OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Sheldon Douglas CURRIE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/662
DELIVERED ON:	3 November 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	03 June 2011, 17 – 21 October 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest; death in custody, health care, infectious diseases

REPRESENTATION:

Counsel Assisting:	Mr Simon Hamlyn-Harris
Family of Mr Currie:	Ms Maria Rinaudo-Lewis (instructed by ATSILS)
Dr Sean Pham:	Mr Geoff Diehm SC (instructed by Quinlan, Miller & Treston Lawyers)
The GEO Group Australia Pty Ltd:	Mr Sandy Horneman-Wren SC (instructed by Blake Dawson)
Department of Community Safety:	Ms Kerri Mellifont SC (instructed by Departmental Legal Unit)
Princess Alexandra Hospital:	Ms Anna-Maria Lofaro (Minter Ellison Lawyers)

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The *Coroners Act 2003* provides in s47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest, and to various officials with responsibility for the justice system. These are my findings in relation to the death of Sheldon Douglas Currie. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

Introduction

Sheldon Currie was eighteen years of age and had been in custody for a little over a month when he was transferred from the Arthur Gorrie Correctional Centre (AGCC) to the Princess Alexandra Hospital (PAH) on 16 February 2010 after he had been found unconscious in his cell. He died four days later from the effects of severe liver failure.

These findings:

- Confirm the identity of the deceased person, the date, place and medical cause of his death and the circumstances in which it occurred as required by section 45(2) of the Act;
- Critique the quality of care provided to him while a prisoner at the AGCC; and the quality of the health care provided to him at the PAH; and
- Consider whether any changes to the policy or procedures of the AGCC would reduce the likelihood of deaths occurring in similar circumstances in future or otherwise contribute to public health and safety.

The investigation

The death was investigated by officers from the Queensland Police Service Corrective Services Investigation Unit (CSIU). Those officers did their best to access all relevant information and effectively demonstrated no criminal conduct by any third party was involved in the death. Understandably perhaps the CSIU officers did not critique the quality of the health care provided to Mr Currie so as to enable a consideration of whether his death could have been prevented.

In his final report, the CSIU investigator expressed some dissatisfaction with the manner in which the staff from the AGCC provided their versions of the relevant events. He suggested all such versions should be compiled by the QPS investigator. However the emails passing between the investigator and the staff seem to indicate the investigator was content if they provided statements themselves and indeed he sought the issuing of notices under s16 of the Act to cause this to happen. Accordingly, I am not persuaded there was any lack of cooperation by AGCC staff members.

An investigation was also undertaken by inspectors appointed by the Chief Inspector of Prisons. Their investigation looked into the circumstances of the

death; the medical assessment of Mr Currie on admission to the AGCC and subsequently; and the response to Mr Currie's collapse. It made six recommendations.

The CSIU investigator queried the utility of concurrent investigations undertaken by that unit and those appointed by the Chief Inspector. He recommended a single investigation addressing both the needs of the coroner and the Chief Inspector. I don't accept that the needs to both offices are identical. Coroners and the Chief Inspector have different statutory responsibilities. It is appropriate they commission separate investigations. Further, the delay usually encountered with provision of reports from the CSIU would not be acceptable to the Chief Inspector who needs to be alerted urgently if any prison procedures are connected to a death in custody.

A further investigation was undertaken by the Health Quality and Complaints Commission. It focussed on five of the recommendations contained in the Chief Inspector's report which dealt with health issues.

Those assisting me obtained reports from independent medical experts to further address the adequacy of care issue.

As a result of considering the material generated by the three investigations and the expert reports, I am satisfied all necessary inquiries have been made and all relevant evidence was put before the inquest.

The inquest

A pre-inquest conference was held in Brisbane on 3 June 2011. Mr Hamlyn-Harris was appointed counsel assisting and leave to appear was granted to the family of Mr Currie, the operators of the AGCC, the PAH, the Department of Community Safety and Dr Pham.

An inquest was held in Brisbane over five days commencing 17 October 2011. Evidence was heard from 18 witnesses and 131 exhibits were tendered. On the final day helpful submissions were received from those granted leave to appear.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits and transcript of proceedings but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Social history

Sheldon was born on 14 March 1991 in Brisbane. His father died when he was very young. He had one older brother. Sheldon was a member of the Bunjalung group of tribes via his father's family. These people were the traditional owners of the land around the catchments of the Logan and Albert Rivers.

He went to Serviceton South State School in Inala but didn't proceed to high school. When he was quite young he started getting into trouble with the police for stealing from shops and unlawfully using motor vehicles. He was sniffing paint and regularly spent time in juvenile detention centres.

When Sheldon wasn't incarcerated he lived with his mother, Donna Smith in Inala.

It is apparent that at various stages throughout his life Sheldon abused illicit drugs – he sniffed paint and injected amphetamines and reported to the AGCC staff member who interviewed him on reception that he had been using heroin daily.

Custody

On 20 November 2009 Mr Currie was released from the AGCC after serving a sentence for property offences. During that sentence he had also been dealt with in relation to other matters which resulted in him being placed on probation for a period of thirty months.

On 7 January 2010 he was arrested and charged with unlawful use of a motor vehicle, shop stealing and burglary. He was taken to the Richlands Watch House.

On 8 January 2010 he appeared in court, bail was refused and Mr Currie was remanded in custody.

On 12 January 2010 he was transferred to the AGCC.

Admission to AGCC

Upon admission to the AGCC Mr Currie went through the usual assessment process. He was first seen by a counsellor who undertook an Immediate Needs and Risk Assessment (INRA), which, as the name suggests, identifies those prisoners who might need immediate psychiatric or other medical attention. No such needs were identified in Mr Currie's case.

The next step in the reception process was a two stage medical in confidence assessment. The first stage involved his being seen by a nurse who undertook a basic clinical assessment. That revealed nothing of concern but alerted staff to the fact Mr Currie had been prescribed Flucloxacillin, a penicillin type antibiotic, for boils while at the watch house. This information was conveyed to one of the AGCC visiting medical officers (VMO), Dr Pham, who said he viewed the watch house medications sheet confirming this but not the patient, before he ordered the medicine be given to Mr Currie, twice per day, for the next five days to complete the course.

The medication sheet in Mr Currie's medical file indicates that on no occasion did Mr Currie take the antibiotics twice per day as ordered and in fact he only took it on four occasions.

Next, Mr Currie was seen by Nurse Gibson who administered a lengthy medical history questionnaire, which, relevantly to these proceedings, resulted in Mr Currie disclosing he had engaged in intravenous drug use with shared needles. This caused Mr Gibson to persuade him to undergo testing for blood born diseases.

Mr Currie was then seen by another VMO, Dr Kathrada, who reviewed the information gathered by the in-take nurse and conducted a general examination which he said included looking for signs of jaundice in Mr Currie's sclera and questioning him as to whether he was suffering from any ailments. Dr Kathrada noted nothing of concern.

On-going health care

Mr Currie was allocated a cell in unit D5. In that cell block were other prisoners with whom he had previously been friendly including Alonzo McAvoy and Branson Frazer.

It seems Mr Currie resumed his friendship with these and other inmates. He regularly used the gymnasium and played football on the weekends.

The correctional officers who worked in D5 report he was polite, courteous, sociable and outgoing.

On 14 January, a blood sample was taken for testing in accordance with the consent given by Mr Currie on his reception to the centre. It was sent to the pathology laboratory at the PAH. The results indicating Mr Currie was positive for Hepatitis B and C were faxed to the AGCC on 18 January. As a result he was seen by Dr Pham on 22 January.

No record was made of this consultation and Dr Pham admitted he had no recollection of what was said. He was sure he advised Mr Currie of the outcome of those tests and counselled him on how to manage his illness and avoid infecting others.

Dr Pham said that because Mr Currie did not show any physical signs of liver disease he did not think further blood tests or a liver function test were necessary. Dr Pham did not undertake a physical examination of Mr Currie. At the inquest he unconvincingly suggested either he had offered to order a liver function test which Mr Currie had refused, or he did not order a test because despite being advised of it Mr Currie did not ask for one. I conclude Dr Pham did not discuss any testing or treatment of Mr Currie's Hepatitis with him because he did not believe either was appropriate in a remand setting.

It seems from entries in various log books Mr Currie also went to the medical centre on 20, 21 and 24 January but no entry was made in his medical file recording the reasons for these visits. The medical file does contain a permission form excusing him from work on 1 February on the basis he was "*unable to lift*".

The medication chart indicates that on 13 February Mr Currie was prescribed Dicloxacillin by a Dr Hussain. There is no record of the consultation in the progress notes. It is likely he sought treatment for his boils as cctv recorded vision shows him leaving the medical centre with what appears to be fresh dressings. However, he did not present to the nurse doing the medication rounds on the next two days to receive the medication.

The next day Sheldon was unwell. Max Hayat, a CSO working in the unit, said that before lunch he told him he wasn't hungry and just wanted to sleep. CSO Hayat said he was unsuccessful in attempts to persuade Mr Currie to go to the medical centre. It seems he spent most of the day sleeping in his cell.

Mr Currie was no better on 15 January. He did not leave his cell when the door was unlocked at about 8.00am. He looked unwell and did not want to get up. Mr Hayat said in his statement, "*He looked very tired and could barely lift his head*." He came out of his cell for the 11.00am muster but was clearly still unwell.

Early in the afternoon Mr Currie was persuaded to go to the medical centre. CSO Hayat asked his friend Mr McAvoy to go with him. The cctv footage shows them leaving the unit at 2.02pm. Mr Currie can be seen to be walking slowly but does not appear noticeably unwell.

Mr Currie was let into the nurses' treatment room by the CSO regulating access to the medical centre. When Nurse Innes returned from lunch she attended to him. She said he told her he was there for treatment of his boils and that he felt unwell. She did not ask him how long he had been unwell nor anything else about his condition. Indeed, she told the inquest he looked "*bright and responsive*".

When she reviewed Mr Currie's file she noticed he had been seen two days earlier for boils and that he had not taken the antibiotics he had been prescribed on any occasion since then. She therefore lectured him on the need to do so and administered a tablet herself. She took basic observations and noted Mr Currie's temperature was elevated at 38 degrees but nothing else seemed out of the ordinary. Nurse Innes dressed Mr Currie's boils, gave him Panadol and sent him back to his unit. She believed his symptoms were consistent with a mild infection. The unit log records him being re-admitted at 3.07pm. He returned to his cell. Nothing more is known about how Mr Currie spent the remainder of the day.

Because Mr Hayat was concerned about him, when he finished work for the day at 6.30pm he made an entry in the officers' handover book, "*Keep a close watch on Sheldon.*" He also noted Sheldon had been sent to the medical unit that day.

Apparently none of the CSOs undertaking head counts during the night noticed anything out of the ordinary.

Hypoglycaemic coma

The next morning CSO Ann-Maree O'Brien was working in unit D5. She didn't do the head count and welfare check as required: she said she was too busy getting prisoners who were to work outside of the unit ready to go.

At about 8.10am the nurse doing the regular medication round, Lynette Brown accompanied by a "rover" CSO arrived at D5 and commenced to dispense medication to those prisoners who presented to receive it. The nurse and CSO agreed that soon after, they were approached by a prisoner and a CSO both of whom expressed concern about Sheldon and asked Nurse Brown to review him urgently. She did so.

When Nurse Brown entered Sheldon's cell she saw him lying on his back on top of the bed clothes with his eyes closed. She repeatedly called his name, shook his arm and rubbed the front of his chest to try and get a response. None was forthcoming and so she asked one of the two CSOs who had accompanied her to the cell to call a "Code Blue", the term used in correctional centres for a radio broadcast to alert all staff of a medical emergency. While waiting for the staff she knew would bring an emergency medical trolley, Nurse Brown rolled Mr Currie onto his side, confirmed that his airway was unobstructed and that he was breathing and measured his pulse – 70 bpm, and his respiration – 20 bpm.

A few minutes later Nurse Crowe arrived with the medical trolley. She suggested a blood sugar level be taken. It registered a very low 1.7mmol which prompted the nurses to administer a Glucogen injection. Mr Currie was then carried downstairs and put on a trolley so he could be taken to the medical centre. As this was happening he regained consciousness but was obviously confused and disorientated. He was given oxygen as he was transported to the medical centre.

At the medical centre a full suite of vital signs were gathered: of note were a body temperature of 34 degrees and a blood sugar level of 1.3 mmol/L. A second dose of Glucogen was given intramuscularly, blood was taken for testing and intravenous fluids were started, including a bolus dose of 12.5 gms of glucose. It seems Mr Currie lapsed into unconsciousness again during this period as the neurological observations chart recorded at 9.30am *"eyes open spontaneously, verbal response, confused, obeys commands."* Nurse Crowe also noted in her statement that he regained consciousness about this time and was insistent he was "alright." For the next two hours Nurse Crowe had Mr Currie under constant observation in a one on one nursing setting in the treatment room. During this time he ate a sandwich, drank some water with assistance and communicated freely.

Accordingly, at about 11.30 he was moved to an 8 bed ward and monitored intermittently. All who had contact with him during this period say he was alert and responsive.

At 3.53pm the blood test results were faxed to the medical centre. Dr Pham said he saw them at 4.30pm. They showed Bilirubin total of 143 (normal < 20);

Alanine Transaminase – 5290 (normal < 45); Aspartate Transaminase -5150 (normal < 35); lactate dehydrogenase – 3220 (normal 150 – 280); glucose - 0.8 (normal 3.0 – 7.8.) These results made it clear Mr Currie was undergoing complete liver failure. Dr Pham said that for the first time he noticed Mr Currie was jaundiced.

Dr Pham called the emergency department at the Princess Alexandra Hospital (PAH) and discussed his case. It was agreed an immediate transfer was required.

An ambulance was called at 5.22pm and a crew arrived at the medical centre at 5.47pm. The QAS assessment notes Mr Currie to be jaundiced, dizzy, light headed, and anxious.

Transfer to PAH

He was examined at the PAH emergency department at 6.45pm. His consciousness level fell (GCS – 7) and at 9.10pm Mr Currie was intubated, mechanical ventilation was instituted and a central arterial line was installed. He was transferred to the Intensive Care Unit (ICU). It was realised immediately that Mr Currie was suffering from acute liver failure. It caused cerebral oedema, and severe hepatic encephalopathy and coagulopathy. The ICU clinicians attempted to manage these symptoms while consulting the gastroenterology team to try and establish the cause of the liver failure.

Numerous relatives visited on 18 February but Mr Currie could not communicate with them.

On 19 February test results confirmed an extremely high viral load of Hepatitis B infection. A specific anti viral therapy was started.

On 20 February Mr Currie's pupils were fixed and dilated. A CT scan confirmed catastrophic brain injury: cerebral oedema and tonsillar herniation. It was explained to Mr Currie's mother that death was now inevitable. Accordingly, she agreed that invasive therapies should be withdrawn and Mr Currie died at 8.38pm.

Autopsy results

On 22 February a three cavity autopsy was undertaken by Dr Beng Ong, an experienced forensic pathologist. He noted a number of boils and healing sores on Mr Currie's arms and legs. There were otherwise no signs of recent injury and no sign of any third party involvement in Mr Currie's death.

Although the liver appeared unremarkable externally, histology showed extensive necrosis of the hepoatocytes leaving few viable portal tracks. Significantly there was only a small amount of fibrous reaction suggesting Mr Currie did not have long standing liver disease.

The autopsy found that Mr Currie's brain was swollen with signs of herniation. Neuropathology showed hypoxic-ischaemic injury in a pattern suggestive of

hypoglycaemia. There were no findings suggestive of hepatic encephalopathy.

Dr Ong expressed the opinion that the brain injury showed features that it had been caused by the low blood sugar. In the absence of any other explanation these symptoms were most likely explained by the combined hepatitis B and C infections. Dr Ong opined that the cause of death was:

1(a) hypoglycaemic hypoxic-ischaemic encephalopathy, due to, or as a consequence of
1(b) massive liver necrosis, due to or as a consequence of
1(c) Hepatitis B and C infection

Other expert evidence

I was greatly assisted by the evidence of Dr Kevin Hourigan, an independent experienced gastroenterologist who has specialised in research, teaching and the treatment of liver disease for almost 40 years.

Dr Adam Griffin, a general practitioner employed by the Clinical Forensic Medicine Unit also provided specialist expertise in relation to the treatment of prisoners that was pertinent to the issues raised by this case.

Where it is relevant, the evidence of those practitioners is referred to in the conclusions below.

Conclusions

Liver failure

Acute liver failure is rare but is associated with high mortality. Apparently, the incidence in the developed world is between one and six cases per million people, per year. [1]

An increased risk of death from acute viral infection has been noted in patients with underlying chronic liver disease, especially that resulting from hepatitis C infection.[2]

Acute liver failure associated with hepatitis B can result not only from acute infection but also from chronic infection when the sufferer's viral status changes.[3]

The seriousness of the disease is highlighted by the following quotation:

> *Acute liver failure leads to a unique combination of often rapidly progressive severe multi-organ failure with unpredictable complications and necessitates urgent decision*

[1] Bernal With, Asuinger G, Dhawan A, Wedon J, the Lancet, "*Acute Liver Failure*", Volume 376 July 17 2010 page 190.
[2] *Ibid* page 191
[3] *Ibid* Page 192

> *making about use of the only effective treatment for those with advanced disease: emergency liver transplantation*.[4]

In Mr Currie's case there was little warning of the impending flare up of the disease. By the time the cause of his illness was identified he was far too sick for an emergency liver transplantation.

Dr Hourigan said in his report:

> *It is unlikely that earlier intervention and involvement of specialist advice in treatment in the few days of illness prior to admission to the Princess Alexandra Hospital would have changed the course of events. The die was cast at and before the deceased himself noticed any symptoms and no amount of specialist advice and treatment would have changed the course of the illness had it been applied in the four days of the clinical prodrome, February 13th to 16th 2010.*

There is no suggestion the treatment given at the PAH was anything other than entirely appropriate.

I have some concerns about some aspects of the way in which Mr Currie was treated while he was incarcerated at the AGCC that I shall detail below. However, it is important to keep in mind the unchallenged expert evidence that nothing about the way in which Mr Currie's illness was responded to by the staff of the AGCC caused or contributed to his death. He was suffering a relatively common and largely benign disease that without warning flared into a hyperacute presentation that could not be reversed. That could not have been reasonably foreseen or prevented by the medical staff at the AGCC.

Further, I saw no evidence that any lack of care or compassion impacted on the quality of the health care given to Mr Currie. All of the witnesses who gave evidence impressed me as dedicated and professional.

Quality of care

The standard against which medical care of prisoners should be judged is found in the G*uidelines for Corrections in Australia 2004* to which the Queensland Government is a signatory. It says in paragraph 2.26

> *Every prisoner is to have access to evidence based health services provided by a competent registered health professional who will provide a standard of health care comparable to that of the general community.*

The standard also provides in paragraph 1.10 that *"the treatment of remand prisoners should not be less favourable than that of sentenced prisoners"*.

[4] Ibid Page 194

I will now attempt to apply that standard to the care provided to Mr Currie.

Prescription of Flucoxacillin

The medication sheet which came with Mr Currie from the watch house to the AGCC showed he had been prescribed an antibiotic, Flucoxacillin, to assist with the treatment of skin boils. Drugs do not accompany prisoners from the watch house to prison. Dr Pham was shown the medication sheet and noted the course had five days to run. He did not see the patient but prescribed the drug nonetheless. Two issues are raised:

- Should Dr Pham have prescribed the drug without examining the patient; and
- Should he have prescribed Flucoxacillin

Prescribing in absentia

There are many circumstances in which a doctor might prescribe drugs without seeing a patient. The question is not whether he or she examines the patient but whether he or she has sufficient information about the patient's condition to form a properly considered view as to the appropriateness of the medication in question.

In this case the doctor was aware another doctor had seen fit to prescribe a common medication for a minor aliment. It is almost always beneficial for patients to complete a course of antibiotics particularly when, as in this case, the symptoms which had initiated the administering of the drug persisted. I conclude there was nothing inappropriate about Dr Pham prescribing sufficient drugs to enable Mr Currie to complete the course of medication without having personally examined Mr Currie.

Should he have prescribed another drug?

The inquest heard evidence that Flucoxacillin has been associated with liver damage. The incidence of this is extremely low. Dr Griffin suggested 4-7 cases per hundred thousand patients. The antibiotic is still widely used although some doctors, including Dr Griffin and others who gave evidence at the inquest, avoid it because of this slightly elevated risk and because there is another drug, Dicloxacillin, which has similar therapeutic benefits with slightly less risk of liver damage.

In this case, Dr Pham had no basis to suspect Mr Currie had liver disease that might be exacerbated by his taking Flucoxacillin and he was aware the patient had already commenced a course of that drug. In those circumstances, I am of the view he acted appropriately in enabling Mr Currie to complete the course of Flucoxacillin commenced in the watch house.

Further, there is no evidence the drug actually caused or contributed to the subsequent liver disease suffered by Mr Currie in this case.

Response to Hepatitis B and C tests

As detailed earlier in this report when Mr Currie's blood tests indicated he was positive for hepatitis B and C, Dr Pham apparently made arrangements to see him and advise him of the results. Dr Pham says he also told Mr Currie about lifestyle issues that would reduce the likelihood of the disease negatively impacting upon him and the likelihood of his spreading the infection to other people. I have found that Dr Pham did not offer Mr Currie a liver function test nor initiate any treatment in an endeavour to cure Mr Currie of the illness. I shall deal with each of those issues separately.

Liver function test

Dr Griffin and Dr Hourigan both gave evidence that even though Mr Currie was not symptomatic when seen by Dr Pham when he explained the positive hepatitis results, a liver function test would in the ordinary course be ordered by a general practitioner in the circumstances. According to Dr Griffin *"A routine assessment for a newly diagnosed patient would include a physical examination and blood tests examining liver enzymes."* Alternatively, Dr Hourigan said some practitioners might not do this and would simply refer their patient to an appropriate specialist.

I am of the view the equivalence principle required either a liver function test to be ordered or arrangements made for Mr Currie to see a specialist. I accept it was not the usual practice of the doctors working at the AGCC at the relevant time to do so. I also accept that practice has now been changed as a result of a direction issued by Offender Health Services.

It is most unlikely had a liver function test been ordered its results would have forewarned those caring for Mr Currie of the incipient infection that was likely to flare and lead to Mr Currie's death.

Antiviral treatment

The expert evidence given at the inquest indicated Hepatitis B can be treated with anti-viral therapy and that this is more urgent and necessary when the patient also suffers from Hepatitis C. The inquest also heard the management of that treatment is complex and requires ongoing clinical monitoring and consistent abstinence from behaviour likely to lead to re-infection. It is also very expensive.

It is easy to accept that prisoners on remand and or serving short sentences may have difficulty meeting these conditions. The possibility was not explored in this case because of assumptions Dr Pham made about Mr Currie's suitability for treatment. It is almost certain his assumptions were soundly based. However, this is a systemic issue I shall deal with in the comments section of this report.

Quality of health care on 13 and 15 February

On 13 February Mr Currie was seen by Dr Hussain who prescribed him the antibiotic Dicloxacillin. It is likely he was also seen by a nurse who dressed his boils for which the antibiotics had been prescribed.

I am of the view there was no basis to conclude either health care worker should reasonably have made further investigation of Mr Currie's condition and in all of the circumstances the care provided to him on that day was appropriate.

On 14 and 15 February Mr Currie was increasingly unwell. On 14 February he spent most of the day sleeping in his cell. The next day he was no better. CSO Hayat said he "*could barely lift his head*" from the pillow when Mr Hayat went into the cell.

Sheldon was persuaded by Mr Hayat to go to the medical centre at about 2:00pm.

Nurse Innes claimed Mr Currie told her he was there for treatment of his boils. She provided appropriate treatment for that complaint and reasonably concluded on the information known to her that his raised temperature was due to the infection manifesting in those boils. She did not however have an adequate understanding of the length or seriousness of his condition. She agrees she did not ask him how long he had been sick nor did she seek any information from the CSO's on the unit.

It was submitted by those representing the family of Mr Currie that a failure to obtain this information was a result of lack of cultural competence – that because Mr Currie was an Aborigine and therefore less likely to communicate freely with older Caucasians in positions of authority, Ms Innes should have used other techniques to better explore and gain a full understanding of his health condition.

Nurse Innes gave evidence about her training in cultural awareness. In my view it was as full and complete as one could reasonably expect of a person in her position. No lack of cultural awareness contributed to any suboptimal treatment in my view. Rather, I suspect Nurse Innes may have been affected by what is referred to as confirmation bias: she knew Mr Currie had boils; she knew he had been prescribed antibiotics for them two days earlier and she knew he had not been taking those antibiotics. She concluded his current symptoms which were consistent with an untreated skin infection were as a result of that condition and she looked no further.

Fifteen hours later Mr Currie was found in a hypoglycaemic coma as a result of severe liver failure. It is possible had he been more thoroughly examined in the afternoon of 15 February his insipient disease may have been detected. However, it would not have made any difference to the outcome.

Dr Pham suggested had he been made aware of Mr Currie's fever he would have considered transferring him to hospital to enable him to receive intravenous antibiotics. In view of the fact Dr Pham did not take this step even when Mr Currie was found in a coma the next day, I place little weight on it.

Response to Sheldon's collapse on 16 February

The CSO's who were alerted to Mr Currie's continuing ill health responded promptly by requesting a nurse to attend his cell. When Nurse Brown found Mr Currie unconscious, she and her colleague, Nurse Crowe, responded appropriately.

He was quickly moved to the medical centre after being given an appropriate glucose injection.

Dr Pham examined Mr Currie and was unable to immediately diagnose the cause of the hypoglycaemia that was precipitating his unconsciousness. The doctor appropriately responded to the patient's extremely low blood sugar levels by ordering IV glucose. He sought to investigate its cause by sending blood samples for testing.

I accept the evidence of Dr Hourigan that it is almost certain Mr Currie would have been exhibiting jaundice at the time he was seen by Dr Pham but this was inadvertently overlooked by the general practitioner. Apparently this is easy to do if the examiner is not specifically looking for it.

I accept that Mr Currie was appropriately monitored with one on one nursing until he was stabilised and then periodic review in the ward throughout the afternoon.

The only contentious issue is when Mr Currie should have been transferred to the PAH.

I accept Dr Pham's evidence that his first priority was to stabilise the patient. He did this by intravenous glucose and fluids. This had been achieved by about 10:30am. Dr Pham then chose to take no further action other than monitoring Mr Currie's condition pending the receipt of the blood test results. When these were to hand he immediately recognised Mr Currie was suffering from fulminant liver failure and he was transferred to the PAH. The decision was complicated for Dr Pham as a result of Mr Currie's positive response to the intravenous glucose. By mid morning he was able with assistance to drink from a cup and was apparently well enough to eat a sandwich. He was asking to be sent back to his unit.

Those representing Dr Pham sought to justify his decision not to arrange for Mr Currie's earlier transfer by citing the evidence of the intensivist who treated Mr Currie at the PAH. Dr Walsham said that awaiting the test results didn't seem to him unreasonable. However, Dr Walsham preceded that answer with the observation that the subject was outside his area of expertise and followed it with the comment that he was not the best person to ask because it did not relate to his specialty.

A far more valid perspective from which to critique the decision not to transfer Mr Currie sooner was provided by Dr Griffin, a general practitioner with extensive experience in responding to the health needs of prisoners. He was of the opinion Mr Currie should have been transferred straight away – perhaps

even before the stabilising of his blood glucose levels. Dr Griffin said in the absence of knowledge of the cause of Mr Currie's unconsciousness immediate transfer was warranted. In his view nothing was to be gained by delaying what would inevitably be necessary.

Mr Currie was found unconscious and despite two injections of Glucogen he again lost consciousness. He was not known to be diabetic. Dr Pham's suggestion he may have been in a hypoglycaemic coma as a result of using someone else's insulin was too unlikely to provide a reasonable basis for deciding about his care. I accept Dr Griffin's opinion that delaying transfer for over eight hours was inappropriate.

I reiterate an earlier transfer would have made no difference to the outcome.

Section 45 findings

I am required to find, as far as is possible, who the deceased person was, how he died, when and where he died and what caused his death. As a result of considering all of the material contained in the exhibits and the evidence given by the witnesses, the material parts of which I have summarised above, I am able to make the following findings.

Identity	The deceased person was Sheldon Douglas Currie.
How he died	Mr Currie died from natural causes while in custody on remand.
Place of death	He died at the Princess Alexandra Hospital Secure Unit in Queensland.
Date of death	Mr Currie died on 20 February 2010.
Cause of death	He died from Hypoglycaemic hypoxic-ischaemic encephalopathy, due to, or as a consequence of massive liver necrosis, due to, or as a consequence of Hepatitis B and C infection.

Comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

The circumstances of Mr Currie's death raise a number of such issues. The Chief Inspector's report highlighted many of them and the HQCC reviewed the way those relating to health issues have been responded to.

Hepatitis testing and treatment

It was of concern that liver function tests were not ordered when Mr Currie was found to be positive for Hepatitis B and C. Offender Health Services has

since issued guidelines in relation to when they should be undertaken. Nothing more is needed from me in relation to that issue.

However, I am concerned there appears to be no process in place to ensure prisoners who are found to be positive for Hepatitis are systematically assessed for suitability for antiviral treatment. The correctional centre doctors who gave evidence seemed to rule it out for AGCC remand prisoners and were vague about when it might be appropriate for sentenced prisoners in other centres. Such an approach risks the equivalence standard not being met.

Hepatitis B and C are notifiable conditions under the Public Health Act, the object of which is to protect and promote the health of the Queensland public by preventing, controlling and reducing risks to public health and providing for the identification of, and response to notifiable conditions.

There is a high incidence of Hepatitis infection among prisoners. The risk this poses to the community when prisoners are released is obvious. The lives of many incarcerated people are much more stable and controlled when they are in prison than when they are living in the community – for example, regular attendance at medical appointments can be managed and while far from perfect, for most there is a greater opportunity to overcome addiction to illicit drugs. Full advantage should be taken of this opportunity. It was submitted on behalf of Queensland Corrective Services (QCS) that to make any recommendations about this would be inappropriate because Offender Health Services were not represented and little evidence was led in relation to the issue. I accept that but no unfairness is done to Queensland Health unless I am critical of the agency, and lack of evidence is only a problem if I am unduly prescriptive. I will do neither. The issue should not be ignored when it is otherwise so clearly within jurisdiction in this case.

Recommendation 1 – OHS review Hepatitis treatment

I recommend Offender Health Services review the availability of treatment for prisoners infected with viral Hepatitis to ensure reasonable endeavours are being made to contain the spread of this notifiable condition by treating its carriers while they are in custody.

Medical records

It became apparent during the course of the inquest that the keeping of medical records at the AGCC was seriously substandard. Some attempt was made to suggest this was an aberration peculiar to this case. Neither I nor the Chief Inspector's investigators accepted that. I am however satisfied the operators of AGCC are constructively seized of the issue.

Communication

As a result of concerns, CSO Hayat had information relevant to the assessment of Mr Currie when he went to the medical centre on 15 February which was not conveyed to the medical staff who reviewed him. The Chief Inspector's report recommended a review of the procedures for the provision

of information from custodial staff to health staff in such situations. I have been advised by QCS this has been implemented by GEO and that QCS is currently in the process of ensuring it is implemented state-wide.

Indigenous liaison

While the Chief Inspector's report did not make any finding that cultural competency contributed to lack of appropriate care for Mr Currie, it did recommend that GEO implement a process for ensuring greater involvement of the indigenous counsellors in the management of the health care of indigenous prisoners. This has happened at GEO and QCS is in the process of ensuring it happens state wide.

I do not consider there are any other issues of a prevention nature raised by the circumstances of Mr Currie's death that warrant comment from me.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
3 November 2011