CORONERS FINDINGS AND DECISION

PLACE INQUEST HELD: Brisbane
DATE: 12 October 2005

This is the inquest into the death and circumstances of death of **Mark Anthony Waldon, known as Mark Anthony Herricane**

1. I must deliver my findings pursuant to the provisions of the *Coroners Act 1958.* I do so, reserving the right to revise these reasons should the need or the necessity arise.

2. The purpose of this inquest, as of any inquest, is to establish, as far as practicable –

- The fact that a person has died:
- The identity of the deceased person; and
- Whether any person should be charged with any of those offences referred to in section 24 of the Act.
- Where, when and in what circumstances the deceased came by his death

3. It should be kept firmly in mind that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence suitable for a criminal trial are not suitable for an inquest.

4. In an inquest there are no parties; there is no charge; there is no prosecution; there is no defence; there is no trial. An inquest is simply an attempt to establish facts. It is an inquisitorial process, a process of investigation: These observations were confirmed by Justice Toohey in *Anetts v McCann* ALJR at 175.

5. A Coroner's Inquest is an investigation by inquisition in which no one has a right to be heard. It is not inclusive of adversary litigation. Nevertheless, the rules of natural justice and procedural fairness are applicable. Application of these rules will depend on the particular circumstances of the case in question.

6. In making my findings I am not permitted, under the Act, to express any opinion, on any matter which is outside the scope of this Inquest, except in the form of a rider or recommendation.

7. The findings I make here are not to be framed in any way which may determine or influence any question or issue of liability in any other place or which might suggest that any person should be found guilty or otherwise in any other proceedings.

8. All proceedings before this Court are sad proceedings. At this stage I express my sympathy and condolences, and that of the Court, to the family and friends of the deceased in their sad loss, in the tragic death of Mark Herricane

The mother and brother of the deceased were present during the inquest as well as a former partner. Also appearing by leave were legal representatives for GEO Group Australia Pty Ltd formerly known as Australian Correctional Management Pty Ltd, the operators of the Arthur Gorrie Correctional Centre. The Department of Corrective Services were represented as well as a registered nurse, Ms Juanita Graham.

Summary of evidence and discussion.

Detective Acting Sergeant Steven McCartney, was the principal investigator of this death with the Corrective Services Investigation Unit. He was notified of a death at the prison by pager at 9. 54 am on 3 January 2002. The death occurred in Unit B4 and when Detective McCartney arrived at the prison, all prisoners in the unit were locked down. B4 is a protection unit with forty cells, some with double up capacity. Cell number 2 was a double capacity cell housing the deceased and Paul Beaumont.

I note that records show that Mr Herricane came into police custody on 26 December 2001 and into the Arthur Gorrie Correctional Centre on 28 December 2001. He died on 3 January 2002, six days later. On entry to Arthur Gorrie he is recorded as weighing sixty nine kilograms, but at the autopsy he weighed sixty three kilos, a loss of six kilos in five days.

The cell was searched and nothing suspicious was located. Detective McCartney interviewed other prisoners. The collective view of other prisoners was that it was clear to them that Herricane was ill, appearing inactive and wrapping himself in a doona despite the heat. He was not eating or drinking sufficiently and other prisoners took him food and drinks and tried to get him to take it. There was a previous incident when Herricane had fallen in the laundry area. It was reported that he was constantly vomiting and dry retching. Some of these other prisoners had known Herricane for an extended time of up to ten years and also knew that he was a long term user of heroin.

The records showed that Herricane had revealed his heroin dependent status and was accordingly accessing the withdrawal treatment regime at the time of his death. Upon admission to Arthur Gorrie Mr Herricane was initially placed under observation but after assessment, was able to go into a shared cell from the night of 2 January 2002.

Detective McCartney ascertained from the cellmate Mr Beaumont, and from the log, that calls were made to notify prison authorities of concern for Mr Herricane. Each cell has an intercom system to enable a prisoner after lock down to contact master control or remand control. Prison officers perform random visual headcounts throughout the night when they attend each unit and look into each cell, but otherwise the units are locked down at night and not physically manned. The intercom can be diverted either to remand control (in charge of the remand section where Mr Herricane was housed,) or to Master Control, which is the control of the whole prison.

The records show the first call during the night of 2 January was at 9 .21 pm and was answered six seconds later. The next call was at 4.31 am and was answered three seconds later. A further call was made 5.04 am and was answered two seconds later.

Another call was made at 5.30 am and answered twelve seconds later. A call was then made at 6.09 and answered five seconds later. There was a call at 6.35am, answered 10 seconds later and finally a call was made at 9.03 answered 26 seconds later.[1]

Matangirau Taylor was a correctional officer on duty on the medical unit overnight on 2 / 3 January 2002.[2] He was there to provide security for the medical centre and observing prisoners in the medical unit. His statement was that he received a call from master control at 9. 17 pm on 2 January 2002. He logged that call in the night shift medication log book. He was informed that Mark Herricane from unit B4 cell 2 was suffering from cramping. He wrote this down in the medication book. He said he informed medical staff of this phone call. He said it is their duty to respond. He remembers one of the nurses was Juanita Graham. He does not remember the other one. He remembers one of the nurses went out to do some medication rounds. He does not know if Herricane was visited. There is no record of Mr Herricane being visited until about 5.17 the following morning.

He then recalls another call from master control about Herricane at 4 .30am on 3 January 2002. Again, his evidence is that he told medical staff that Herricane was suffering from cramps. This is consistent with Nurse Kambouris and Nurse Fraser's evidence that at hand over, Nurse Graham told them there had been numerous calls during the night from Herricane.

He said he could not remember whether or not he filled out the medication book but he told the medical staff about it. **The record shows that Mr Taylor did not document the 4.30am call.**

He knows that Nurse Graham left the medical centre some time after this with other correctional staff and Manager Lackey to visit Herricane. He had finished his shift before she returned.

The statement of **Shannon Coffey** is noteworthy.[3] She was a roving officer doing the night shift headcounts. She did not see anything unusual. But she did recall speaking with Nurse Graham sometime during that shift. Nurse Graham said that Herrricane had buzzed up during the night but she could do nothing for him as he was going through withdrawals. The conversation happened on the walkway as they walked out of the unit and headed back to movement control. She cannot recall when that happened during the night. She completed her shift at 6. 30am.

The calls via the intercom for medical assistance from Mr Herricane's cell were all made by his cellmate, **Paul Beaumont**. Mr Beaumont, according to his sworn statement, had known Mr Herricane for about fifteen years. Mr Beaumont had asked to double up with Mr Herricane as a buddy because he was sick.

When Mr Herricane arrived to share the cell with Mr Beaumont, (having been released from the observation cells,) Mr Beaumont noticed that he had lost a lot of weight since last seeing him about a year earlier. He was exceptionally thin. From 3pm on 2 January 2002 Mr Herricane shared a cell with Mr Beaumont. Mr Beaumont

[1] Exhibit 98
[2] Exhibit 14
[3] Exhibit 16

observed Mr Herricane to be constantly vomiting. Mr Beaumont and another prisoner helped him into the cell at lockdown. Mr Beaumont's statement details trying to get Mr Herricane to hold down fluids, but that Mr Herricane continually vomited and he was in cramping pain. He needed assistance to shower.

Mr Beaumont used the intercom during the night to request medical assistance for Mr Herricane. I accept the number of calls made by Mr Beaumont is as documented by the prison record of intercom calls, namely;
9.21pm, 4.31am, 5.04am, 5.30am, 6.09am, 6.35am.
I accept his evidence that no-one responded to those calls by visiting the cell until shortly before 5.30 in the morning. He recalls a nurse, (Juanita Graham) attended with other officers but she merely looked through the window and left. He was not clear about conversation and I find he did not really hear it, although I also find that any conversation between Mr Herricane and Nurse Graham was extremely brief and cursory.

Mr Beaumont was helping Mr Herricane at the time. He says he was still vomiting. The evidence of Mr Herricane's position on the floor next to the toilet would support this. Mr Beaumont's statement is that an officer asked the nurse if she wanted the door open but no-one came into the cell and no assistance was given. He assumed that when she left she was going to get the key to access the cell but this did not happen. He was persistent for his friend and made another three calls. He was told the nurse had gone home.

I find that Mr Beaumont was probably asleep during periods during the night. He cannot recall the head count visits of officers, although of course these visits are brief visual inspections only. It is to be pointed out that whatever the informal role as "buddy" that Mr Beaumont was cast in, he bears no responsibility for Mr Herricane's welfare and I do not accept any criticism of his role at all. He was incarcerated and did the best he could to get help for Mr Herricane. The response by other people failed Mr Herricane, not Mr Beaumont.

Detective **McCartney's** investigation indicates there were other occasions during the night that the unit was visited for the purposes of head counts- which is simply a visual check into each cell. These occurred at;

22.48pm, (after the first call for assistance);
12.26am;
1.59am ;
3.47am..

The unit book records the supervisor and correctional officer and nurse attending at 5.17am. I remark that there were clearly opportunities for Mr Herricane to have been checked upon throughout the night after the first call was made. Head counts involve more than one officer attending the unit. Arrangements could have been made for a nurse to liaise with those head count officers and attend to check the prisoner.

Juanita Graham was a registered nurse at the prison. She saw Mr Herricane when he came into prison on 28 December. She could not recall whether she measured his height and weight, or whether an enrolled nurse did this. The measurements were recorded at 195 cm and 69 kilograms. She confirmed he appeared extremely underweight and this was often the case with people who had been long term users of

drugs. Mr Herricane indicated to her he used heroin and cannabis daily. She commenced him on the standard regime of diazepam, clonidine, quinine, maxolan and ibuprofen.

She saw him on various occasions including the night of 1 January. He had spoken with an officer about cramps and the nurse had attended and provided Panadol.

She was the senior nurse on duty overnight on 2-3 January. Mr Herricane died on 3 January by 9.15am. Nurse Graham saw him at about 5.17am on the morning he died, shortly before she finished her shift at 6.00am. This was after a phone call from Mr Lackey, the prison manager during that overnight shift prompted the visit. She had been on duty overnight, from 6.00pm to 6.00am.

Her evidence was that she could not recall any other information about Mr Herricane being brought to her attention during the night. She was referred to the log of calls, in the medication book and an entry at 9.17 pm.[4] The entry was deficient in that it did not record any detail. The practice was for nurses go with the officers doing the head counts to administer any pills required during the night. Nurse Graham explained that the process would be that an officer would inform the nurse that a prisoner had called up. The nurse does not periodically check the log book. She could not recall whether she had been told about Mr Herricane's request or not.

Nurse Graham's evidence was that; "Usually the officer on duty in the medical centre will let the nurse know that an inmate has called up for attention. We do not periodically go and check on this log book ourselves."
The procedure needs to be spelled out exactly whose responsibility it is to properly document the receipt of information to the medical unit, and whose responsibility it is to convey that information and respond to it. Again this should be documented.

Nor was there any documentation of the calls into either the medical record of Mr Herricane or into the medication book. The only entry in that in that book for Mr Herricane was at 21.12 listed for "cramps." None of the seven night shift entries are signed off. Ticks would suggest that two prisoners received milanta and largactil at 20.07 and 20.29. There is simply a dash in the time column to indicate when Mr Herricane was visited after the call entered at 21.17. The weight of evidence is that he wasn't visited until 5.17 am the following morning, and then only to the outside of the cell. Nurse Graham acknowledged that a tick in the medication log must mean she had seen the prisoner. But there was no detail of what response was made. Next to Herricane's name was a dash- her evidence was she could not recall what that meant.

Nurse Graham could not recall attending Mr Herricane during the night. She did not recall any earlier request on that shift. Nurse Graham's responded; "I don't recall" when she was asked whether or not she had been told that Herricane's cellmate requested assistance for Mr Herricane. This is contrary to evidence of Nurse Kambouris and Nurse Fraser, Theor evidence was that Graham had told them at handover that Herricane had called numerous times during the night. This was suggested to Ms Graham but she stated it did not assist her memory. She did not recall the nature of information she gave in hand over. There was no written record of the

[4] exhibit 97

handover or of notes in the medical record referring to Mr Herricane during that night made by Nurse Graham. There is no written record of the handover as the process seemed to be loose sheets of paper that were not retained.

She went down with Mr Lackey and other officers to the cell. She went to cell and looked into it. Mr Gardiner then claimed privilege for her. As it appeared possible that nurse Graham might expose herself to disciplinary action from the nurse registration board in answering further questions, she was excused from giving further evidence which might tend to incriminate her. There remains the evidence of her statement and other witnesses concerning her actions.

I am not concerned about discrepancies between accounts of what was said or what was seen when Nurse Graham came to the cell door around 5.00am. The significant event is that her inspection of the prisoner was cursory and from a distance and with apparent prejudgement of what the problem was. To put this in a fair context, she was relying on her previous recent experience of Mr Herricane's condition, namely he was experiencing symptoms due to withdrawal from opiates. She made the assumption that there was nothing else impacting on Mr Herricane' s welfare and left the prison in the expectation that he would be seen and given pain killer medication by the nurse on the pill round early in the day shift.

Officer Kim was in master control at about 5.00am on 3 January 2002 and remembers a call coming in to master control officer Ray Mackey from the intercom. Herricane's cell mate, Beaumont, reported that Herricane was sick and throwing up. The manager Mr Lackey was advised.

The Correctional Manager on duty at the time was **Mr Lackey.** He gave evidence. He was contacted for the first time and became aware of Mr Herricane when the master control officer, **Mr McCay** called him directly at about 5 10am. He indicated there had been calls through the night from Herricane's cell mate for medical assistance He explained ,
"if there's an unusual occurrence or if there was a requirement generally to open the cell door, its preferable if the correctional manager is present."
Australian Correctional Management required that there be three staff members on the floor and one in the officer's station (to open a cell.)

Mr Lackey tried to look into the cell before entering the unit but could only see the other prisoner. One officer went into the officer's station and Lackey and the nurse proceeded to the cell. He looked in and saw Mr Herricane on the floor with an arm supporting him onto the toilet. This was consistent with Mr Beaumont's account. The nurse then moved forward to look through the window. He recalled there being a short conversation between the nurse and someone in the cell. He then asked her whether she wanted the cell door open and Nurse Graham responded in the negative, indicating she had dealt with Mr Herricane before and that he was on drug withdrawal.

Lackey could not say who Nurse Graham spoke to or who responded. He acknowledged that although he deferred to the nurse as a medical specialist he was the one with authority to open the cell. He relied on Nurse Graham who said;

" No, I can see him from here. We've dealt with him before. He's on a drug withdrawal program. He's had all the drugs we can give him. He's just going through the withdrawals."

Another record book he kept documents that he was told that Beaumont had reported Herricane as having "collapsed."[5]

He could **not** confirm whether procedures now required a nurse to attend and physically examine a prisoner who called for medical assistance during the night.

Exhibit 97 was the record book in which a corrections officer in the medical centre recorded calls from master controller. The time, cell number, prisoner's name and description of the problem are all to be recorded.

Mr Lackey could not state what record systems were in place at the time to record calls. He had not, for example, seen the record book in the medical centre recording calls from master control. [6] . ***I comment that the person with overall management control during the night shift must be required to be familiar with all of the systems and record keeping in place if he is to be effective in maintaining the safety of prisoners and all other personnel.***

I also remark that inspection of the medical record showed it to be deficient in details including names, times and details of the problem and the response, if any. The record also did not seem to require any notation for why an action, or no action, was taken.

Mr Lackey says that the cell mate Beaumont was quite vocal about trying to convince someone that Mr Herricane was indeed in need of some medical assistance.

Mr Beaumont buzzed again (as recorded in prison records at 4.31am, 5.30am, 6.09am and 6.35am.) The cell was unlocked at about quarter past seven and Mr Beaumont says that that an officer showed some interest in Mr Herricane's condition.[Ngati and Capmbell] He said he had tried to get someone down but was told they would be around when medication was handed out. This version is as stated by Officer Ngati who says he rang the medical unit and spoke with Nurse Kambouris at 6.50am saying that Mr Herricane was "not looking too well."
His statement is that Nurse Kambouris' response was that he would have to wait for the pill round. (This I note was the response after a documented number of calls requesting assistance, commencing at 9.17 the previous evening, with four calls between 4.30 am and 6.09am.)

Officer Ngati's offsider, Officer Campbell saw Herricane in his cell that morning. He recalls that he was slurred in his speech, he was without energy, and was requesting to see the doctor. He was breathless. Officer Campbell thought he was dehydrated. Campbell relayed the request to Ngati who rang the medical unit.

[5] exhibit 68
[6] exhibit 97

Attempts by prisoners that morning to feed Mr Herricane weet bix were futile and Mr Beaumont reports that Mr Herricane said he needed a drip as he couldn't handle the pain.

Nurse Merryl Fraser gave evidence. I accept her evidence without reservation. She attended the cell at 8.40am with the morning medication. She recalled a written handover from Nurse Graham that stated Mr Herricane had buzzed several time during the night requesting several things. She recalled nurse Graham's oral handover was in the same terms. Nurse Fraser's statement was made on 3 January when she says her memory was fresh regarding the events. When pressed regarding what "several times "meant, she explained it could have been three or four times, or it could have been twice.

She thought Mr Herricane looked unwell and possibly dehydrated with sunken eyes and pale appearance. Mr Herricane told Nurse Fraser that he felt terrible. He sat up and took the crushed valium and brufen tablets with some water. He dribbled a bit but was sitting up. It was the first time she had ever seen Mr Herricane so she had no comparison available regarding any previous condition, however she thought he was unwell enough to require to see the doctor, within half an hour. She did not examine him regarding his vital signs- she was there to dispense pills, but made arrangements for him to be transferred to the medical unit because she thought he needed to be seen. She told the unit officer that she would call the medical unit and send Mr Herricane for review. She told the senior nurse in the medical unit, Nurse Kambouris that he was dehydrated.

At 8.45am, according to her statement, she told Officer Campbell to go to the medical centre and get a wheelchair. She continued on her medication round and recalls hearing a "CERT 1, medical emergency being called in over the radio. This was not until about ten past nine.

There was also a statement from **Elizabeth Mawson**, classification specialist with Australasian Correctional Management. She happened to be approaching the unit to visit it when Officer Campbell went to get a wheel chair for Herricane. This was at 8. 45 am 3 January. Herricane was one of the prisoners to be seen on Mawson's list, but inside the unit, Officer Ngati said he was withdrawing, was dehydrated and not able to communicate. Mawson observed a male prisoner seated in a wheel chair with someone standing behind supporting his head. There was no sense of urgency in the situation that was apparent to Mawson.

A conversation with Ngati then occurred. He said he was waiting on a call from the medical unit for a stretcher for ease of transport. He seemed concerned and agitated to Mawson that it was taking so long. Mawson says they were in the unit half an hour.

She estimated the CERT call twenty minutes after Ngati's call to medical for a stretcher.

Mr Beaumont was still in the unit while Mr Herricane remained in his cell. He says that finally a wheel chair was brought. Officer Ngati's statement is that officer Campbell returned with the wheel chair at 8.55 am and prisoners helped dress Mr Herricane, and according to Mr Beaumont tried to put him into the wheel chair. Mr

Beaumont said Mr Herricane was stiff and not breathing properly. They could not get him into the chair. (This is consistent with the account that someone was standing behind holding his head in position to hold him in the wheelchair, as observed by Elizabeth Mawson.

Officer Ngati says he was still relying on Nurse Fraser's assessment at that time (that he needed to see the doctor but that it was not an emergency situation.) Under cross examination he said Herricane looked sick but he did not recognise a medical emergency.

Nurse Fraser was the first medical officer to respond to the medical emergency call and returned to the unit to observe Mr Herricane in the wheelchair, but being supported by officers and inmates. Her evidence is that he did not appear to be breathing. Despite some confusion in the evidence I infer that by the time Nurse Fraser arrived back at the unit, the medical emergency had been called, and her arrival was just ahead of the trolley and other medical staff. It was at 9.03 am when Officer Ngati says he rang medical and said the Herricane had seized up. He asked nurse Bilrough whether he should call a medical emergency. He says that nurse said she would refer the question to Nurse Kambouris. Ngati responded that if he didn't get a reply within a minute he would call the CERT 1. According to her statement nurse Bilrough didn't register that there was any urgency but called back promptly confirming a trolley would be sent down.

Although it appears from the evidence that Officer Ngati was criticised for apparently "threatening" to call a medical emergency, I disagree with this criticism. The evidence shows a series of events over time when repeated requests for medical assistance have gone unanswered or been delayed or postponed. Officer Ngati contacted the medical unit and asked for advice. He was concerned for he prisoner's welfare and when he did not receive a prompt response to his query, he threatened to call an emergency to elicit a response. Although it is appreciated that a medical emergency procedure should not be undermined by too ready a recourse to it, hindsight has shown that indeed Mr Herricane was in urgent need of assistance.

Nurse Bilrough states that prior to the trolley leaving the medical unit the emergency equipment was removed. The explanation that was provided was that it was thought it was "transport only" that was required. (I note that this decision seems incomprehensible given Officer Ngati saying he wanted a trolley immediately and if he didn't get a response within a minute he would call a medical emergency.) Without the trolley's emergency equipment there was no equipment to suction and then commence resuscitation. Given Dr Todd's, Mr McGrane and Dr Naylor's subsequent evidence, this delay probably made little difference to the outcome. However, the emergency equipment should not have been removed from the trolley.

Nurse Kambouris had started his shift at 6 .00 am. He was the senior nurse on the day shift. It was his first day back after holidays. Nurse Kambouris' statement records his recollection of the handover from Nurse Graham. He said that he arrived at about 5.45am. Nurse Graham mentioned to him that inmate Herricane had called numerous times during the night in relation to not feeling well. Nurse Fraser's evidence was consistent with Nurse Kambouris' recollection. I find that Nurse Graham did inform the two day shift nurses that calls had been made for Mr Herricane during the night.

Nurse Graham's response was that she did not recall this, and it did not help to prompt her memory. Nor could she remember the nature of information she gave to Nurse Kambouris in the hand over concerning Mr Herricane. There was no record in the notes concerning Nurse Graham's visit to his cell shortly before the end of her shift.

This is unsatisfactory. I recommend a review of compliance with the requirement to adequately document any attendance upon a prisoner in response to a request for medical assistance.

Nurse Kambouris clearly did not understand there was any sense of urgency about Herricane's condition. I remark that this is not surprising given that no medical staff had physically attended upon Herricane apart from the one attendance to the outside of the cell by Nurse Graham at about 5.17am. Nurse Kambouris' evidence also revealed that he did not know that Herricane was on withdrawal from drugs, (implying that he was not told this by Nurse Graham, or failed to note it.) That information was available in the prisoner's record.

The hand over was unsatisfactory on the part of both nurses. Nor was Nurse Kambouris' response to Officer Ngati satisfactory when that officer reported concern for the prisoner. Nurse Kambouris had several opportunities to suspect that there was something wrong with Mr Herricane. He failed to make adequate inquiry, to assess or determine what the situation was. There was information the medical centre from the hand over nurse, then correctional Officer Ngati at 6.50 am , the pill nurse Merryl Fraser at 8.40am , then Nurse Bilbrough at 9.00am requesting the trolley instead of the wheel chair. The accumulation of this information should have alerted Nurse Kambouris. He should not have been "shocked" as he indicated when he saw the condition of Mr Herricane.

The Oxyviva was removed from the trolley which was used to transport Mr Herricane. An assumption was made that it was a transport request only. The equipment is strapped onto the trolley ready for an emergency. The equipment was an oxyviva with a cylinder of oxygen, a defibrillator, hand held oxyviva and the trauma kit. If a patient has to go onto the trolley, then someone needs to carry the equipment. Detective McCartney's evidence concerning the emergency equipment was that it was in a carry case and can be easily removed. I cannot see any explanation of why it was removed from the trolley, other than it was easier to handle the trolley. The erroneous presumption was that the trolley was only to assist in transport.

When Senior Nurse Kambouris arrived outside Mr Herricane's cell his instant reaction was shock. He saw that Herricane was withdrawn and white. He was limp with his head over to one side, with legs straight out. He was unconscious, and not breathing. There were no signs of life. There was no pulse.

Mr Herricane was put into the recovery position. Corey Blair was sent back immediately to the medical centre to get it ready for resuscitation. This was in the absence of the emergency equipment to suction and resuscitate. There was some evidence that it only thirty seconds to get Mr Herricane back to the medical centre, but I doubt this, given Beaumont's evidence that it appeared they left the cell area in a

controlled manner before then proceeding rapidly back to the medical centre. There was no attempt to provide resuscitation at the cells.

Despite the history of numerous calls given by Nurse Graham to Nurse Kambouris, Nurse Kambouris has not responded in any real way when Correctional Officer Ngati has called in to also report that Herricane is not looking too well. This was at about 6.50am according to Ngati, or 7.20 according to Kambouris. Again I prefer the evidence of Ngati as the response from the nursing unit was so casual that I am disinclined to rely on the estimate of time.

Nurse Kambouris recalls the pill nurse, Nurse Fraser calling him at about 8 40am indicating Herricane needed to be conveyed to the medical centre to see the doctor as he was unwell. When another contact was made by Nurse Bilrough to Nurse Kambouris at about 9.00am, Kambouris indicates he still did not think there was any urgency, even though this was a request for a trolley because Herricane had "seized up". He presumed lack of co-operation of the part of the prisoner.

He decided to go with the trolley (and he makes no mention or explanation of why emergency equipment was taken off the trolley.) On the way he heard the medical emergency call, and then they commenced to walk briskly. On arrival at the unit he instantly recognised it was indeed a medical emergency with an apparently lifeless Herricane being supported in a wheelchair.

I prefer the evidence of Ngati as to the progress of the trolley than other evidence. He refers obviously to being anxious waiting for it and checking the progress of the trolley via movement control. The response was they were just dawdling down the path. Ngati responded saying, "We're calling a CERT, the prisoner is turning blue."

Ngati told the other officer, Campbell to call in the CERT 1 because by this stage Herricane was clearly only breathing intermittently. Campbell called in the CERT at 9. 11 am (while the trolley was underway to wards the unit.) He says this was because Herricane had taken a large breath, and then stopped.

Ngati seems to suggest that Nurse Fraser arrived with other medical staff at 9 .12am, whereas she suggests she was the first medical person to arrive. I find that the trolley arrived very shortly after the emergency call, and shortly after the arrival of Nurse Fraser. No emergency treatment was given at the unit; he was transported away to the medical centre. There was finally the realisation that there was an emergency and by this time it was appropriate to evacuate him urgently to the medical unit for treatment if possible. Nurse Fraser's evidence indicates there were no signs of life from Herricane by this time. No resuscitation attempt was made in the cell unit and it seems that staff was anxious to leave in an orderly fashion rather than precipitate a panic in the open area of the unit with other prisoners present. Mr Beaumont recalls them leaving the unit and then appearing to run.

Later, Nurse Fraser returned to the medical unit where they were then still attempting resuscitation. The ambulance also arrived. Dr Todd then pronounced life extinct.

Dr Bryon Todd has practised medicine for over forty five years. He was the doctor who last saw Mr Herricane before his death. He gave evidence that he had treated Mr

Herricane in prison over a number of years. He knew him to be a heavy use of opiates, usually heroin. On this admission to prison Mr Herricane had been seen by another doctor and been initiated onto the detoxification program by nursing staff. He was seen once only by Dr Todd after he had been in prison some seven days. Dr Todd only saw him on the one occasion on 2 January 2002, prior to his death the following day. Through Dr Todd's evidence it became apparent that Mr Herricane was receiving methadone from the Biala clinic prior to imprisonment but also still using 2 grams of heroin a day.

The record showed that the standard two week detoxification program which was applied to Mr Herricane included;

(1)Diazepam (valium) which was given to reduce anxiety, reduce muscle spasm and assist with sleep.

(2) Maxolan was used as an anti nausea agent.

(3) Lomotil was prescribed to inhibit bowel spasm.

(4) Quinine and clonidine to reduce muscle spasm. There was also a blocking effect to any residual opiate uptake which would be metabolised through the body.

(5) Ibuprofen (brufen), an anti inflammatory to reduce back and leg pain

The withdrawal regime was the Qld state authorised method in use at the time.

Mr Herricane had been treated in 1996 with a similar drug withdrawal regime. Dr Todd's view was that any cramping during the detoxification regime would be due to the opiates rather then the treatment. Initially on that earlier admission Mr Herricane had not volunteered any information and had tried to withdraw without other assistance. But, Dr Todd then implemented the withdrawal regime to assist him to deal with the symptoms. He had been on a methadone program in the community, but this was not available in prison.

When giving evidence, Dr Todd reviewed his medical contacts during the time he was in prison. He could not identify any problem until 1 January when Mr Herricane collapsed in the laundry. Mr Herricane was seen by a nurse after this and it was documented that he was given maxolan. Mr Herricane reported dry retching all day, had cramps and was unwell. He spent that night in the medical centre. During that night he was complaining of pain and was given pandaol.

The next morning, 2 January, he told Nurse Bilborough he was feeling better regarding the symptoms experienced due to withdrawal. That morning Dr Todd saw him and Mr Herricane requested to return to the unit. He presented with a history of vomiting but when he saw Dr Todd he was asymptomatic. He was pleading to return to the unit and not to remain in the observation area. Dr Todd could not see any reason to hold him in observation and agreed. (I note the decision to place him in the observation unit was due to a previous record of being on suicide watch and not due to a medical condition at the time.) Mr Herricane had been dizzy the day before. Dr Todd considered that the clonidine could have caused this and so he ceased the order for clonidine, checked his blood pressure and recommended he return to the unit. Dr Todd refuted the need to have put Mr Herricane on a drip when he saw him on 2 January, saying he was taking fluids at the time and was no longer vomiting when seen by the doctor. He knew Mr Herricane from previous admissions. He felt there was effective communication between the two of them and there was no need to insist on him remaining under observation. The abdominal cramping was consistent with

withdrawal symptoms. Dr Todd explained that behaviour of not eating or drinking much initially, lying around and having low blood pressure were all associated with typical presenting behaviours of a person coming into prison and suffering withdrawal and anxiety.

Then on the morning of 3 January Dr Todd heard the emergency equipment being taken to retrieve a person back to the medical unit. He did not realise there was a medical emergency, just that the trolley was being used to assist to transport a person. Dr Todd was then told there was a person to be seen. Usually when a medical emergency is called, a siren sounds to alert medical and other staff. But this did not happen in Mr Herricane's case. It should have. Dr Todd recalls Nurse Corey Blair returning to the unit to get the resuscitation equipment but nothing being communicated about a medical emergency. The equipment had been removed as the trolley was thought to be needed only for transport purposes initially rather then due to an emergency. Usually when the siren sounds, Dr Todd goes out into the unit and checks with the officers. The officers are in radio contact with the other officers and will alert the doctor to what sort of situation is unfolding.

At 9. 20am Nurse Kambouris asked Dr Todd to help and he discovered that resuscitation was being attempted on Mr Herricane. Dr Todd examined Mr Herricane and could not discover any signs of life. Narcan was administered at the medical centre as a straight antagonist to opiates. This was a precautionary measure when he was presented comatose in case he had somehow accessed opiates and was in an overdose situation.

Dr Todd thought he had probably been dead for twenty minutes, due to the degree of post mortem lividity. The team was still attempting to resuscitate him and continued until the arrival of the ambulance. This is standard procedure. Dr Todd's professional opinion was that given what he observed at 9. 15 am, he would have expected there would be sign of the patient being very unwell at five am that morning, and at 8.40 am when seen by the pill round nurse.

Dr Todd was unaware of the calls placed via the intercom by Mr Herricane's cell mate, Mr Beaumont. Those calls were at about 9.21 on the previous evening, then at 4.31am that morning followed by four calls between 5.04am until 6.354am.)

The message from the cellmate was that Mr Herricane was vomiting, cramping and at one stage had passed out. Dr Todd expected that the nurse would attend in response to this information. But a nurse did not attend until about 5.17am. Dr Todd was surprised and disappointed that this was the level of response to the scenario described.

He was then informed that that the nurse simply made visual observation through the cell window. Dr Todd's response was that medicine was a **"touchy, touchy business- you've got to actually see the patient, talk to them and observe their demeanour. It's a holistic thing, not peep through a door."**

The description of Mr Herricane's inability to sit and bend into the wheel chair and needing his head supported indicated to Dr Todd that there was something seriously wrong. Dr Todd thought it to be an extraordinary set of circumstances, of a patient

swallowing tablets at 8 .40 am, and than losing consciousness and being dead at nine fifteen.

As Dr Todd remarked**, "Its always communication (that) can be improved."**
Dr Todd says if there is a medical emergency the most important thing is to get the patient back to the medical unit for treatment as soon as possible. The nurse's task is to stabilise and retrieve the patient. Dr Todd thought it would be best if the correctional staff had responsibility to contact the doctor at the medical unit and they could update the doctor via the nurse, who might be stabilising the patient.

Dr Todd's understanding was that if a cell mate called via intercom after hours that the call would go to the officers first. If it was assessed as genuine it would go to the medical unit. Dr Todd then stated the nurse would ascertain the degree of urgency and (usually) go down and see the patient.

Dr Todd was asked to comment on the distension of Mr Herricane's stomach before his death. The autopsy found that there was no physical blockage although there was no normal flow between the stomach and the small intestine. Dr Todd acknowledged that this could have caused significant pain. Although he knew of this occurring post surgery, he could not explain it in Mr Herricane's case.

There was a system of request for medical attention. The request form signed by the prisoner was picked up by the nurse on the medication delivery round. An informal triage system would then be implemented with the nurse indicating to the doctor at the medical centre if someone should be seen ahead of another person.

He discounted suggestions that Mr Herricane might still be suffering ill effects from a head injury which was apparent at the time of his arrest. He had been seen at the Gold Coast Hospital before coming into police custody.

Dr Todd could inform the court that nurses were now given a more extensive orientation and worked with a senior nurse for three days on arrival. They receive a procedure manual.

Dr Todd remarked that toxicology test indicating the presence of morphine could only be explained on the basis that he had accessed morphine, (heroin) in the prison. He explained that the half life of the drug meant that any of the drug consumed before arrest would heave been fully expelled from the body the time of his death.

Naltrexone was not available as a method of managing opiate dependent prisoners at the time of Mr Herricane's death. Dr Todd explained that there had been a period of about eighteen months when a Commonwealth funded trial of buprenorphine was available. He believed it was still available in the women's prison. Methadone was also not available in the Arthur Gorrie Remand centre. Dr Todd's view, on the basis of his experience, was that buprenorphine was the preferable treatment to naltrexone. Dr Todd explained that the buprenorphine discouraged the concomitant use of heroin because it made a person feel ill if they did so. But whilst receiving the clonidine the receptors in the brain would have been blocked, causing the drug to be returned to the body to be excreted. The euphoric effect would be blocked but the opiate could still impact on the body to reduce respiration.

Mr McGrane was a prisoner at the Arthur Gorrie Centre when Mr Herricane died. He also happened to be medically qualified. He had limited recall of events but agreed that his statement was true to the best of his recollection. Mr McGrane's evidence is that he saw Mr Herricane being carried into the wheelchair. He saw that his arms were flexed and his lower limbs fixed and extended. He said he was unable to sit in the wheelchair. Mr McGrane expressed the view that he was at the point of death with his eyes rolling back. This evidence is consistent with Dr Todd's comments when he first saw Mr Herricane when he was returned to the medical centre.

Mr McGrane w as asked for any comment on medical assistance that could have been improved. He did not think anything else could have been done. He said his view was that access to medical treatment in Arthur Gorrie was very good. He had been in Arthur Gorrie for a number of months on separate occasions.

Mr Luke O'Reilly gave evidence. He had known Mr Herricane over a fourteen year period. He had been involved for many years in the Boys Town organisation. He first knew him when Mr Herricane was a sixteen year old lad leaving Boystown, fit and well, although not heavily built.

Through the organisation he knew both Mr Herricane and another inmate, Mr Herricane's cellmate, Mr Beaumont. When Mr O'Reilly saw him in prison on Mr Herricane's final incarceration he described him as looking dreadful. He described him as looking like a skeleton. He knew him and was shocked at the deterioration in his appearance and his thinness. Mr O'Reilly expressed fait on thew authorities at Arthur Gorrie. He said he did not follow up because he did not realise at the time that Mr Herricane was seriously ill- he just thought that his physical condition had deteriorated sine he had last seen him.

Mr O'Reilly had access to speak to prisoners. His impression was that the staff were "wonderful." It was a Monday when Mr O'Reilly last saw Mr Herricane, and he died within days. He believed (from what other people told him) that Mr Herricane had been a very heavy user of heroin and that this had suppressed his appetite. He was this when he came into jail.- he was only there for less than week.

A new document related to monitoring prisoners during withdrawal was tendered, dated 15 January 2004. That document includes a daily record of solid and fluid intake to be recorded y the unit officer. [7]
Mr Keim was to provide to the court the updated scheme for drug withdrawal now in use by his client in the Arthur Gorrie Correctional Centre. After Mr Herricane's death there was an eighteen month commonwealth government funded trial of another drug, buprenorphine, otherwise known as subutex.

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[7] Exhibit 103

Dr Charles Naylor, Associate Professor, performed the autopsy on Mr Herricane and provided the initial autopsy report, evidence at this in quest and a supplementary statutory declaration dated 19 February 2004.

Dr Naylor noted regurgitated stomach contents present in the oesophagus and aspiration of stomach contents which were present in the trachea and main bronchi. The stomach was grossly distended by gas and approximately one litre of fluid. He could discern the remains of two white tablets.

The entire duodenum was similarly dilated but the mucosa was normal. There was no physical obstruction at the end where the gross dilatation ceased abruptly. Further down, the bowel was essentially normal and there was nothing to indicate bowel obstruction, peritonitis or perforation. He said ;
"it appears there is some functional obstruction at the distal duodenum, giving rise to the dilation of the duodenum and stomach. This would account for the vomiting that was reported the night before he died."

Dr Naylor was clear about the cause of death itself; Mr Herricane had aspirated vomitus and that this was due to the acute gastric dilatation. What caused the acute dilatation was more problematic. It can arise in the context of recent abdominal surgery, eating disorders such as anorexia nervosa, diabetes, cancer, diseases of the nerves or muscle, hernia through the diaphragm and intestinal compression by the superior mesenteric artery.

At page 154 of the transcript Professsor Naylor explained that the blockage of the duodenum that he observed would explain the symptoms of both severe cramping and vomiting which Mr Herricane was experiencing throughout the night before he died. At page 159 he also stated he would expect from what he observed at autopsy, that Mr Herricane would have been ill for twelve to twenty-four hours in the lead up to the stomach reaching the condition in which he saw it. During that time he would have expected him to have increasing cramping abdominal pain and increasing vomiting. Professor Naylor also explained that as a result of the obstruction, the cramping and the vomiting, a biochemical disturbance would occur, and as part of this, Mr Herricane would become dehydrated. In these circumstances of blockage of the stomach and resulting dehydration, the Professor stated that a naso gastric tube (to empty the stomach and stop the vomiting) and an intravenous drip were needed to rehydrate the patient.

Had he been examined, Professor Naylor said (at page 164) there would have been signs of dehydration, rapid pulse and low blood pressure. He pointed out that the obstruction he observed was not a physical obstruction but changes in the motility of the wall of the bowel.

Dr Naylor was informed in the course of his evidence that Mr Herricane was a heroin addict and was undergoing detoxification He offered a further opinion. Dr Naylor noted that Mr Herricane had received brufen (nurofen) administered for leg, back and opiate withdrawal pain. Diazepam (valium) had also been given to reduce anxiety as well as quinine, used in this instance to control muscle spasm and bowel cramps experienced during opiate withdrawal. All these drugs were detected by toxicology tests.

Two other drugs may have been present but testing was not targeted for them, so it is unclear whether or not they were present.

Clonidine, which is traditionally used to treat hypertension and migraine, was used here to reduce withdrawal symptoms due to autonomic hyperactivity, for example sweating, anxiety, tachycardia and hypertension. However, Dr Todd had discontinued this medication the day before death because of Mr Herricane's low blood pressure.

Naloxone (Narcan), a heroin antagonist, was used during resuscitation attempts in case Mr Herricane had accessed heroin. It was not detected- nor was it specifically targeted by toxicology testing.

Another drug, Chloroquine was also detected at significant levels - 0.15 mg / kg in the blood. This could only be accounted for on the supposition that it is frequently detected in street samples of heroin. As it persists in the body for some time its presence may be explicable in a shot of heroin that may have been accessed by Mr Herricane prior to entry into jail.

There were however, no signs of morphine (heroin) in the blood, but it was detected in the urine. Professor Naylor speculated that this could have been a sign that he had heroin a few days before. There was also a curiously high alcohol level in the sputum but not reflected in either blood or urine. This could not be explained.

Returning to the crucial issue of the acute dilatation of the stomach and duodenum area which, I accept, led to the aspiration and death. Dr Naylor arranged for literature search and discovered that there are documented cases of such a reaction in people linked to the use of clonidine. The literature indicated that the pseudo-obstruction due to clonidine rapidly improved following its withdrawal. (Here, Dr Todd had stopped the clonidine the day before death for other reasons.)

Despite this, the evidence of Mr Herricane's background of heroin use and sudden withdrawal upon incarceration, his treatment, symptoms and death when looked at together lead to the conclusion that this is the most likely explanation of the pseudo obstruction. It was the gross dilatation that led to his death although Dr Naylor also added that dehydration and biochemical disturbance due to the acute vomiting and accumulation of secretions in the stomach may have been just as important as the aspiration of vomit. (I note in this regard the evidence that over a five day period Mr Herricane went from sixty nine to sixty three kilos.)

There was also the possibility of another contributing risk in Mr Herricane's case. Dr Naylor's research indicated that acute gastric dilatation can also occur in someone suffering from anorexia nervosa. Although there was no diagnosis before this inquest that Mr Herricane suffered this condition it is noted that there had been an acute loss of weight and that Mr Herricane was very thin given his weight of sixty three kilograms over a one hundred and eighty seven centimetre frame, according to the autopsy measurement. (I note a different measurement for height was recorded by Nurse Graham at the initial medical assessment record, of one hundred and ninety three centimetres.)

Dr Naylor explained that the condition of pseudo obstruction caused by clonidine was rare, but if clonidine is continued to be used without appreciating this risk then the prison population are at risk given their higher incidence of heroin withdrawal at the time they come into custody.

This information raising awareness of this possibly fatal side effect of the use of clonidine must be circulated among health professionals including nurses working in the prison / watch house sector. This is particularly so given that the normal unpleasant side effects from sudden enforced withdrawal from heroin include symptoms of vomiting and abdominal cramps which can mask the features of intestinal obstruction, as in the case of Mr Herricane.

A life extinct Certificate was issued in respect of the deceased by Dr B E Todd at the Medical Centre at the Arthur Gorrie Correctional Centre. It certifies that at 9. 41 am on 3 January 2002 life was extinct.

Subsequently a post mortem examination was performed on 4 January 2002 at the John Tonge Centre, Coopers Plains. Dr CPE Naylor found the medical cause of death was aspiration due to acute gastric dilation. (cause unknown.) . Subsequent to this a supplementary statutory declaration was provided by Dr Naylor sworn on 19 February 2004.

There was information presented to the inquest at its conclusion by Amy Kay Lobegeiger. She identified herself as Mark's mother. She said that Mark's birth name name was Mark Anthony Waldon. "Herricane" was his mother's second husband's name, which was simply adopted for use at some time.

I am satisfied on the balance of probability and find that:

(a) The identity of the deceased was Mark Anthony Waldon, (also known as Herricane.)

(b) His date of birth was 18 April 1972.

(c) His last known address was Arthur Gorrie Correctional Centre

(d) At the time of death his occupation was prisoner.

(e) The date of death was 3 January 2002.

(f) The place of death was Arthur Gorrie Correctional Centre

(g) The formal cause of death was aspiration due to acute gastric dilatation.

This Court has jurisdiction in appropriate cases to commit for trial any person/s which the evidence shows may be charged with the offences mentioned in section 24 of the Act., I am satisfied the evidence is not sufficient to put any person or persons upon any trial.

RECOMMENDATIONS:

Pursuant to section 43 of the Act, the following recommendations are made by way of rider to the formal findings. These recommendations address the issues raised in evidence at the time of the death of Mr Herricane's death, and may not be relevant to subsequent conditions at the institution. I note Exhibit 103 detailed a new regime of monitoring withdrawal program for prisoners suffering from a range of addictions, including alcohol. The program looked to be a significant improvement. Food and fluid intake were to be documented as well as symptoms of withdrawal. The only comment I would offer is that a satisfactory fluid and food intake may be deceptive if information is not also recorded regarding symptoms, severity and frequency of vomiting and diarrhoea.

I recommend:

1 Prison and medical and nursing staff from prisons be alerted to the possibility that use of clonidine as part of the medication used to assist a person withdrawing from heroin may have a rare side effect of inducing acute gastric pseudo obstruction. This condition can be life threatening and can be masked by the anticipated usual side effects of heroin withdrawal, namely vomiting and cramping.

2 There be a review of the suitability of the prescription of clonidine to the prison population as part of the standard drug detoxification regime.

3 The operator of the prison review the process of response to after hours calls for medical issues or when prisoners are locked in their cells, requiring that;

- a system be reviewed / implemented/ and required to be adhered to by all staff to ensure that prisoners receive access to appropriate medical care in a timely manner , and
- all requests for or on behalf of prisoners for medical assistance, review or treatment be contemporaneously documented and considered in a timely manner.
- the lines of communication and responsibility are clear and documented to indicate when information is received, by whom, and what response is made to that information, again with reference to time and identification of the person spoken with and the actions taken.

4 There be a review of procedures whereby a nurse attends a cell in response to a possible medical problem with a prisoner. The appropriateness of visual inspection of the prisoner through a locked cell door via an observation window without physical examination is to be reviewed. Suitable security support should be provided so that proper and timely medical access to a prisoner is assured.

4 The operator of the prison require and insist on contemporaneous and adequate notes of all requests for medical assistance by or on behalf of prisoners to correctional officers, nurses or any other staff members.

Copies of the recommendations are to be sent to parties as well as the minister and director general of relevant departments.
This summary and the published findings will be distributed.

The inquest is now closed. I thank those appearing and investigating officers for their assistance in this inquest. I extend condolences to the family of friends of Mark Herricane who died unexpectedly and tragically while in custody.

Chris Clements

Deputy State Coroner