QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Richard William Hobbs**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2017/5194
DELIVERED ON:	17 December 2020
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 December 2020
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Sarah Lio-Willie
QCS:	Megan Lincez

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Introduction

1. Richard William Hobbs was aged 48 years at the time of his death. Mr Hobbs had recently commenced a term of imprisonment at the Brisbane Correctional Centre (BCC). He suffered a variety of significant health conditions at the time of his reception to prison. On 21 November 2017, Mr Hobbs suffered a cardiac arrest and subsequently died just outside the BCC health centre.

The investigation

2. A targeted investigation into the circumstances surrounding Mr Hobbs' death was conducted by Detective Sergeant (DS) Stephen Carr of the Corrective Services Investigation Unit (CSIU). The CSIU report was provided on 5 January 2020.

3. After being notified of Mr Hobbs' death, CSIU officers attended the BCC on 21 November 2017. His correctional records and medical files from BCC were obtained. The CSIU investigation was informed by statements from relevant custodial correctional officers, medical and nursing staff at the BCC, and a prisoner who shared a cell with Mr Hobbs. These statements were tendered at the inquest.

4. DS Carr concluded that he was satisfied Mr Hobbs received adequate medical care as a prisoner.

The inquest

5. As Mr Hobbs died while he was in custody, an inquest was required by s 27 of the *Coroners Act* 2003. The inquest was held on 17 December 2020. All the statements, medical records and material gathered during the investigation into Mr Hobbs' death were tendered to the court. Counsel Assisting proceeded to submissions in lieu of any oral testimony being heard.

The evidence

Personal History

6. Mr Hobbs was the father of five children. He was married in 1991 and separated in 2011. At the time of Mr Hobbs' death his next of kin was identified as his mother, Merle McIlveen. She was aware of his medical conditions and told investigators about his hospital admissions before he was incarcerated. Unfortunately, Ms McIlveen died on 26 December 2018 before police obtained a formal statement from her. Mr Hobbs' other family members had no contact with him in prison or involvement in the coronial investigation.

Criminal history

7. Mr Hobbs had a single entry on his criminal history. He was sentenced on 10 October 2017 to a head sentence of 3 years 6 months imprisonment for:

    - 1 x rape
    - 2 x sexual assault
    - 6 x indecent treatment of a child under 16 years.

8. The term of imprisonment was to be suspended for 4 years after serving 12 months in custody.

Medical history

9. Mr Hobbs had several co-morbidities, including diabetes, obesity, blood pressure and cardiac problems. As a result, he was required to attend the prison health centre three times a day to test his blood sugar level and receive insulin.[1] Mr Hobbs had difficulty walking up the hill to visit the BCC health centre. Consequently, he needed to use a bariatric wheelchair to move between his unit and the centre.[2]

10. Before his sentence, Mr Hobbs underwent percutaneous coronary intervention on 13 September 2017 using a drug-eluting stent to the mid left ascending artery for severe coronary artery disease, along with a 'plain old balloon angioplasty' to the first diagonal arterial branch. He experienced further chest pain post procedure for which he was admitted to Royal Brisbane and Women's Hospital (RBWH) from 25 to 27 September 2017.[3]

11. On 10 October 2017, at the time of his reception at BCC, Mr Hobbs complained of chest pains and advised correctional staff that he had taken two sprays of angina medication, but this was ineffective. The Queensland Ambulance Service (QAS) was called and he was transported to the Princess Alexandra Hospital (PAH) where he was admitted to the secure unit.

12. On 16 October 2017, Mr Hobbs was returned to BCC late in the evening. BCC nursing staff rang the Visiting Medical Officer (VMO) and read out the hospital discharge summary. The VMO gave a phone order for the medications required. Mr Hobbs' medication chart was subsequently updated, and his medications included:

    - Aspirin 100mg to be taken orally in the morning for his history of ischemic heart disease (IHD)

[1] Ex B8
[2] Ex B2
[3] Ex E – West Moreton SAC 1 HEAPS Prison Health RM175074

- Atorvastatin 80mg daily to be taken orally for IHD
- Vitamin D 1000 as a supplement
- Clopidogrel 75mg in the morning for IHD
- Frusemide 40mg in the morning
- Frusemide 20mg at lunch
- Lantus insulin 44 units to be taken subcutaneously with meals
- Metformin XR 1gm to be taken orally at night for diabetes
- Pantoprazole 40mg to be taken orally in the morning for GORD
- Paracetamol 1g to be taken orally three times daily for pain
- Pregabalin 75mg to be taken orally twice daily for pain
- Ramipril 5mg to be taken orally one daily for hypertension

13. On his return from the PAH, Mr Hobbs was categorised as a Category 3 patient, which required the VMO to see him within 14 days.[4]

14. On 19 October 2017, Mr Hobbs was found to be in a semi-conscious state and a *Code Blue* was called. Mr Hobbs complained of chest pain and said he felt like he had "been hit by a truck". After monitoring using the Queensland Adult Deterioration Detection System (Q-ADDS) tool, he was transferred to the PAHSU for examination and treatment. Mr Hobbs was discharged from the hospital and returned to BCC the same day.[5]

15. On 27 October 2017, 17 days after his term of imprisonment started, Mr Hobbs was seen by the VMO at the BCC satellite clinic. The VMO made a referral to an optometrist and podiatrist in view of Mr Hobbs' concerns about callous build up and a recurrent ulcer under his right food. Mr Hobbs was commenced on Amitriptyline (Endep) 10mg to be taken orally at night for nerve pain management. The VMO also ordered bloods be taken and collected. The plan was to see Mr Hobbs again in four weeks unless he indicated he wanted to be seen sooner.[6]

16. On 31 October 2017, Mr Hobbs was again seen by the VMO at the BCC satellite clinic. The results of the blood test noted that his renal function was showing signs of impairment. The VMO then reduced the morning dose of Frusemide from 40mg to 20mg.[7]

[4] Ex B10
[5] Ex D – Incident 217573 191017; Ex E – HOBBS, Richard F08220 PHS Vol 1 IM
[6] Ex B10
[7] Ex B10

17. On 1 November 2017, a nurse was called to attend Mr Hobbs' cell at about 2:00am. Mr Hobbs complained of vomiting and diarrhoea since he had been locked in his cell after dinner at about 6:00pm. He advised the nurse of stomach pains he had since lunch time. The nurse undertook his observations, all of which were within normal limits. The nurse considered he needed medication to stop the diarrhoea, and was administered nurse initiated Loperamide 4mg. It was not clear what had caused the vomiting and diarrhoea.[8]

18. On 13 November 2017, Mr Hobbs attended the Royal Brisbane Women's Hospital (RBWH) for a review at the cardiology clinic and returned to BCC that same day.[9]

19. On 14 November 2017, the VMO was asked to make medication changes to Mr Hobbs' medical chart following his visit to the RBWH the previous day. No outpatient consultation notes were provided to explain the reason for the medication changes. When the VMO called the RBWH, a nurse advised that a letter would be sent within one week.

20. Later that day the VMO reviewed Mr Hobbs. Mr Hobbs advised the VMO the reasons he was prescribed certain medications but was uncertain about others. Mr Hobbs advised the VMO he had increased swelling and pain from the distal quads to his calf. The VMO assessment was that he was afebrile with no heat or redness in the leg. The plan was to commence Mr Hobbs on Ibuprofen and Colchicine, evaluate him overnight, and await the letter from the RBWH cardiology outpatient department (OPD). The VMO noted there was no history of deep vein thrombosis (DVT).[10]

21. On 17 November 2017, upon review of Mr Hobbs' pathology results (D-dimer) it was considered that he would require imaging and hospital treatment to exclude and/or treat a DVT. He was taken to the PAH that morning. There was no evidence of DVT found. However, a chest x-ray revealed "alveolar opacification throughout the right mid zone, suggestive of pneumonic consolidation" and "blunting of the right costophrenic angle" which likely represented a small pleural effusion.[11] Mr Hobbs was discharged and returned to BCC that same day.

22. On 18 November 2017, Mr Hobbs attended the health centre for a blood sugar level check and to self-administer insulin. He advised the nurse that he was told by the hospital that he had a chest infection and he requested antibiotics. The nurse conducted a physical assessment of Mr Hobbs and listened to his chest which was clear with decreased air entry to the bases. There were no crackles or wheezes noted. He could speak in full sentences and had a dry cough which was unproductive.

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[8] Ex B11

[9] Ex E – HOBBS, Richard F08220 PHS Vol 1 IM, pg. 43

[10] Ex B10

[11] Ex E – West Moreton SAC 1 HEAPS Prison Health RM175074

23. Given his vital signs were normal the nurse decided not to commence antibiotics as there were no signs of chest infection. After Mr Hobbs left the health centre, the nurse reviewed the 'Statement of Attendance' from the PAH Emergency Department dated 17 November 2017. The statement recommended that if Mr Hobbs *'develops respiratory symptoms in the next 2-3 days it would be reasonable to commence oral antibiotics.'*[12]

24. On 19 November 2017, Mr Hobbs was reviewed at the BCC medical centre and found to have a mildly elevated temperature of 37.6°C, reduced oxygen saturations of 92% and his chest was slightly wheezy. He was commenced on oral antibiotics (amoxycillin) after discussion with the Nurse Practitioner (NP).[13]

Events leading up to the death.

25. On 21 November 2017, at about 5:00am a *Code Blue* was called for nurses to attend Mr Hobbs' cell. On arrival, Mr Hobbs complained of shortness of breath. The nurse listened to his chest and noted wheezes in the right lung. Mr Hobbs told nurses he had been commenced on antibiotics and said he had been sleeping on his side when he woke feeling distressed and short of breath. He self-administered 2 puffs of Ventolin in front of nurses. This seemed to improve his breathing. He was told that he would be reviewed at the health centre later when he attended for his blood sugar check at 7:30am. He was satisfied with this plan.[14]

26. At approximately 7:20am, Mr Hobbs arrived at the health centre for his blood sugar level check and insulin. Mr Hobbs appeared anxious, which was not uncommon due to his health and mobility issues. Nursing staff auscultated his chest and did not note any crackles or stridor. A mild right sided wheeze was noted in the right middle lobe, which Mr Hobbs was using Ventolin for. He appeared well enough to return to his unit. Blood pressure was elevated (169/93), oxygen saturations were acceptable (94% on room air), heart rate was elevated (99), respiratory rate was normal (20) and he was afebrile (36.4).

27. At approximately 12.30pm, nursing staff attended Mr Hobbs' unit to conduct a blood sugar level check. Upon arrival a correctional officer (CO) informed nursing staff that Mr Hobbs refused to leave his cell or to accept other visitors because he had diarrhoea and wanted to rest. Nursing staff attended Mr Hobbs' cell, but he declined to see them. Arrangements were made for his insulin to be made available for his evening check at 3.30pm at the clinic.

[12] Ex B12
[13] Ex A3
[14] Ex B12

28. As the day progressed nursing staff had not seen the VMO or NP to discuss Mr Hobbs' condition. They were advised that the VMO was working in the Satellite Clinic, which was in the south side of the prison and accessible only by two large flights of stairs. It was not practical for Mr Hobbs to be reviewed there as he was not capable of climbing the stairs. Given this, it was decided to wait until a NP arrived at the centre to discuss Mr Hobbs' situation.[15]

29. At approximately 3:07pm, Mr Hobbs' cellmate was in the common area of the unit and observed Mr Hobbs laying on a mattress on the floor, groaning and saying he could not get up. Correctional officers (CO's) were notified and attended his cell. When asked what had happened, Mr Hobbs murmured in response and told officers he could not get up from the ground. At 3:09pm a *Code Blue* was called for medical staff only to attend Mr Hobbs' cell.

30. Two registered nurses (RN's) arrived at Mr Hobbs' cell at approximately 3:14pm. Mr Hobbs was lying on his side on the floor of the cell. He was responsive with the nurses. He told them he had gastro all day with diarrhoea and vomiting, and when he stood up, he felt weak and fell on the ground and hurt his right shoulder. He did not report hitting his head. An oxygen mask was placed on Mr Hobbs to assist with his low oxygen saturation levels. However, Mr Hobbs did not want to keep the mask on because of feelings of claustrophobia. After nurses reassured him that he needed to keep the mask he agreed to do so. The correctional officers assisted him onto the stretcher trolley, and he was taken to the health centre. On the way to the health centre Mr Hobbs kept trying to take the oxygen mask off.[16]

31. Upon arrival at the health centre the RN's requested a review of Mr Hobbs' by a NP) and requested that he be transferred to hospital. The NP took over treatment of Mr Hobbs and observed him to be grossly swollen with normal colour. He was in pain, distressed, short of breath and sweaty. The result of the NP's assessment was that he had a productive cough, spitting sputum and distended abdomen. On auscultation his chest had crackles and wheeze. The NP determined that Mr Hobbs was possibly suffering from pneumonia, sepsis or congestive cardiac failure. He administered pain relief and antibiotics and called the QAS at 4:15pm. The VMO was present at BCC that day but the NP did not consult them, instead was comfortable with his assessment that Mr Hobbs was in an emergency and required an ambulance.[17]

[15] Ex B2
[16] Ex B13
[17] Ex B1

32. The QAS arrived at BCC 4:28pm and Mr Hobbs was wheeled to the ambulance on the stretcher trolley he was originally placed on in the unit. Once at the back of the ambulance bay Mr Hobbs had to be removed from the stretcher trolley as there were stairs to the ambulance that prisoners needed to use to get to the ambulance. There was no ramp. The trolley could not be taken down the stairs. Mr Hobbs was mildly short of breath as he was assisted down the stairs. He walked approximately 4 metres.[18] He was then assisted onto the stretcher and loaded into the ambulance. At this time paramedics exited the ambulance so that correctional officers could place restraints on him.[19]

33. At this time, Mr Hobbs had a cardiac arrest and lost consciousness, and a *Code Blue* was called at 4:53pm. Mr Hobbs was removed from the ambulance, and paramedics began CPR. Nursing staff arrived from the health centre and assisted in resuscitative efforts, including CPR and the administration of adrenaline. Mr Hobbs was declared life extinct at 5:26pm.[20]

Autopsy results

34. An external and full internal post-mortem examination (*to the extent necessary to determine cause of death)* was performed by Dr Nadine Forde on 23 November 2017 at the Queensland Health Forensic and Scientific Services.

35. The external examination showed a morbidly obese man (height 181cm, weight 141 kg) with evidence of recent medical therapy. There were no significant injuries.

36. A focused internal examination showed:

- Severe coronary atherosclerosis with no acute thrombosis;
- A dilated heart with areas of old and recent infarction (10-14 days);
- Firm, heavy right lung with purulent fluid in the airways Microscopic examination showed acute and organising bronchopneumonia throughout the lungs, most prominent in the right lower lobe, as well as chronic bronchitis;
- Right-sided pleural effusion;
- Small abdominal ascites;
- Sternal and rib fractures consistent with the effects of CPR;
- Congested liver with some scarring and chronic inflammation;
- Acute gastritis.

37. CT scans showed coronary artery calcification, right pleural effusion and patchy opacification of the lungs, consistent with the microscopic findings of bronchopneumonia.

[18] Ex A3
[19] Ex A4
[20] Ex B11, Ex B16, Ex D – BCC occurrence log

38. Toxicological analysis of post-mortem femoral vein blood detected prescription and over the counter medications only.

39. Dr Forde concluded that the cause of death was coronary atherosclerosis. This is a condition in which the arteries of the heart become narrowed by fatty plaques and impair blood flow to the heart. This can lead to heart attacks (infarction), sudden abnormal heart rhythms and heart failure. There were changes in the heart indicating areas of recent infarction of around 10-14 days on the background of old infarction. Mr Hobbs had also been complaining of leg swelling, had a right sided pleural effusion and a congested liver, which are features which can be seen in heart failure. His collapse in the ambulance was in keeping with a sudden cardiac event.

40. Mr Hobbs also had chronic bronchitis and acute bronchopneumonia, which was likely to have been a significant contributing factor. Diabetes mellitus and morbid obesity were also considered to be contributing factors as these conditions can predispose to infection and place additional strain on the heart.

Human Error and Patient Safety Analysis

41. A Human Error and Patient Safety (HEAPS) analysis report conducted by WMHHS identified the following as contributing factors:

- Patient with complex multi-morbidity;
- Diffuse diabetic disease, with micro and macro complications;
- High body mass index;
- Chest x-ray on 17 November 2017 identified possible pneumonia changes and a small pleural effusion;
- Delay in commencing treatment for pneumonia;
- Patient located in the correctional environment;
- Possible poor understanding by secondary and tertiary health services of the capacity, capability and resources of primary health services within correctional centres;
- Inadequate monitoring;
- Failure to recognise and respond to deterioration;
- Early warning response system not sued for general observations;
- Failure to rescue patient;
- Patient walked from health centre to ambulance vehicle; and
- Design issues with ambulance access area at back of health centre.

Information sharing

42. When Mr Hobbs returned from the RBWH on 13 November 2017, the VMO did not make all the changes to Mr Hobbs' medication as requested by the RBWH because he wanted to see the OPD report to confirm why the changes were required. He called the RBWH to clarify the situation. The OPD letter was received after Mr Hobbs' death and was dated 21 November 2017, the day of his death.

43. The VMO stated he would have made the medication changes recommended had the letter been available to him at the time. However, having regard to the letter the VMO considered that the proposed changes were aimed at improving Mr Hobbs' long term cardiac management rather than treating acute symptoms. There were no acute concerns arising from the cardiology review.

44. The VMO also commented that in his experience, very few prisoners attend the RBWH because the PAH has the only secure unit in Brisbane. The usual practice following PAH outpatient appointments is that the BCC health centre routinely receives a faxed copy of the OPD notes the same day. The BCC does not have such an established routine with other hospitals including the RBWH.[21]

Absence of a ramp

45. The back of the health centre where the ambulance access is situated has a heavy locked door which is opened by QCS officers. There were two separate steps. The top step was approximately 13cm deep and lead down a 3m stretch of sloping concrete to the second step, which was approximately 18cm deep. Therefore, staff were unable to safely manoeuvre a stretcher or wheelchair out of the health centre to an ambulance.

46. Ambulance vehicles park outside a heavy locked double wired gate. Only one side of the gate may have been opened at a time. Paramedics required Mr Hobbs to walk from just inside the back door of the health centre to the outside wire gate, where he was then placed on a QAS stretcher and loaded into the ambulance.[22]

47. The HEAPS report discussed requests going over some time to have a ramp installed to the ambulance reception area at the back of the health centre. The issue had been tabled and discussed at QCS and Queensland Health Forums. The Nursing Director PHS had been told by Building and Services (BAS) and QCS facilities that the area was not able to support the changes due to building code limitations. The issue was therefore placed on the WHMHHS, Mental Health & Specialised Service risk register (DIV17) in 2016, as a medium risk, with a response that the risk be tolerated.[23]

[21] Ex B10

[22] Ex E – West Moreton SAC 1 HEAPS Prison Health RM175074

[23] Ex E – West Moreton SAC 1 HEAPS Prison Health RM175074

Progress notes and handover information on 20 November 2017

48. The HEAPS report discussed that care planning would have been supported by the development of a plan for follow up and the implementation of strategies to ensure safety netting. The plan would have identified the health issue, articulated the monitoring requirements, set parameters for escalation, noted the requirement for a clinical review by the nurse practitioner or medical officer, and established the time frame.

49. There were no observations of vital signs or clinical entry made in relation to the patient's progress or mention on the clinical handover sheet from the beginning of the afternoon shift on 19 November 2017, when the antibiotics were ordered, to the time of the first code blue on 21 November 2017. However, on 20 November 2017 blood glucose levels were recorded and medications were given, at the usual breakfast, lunch and dinner times.

Use of the Queensland Adult Deterioration Detection System (Q-ADDS) tool

50. The HEAPS review noted that while vital sign and observation assessment using Q-ADDS is a mandatory requirement for all prison *Code Blue* events, the use of Q-ADDS at other times is deferred to clinical judgment. Each person who saw Mr Hobbs considered their episode of care with him did not raise any red flags. However, there were subtle trends of deterioration for Mr Hobbs with complex multi-morbidity. From a retrospective point of view, the antipyretic properties of Ibuprofen 400mg twice daily may have potentially masked symptoms of fever and clouded the clinical picture.

51. The Primary Clinical Care Manual 2016 noted that clinical incident analysis involving early warning response systems has demonstrated issues with clinician failure to use the tools, incomplete recording of observations and clinician failure to take the actions indicated by the score. There needs to be a shift in focus from just crisis management in the PHS to monitoring of trends in vital signs to facilitate early detection and response to deterioration.

52. The review noted that Q-ADDS remains a valuable tool in the PHS in emergency situations for recording observations, assessment and treatment, as well as for communication and handover to ambulance and tertiary health care providers when the patient requires transfer.

HEAPS conclusions and Prison Health Services and West Moreton Hospital & Health Service' response

53. The HEAPS report concluded that while no red flags were raised for each clinician who saw Mr Hobbs, there were subtle trends in deterioration for him, and he eventually experience a cardiac arrest.

54. The HEAPS report made three recommendations to reduce the risk of recurrence and make care safer:

    i. Nursing Director and Clinical Director, for the Prison Health Service (PHS) to review the local business rules for the use of the Queensland Adult Detection System (Q-ADDS), to extend the use of the tool to include the recording of general daily observations;
    ii. Nursing Director and Clinical Director, for the Brisbane PHS to review clinical handover tools and redesign the tools so that they highlight patients of concern;
    iii. Nursing Director and Clinical Director, for the PHS to develop an escalation process from the nurse practitioner to medical officer.

55. The Director of Operations/ Nursing Director Prison Health Services, West Moreton Hospital & Health Service provided a statement dated 23 November 2018, confirming that all three recommendations of the HEAP report had been completed.[24]

- Recommendation 1 – the updated form will allow nursing staff to more easily detect if a prisoner's health status is deteriorating and to escalate this to a medical officer. This use of this tool will assist in preventing the events that occurred in Mr Hobbs' situation.

- Recommendation 2 – the revised tool contains an escalation process. This clinical handover tool is conducted shift to shift and completed by nursing staff. Education for all relevant staff has been provided.

- Recommendation 3 – the new escalation process will give clear guidance for nurse practitioners of when and how to escalate concerns about a prisoner's health to a medical officer. Education to all relevant staff has been provided.

56. In addition to the HEAPS recommendations, WMHHS wrote to QCS and the QAS about the absence of a suitable ramp at the rear of the BCC health centre at the ambulance bay. The ramp has since been constructed and has been in use since 8 March 2019.

[24] Ex B4

Clinical Forensic Medicine Unit Medical Review

57. Dr Natalie MacCormick of the Clinical Forensic Medicine Unit conducted a review of the medical treatment provided to Mr Hobbs while he was in custody. After considering the relevant materials, including the HEAPS and the autopsy reports, Dr MacCormick concluded that Mr Hobbs received appropriate medical care while incarcerated at BCC.

58. Dr MacCormick noted that Mr Hobbs was regularly reviewed by nursing and medical staff who appeared to have been attentive his concerns. Decisions to transfer him to the hospital for further investigation were made appropriately and in a timely fashion. Clinical issues identified at hospital visits were followed up appropriately by the prison staff and clinical documentation was generally clearly detailed.

59. Dr MacCormick also concluded that the medical care received at the Princess Alexandra Hospital was also reasonable. She said that Mr Hobbs had significant cardiac risk factors and acute coronary syndrome was appropriately excluded during his repeated presentations.

60. Dr MacCormick was not convinced of the diagnosis of costochondritis (an inflammation of the cartilage that connects a rib to the sternum). Pain from this condition may mimic that of a heart attack or other heart conditions. She considered that it may have been prudent to arrange an exercise stress test or echocardiogram to evaluate the function of his heart, and further investigations on 17 November 2017 may have revealed congestive cardiac failure.

61. Dr MacCormick also expressed some concern about the communication from the RBWH to the BCC Health Centre following the cardiology outpatient review and medication changes on 13 November 2017. She noted that the decision to commence regular ibuprofen and colchicine therapy was potentially questionable in a patient with heart disease, acute kidney injury, deranged liver enzymes and gastro-oesophageal reflux disease.

62. I note that the letter from the Cardiology Department at the RBWH to the BCC Medical Centre dated 21 November 2017 indicates that there was a suspicion of post percutaneous coronary intervention pericarditis. The plan was to trial Mr Hobbs on Ibuprofen for two weeks as well as colchicine for three months with renal function to be monitored.

63. Dr MacCormick considered that colchicine therapy may have also contributed to Mr Hobbs' sudden deterioration. However, as this drug was not analysed for on toxicology it is difficult to comment whether it contributed to the death.

64. Dr MacCormick was asked whether the lack of assessment and consultation with a nurse practitioner or VMO following the code blue on the morning of Mr Hobbs' death contributed to his cardiac event or death. Dr MacCormick noted that his vital signs on the morning of 21 November 2017 were

acceptable and the decision to return him to his cell was reasonable. Dr MacCormick also noted that Mr Hobbs declined to be assessed at noon on that day. Accordingly, his clinical status at that time was unclear. While an assessment by the nurse practitioner or VMO at that time may have changed the outcome, Mr Hobbs declined that assessment.

65. Dr MacCormick concluded that the requirement for Mr Hobbs to walk four metres to the ambulance from the health centre was one of several factors that contributed to his cardiac event and death, given his acute unstable condition combined with his pre-existing limited exercise tolerance and coronary artery disease. Dr MacCormick said that from a patient safety perspective the absence of a ramp connecting the ambulance bay was a matter requiring urgent review.

Conclusions

66. Mr Hobbs' death was the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

67. None of the correctional officers involved at BCC contributed to his death. I am satisfied that Mr Hobbs was given appropriate medical care by staff at BCC and the PAH while he was admitted there. His death could not have reasonably been prevented.

68. It is an accepted principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest, including Dr MacCormick's review, established the adequacy of the medical care provided to Mr Hobbs when measured against this benchmark. The issue she identified in relation to the absence of a ramp from the health centre has now been addressed.

69. The significance of the prescription of colchicine one week before his death could not be investigated further as its presence was not detected on autopsy as part of routine toxicology. Given the proximity of this prescription to his death and the extent of his other co-morbidities I consider it was unlikely to have altered the outcome.

70. Although its use is off-label, low-dose colchicine is reported to be well tolerated with infrequent side effects, although high doses, specifically with prolonged use, can lead to irreversible toxicity. The European Society of Cardiology's 2015 Guidelines for the diagnosis and management of pericardial diseases support the concurrent use of colchicine with NSAIDs to prevent recurrent pericarditis. It is common practice to use colchicine for the first episode of pericarditis, unless there are specific contraindications.[25] It was clear that the cardiology department at the RBWH were mindful of the need to monitor Mr Hobbs renal function after he started this medication.

[25] Pericarditis, Australian Family Physician, 2017, Volume 46, No.11, Pages 810-814

71. It is evident that Mr Hobbs suffered from many very significant chronic medical conditions at the time he was sentenced to a term in custody. Those conditions contributed to the sudden cardiac event which was the ultimate cause of death.

Findings required by s. 45

Identity of the deceased – Richard William Hobbs

How he died – Mr Hobbs had multiple and significant co-morbidities, including diabetes, morbid obesity, high blood pressure and cardiac problems when he was admitted to custody on 10 October 2017. Despite being treated for those conditions his health deteriorated and he died suddenly after a cardiac arrest at the prison.

Place of death – Brisbane Correctional Centre, Wacol Station Road, Wacol.

Date of death– 21 November 2017.

Cause of death – Mr Hobbs died from coronary atherosclerosis (previous coronary artery stent insertion). Other significant conditions were acute bronchopneumonia; chronic bronchitis; diabetes mellitus and morbid obesity.

Comments and recommendations

72. Having regard to changes implemented by WMHHS in response to the HEAPS report and the construction of a suitable ramp at the BCC, the circumstances of Mr Hobbs' death do not call for any further comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.

73. I extend my condolences to Mr Hobbs' family. I close the inquest.

Terry Ryan
State Coroner
Brisbane
17 December 2020