OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Melvin Thomas Mott**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2014/1696
DELIVERED ON:	19 January 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 January 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Ulrike Fortescue
West Moreton Hospital and Health Service:	Ms Holly Ahern

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Introduction

1. On 17 February 2014, Melvin Thomas Mott, aged 70 years, was transferred from the Wolston Correctional Centre (WCC) and admitted to the Princess Alexandra Hospital (PAH). He had presented to the WCC medical centre in relation to pain in his lower abdomen. An examination was conducted and a large mass was identified on his bladder.

2. On 19 February 2014, a biopsy was conducted which confirmed bladder cancer. He was discharged and arrangements were made for him to re-attend the hospital as an outpatient.

3. On 24 April 2014, Mr Mott was readmitted to the PAH and the progression of his cancer was confirmed. An Acute Resuscitation Plan was put in place. On 9 May 2014, Mr Mott was transferred to the secure palliative care unit. He was pronounced deceased on 13 May 2014 at 10:37pm.

The investigation

4. An investigation into the circumstances leading to the death of Mr Mott was conducted by Detective Sergeant Greg Bishop from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

5. Upon being notified of Mr Mott's death, the CSIU attended the PAH and the WCC and an investigation ensued. Mr Mott's correctional records and his medical files from WCC and the PAH were obtained. The investigation was informed by statements from all relevant custodial officers at WCC and medical staff from the PAH. Photographs were also taken of Mr Mott's bed at the PAH and his cell at WCC. These materials were tendered at the inquest.

6. An external autopsy examination, and associated CT scans, was conducted by specialist forensic pathologist, Dr Beng Ong. CT findings were consistent with a large tumour mass occupying the central pelvis with extensive local adenopathy and bilateral renal tract obstruction, decompressed with nephrostomies. Dr Ong noted that the medical history clearly documented progression of urothelial carcinoma complicated by secondary infection. After reviewing medical records Dr Ong noted that the cause of death as:

   1(a) Invasive bladder cancer (urothelial carcinoma).

7. At the request of the Office of the State Coroner, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Mott from the PAH and WCC and reported on them.

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

The inquest

9. As he was in custody when he died an inquest into Mr Mott's death was required by the *Coroners Act 2003.* The inquest was held on 19 January 2016. All of the statements, medical records and material gathered during the investigation was tendered in lieu of oral testimony and submissions were heard from Counsel Assisting.

Circumstances of the death

10. At the time of his death, Melvin Thomas Mott was aged 71 years. He had been in custody for many years, having been sentenced in 1968 to life imprisonment for the murder of a child in 1964. He had also been sentenced for other offences including indecent treatment of a child, unlawful carnal knowledge, property related offences and escaping from custody. His first parole eligibility date was in April 1981, however, he was never granted release on parole.

11. I was provided with a statement from the Nurse Unit Manager at WCC, Mr Michael Wilson, which outlined Mr Mott's care while at WCC. Between May 2007 and 5 February 2014, Mr Mott was seen at the WCC medical clinic some 15 times. He received routine treatment, and the only matter relevant to his abdomen was treatment for a previous urinary tract infection with antibiotics.

12. On 17 February 2014, Mr Mott presented to the WCC medical centre in relation to pain in his lower abdomen. He had reportedly been experiencing this pain for some two weeks. A CT scan was conducted and a large mass was identified on his bladder, originating from the ureteral-vesico junction, with prominent pelvic nodes.

13. On 19 February 2014, a transurethral resection of the bladder tumour was performed at the PAH without complication, which confirmed bladder cancer. The histology showed high grade papillary and invasive urothelial carcinoma, with evidence of invasion into the muscularis propria[1]. He was discharged and arrangements were made for him to re-attend the hospital as an outpatient for staging CT scans and bone scans. Radiation therapy was recommended and booked to commence in April 2014.

14. On 24 April 2014, Mr Mott was readmitted to the PAH for the commencement of his radiation therapy. Dr David Pryor, radiation oncologist at the PAH, was in charge of Mr Mott's care. He provided a statement to the inquest outlining his care of Mr Mott. Upon examination, Mr Mott was found to have a significantly distended bladder and bilateral pedal oedema. Radiation therapy was aborted and a staging CT scan showed progression of the cancer with increased nodal involvement. He was admitted for further investigations and management. An Acute Resuscitation Plan was put in

[1] A deep muscle layer consisting of thick smooth muscle bundles that form the wall of the bladder.

place, authorising no resuscitative efforts in the event he went into cardiac arrest.

15. Investigations over the following days showed that Mr Mott had an acute kidney injury as a result of the bladder obstruction, severe prostatitis, bilateral hydro-ureters and bilateral pyelonephritis. He was treated with fluids, antibiotics and pain relief. Despite the antibiotics, his white cell count was elevated and he developed a low grade temperature. A repeat CT scan was conducted, which showed ongoing progression of the malignant process involving the bladder and prostate, with a possible infective component.

16. On 8 May 2014, Mr Mott underwent surgery for a transurethral resection of the prostate in order to investigate a likely infective process. Findings showed necrotic prostatic tissue with small amounts of pus, and histology was consistent with high grade invasive urothelial carcinoma. Radiation therapy and further treatment was considered futile in light of the rapid progression of the cancer.

17. On 9 May 2014, Mr Mott was transferred to the secure palliative care unit. He was pronounced deceased on 13 May 2014 at 10:37pm.

18. Dr Home's report concluded that Mr Mott was diagnosed with an invasive form of bladder cancer. Urothelial carcinoma is very common, and accounts for 90% of all bladder cancers. Dr Home was impressed that only 12 days had passed between Mr Mott's first presentation with symptoms suggestive of a urinary tract infection, and his initial presentation to the PAH where the bladder mass was identified.

19. Dr Home confirmed from the medical records that Mr Mott was resistant to surgical treatment for the cancer, thus he was referred for radiology treatment. However, before he could undergo his first round of radiotherapy, Mr Mott became too unwell to proceed with the treatment.

20. Dr Home identified no issues with Mr Mott's care in the lead up to his death. However, he did question why more than 2 months had elapsed between the initial diagnosis and the planned first round of radiotherapy treatment. To address this query, I asked for a response to Dr Home's concern from Dr Pryor who explained that the time between the initial diagnosis and the planned first round of radiotherapy treatment (some 5 weeks) was appropriate given the complex circumstances of Mr Mott's presentation.

21. Dr Pryor explained the 5 week time period incorporated the initial diagnostic procedures, histological confirmation of the diagnosis, return visits to urology to discuss the diagnosis, further staging scans (given the aggressive nature of the cancer and the concern it would spread beyond the bladder), presentation of the case at the multidisciplinary team meeting and final consultation with urology to explain why the cancer was inoperable.

22. Dr Pryor also explained that standard turnaround time from assessment by a radiation oncologist to commencing treatment (in a non-emergency

situation) at that time was routinely 3-4 weeks. Dr Pryor confirmed that Mr Mott deteriorated rapidly within two weeks of his initial assessment and it became clear that no active treatment would change his disease course.

23. I accept Dr Pryor's explanations in this regard.

24. Mr Mott's death was the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

Conclusions

25. I conclude that Mr Mott died from natural causes. I find that none of the correctional officers or inmates at WCC or PAH caused or contributed to his death. I am satisfied that Mr Mott was given appropriate medical care by staff at the PAH and WCC while he was in custody. His death could not have reasonably been prevented.

26. It is a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Mott when measured against this benchmark.

Findings required by s. 45

27. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all of the evidence I am able to make the following findings:

Identity of the deceased – The deceased person was Melvin Thomas Mott.

How he died - Mr Mott died from natural causes at the Princess Alexandra Hospital after he became too unwell to receive treatment for an invasive form of bladder cancer.

Place of death – He died at the Princess Alexandra Hospital, Ipswich Rd, Woolloongabba, Queensland.

Date of death – He died on 13 May 2014.

Cause of death – Mr Mott died from invasive bladder cancer (urothelial carcinoma).

Comments and recommendations

28. The *Coroners Act 2003* enables a coroner to 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. In the circumstances, I accept that there are no

comments or recommendations to be made that would assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
19 January 2016