QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kenneth Douglas Wright**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2015/1085
DELIVERED ON:	3 August 2018
DELIVERED AT:	BRISBANE
HEARING DATE(s):	7 February 2018, 26-27 March 2018, submissions received 20-21 April 2018.
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, prisoner with impaired capacity, palliative care, deteriorating patient, emergency response.

REPRESENTATION:

Counsel Assisting:	Mr Daniel Bartlett
Serco Asia Pacific Pty Ltd:	Ms Geraldine Dann, instructed by Herbert Smith Freehills
Registered Nurses Hogg and Glynn:	Ms Sally Robb, instructed by Roberts and Kane Solicitors
Queensland Corrective Services:	Mr Dominic Robinson, Department of Justice and Attorney-General

Table of Contents

Introduction

1. Mr Kenneth Wright died on 20 March 2015. He was 71 years of age. At the time of his death he was a prisoner at the Southern Queensland Correctional Centre (SQCC) at Spring Creek, near Gatton.

2. Mr Wright had a moderate cognitive impairment and was bedridden in his cell in the SQCC's Advanced Care Unit (ACU) as a consequence of significant head and other injuries sustained at the Capricornia Correctional Centre in September 2014. On the afternoon of 20 March 2015 he was found by nursing staff in a deteriorating state with oxygen saturations at 77 per cent. He was left unattended, and approximately one hour later was found deceased in his cell.

3. These findings consider the following issues:

   - the identity of the deceased person, how he died, and the time, place and medical cause of his death;
   - the adequacy and appropriateness of the care provided to Mr Wright at the SQCC, particularly on 20 March 2015;
   - the management of the Code Blue on 20 March 2015 and decisions surrounding resuscitation, in particular the decision not to commence CPR; and
   - whether any recommendations can be made to prevent a death in similar circumstances from happening in the future.

The investigation

4. An investigation into the circumstances leading to Mr Wright's death was overseen by Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

5. Upon being notified of Mr Wright's death, CSIU officers attended the SQCC on 20 March 2015. Mr Wright's correctional records and his medical files from SQCC and the Princess Alexandra Hospital (PAH) were obtained, together with relevant records from the Office of the Public Guardian.

6. The CSIU investigation was informed by statements from relevant custodial correctional officers and nursing staff at SQCC, and a medical officer at the PAH. These statements were tendered at the inquest.

7. At the request of the Coroners Court, Dr Natalie MacCormick from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the statements as well as the medical records for Mr Wright from SQCC and the PAH and reported on them.

8. The CSIU investigation concluded that Mr Wright died as a result of natural causes, and that he was provided with adequate medical care at SQCC. It also found that there were no suspicious circumstances associated with the death or the earlier fall at the Capricornia Correctional Centre. I am satisfied that the CSIU investigation was professionally conducted and that all relevant material was accessed.

The inquest

9. As Mr Wright died while in custody an inquest was required by s 27 of the *Coroners Act 2003*. A pre-inquest conference was held in Brisbane on 7 February 2018. Mr Bartlett appeared as counsel assisting, and leave to appear was granted to Serco, Registered Nurses Glynn and Hogg and Queensland Corrective Services.

10. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Written submissions were provided from the represented parties following the conclusion of the evidence.

11. The following persons were called to give oral evidence at the inquest on 26 March 2018:

    - Former Detective Sergeant Andy Seery – Investigating Officer, Corrective Services Investigation Unit
    - Alice Glynn – Registered Nurse
    - Fiona Hogg – Clinical Nurse
    - Mark Walters – Director, SQCC
    - Dr Natalie MacCormick – Forensic Medical Officer, Clinical Forensic Medicine Unit

The evidence

Autopsy results

12. An autopsy examination with associated CT scans and toxicology testing was conducted by Forensic Pathologist, Dr Rohan Samarasinghe. The autopsy report was tendered at the inquest.

13. The CT scans showed metallic fixative devices within Mr Wright's jawbone. There was evidence of a C5/C6 anterior spinal fusion with metallic fixatives. Post mortem examination showed evidence of old head injuries with resolved subdural/subarachnoid haemorrhage. There was evidence of previous cerebral infarctions, as well as an organising thrombus in the left main common carotid artery.

14. The major acute pathology identified at autopsy was bilateral aspiration type bronchopneumonia, which had developed on a background of severe chronic obstructive pulmonary disease with emphysema and anthracosis. Dr Samarasinghe found that the cause of death was aspiration pneumonia, due to or as a consequence of traumatic brain injury, which was a consequence of a fall from height.

Correctional history

15. On 24 June 2011, Mr Wright was sentenced in the Rockhampton District Court to 3 years imprisonment to be suspended after 12 months. The charges related to his possession and sharing of significant amounts of child pornography, described at sentencing as the 'worst imaginable', as well as weapons offences.

16. The sentencing remarks for these offences noted that Mr Wright had been separated for a period of about 15 years. He had two adult children who he maintained contact with. He had served no previous time in custody. It was also noted that in 1991, Mr Wright was involved in a serious motor vehicle accident, following which he was hospitalised for a period of three years.

17. On 5 November 2013, Mr Wright was charged with further child pornography offences committed after he had served his initial period of imprisonment. Mr Wright was remanded in custody on these charges up until his death. The further charges were listed for mention in the District Court in late March 2015.

Medical History

18. Mr Wright's medical condition was significantly affected by an incident that occurred on 4 September 2014, just over 6 months before his death. On that date Mr Wright was seriously injured as a result of a fall from a balcony at the Capricornia Correctional Centre. He sustained multiple traumatic injuries in that fall including extensive fractures and a subarachnoid haemorrhage.

19. An internal investigation was conducted by Queensland Corrective Services into this fall. This led to a finding that no one else was involved in the fall and the incident was assessed as an attempted suicide. This finding was confirmed by the CSIU investigation. Mr Wright expressed a wish to die on other occasions after this incident.[1]

20. On 8 September 2014, Mr Wright was transferred from Rockhampton Hospital to the PAH in Brisbane where he remained until 16 October 2014. He was then transferred to the SQCC where he remained until his death, apart from one brief admission to the PAH.

[1] Exhibit C3.1, pages 34,106 and 160

21. Mr Wright received ongoing medical management from 16 October 2014 until March 2015 at SQCC. The PAH Discharge Summary from October 2014 recorded that he required 'full nursing care for feeding and all hygiene cares' and had 'very low insight into location and current medical condition'.

22. The Advanced Care Placement Application that preceded his transfer to SQCC recorded his need for advanced care as a prisoner who had complex/chronic health conditions or disabilities. It listed 12 current health conditions and indicated he required assistance with activities of daily living and transferring from bed to chair, observing he 'cannot follow commands and is unable to participate in any rehabilitation.[2]

23. Mr Wright refused medication, food and fluids at SQCC throughout December 2014. He was consequently referred by the SQCC Visiting Medical Officer to the PAH on 30 December 2014 for assessment. He remained there until 8 January 2015. The PAH discharge summary recorded that he would need Prison Mental Health Service follow up, which was provided. He was closed to the PMHS in late January 2015 after he was assessed as not suffering a major mood or psychotic disorder and was consistently denying suicidal ideation.[3] The PMHS recommended that he be referred to the Public Guardian.

24. On 3 February 2015, the Queensland Civil and Administrative Tribunal appointed the Public Guardian to provide decisions for Mr Wright for a period of three months in relation to legal matters, accommodation decisions, health care and service provision. The application noted that Mr Wright suffered cognitive impairment as a result of an acquired brain injury and underlying dementia, and he was refusing all treatment.[4] At the time of the application to QCAT, he had scored 14/30 on a Mini Mental State Examination, indicating a moderate level of cognitive impairment. Mr Wright's son was appointed as his administrator on 5 March 2015.

25. Advice of the QCAT appointment was given to SQCC on 4 February 2015. The Office of the Public Guardian confirmed on 22 March 2018 that no formal health care decisions had been made by the delegate guardian for Mr Wright in the lead up to his death. A representative of the Public Guardian visited Mr Wright at SQCC on 17 February 2015. A file note of that visit records Mr Wright as saying that he did not want any help and 'he wanted them to go away and not come back'.[5]

[2] Exhibit C3.1, page 104
[3] Exhibit C3.1, page 263
[4] Exhibit C6
[5] Exhibit C6, page340-341

SQCC – Advanced Care Unit

26. At the time of Mr Wright's death, SQCC was a high security prison for men with a capacity of 380 inmates. SQCC is operated by Serco, the Asia-Pacific Arm of Serco Group PLC, which is a UK based company. Serco manages SQCC pursuant to an agreement with Queensland Corrective Services. On 3 July 2018, it was announced that SQCC would be converted to a prison for women in order to ease capacity problems in Queensland's female prison system.

27. Mr Walters' evidence was that the ACU at SQCC was located within the Medical Centre, which provided assistance with very minor ailments and the distribution of medication to prisoners.[6] More complex medical complaints requiring higher levels of care were dealt with by transferring prisoners by ambulance from the ACU to the secure ward at the PAH.[7]

28. The purpose of the ACU was to permit 24-hour advanced medical care that could not be provided in any other prison in Queensland. The ACU was able to receive prisoners from the PAH who no longer required in-patient care. It was able to manage prisoners who required palliative or post-operative care, who had complex and chronic conditions and needed full-time living assistance. The ACU was comprised of two cells with two beds each and could accommodate up to four patients.[8] The ACU contained equipment to respond to medical emergencies, including oxygen.

29. Serco engages part time visiting medical officers who attend the medical centre on a regular rostered basis. The VMOs are also consulted by the medical staff at SQCC for the purpose of authorising prescriptions when they are not on site.

30. The services which were provided for Mr Wright in the ACU were similar to those in a nursing home and included dealing with pressure areas, servicing an indwelling catheter, bathing in bed, and when possible getting him out of bed and into a chair, managing and administering medications and monitoring food intake.

CFMU Review

31. Dr MacCormick assisted the inquest by reviewing the available medical records, witness statements, and the autopsy report completed by Dr Samarasinghe. She provided a detailed and helpful report which was tendered at the inquest, and also gave evidence at the inquest.[9]

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[6] Some witnesses, including Nurses Hogg and Glynn, referred to the ACU as the 'Acute Care Unit'
[7] Exhibit B7
[8] Exhibit B7
[9] Exhibit B4

32. Dr MacCormick's report noted that Mr Wright suffered significant injuries from the fall sustained in September 2014, and his recovery from these injuries was significantly hampered by his age, comorbidities, poor compliance with treatment, and refusal of food, water and medications.

33. Dr MacCormick also noted that it was unclear what precipitated the vomiting that led to the aspiration event on the day of his death, and that patients who are on strong pain medication, have altered levels of consciousness due to delirium, have swallowing difficulties or are frail, are at higher risk of aspiration.

34. Dr MacCormick expressed concern about Mr Wright's management after he was found unstable on 20 March 2015, particularly the decision to leave him unmonitored and unattended after his oxygen saturations were found to be 77 per cent. Dr MacCormick considered that an assessment of his airway and breathing with immediate delivery of supplemental oxygen was indicated from 1:33pm on that day, and that Mr Wright needed to be constantly monitored until his clinical findings improved. It was necessary to act immediately to avoid further deterioration

35. Dr MacCormick's evidence was that she would expect a nurse to be familiar with basic life support, which would include the supply of oxygen if it was available.

36. Dr McCormick also expressed concern about the accessibility of the Code Blue alert systems at SQCC, as it appeared that Nurse Glynn needed to leave Mr Wright's bedside to activate a Code Blue. Dr MacCormick considered that should be able to be done from the patient's bedside or from a personally worn device.

Events of 20 March 2015

37. On 19 March 2015, Mr Wright was transported to the Princess Alexandra Hospital Secure Unit for an outpatient appointment for radiological review. He was then returned to SQCC, where he vomited later that evening.

38. On 20 March 2015, Mr Wright was in the care of registered nurses Alice Glynn and Fiona Hogg in the ACU at SQCC. There were a total of four nurses on duty on that date. Nurse Hogg was required to take on some of the duties of the Clinical Manager, who was on leave. She provided assistance to Nurse Glynn, who regarded Nurse Hogg as her supervisor.

39. At the time of Mr Wright's death, Nurse Glynn was working as a casual nurse at SQCC two or three shifts a week. She had graduated as a registered nurse in 2014, and her only previous work experience as a registered nurse was as an agency nurse in Toowoomba. Nurse Glynn said that she had not received a full orientation when she first commenced at SQCC and that she was not shown any policies, procedures or protocols to guide nursing practice. She used the Primary Care Clinical Manual to guide her practice, a tool used by nurses in rural and remote settings.[10]

40. CCTV footage was available from the corridor outside the cell where Mr Wright's bed was located. There were some discrepancies in the statements of Nurses Glynn and Hogg. However, each accepted that the chronology provided by the times noted on the CCTV footage was accurate. These discrepancies were resolved in supplementary statements and at the inquest.

41. Nurse Glynn attempted to administer morning medications to Mr Wright at approximately 8:56am and was in his room for about 2 minutes. Between 11:43am and 11:51am, Nurse Glynn and Nurse Hogg attended to Mr Wright in his cell. At the inquest the nurses described attending to Mr Wright's pressure care area at this time. Each described talking to Mr Wright and getting verbal and non-verbal responses indicating that Mr Wright was comfortable.

42. From approximately 12:00pm to 1:00pm, Nurse Glynn took her lunch break. Between 1:26pm and 1:33pm, Nurse Glynn checked Mr Wright's vital signs. An oxygen saturation level of 77 per cent was recorded. These observations were entered in the progress notes under a 2:00pm entry, after Nurse Glynn had discussed her concerns about the recorded observations with Nurse Hogg.

43. Nurse Glynn's evidence was that 'the observations appeared unstable' so she immediately left the ACU and notified Nurse Hogg. Nurse Glynn's evidence was that she was concerned about Mr Wright's deterioration, and that was why she communicated the observations to Nurse Hogg, who was her supervisor. Nurse Glynn's evidence was that she understood Mr Wright was being monitored (although not by her) after she communicated her concerns to Nurse Hogg. Nurse Glynn left to perform other duties in the clinic.

[10] Exhibit B2.1

44. In her evidence at the inquest Nurse Hogg accepted that she was told of the 77 per cent oxygen saturation level. Nurse Hogg's Officer Report, made on 20 March 2015 at 18:20, stated, '*RN Glynn approached me, informing me of the observations she had just conducted on Prisoner Wright, with these findings I made a clinical decision to send Prisoner offsite to the Princess Alexander Hospital via QAS*'.

45. Nurse Hogg said that after speaking with Nurse Glynn she contacted Head of Residential, Wayne Gurski, and told him that Mr Wright required transport offsite by the Queensland Ambulance Service (QAS) to the Princess Alexandra Hospital. Nurse Hogg said that she was told that an ambulance could not attend as more corrective services officers were required for that to happen, and they had to be called in to work. The progress notes entry on 20 March 2015 at 2:15pm supports Nurse Hogg's evidence that they were awaiting staff for the transfer.

46. It was not clear from Nurse Hogg's evidence that she conveyed any degree of urgency when requesting that Mr Wright be transferred offsite. It was also not clear that she was not given a time frame within which to expect QAS assistance. Her evidence was that the timing of calling an ambulance was subject to operational requirements, and that an ambulance might be dispatched from Gatton, Laidley or Ipswich.

47. Mr Walters disputed that the calling of an ambulance was ever delayed for operational reasons, based on the need to call in staff. He said that Serco determines whether and when an ambulance is called based on medical priorities. The procedure for a prisoner going off site for treatment was outlined as:

- medical staff contact correctional staff and advise of the need for the ambulance and the level of priority; and
- corrections staff contact the QAS.

48. Mr Walters' evidence was that when nursing staff contact corrections staff to advise of the need for an ambulance, the process required that they use the QAS patient transport categories guide[11] to state the level of priority involved, so that the corrections officers could then provide that information to the QAS. If the QAS was given a Priority One, the response time from Gatton would be in the order of 15 – 20 minutes. This meant that the earliest an ambulance might have arrived at SQCC from Gatton was after 2:00pm. Mr Walters accepted in oral evidence that there was scope to improve the communications channels between the nurses and the corrections staff.

[11] Exhibit B7.8

49. No observations were carried out, nor was any medical treatment provided to Mr Wright from 1:33pm to 2:40pm when Nurse Glynn again checked on him. Nurse Glynn acknowledged that she could have returned to monitor Mr Wright's condition sooner but she did not consider that this was required of her and she attended to other duties.

50. Both Nurses Hogg and Glynn also accepted in their evidence that there was oxygen available in the Medical Centre which could have been used in response to Mr Wright's oxygen saturation level of 77 per cent. Nurse Hogg stated that, in hindsight, she would have advised Nurse Glynn to place Mr Wright on oxygen, given his low oxygen saturation level. She was not able to explain why she did not do so at the time.

51. From the evidence of Nurse Glynn, and the CCTV footage, it appears that that the 2:40pm check-up was only conducted at the behest of Mr Wright's carer, Mr Kennedy.

52. After finding Mr Wright unresponsive at 2:40pm, Nurse Glynn left Mr Wright to notify Nurse Hogg, and Nurse Hogg initiated a Code Blue. Nurse Glynn's evidence was that she did not call a Code Blue immediately after attending Mr Wright and finding him not breathing, without a pulse and cold to touch. Her evidence was she left to get help because she had never been in this position before.

53. Nurse Hogg asked CSO Martin Belford to call a Code Blue immediately after being informed by Nurse Glynn that Mr Wright was not breathing. Nurse Hogg accepted Nurse Glynn attended Mr Wright at 2:40pm. Nurse Hogg asked Nurse Fogarty and Nurse Roberton to assist with the Code Blue. The CCTV footage showed the medical team and the corrections officers arriving at 2:43pm.

54. The evidence of the persons present in relation to the assessment of Mr Wright after the Code Blue was called was broadly consistent. It supports the conclusion that by the time of the assessment, Mr Wright was deceased and, in those circumstances, CPR would not have assisted.

55. Nurse Hogg stated that Nurse Fogarty, Nurse Glynn, and possibly Nurse Roberton, each assessed Mr Wright and assisted with the assessment for declaring life extinct. Nurse Hogg's evidence was that CPR was not initiated because of the findings of Nurses Fogarty and Glynn's assessments.

56. Nurse Fogarty's officer report stated that she attended the Code Blue in her capacity as a clinical nurse. Prisoner Wright was observed to be very pale, cold and unresponsive. No signs of breathing could be detected and no pulse could be found. Nurse Fogarty advised the other nurses of the five criteria needed to pronounce life extinct and gave a penlight to Nurse Roberton to check for pupil reaction. She stated there was none. Nurse Fogarty gave Nurse Roberton a stethoscope to check for heart sounds and she stated there were none. Nurse Fogarty's report indicates that they decided as a group to call life extinct.

57. Custodial Corrections Officer Darren Chick was in the room with the nurses at the time of the Code Blue. He stated that he observed the nurses checking Mr Wright's vital signs. He saw that Mr Wright was not breathing as there was no fall or rise of the chest and that he appeared to be white in colour. He also stated that the nursing staff held a discussion as to whether CPR was required but the general consensus was that it was not required.

58. Dr MacCormick's evidence was that the way to determine if someone was deceased was to go through a number of steps:

- Look for a response to voice and other stimuli (such as squeezing externally);
- If there is no response, look at the pupils. If they are fixed and dilated that is a sign that the patient is deceased;
- Examine the patient for breath and heart sounds for up to one minute; and
- At the same time, check for peripheral pulses.

59. Dr MacCormick accepted that where there had not been medical observations for more than one hour, it was possible that the body would have been quite cold and that rigor mortis may have commenced. In plain terms, it may have been obvious that Mr Wright had been dead for some time. Dr MacCormick's evidence as to what should be done was consistent with the nurses' evidence about what they did to confirm life extinct on 20 March 2015.

60. Mr Walters explained that the term 'Code Blue' has a meaning in a correctional setting that was different to a hospital setting. Mr Walters' evidence was that a Code Blue can be called for anything from a twisted ankle in the yard to a cardiac arrest. Typically, they are called by corrections staff to get the medical team to respond. In this case, the medical team had initiated the Code Blue.

61. Serco had implemented the "Incident Response Guidelines – Code Blue – Medical Emergency v02" which formed part of the Incident Management Custodial Operations Practice Directives at SQCC. Nurse Glynn's induction assessment indicated that she was trained in the five basic rules of first officer response for an emergency procedure, including to raise the alarm and call a Code.

62. The Code Blue guidelines provide that having raised the alarm and secured the area, the first officer response is to administer first aid: "Caution DRABC[12]" and "Universal Infection Control Practices" must be adopted. As Nurse Glynn had a statement of attainment for providing first aid dated 12 March 2015 she was qualified to provide CPR. Staff are obliged to provide immediate first aid until the arrival of primary response and medical team/emergency services.[13]

63. The Death in Custody Procedure, contained within the Death in Custody COPD requires custodial officers to commence all lifesaving measures. However, this procedure also expressly recognises that a registered nurse can instruct that resuscitation is to cease and can make a declaration of life extinct.

64. The evidence at the inquest was that it was not necessary for Nurse Glynn to leave Mr Wight to call a Code Blue. At the time of Mr Wright's death staff could request assistance from the Master Control Room via the prisoner's intercom button, beside the bed. Staff could also request assistance from the Master Control Room or the Medical Officer's station by radio, personal duress, telephone or shouting. Nurse Glynn accepted in her evidence that there was an intercom at the bedside which she could have used to contact the MCO. However, she left to seek help because she had never been in such a position before. I am not critical of her for doing so in the circumstances.

65. After the conclusion of oral evidence, I sought the production of records from the QAS. The QAS records indicate that only one contact was had between SQCC and QAS in relation to Mr Wright on 20 March 2015. This was at 2:46pm, after the Code Blue was called. The corrections officer can be heard to say words to the effect: "… *it's an acute medical condition*". The officer asks the QAS person to hold the line and then says "*Dot, what's the story with Wright, how am I to describe his condition to the ambulance*". At this point the officer then tells the QAS operator he has been told to stand down and an ambulance is no longer required.

[12] Danger, Response, Airway, Breathing, Circulation.
[13] Exhibits B6.7, page 3 and B7.6

Conclusions

66. I accept the submissions from Serco and Nurses Glynn and Hogg that, at the time of his death, Mr Wright was a bedridden, chronically unwell man. He had multiple comorbidities and no prospect of significant improvement in his health. He was non-compliant with his prescribed medications (other than for pain management), some of which were for life threatening conditions. He was also non-compliant with other recommendations for his medical management.

67. Dr MacCormick's evidence was that Mr Wright's case was complex and difficult, and his medical conditions placed him at risk of an aspiration event. It was also clear that his will to live had fluctuated after he was faced with the prospect of an additional prison term for child pornography offences. This had led to a suicide attempt in October 2014 and subsequent refusal of food and medication.

68. Mr Wright was also a remand prisoner, rather than a sentenced prisoner, which made him ineligible for exceptional circumstances parole.

69. Although steps were taken to have the Public Guardian appointed, Mr Wright died before any formal health care decisions were made by the delegate guardian on his behalf. It is possible that more proactive communication between SQCC and the Public Guardian may have resulted in consent being given for withholding of ventilation and CPR. This might have removed any contention in relation to the Code Blue response to Mr Wright on 20 March 2015.

70. Mr Wright died shortly before the criminal charges against him were finalised. He might then have been released into a more suitable residential aged care placement in the community.

The adequacy and appropriateness of the care provided to Mr Wright at the SQCC, particularly on 20 March 2015

71. The evidence supports the conclusion that the care provided to Mr Wright in the ACU at the SQCC was generally of a high standard. The increasing prison population in Queensland is likely to result in more aged prisoners such as Mr Wright who require palliative care or have chronic conditions and need assistance with basic care. A four bed facility such as the ACU will clearly not meet those needs.

72. The focus of the inquest was on the care Mr Wright received on 20 March 2015. I accept that Nurse Glynn communicated the detail of the observations she had taken to Nurse Hogg shortly after 1:33pm on 20 March 2015.Dr MacCormick's evidence was that she would expect a nurse to be familiar with basic life support, which would include the supply of oxygen if it was available. Nurses Glynn and Hogg both accepted in their evidence at the inquest that they were accountable for the provision of safe and proper nursing care.

73. I accept the evidence of Nurses Glynn and Hogg that they had done their best in looking after Mr Wright in the lead up to 20 March 2015. However, I consider that their response to Mr Wright's deteriorating state on 20 March 2015 should have been to provide supportive oxygen as a matter of urgency, while QAS assistance was enlisted and the VMO was consulted. The failure to do so was not consistent with good nursing practice.

74. Nurse Hogg accepted that, in hindsight, she would have advised Nurse Glynn to provide Mr Wright with oxygen, given his oxygen saturation levels. She was not able to explain why she did not take that action at the time. Supplemental oxygen was available nearby that could and should have been administered.

75. While Dr MacCormick agreed in her evidence that the administration of oxygen would have been useful, there was also no guarantee this would have changed the outcome for Mr Wright. Notwithstanding, it is likely that it would have assisted with the stabilisation of his condition before he could be transferred to the PAH by ambulance.

76. An ambulance did not arrive at SQCC for Mr Wright at any time on 20 March 2015. In particular, no call was made from SQCC for an ambulance to transfer Mr Wright to the PAH after his oxygen saturations were recorded at 77 per cent at 1:33pm. This represented a failure in the emergency response to Mr Wright.

77. I accept the submission made by Serco that that Nurse Hogg did not convey a specific level of priority to the custodial corrections officer when she made the request for an ambulance transfer. Although Nurse Hogg understood there would be a delay in calling the ambulance, Mr Wright was not having his observations monitored or oxygen supplemented while waiting for the ambulance to be called. He was left unattended by the nursing staff. I agree that this would suggest that Nurse Hogg did not regard his need for transfer as urgent.

78. It was also submitted on behalf of Serco that the precise role the lack of observations played in Mr Wright's death cannot be determined, as the exact time of his death after 1:33pm could not be established. Similarly, it was submitted that the fact an ambulance did not arrive between 1:33pm and 2:40pm cannot be said to have been directly causative of Mr Wright's death.

79. Having regard to the Mr Wright's range of comorbidities, it is possible that those factors may not have influenced the outcome for him. However, an observations regime is a vital and basic component of the patient care nurses provide. In this case there was a failure to respond to the clear warning sign of diminishing oxygen saturation levels in timely way. The response should have been to provide supplementary oxygen, increase observations and call for urgent QAS assistance.

80. It was submitted on behalf of Nurses Hogg and Glynn that while the SQCC is a highly structured and secure environment where most aspects of prisoner management are the subject of operational procedures and directives, the management of prisoner health issues at the time of Mr Wright's death was an area that seemed to be an exception. They submitted that there was little in the way of policy or procedure to guide nursing practice at SQCC generally, and specifically in the ACU.

81. However, Nurse Glynn gave evidence that she had access to standards developed by the Royal Australian College of General Practitioners and the Primary Clinical Care Manual. Mr Walters' evidence was that SQCC is subject to close oversight by QCS, with on-site monitoring by QCS staff and biannual audits. Serco is required to comply with its contractual obligations, as well as the *Corrective Services Act* and Regulation, and Custodial Operations Practice Directives. He pointed to a range of improvements in clinical practice which are discussed below.

82. It was also submitted on behalf of Nurses Hogg and Glynn that the procedure relating to calling an ambulance was confusing, and if there is no operational bar to calling an ambulance, a nurse who requires the ambulance to attend should be able to call QAS directly. I accept that submission.

The management of the Code Blue and decisions surrounding resuscitation, in particular the decision not to commence CPR

83. It was clear that nursing staff are able to call a Code Blue by using a range of mechanisms, including the use of the intercom located beside the prisoner's bed. Dr MacCormick accepted that the presence of the intercom addressed the concerns she identified in her report.

84. The operational procedures in place at SQCC also established that nursing staff were given the authority to instruct that resuscitation is to cease and could make a declaration of life extinct.

85. The evidence established that more than one hour passed between Nurse Glynn's observations indicating a pulse oxygen level of 77 per cent and when Mr Wright was found unresponsive and a Code Blue was called at 2:43pm. I accept that at that time suitable actions were taken by the nursing staff to review Mr Wright's vital signs. They appropriately formed the view that CPR efforts at that stage would be futile.

Findings required by s. 45

86. 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 evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – Kenneth Douglas Wright

How he died – Mr Wright died in custody after a protracted illness resulting from an attempted suicide where he fell from a prison balcony. He sustained significant head and other injuries in this fall. He was transferred to the Advanced Care Unit at the South Queensland Correctional Centre in late 2014 after an admission to the Princess Alexandra Hospital Secure Unit. He was bed bound and required assistance with activities of daily living. Mr Wright was assessed as having impaired capacity and was the subject of a guardianship order. However, an acute resuscitation plan was not in place at the time of his death. He was found in a deteriorating state in his cell at 1:33pm on the afternoon of 20 March 2015. Although his oxygen saturations were below 80% he was not provided with supplemental oxygen or increased observations. He was left unattended and was found deceased in his cell at 2:40pm.

Place of death – Southern Queensland Correctional Centre, Spring Creek, Queensland

Date of death– 20 March 2015

Cause of death – Mr Wright died as a result of aspiration bronchopneumonia, as a consequence of traumatic brain injury, due to a fall from height. He also had underlying chronic obstructive pulmonary disease, congestive cardiac failure, atrial fibrillation, systemic hypertension, and malnutrition.

Post incident actions

87. Following Mr Wright's death, Serco has taken steps to have all prisoners located in the ACU, and other elderly prisoners at SQCC who have expressed a wish not to be resuscitated, complete appropriate documentation to give effect to those wishes.

88. Serco's induction for new staff includes a unit on emergency procedures and contingency codes. The information contained in this unit details each code, and the requirements and processes for responding to critical incidents (which include the Code Blue medical emergency).

89. In February 2017, Queensland Health produced a Prison Health Services Queensland Adult Deterioration Detection System (Q-ADDS) tool, designed for detecting deterioration in the context of the prison setting, taking into account the environment and available resources. This tool did not exist at the time of Mr Wright's death. It was introduced to SQCC on 19 March 2018 and is to be used for all prisoners admitted to the ACU.

90. Staff in the ACU, including Nurse Glynn, have been briefed about the introduction of the Prison Health Services Q-ADDS. Dr MacCormick has noted that this tool would assist clinicians to detect the early signs of deterioration.

91. Dr MacCormick also noted that when the tool was applied to Mr Wright's observations taken by Nurse Glynn on 20 March 2015, it would have prompted (as a minimum) an increased frequency of observations to at least every 10 minutes. It would also have prompted escalation of help seeking if the nurse practitioner or medical officer could not be contacted. While the low oxygen saturation would not trigger an automatic emergency response, the more frequent observations may have altered the way this case was managed.

92. Serco has also employed another senior practitioner in the role of Health Services Director – Justice to provide clinical leadership and support and assistance for clinical practitioners. This position is to provide the oversight to the four Serco managed facilities in Australia and New Zealand; and provide governance for review of systems, policies and procedures.

Comments and recommendations

93. Section 46 of the *Coroners Act* provides that a coroner may comment on anything connected with a death investigated at inquest that relates to public health and safety, the administration of justice or ways to prevent deaths happening in similar circumstances.

94. I am satisfied that the actions outlined above taken by Serco following Mr Wright's death will go some way towards preventing a death in similar circumstances.

95. Mr Walters agreed during his evidence that there may be scope to improve internal communications between the nursing and correctional staff in relation to procuring the attendance of an ambulance. I have also had regard the submission on behalf of Nurses Glynn and Hogg in relation to the need for more defined policies, procedures and protocols in the Advanced Care Unit.

Recommendation

1. **I recommend that Serco, in conjunction with Queensland Corrective Services, conduct a review of the process for calling for ambulance attendance at the SQCC, and the priority given to those requests. Consideration should be given to authorising clinical staff to directly requests urgent ambulance assistance.**

96. The recent redesignation of SQCC as a correctional centre for women clearly requires that Serco and QCS plan for the range of very different primary, secondary and mental health care needs that will present with this population and any children residing with them.

97. I close the inquest.

Terry Ryan
State Coroner
Brisbane
3 August 2018