QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Kelly PETER**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	COR 2013/4619
DELIVERED ON:	25 November 2014
DELIVERED AT:	Cairns
HEARING DATE(s):	24 November 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes
REPRESENTATION:	
Counsel Assisting:	Mr Peter Johns

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The *Coroners Act 2003* provides in ss. 45 and 47 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 John Kelly Peter. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

John Peter was 61 years of age when he was incarcerated in March 2013. At that time he was suffering numerous chronic health conditions, including congestive heart disease. That condition deteriorated rapidly throughout the course of 2013 and despite regular treatment in hospital, it led to his peaceful death on Boxing Day.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care adequately discharged that responsibility; 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

An investigation into the circumstances leading to the death of Mr Peter was conducted by Detective Senior Constables Amanda Watt and David Caruana from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). The report of DSC Watt report was tendered at the inquest.

Local police attended Lotus Glen Correctional Centre (LGCC) where they were advised Mr Peter had died in the medical facility. Those officers inspected Mr Peter's body and secured the area. Officers from Atherton CIB also attended along with a forensic services officer. Numerous photographs were taken of the body in situ and these were later tendered at the inquest. An incident log had been commenced by Queensland Corrective Service (QCS) officers and this was secured by police. Mr Peter's body was transported to the Cairns morgue where an autopsy examination later took place.

The CSIU officers attended LGCC on 27 December 2013 and inspected the medical centre and Mr Peter's cell. They took statements from prison and medical staff. They also took a statement from Wilfred Mooka, Mr Peter's nephew and fellow prisoner, who had acted as his carer up until his death.

Medical records were seized from LGCC and Mareeba and Cairns hospitals. These were supplied to the pathologist conducting the autopsy. A statement from the Senior Medical Officer at Mareeba Hospital was provided to the inquest. This set out the history of Mr Peter's chronic conditions and the steps taken to treat them while he was in custody.

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

The Inquest

An inquest was held in Cairns on 24 November 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from the investigating police officer, Detective Senior Constable Caruana.

Members of Mr Peter's family attended the inquest and I take this opportunity to extend to them my sincere condolences.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

John Kelly Peter was born on 21 May 1951 at Thursday Island making him 62 when he died. On 5 March 2013 he was convicted of a number of sexual offences which had occurred between 1993 and 2003. He was sentenced for the most serious offence to four years imprisonment. The sentences of imprisonment were to be suspended after he served 18 months imprisonment, with an operational period of five years.

On 6 March 2013 Mr Peter was received at LGCC where he underwent a medical assessment. That assessment and analysis of medical records established that he had many chronic medical conditions. Dr Margaret Purcell, a senior medical officer at Mareeba Hospital regularly treated Mr Peter in her capacity as a visiting medical officer at LGCC. She noted these conditions to include "*…diabetes, hypertension, heart failure, raised lipids and chronic hep B."* Dr Purcell stated that all relevant medication was provided to Mr Peter from the time of his reception at LGCC. Records indicate that Mr Peter remained compliant with his medication regime throughout his time in custody.

Events leading to death

On 13 April 2013 Mr Peter was transported to Mareeba Hospital where he was found to have a large right pleural effusion. This was tapped at Mareeba before Mr Peter was transferred to Cairns Hospital where he was admitted for further management.

Over the following months Mr Peter returned to hospital on a number of occasions to have the pleural effusion drained. It was noted by medical staff that the effusion was resulting from Mr Peter's congestive cardiac failure and ultimately decided that the repeated draining was not helping him. Focus turned to ongoing treatment for his heart failure, which involved regular admission to hospital during which he would be given diuretics and have his electrolytes corrected.

Over the second half of 2013 it became increasingly evident that Mr Peter was not responding to treatment. His heart condition was deteriorating with no obvious treatment options. In consultation with medical staff at Cairns and Mareeba on 7 December 2013 Mr Peter agreed to the implementation of a 'do not resuscitate' order. I am satisfied that the implications of this order and the other options available were explained appropriately prior to Mr Peter's consent being obtained.

In July 2013 Wilfred Mooka, Mr Peter's nephew, who was also in custody at LGCC, was moved into a nearby cell. Over the following months Mr Mooka provided daily care for Mr Peter as he became increasingly frail.

On Christmas day 2013 staff at LGCC contacted Dr Purcell to advise that Mr Peter had collapsed and his condition was deteriorating. Dr Purcell gave advice to nursing staff about appropriate management for Mr Peter. She knew it was Mr Peter's preference to stay at LGCC rather than being transported to hospital. On this basis Mr Peter remained in the palliative care of nursing staff and his nephew, Mr Mooka, until Boxing Day when, at 10:30am, he passed away.

Autopsy results

An external autopsy examination was carried out on 31 December 2013 by an experienced forensic pathologist, Dr Paull Botterill

Samples of blood were taken and sent for toxicological analysis. Dr Botterill examined Mr Peter's medical records before submitting his report.

After his initial assessment Dr Botterill agreed with the clinical assessment that Mr Peter had likely died from congestive heart failure caused by ischaemic heart disease. Dr Botterill predicated this opinion upon his receipt of toxicology results which he noted, when they were later received, did not indicate anything unusual.

Dr Botterill issued a certificate listing the cause of death as:

> *1(a) Congestive cardiac failure,* due to or as a consequence of,
> *1(b) Ischaemic heart disease.*
>
> Other significant conditions:
>
> 2. *Type 2 diabetes mellitus; chronic kidney disease*.

Conclusions

I conclude that Mr Peter died from natural causes. I find that none of the correctional officers or inmates at LGCC caused or contributed to his death.

I am also satisfied that the medical care provided to Mr Peter at LGCC and prior to his death was adequate and appropriate. In this respect I note that Mr Mooka, who had the opportunity to closely follow the course of Mr Peter's medical treatment, raised no concern about its adequacy.

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:

Identity of the deceased – The deceased person was John Kelly Peter.

How he died - Mr Peter died while he was in custody from natural causes after receiving adequate and appropriate medical care for his chronic medical conditions.

Place of death – He died at Lotus Glen Correctional Centre, Arriga in Queensland.

Date of death – He died on 26 December 2013.

Cause of death – Mr Peter died from congestive heart failure caused by ischaemic heart disease.

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.

Nothing has arisen on the evidence tendered at this inquest which warrants such comment.

I close the inquest.

Terry Ryan
State Coroner
Cairns
25 November 2014