]

There is little that I can add to these graphic statistics, other than to note that this death is yet another tragic example of the lamentable health of Aboriginal Australians.

Medical treatment of the deceased

I am satisfied that the medical practitioners and nurses at the Normanton Hospital did all that they reasonably could have to save the life of Mr Casey on the day of his death.

I am also satisfied that he was given appropriate treatment in the months and years before his death. He was repeatedly medically evacuated to larger centres and offered what could have been life saving surgery. Mr Casey declined these offers and failed to take his medication consistently, even though he had seen four of his brothers die from similar causes. His sometimes bizarre behaviour and self destructive tendencies hint at undiagnosed mental illness, but I have no evidence to comment further on this possibility.

Conclusion

I am satisfied that this investigation has established the cause and circumstances of Mr Casey's death. However, it has not been able to reveal why he engaged in such self-destructive behaviour over a lengthy period and

[13] See the 2001 the Report of National Workshop on Heart Disease in Aboriginal People, Torres Strait Islanders Canberra, National Aboriginal Health Strategy Working Party; Heart, stroke and vascular diseases: Australian facts 2001. Cardiovascular Disease Series, No. 14. Canberra: Australian Institute of Health and Welfare, National Heart Foundation of Australia, National Stroke Foundation of Australia, 2001. (AIHW Catalogue No. CVD 13.); National health priority areas report: cardiovascular health 1998. Canberra: Commonwealth Department of Health and Aged Care and Australian Institute of Health and Welfare, 1999. (AIHW Catalogue No. PHE9.); Report of National Workshop on Heart Disease in Aboriginal People, Torres Strait Islanders and Rural and Remote Populations. Townsville: James Cook University, 1999; The health and welfare of Australian Aboriginal and Torres Strait Islander People. Canberra: Australian Bureau of Statistics and Australian Institute of Health and Welfare, 1999. (ABS Catalogue No. 4704.0.); Health is life. Report on the Inquiry into Indigenous Health. House of Representatives Standing Committee on Family and Community Affairs. Canberra: AGPS, May 2000; Deeble J, Mathers C, Smith L, et al. Expenditure on health services for Aboriginal and Torres Strait Islander People. Canberra: National Centre for Epidemiology and Population Health and Australian Institute of Health and Welfare, 1998. (AIHW Catalogue No. HSW 6.)Ring I, Firman D. Reducing Indigenous mortality in Australia: lessons from other countries. *Med J Aust* 1998; 169: 528-533National Aboriginal Health Strategy Working Party. A national health strategy. Canberra: National Aboriginal Health Strategy Working Party, Commonwealth of Australia, 1989..

[14] *Medical Journal of Australia*, 2001; 175: 351-352

why, even at the end, he resisted the only action that might have saved him. In a novel submission, counsel assisting suggested to one witness that Mr Casey may have deliberately precipitated his death as a preferable alternative to being removed from his country and kin for a lengthy period which he well knew was the likely consequence of his evacuation to Mt Isa. I don't consider I have sufficient evidence to accept suicide by cardiac arrest as a cause of death in this case. However I do know, from having reviewed tens of thousands of sudden deaths that some people seem to know when their death is imminent. I am sure that Mr Casey would not have wanted to die away from Normanton.

Commendations

I consider the performance of the police officers in this matter to have been exemplary. They moved quickly to take into custody a suspect for a serious, violent crime. They acted equally expeditiously when it became apparent that Mr Casey needed medical attention. Apart from the small blemish I have mentioned concerning contact with his brother, the officers thereafter successfully balanced the competing demands of caring for a prisoner/patient. I saw no evidence that the antipathy that the crime Mr Casey was suspected of would have naturally engendered was allowed to compromise the provision of health care, nor that those needs were permitted to jeopardize security. Another positive factor of this case was the effective co-operation between the police, the ambulance and the hospital staff. All are to be commended

This inquest is closed.

Michael Barnes
State Coroner
Normanton
10 August 2006