QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Sen Hung CHEN**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/4150
DELIVERED ON:	26 October 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 June 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Fiona Banwell

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The *Coroners Act 2003* provides in s. 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Sen Hung Chen. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Sen Hung Chen was 65 years of age when he died while in custody, but under the care of medical staff, at the Princess Alexandra Hospital Secure Unit (PAHSU) in the early hours of 6 December 2010. Mr Chen had been imprisoned 15 months earlier at the Borallon Correctional Centre (BCC). Three months prior to his death, investigations by medical staff at PAHSU revealed cancerous lesions that had spread in such a way as to make them untreatable.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care needs adequately discharged those responsibilities; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

An investigation into the circumstances leading to the death of Mr Chen was conducted by Detective Senior Constable Suzanne Newton from the QPS Corrective Services Investigation Unit (CSIU).

Once Mr Chen had been found deceased in his hospital bed the room was appropriately secured. A QPS officer attended and took a series of photographs of the room and the body *in situ*. Detective Senior Constable Newton and another CSIU officer attended the hospital and made their own observations of the scene before liaising with hospital staff in order to access relevant medical records. Those officers later attended BCC and seized all documentation relating to Mr Chen. They took statements from several corrective services officers (CSO's) and nursing staff. The CSIU officers conducted interviews with six inmates who had the most detailed knowledge of Mr Chen and the circumstances leading to his hospitalisation.

A statement was obtained from the doctor at PAHSU who declared Mr Chen deceased and from nursing staff who had cared for Mr Chen in the month preceding his death.

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

The Inquest

An inquest was held in Brisbane on 7 June 2012. Mr Johns was appointed counsel assisting and leave to appear was granted to Queensland Corrective Services. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigating officer gave evidence and Mr Johns proposed that no further oral evidence be heard subject to objection from any other party. Mr Johns had earlier written to Mr Chen's wife, enclosing a copy of the police investigation report and explaining that he would make this submission. No objection was received to the proposed course from any party.

As a result of some concerns about a delay in medical image results being reported and disseminated, I caused inquiries to be made of the PAH. The responses satisfied me that the delay had not in any way contributed to Mr Chen's death and that the hospital was taking steps to address the causes of the delay.

The evidence

Personal circumstances

Mr Chen was born on 5 May 1945. He was a Taiwanese national who is survived by his wife, Chiu Yuan Hsiao, and his children.

On 11 November 2004 he was residing at Aspley in the northern suburbs of Brisbane with his wife and children when he and his wife were arrested and charged under Commonwealth legislation with two counts of conspiracy to defraud. These charges were not finally dealt with until 28 August 2009 when Mr Chen and his wife were both convicted. Mr Chen was sentenced to 10 years imprisonment on the most serious charge. A parole eligibility date was set for 27 August 2016 with Mr Chen to be deported to Taiwan on release.

Mr Chen was transported on the day of his conviction to the BCC where, apart from brief stays at PAHSU, he remained. Ms Hsiao was incarcerated at Brisbane Women's Correctional Centre (BWCC). After the diagnoses of Mr Chen's cancer, arrangements were made for Ms Hsiao to visit her husband on a number of occasions.

Medical history

On arrival at the BCC Mr Chen underwent an intake medical assessment where he was noted to have the following long-term medical conditions:

- Hepatitis C;
- Child Pugh B cirrhosis;
- Type II diabetes mellitus; and
- Hypertension.

During his intake assessment Mr Chen denied any history or thoughts of suicide or self harm.

Medical records from BCC which were tendered at the inquest show that Mr Chen was seen regularly by nursing staff and visiting medical officers (VMO's) throughout his stay there. In 2009 and the first half of 2010 the purpose of these assessments related to the monitoring of Mr Chen's hypertension and treatment of the side effects of that condition.

Treatment prior to death

In June 2010 Mr Chen began to complain to medical staff of a "*tender flank*" and a loss of appetite. This worsened over the course of the next month with pain levels increasing and the added symptoms of nausea and a distended stomach.

On 24 July 2010 Mr Chen was referred by a VMO to the PAHSU for a thorough assessment. On 10 August he was seen by the medical director of the unit, Dr Stuart McDonald. He thought Mr Chen might have renal/ureteric colic and ordered a CT scan of the kidneys and bladder. This was not performed until 31 August. It was not apparent to Dr McDonald when he viewed the scan, but it showed multiple pulmonary nodes and a right pleural effusion. This was picked up by the radiologist who examined the scan and reported to Dr McDonald three days later.

In the interim Mr Chen had been returned to the BCC. It is clear from the medical records that by early September 2010 Mr Chen was in significant pain. Whereas only eight weeks earlier his abdomen had been described in medical records as merely "*tender*" and the VMO had noted that he was "*not in distress*", by 3 September 2010 Mr Chen's fellow inmates were sufficiently concerned for him that they contacted the BCC medical centre on his behalf. On that day one of Mr Chen's fellow inmates told nursing staff that Mr Chen was squatting on the floor next to his bed holding his side. When nursing staff attended on him Mr Chen told them that the pain was "*different to the pain he has experienced before*".

Mr Chen was sent to Ipswich Hospital emergency department and admitted for a chest CT scan. That showed a large lesion of the right lobe of the liver which was deemed consistent with, amongst other possible causes, primary hepatocellular carcinoma. Mr Chen was transferred to the PAHSU where further diagnostic testing was conducted.

On 8 September 2010 Dr McDonald from the PAHSU rang the nursing staff at the BCC to inform them that Mr Chen had been diagnosed from CT scans with *hepatocellular* cancer which appeared to have spread to the lungs and

lung cavity. It was immediately clear that the prognosis for Mr Chen was extremely poor.

On 13 November 2010 Mr Chen was readmitted to the PAHSU as a result of medical complications arising from the cancer and his underlying liver disease. Tests performed at this time revealed the malignant cells were adenocarcinoma (glandular cancer cells) indicating that the primary cancer was not in fact from the liver even though that is where it was now most prominent. Palliative care was provided to Mr Chen and after some improvement he was returned to the BCC on 22 November 2010.

On 30 November 2010 Mr Chen was again admitted to the PAHSU as his condition had deteriorated significantly and he could no longer be managed by health staff at the BCC. He was reviewed by the palliative care team at PAHSU with this condition being considered by that time "*pre-terminal*". Mr Chen was managed medically with an emphasis on keeping him comfortable.

Shortly before 4:00am on 6 December 2010 registered nurse Argie Serina was performing a regular check on Mr Chen when she noticed that his breathing was very shallow and infrequent. Minutes later it appeared that Mr Chen had stopped breathing and the resident medical officer was notified. That medical officer, Dr James Hung examined Mr Chen and pronounced him deceased.

Two CSO's were on duty at the PAHSU at the time and they locked and secured the room that Mr Chen had occupied and made arrangements for his wife to be notified.

Autopsy results

An external autopsy examination was carried out on 7 December 2010 by an experienced forensic pathologist, Dr Beng Ong.

Samples were taken for toxicological testing and this revealed only the presence of drugs administered at the PAHSU at appropriately therapeutic levels.

Dr Ong had access to all medical records relating to Mr Chen. After considering these, the toxicological results and his own observations he issued a certificate listing the cause of death as:

> *1(a) Metastatic adenocarcinoma (unknown primary)*

Investigation findings

None of the other inmates at the BCC provided information to the investigating officers suggestive of foul play or of any deficiency or inappropriateness with regard to the treatment received by Mr Chen while in custody.

The examination of Mr Chen's room at the PAHSU revealed no signs of violence.

The investigating officer, Detective Senior Constable Newton, told the inquest that the CSIU investigation into Mr Chen's death did not lead to any suspicion that the death of Mr Chen was anything but natural.

Medical Review

The medical records pertaining to Mr Chen were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Gary Hall. He considered the treatment provided to Mr Chen following his diagnosis of cancer to have been of a very high standard. Mr Chen was provided with appropriate palliative care, his dietary needs were catered for and translation services were provided. Dr Hall was, though, concerned at the three week delay, between 10 and 31 August 2010, for a CT scan to be arranged and the three day delay in the results of that scan being reported to Dr McDonald. He noted this concern while acknowledging the delay would not have had impact on the outcome for Mr Chen.

In response Dr McDonald advised that these time frames were not unusual in his experience depending upon the clinical circumstances. In this case Dr McDonald was not concerned that the clinical presentation of Mr Chen as at 10 August 2010 called for more urgent examination. Further, representatives for the PA Hospital have stated that these timings are consistent with those that might be expected by members of the public, with a similar clinical presentation, who are being treated at the hospital.

Conclusions

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

I am satisfied that Mr Chen was given adequate medical treatment at the BCC during the latter part of 2010. Although it is clear in hindsight that his presentation in June and July 2010 was related to his cancer, the symptoms were at that time reasonably attributed to various other causes that needed to be discounted before further testing was justified. This was especially so given Mr Chen's underlying medical conditions. A timely referral was made to the PAH where more extensive testing could be conducted.

I am satisfied that the care afforded to Mr Chen by staff at the PAH after his diagnosis of cancer was of a high standard.

The opinion of Dr Hall is that a patient in a large public hospital should reasonably expect to obtain an appointment for a CT scan within a shorter time than did Mr Chen in August 2010. This is not disputed by Dr McDonald or the PAH. In response it was noted only that there was no difference in this regard between the quality of treatment provided to prisoners and that provided to other members of the public. There is no evidence contradicting that submission.

Findings required by s45

I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased –	The deceased person was Sen Hung Chen
How he died -	Mr Chen died from natural causes while in custody within the secure unit of the Princess Alexandra Hospital.
Place of death –	He died at Buranda in Queensland.
Date of death –	He died on 6 December 2010.
Cause of death –	Mr Chen died from metastatic adenocarcinoma of unknown origin.

Comments and recommendations

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

The delay in Mr Chen's receipt of a CT scan in August 2010 and the three day delay in the reporting of the result are the two matters on which I have considered commenting. I am aware, from the evidence tendered in this inquest and another recent inquest, that significant changes are underway to the manner in which radiology results are reported at the PAH. In short, the new system will provide for electronic reporting and better access by the radiologist to the patient file.

The three week delay for a CT scan is inherently linked to the availability of appropriately qualified medical staff and equipment. I am acutely aware that these matters are constantly reviewed by hospital administrators in the much wider context of a surplus in the demand for medical services over the finite resources available. In circumstances where there was no link between the death and the delay in this case, I do not consider that I can make useful comment or recommendations in this regard.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
26 October 2012