CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of David Frederick Smith**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/3343
DELIVERED ON:	24 January 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 January 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, essential thrombocytosis, provision of medication.

REPRESENTATION:

Counsel Assisting:	Alex Vannen
Queensland Corrective Services:	Vanessa Price
Metro North Health:	Myla Ruttan

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Introduction

1. David Frederick Smith was born on 18 June 1974. He died aged 45 on 22 July 2019. Mr Smith was a remand prisoner at Woodford Correctional Centre (WCC).

2. Mr Smith suffered from essential thrombocytosis, a disorder leading to the overproduction of platelets. This condition was the result of a genetic mutation of the calreticulin gene (CALR). It placed Mr Smith at increased risk of ischaemic and haemorrhagic complications.

3. Mr Smith was being treated with Anagrelide and Hydroxycarbamide to reduce his platelet count. He was also prescribed Rivaroxaban (an anticoagulant) to reduce his risk of thromboembolism that might otherwise lead to strokes or heart attacks.

4. Following a medical episode on 9 July 2019, Mr Smith was taken from Woodford Correctional Centre (WCC) to the Caboolture Hospital. CT brain scans and CT angiograms identified an evolving infarct.

5. On 10 July 2019, Mr Smith was transferred to the Royal Brisbane and Women's Hospital (RBWH) so he could receive tertiary level care. Additional CT scans confirmed an evolving, moderate-effect acute infarct in the left mid-cerebral artery (MCA) territory. He was commenced on a Heparin infusion with close monitoring.

6. Mr Smith responded positively to the treatment at the RBWH. By 17 July 2019, it was planned to transfer him back to Caboolture Hospital where he would continue to receive treatment. However; on 20 July 2019, the day he was due to be transferred, he suffered a catastrophic, inoperable cerebral infarct.

7. Mr Smith was placed on life support but proceeded to brain death on 21 July 2019. He was continued on life support until 22 July 2019 to allow for organ donation. He was pronounced deceased on that day at 11:30am.[1]

The investigation

8. Detective Sergeant Greg Bishop from the QPS Corrective Services Investigation Unit (CSIU) carried out the investigation into the circumstances surrounding Mr Smith's death. A Coronial Report was provided dated 19 May 2020 with various annexures.

9. The CSIU was contacted on 21 July 2019 and attended the RBWH and spoke with medical staff, correctional officers and Mr Smith's mother, Iris McCann.

10. On 23 July 2019, following organ donation, a QPS scenes of crime officer went to the RBWH, and photographs were taken of Mr Smith in the Intensive Care Unit (ICU). There were no recent injuries observed and no signs of defensive wounds on his hands or body. There appeared to be no external injuries other than medical intervention. A cell search conducted at WCC revealed no items of interest.

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[1] Exhibit E6 - p. 390/408

11. The investigation was informed by statements from the relevant custodial correctional officers, medical and nursing staff. These statements were tendered at the inquest. I was provided with annexures including witness statements, recordings, Corrective Services Records and photographs.

12. The investigation concluded that Mr Smith died from natural causes, and that he was provided with adequate medical care in prison. It also found that there were no suspicious circumstances associated with the death. I am satisfied that all relevant material was accessed.

The inquest

13. The purpose of a coronial investigation is to establish the findings required by s 45 of the *Coroners Act 2003,* namely: the identity of the person who died, when and where and how they died, and what caused the death.

14. At the time of his death, Mr Smith was a prisoner in custody under the *Corrective Services Act 2006*. His death was a 'death in custody' and an inquest was required by the *Coroners Act 2003*.

15. When a person is detained in custody after being charged with a criminal offence, or sentenced following conviction, the State is responsible for their care. The community has an expectation that such deaths are carefully and independently investigated in the coronial process.

16. In addition to the matters required by s 45 of the *Coroners Act*, the inquest considered:

    - Whether the medical treatment received by Mr Smith was reasonable and appropriate in the circumstances;
    - Whether there are any further recommendations which can be made which could prevent deaths from happening in similar circumstances in the future.

The evidence

Personal and Correctional History

17. Mr Smith is the son of Iris McCann. He was the eldest of her four children. Mr Smith had significant vision impairment from the age of 5 to 17, when he was prescribed corrective contact lenses. Ms McCann said that he was always a very happy outgoing person. He was caring and compassionate and wanted to help everyone.

18. Ms McCann said that after Mr Smith was diagnosed with essential thrombocytosis, he commenced chemotherapy. He then suffered a significant spinal injury at work and his partner of 16 years left him.

19. Mr Smith had a lengthy criminal history for property and drug offences. He was first convicted of a criminal offence in 1995. At the time of his death Mr Smith was on remand for drug, property, traffic, weapons and other offences.

20. Mr Smith had periods of imprisonment in 1996 –1997; 1999 –2001; 2014; and from 23 April 2019 to the date of his death.

Medical History

21. Mr Smith had a medical history that included:

- Essential thrombocythaemia – diagnosed in 2011.
- Traumatic ruptured spleen in 2014 with splenectomy.
- Cerebrovascular accident - 2015.
- Portal vein thrombosis - 2014.
- Atrial fibrillation.
- Bowel obstruction with laparoscopic division of adhesions - 2017.
- Chronic back pain.
- Depression.

22. Mr Smith was prescribed a range of medications to treat these conditions including:

- Rivaroxiban (blood thinner used to prevent clots)
- Hydroxycarbamide and Anagrelide (cytotoxic agents used in the treatment of thrombocytosis).
- Pregabalin (for pain).
- Reboxetine (antidepressant).
- Metoprolol (beta blocker used as antihypertensive).

23. There was documented non-compliance with the prescribed cytoreductive medication, Hydroxycarbamide and Anagrelide.

24. Mr Smith began to experience headaches in the watchhouse on 22 April 2019, following his arrest. He was admitted to the RBWH on 22 April 2019, and underwent a non-contrast CT head scan that did not identify evidence of an acute intracranial abnormality.[2] It was noted; however, that his platelet count was "*significantly elevated*" at $2090x10^9$/L.[3] He was discharged from the RBWH and transferred to the Brisbane Correctional Centre on 24 April 2019.

25. On 29 April 2019, Mr Smith was admitted to the Princess Alexandra Hospital (PAH) following recurrent syncope events. There was evidence of atrial tachy-arrythmia with intermittent ventricular ectopy. However, this was not considered to be causing the syncope events.[4]

26. At about 3:00pm on 3 May 2019, [5] Mr Smith's mother (Iris McCann) called nursing staff at Brisbane Correctional Centre (where Mr Smith was then incarcerated). She expressed concerns that her son was experiencing suicidal ideation and his health needs were not being met. Ms McCann was reassured that Mr Smith's medical needs were being looked after and his level of care would be escalated if requested.

27. At about 10:40am on 5 May 2019,[6] Mr Smith disclosed right-sided chest pain having commenced about 20 minutes prior. He described the pain as "*8/10 (10 being worst)*". While sharp, the pain was non-radiating. Mr Smith's vitals were recorded as:

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[2] E12 - p. 71/223
[3] B15 – para. 7
[4] E12 - p. 65/223
[5] E12 - p. 27/223
[6] E12 - p. 28/223

- Blood pressure (BP) 120/85
- Heart rate (HR) 88/min (regular)
- Respiration rate (RR) 24/min
- Oxygen (O2) 98%

28. While being taken to medical ward in a wheelchair, Mr Smith disclosed his chest pain had resolved slightly. An ECG was completed at the medical ward.

29. During the AM medication round on 6 May 2019,[7] Mr Smith refused all medications and informed the nurse to the effect that he 'did not want them' and 'wanted to end his life'. Mr Smith was placed on 15-minute observations. While his mood was documented as having improved at lunchtime, Mr Smith continued to refuse medication.

30. During the PM medication round Mr Smith continued to refuse all medications. A plan was developed for an urgent psychologist review that was scheduled for 7 May 2019. A nursing entry dated 7 May 2019 documented Mr Smith was to be transferred to WCC.

31. At 12:40pm on 8 May 2019,[8] Mr Smith was received at WCC in the Crisis Support Unit.

32. On 9 May 2019,[9] Mr Smith experienced a medical event during routine observations. He disclosed feeling "*dizzy*", "*wobbly on feet*" with a "*slight headache*". While denying chest pains, he disclosed pins and needles to the base of his hands. Mr Smith was also documented as being disorientated to time, date and place and the stroke protocol was implemented.

33. Mr Smith was taken to the Caboolture Hospital. However, the clinical impression was that he was experiencing a dissociative episode requiring psychiatric follow up. He was discharged on 10 May 2019.

34. Between 1 June 2019 and 5 June 2019, Mr Smith did not receive his Anagrelide. This was due to medication being out of stock at WCC between 1 June and 4 June 2019. Chart notes for 5 June 2019 indicate this medication was available, but Mr Smith refused to take it.[10]

35. Medication charts also indicate there were further refusals on 15, 17, 28 and 29 June 2019, and 1 July 2019. While those incidents are indicative of occasional non-compliance with medication, Mr Smith's medication charts suggest he was generally compliant. On the days that he did not take Anagrelide he did take Hydroxycarbamide, which also has the effect of reducing the number of platelets in the blood.

36. At about 3:32pm on 9 July 2019,[11] Mr Smith became "*unresponsive for a few seconds*" resulting in a Code Blue call being made. After a sternal rub was administered, he regained consciousness. It was determined that Mr Smith's level of care should be escalated to the Caboolture Hospital.

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[7] E12 - p. 28/223
[8] E12 - p. 29/223
[9] E12 - p. 29/223 | B7- p. 1/2
[10] E12 - p. 119/223
[11] E13 - p. 5/180

37. A call was placed to the Queensland Ambulance Service (QAS) at 3:29pm and the ambulance arrived at 3:52pm. The QAS documented Mr Smith was experiencing occipital region headache, nausea, photophobia and dizziness. He was tachycardic with a HR of 102/min and had BP of 160/100.[12] Mr Smith was documented as having a GCS of 14. Paramedics administered 8mg ondansetron IV and a total of 50mcg fentanyl IV.

38. The QAS transported Mr Smith to Caboolture Hospital, arriving at 4:48pm.[13] At 5:15pm, Mr Smith underwent a non-contrast CT brain scan and CT angiogram.[14] The findings from the brain scan were:

    "*There is no evidence of intracranial haemorrhage. Grey and white matter differentiation is preserved, no evidence of hydrocephalus, no extra-axial fluid collection. No established territorial infarction seen.*

    No convincing abnormality seen on perfusion study"

39. The findings from the CT angiogram were:

    "*Adequate opacification of the cervical and intracranial arterial system achieved. Right PCA is mainly nourished by the anterior circulation. No evidence of significant stenosis or occlusion seen within the cervical carotid arterial system as well as intracranial arteries. Bilateral vertebral artery origin appear unremarkable. Left vertebral artery is hypoplastic*".

40. The overall conclusion of the scan was:

    "*No evidence of acute arterial occlusion or stenosis within the cervical and intracranial arteries. No evidence of convincing perfusion abnormality*".

41. Mr Smith was triaged at 5:23pm and identified as Category 3. Emergency Department records indicate Mr Smith was triaged on the 'ramp'. Noting his arrival time was 4:48pm, it appears his CT scan and CT angiogram were given immediate priority.[15]

42. Mr Smith was assessed in the Emergency Department at 6:30pm. The primary diagnosis was cerebral infarction. His blood sample was showing elevated platelets (876) though noticeably lower than his April 2019 admission. Mr Smith had a decline in his GCS from 14 to 10. The plan was to take further blood samples, maintain close observations and follow CT stroke protocol.

43. A repeat non-contrast CT brain scan and CT angiogram was performed at 6:38pm.[16] The results from that brain scan were:

    "*The cerebral hemispheres, brainstem and cerebellum appear normal. The ventricular size is normal and there is no evidence of mass effect. There is no acute infarct identified on the conventional CT images … the presence of large filling defects [was suggested] proximally within both internal carotid arteries.*

[12] F1 - p. 59/78
[13] F1 - p. 59/78
[14] E13 - p. 145/180
[15] E13 - p. 23/180
[16] E13 - p. 143/180

These changes were quite focal but each appear to reduce the lumen by at least 75%"

44. The later finding resulted in a repeat study being performed 45 minutes later (approximately 7:23pm). The results of which were:

    "*This showed the filling defect on the left side persisting while that on the right was largely gone but leaving a small residual change posteriorly in relation to the vessel at this point. The possibility of an embolic shower extending up to the brain was considered but could not be readily identified on the subsequent angiographic images more superiorly*".

45. Reference was made to the study that had been performed two months earlier that showed the internal carotid arteries appeared "*essentially normal*".[17]

46. At 9:00pm, a progress note recorded Mr Smith was experiencing atrial fibrillation and recurrent syncopal episodes. He was described as not responding to voice. Results from blood sample testing indicated an increase in his platelet count to 939.[18]

47. Staff at the Caboolture Hospital were liaising with the RBWH about the CT results. It was considered that the poor-quality image areas in carotid arteries (as imaged at 6:38pm and 7:23pm) were "*likely to be an artefact*". The progress note documented a lesion was visible in the Broca's area however Mr Smith was not a candidate for lysis.

48. The results of Mr Smith's CT scans were discussed with the RBWH's on-call Vascular Registrar (Dr Tom) at 9:45pm and 10:15pm. Dr Tom also discussed whether there was a clinical basis for surgical intervention with Professor Coulthard, Neurointerventional Radiologist.

49. Following those consultations, it was agreed to continue administering aspirin with further investigation in the morning. It was also agreed that if there was deterioration overnight there may be a need to transfer Mr Smith to the Princess Alexandra (PA) Hospital for a suction thrombectomy.[19]

50. A retrospective progress note entered at 11:35pm identified the best course would be to transfer Mr Smith to the RBWH so that he was "*best placed in tertiary care*".

51. On 10 July 2019, Mr Smith's transfer from Caboolture Hospital to the RBWH was facilitated by QAS.[20] He departed Caboolture Hospital at 2:38am and arrived at the RBWH at 3:16am. The eARF from that journey indicates no interventions by the QAS were required. His vitals (as recorded at 2:23am) were:

    - Pulse 68
    - BP 116/74 (MAP 88.0)
    - O2 98%
    - RR 18/min

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[17] E13 - p. 143/180
[18] E13 - p. 24-26/180
[19] E13 - p. 27/180
[20] F1 - p. 75-78/78

52. At 3:22am, Mr Smith was assessed in the RBWH Emergency Department. There was a discussion between Vascular Registrar (Dr Tom) and ICU Consultant (Dr Pincus). There was a reluctance to perform a 'clot retrieval' due to the "*lesion's distal site (and high risk of iatrogenic thrombosis given pt's coagulopathy)*".[21]

53. The plan was to commence Mr Smith on Heparin infusion and continue "*vigilant*" neurological observations, intubate, ventilate (if required) and rescan if there was a greater than 2 point drop in Mr Smith's GCS score, or if the ICU were unable to maintain his airway due to aspiration or seizure. It was planned to admit Mr Smith to the wards. However, if intubation and ventilation were required, he would be admitted to the ICU.[22]

54. After arriving at the RBWH a repeat CT scan was conducted at 3:49am.[23] The results of that CT were compared with those performed on 9 July 2019. As a result of the new imaging and comparison with the earlier, the impression was of an:

    "*Evolving moderate volume acute infarct in the left MCA territory, corresponding to the site of perfusion changes on the recent CT perfusion study. Mild positive mass effect. No acute intracranial haemorrhage.*

    Apparent occlusion of the left M2 branch, corresponding to the site of acute ischemia.

    Hypoattenuating thrombus/plaque in bilateral proximal internal carotid arteries, causing significant potentially flow-limiting stenosis. Of note, the right ICA thrombus / plaque was present on the initial study on 09/07/2019 at 1924hrs, appeared almost resolved at 2010hrs, and has returned on this study performed a few hours later."

55. A review of Mr Smith's condition at 11:02am[24] documented he was haemodynamically stable, with the following vital signs:

    - HR 100-120
    - GCS 7-9
    - Pupils (R) 4+ (L) 3+

56. A progress note at 11:30pm on 10 July 2019,[25] indicated Mr Smith had been admitted to wards. His GCS was then documented as 10, however there had been a reduction in his pupil size to (R) 3+ and (L) 2+.

57. A progress note at 8:50am on 11 July 2019,[26] noted Mr Smith was experiencing spontaneous movement in his left side. The impression was that he had sustained a bilateral MCA stroke impacting the left side more than the right. The plan was to continue the Heparin infusion and maintain IV fluids.

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[21] E13 - p. 54/180
[22] E13 - p. 54/180
[23] E13 - p. 147/180
[24] E13 - p. 54/180
[25] E13 - p. 58/180
[26] E13 - p. 59/180

58. At 11:50am on 11 July 2019,[27] Mr Smith was responsive and attempting verbal communication. During a meeting with a social worker at 12:05pm, it was documented that Mr Smith's mother and sister were present. While both were distressed, there were no concerns raised as to his care and treatment at that time.[28]

59. Subsequent progress notes are unremarkable although there is an impression that Mr Smith's condition was improving. On 17 July 2019, plans had commenced to transfer Mr Smith from the RBWH back to Caboolture Hospital.[29]

60. A progress note at 4:00pm on 17 July 2019 documented Mr Smith's mother had raised concerns with the Office of the Health Ombudsman in relation to Mr Smith's transfer to Caboolture Hospital. Her preference was for him to transfer to Metro South (QEII Hospital).[30]

61. On 20 July 2019, at about 7:15pm,[31] Mr Smith experienced vomiting and a drop in his GCS. He was intubated and transferred to the CT scanner which identified a large haemorrhagic transformation. There was sulcal and basal cistern effacement. Mr Smith was haemodynamically unstable, and he was admitted to the ICU

62. Mr Smith's family was informed that he was unlikely to make a "*meaningful functional recovery*". It was considered that surgery too high a risk given his anticoagulation therapy and that he would not survive an operation.[32] It was also documented that the pressure was unable to be controlled with medical means.

63. The impression from the CT scan was that Mr Smith had experienced a "*multifocal parenchymal haemorrhage at the site of the recent cerebral infarction, with subarachnoid and intraventricular haemorrhagic extension, 12mm midline shift to the right, transtentorial and tonsillar herniation*".[33] The plan was for palliation only.

64. At 11:32pm on 20 July 2019,[34] there was a meeting between Mr Smith's treating team and his family. The family were informed that he had sustained catastrophic brain injury and he was no longer able to independently maintain vital functions such as breathing and blood pressure. They were informed he was being kept alive with medication and life support and that he was unlikely to survive the night. It was agreed by family that he was not for CPR if he arrested.[35]

65. As at 3:50pm on 21 July 2019, it was documented that Mr Smith had proceeded to brain death which was confirmed by CTA scan on 22 July 2019. Death was declared at 11:30am on that date. However, life support was maintained for the purpose of organ donation.[36]

66. During a family discussion on 22 July 2019, Mr Smith's mother raised questions about his anticoagulation therapy.

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[27] E13 - p. 59/180
[28] E13 - p. 65/180
[29] E13 - p. 99/180
[30] E13 - p. 97/180
[31] E13 - p. 117/180
[32] E13 - p. 118/180
[33] E13 - p. 120/180
[34] E13 - p. 121/180
[35] E13 - p. 122/180
[36] E13 - p. 131/180

67. The coronial investigation examined the issue of the gaps in the provision of Anagrelide to Mr Smith, whether due to lack of availability or non-compliance, and the extent to which that may have contributed to the infarcts.

68. A statement was taken from Dr Chng, the Visiting Registered Medical Officer at the WCC at the time of Mr Smith's death. Dr Chng had held that position since 2017. He was also Senior Medical Officer at Kilcoy Hospital and an Associate Lecturer at the University of Queensland. Dr Chng has not previously treated Mr Smith.

69. Dr Chng had the benefit of reviewing Mr Smith's medical records from WCC. He consulted with Haematologist, Associate Professor Kennedy of the RBWH in preparing his statement.

70. Dr Chng identified Mr Smith initially suffered a right middle cerebral artery (MCA) infarct that "*subsequently transformed*" into a haemorrhagic stroke from which Mr Smith did not recover.[37]

71. Noting Mr Smith's underlying condition of essential thrombocytosis, and associated high platelet count, Dr Chng confirmed that Mr Smith had a higher risk profile for thromboembolism, potentially leading to strokes or heart attacks.[38]

72. Dr Chng was satisfied that the treatment and care received by Mr Smith at WCC was appropriate. While acknowledging several gaps in the provision of Mr Smith's Anagrelide, Dr Chng considered it "*highly unlikely*", that those gaps contributed to Mr Smith's "*demise*".[39] He reported that this view was supported by A/Professor Kennedy.

73. It was also Dr Chng's opinion that Mr Smith had "*end stage*" essential thrombocytosis and that the death was not unexpected.[40]

74. A statement was also taken from Dr Nicholas Weber, Consultant in Haematology at the RBWH. While Dr Weber limited his comments to the care and treatment received by Mr Smith at the RBWH, he referred to the issues surrounding non-compliance with medication, and by extension non-availability. Dr Weber commented:

> "*Mr Smith's complex co-morbidities placed him at paradoxically increased risk of both ischaemic and haemorrhagic complications. His noncompliance with prescribed medication compounded these risks. Based on his more recent symptoms which were consistent with microvascular ischaemia, I believe it was appropriate for him to be treated with anticoagulation (rivaroxaban) and cytoreductive agents (hydroxyurea and anagrelide). I also believe it was appropriate for him to be therapeutically anticoagulated when he developed his ischaemic stroke in July*".[41]

[37] B4 - p. 2/6, para. 8
[38] B4 - p. 2/6, para. 9
[39] B4 - p. 5/6, para. 27
[40] B4 - p. 5/6, para. 26
[41] B15 - p. 4/4, para. 13

75. Significantly, Dr Weber commented on the brief period of non-administration of Anagrelide between 1 June 2019 and 4 June 2019, stating:

> "*In my opinion the significance of this brief interruption in treatment is minor and would have been unlikely to precipitate his stroke which occurred almost a month later*".[42]

76. Ms McCann expressed a number of specific concerns in relation to the circumstances of her son's death and the care he received. Ms McCann was concerned in relation to Mr Smith being ceased on the drug Lyrica following his admission from 9 July 2019. In circumstances where that drug was not prescribed to treat the essential thrombocytosis and did not affect the risk of stroke, I do not consider that concern had any bearing on his death.

77. Ms McCann also expressed a concern about the decision to transfer Mr Smith from the Brisbane Correctional Centre (BCC) to WCC. Having regard to associated progress notes, that decision was based on the need to facilitate a psychiatric assessment in light of suicidal ideation and non-compliance with medication.

Autopsy results

78. An external only autopsy was performed on 25 July 2019. The forensic pathologist, Dr Forde, had the benefit of the medical records from WCC, Caboolture Hospital and the RBWH. A full CT scan was also undertaken as part of the autopsy and revealed a large left side intracerebral haemorrhage.

79. Dr Forde explained his essential thrombocytosis increased his platelet (clotting component of blood) count. This can increase the risk of blood clot formation. Despite Mr Smith being on blood thinning medication, he developed clots in his internal carotid arteries, the main vessels that provide blood to the brain. These clots subsequently led to a stroke. Dr Forde noted that blood thinning medications are used to reduce the progression of a stroke. However, a risk of this treatment is haemorrhagic transformation of the stroke.

80. The cause of death was recorded as:

> 1(a) Haemorrhagic transformation of cerebral infarction, *due to, or as a consequence of*
> 1(b) Bilateral internal carotid artery thrombosis (anticoagulated), *due to, or as a consequence of*
> 1(c) Essential thrombocythaemia.

Conclusions

81. I accept the conclusions of the CSIU investigation that Mr Smith died from natural causes and that there were no suspicious circumstances associated with the death.

82. After considering all the evidence, including Mr Smith's health records from the WCC, Caboolture Hospital and the RBWH am satisfied that the medical care and treatment he received while in custody was appropriate in the circumstances.

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[42] B15 - p. 4/4, para. 14

83. I accept the evidence of Dr Chng that after Mr Smith was transferred to WCC he continued to received appropriate care and treatment. His placement at WCC did not prevent him from accessing medical care as his treatment was quickly escalated to the RBWH, a tertiary hospital.

84. While there were several days where there were gaps in the administration of Anagrelide, only three of those days were the result of the WCC Health Service not having this medication in stock. The remaining occasions were the result of medication refusal by Mr Smith.

85. I acknowledge Ms McCann's concern that Mr Smith did not receive all of his medication. However, I accept the evidence of Dr Chng and Dr Weber that it was unlikely to have contributed to the circumstances of Mr Smith's death, particularly as he was given ongoing access to other cytoreductive medication while in custody.

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. After considering all of the evidence, including the material contained in the exhibits, I make the following findings:

Identity of the deceased – David Frederick Smith

How he died – Mr Smith was a remand prisoner at the Woodford Correctional Centre. He suffered from essential thrombocytosis, a disorder leading to the overproduction of platelets. Mr Smith had a genetic mutation which caused this condition. As a consequence, the risk of thromboembolism was high.

Early on 10 July 2019, Mr Smith was transferred from Caboolture Hospital to the Royal Brisbane and Women's Hospital with an acute ischaemic stroke and bilateral internal carotid artery thrombus. He was managed with heparin anticoagulation.

Plans were made for Mr Smith to transfer back to Caboolture Hospital on 20 July 2019, but he suffered an acute neurologic decline and was transferred to the RBWH Intensive Care Unit. Brain imaging showed haemorrhagic transformation of the infarct with established signs of elevated intracranial pressure. This is a recognised complication of ischaemic stroke.

Place of death – Intensive Care Unit, Royal Brisbane and Women's Hospital, Herston

Date of death– 22 July 2019

Cause of death – 1(a) Haemorrhagic transformation of cerebral infarction, *due to, or as a consequence of*
1(b) Bilateral internal carotid artery thrombosis (anticoagulated), *due to, or as a consequence of*
1(c) Essential thrombocythaemia.

87. There was no evidence of any systemic deficiency in the care and treatment Mr Smith received while in custody. Accordingly, there is no basis for making any comment or recommendations under s 46 of the *Coroners Act* in this matter.

88. I extend my condolences to Mr Smith's family and friends. I close the inquest.

Terry Ryan
State Coroner
BRISBANE