QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Leonard John FRASER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 0003/07(7)
DELIVERED ON:	20 March 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 June 2010 & 20 April 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Dr Ronie Acabado:	Mr Geoff Diehm SC (instructed by Quinlan Miller & Treston)
Queensland Corrective Services:	Ms Melinda Zerner
Queensland Health:	Mr Philip Scott (Crown Law)

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The *Coroners Act 2003* provides in s47 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 officials with responsibility for the justice system. These are my findings in relation to the death of Leonard John Fraser. 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

Leonard Fraser was 55 years of age when he died in the early hours of New Year's Day 2007. He was a prisoner at the time of his death and had been for 19 of the last 21 years of his life. In the month prior to his death his health deteriorated and he was seen by a number of visiting medical officers (VMO's) at Wolston Correctional Centre (WCC) where he was then accommodated. On 26 December 2006 he was rushed to the Princess Alexandra Hospital (PAH) Secure Unit after presenting to nurses at WCC with the serious symptoms of what is now known to have been a myocardial infarct. That infarct was able to be halted and Mr Fraser began to recover over subsequent days. He again suffered an acute myocardial infarction shortly after the turn of the New Year and, when discovered, could not be revived.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care needs adequately discharged those responsibilities; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

Detective Sergeant Gavin Pascoe of the QPS corrective services investigation unit (CSIU) led the investigation into the circumstances of the death of Mr Fraser.

Detective Sergeant Pascoe attended the PAH and later WCC where he seized relevant documents and conducted interviews with Queensland Corrective Services (QCS) staff. CSIU officers conducted interviews with all prisoners in unit S8 at WCC where Mr Fraser had been accommodated prior to his transfer to hospital. Detective Sergeant Pascoe obtained information in relation to the antecedents of Mr Fraser and confirmed via the Registry of Births, Deaths and Marriages his correct birth date over which, until then, there had been some doubt. Detective Sergeant Pascoe obtained information from both the PAH and WCC relating to Mr Fraser's medication; he obtained all relevant medical material on file at those two locations and obtained a summary of the medical care provided to Mr Fraser while he was in hospital.

The body of Mr Fraser was photographed *in situ* at PAH and his cell at the WCC was forensically examined.

Formal identification of the deceased was conducted via a fingerprint examination conducted by Sergeant Mark Tobin. He was able to confirm that the fingerprints taken from the body matched those on QPS file for Leonard John Fraser.

Although it should have been clear early in the investigation that the medical treatment provided to Mr Fraser in the weeks prior to his being transported to PAH would be relevant, no steps were taken until much later (and then only at the behest of this court) to identify the VMO's who had provided that treatment. Not unexpectedly, the passage of time meant that this process was far more difficult than it would otherwise have been and the evidence obtained less reliable.

Mr Fraser died on 1 January 2007 but the investigation report is dated 30 July 2009 and was received at this office well after that date. At the inquest the investigator outlined some of the difficulties he had experienced obtaining evidence from nursing staff at WCC. He also stated that he had been required to relieve as officer in charge of the CSIU for 12 months during this period and had been required to lead investigations into a large number of other significant deaths in custody. Although I readily accept the significance of the officer's workload during the relevant period, such delays are unacceptable. In this case it is fortunate that the delay has not materially affected the capacity to adequately discharge my responsibilities under the Act.

The Inquest

The Coroners Act 2003 ("the Act") mandates the holding of an inquest into the circumstances of all deaths in custody in Queensland. The Act requires those inquests to be conducted by either the State Coroner or Deputy State Coroner. Accordingly, I opened and conducted an inquest into the death of Mr Fraser.

A pre-inquest conference was held in Brisbane on 16 June 2010. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to Queensland Corrective Services and Queensland Health.

An inquest was held in Brisbane on 20 April 2011. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigating officer gave evidence and a report from an independent medical expert, Dr Bob Hoskins, was tendered. The matter was adjourned to consider what, if any, further evidence should be heard. I agreed with the submission of Mr Johns that further statements needed to be obtained from three, then unidentified, doctors who had treated Mr Fraser at WCC in the weeks prior to his transfer to hospital.

The investigating officer found the task of locating the three doctors difficult. Their identity was not immediately clear from the material; Queensland Corrective Services were not able to immediately identify them, and when eventually identified it was discovered that one had moved interstate and one overseas. After the report of Dr Hoskins was shown to these doctors and their statements in response were obtained, Dr Hoskins was asked for a further opinion.

Mr Johns distributed submissions based upon the material that had by then been collated and tendered. He proposed that no further oral evidence be heard subject to objection from the parties. No objection was received to this proposed course. Two parties filed submissions in response to those of Mr Johns based on the tendered written material and the oral evidence of the investigating officer.

The evidence

Personal circumstances

Leonard Fraser was born on 27 June 1951 in Ingham, Queensland. He had an extensive criminal history for offences which included stealing, unlawful use of a motor vehicle, unlawful carnal knowledge of an intellectually impaired person, serious assault, rape, manslaughter and murder. Mr Fraser spent more than 11 years in custody between 1985 and 1997 after being convicted of rape. He began his latest term of imprisonment on 23 April 1999 after being sentenced to life imprisonment for the offence of murder. In 2003 he was sentenced to 16 years imprisonment for the offence of manslaughter and another term of life imprisonment for a second offence of murder.

Mr Fraser's next of kin was identified as his adult daughter then living in Mackay. She was notified of his death but advised police she had had no contact with her father for at least 15 years.

Medical history and treatment at WCC

In March 1999 Mr Fraser was admitted to Rockhampton Hospital suffering from chest pain which was later diagnosed as a myocardial infarction. It is clear from those records that he had suffered earlier cardiac problems in addition to respiratory problems, a hiatus hernia and aggravation to his gastrointestinal tract amongst other conditions.

The inquest focused on the medical treatment provided to Mr Fraser by staff at the WCC between 7 and 26 December 2006. The latter date was set by Mr Fraser's transfer on that day to PAH while the earlier date reflects the first in a series of presentations made by Mr Fraser to medical personnel at the WCC in December 2006 (and this being the first he had sought medical assistance for more than two months).

Mr Fraser presented to the medical centre on the afternoon of 7 December 2006 complaining of central chest pain having been present for two days. He told nurses that the pain was radiating along his left arm causing him to suffer pins and needles and excess sweating. He was observed to be quite red in the face but was not in distress and was conversing calmly. Nursing staff recorded Mr Fraser's blood pressure, temperature and heart rate. The nursing notes state as follows:

> *"ECG machine not functioning – ECG unobtainable. Inmate advised at this stage to rest and take 20 ml Mylanta and aspirin as administered, with instruction to return if pain not resolved/worsening/changing. Returned to unit."*

Mr Fraser returned to the medical centre on 14 December 2006 complaining of central chest pain which was worse on inspiration. He told the nurses that he had been vomiting and had developed a rash on his chest and neck in the last 24 hours. He was given a Panadol and arrangements were made for him to see the VMO later that day.

The VMO on 14 December 2006 was Dr Ram Sami Naidu. He provided a written account of his examination to the inquest. He says that Mr Fraser presented to him with generalised aches and pains and was complaining of producing a "*yellowish expectoration*". Dr Naidu had familiarised himself with the nursing notes from earlier

in the day but it is not clear whether he had seen the nursing entry of 7 December 2006. Dr Naidu examined Mr Fraser and considered him to be suffering from a respiratory ailment. He prescribed increased fluids and Panadol as required.

At a headcount early on 16 December 2006, Mr Fraser complained of shortness of breath. He was assessed by a nurse and arrangements were made for him to see the VMO later that day. That VMO was associate Professor Noel Hayman. In a written submission to the inquest he stated that when Mr Fraser came to see him in the medical centre consulting room he walked unassisted and had no signs of the shortness of breath. Mr Fraser's presenting complaint was his coughing up of yellow phlegm, a sore throat, fevers and headache. Associate Professor Hayman found Mr Fraser's chest to be clear. He was confident that Mr Fraser had a viral illness and that he exhibited no signs of cardiac failure. Associate Professor Hayman did not become aware of the nature of Mr Fraser's presentation on 7 December 2006 nor that the ECG machine was not working on that day.

Mr Fraser was again reviewed by a nurse on the morning and afternoon of 17 December 2006 as he continued to complain of shortness of breath and looked unwell. He was listed to be assessed again by a VMO the following day. On 18 December 2006 Mr Fraser was seen by Dr Ronie Acabado. Dr Acabado provided two written statements outlining his recollections of this assessment. He says that Mr Fraser gave him "*no history of chest pain, palpitations, nausea, vomiting or sweating or demonstrated any signs of cardiac origin* (sic)". He noted Mr Fraser to have a slight shortness of breath and a cough. On an examination of the chest he made this entry in Mr Fraser's progress notes:

> "…*crackles noted all over lung fields …. Lower respiratory tract infections/pneumonia".*

Dr Acabado says that he listened for any abnormality of the heart and lungs when conducting this chest examination and also measured Mr Fraser's pulse. He made no note of the examination for abnormal heart sounds or of the pulse rate as he detected no abnormality. He did not record Mr Fraser's temperature as a thermometer was not available to him.

Dr Acabado recalls examining the clinical entries of 16 and 17 December 2006 for Mr Fraser. He makes no mention in either of his two statements of having examined Mr Fraser's medical notes covering any earlier date. It was his experience that medical records at the time were often in such a state of disorganisation that it was difficult to examine them sequentially. It is most unlikely, therefore, that he was aware of Mr Fraser's complaints of chest pain and excess sweating on 7 December 2006.

Dr Acabado prescribed antibiotics and Ventolin, each to be taken over the course of 10 days.

On 20 December 2006 another inmate told nursing staff that Mr Fraser was "*looking crook*" and on 23 December 2006 he was noted to be vomiting after use of his Ventolin nebuliser. At 9:00am on 25 December 2006 Mr Fraser was taken by wheelchair to the medical centre for his daily Ventolin nebuliser. He was assessed by a nurse after complaining of being unable to keep any food and fluids down. It was noted that his feet were red and swollen and that he looked unwell. He was reassessed at 1:00pm at which time his condition had not improved but, on the assessment of nursing staff, had not deteriorated either. He was given glucolyte for rehydration and returned to his cell.

Early on 26 December 2006 Mr Fraser again presented to the medical centre for his nebuliser. It was clear to the nurse on duty that he was acutely unwell. The progress notes for this presentation state:

> "*Respiratory exertion. Colour pale and clammy. Feet swollen and red bilaterally >6 sec capillary return. Dehydrated: very dry. States drinking minimal amt, decreased urine output. Obs T36.6 P104 RR38 BP105/70 SpO2 94% RA. Chest consolidated all lobes. States coughing small amt white sputum. ?chest infection – pneumonia – other pathology. Transferred via QAS to PAH A&E"*

The ambulance arrived at WCC at 8:40am and Mr Fraser arrived at PAH at 9:35am.

Treatment at Princess Alexandra Hospital

According to the PAH progress notes Mr Fraser was not assessed by a doctor until 1:30pm and when he was, he was diagnosed with a possible myocardial infarct. He was seen by a doctor from cardiology at 3:40pm and a diagnosis of inferior myocardial infarction was confirmed. Mr Fraser was treated with thrombolysis (clot dissolving medication) which led to a resolution of his chest pain. He was subsequently admitted to the Coronary Care Unit for treatment and monitoring.

Professor Tom Marwick, a cardiologist at PAH, provided a written account of the treatment received by Mr Fraser to the inquest. He says that after initial treatment, Mr Fraser began exhibiting signs of heart failure. He had bilateral leg swelling and it was thought he may have developed cellulitis prior to presentation to hospital. A plan was developed to treat his heart failure before proceeding to coronary angiography.

After an assessment on 29 December 2006 it was determined that the severity of Mr Fraser's left ventricular dysfunction required further medical management before any surgical intervention. On that day Mr Fraser was transferred out of the Coronary Care Unit and into the PAH Secure Unit.

Mr Fraser was on six-hour observation intervals and was seen at 10:00pm on 31 December 2006 by nurse Yvonne Ericssen. She noted that Mr Fraser had complained of epigastric pain during the day but denied any chest pain. She noted that Mr Fraser denied any chest pain throughout the course of the earlier shift. At 3:00am Nurse Ericsson checked on Mr Fraser and saw that he was not breathing. A code blue was called and the Cardiac Arrest Team responded. Dr Sorab Shavaksha was the medical registrar attached to that team. He arrived approximately two minutes after the calling of the code blue and conducted observations on Mr Fraser. It was immediately apparent to him that Mr Fraser had been deceased for some time and that active resuscitation would have been futile. Mr Fraser was not warm to touch, had fixed pupils and no central pulse. Dr Christine Verdac issued a life extinct certificate at 3:40am.

Autopsy results

An autopsy examination was carried out on 2 January 2007 by an experienced forensic pathologist Dr Beng Ong. After considering toxicology and histology results Dr Ong issued a report in which he stated:

> *"There was extensive myocardial infarction which showed two different phases; the first was extensive concentric subendocardial infarction with granulation tissue. The infarction would be about one week's duration and would be consistent with presenting symptoms prior to admission to the*

hospital. The second was a more recent infarct which was limited to the entire septum and postero-lateral aspect of the left ventricle….. In summary, there was a significant myocardial infarction involving a large portion of the heart."

"There was a thrombus occluding the right coronary artery (which supplied the area infarcted). This thrombus appeared to be recent (after the initial admission to hospital) and might be the cause for the second phase of infarction."

Dr Ong found the toxicology results to be unremarkable and concluded that they had not contributed to the death.

Counsel assisting considered the reference by Dr Ong to "one week's duration" to be ambiguous and subsequently sought clarification. In particular it was important to identify, if possible, the likely duration of any infarction prior to hospital admission. In response, Dr Ong re-issued his autopsy report to include the following information:

"The histology picture showed evidence of two infarctions i.e. at one infarction which showed healing process in keeping with about seven days old at the ***time of death*** (Dr Ong's emphasis) *and would be consistent with occurring at the time of admission to Princess Alexandra Hospital. The distribution was concentrated within the subendocardial region and would be consistent with global ischaemia to the heart. To phrase it differently, at the time of admission (26 December), the infarction* ***would be acute and had just occurred*** (my emphasis). *Because he survived the initial episode, there were healing changes to the affected area which was as observed during the post-mortem examination. There were also changes in the myocardium which showed that he had another infarction days later in the surviving portion of the myocardium specifically in postero-septal region of the left ventricle. The changes were in keeping with 1 to 2 days and possibly earlier before death. The distribution of this section infarction was consistent with that of the supply from the right coronary artery which was acquitted by a thrombus.*

"He has succumbed after the second infarction is due to extensiveness of damage to his heart as a result of the two infarcts."

As a result of his findings, Dr Ong issued a certificate listing the cause of death as:

1(a) Acute myocardial infarction, due to*,* or as a consequence of

1(b) Coronary thrombosis, due to*,* or as a consequence of

1(c) Coronary atherosclerosis

Investigation findings

Detective Sergeant Pascoe could not locate any signs of trauma on the body of Mr Fraser when he observed him in hospital. The forensic examination of Mr Fraser's cell did not reveal any signs of a physical altercation.

The toxicology results on blood and urine taken an autopsy showed the presence of a number of drugs used at PAH to treat Mr Fraser's presenting condition. All were in concentrations that were to be expected in their normal therapeutic use and Dr Ong has opined that none contributed to the death.

Conclusions

I conclude that Mr Fraser died for natural causes. I find that none of the correctional officers or inmates at the WCC caused or contributed to his death. I am satisfied that the care afforded to Mr Fraser by staff at the PAH in the week prior to his death was adequate and appropriate.

It is likely that the pain suffered by Mr Fraser on 7 December was angina due to cardiac ischemia. It appears that the three VMO's who subsequently saw Mr Fraser in December 2006 were not aware of the nature of that earlier presentation. They would not have been aware that an ECG was considered desirable on that day but could not be conducted because of equipment failure, although a more careful review of the chart would have disclosed this.

I also conclude that when Mr Fraser was seen by the three VMO's his cardiac condition had probably temporarily resolved and their diagnosis of a respiratory tract infection, viral in nature, was probably correct. In those circumstances the treatment provided was appropriate.

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 in relation to the other aspects.

Identity of the deceased –	The deceased person was Leonard John Fraser
How he died -	Mr Fraser died of natural causes while he was a prisoner being held in a secure hospital ward in the custody of Queensland Corrective Services.
Place of death –	He died at Princess Alexandra Hospital, Buranda in Queensland.
Date of death –	He died on 1 January 2007
Cause of death –	Mr Fraser died from natural causes, namely acute myocardial infarction due to coronary thrombosis and coronary atherosclerosis.

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.

Although I do not find that it directly contributed to his death, I am concerned that the medical care afforded to Mr Fraser at WCC was not of the expected standard in some aspects.

Mr Fraser should have received an ECG on 7 December 2006. If the equipment at the prison was not functional he should have been sent to a hospital to have this done.

It is likely that if any of the VMO's who subsequently saw Mr Fraser had been made aware that on 7 December 2006, Mr Fraser had symptoms strongly suggestive of a cardiac origin and he had not received an ECG they would have made arrangements for it to be conducted. That earlier progress notes were not brought to their attention points to a systemic failure. Indeed, one is left to wonder whether the medical practitioners who saw Mr Fraser in the month before his death were even made aware that he had previously suffered myocardial infarctions.

It is also unacceptable that the doctor who examined Mr Fraser on 18 December was unable to take his temperature because no thermometer was available.

It is evident both from the information provided to me in this inquest and others that significant changes have occurred in the provision of healthcare to prisoners. Most significantly, it is no longer provided by QCC. It is now the responsibility of Queensland Health and, in general terms, can be said to be better managed and certainly better resourced.

It can not be shown that the shortcomings evident in the treatment of Mr Fraser contributed to his death. Further, I am satisfied that ECG facilities are now readily available and in a serviceable condition at WCC and I accept that significant changes have been made to the management of prisoner medical records in the last five years.

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

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
20 March 2012