OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Thomas Andrew Clumpoint**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Townsville
FILE NO(s):	2009/381
DELIVERED ON:	27 August 2010
DELIVERED AT:	Townsville
HEARING DATE(s):	11 June & 26 August 2010
FINDINGS OF:	Ms Christine Clements, Deputy State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes; adequacy of medical and emergency treatment; cell intercom system faults; contingency planning

REPRESENTATION:

Counsel Assisting:	Ms A Kirkegaard
Department of Community Safety:	Mr M Nicolson
Townsville Health Service District:	Ms D Callaghan i/b Cooper Grace Ward
Aboriginal and Torres Strait Islander Legal Service:	

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 Thomas Andrew Clumpoint. 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

Mr Clumpoint was a 40 year old indigenous man who died suddenly at the Townsville Correctional Centre (TCC) on 12 June 2009. He was serving a period of two years, four months imprisonment at the time of his death.

Mr Clumpoint had been diagnosed with a tongue cancer in February 2007. The malignancy was successfully removed and he was reviewed regularly by the Townsville Hospital Head and Neck Cancer Clinic. In December 2008, Mr Clumpoint was diagnosed with a new head and neck cancer. He underwent further surgery, followed by a course of postoperative chemo-radiation. When last reviewed at the Head and Neck Clinic on 1 June 2009, Mr Clumpoint was noted to have a swollen epiglottis, which was considered consistent with his recent radiotherapy. There was no evidence of a recurrence of the malignancy. He was scheduled for another CT head scan and review in the Clinic in six weeks time.

Mr Clumpoint presented to the Townsville Hospital emergency department on 6 June 2009 with symptoms considered to be related to his recent radiotherapy. He was admitted overnight and returned to the prison the next day.

At the time of his death, Mr Clumpoint was accommodated in unit 5B of the Chris McCann Units – this unit housed six prisoners, including Mr Clumpoint's nephew and unofficial 'carer', Mr Chapman. Corrective services staff, Mr Clumpoint and other unit 5B prisoners were aware the intercom in Mr Clumpoint's cell did not work. Mr Clumpoint is reported to have declined attempts made by staff to move him into the medical centre or into another cell with a working intercom.

Sometime after 5:00am on 12 June 2009, Mr Clumpoint started to have trouble breathing. He initially sought help from his nephew, who tried to summon help via the intercom in his room. This call was made at 5:27am, shortly after which Mr Clumpoint collapsed and stopped breathing and did not have a pulse. No one responded to this call, as it was garbled at the receiving end in the Master Control Room.

Another prisoner attended the scene and used the intercom in Mr Chapman's room to call again for help. This call was made at 5:32am. This time, a Code Blue medical emergency was called at 5:34am. Corrective Services officers arrived on the scene at 5:36am and started CPR. They continued CPR until the nurse arrived at 5:41am with a defibrillator. Unfortunately Mr Clumpoint

could not be revived. His death was pronounced at the scene at 5:57am and confirmed by paramedics at around 6:05am.

Because Mr Clumpoint was in custody, his death was reported to the Acting 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 the death;
- consider whether the medical treatment afforded to Mr Clumpoint while he was in custody was adequate and reasonable;
- consider whether the arrangements made by the Townsville Correctional Centre for monitoring Mr Clumpoint's condition from 12 May - 12 June 2009, pending repair of known intercom faults in the custodial unit where he was accommodated during this period, were adequate and reasonable;
- consider whether the emergency response to Mr Clumpoint's collapse on 12 June 2009 was adequate and reasonable; 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

Detective Senior Constable Rachael Gray of the QPS Corrective Services Investigation Unit (CSIU) conducted the investigation.

Mr Clumpoint's death was reported to the Townsville Police Communications Centre at 6.28am on 12 June 2009. Uniformed police attended the scene and secured the area. A Scenes of Crime officer attended and photographed the scene, with Mr Clumpoint in situ. Mr Chapman was interviewed electronically at the scene by Detective Senior Sergeant Miles from Townsville CPIU.

Mr Clumpoint's body was conveyed to the Townsville Hospital mortuary at approximately 11:30am for autopsy.

Mr Clumpoint's death was formally reported to CISU at approximately 7:20am that morning. Detective Senior Constable Gray and Detective Sergeant

[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

Stephen Wild travelled to Townsville, arriving at TCC at approximately 3:00pm that afternoon.

After inspecting Mr Clumpoint's room, the CSIU officers conducted tests of the intercoms in each room within Unit 5B of the McCann Units. These tests revealed that all of the intercoms worked only intermittently. The CSIU officers then met with the TCC General Manager, Mr John Harrison, to discuss this finding.

Detective Senior Constable Gray then conducted electronic interviews with all of the other prisoners who had been housed in Unit 5B of the Chris McCann Units with Mr Clumpoint.

Professor David Williams performed an external and full internal autopsy on the morning of 13 June 2009. The autopsy was observed by the CSIU officers.

Further enquiries made by the CSIU officers included obtaining the correctional centre offender files and medical records and the hospital medical records relating to Mr Clumpoint; internal reports prepared by the corrective services officers who were involved in the response to Mr Clumpoint's collapse; recordings of the intercom calls and Master Control Room and McCann Unit video footage; the Night, Control and Gatehouse log books and copies of relevant entries in the TCC System Fault Register entries. The investigating officer also obtained statements from Mr Clumpoint's sister and all of the corrective services officers and the registered nurse who responded to Mr Clumpoint's collapse.

Queensland Corrective Services (QCS) conducted an internal investigation into Mr Clumpoint's death, concurrently with the CSIU investigation. The findings of this investigation informed the police investigation and enabled Detective Senior Constable Gray to finalise her investigation report within five months of Mr Clumpoint's death. I thank Detective Senior Constable Gray for conducting a timely investigation.

I have had regard to the findings of the QCS investigation. It appears to have been a timely and thorough review of the incident. I will also comment on the recommendations made as part of that investigation and the extent to which they have been implemented.

The Office of the State Coroner supplemented the findings of Detective Senior Constable Gray's investigation by arranging for a doctor from the Queensland Health Clinical Forensic Medicine Unit to review the investigation material to assess whether Mr Clumpoint was given appropriate access to, and received adequate medical and emergency treatment while he was in custody. This review was undertaken by Dr Ian Mahoney.

The inquest

The inquest was opened with a pre-inquest conference in Townsville on 11 June 2010. Ms Kirkegaard was appointed counsel assisting and leave to

appear was granted to the Department of Community Safety and Queensland Health.

Prior to the inquest, the Aboriginal and Torres Strait Islander Legal Service was given leave under section 36(2) of the *Coroners Act 2003* to make written submissions.

An inquest was held in Townsville on 26-27 August 2010. All coronial documents and investigation material, including the QCS internal investigation report, were tendered. Four witnesses were called to give evidence.

The evidence

Mr Clumpoint's sister Dianne Foster was present during the inquest and heard all of the evidence. I will only summarise the evidence I believe is necessary to understand the findings I have made.

Personal background

Ms Foster provided a personal background statement for her brother, I am grateful for this information as it helps to understand the person whose death is being investigated, and whose loss is being mourned by those who loved him.

Mr Clumpoint was a descendant of the Djiri tribe (Mission Beach), Waanyi tribe (Lawn Hill), and Kalkadoon tribe (Mount Isa). He grew up in a large family and spent his childhood at Hughenden and Palm Island. He was very close to his sister Dianne and remained in regular contact with his mother. He was involved in sporting and cultural dance in his youth and particularly enjoyed rugby league.

Mr Clumpoint's formal education ended before completion of grade 10 at Mt Carmel College in Charters Towers. His employment history included gardening and labouring for the Palm Island Council, working at the Palm Island canteen and employment on a fishing boat.

In his younger years, Mr Clumpoint actively participated in sports including football, soccer and cricket.

Mr Clumpoint is survived by three daughters and grandchildren.

Imprisonment

On 14 February 2008 Mr Clumpoint commenced serving a two years four months term of imprisonment for unlawful wounding, as well as common assault against his de facto partner, breaches of domestic violence protection orders, disqualified driving and breach of a suspended sentence imposed in May 2005.

The Queensland Corrective Services files show that throughout his various periods of incarceration at TCC, Mr Clumpoint was a generally compliant prisoner who got on well with staff and other prisoners. He was employed in

various roles during his imprisonment, including as a cleaner, gardener and cook. Mr Clumpoint was considered to be a conscientious worker and received very favourable work and behaviour reports. He was also noted to "keep the peace" in his block and at times, acted as a "problem solver" for fellow prisoners.

Mr Clumpoint was eligible for release on 28 September 2009.

Mr Clumpoint's medical history

Mr Clumpoint had been a very heavy drinker and a heavy smoker. He had also been a regular user of marijuana.

Prior to 2007 Mr Clumpoint's medical history was relatively unremarkable, with several hospital presentations for a variety of minor injuries and health complaints. In August 2006, he was diagnosed with pancreatitis secondary to alcohol abuse.

The TCC medical records indicate that during his periods of incarceration prior to November 2006, Mr Clumpoint was seen at the prison medical centre for a variety of minor health complaints. He was taken to the Townsville Hospital emergency department in June 2004 with persistent chest pains. On review these were determined to be of musculoskeletal origin.

Diagnosis and management of Mr Clumpoint's head and neck malignancy

The TCC medical records show that when reviewed by Dr Kuen, a visiting medical officer on 9 December 2006, Mr Clumpoint was noted to have a chronic 'ulcer' under the tip of his tongue. He was initially given Bonjela for the lesion.

A different medical officer reviewed the lesion on 8 January 2007 and prescribed a course of antibiotics and brufen. Mr Clumpoint was scheduled for review in a fortnight. The medical notes for this presentation acknowledge that a biopsy might be required.

Mr Clumpoint was reviewed by Dr Kuen on 24 January 2007. The floor of his mouth under his tongue was still inflamed and swollen. Mr Clumpoint reported having developed a swelling in his left neck one day after eating. Dr Kuen ordered a biopsy, which was performed on 7 February 2007.

The biopsy report revealed squamous carcinoma in-situ. Consequently, on 16 February 2007, Dr Kuen urgently referred Mr Clumpoint to the Head and Neck Cancer Clinic at the Townsville Hospital.

Dr Kuen arranged for a CT brain, neck and chest scan, which was performed on 21 February 2007. The CT neck scan showed the involvement of one lymph node and some irregularity in the left base tongue region.

Mr Clumpoint was first seen in the Head and Neck Cancer Clinic on 1 March 2007. The clinical note for this presentation indicates that Mr Clumpoint first noticed the lesion five or six years earlier and reported it had recently become swollen and painful. He also reported a fluctuating swelling in the left side of his neck. A nasendoscopy revealed a suspect area on his right vocal chord.

I note an entry made by Dr Kuen in the TCC medical records on 19 February 2007 that "*it is not a certainty that either he or we have jeopardised his chances. It has only been two-and-a-half months since he pointed out his lesion and it has not changed*".

A review of the TCC medical records shows that Mr Clumpoint had not sought medical attention for the lesion during his incarcerations prior to 9 December 2006, nor was it identified in any of his medical reception histories, including those taken when he was received into TCC in 2003 and November 2006.

I am satisfied there was nothing the TCC medical centre could have done to detect the lesion any earlier.

Mr Clumpoint was admitted to the Townsville Hospital on 21 March 2007 for a panendoscopy, microlarygoscopy, biopsy of the right vocal chord, wide local excision of the floor of mouth lesion and a left neck dissection. The surgery was uneventful. He remained in hospital until 29 March 2007, when he was discharged back to the TCC medical centre. Mr Clumpoint recovered well and at his request, returned to his cell on 5 April 2007.

Following review at the Head and Neck Cancer Clinic on 3 April 2007, Mr Clumpoint was staged as having a left anterior floor of mouth squamous cell carcinoma stage T10M0 with a noted glottic hyperkeratotic lesion which was non-malignant. I note this information was communicated to the TCC medical centre. Dr Joshua Dass, who subsequently treated Mr Clumpoint when he developed tonsillar cancer, explained there is a seventy per cent risk of recurrence of a head and neck cancer or of developing a new cancer within two years of the first diagnosis. However, the surgical treatment of the first cancer was presumed to be successful but required regular review.

Mr Clumpoint's condition was then monitored with regular ENT outpatient appointments until September 2007.

The Townsville Hospital records show that Mr Clumpoint failed to attend ENT outpatient appointments between December 2007 and February 2008. I note Mr Clumpoint had been released from TCC on 25 July 2007 and returned to the centre on 14 February 2008.

Over the period February – December 2008, Mr Clumpoint presented for medical review with symptoms of insomnia, dry mouth and difficulty breathing which were determined to be anxiety-related. He was recommenced on Amitriptyline.

From May 2008 onwards, Mr Clumpoint was treated for several upper respiratory tract infections. He was seen regularly by Dr Kuen, who being well aware of Mr Clumpoint's prior diagnosis, appears to have conscientiously checked for signs of recurrent malignancy on each presentation. Mr Clumpoint was diagnosed with type 2 diabetes in early December 2008.

Mr Clumpoint was reviewed in the ENT outpatient clinic on 18 March 2008. Examination showed no recurrence of the malignancy. He was scheduled for further outpatient review in six months time.

The hospital records show that Mr Clumpoint failed to attend ENT outpatient appointments in September and October 2008. There appears to have been a communication breakdown between the hospital and TCC about the booking of these appointments, as it was not until one of the TCC medical centre nurses phoned the hospital on 5 November 2008 to enquire about follow up appointments for Mr Clumpoint, that the situation was rectified.

Mr Clumpoint was reviewed in the ENT outpatient clinic on 11 December 2008. He was found to have a suspicious lesion on the left base of his tongue. He was admitted to the Townsville Hospital on 19 December 2008 for a panendoscopy with biopsy. The procedure found a growth on his left tonsil, which histopathology determined was an infiltrating squamous cell carcinoma. Mr Clumpoint returned to TCC that day and chose to return to his cell, rather than stay in the medical centre overnight.

Mr Clumpoint presented to the Townsville Hospital emergency department on 26 December 2008 complaining of pain at the site of his recent biopsy. It was during this presentation that he was told about his left tonsillar cancer.

Mr Clumpoint was reviewed in the Head and Neck Cancer Clinic on 6 January 2009. His left tonsillar cancer was staged T2N1M0 but he was noted to have suspicious neck nodes. He was subsequently admitted to the Townsville General Hospital on 7 January 2009 for radical surgical resection of the cancer, involving neck dissection and removal of his left tonsil. Although the surgery itself was uneventful, an emergency tracheotomy was performed on 9 January 2009 to address upper airway obstruction. Mr Clumpoint otherwise recovered well and remained in hospital until he was discharged back to TCC on 16 January 2009.

Histopathology confirmed the diagnosis of left tonsillar squamous cell carcinoma and revealed the cancer had metastasised into some of the lymph nodes. Consequently, it was decided to start Mr Clumpoint on a course of radiotherapy.

When reviewed in the Head and Neck Cancer Clinic on 20 January 2009, Mr Clumpoint was noted to have recovered well from the surgery. His post-operative pain and discomfort was being managed by the TCC medical centre staff.

On 9 February 2009, it was decided Mr Clumpoint required the additional treatment of chemotherapy which commenced from 17 February 2009 and concluded on 30 March 2009.

In the course of chemotherapy treatment it was discovered that Mr Clumpoint had developed a new neck lump. This lesion was too small to be biopsied but a repeat CT scan suggested it was an inflammatory change consistent with side effects of radiotherapy, with a mild asymmetry of the epiglottis and pharynx due to oedema. When reviewed in the Head and Neck Cancer Clinic on 17 March 2009, it was decided to continue his chemo-radiation.

Mr Clumpoint was reviewed weekly in the oncology clinic throughout his course of chemo-radiation. Mr Clumpoint tolerated the treatment reasonably well, which caused mild dryness of mouth, pain and difficulty swallowing, slight fatigue and significant inflammation of the mucous membranes in his mouth. He was given MS Contin for pain relief and used Xylocaine viscous (a local anaesthetic), anti-heartburn medication and mouth cares regularly.

Mr Clumpoint was scheduled for routine review in the Head and Neck Cancer Clinic one month later.

On 14 April 2009 Mr Clumpoint told the speech pathologist he had an area of swelling on the left side of his neck. The speech pathologist wrote to the TCC Health Co-ordinator asking staff to contact the treating team if Mr Clumpoint reported any pain or change or increase in swelling. The TCC medical records show that after Mr Clumpoint presented to the medical centre in late April and early May 2009 with ongoing concerns about the swelling and difficulty swallowing, the medical centre staff arranged for Mr Clumpoint to be seen by a radiation oncologist in early May.

When examined by a radiation oncologist on 6 May 2009, he was considered to be recovering as expected. There was no evidence of any recurrent malignancy. He was noted to have some anticipated swelling of the neck which was expected to improve over the next six to twelve months. A routine follow up appointment was made for three months' time.

Mr Clumpoint transfers to the Chris McCann Units

Prior to May 2009, Mr Clumpoint was accommodated in Block 3 of the centre.

On 12 May 2009, Mr Clumpoint was transferred to the Chris McCann Units (CMU). Entries in the Integrated Offender Management System (IOMS) file indicate this was because his recent unwillingness to attend muster or make his bedpack made him no longer suitable for accommodation in Block 3.

The CMU provides residential accommodation in units of six prisoners, with a shared kitchen, laundry and bathroom facilities. Each prisoner has his own cell and is able to lock and unlock his own cell door. Only the external door to the unit is locked down at night, leaving prisoners to move freely around their cell and the common areas of the unit.

Mr Clumpoint was placed in room 2 of Unit 5B of the CMU. This unit housed a number of other prisoners from the Palm Island community, including Mr Clumpoint's nephew, Mr Chapman, who performed a peer support role within the centre.

The intercom in Mr Clumpoint's room did not work. The investigation material shows that staff, Mr Clumpoint and other Unit 5B prisoners were aware of this situation. Consequently, Mr Clumpoint was permitted to sleep with the door to his cell open, in case of a medical emergency, and Mr Chapman agreed to a request by staff to keep an eye on Mr Clumpoint and keep his own door unlocked at night in case Mr Clumpoint needed his help. I will comment on this situation later.

Mr Clumpoint's condition over the period 1-8 June 2009

The TCC medical records show that Mr Clumpoint experienced ongoing significant pain. He was reviewed in the Head and Neck Cancer Clinic on 1 June 2009. He was noted to have lost 5kg of weight over the previous three weeks. Clinical examination revealed a significantly swollen epiglottis but no recurrence of the tonsillar cancer and no new lesions of concern. It was expected that Mr Clumpoint would continue to experience difficulty swallowing for the next couple of weeks while the swelling resolved. He was scheduled for a CT neck scan in four weeks' time and a routine review appointment in six weeks' time. In the meantime, he was to continue with his MS Contin and Aspirin to reduce some of the inflammation.

A statement provided by Dr Joshua Dass, the consultant radiation oncologist who was responsible for Mr Clumpoint's care, indicates that as at the clinic review on 1 June 2009, it was considered Mr Clumpoint had responded successfully to treatment and there was no evidence of remaining tonsillar cancer. Inflammation and swollen epiglottis was consistent with post radiation changes.

Dr Dass' evidence at inquest was that as at 1 June 2009, Mr Clumpoint had a 70-80 per cent chance of surviving for at least five years. He explained there is no test to detect a mucous cell cancer after treatment. Usually a cancer will commence to grow again if still present within a period of two years. Monitoring continues for five years.

Dr Dass stated that the proposed clinical management plan was to continue to review Mr Clumpoint every six to twelve weeks. Dr Dass states that their standard management plan at complete clinical resolution of a malignancy is to continue observation. If there is clinical evidence of the malignancy, repeat biopsies and further imaging would be undertaken.

Dr Dass further stated that their usual approach would be to arrange for a PET (positron emission tomography) scan to be performed three months after the completion of treatment to assess treatment response and any residual disease. In Mr Clumpoint's case, this would have been arranged for the end of June 2009. Dr Dass explained that it was unknown whether a PET scan would have identified the malignancy which was found at autopsy. I also note

PET scanning cannot be accessed in Townsville but requires transfer to Brisbane to access the scan.

The discovery of small nodes on the scan established Mr Clumpoint in a range of stage 2 to stage 3 of the disease. This meant his chance of survival might be within a broader range from 50-80 per cent. The fact that he had a previous cancer in 2007 increased the probability of a recurrence or development of a new cancer. However, repeated reviews by treating clinicians after radiation therapy had not detected any sign of fresh disease. The various symptoms of swelling were attributed to the expected unpleasant side effects of radiation therapy.

Unexpectedly, Mr Clumpoint died before the next scheduled review. In Dr Dass' opinion, Mr Clumpoint was not in a terminal phase of illness in June 2009. He did not expect him to die at this time.

I note Dr Dass' evidence that Mr Clumpoint would require ongoing surveillance for a period of five years.

I note from the time of Mr Clumpoint's initial diagnosis in March 2007 to his last outpatient review on 1 June 2009, the hospital provided both the TCC medical centre and the Aboriginal and Torres Strait Islander Health Centre with reports updating information of his treatment. However, I note that although a copy of the progress note about the outcome of the 1 June review was made for the TCC medical centre, it does not appear in the TCC medical records. It has not been explained how the last report was not received by the TCC medical centre. Dr Dass explained the usual process of timely dictating of the report which was dispatched within 48 hours.

The TCC medical records show Mr Clumpoint presented to the medical centre on 5 June 2009 complaining of increased difficulty swallowing and blood stained saliva. He was prescribed antibiotics and his oxycodone dose was increased, with the plan to take him to hospital if his condition deteriorated. He was taken to the Townsville Hospital emergency department on 6 June 2009 after coughing up blood for a day.

On examination, it was considered that Mr Clumpoint had experienced an episode of haemoptysis (coughing up blood). After discussion with a consultant radiation oncologist, Mr Clumpoint was admitted overnight for observation. A chest x-ray revealed nothing of concern. The chest x-ray report noted that '*appearance of narrowing of the trachea superiorly has been seen on previous imaging*'. Dr Dass considered the episode of haemoptysis was appropriately investigated. A chest x ray excluded respiratory causes in the lungs or any secondary lesion in the chest. Mr Clumpoint's condition was reviewed as there was some difficulty with his breathing but he was assessed as not suffering an acute respiratory condition and therefore suitable for discharge.

It was considered that his symptoms were related to his recent course of radiotherapy. Dr Dass explained the effects of radiation therapy can cause

intermittent swelling for three to six months and sometimes, up to twelve months.

The nursing notes indicate that in the early hours of 7 June 2009, Mr Clumpoint complained of pain and tightness in his throat region and difficulty breathing. He was given oxygen therapy and noted to settle with good oxygen saturation.

After an uneventful night, Mr Clumpoint was discharged and returned to TCC on 7 June 2009. The medical registrar's notes indicate that he discussed Mr Clumpoint's presentation with Dr Hewitt, a consultant radiation oncologist, who indicated she would arrange a follow up appointment for Mr Clumpoint with the oncology clinic the following Tuesday or early that week.

The TCC medical records show that Mr Clumpoint was advised to remain in the medical centre until the following Tuesday, 9 June 2009, due to the risk of bleeding. Mr Clumpoint refused to do so and returned to his cell in Unit 5B of the CMU.

An entry made in IOMS on 7 June 2009 noted that the intercom in Mr Clumpoint's cell did not work. He was noted to be comfortable there and did not wish to move. The other Unit 5B prisoners were noted to have agreed they would monitor him so he could stay there. The Duty Manager and night staff were made aware of the situation.

The TCC medical centre nurses are noted to have conducted four night time health checks over 7-8 June 2009.

Mr Clumpoint was noted to be experiencing pain on 8 June 2009, which settled after he was given oxycodone. No bleeding from the throat was noted. The following day, a medical centre nurse contacted the oncology unit to clarify arrangements for Mr Clumpoint's follow up appointment. It was scheduled for the following Monday, 15 June 2009.

Attempts to encourage Mr Clumpoint to move from his cell because there was a problem with the cell intercom

The investigation material shows that from 8 June 2009 onwards, corrective services officers tried several times to encourage Mr Clumpoint to either swap cells so he had a working intercom or stay in the medical centre. Mr Clumpoint declined on each occasion saying that he wished to remain in his cell where he was comfortable. He was reminded that the intercom in his cell was not working and that he would have to ask the other Unit 5B prisoners for help if he needed to make an emergency call.

Mr Chapman states that he spoke to a nurse about getting Mr Clumpoint back down to the medical centre or in to hospital.

CSO Wayne Shellhorn states that on 8 June 2009, he reported Mr Clumpoint's faulty intercom in the Fault Maintenance Register. He also arranged for an email to be sent to the Centre Services Manager and copied

to several others including the Q-Build Maintenance officer, seeking to escalate this maintenance issue which he considered had become urgent due to Mr Clumpoint's condition. I note that a copy of this email has not been produced to this inquest.

The TCC System Fault Register shows that the faulty CMU intercoms were reported on 3, 10 and 12 June 2009. The Honeywell Maintenance Report for June 2009 shows that a technician responded to these reports within 24 hours. However, I note that the Honeywell maintenance report entry for these jobs indicates that the intercom faults in Unit 5 were not rectified on 10 or 12 June 2009, but rather were '*being investigated'* and the jobs weren't completed until 22 June 2009, when the intercoms "*tested all OK*".

I remark it was entirely unsatisfactory that the unreliable intercoms were not repaired before 22 June.

Mr Clumpoint's condition over the period 9-11 June 2009

The TCC medical records show that Mr Clumpoint did not seek or require any nursing or medical assistance after 8 June 2009, other than being given his regular medications.

I note there is a retrospective entry in IOMS made by the TCC Indigenous Cultural Officer, Mr Edward Albert, regarding a meeting he had with Mr Clumpoint on 10 June 2009. The CMU supervisor, Ms Julie Harwood, had asked Mr Albert to speak with Mr Clumpoint. Mr Clumpoint was noted to consider that he was in good health, apart from his neck pain. The IOMS entry records that after a lengthy discussion, Mr Clumpoint agreed for Mr Albert to speak with Ms Harwood about moving him closer to the medical centre. The entry indicates that Mr Albert then discussed this with Ms Harwood but they were informed that Mr Clumpoint could not be moved back to the Village as it was full. The entry concludes with a comment that they had *"exhausted all avenues to have [Mr Clumpoint] moved short of using force*" and it was not possible to issue a notification of concern because Mr Clumpoint was not refusing his medication.

Mr Chapman considered that Mr Clumpoint was "starting to come good" as he had begun to eat things other than his soft food diet. Mr Clumpoint had started producing a lot of saliva at this time and told Mr Chapman he could feel a lump in throat. Apart from Mr Clumpoint's ongoing pain, there was nothing else to indicate he was unwell at this time.

I note Mr Clumpoint is described by several of the Unit 5B prisoners as not being one to complain or burden other people with his pain. Nurse Featherstone described him in her evidence as quiet and stoic.

A statement provided by Registered Nurse Janine Featherstone indicates that Mr Clumpoint had experienced difficulty swallowing and breathing for several months and these symptoms had increased gradually over time. However, I note the last reference in the TCC medical records to Mr Clumpoint complaining of breathing difficulties was in late October 2008.

Although the other Unit 5B inmates were aware Mr Clumpoint had cancer and was generally in pain and found it hard to swallow, none of them reported he was experiencing difficulty breathing that evening.

The Unit 5B inmates report Mr Clumpoint was with them at dinner that night. Mr Desatge reports that afterwards, he and Mr Clumpoint talked and joked together over a game of cards and Mr Clumpoint seemed '*pretty good*' at that time.

Ms Featherstone states she saw and spoke to Mr Clumpoint at 9:00pm on 11 June 2009 when she gave him his evening dose of oxycodone. She states Mr Clumpoint appeared '*a little short of breath*' and had difficulty swallowing his medication. Ms Featherstone described this presentation as normal for Mr Clumpoint. She described his breathing rate as slightly higher than normal and that his breathing was audible, as if he was breathing through a straw. I accept that Nurse Featherstone did not describe his condition as consistent with stridor. When asked this question her answer was no, just constricted. She had not been working recently in Mr Clumpoint's area. Her impression was his breathing was consistent with what she had previously observed. She was unaware of recent complaint by Mr Clumpoint that he felt a lump in his throat. I accept her evidence that Mr Clumpoint was not showing any sign of distress.

Mr Chapman reports he checked on Mr Clumpoint at 11:30pm and noted he was asleep in his cell.

Mr Clumpoint collapses

Interviews with the other Unit 5B prisoners indicate that sometime after 5:00am on 12 June 2009, Mr Clumpoint woke up his nephew and indicated he was in trouble with his breathing.

He initially sought help from his nephew, Mr Chapman. Mr Chapman reports that he was woken by Mr Clumpoint slapping him. He saw Mr Clumpoint run to the laundry where he turned on the tap. Mr Clumpoint then returned to Mr Chapman's room, pointing to his throat and indicating he couldn't breathe. He appeared distressed and sounded like he was trying to cough up phlegm.

Mr Chapman used the intercom in his room to call for help for Mr Clumpoint. Shortly afterwards, Mr Clumpoint fell to his hands and knees and collapsed face down on the floor, making a gurgling sound. Mr Chapman reports he couldn't feel a pulse or hear him breathing at this time.

Mr Desatge reports that he was woken by Mr Chapman calling out for help. He went into Mr Chapman's room where he saw Mr Chapman trying to help Mr Clumpoint. At Mr Chapman's request, he checked through the front windows of the unit to see if the officers were coming.

Mr Desatge reports that he saw Mr Clumpoint take a sharp breath in but he appeared to stop breathing after that. At Mr Chapman's request, Mr Desatge

used the intercom on Mr Chapman's room to make another call for help. Mr Chapman rolled Mr Clumpoint onto his side and tried to remove the build up of saliva from Mr Clumpoint's mouth. He also tried to dislodge Mr Clumpoint's tongue, as he thought Mr Clumpoint was choking on it.

Mr Desatge reports that he then re-checked Mr Clumpoint's breathing and pulse. Mr Clumpoint still wasn't breathing and didn't have a pulse. Mr Chapman held Mr Clumpoint where he lay, while Mr Desatge then went over to the front windows and started yelling out for the officers to hurry up.

The three other Unit 5B prisoners were woken up by the yelling and came out of their rooms to see what was going on. Two of them joined Mr Desatge at the front windows to call out for help.

None of the prisoners attempted CPR.

TCC officer response to the intercom calls from Unit 5B

I have had regard to the findings of the Queensland Corrective Services investigation report about this part of the sequence of events leading to the emergency response to Mr Clumpoint's collapse.

At the time of Mr Chapman's call, the two night shift officers assigned to CMU were at another unit helping with the early unlock of prisoners being discharged. In their absence, Mr Chapman's cell call was automatically directed to the Master Control, which was staffed by CSO Rick Wood.

The TCC automated recording system logged Mr Chapman's call at 5:27:46am. Unfortunately the recording was of poor quality, but Mr Chapman can be heard to identify a medical emergency involving Mr Clumpoint:

Mr Chapman:	"*Medical emergency*"
CSO Wood:	"*Control Room – state your emergency*"
Mr Chapman:	"*Thomas Clumpoint – hey quick hurry, get the fuck down here*"

The same call recorded from the Master Control speakers through the control room CCTV system, as heard by CSO Wood, was quite different:

CSO Wood:	*"Control room – state your emergency"*
Mr Chapman:	*"Chief we (inaudible)"*
CSO Wood:	"*Control room – state your emergency*"
Mr Chapman:	*"(inaudible) get the fuck down here"*

I note that the QCS investigators could not find a technical explanation for these different recordings of the same call. Mr Crothers explained how one recording was made in the Master Control room which had other background noise present. This could account for the variation.

CSO Wood states he didn't understand the call and only heard the swearing. He stated that abusive calls were not uncommon at that time of the morning

from prisoners who are due for discharge or to attend court or think they should be unlocked early.

CSO Wood told the QCS inspectors he could see from the cell call monitor the call came from cell 4 in Unit 5B of the CMU, but he did not check to see who occupied the cell. He left the call in 'listening mode' and reported that he heard nothing further from the caller. I note his evidence in this regard differs from that provided in his statement to the investigating officer, which stated he disconnected the call.

At 5:28:46am, a prisoner is recorded as saying "*Where the fuck are these characters*?" CSO Wood did not speak to the prisoner on the open intercom after he put it on listening mode.

The TCC automated recording system logged Mr Desatge's call from Mr Chapman's cell at 5:32:45am. A prisoner is clearly heard to say "*this bloke looks like he's fucking dead on the fucking floor*" and that help was required right away to Unit 5B in CMU. The recording also captured another prisoner in the background saying "*can't really find a pulse here mate*". CSO Wood advised he would get someone there.

The QCS investigators noted that unlike the initial call from Mr Chapman, there was no apparent difference between the two recordings of Mr Desatge's call.

CSO Wood states that he immediately phoned the CMU officers' station but no one answered the phone. Although he says he then tried unsuccessfully to radio the CMU officers and the Duty Supervisor, these calls are not shown or recorded on the Master Control room video recording, which only shows CSO Wood making two unsuccessful telephone calls and then speaking on the phone.

CSO Wood successfully phoned the night supervisor, SCSO David McNulty, who instructed him to call a 'Code Blue' medical emergency. CSO Wood then radioed a Code Blue call at 5:34:17am and confirmed the Code Blue call by radio again at 5:34:50am.

Emergency medical response

Video footage from an internal camera in Unit 5B shows five CSO officers entering the unit at 5:36:13am. They found Mr Clumpoint lying face down in Mr Chapman's cell. Mr Chapman told them Mr Clumpoint had collapsed after telling him he couldn't breathe. The CSOs tried unsuccessfully to rouse Mr Clumpoint before rolling him over to check whether he was breathing and had a pulse. Neither signs were present. CSO Thomas then commenced expired air resuscitation while CSO Laurie Bell started chest compressions. The other Unit 5B prisoners were moved out of the unit at this time.

Registered Nurse Janine Featherstone was at the medical centre when she heard the Code Blue. She proceeded immediately with a medical emergency

trolley. RN Featherstone states she was not aware of the nature of the medical emergency or which prisoner was involved, at that time.

RN Featherstone states she was stopped at a locked gate near the Village for about three minutes. This is confirmed by the electronic gate activation log which shows that RN Featherstone pressed the gate call button at 5:36:37am and CSO Wood opened the gate at 5:39:50am.

The QCS inspectors report that radio traffic at this time suggests CSO Wood had lost track of RN Featherstone, who he thought he saw on camera at the CMU gate. He did not locate her until after he was told she was not the officer at the CMU gate.

The CSOs continued their resuscitative efforts until RN Featherstone arrived. The video footage shows she arrived on the scene at 5:41:46am. She states she observed Mr Clumpoint was not breathing; had no pulse and his pupils were fixed and dilated. She attached a defibrillator to his chest while the CSOs continued with CPR. The defibrillator showed there was no shockable rhythm. After reassessing Mr Clumpoint's vital signs and finding no signs of life, RN Featherstone pronounced Mr Clumpoint's death at 5:57am.

CSO Wood called for an ambulance at 5:48am. An ambulance had already been dispatched in response to an earlier call from CSO Peter Davidson.

The electronic ambulance report form records that an intensive care paramedic arrived at TCC at approximately 6:00am and attended the scene at approximately 6:08am, followed by an ambulance crew who arrived at the scene at approximately 6:18am. The intensive care paramedic performed ECG monitoring which confirmed that Mr Clumpoint was dead.

Cause of death

Professor Williams performed an external and full internal autopsy on the morning of 13 June 2009.

The examination showed no evidence of injury.

The autopsy revealed Mr Clumpoint had residual squamous cell carcinoma infiltrating the structures at the back of the throat and at the superior aspect of the larynx. This was associated with severe swelling of the structures of the larynx. Professor Williams described the appearance of the larynx as "severely abnormal", as the lumen of larynx was 2mm where it should normally be 20mmm.

Histological examination confirmed the back of the tongue, the pharynx, structures in the perilaryngeal tissues and salivary tissue within the neck were infiltrated by squamous cell carcinoma. Exophytic squamous cell carcinoma was noted to be growing out from the mucosal aspect of the pharynx.

The autopsy also revealed a degree of coronary atherosclerosis and emphysema of the lungs.

Toxicological examination of post mortem blood and urine samples detected no significant drugs or alcohol.

On the basis of these findings, Professor Williams considered that the infiltration by carcinoma had probably precipitated severe laryngeal oedema causing laryngeal stenosis, which he identified as the primary cause of Mr Clumpoint's death. He found nothing to indicate any other person was involved in Mr Clumpoint's death.

I note Professor Williams' explanation that because there is no separation of the lymphatic drainage of the larynx into a left and right side, any blockage to lymphatic drainage affects the larynx as whole and consequently, a major problem can develop very quickly.

I further note Professor Williams' advice that laryngeal stenosis caused by laryngeal oedema is a recognised complication of malignancy involving the structures in and around the larynx. Dr Dass agreed with this opinion explaining the cause of death.

Adequacy of the clinical management of Mr Clumpoint's condition

Dr Ian Mahoney of the Queensland Health Clinical Forensic Medicine Unit reviewed the adequacy of the clinical management by the Townsville Hospital and the TCC Medical Centre of Mr Clumpoint's condition while he was in custody. His report acknowledged that the treatment of head and neck cancer is a very specialised area involving a multidisciplinary approach. He could not identify any deficiencies in the medical treatment Mr Clumpoint received.

Having regard to Dr Mahoney's report and the hospital and corrections centre medical records, I consider that Mr Clumpoint received a reasonable and appropriate level of medical treatment for his condition.

I note that a number of the witness statements describe Mr Clumpoint as critically or terminally ill. Having regard to Dr Dass' evidence about Mr Clumpoint's prognosis as at the beginning of June, I am satisfied Mr Clumpoint's condition was not serious enough at that stage to have triggered the compassionate parole process. Notwithstanding this, and oblique criticism that communication about the status of Mr Clumpoint's condition between the medical centre and corrective services staff could have been better, the actions taken by various corrective services staff to ensure Mr Clumpoint's wellbeing in CMU show that corrective services staff were sufficiently aware of his condition.

I accept the evidence from the current General Manager, Mr Pike, that he must balance inmates' privacy issues with concerns for their medical safety. I consider the communication of medical information between the Nurse Unit Manager at TCC and the General Manager as appropriate. Mr Pike has the responsibility of informing other correctional staff to the extent he considers is necessary to ensure inmate's welfare while maintaining their privacy.

Shortcomings in the TCC response to Mr Clumpoint's collapse and death

The Chief Inspector, Queensland Corrective Services immediately commissioned an investigation into the circumstances of Mr Clumpoint's death (the 'QCS investigation'). The investigation was conducted under section 294 of the *Correctives Services Act 2006*.

As required by section 295 of the Corrective Services Act, the investigation team comprised an internal inspector, Mr David Crothers, an external inspector and an indigenous inspector. Mr Crothers gave evidence at the inquest.

The QCS investigation involved the inspectors:

(a) attending the TCC on 16-17 June 2009 to conduct interviews and inspect the CMU, Master Control and the medical centre;
(b) conducting interviews with all of the staff involved in the response to Mr Clumpoint's collapse, as well as the General Manager, other senior managers and the cultural liaison officer;
(c) having regard to the outcomes of the operational debrief conducted by TCC on 19 June 2009;
(d) reviewing audio recordings from the cell intercom system, visual only recordings from cameras inside and outside the CMU and an audio-visual recording from insider the Master Control; and
(e) reviewing relevant QCS and TCC documents.

The final investigation report was provided to Custodial Operations, QCS under cover of a memorandum dated 30 August 2009.

The QCS investigation identified shortcomings in the TCC's response to Mr Clumpoint's collapse and death. It concluded that although CSO Wood was central to some of those, they were indicative of systemic deficiencies that impacted on TCC's ability to deal with a contingency situation. The QCS investigation made recommendations aimed at improving incident management at TCC and other recommendations with state-wide application.

I will deal with each of the QCS investigation findings and corresponding recommendations in turn and comment on the extent to which QCS and TCC have implemented those recommendations.

Testing and maintenance of cell intercoms

The QCS investigation found there were no systematic procedures in place at TCC for the testing and maintenance of cell intercoms.

Maintenance of the intercom systems at TCC is dealt with in a contract between the Department of Public Works and the manufacturer, Honeywell Pty Ltd. QBuild manages the overall performance of the contract, through weekly and monthly reporting by Honeywell and site audits.

The contract requires designated correctional centre officers to notify the Honeywell call centre of any breakdowns or faults. Honeywell is required to respond to urgent and high priority notifications within 0.75 – 3 hours during normal working hours and within 1.5 – 3 hours outside normal working hours.

The current TCC General Manager, Mr Andrew Pike, stated that intercoms were installed in CMU prior to them being commissioned on 4 January 2000 and from this time, TCC experienced a consistent level of intercom faults of varying types. Over 27 February 2009 – 24 June 2009, 32 intercom faults were recorded, with 12 of those isolated to the CMU.

Mr Pike considered that in the context of an intercom system of the type and size of that at TCC, the level of reported faults was not excessive or indicative of a broader problem with the intercom system.

Whilst I consider it was reasonable for TCC to rely on the contractual arrangements for reporting the fault with Mr Clumpoint's cell intercom, I consider that CSO Schellhorn's urgent maintenance request could have been actioned sooner than 10 June 2009 and the contractor's ongoing investigation of the intercom faults in CMU could have been more effectively monitored by TCC.

The QCS inspectors were critical of amendments made to the QCS Procedure – Maintenance of Safety and Security Equipment in June 2009 that required weekly checks of cell intercom systems and the immediate reporting of faults for rectification as soon as possible.

Consequently, they recommended that QCS review, research, design and implement a comprehensive documented state-wide regime for the maintenance and testing of cell intercoms.

A statement provided by the Deputy Commissioner of QCS Custodial Operations, Ms Marlene Morison, indicates that the QCS Procedure – Maintenance of Safety and Security Equipment was subsequently amended to direct how intercoms are to be checked on a weekly basis, tested and maintained.

The amended procedure requires the General Manager to establish a local process to ensure all cell intercoms are tested each week. It directs how the test results are to be recorded and reported and requires shift supervisors to check the Honeywell fault register on a weekly basis. It directs how faults are

to be reported and documented. It also requires officers to demonstrate their competency and understanding of cell intercom testing requirements.

The amended procedure was accepted by the QCS Incident Oversight Committee and implemented on 1 April 2010.

Mr Pike states that the TCC has since implemented a testing matrix for all accommodation intercoms and a process for recording faults via a daily electronic systems reporting framework. It records all intercom calls made every night as a test and the control room operator tests the intercom for one cell from each accommodation unit every night and records these results in the control room operator log.

I am satisfied with the evidence from both Mr Crothers and the current manager Mr Pike of the appropriateness of state-wide and local response.

I consider these measures will help ensure cell intercom faults are identified, reported and monitored more effectively by correctional facilities.

Use of cells with a faulty intercom

Clearly, it was not optimal for Mr Clumpoint to be accommodated in a cell with a faulty intercom. It was unsatisfactory that consideration had to be given to move Mr Clumpoint away from his family member and established support due to a faulty intercom. The priority should have been to repair the intercoms. However, I consider the attempts made by TCC officers and staff to encourage Mr Clumpoint to relocate to a cell with a working intercom or to the medical centre, were reasonable and appropriate, and sensitive to Mr Clumpoint's strong desire to remain where he was comfortable, with members of the Palm Island community. Unfortunately by the time Mr Clumpoint was persuaded to move to accommodation closer to the medical centre, there was no alternative accommodation available.

The QCS inspectors recommended that QCS include as a state-wide documented practice, a direction that a secure accommodation cell identified as having a faulty intercom must not be used for prisoner accommodation.

Ms Morison states that on 30 September 2009, all General Managers were issued with a direction to this effect. The QCS Procedure – Maintenance of Safety and Security Equipment was subsequently amended to incorporate this requirement. It requires the cell to be recorded as unserviceable on IOMS until the fault has been rectified.

The amended procedure was accepted by the QCS Incident Oversight Committee and implemented on 1 April 2010.

I acknowledge the appropriateness of Mr Pike's overall responsibility to direct inmates regarding accommodation. This includes the necessity to move an inmate against their will to other accommodation where circumstances dictate this.

Ms Morison rightly acknowledges there will be some situations such as a systemic failure or fault affecting a number of cells simultaneously, where it will not be feasible to remove prisoners from affected cells. In these circumstances, other possible risk mitigation strategies include deployment of staff to the affected unit to regularly check on prisoner welfare, additional patrols by staff in affected units and the use of available CCTV capability to monitor prisoners.

I consider these measures will ensure that prisoner safety and welfare is not compromised by cell intercom faults, which I acknowledge will continue to occur from time to time in a correctional setting.

Mr Pike states that TCC has since designated a residential unit close to the medical centre as a special carers' unit for prisoners with medical conditions and designated inmate carers.

Mr Pike explained that this facility is simply the closest unit to the medical centre that has a designated prisoner carer to assist other prisoners if necessary. I note there is no formal process for the assessment of prisoners for placement in this unit, but rather an informal arrangement managed by the Residential Accommodation Manager and the Nurse Unit Manager.

I consider the designation of a special carers' unit proximate to the medical centre is a sensible and sensitive measure to deal with prisoners like Mr Clumpoint who are unwilling to transfer to the medical centre. It also ensures the efficient allocation of medical centre resources and accommodation to prisoners who need it most, noting that the medical centre only has capacity to accommodate two prisoners requiring intensive nursing and medical care. I note this arrangement occurs in some correctional facilities. It is not aimed to replace appropriate necessary medical care but to assist elderly and infirm inmates with willing peer support. I note the overall strategic planning by QCS for an aging prisoner population.

Early unlocks

The QCS inspectors considered the decision to remove both of the night shift officers assigned to CMU to assist with early unlocks in another unit was unsound from a prisoner safety perspective, particularly when officers and management were aware of the intercom problems in CMU. They did not make any recommendations in this regard.

I note Mr Pike considered the night shift staffing levels were sufficient to enable a fluid and timely response of under two minutes from anywhere in the centre in the event of an incident.

Response to garbled or inaudible intercom calls

The QCS inspectors found there were no procedures in place at TCC for dealing with inaudible or 'garbled' intercom calls from prisoners.

The investigation report rightly acknowledges there could be a number of reasons why a cell call could be inaudible or not understandable at the

receiving end, including technical faults, background noise, English language difficulties and a prisoner being unable to speak clearly or at all.

The QCS inspectors recommended that QCS implement a uniform state-wide practice that ensures inaudible or 'garbled' intercom calls from prisoners are dealt with in a responsive and timely manner.

Ms Morison states that on 30 September 2009, all General Managers were directed to establish local practices to ensure inaudible or garbled calls from prisoners were addressed in a responsive and timely manner and to incorporate this practice in training programs for control room operator accreditation training.

Mr Pike states this direction has been given to staff and incorporated in duty statements, which require staff to respond immediately to these calls.

I accept the evidence from Mr Crothers and Mr Pike that there is now an appropriate local response to the state-wide recommendation.

Assessment of CSO Wood's actions

The QCS inspectors considered that CSO Wood made mistakes that resulted in delays to the provision of aid to Mr Clumpoint.

These mistakes included CSO Wood:

- not responding to the first cell call from Mr Chapman;
- not checking to see who occupied the cell indicated on the cell call monitor;
- not attempting to clarify the situation with the caller after a prisoner is heard on the open intercom to ask where "these characters" are;
- not calling a Code Blue immediately after receiving the second cell call from Mr Desatge;
- not conveying any information to health services staff about the nature of the emergency or which prisoner was involved, as required by the QCS Procedure – Emergencies; and
- losing track of RN Featherstone when she was stopped at Gate 6 near the Village, which fell short of his obligation under the QCS Procedure – Emergencies to ensure clinical staff are given direct and speedy access to prisoners, regardless of location.

The QCS inspectors considered that given the position of Master Control plays a critical role in the management of incidents within a correctional centre, it is essential that all staff who perform this role be fully conversant with the 'technology' under their control and the operational processes to be followed by them and staff responding to the incident. Consequently, they recommended relevant staff receive refresher training in all aspects of Master Control duties and certification of this training be signed off by a senior officer and recorded on file.

Having regard to Mr Pike's evidence about the nature and regularity of Master Control training provided at TCC, I am satisfied this recommendation has been appropriately implemented at TCC.

I note the QCS investigation report did not recommend that QCS review CSO Wood's performance or take disciplinary action against him. Counselling and training has been undertaken to address this issue.

I accept the QCS inspectors' rationale that this action was not warranted because the issues experienced in responding to this incident related more to systemic deficiencies at both a local and State-wide level, rather than poor performance or misconduct by CSO Wood or any other officer involved in the incident.

I note that CSO Wood was informally counselled by Mr Pike about his conduct during the incident and has since completed refresher Master Control training.

Assistance to clinical staff

The QCS inspectors found that RN Featherstone needed, and should have been provided with, the assistance of a CSO to respond to the Code Blue call. They acknowledged that medical centre staff can experience difficulty manoeuvring medical response trolleys and gurneys, particularly when trying to negotiate the heavy gates at TCC.

They noted that RN Featherstone did not have the immediate assistance of a CSO, though one eventually helped her of his own volition.

Consequently, they considered that in the event of a medical emergency at any correctional centre, a CSO should be assigned immediately to assisting responding clinical staff.

I accept this issue has been appropriately dealt with at the local level. Differences exist across the state within correctional facilities which mean this is an issue best dealt with at the local level.

Assessment of TCC's ability to deal with a contingency situation

The QCS inspectors found that TCC did not have formally documented and endorsed plans for, or a structured annual training program directed at, dealing with contingency situations such a medical emergency or a death in custody or any other credible contingency.

I note this is despite the requirements of a number of QCS procedures relevant to the circumstances of Mr Clumpoint's death including that for contingency planning, which requires correctional centres to develop a risk analysis program and develop individual contingency plan responses to identified risks.

The inspectors found that the officers they interviewed were generally unclear about who should do what in the event of an emergency. They remarked on a

lack of co-ordination and control of the incident, exemplified by the fact two 000 calls were made for an ambulance.

Consequently, they recommended the TCC General Manager:

(a) conduct a risk analysis program in accordance with the QCS Procedure – Contingency Planning and then develop and promulgate necessary contingency plans and checklist setting out staff position responsibilities in response to emergency situations on both day and night shifts (including but not limited to the management of deaths in custody); and

(b) develop and implement an annual training and exercise program concerning TCC responses to credible contingency situations which could occur in the Centre.

I note Mr Pike's evidence that the risk analysis was undertaken in April 2010 and resulted in a full review of the few contingency plans that had been implemented after Mr Clumpoint's death. Fifty-two local procedures have been developed for TCC and cover an appropriate range of contingency situations across all three divisions of the centre. I note although most of them are to be published on the agency intranet in the near future, all of the plans are currently operational. Further, Mr Pike provided evidence that an annual training and exercise plan is currently being implemented. I am satisfied that TCC has adequately implemented these recommendations.

Assessment of TCC's compliance with relevant QCS protocols

The QCS inspectors assessed TCC's compliance with six QCS Procedures relating to medical emergencies, first officer response to a medical/assault incident, scene preservation, emergencies, deaths in custody, contingency planning and incident reporting.

Apart from the major deficiencies identified in respect of TCC's contingency planning, I consider the only other deficiency of significance was failure to manage Unit 5B as a crime scene, as required by the Preservation of a Crime Scene and Evidence procedure.

The other five prisoners from Unit 5B were relocated to Unit 5A during the attempted resuscitation, without being searched, clothing secured, separated or being placed under direct supervision.

Whilst I accept this oversight did not compromise the investigation in this instance, failure to comply with this procedure in future incidents could result in the loss of crucial evidence.

I am mindful of the State Coroner's very recent recommendation that the Queensland Corrective Services Commissioner seek the assistance of the Queensland Police Service Corrective Services Investigation Unit to review existing policies for crime scene and evidence preservation at all correctional centres and where necessary assist in the provision of training to CSOs.

It is hoped the annual contingency situation training program for TCC staff will achieve an improved understanding by staff of the importance of compliance with relevant QCS and local procedures in incidents such as this.

Assessment of TCC's post-incident response

Finally, I acknowledge that the QCS investigation also commended the range of culturally sensitive post-incident management measures instituted by the TCC General Manager, Mr John Harrison, to help prisoners and the Palm Island and wider indigenous community generally to understand and come to terms with Mr Clumpoint's death.

Adequacy and timeliness of the emergency response to Mr Clumpoint's collapse

Mr Chapman's evidence suggests Mr Clumpoint collapsed and stopped breathing shortly before he made the first cell call at 5:27:46am.

CPR was not administered to Mr Clumpoint until shortly after the CSOs arrived on the scene at 5:36:13am, approximately nine minutes later. It appears Mr Clumpoint was not breathing and without a pulse during this nine minute interval. Mr Chapman and Mr Desatge were understandably panicked in the situation and rightly expected that help was not far away.

CPR was administered until RN Featherstone determined that Mr Clumpoint was in asystole and could not be revived.

The QCS investigation found the officers involved in the first response fully complied with the requirements of the QCS First Officer Response – Medical and Assault procedure. I agree with the inspectors' assessment that CSOs Thomas and Bell made every possible effort to revive Mr Clumpoint at the scene.

Dr Mahoney was asked to review the adequacy of the emergency medical response. He considered that the severity of Mr Clumpoint's upper airway obstruction revealed at autopsy was such that the timeliness of the emergency response had no bearing on the outcome, as no resuscitative measures available outside a hospital environment, where an emergency percutaneous tracheotomy could only be performed, would have been successful in this case. Dr Mahoney commented that nothwithstanding the delays, Mr Clumpoint received a more rapid response than he would have had he collapsed in the general community.

Whilst I accept Dr Mahoney's opinion that in this case delays in the emergency medical response did not contribute to Mr Clumpoint's death, it is clear resuscitative efforts could have been commenced considerably faster had a Code Blue been called after Mr Chapman's initial cell call and RN Featherstone could have been on scene at least three minutes earlier, had she not been stopped at a locked gate. It is trite to say the response time to any medical emergency regardless of where it occurs, needs to be as short as possible to maximise successful resuscitation outcomes.

I consider that the QCS investigation has appropriately identified the causes of the delay in this case and that action taken by TCC and QCS in response to the findings and recommendations of that investigation will satisfactorily address the systemic issues underlying the unfortunate convergence of events that delayed the emergency response in this incident.

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 Thomas Andrew Clumpoint who was born on 23 May 1969.

How he died – Mr Clumpoint died of natural causes while a prisoner at the Townsville Correctional Centre.

Place of death – He died in unit 5B (room 4) of the Chris McCann Units at the Townsville Correctional Centre.

Date of death – Mr Clumpoint died on 12 June 2009.

Cause of death – He died from laryngeal stenosis caused by laryngeal oedema due to squamous cell carcinoma of the head and neck.

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.

In this case, some of the issues identified by the QCS investigation warrant consideration from this perspective. I commend the Office of the Chief Inspector for its timely and thorough investigation of the circumstances leading up to Mr Clumpoint's death.

It is important to acknowledge that most of these deficiencies have been or are currently being addressed at both a local and whole of agency level. Both TCC and QCS are to be commended for their efforts in this regard.

I will simply record what I understand to be the Department of Community Safety response to the following issues:

1 Where there is a defective intercom in an inmate's cell, it is deemed unserviceable and not to be used until rectified. This is always subject to the overall responsibility of the General Manager to direct inmates' accommodation. This acknowledges the possibility that circumstances could arise where multiple cells have difficulties with the intercom which would require other staffing responses to ensure safety. Community Safety acknowledges this a state wide issue.

2 Where there is an undecipherable intercom communication from a cell or unit, Community Safety has acknowledged there must be an immediate response to establish what is occurring. Local and state wide directions have been established.

3 I note Community Safety's overall planning and acknowledgement of the increasing population of aged and infirm inmates. I note the local response at TCC where a designated care unit has evolved. This aims to provide peer support in non medical general assistance roles. I accept this issue of an aging inmate population is being addressed by Community Safety at a state level.

4 Emergency access to inmates and the prison facility itself by staff and external agencies must be facilitated and enabled. Community Safety is ensuring state wide and local reviews to reduce any possibility of delay.

5 Compliance with scene preservation requirements where there has been a death in custody must be complied with irrespective of whether or not the death is considered to be due to natural causes. Community Safety acknowledges the importance of adherence to these requirements.

6 Overall contingency planning is being addressed at TCC, but is was conceded by the QCS Inspector that this is an area which requires state wide review and direction to local facilities to review their preparedness for a range of contingencies which could impact on the safety and good order of prison facilities. This should be a matter of priority.

I thank all those who have participated and assisted in this inquest which is now closed.

Christine Clements
Deputy State Coroner
Townsville
27 August 2010