QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Eric James Murray**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2016/3277
DELIVERED ON:	6 February 2018
DELIVERED AT:	Brisbane
HEARING DATE:	6 February 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

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

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Introduction

1. On 8 August 2016, a Code Yellow was called at 4:11am at the Wolston Correctional Centre (WCC) Unit S8, after a fellow prisoner reported he could hear screaming from within the unit.

2. Custodial Correctional Officers (CCO) responded and located Mr Murray, who was clearly finding it difficult to breathe. A Code Blue was called and while paramedics from the Queensland Ambulance Service (QAS) were en route, CCO's commenced CPR.

3. Paramedics from the QAS continued CPR after arriving at the Unit at 4:37am, including the administration of adrenaline, along with calcium carbonate and sodium bicarbonate. CPR efforts continued for some 50 minutes but were unsuccessful, and Mr Murray was pronounced deceased at 5:25am.

The investigation

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

5. Upon being notified of Mr Murray's death, the CSIU attended WCC at 8:40am on 8 August 2016. Mr Murray's correctional records and his medical files from WCC and the Princess Alexandra Hospital (PAH) were obtained.

6. The investigation was informed by statements from the relevant custodial correctional officers and from the director of the secure unit at the PAH. These statements were tendered at the inquest. Mr Murray's sister was contacted to provide a statement. However, she informed investigators that she had no concerns and did not wish to provide a statement.

7. An external autopsy examination with associated CT scans and toxicology testing was conducted by Senior Forensic Pathologist, Dr Nathan Milne. The CT scans showed obesity, dilated cerebral ventricles, sternal wires, triple vessel coronary artery calcification and aortic calcification. While there were no acute injuries, there were some resolving injuries and signs of attempted resuscitation. Dr Milne concluded that the cause of death was ischaemic cardiomyopathy.

8. At the request of the Coroners Court, Dr Natalie MacCormick from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the statements as well as the medical records for Mr Murray from WCC and the PAH 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. Although Mr Murray's death was from natural causes, as he was in custody when he died, an inquest into the death was required by the *Coroners Act 2003.* The inquest was held on 6 February 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. Eric James Murray was 69 years of age at the time of his death. He was an Indigenous man with a long criminal history in the Northern Territory, Queensland and New South Wales.

12. In 1981 he was convicted of murder in New South Wales and sentenced to 14 years imprisonment. In 2005, he was convicted in the Supreme Court of the Northern Territory of multiple offences of a violent and sexual nature, and sentenced to an indefinite term of imprisonment.

13. In February 2011, Mr Murray was the subject of an interstate transfer from the Northern Territory to Queensland, after he was charged with the murder of a 60-year-old woman at a vacant lot in West End in 1996. He was returned to the custody of Queensland Corrective Services on 28 July 2011.

14. On 25 July 2013, Mr Murray was convicted of the 1996 murder, and sentenced to life imprisonment. The sentencing Judge noted that Mr Murray had a "monstrous criminal history which included many convictions for offences of serious violence, including murder. Mr Murray was accommodated at various correctional centres before 8 December 2014 when he was received at WCC. He remained there until his death.

15. Mr Murray was a morbidly obese man, and was domiciled in a single bed cell in a unit for special needs prisoners. He was wheelchair-bound and had a lengthy medical history, including:
    - Ischaemic heart disease with ischaemic cardiomyopathy (myocardial infarction and triple coronary bypass graft in 2000);
    - Type 2 diabetes mellitus since the 1980's;
    - Hypertension;
    - Hyperlipidaemia;
    - Obesity (138kg, BMI 39.8);

- Falls;
- Admission for an atypical mycoplasma pneumonia in 2011;
- Admission for urosepsis in 2012;
- Admission for angina in 2014;
- Admission for cataract surgery in 2014 and 2016.

16. Over the years, Mr Murray was reviewed regularly by nursing, medical and allied health staff while he was in prison. Most of the medical issues in the lead up to his death stemmed from hypoglycaemia, warfarin dosing and dressing changes.

17. At 4:11am on 8 August 2016, a prisoner called a Code Yellow (officer distress call), to Master Control after he could hear Mr Murray moaning loudly.

18. CCO Mr Alex Vujanic attended at Mr Murray's cell and provided a statement to the inquest[1]. He explained that the cell was accessed at 4:23am, and Mr Murray was located position on his bed, trying to get up. Mr Murray said *"help me, help me. I cannot breathe."*

19. Mr Vujanic asked Mr Murray where the pain was, and it was at that point that Mr Murray stopped communicating. Mr Vujanic contacted Master Control so as to have an ambulance called, and CCO's Hawyes and Cameron commenced CPR. A short time later, Custodial Corrections Supervisor Clark arrived with a defibrillator, which was used in the administration of CPR, with each of the CCO's rotating through the different roles. At all times the defibrillator instructed the officers 'no shock' and to continue CPR.

20. Paramedics arrived just after 4:30am, and took control of resuscitation efforts. There were no signs of life at this time and Mr Murray was in asystole. Paramedics administered adrenaline and oxygen while CCO's continued to help with manual compressions.

21. Mr Murray's rhythm changed to pulseless electrical activity with a wide QRS complex and a rate of 30 beats per minute. This increased to a rate of 60 beats per minute, with audible heart sounds and cardiac output evidence on capnography. This was maintained for several minutes, until Mr Murray re-arrested. Despite continued efforts, Mr Murray was declared deceased at 5:25am.

[1] Exhibit B2.

22. The statement from the medical director of the Security Unit at the PAH indicated that Mr Murray was under the care of both ophthalmology and endocrinology teams between July 2011 and May 2016. Among numerous other admissions, he was admitted due to a myocardial infarction in August 2012, and again in April 2014 due to symptoms of angina.

23. Dr MacCormick assisted the inquest by reviewing the available medical records, witness statements, and the autopsy report completed by Dr Milne. She provided a detailed report which was tendered at the inquest.[2] Dr MacCormick helpfully included explanatory information about each of the drugs detected in Mr Murray's system at autopsy, and an explanation of ischaemic cardiomyopathy, which is the most common cause of heart failure and remains the most common cause of death in the world.

24. Dr MacCormick explained that patients with ischaemic cardiomyopathy are at increased risk of further ischaemia and myocardial infarction, heart failure, and fatal arrhythmias. She notes that although the signs of wheezing in the days preceding the death may have been a sign of heart failure, these were not persistent, and the nature of Mr Murray's emergency presentation was consistent with an acute cardiac event.

25. Dr MacCormick's opinion was that Mr Murray was provided with an equivalent (if not better) level of health care in custody in the 12 months prior to his death, as would be expected in the general community. He had access to regular specialist review of his diabetes with an endocrinologist, and the medical records showed that his blood sugar levels were very closely monitored in prison. He was also provided with appropriate podiatry and specialist ophthalmology care.

26. Dr MacCormick explained that Mr Murray's heart failure was very severe, and he was at high risk of cardiac arrest. While the hypoglycaemic episodes that Mr Murray underwent in the lead up to his death were concerning, Dr MacCormick was satisfied that his diabetes was being closely monitored by nursing staff with frequent specialist input.

27. It appeared that the hypoglycaemia was not a precipitating factor for the cardiac arrest. Dr MacCormick also confirmed that, in her opinion, the first aid provided to Mr Murray by each of the CCO's, and the paramedics, appeared to be of a very high quality.

[2] Exhibit B3.

28. The unit which housed to Mr Murray has electronically operated doors which could not be opened by prisoners once they were locked inside their cells. The cell doors are remotely operated by Master Control after hours, and by a central control station located in the unit when CCOs are present. There is no evidence of unauthorised access to his cell on the night of his death.

Conclusions

29. Mr Murray'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.

30. I conclude that Mr Murray died from natural causes. I find that none of the correctional officers involved or other prisoners at WCC caused or contributed to his death. I am satisfied that Mr Murray was given appropriate medical care by staff at WCC and the PAH while he was admitted there. His death could not have reasonably been prevented.

31. 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 Murray when measured against this benchmark.

Findings required

32. 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 – Eric James Murray.

How he died - Mr Murray died after suffering a myocardial infarction in his cell in the special needs section of Wolston Correctional Centre. He had suffered from ischaemic cardiomyopathy for many years, and as such was at greatly increased risk of further ischaemia and myocardial infarction, heart failure, and fatal arrhythmias.

Place of death – Wolston Correctional Centre, Wacol in the State of Queensland.

Date of death – 8 August 2016.

Cause of death – Ischaemic cardiomyopathy, due to or as a consequence of coronary atherosclerosis (previous bypass graft surgery). Other significant conditions were Type 2 diabetes mellitus, and obesity.

Comments and recommendations

33. 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.

34. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future, or that otherwise relate to public health or safety or the administration of justice.

35. I close the inquest.

Terry Ryan
State Coroner
Brisbane
6 February 2018