OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Allan Clive Millard**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 5830/07(9)
DELIVERED ON:	15 April 2010
DELIVERED AT:	Brisbane
HEARING DATE(s):	14 April 2010
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes; adequacy of access to medical treatment

REPRESENTATION:

Counsel Assisting:	Ms Ainslie Kirkegaard
Department of Community Safety:	Mr Kevin Parrott (Crown Law)

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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 Allan Clive Millard. 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 Millard was a 63 year old man who died suddenly at the Darling Downs Correctional Centre (DDCC) on 11 December 2007. At the time of his death, Mr Millard was serving a four month custodial sentence.

Mr Millard was a heavy smoker and a heavy drinker. He didn't see a doctor regularly. He had declined medical examination on reception to DDCC and had neither sought nor required nursing or medical assistance during his short time in custody.

At approximately 1:25pm on 11 December 2007, another prisoner found Mr Millard lying on his bed in his cell in the Coolibah Unit. Mr Millard had a cut above his right eye. The prisoner could not wake Mr Millard and sought help from DDCC officers, who immediately called a Code Blue. A nurse attended Mr Millard's cell immediately. She found Mr Millard's pupils were fixed and dilated; he was not breathing and he had no pulse. The nurse pronounced him dead.

Because Mr Millard was in custody, his death was reported to the State Coroner for investigation and inquest.[1]

These findings:

- confirm the identity of the deceased, the time, place, circumstances and medical cause of his death;
- consider whether the actions or inactions of any person contributed to the death;
- consider whether the medical and emergency treatment afforded to Mr Millard while in custody were 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.

[1] 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. S27 requires an inquest be held in relation to all deaths in custody

The investigation

Detective Sergeant Gavin Pascoe, then of the QPS Corrective Services Investigation Unit (CSIU), conducted the investigation.

He and Scenes of Crime officer Sergeant Kech attended the DDCC at 2:14pm. They observed the door to Mr Millard's cell was closed and padlocked.

Mr Millard's body had remained *in situ* on the bed in his single occupant cell in the Coolibah Unit. A physical examination of Mr Millard's body, performed by the Detective Sergeant Pascoe, found a 10cm cut on Mr Millard's forehead above his right eye. There was blood on his right palm and on his abdomen. The examination did not reveal any other signs of suspicious injury or trauma. Mr Millard's body was photographed *in situ* during this examination.

Detective Sergeant Pascoe then searched the cell. The search revealed urine in the toilet basin; a small smear of blood on the shelf directly above the toilet and a small pool of about 5 millilitres of blood on the floor adjacent to where Mr Millard was found lying on his bed. There were also several blood spots on his pillow. The cell was photographed by Sergeant Kech during the search.

Sergeant Kech took swab samples at the scene and seized Mr Millard's bed linen. I note that Mr Millard's clothes were destroyed at the mortuary prior to the investigating officers attending the autopsy.

On the same day, Detective Sergeant Pascoe arranged for statements to be taken from all the correctives services officers who responded to the discovery of Mr Millard's body, as well as statements from all the prisoners housed in the Coolibah Unit. The prisoner interviews were recorded on audio tape.

Detective Sergeant Pascoe seized all prison records concerning Mr Millard, including his medical and offender files.

Police then accompanied Mr Millard's body to the Queensland Health Forensic and Scientific Services mortuary for autopsy.

Dr Janse Van Vuuren performed an external and full internal autopsy on the morning of 13 December 2007. The autopsy was observed by Detective Sergeant Pascoe and a member of the QPS Coronial Support Unit.

Mr Millard's body was formally identified by fingerprint examination. This was performed by Sergeant Paul Peacock, a qualified fingerprint expert.

Further inquiries made by CSIU about the circumstances of Mr Millard's death included obtaining Queensland Ambulance records, a statement from one of the advanced care paramedics who attended the scene and communication with one of Mr Millard's daughters.

I note that the investigation report was not finalised until nearly two years after Mr Millard's death. Given that it appears that almost all of the investigation

material was gathered in a timely manner, it is regrettable the investigation report was not finalised sooner. That aside, I consider that Detective Sergeant Pascoe conducted a thorough and professional investigation.

The Office of the State Coroner supplemented the findings of Detective Sergeant Pascoe's investigation by following up on Mr Millard's general medical history, initially through the medical practice identified by his daughter, and subsequently with records from the Redcliffe Hospital. Associate Professor Bob Hoskins, Director of the Queensland Health Clinical Forensic Medicine Unit, subsequently reviewed this material and the Queensland Corrective Services medical records to assess whether Mr Millard was given appropriate access to, and received adequate medical and emergency treatment while he was in custody.

The inquest

An inquest was held in Brisbane on 14 April 2010. Ms Kirkegaard was appointed as counsel to assist me. Leave to appear was granted to the Department of Community Safety.

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

Ms Kirkegaard submitted the material tendered was sufficient to enable me to make the findings required by the Act and there was no other forensic purpose to be served by the calling of any oral evidence. Mr Millard's family was advised that this was proposed and raised no concerns about this approach. I accepted that submission.

The evidence

I turn now to the evidence. Rather than summarise all of the information contained in the exhibits, I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal background

Mr Millard was born in Lismore, New South Wales on 19 November 1944. He was one of 11 siblings, some of whom were adopted. He was very close to his sister Alice and her son Johnny, who was born with disabilities. He also lived with his brother Reg during the later years of his life. He finished school at 13 years of age and readily acknowledged that he had difficulty reading and writing.

Mr Millard married and had four children from that relationship. The family moved to Queensland when the children were quite young. They spent many years in the Sandgate area where Mr Millard worked as a panel beater and spray painter. He held a truck licence as well as licences to operate a borer, bulldozer, backhoe, excavator and a bob cat. He had been on a disability pension for about six years prior to his imprisonment.

Mr Millard was a keen fisherman and also developed an interest in horseracing, as he lived next door to a well known Brisbane horse trainer.

Mr Millard and his wife separated about twelve years ago and ultimately divorced several years before his death. Mr Millard lived on Bribie Island with his brother Reg for while, before moving to the Bundaberg region where they bought a block of land at Gin Gin. Mr Millard was grandfather to seven grandchildren.

Mr Millard's daughter described her father as a very generous man, who gave freely of himself to other people, even though he didn't have much in a material sense. He often took troubled folk under his wing and in the later years of his life, was the beneficiary of reciprocal support from these friends.

Mr Millard's oldest daughter visited him regularly while he was in custody. He also had regular telephone contact with several family members during this time. His younger daughter wrote to him in prison and marked her letters to the attention of "Pops Millard". Statements from several of his fellow inmates at DDCC indicate that they adopted this nickname for Mr Millard.

Basis for imprisonment

Mr Millard had a significant traffic history going back to 1983 with convictions for speeding, unlicensed driving and other minor traffic violations. He also had a number of drink driving convictions. He had a short criminal history going back to 1980 with convictions for receiving and possessing stolen property and drink driving. He did not serve time for these convictions.

At the time of his death, Mr Millard was serving a four month custodial sentence for convictions of unlawful possession of a motor vehicle and bringing stolen goods into Queensland. He was initially sentenced to two years imprisonment for these offences, starting on 21 September 2007. His appeal to the Bundaberg District Court was allowed and on 12 October 2007, he was resentenced to 18 months imprisonment suspended for two years after serving four months imprisonment. Consequently, Mr Millard was scheduled for release on 19 January 2008.

Mr Millard started serving his sentence at the Maryborough Correctional Centre. He was classified as a low security prisoner and transferred to the DDCC on 16 October 2007, where he remained until his death on 11 December 2007. He was housed in the Coolibah Unit during this time.

Mr Millard's recent medical history

The QCS medical records show that when Mr Millard was received at the Maryborough Correctional Centre on 21 September 2007, he disclosed that he was a heavy smoker (30 cigarettes a day) and a heavy drinker (six tall beers a day). Mr Millard advised that he suffered shortness of breath which he attributed to having worked as a spray painter. Although he had been prescribed Ventolin for this condition, he did not use it. Mr Millard also advised that he was deaf in his right ear; had been referred to an orthopaedic surgeon

to review possible tendon damage in his right shoulder and that he had steel pins in his left knee as the result of injuries sustained in a bulldozer accident. He was not taking any medication at that time.

These medical records show Mr Millard did not seek or require any nursing or medical assistance while he was at the Maryborough Correctional Centre.

Mr Millard was interviewed by Clinical Nurse Lorraine Blackey on his reception at the DDCC on 16 October 2007. Her entry in the QSC medical records on 17 October 2007 notes his significant history of alcohol abuse. It also records a conversation with his daughter, who advised that Mr Millard had been passing blood in his stools for several years. It appears that Ms Blackey followed this up with Mr Millard, as her notes record he declined to see the visiting medical officer. He was not taking any medication at that time.

The QCS medical records show that Mr Millard did not seek or require any nursing or medical assistance before the day of his death at the DDCC. It appears that he had been started on Nicorette patches on 27 October 2007 but there is no record of this continuing beyond the first issue.

After being informed of Mr Millard's death, his daughter mentioned to police that her father did not see doctors very often. She believed he had last seen a general practitioner at the KippaRing Medical Centre, but was not sure when.

Subsequent enquiries conducted by the Office of the State Coroner revealed that Mr Millard was not a patient of the KippaRing Medical Centre but had been treated at the Redcliffe Hospital. The Redcliffe Hospital medical records show that Mr Millard was in fact a patient of the Redcliffe Peninsula 7 Day Medical Centre.

The Redcliffe Hospital medical records show that over the years, Mr Millard's general practitioner had referred him to the Redcliffe Hospital for further investigation of a number of health complaints.

The Redcliffe Hospital medical records confirm Mr Millard's long history of heavy drinking and smoking and shortness of breath. I note there is also an isolated reference to a history of angina and epilepsy, but these conditions do not appear in the medical histories reported in his general practitioner's letters of referral to the hospital over the years. Mr Millard did not disclose either of these conditions in his medical reception histories.

Discovery of Mr Millard's body

Statements taken from all the prisoners housed in the Coolibah Unit did not indicate anything to suggest that Mr Millard had been unwell in the days prior to his death.

On the evening of 10 December 2007, Mr Millard was seen playing cards in the kitchen, after having cleaned up after dinner. He was observed to be quite cheerful at this time.

A statement from inmate Adrian Watson indicates that he seen and spoken with Mr Millard several times on 11 December 2007. The first occasion was at about 8:30am – 9:00am when Mr Millard made him a cup of coffee and they had a general chat. Prisoner Watson was in a detention unit cell when this occurred. Mr Millard drank his coffee and appeared happy at this time.

The second occasion was when Mr Millard came back to the detention unit at around 1:00pm and offered to make prisoner Watson another coffee. Mr Watson states Mr Millard "looked alright" at this time. He then saw Mr Millard walk off to his cell.

At approximately 1:20pm, fellow Coolibah inmate Jason Logan returned to the unit from work at the prison dairy. He went into the kitchen and made a coffee. He was aware there were other prisoners in the block at this time, but did not pay any attention to who they were, other than prisoner Watson who he saw sitting out the front of his detention unit cell. He states that he did not see any of the other prisoners near Mr Millard's room at this time.

It was Mr Logan's habit on returning from the dairy to make a coffee and then go and talk to Mr Millard in his cell. Mr Watson states that prisoner Logan offered to make him a coffee, which he declined because he had just finished one with Mr Millard. He then saw Mr Logan go into Mr Millard's cell. Mr Watson states that he couldn't see anyone else in the yard or in their cells in the block at that time.

Mr Logan states that as he approached Mr Millard's cell, he could hear a clicking noise that seemed to be coming from near Mr Millard's cell. He placed his coffee cup on a table outside the door to Mr Millard's cell and walked inside.

On entering Mr Millard's cell, Mr Logan realised that the clicking sound was coming from a fan on a desk situated to the left immediately inside the door. He saw that the fan was not oscillating because it was stuck against a shelf immediately above it. He moved the fan to stop it clicking. As he turned away from the fan, he noticed Mr Millard lying on his left side on the bed, with his head at the foot of the bed. Mr Logan saw what he described as a 2-3cm long bloody cut above Mr Millard's right eyebrow.

Mr Logan tried to rouse Mr Millard by first touching and then shaking his right shoulder, while saying "Pop" several times. Mr Millard did not respond. Mr Logan then left the cell to get an officer.

Mr Logan estimates that he was in Mr Millard's cell for no longer than half a minute. This is consistent with Mr Watson's observation that prisoner Logan "popped his head in with Pops".

Messrs Logan and Watson gave differing accounts about whether prisoner Logan checked Mr Millard's pulse before or after he sought help from an officer. I prefer Mr Logan's account that he immediately sought help from food services officer Warren Gleeson, who was just walking into the unit, before he

went back to Mr Millard's cell and checked Mr Millard's pulse. This is consistent with Mr Gleeson's account that as he entered the Coolibah unit at approximately 1:25pm, he was approached by Mr Logan who asked him to look at a prisoner who had fallen and hit his head and couldn't be woken. Mr Gleeson immediately alerted CSO Grant Abraham, who was nearby, and together they attended Mr Millard's cell where they both saw Mr Logan check Mr Millard's pulse.

Mr Logan could not find a pulse. He noticed that Mr Millard's skin was cool to touch, his lips were blue and his eyes half open and glazed. CSO Abraham immediately radioed a Code Blue. This occurred at approximately 1:30pm. Neither Mr Gleeson nor CSO Abraham entered the cell. Their observations of the position of Mr Millard's body, the cut on his forehead and the small pool of blood on the floor adjacent to the bed are consistent with prisoner Logan's initial observations of the scene.

Emergency medical response

Five CSOs and Clinical Nurse Blackey responded almost immediately to the Code Blue.

Nurse Blackey examined Mr Millard. She noted that his pupils were fixed and dilated, he was not breathing, his extremities were mottled and she could not detect any heart sounds. Nurse Blackey pronounced Mr Millard dead at 1.33pm. She asked for the ambulance to be called and closed the door to his cell.

QAS records show that they were contacted at 1:37pm. One unit was dispatched at 1:39pm and arrived at the DDCC at 1:50pm. Paramedics assessed Mr Millard at 1:52pm. Their examination confirmed that Mr Millard was dead.

DDCC response following pronouncement of Mr Millard's death

Immediately after Nurse Blackey concluded Mr Millard was dead, the CSO officers in attendance took action to start a running log; secure the scene; secure and account for all prisoners in the centre and identify and secure all prisoners in the block at the time of the incident, in the kitchen.

The CSOs observed Mr Logan was quieter than usual but they did not see any blood on him or other signs of suspicious injury. Mr Logan was secured and spoken to separately from the other Coolibah prisoners. His statement to Detective Sergeant Pascoe is consistent with the account he gave to CSO Neill Crothers at this time. His clothes were later removed and bagged as evidence. Mr Logan was kept under supervision until he was later interviewed by police.

At about this time, prisoner Watson told CSO Joe Korts about his recent conversation with Mr Millard and that after Mr Millard went off to his cell, Watson had not seen or heard anything to indicate there was a problem.

CSO officers searched the unit but did not find any evidence of interest.

All of the Coolibah prisoners were strip searched and their clothing removed and individually bagged as evidence before they were transferred out of the Unit while the CISU investigation continued.

Cause of death

Dr Janse Van Vuuren performed an external and full internal autopsy on the morning of 13 December 2007.

External examination showed two superficial lacerations on the right lateral upper brow but noted no other recent injuries. Internal examination showed no major subcutaneous injury of the scalp and no skull or brain injuries.

Internal examination revealed severe atherosclerosis of the coronary arteries, which was subsequently confirmed by histology. There was some fibrosis of the heart, but no sign of acute ischaemic changes. The lungs had emphysema and heavy pigment change, consistent with smoking. The kidneys had cysts and the blood vessels had thickened walls, consistent with hypertensive changes.

Toxicological examination detected no alcohol or drugs in the blood or urine.

On the basis of these findings, Dr Janse Van Vuuren concluded that the cause of Mr Millard's death was ischaemic heart disease due to coronary artherosclerosis. He considered that his findings were consistent with the circumstances outlined in the police report of the death. He found nothing to indicate that any other person was involved in Mr Millard's death.

Adequacy of medical and emergency treatment provided to Mr Millard

Dr Bob Hoskins, Director of Queensland Health's Clinical and Forensic Medicine Unit (CFMU) was asked to review the QCS and Redcliffe Hospital medical records to assess the adequacy of the medical and emergency treatment provided to Mr Millard while he was in custody.

Dr Hoskins advised he did not have any concerns in this regard.

Investigation findings

Mr Millard's body was formally identified by fingerprint examination, performed by a qualified fingerprint expert.

Physical examination of Mr Millard's body in situ revealed no signs of injury or trauma, other than the cut to his forehead.

I note the advice of correctional services officers to CISU that Mr Millard had not been involved in any previous altercations with other prisoners.

I note that Mr Millard had several friendly exchanges with a fellow Coolibah inmate on the day he died, the last of which took place about half an hour before Mr Logan found Mr Millard's body.

Mr Watson, the last person to have seen Mr Millard alive, stated that after he saw Mr Millard walk off to his cell, he did not see or hear anything to suggest there was a problem.

A search of Mr Millard's cell did not reveal any signs of a struggle and Mr Millard's belongings did not appear to have been disturbed. A wider search of the Coolibah Unit by corrective services officers revealed no signs of assault or anything else suspicious.

Autopsy examination confirmed that there were no recent injuries, other than two superficial lacerations to Mr Millard's upper right brow. The examination revealed severe coronary atherosclerosis. The pathologist found nothing to indicate that any other person was involved in Mr Millard's death, which he considered to have been caused by ischaemic heart disease due to coronary atherosclerosis.

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

I note that the police report of Mr Millard's death references Nurse Blackey's conjecture that Mr Millard collapsed forward while urinating and hit his head on the shelf that was fixed at about head height above the toilet. She thought that he may have then sat down on the bed, stood up again and finally collapsed back onto the bed into the position in which his body was found by Mr Logan.

Having regard to the autopsy findings, the nature of his injury and the location of blood smears on the shelf above the toilet and the small pool of blood on the floor adjacent to where his head finally came to rest, I consider this to be a plausible explanation of the circumstances in which Mr Millard died.

Independent medical review confirmed that Mr Millard had appropriate access to medical treatment while he was in custody. It also confirmed the adequacy of the emergency medical response to the discovery of Mr Millard's body.

Coronary atherosclerosis is a very common cause of sudden death. I consider that the attempts to take Mr Millard's medical history on his reception to both the Maryborough and Darling Downs Correctional Centres were reasonable and appropriate. I note Dr Hoskin's comment that the material he reviewed hinted at a man who was something of a stoic and probably didn't complain

much. It is reasonable to suggest that even had Mr Millard been feeling unwell on the day of his death, it does not appear to have been in his nature to complain or seek medical assistance.

I consider that the DDCC officers responded quickly and appropriately to the discovery of Mr Millard's body and to Nurse Blackey's subsequent pronouncement of his death.

Findings required by s45

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

Identity of the deceased – The deceased person was Allan Clive Millard who was born in Lismore, New South Wales on 19 November 1944.

How he died – Mr Millard died of natural causes while a prisoner at the Darling Downs Correctional Centre.

Place of death – He died in his cell (number 24) in the Coolibah Unit of the Darling Downs Correctional Centre.

Date of death – Mr Millard died on 11 December 2007.

Cause of death – He died from ischaemic heart disease due to coronary atherosclerosis.

Comments and recommendations

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

I have found that Mr Millard died suddenly of natural causes and that the response to the discovery of his body was timely and appropriate. There was no basis to be critical of the health care afforded him while in custody.

In the circumstances, I consider there is no basis on which I could make any preventative recommendations.

I close the Inquest.

Michael Barnes
State Coroner
15 April 2010