OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Gordon Currie**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	2013/1413
DELIVERED ON:	2 December 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	29 November 2013
FINDINGS OF:	Christine Clements, Deputy State Coroner
CATCHWORDS:	CORONERS: Inquest – Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Ms E Cooper, Office of the State Coroner
Corrective Services:	Ms H Vickers, Qld Corrective Services

Introduction

Gordon Currie was born on 27 November 1954 in New South Wales. He died on 22 April 2013 when he was aged 58. He died in the Palen Creek Correctional Centre, at Palen Creek in Queensland.

Mr Currie was an inmate at the correctional centre. On 24 April 2007 he was sentenced to two years custody for 14 charges relating to break and enter, wilful damage, unlawful use of a motor vehicle and fraud matters. Mr Currie was released on parole on 23 April 2008 but failed to comply with the terms of his parole. He was re-sentenced on 30 April 2012 and was due to be released from custody on 25 April 2013. He died three days prior to his scheduled release.

Death in custody

Mr Currie's death was a death in custody in accordance with the *Coroners Act 2003*.[1] He was in detention under authority of a court order at the time of his death. In accordance with legislative requirements, an inquest must be held.[2]

The independent review of the coronial jurisdiction is an important mechanism to ensure a transparent examination of the circumstances of the death of every person held in detention. This ensures the family of the deceased can be fully informed. The coronial process also assists in maintaining public confidence in the custodial system. Finally, the process allows independent review of custodial officers as well as those responsible for the health and medical care of inmates.

Notification and investigation

Mr Currie's death was formally reported to the Office of the State Coroner on 23 April 2013. Detective Sergeant Michael Anderson was at the time working with the Corrective Services Investigation Unit. He was the officer who investigated the circumstances of Mr Currie's death in custody and the author of the report to the coroner.[3] Detective Sergeant Anderson gave evidence at the inquest.

He was notified of Mr Currie's death by custodial correctional supervisor Leonie Mercer at 12:15 on 22 April 2013. Detective Sergeant Anderson, together with Detective Senior Constable Brendan Anderson, attended the Palen Creek Correctional Centre on Mt Lindesay Highway at Palen Creek. They were at the scene before 14:30 that afternoon. Mr Currie had been declared deceased at 11:25 that morning.

Events of 22 April 2013

At about 08:00 in the morning, Mr Currie and another inmate named Larry Manager were directed to work in the banana plantation which was

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[1] Section 10
[2] Section 27(1)(a)(i)
[3] Exhibit A6

approximately 1.2 kilometres from the correctional centre. They were driven to the plantation by correctional officers who then left them to their assigned tasks.

It was clear both inmates were considered to be trustworthy to perform their work without direct supervision. There was an emergency contact radio available to contact the administration block if required.

Larry Manager was the only witness to the events that occurred at the banana plantation. He was interviewed by Detective Sergeant Anderson on 8 November 2013.[4]

The tasks to be undertaken by Mr Currie and Mr Manager included mowing the grass, whipper snipping around the trees, weeding, slashing, collecting and storing the bananas and constructing a wall. These were ongoing tasks and did not have to be completed on that particular day.

Mr Manager confirmed he knew Mr Currie as another inmate and also considered him a friend. He was not aware that Mr Currie had any health problems.

Mr Manager and Mr Currie made themselves a cup of tea when they arrived at the caravan facility at the banana plantation. Mr Manager then inspected the banana plantation and started mowing. Mr Currie commenced operating the whipper snipper.

After about an hour, Mr Manager ran out fuel and returned to the caravan. Mr Currie was there and complained to him of 'a bit of a pain in his left shoulder', but he said he was alright. Mr Currie said it was an old football injury. Mr Manager told him to take it easy and rest. He was not concerned as Mr Currie looked fine. Mr Manager said he would take over the whipper snipping and left Mr Currie to rest at the caravan.

When the whipper required refuelling, he returned to the caravan to obtain fuel. This was about an hour later. As he approached the caravan, Mr Manager saw Mr Currie lying on the grass on his back, with his hands in an open position near his shoulders. He appeared to be looking at the sky. Mr Manager called out to him but there was no response from Mr Currie and no movement. He realised there was something wrong as he got closer. Mr Currie looked very pale and his eyes were in an open fixed position. Mr Manager immediately went to the caravan and pressed the prisoner radio duress alarm. This was activated at 11:15. He then went back to check Mr Currie to ensure he had not swallowed his tongue. He checked for a pulse or sounds of breathing, but there was neither. He could not detect a heartbeat on placing his ear to Mr Currie's chest.

He tilted Mr Currie's head back and blew two breaths into his mouth before doing 30 chest compressions. He continued to do this until the arrival of two

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[4] Exhibit B8

correctional officers about two minutes later. They took over cardiopulmonary resuscitation until the nurse arrived a short time later.

Mr Manager observed clinical nurse Rosemary Ryan make a visual and physical examination of Mr Currie. She placed a defibrillator machine on Mr Currie but there was no shockable rhythm. The nurse confirmed there was no pulse, the pupils were fixed and dilated and there was no sign of breathing. She declared Mr Currie deceased and cardiopulmonary resuscitation was halted at 11:25.

Mr Manager confirmed the standard protocols were followed, namely the removal of all his clothing and photographing of Mr Manager and the swabbing of his hands and fingers. An initial electronic record of events described by Mr Manager was recorded that evening by Detective Sergeant Anderson.

Mr Manager stated he had no concerns regarding Mr Currie's sudden death. He did not blame anyone for his death. He knew that Mr Currie smoked but did not know anything about any medical condition.

Statements from the attending Corrective Service Officers confirmed they saw Mr Manager performing cardiopulmonary resuscitation on Mr Currie when they arrived at the scene at about 11:20. They also observed Mr Currie's hands and face were blue.

The ambulance service had been notified of Mr Currie's collapse and two vehicles attended at 12:00 and 12:09. They did not instigate any treatment as by this time the clinical nurse had declared Mr Currie deceased. They confirmed there were no signs of life.

Investigation by Corrective Services Investigation Unit

Upon notification of Mr Currie's death, Detective Sergeant Anderson directed preservation of the scene until his arrival. The scene at the banana plantation was examined. Detective Sergeant Anderson was satisfied there were no signs of a struggle or anything of a suspicious nature. Mr Currie was inspected where he lay. The defibrillator pads were still in place and there were no signs of injury or anything to suggest Mr Currie's death was other than due to unknown sudden natural causes.

Further investigations followed which confirmed Mr Currie was not known to have any issues with other inmates or correctional staff. The other inmate with whom Mr Currie was working on the day of his death, Mr Manager, was fully cooperative with police investigations including consenting to physical examination and collection of samples.

An examination of both Mr Currie and Mr Manager's cells did not reveal anything of interest or concern.

The 23 other inmates domiciled with Mr Currie in Block B were interviewed. No information was provided that would suggest a suspicious cause of death or any act of negligence.

Autopsy

On 24 April 2013 forensic pathologist Dr Rebecca Williams conducted an autopsy on Mr Currie's body. She documented scars and tattoos in her report. There were only two minor injuries noted. Both injuries were healing crusted abrasions on the posterior distal right forearm.

Internal examination did not detect any other injuries apart from broken ribs, commonly observed as a complication of cardiopulmonary resuscitation. There were signs in the lungs consistent with smoking. The most significant finding was of severe atheroma of the coronary arteries with 90% blockage of the right coronary artery, as well as the left anterior descending artery.

Radiology testing by CT imaging confirmed calcification in the coronary arteries, aorta and common iliac arteries.

Examination of tissue under microscope magnification confirmed severe coronary atherosclerosis and a thrombus (clot) in the left anterior descending coronary artery. Testing of blood samples confirmed Mr Currie was reactive for hepatitis C. No drugs or alcohol were detected.

Dr Williams noted Mr Currie's medical history was documented as:

- Hepatitis C infection.
- Cigarette smoking.
- Gastric reflux.
- Arthritis.
- Self-harm history.
- Recurrent ear infections.[5]

Dr Williams' report noted that coronary atherosclerosis was a common cause of sudden unexpected death and that smoking was a major risk factor for this to occur. She also expressed the view it was likely that the physical exertion further exacerbated the strain on the heart. The shoulder pain experienced just prior to death was likely to be referred pain from the heart.

The pathologist concluded Mr Currie died due to coronary atherosclerosis. I accept that conclusion.

Medical history

Detective Sergeant Anderson examined the records and confirmed Mr Currie was subjected to the normal medical questionnaire when he was received into custody of the Queensland Corrective Services on 4 May 2012.

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[5] Exhibit A5

He had access to medical services at Palen Creek and the only issue identified for which he received treatment was related to gastritis and gastric and duodenum ulceration. He was prescribed a daily dose of 20mg of Omeprazole. There was nothing in his known medical history suggesting heart disease.

Review of medical care

An independent review of Mr Currie's medical record was arranged by the coroner. Dr Nelle van Buuren, of the Clinical Forensic Medicine Unit, provided her report.[6] She noted Mr Currie's record included a history of attempted suicide, but there was no current mental health concern on admission to custody. A history of shoulder pain from a football injury as well as arthritis was recorded. Specifically, Mr Currie denied any cardiac condition, including chest pain or shortness of breath. His assessment did not reveal any medical condition which would be problematic for management. He was also identified as positive for hepatitis C, and as suffering from gastric reflux.

Dr van Buuren noted he was transferred to Palen Creek on 15 November 2012. On assessment by a clinical nurse, the guideline stated a mandatory electrocardiogram (ECG) was required for all inmates over 50, 'if clinically indicated'.

It is this issue which is the primary focus of review of Mr Currie's medical care.

The visiting medical officer at the time was Dr Michael Glover. His statement clarified that the decision whether or not to perform an ECG was made by the clinical nurse, who performed the initial assessment.[7] He noted there was no further detail to elucidate how the clinical nurse applied the guideline, 'if clinically indicated'. The clinical nurse exercised her decision-making responsibility and decided that Mr Currie did not require a baseline ECG. Had this been performed, the visiting medical officer would have reviewed it on the next visit.

Although Dr Glover had no memory of Mr Currie, the record shows that Mr Currie saw Dr Glover for the last time on 15 January 2013. Mr Currie was complaining about his chronic neck pain and was reviewed also regarding gastro-oesophageal reflux disorder. Dr Glover noted Mr Currie maintained a full range of movement and was tender at the C7 and T1 levels of his spine.

Dr van Buuren's review confirmed that the presence of tenderness in the neck did not suggest a cardiac cause for the pain.

Further independent review of medical care was provided by Dr Anthony Falconer, who was the Acting Director of Medical Services at Logan-Beaudesert Hospital. He previously acted as the Medical Director for Queensland Department of Corrective Services.

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[6] Exhibit C1
[7] Exhibit B12

Dr Falconer reviewed Mr Currie's medical records. He considered an ECG itself was a very poor screening tool for a person such as Mr Currie who had no symptoms suggestive of cardiac disease.[8]

Dr Falconer suggested a stress echocardiogram was much more likely to provide useful information in an asymptomatic person, but was more invasive and expensive. If such a screening mechanism were to be implemented it would only be feasible to do so in the larger correctional facilities with greater staff resources. This would be prior to any inmate being transferred to a smaller more remote facility such as Palen Creek.

Dr Falconer agreed with Dr van Buuren's reference to a higher mortality rate of inmates due to cardiovascular disease. He suggested more effective use of funding (than routine ECGs) would be education, improved diet and limitations on smoking for inmates. He also noted the high mortality due to cardiovascular disease of inmates reflected the over-representation of indigenous Australians who suffer a higher cardiovascular disease rate.

A statement was also provided by Dr Alun Richards, who formerly held the position of Director of Health and Medical Services for Queensland Corrective Services until the end of June 2008. The responsibility for medical care and the health of inmates passed to Queensland Health on 1 July 2008. The state wide service is within the division of the Chief Health Officer.

As part of this change in health services for prisoners, devolution to individual hospital and health services occurred.

During his time as Director of Health and Medical Services, Dr Richards instigated routine ECGs on targeted prisoners who were non-asymptomatic. He considered an ECG to be a cheap and non-invasive test that was capable of indicating previous or current heart problems. The procedure also established a baseline for comparison. He expected an ECG would be performed at the initial reception of a prisoner into Corrective Services custody, rather than on transfer to Palen Creek. He said this was the most appropriate time to enable transfer as required to a hospital.

He expressed the view that the absence of an ECG in an asymptomatic inmate such as Mr Currie would not be negligent.[9]

Dr van Buuren confirmed on her review of the medical records that Mr Currie consistently denied any symptoms associated with a cardiac health problem and he was within the normal range of testing for weight, blood pressure and heart rate. There was no evidence from any of the reviewing doctors suggesting that had an ECG been performed, it would have identified Mr Currie to be at risk of or suffering from ischaemic heart disease.

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[8] Exhibit B13
[9] Exhibit B14

Dr van Buuren noted symptoms for gastro-oesophageal reflux disorder can be similar to those indicating a cardiac problem, but she also noted the medication prescribed for the condition had achieved resolution and relief of Mr Currie's symptoms.

She concluded it was possible, and even likely that Mr Currie was asymptomatic regarding ischaemic heart disease/atherosclerosis. She agreed that it was not possible to say whether or not an ECG would have led to diagnosis of ischaemic heart disease.

Dr van Buuren noted it was the clinical nurse who declared Mr Currie deceased and made the decision that cardiopulmonary resuscitation could end. This was prior to the arrival of the Queensland Ambulance Service.

I do not consider this was inappropriate given the evidence Mr Currie had been examined by three people prior to the nurse's arrival. None of those people had detected any sign of life. Cardiopulmonary resuscitation had been performed from the time when he was first discovered on the ground. The nurse examined him and applied defibrillation pads which indicated there was no shockable rhythm.

Conclusion reached after medical reviews

In all of these circumstances I am satisfied that Mr Currie received appropriate medical care throughout his period of incarceration. He was assessed upon incarceration at Arthur Gorrie Correctional Centre on 14 May 2012 and on transfer to the Brisbane Correctional Centre on 28 May. He was next assessed on 20 July 2012 when he was transferred to the South Queensland Correctional Centre. Finally, he was assessed upon arrival at the Palen Creek facility on 15 November 2012.

I am also satisfied on all of the evidence that he received appropriate medical care on the day he died.

Review by the Queensland Corrective Services

Finally, I note the contents of the Queensland Corrective Services review.[10]

Two issues arose in the context of the review. The first was that the Correctional Services Officers who responded to the emergency duress callout initiated cardiopulmonary resuscitation without the use of protective equipment. I am satisfied that the review established this was due to the stress of the situation and their desire to assist rather than the lack of equipment or training to use protective masks. It is of course a significant health and safety issue for Corrective Services Officers.

The second issue was the Corrective Services Officers failure to recognise the caravan as part of the immediate scene which should have been declared part of the crime scene and preserved. This has been addressed with training.

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[10] Exhibit C2, not to be released

Findings

Section 45(2) of the *Coroners Act 2003* requires an investigating coroner to make findings if possible as follows:

(a) Who the deceased person is.
(b) How the person died.
(c) When the person died.
(d) Where the person died.
(e) What caused the person to die.

I find the deceased person was Gordon Currie born on 27 November 1954.

Gordon Currie died suddenly and unexpectedly after performing whipper snipping at the banana plantation at Palen Creek. He had been performing this task as directed for a period of about one hour. He complained to another inmate of pain in his left shoulder which he attributed to an old football injury. The other inmate took over the task of whipper snipping and left Mr Currie to rest at the caravan located in the banana plantation. One hour later, Mr Currie was found to be apparently deceased by Larry Manager upon his return.

Mr Currie died at approximately 11:15 on 22 April 2013. A Corrective Services clinical nurse declared him to be deceased at approximately 11:25 that day after cardiopulmonary resuscitation efforts by three people had been unsuccessful. The clinical nurse had applied defibrillation pads but found there was no shockable rhythm.

Mr Currie died at the Palen Creek Correctional Centre at Palen Creek in Queensland.

Mr Currie died due to coronary atherosclerosis which was previously undiagnosed. Coronary atherosclerosis is a common cause of sudden unexpected death.

It is concluded Mr Currie's death was due to natural causes. He died in custody. I am satisfied he received appropriate medical care throughout the period of his incarceration and on the day he died. There was no evidence to suggest his death was preventable.

In these circumstances no comments are required as I am satisfied Mr Currie's death was appropriately and thoroughly investigated both by the Queensland Police Corrective Services Investigation Unit and by Corrective Services itself.

Christine Clements
Deputy State Coroner
2 December 2013