# CORONERS COURT OF QUEENSLAND

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Wesley Ronald John Fitton** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| FILE NO(s): | COR 2015/4454 |
| DELIVERED ON: | 23 January 2018 |
| DELIVERED AT: | Brisbane |
| HEARING DATE(s): | 23 January 2018 |
| FINDINGS OF: | Mr Terry Ryan, State Coroner |
| CATCHWORDS: | CORONERS: Death in custody, natural causes |

REPRESENTATION:

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| Counsel Assisting: | Daniel Bartlett |
| Queensland Corrective Services: | Kendall Dixon, Department of Justice and Attorney-General |

## Introduction

1. Wesley Fitton was aged 50 years at the time of his death in November 2015. He was survived by his three children and his wife of 28 years. Mr Fitton maintained contact with his wife throughout his term of imprisonment. I extend my condolences to his family.

2. In June 2014, Mr Fitton, then aged 48 years, was diagnosed with a metastatic undifferentiated epithelioid tumour. He commenced high dose palliative radiotherapy with chemotherapy. The cancer continued to grow despite ongoing palliative chemotherapy. His condition continued to decline, and he had episodes of nausea and difficulties with breathing which required admission to hospital.

3. Mr Fitton was incarcerated at the Wolston Correctional Centre (WCC). From 1 November 2015 to the date of his death on 10 November 2015, Mr Fitton's health declined and he was transferred to the Princess Alexandra Hospital (PAH) for pain relief on several occasions.

4. On 9 November 2015, Mr Fitton was brought to the WCC health centre by his carer as he was unable to swallow and was very lethargic. In the early hours of 10 November 2015, he was transferred to the PAH secure unit, where he told medical staff that he did not want any medical intervention.

5. Over the course of the day he was provided with pain relief. He became increasingly unsettled and continued to have difficulty swallowing and was struggling to breathe. Later that night, it was noticed that there were no signs of breathing and his pulse had decreased. After a brief period of monitoring no pulse could be detected. Mr Fitton was pronounced deceased by medical staff at 10:00pm.

## The investigation

6. An investigation into the circumstances leading to Mr Fitton's death was conducted by Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

7. Upon being notified of Mr Fitton's death, the CSIU attended the PAH and WCC. Mr Fitton's correctional records and his medical files from the PAH and WCC were obtained. The investigation was informed by statements from the relevant custodial correctional officers, the nurse unit manager at WCC, Mr Fitton's treating doctor at the PAH, and a statement from his wife. These statements were tendered at the inquest.

8. An external autopsy examination with associated CT scans and toxicology testing was conducted by Dr Rohan Samarasinghe. At the request of the Coroners Court of Queensland, Dr Gary Hall from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the statements as well as the medical records from the PAH and WCC and reported on them.

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

## The Inquest

10. As Mr Fitton was in custody when he died, an inquest into his death was required by the *Coroners Act 2003*. The inquest was held on 23 January 2018. All of the statements, medical records and material gathered during the investigation was tendered. Counsel Assisting proceeded immediately to submissions in lieu of any oral testimony being heard.

## Circumstances of the death

11. On 21 October 2013, Mr Fitton was convicted of offences relating to making child exploitation material and indecent treatment, and incarcerated at WCC. He was sentenced to four years imprisonment. This was his second sentence for offences of this nature. In June 2008, he was sentenced to three years imprisonment, to be released on a recognisance after nine months, together with six months probation.

12. Mr Fitton's parole eligibility date was 3 January 2014. On 9 November 2015, Mr Fitton was granted exceptional circumstances parole to commence on 11 November 2015, pending the availability of a bed at a palliative care facility at Caloundra. An earlier application for exceptional circumstances parole was declined in September 2015.

13. In June 2014, Mr Fitton developed swelling in his neck for which he sought medical review. He was referred to the PAH. Investigations revealed he had affected neck lymph nodes from secondary malignant spread of epithelioid sarcoma (a soft tissue tumour) of an uncertain primary source, though it was presumed to be from the lung. At the time of diagnosis, Mr Fitton had extensive tumour involvement of the lymph nodes in his chest area around the large blood vessels from the heart, as well as in his neck causing compressive effects on his upper airway and voice.

14. Mr Fitton was reviewed by an Ear, Nose and Throat specialist and a cancer specialist, who considered that the extent of the disease was such that it was not amenable to curative surgical treatment. It was recommended that management was at best palliative, with a course of aggressive radiotherapy and chemotherapy.

15. Initially, Mr Fitton appeared to respond well to treatment with some evidence of regression of the tumour size. However, by June 2015, his tumour had re-grown with rapid increase in size noted, associated with pain and difficulty swallowing. He was again referred to the PAH, and repeat scanning showed enlargement of the tumour which was encroaching on vital structures. Further radiology was deemed inappropriate due to the lack of previous response. A further course of palliative chemotherapy was put in place.

16. In October 2015, the regimen was changed to a third chemotherapeutic agent. However, the tumour remained unremitting with increasing pain and decreased swallowing and dysphonia. The Nurse Unit Manager at WCC, Lorraine Reid provided a statement to assist the inquest.[1] Ms Reid provided details of the steps taken at the Health Centre throughout early November 2015 to manage Mr Fitton's pain and the increasing swelling in his neck. On the night of 4 November 2015, Mr Fitton was admitted to the PAH for pain management review and further investigations.

17. On 9 November 2015, Mr Fitton was admitted again to the PAH secure unit for palliation of his condition due to increased pain and poor swallow. In the early hours of 10 November 2015, he was reviewed by Medical Registrar, Dr Clare Finch. Dr Finch also provided a statement to assist the inquest.[2] Dr Finch recalled that initially Mr Fitton did not want any medical interventions and was contemplating discharging himself against medical advice. When Dr Finch reviewed him, she noted that he was not confused, he was orientated and he was able to make decisions regarding his own health.

18. Dr Finch discussed Mr Fitton with the Oncologist, Dr McGrath, who agreed with the plan to admit Mr Fitton for medical management overnight. His care was managed by the Palliative Care team, and he passed away later that night.

[1] Exhibit B6.
[2] Exhibit B2.

19. Dr Hall assisted the inquest by reviewing the available medical records, witness statements (including that of Mrs Fitton), and the autopsy report completed by Dr Samarasinghe. He provided a detailed report which was tendered at the inquest.[3]

20. An external autopsy examination was carried out by Dr Samarasinghe. CT scans revealed a significantly large tumour mass on the right side of Mr Fitton's neck with shifting of the midline neck structures to the left causing tracheal obstruction. Metastatic lesions were identified within the mediastinum and possibly within the liver. There were no suspicious injuries.

21. The autopsy report completed by Dr Samarasinghe found the cause of death to be from a tracheal obstruction due to poorly differentiated metastatic malignant epithelioid sarcoma of unknown primary origin. Dr Hall explained that sarcomas are a rare soft tissue tumour deriving from embryonic mesenchymal cells responsible for development of muscle, fat, fibrous tissue, cartilage and bone. They are aggressive tumours with extremely poor prognosis once they spread through the body.

22. Dr Hall confirmed that the medical management of people in custodial settings should mirror that in the community with respect to good medical care, appropriate investigation and treatment of medical conditions.

23. While Dr Hall did have a concern regarding a six week delay for a CT scan in 2015, he clarified that in terms of the overall outcome, this delay did not have any impact.[4]

24. Dr Hall concluded that when Mr Fitton's tumour was viewed in the context of its aggressive presentation and resistance to aggressive treatment, it was unlikely that earlier recognition would have changed the outcome.

25. Dr Hall concluded that he had no concerns regarding the medical management of Mr Fitton either at the PAH or at the WCC medical clinic. Mr Fitton was accepted by the PAH and investigated appropriately. The diagnosis of his tumour was met with appropriate discussion in a number of specialist meetings and clinics. His case was widely discussed and best practice management undertaken. Dr Hall opined that Mr Fitton was received appropriately at the WCC clinic and emergent conditions were actioned appropriately and in a timely manner. Mr Fitton was listened to and when he chose not to undertake treatment, his wishes were respected.[5]

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[3] Exhibit B7.
[4] Exhibit B7, page 17.
[5] Exhibit B7, page 18.

## Conclusions

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

27. I find that none of the correctional officers or inmates at WCC caused or contributed to his death. I am also satisfied that Mr Fitton was given appropriate medical care by staff at WCC while he was in custody, and also at the PAH while he was admitted there. His death could not have reasonably been prevented.

28. Mrs Fitton's statement set out a number of concerns relating to decisions by the Parole Board to deny her husband parole on compassionate grounds, and limits placed on contact with him on his final day at the PAH. I appreciate that these matters are of great concern to Mrs Fitton and others whose family members are diagnosed with terminal illnesses while in custody. However, I do not consider that they were ultimately connected to Mr Fitton's death, or whether deaths in similar circumstances could have been prevented. Accordingly, these issues were not examined in any detail at the inquest.

29. 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 Fitton when measured against this benchmark.

## Findings required

30. 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 Wesley Ronald John Fitton.

**How he died** - Mr Fitton died after he was diagnosed with metastatic undifferentiated epithelioid tumour. The progression of the tumour was rapid, and it was not amenable to curative surgical treatment, despite high dose palliative radiotherapy with chemotherapy.

**Place of death** – He died at the Princess Alexandra Hospital Secure Unit, Woolloongabba in the State of Queensland.

**Date of death** – He died on 10 November 2015.

**Cause of death** – Mr Fitton died from tracheal obstruction, due to or as a consequence of poorly differentiated metastatic malignant epithelial tumour (unknown primary).

## Comments and recommendations

31. 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.

32. I close the inquest.

Terry Ryan
State Coroner
Brisbane
23 January 2018