OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Barry Gordon HADLOW**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 3229/07(6)
DELIVERED ON:	29 September 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 August 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, adequacy of health care

REPRESENTATION:

Counsel Assisting:	Ms Eryn Voevodin
Department of Community Safety:	Ms Annie Little

A copy of the findings of a coroner's inquest must be given to the family of the person who died; each of the persons or organizations granted leave to appear at the inquest; and to officials with responsibility for any activities that are the subject of any recommendations.[1] These are my findings in relation to the death of Barry Gordon HADLOW. They will be distributed in accordance with the requirements of the Act and posted on the website of the Office of the State Coroner.

Introduction

Barry HADLOW was a 65 year old prisoner, serving a life sentence, at Wolston Correctional Centre when he died on the 13 July 2007 at the Princess Alexandra Hospital secure unit, a corrective services facility.

Although it was apparent he died of natural causes, because Mr Hadlow was in custody an inquest was required to be held into his death.[2] In addition to establishing the particulars of his death as required by s45(2) of the Act, the inquest also considered whether Mr Hadlow had received adequate health care while he was in custody.

Social history

Barry Hadlow was born in Brisbane on 2 July 1942, making him 65 at the time of his death. He was one of eight children but never married and had no children of his own.

In 1963, when he was 20, he was convicted and sentenced to life imprisonment with hard labour for the murder of a five year old girl at Townsville. He was released on parole in 1985. In May 1990 he again murdered a young girl. In March the following year he was sentenced to life imprisonment with a recommendation that he never be released. That recommendation was carried into effect.

Apart from a brief period in 1999, Mr Hadlow had been accommodated at Wolston Correctional Centre (WCC) since 1996 until shortly before his death.

Medical history

A report provided by the Director, Health and Medical Services Qld Corrective Services summarised Mr Hadlow's medical conditions as:

- Chronic asthma with notable acute episodes
- Persistent sinus problems
- Arthritis
- Increased cholesterol levels
- Left Cerebral Vascular Accident (1985) - with residual effects that include mild speech loss and a loss of lateral sensation to the left foot.
- Dermatitis and Psoriasis

[1] *Coroners Act 2003* s45 and s46
[s] s27

- Hypertension
- Ex-smoker

Mr Hadlow was taking several medications for these conditions. The Director advises:

> *"In February 2006 he was transferred to the Princess Alexandra Hospital secure unit (PAHSU) for worsening chest (angina) symptoms. Coronary angiography showed 2 vessel coronary artery disease with occlusion of the left anterior descending and aortic stenosis. A change of medication was made and his symptoms resolved and he was transferred back to Wolston Correctional Centre.*
>
> *Mr Hadlow would present from time to time with chest pains and shortness of breath which was sometimes relieved by the use of nebulised ventolin for asthma and sometimes relieved by glyceryl trinitrate (GTN) spray.*
>
> *The medical file reveals that Mr Hadlow was being treated more frequently with acute exacerbations of asthma, blood stained sputum and required treatment with antibiotics and that these presentations of chest pain were difficult to separate."*[3]

On 13 May 2007 Mr Hadlow had presented for his morning medications and complained of tightness in his chest. It seems Mr Hadlow himself associated these symptoms with an exacerbation of his lung disease. His symptoms settled with the use of a saline nebuliser and Ventolin. The nurse recommended increased ongoing use of his Ventolin. A medical review occurred on 18 May and a reducing dose of prednisone was prescribed as treatment for his lung disease.

On 19 May 2007, Mr Hadlow presented to the medical centre complaining of *"chest tightness, a bloated stomach, headache and blurred vision."* He had a self prescribed glyceryltrinitrate spray (for angina) and an additional Ventolin dose. An oral antacid was provided for bloating relief. He was encouraged to return as required.

On the 20 May 2007, he presented with fever, ongoing shortness of breath and haemoptysis (blood in sputum). A chest infection was diagnosed and antibiotics prescribed. He was reviewed by the nurse the next day in much the same condition and then seen by a doctor on 22 May 2007. The doctor ordered a chest x-ray and continued antibiotics and the nebuliser. There were no further presentations until the 13 July 2007.

[3] Entries in WCC medical records are made for visits 13.05.07 (present tightness in chest), 18.05.07 (shortness of breath last 5 days), 19.05.07(presented to medical centre complaining of tightness across chest), 20.05.07 (presented for review, shortness of breath), and 22.05.07 (review for chest infection).

Events surrounding his death

On 13 July 2007, Mr Hadlow attended the health centre presenting with chest pain and coughing up blood stained sputum. He was clearly unwell as another prisoner had to push him there in his wheel chair.

The relevant entry in his prison medical files reads as follows:

> *"NSG- 800 - Bought to Health Centre. Has been coughing up blood for = 1 month states has increased overnight, also has sharp chest pain Right side of chest more intense with respiration out. Sputum specimen obtained, bright blood evident. Vital signs 38.6, P. 118 SaO2 86% (RA). Given ventolin and 1 gm for pain. Post Neb peak flow - SaO2 96%. Returned to unit to see VMO this afternoon".*

As a result, Mr Hadlow was seen in the afternoon by the visiting medical officer who diagnosed bronchitis and ischaemic heart disease, with possible congestive cardiac failure. He was treated intravenously with frusemide (Lasix, a diuretic) and transferred by Qld Ambulance Service to the Princess Alexandra Hospital for treatment and ongoing care. He arrived at 2:40 pm.

He was seen in the Emergency Department with a complaint of chest pain and tightness across the chest, lasting 5 - 10 minutes, with a week of experiencing shortness of breath (worse on deep inspiration). He was diagnosed with moderate to severe pneumonia which was to be treated by antibiotics and physiotherapy and to monitor his oxygenation. He was transferred to a secure ward at 7.05pm.

Each prisoner is confined in a single bed room. Correctional services officers (CSO) have responsibility for the security and safety of the unit. Prisoners are monitored through closed circuit television (CCTV). The correctional officers carry the only set of keys to unlock the rooms for the medical staff, and therefore accompany the medical staff while they are in the prisoner's room

At about 9.15pm the nurse monitoring Mr Hadlow noted his oxygen saturations had dropped to 84% and she called for a medical ward officer to attend. At about 10.26pm, while waiting for this to happen, Mr Hadlow was observed to have collapsed sideways on his bed.

A prison officer and two nurses rushed to the cell. They note that Mr Hadlow was unconscious and not breathing. The nurses commenced CPR while the correctional officer called for a “crash team” to attend.

A medical emergency team attended the cell a few minutes later and continued with the resuscitation efforts without result. Mr Hadlow was pronounced dead at 10.47.

Investigation findings

All medical staff then left and the room was locked. As this was the death of a prisoner the Qld Police Service Corrective Services Investigation unit were contacted and an investigator arrived at the scene at 11:59pm.

A police photographer attended at 12:40am on 14 July 2007 to record the scene. The room was unlocked. Mr Hadlow was lying prone on the bed. The room was a standard hospital room without signs of disorder. There were no apparent or unexplained markings. At the time of the initial investigation, there were no concerns raised as to the cause of his death.

The Coroner was contacted regarding the circumstances of the death and arrangements were made for the autopsy examination.

On 15 July 2007, the investigator interviewed the 5 other prisoners in Mr Hadlow's residential unit at Wolston Correctional Centre[4]. A synopsis of these interviews has been incorporated in the investigating officer's report. In summary the fellow prisoners report that Mr Hadlow was unwell in the weeks leading up to his death and that Mr Hadlow may not have been actively seeking or initiating medical attention during this time. It is suggested, for example, that Mr Hadlow was advised by others in the unit to go to the doctor, but "*Barry being Barry he was stubborn and didn't*".

Identification

Mr Hadlow was formally identified to a Coronial Support unit police officer by his sister on 14 July 2007.

Autopsy

On 16 July 2007 an autopsy was conducted on Mr Hadlow's body by Dr Nathan Milne, an experienced forensic pathologist.

External examination findings concluded that Mr Hadlow was an obese man with signs of recent medical treatment. Internal examination showed severe heart disease. Coronary heart disease was confirmed and there was evidence of old and recent myocardial infarcts (heart attacks).

The coronary arteries had areas of severe calcific atheroma, with the left anterior descending artery shows 40% stenosis of the proximal third and 80% stenosis of the middle third. The left circumflex artery shows stenosis no greater than 25%. The right coronary artery shows 90% stenosis of the proximal third, 60% stenosis of the middle third and 70% stenosis of the distal third. Histologically, there was severe atheromatous stenosis and ischaemic injury of variable age. In the lateral left ventricle there is a small area of very acute infarction that appeared to be 6 - 12 hours old, there were larger areas of infarction that appeared about 2 weeks old, and some areas were at least 2 months old.

The lungs were heavy and contained a lot of fluid. But there was no evidence of pneumonia. The typical features of asthma were not present, there were however features of emphysema.

[4] Residential units at Wolston Correctional Centre consisted of a small bedroom adjoining a communal lounge/kitchenette. There are 6 such bedrooms to each lounge room, and four such combinations to each building.

Microbiology showed no evidence of infection in the lungs. There was incidental cancer in the prostate gland.

In the pathologists opinion the cause of death was acute myocardial infarction, due to or as a consequence of, coronary atherosclerosis.

Medical review

A doctor from the Qld Health Clinical Forensic Medical unit conducted a review of the medical management of Mr Hadlow, specifically in relation to the treatment provided in the two months prior to his death when Mr Hadlow had frequent attendance at the prison medical centre.

The Doctor commented that Mr Hadlow's presentation between the 13 and 22 May 2007 was consistent with an exacerbation of chronic airways disease with a reversible component. The pain he described was atypical for cardiac chest pains. His symptoms recorded as improving or disappearing with the administration of Ventolin. The ECG performed at the prison shows no acute changes as associated with myocardial infarction. Mr Hadlow's chest pain resolved by the end of the consultation. He seemed to symptomatically improve and has not presented for medical review for a two month period prior to the events of 13 July 2007.

Mr Hadlow's presentation on 13 July 2007 with right sided pleuritic chest pain with no ECG changes but systemic symptoms of fever and shortness of breath with blood sputum was appropriately referred to the PAHSU.

The myocardial infarction two months prior to his death (as found on autopsy) appears to have been silent. There is not documented change in his ECG and the pain reported was atypical and brief. While there is no clinical information surrounding the two week period before his death, there were no documented significant changes in the ECG.

The prison health system correctly identified him as unwell and transferred him to hospital care.

At the PAH Mr Hadlow was diagnosed with a lower respiratory tract infection due to his productive cough of discoloured blood stained sputum, fever and shortness of breath. An ECG did not display signs of myocardial infarction.

Mr Hadlow displayed an acute deterioration in signs and symptoms between 2000hrs and 2220hrs, suggesting the onset of cardiac failure symptoms occurring predominantly at this time. This is the first time the sputum is referred to as "frothy", a classic sign of heart failure. The nurse appropriately requested a medical review. However Mr Hadlow's condition deteriorated before this could happen and a code blue emergency was called. The arrival of medical staff was prompt and resuscitation attempts were appropriate and comprehensive.

Conclusions

Mr Hadlow died from an acute myocardial infarct at the Princess Alexandra Hospital on 13 July 2007. He was known to have several pre-existing medical conditions including significant coronary atherosclerosis, asthma, high cholesterol and was taking several medications.

I am satisfied that no third party contributed to his death and that no foul play was involved. I am satisfied that while a prisoner at the WCC he received adequate medical care for his long standing medical conditions.

When seen at the PAH emergency department he was appropriately diagnosed with a lower respiratory infection due to his symptoms.

Between 2200 and 2220hrs, Mr Hadlow showed a deterioration in symptoms and a medical review was appropriately requested. Before the review could be conducted Mr Hadlow suffered an acute myocardial infarct. Despite advanced life support measures he was unable to be resuscitated and was declared deceased.

The medical response to the emergency was rapid and the resuscitation was appropriate and comprehensive.

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. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased –	The deceased person was Barry Gordon Hadlow.
Place of death –	He died at Princess Alexandra Hospital in Buranda, Brisbane Queensland.
Date of death –	He died on 13 July 2007.
Circumstances and cause of death –	Mr Hadlow died from natural causes, namely, a myocardial infarction due to or as a consequence of coronary atherosclerosis while he was in the custody of the Department of Corrective Services.

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.

As detailed earlier I have concluded that no third party played any part in Mr Hadlow's death and that he received adequate medical care while a prisoner at the WCC and at the PAH on the day of his death. In those circumstances it is unnecessary for me to make any comments or recommendations.

Michael Barnes
State Coroner
Brisbane
29 September 2009