OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Joseph Edwin JAMES**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 1400/04(5)
DELIVERED ON:	23 February 2007
DELIVERED AT:	Brisbane
HEARING DATE(s):	06 February 2007
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Acting Inspector Virginia Nelson
Department of Corrective Services:	Ms Kerry Doig

The *Coroners Act 2003* provides in s45 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 specified officials with responsibility for the justice system. These are my findings in relation to the death of Joseph Edwin James. 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

Joseph Edwin James was 67 years of age, when he was found deceased on the floor of his cell at the Lotus Glen Correctional Centre at Mareeba in North Queensland on Wednesday, 9 June 2004.

These findings seek to explain how that occurred.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because when he died, Mr James was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the coroner is required to find:-

- whether the death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

There has been considerable litigation concerning the extent of a coroner's jurisdiction to inquire into the circumstances of a death. The authorities clearly establish that the scope of an inquest goes beyond merely establishing the medical cause of death but as there is no contention around that issue in this case I need not seek to examine those authorities here with a view to settling that question. I will, however, say something about the general nature of inquests.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

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[1] See s10

[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future.[4] However, a coroner must not include in the findings or any comments or recommendations or statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt: an inquiry rather than a trial.[6]

A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Brigenshaw* sliding scale is applicable.[7] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[8]

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[9] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[10] makes clear that includes

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[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[4] s46
[5] s45(5) and 46(3)
[6] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[7] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[8] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J
[9] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[10] (1990) 65 ALJR 167 at 168

being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

Once the paramedics who attended the scene established that Mr James was dead, Detective Sergeant Ahearn of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "death in custody" coronial investigation.

The scene was photographed and forensically examined. All relevant witnesses were interviewed and statements obtained. On 12 June 2004, an autopsy was conducted by Dr David Williams, a forensic pathologist at the Cairns Hospital.

I am satisfied that the investigation was competent and thorough.

The Inquest

An inquest was held in Brisbane on 6 February 2007. Acting Inspector Nelson was appointed to assist me. Leave to appear was granted to the Department of Corrective Services.

A copy of the police investigation report was provided to Mr James' brother prior to the inquest. Mr James' brother, was advised of the date of the inquest but indicated that he did not wish to attend. He provided to the Court a copy of a letter apparently prepared by his dead brother approximately a year before his death. It had been found on Joseph James' computer. I will refer to this letter later in these findings.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

I determined that the evidence contained in these materials were sufficient to enable me to make the findings required by the Act and that there was no other purpose, which would warrant any witnesses being called to give oral evidence.

The evidence

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

Background

Mr. James' family consisted of himself and his brother. His parents are deceased as was another brother. He never married and has no known children.

Medical issues

Prior to this fatal incident, Mr James was not known to suffer from any medical problems.

While at Lotus Glen Correctional Centre at Mareeba, Mr James' medical condition and general health was reviewed on four occasions at routine medical assessments. On each occasion no illness or disease was detected.

The Health Insurance Commission advises that since 1999, Mr James has made no claim for medical services provided by Medicare. The Mareeba Hospital also has no record of Mr James presenting there for any form of medical treatment or consultation.

It seems he enjoyed sustained good health.

Custody

Mr James was serving 2 years imprisonment that was to be suspended for 2 years after serving 6 months, for 155 offences of possession of child pornography. Apart from these convictions, he has no other known criminal convictions. He commenced his incarceration at the Lotus Glenn Correctional Centre on 19 April 2004 and was due to be released on 18 October 2004.

Mr James served his sentence at the Lotus Glen Correctional Centre with Department of Corrective Services' records showing no movement history, breaches of discipline or instances of self-harm. The police investigation has established that his conduct and behaviour whilst in custody was exemplary.

Events leading up to the incident

On the morning of 9 June 2004, Mr. James awoke at 6.30am and commenced talking with his cell mate, Lawrence Edward Jeffery. According to Mr Jeffery, he was behaving normally and showed no signs of ill health. Mr James' cell was unlocked and he and Mr Jeffrey stood outside their cell to be counted during the morning muster.

Once this occurred, their cell was locked and they moved into the unit common areas. Mr James retrieved the cell key from Correctional Services staff and returned to his cell.

A short time later, Mr Jeffery returned to the cell and found Mr James watching television. Mr Jeffrey left the cell and went to receive medication from the unit nurse. At this stage, Mr James was seated watching television in his cell and again he appeared normal and showed no signs of ill health. Mr James did not complain of feeling unwell to Mr. Jeffrey. Mr Jeffrey took the cell key with him, when he left so he could get back into the cell, as it was normal practice to lock their cell from the inside, whenever they were in the cell by themselves.

The death is discovered

Several minutes later, Mr Jeffrey returned to the cell to find that it was locked. He knocked on the door, however there was no answer. He then unlocked the cell door and observed Mr James lying on his back in the shower cubicle within the cell. Mr James was dressed in his prison jeans and shirt.

Mr Jeffrey called out to Mr James, however there was no response. Mr Jeffrey then used the cell intercom to advise Correctional Services Officer Kehrer on the situation.

Correctional Services Officers Kehrer and Tallarico were the first Correctional Services staff to observe Mr James, when they arrived at the cell at 7.37am. They found him lying on his back in the shower cubicle in an unconscious state and dressed in his prison issue clothing. Mr James' rear head and shoulders were observed to be upright against the corner left-hand side of the wall of the shower cubicle.

Correctional Services Officer Tallarico immediately called a "Code Blue" medical emergency, and sought assistance of Clinical Nurse Fitzsimmons, who was dispensing medication to prisoners nearby.

The Unit's other inmates were moved into the exercise yard, where they were secured.

Nurse Fitzsimmons was the first nurse to arrive at the cell. She checked Mr. James and found he was not breathing and had no pulse. He was moved into the spine (corridor) of the unit outside his cell to more readily facilitate medical assessment and treatment.

Nurse Fitzsimmons commenced mouth to mask expired airway resuscitation whilst Correctional Services Officer Buck commenced External Cardiac Compressions. Three cycles of CPR had been completed when Nurses Bakos and Smith arrived. Nurse Fitzsimmons requested that an ambulance be called, which occurred.

Medical personnel continued resuscitation cycles with the assistance of an oxy-viva and a "Life Pak" 500 defibrillator until the arrival of ambulance paramedics at about 8.10am. Ambulance paramedics took over administering medical treatment to the deceased. An area of bleeding was detected on the rear of Mr James' head.

At 8.10am, Mareeba Queensland Ambulance Service officers Richards and Weazel attended and commenced administering medical treatment. They quickly ascertained that Mr James had no circulation, respiration or pulse.

At 8.18am the Queensland Ambulance Services' officers placed Mr James' body onto a stretcher and transported him to the Mareeba Hospital, leaving at 8.31am. The Paramedics ceased treatment to Mr. James at about 8.45am whilst en-route to the Mareeba Hospital, when it became apparent that he had passed away.

The ambulance arrived at Mareeba Hospital at about 8.50am. Upon arrival at Mareeba Hospital, Doctor Than examined Mr James and declared life extinct at 9.00am.

A Crime Scene was established and the circumstances of the death were investigated by Detectives from the Corrective Services Investigation Unit as a "death in custody" situation.

Specialist police attended the scene and conducted forensic examinations.

Autopsy results

Mr James' body was taken to the Cairns Hospital Mortuary where, at the conclusion of the autopsy examination, Forensic Pathologist, Doctor David Williams advised that, in his opinion, Mr James died as a result of natural causes namely "coronary atherosclerosis and emphysema". Coronary atherosclerosis is commonly referred to in the community as heart failure.

Dr. Williams advised that the injuries and bruises to the head were minor. He advised that these injuries were consistent with a fall at the time of Mr. James' heart failure. He confirmed that there is no evidence to suggest that the head injuries contributed to death nor was there any evidence of thew involvement of any third party in Mr James' death.

Independent medical report

Doctor Anthony Brown provided an independent expert medical report into this death. He concluded that Mr. James "*died of a completely unheralded cardiac arrest, related to coronary atherosclerosis, on a background of smoking and emphysematous lung disease".*

Dr. Brown confirms that all the care delivered by Lotus Glen Correctional Centre staff and the Queensland Ambulance Service staff was of the highest quality and entirely appropriate.

Conclusions

I find that Corrective Services staff followed "death in custody" and medical emergency protocols in this instance. Corrective Services staff and Queensland Ambulance Service paramedics did all within their power to provide assistance and resuscitation to Mr. James upon him being located unconscious in his cell.

A comprehensive police investigation has been conducted into the circumstances of this "death in custody" situation. The investigation, coupled with the autopsy, revealed that Mr. James passed away suddenly and unexpectedly from natural causes, whilst in his cell.

I have considered the contents of the letter apparently written by the deceased before his imprisonment. I consider that the contents are such that they could not reasonably be productively investigated and that the contents

do not come within the scope of this Inquest. I do not consider that the concerns that Mr James wrote about are in any way connected with his death.

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. I have already dealt with this last aspect of the matter, the manner of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Joseph Edwin James

Place of death – He died whilst in the custody of the Department of Corrective Services at the Lotus Glen Correctional Centre at Mareeba in North Queensland.

Date of death – He died on 9 June 2004.

Cause of death – He died from natural causes namely coronary atherosclerosis and emphysema.

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.

I find that none of the correctional officers or inmates Lotus Glen Correctional Centre caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr James, who has passed away suddenly and unexpectedly from natural causes.

In those circumstances there is no basis on which I could make any preventative recommendations.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
23 February 2007