QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of William Michael MALLIE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Cairns
FILE NO(s):	2016/1937
DELIVERED ON:	20 June 2019
DELIVERED AT:	Brisbane
HEARING DATE(s):	20 June 2019
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lane
Cairns & Hinterland Hospital and Health Service (CHHHS):	Ms Helen Price
Queensland Corrective Services:	Ms Aggie Honkisz

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Introduction

1. William Mallie was 58 years of age when he died in the Hospital Wing of the Lotus Glen Correctional Centre (LGCC) on the afternoon of 14 May 2016. Mr Mallie had been serving a term of imprisonment since 2008 for attempted murder. He had end-stage kidney disease for which he was on haemodialysis. Mr Mallie died of natural causes from sudden heart failure which occurred while he was receiving dialysis in the LGCC medical centre.

The investigation

2. An investigation into the circumstances leading to Mr Mallie's death was overseen by Detective Sergeant Stephen Carr from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). I am satisfied that the investigation was sufficiently comprehensive, having regard to the circumstances of Mr Mallie's death.

3. Upon being notified of Mr Mallie's death, officers from the Tablelands CIB, Atherton Station and Mareeba Scenes of Crime attended the LGCC on 14 May 2016 at 8:56pm. Mr Mallie's correctional records and his medical files from LGCC and the Cairns Hospital were obtained. An examination of Mr Mallie's body at the scene revealed no concerning marks or injuries.

4. The investigation was informed by statements from the relevant custodial correctional officers and from clinical staff at the LGCC. These statements were tendered at the inquest. On the basis of the evidence obtained Detective Sergeant Carr provided a report to the Coroner dated 14 March 2017. DS Carr arrived at the following conclusions in his report:

> *The deceased died of natural causes as a result of End stage renal disease, haemodialysis, Type 2 diabetes, Hypertension, Dyslipidaemia, Arthritis, Coronary Artery disease, Acute non ST-elevation myocardial infarction.*
>
> *The prisoner was provided with adequate medical care whilst a prisoner in the care of Queensland Corrective Services.*
>
> *The death was unavoidable and there was no act or omission by any person which resulted in the death of Mallie.*
>
> *There are no suspicious circumstances surrounding this death.*[1]

[1] Exhibit A6.

Autopsy results

5. On 17 May 2016, Dr Paull Botterill conducted an autopsy consisting of an internal and external examination of the body. Dr Botterill concluded that:

> *In my opinion, at the time of autopsy, the cause of death is was most probably an arrhythmia complicating cardiac enlargement and coronary artery disease, complicating hypertension and diabetes, although it remained difficult to exclude a fluid balance problem associated with dialysis as possibly precipitating the presumed cardiac event.*[2]

6. The cause of death was given as atherosclerotic cardiovascular disease. Diabetes mellitus was listed as another significant condition which contributed to the death.[3]

7. The toxicology results were negative for alcohol and illicit drugs, and showed only therapeutic quantities of the medications that Mr Mallie had been prescribed or that were administered to him during dialysis.[4]

Social and medical history

8. Mr Mallie was born on 22 January 1958 at Cairns, into a large family of nine children. During their childhood, Mr Mallie and his siblings witnessed their father assaulting their mother, and on occasion some of the children would hold their father back to protect their mother. Mr Mallie was close to his twin brother, Henry, and kept in regular contact with most of his other siblings throughout his life. He had three children, William, Lindsey and Edward.[5] I extend my condolences to Mr Mallie's family.

9. Mr Mallie was a Torres Strait Islander man. He loved fishing, swimming and playing pool and football with his mates. He was a panel beater by trade, and had also worked as a farm-hand, a bricklayer's labourer and a concreter's labourer. He was always employed, and got satisfaction from working. He was a heavy drinker, and would usually go to the pub with mates after work and drink 12 – 15 stubbies of beer.[6]

10. In 1984, Mr Mallie was diagnosed with a kidney condition, and in 1985 he was diagnosed with Type 2 insulin dependent diabetes and hypertension. Mr Mallie's diabetes led to the development of neurovascular disease, and to deterioration in his eyesight. In January 2008, Mr Mallie had coronary artery bypass surgery following a number of admissions to the emergency department with chest pain.[7]

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[2] Exhibit A5.
[3] Exhibit A5, p 5.
[4] Exhibit A3.
[5] Exhibit A1.
[6] Exhibit D1, pp 382, 370
[7] Exhibit C2.6 and Exhibit C2.7.

11. Mr Mallie's criminal history was short, but reasonably serious. His first conviction was in 1994 when he was aged 36 years. He pleaded guilty to the unlawful wounding of his then wife, and was sentenced to 2 years imprisonment suspended for 3 years. In early 2007, he attacked another woman, a girlfriend who had recently broken up with him, with a knife, and was charged with attempted murder but released on bail. However, in July 2007 he breached a condition of his bail, and was taken into custody where he remained until he was sentenced, in November 2008, to 8 years imprisonment. His sentence was subsequently increased to 10 years by the Court of Appeal, and his offence was declared to be a serious violent offence.[8]

12. Mr Mallie was reportedly a polite and softly spoken prisoner who sought employment opportunities and engaged in rehabilitation courses. In 2009, Mr Mallie completed a number of training courses to gain qualifications in cleaning and maintenance, as well as in general safety in the construction industry, and advised that he wanted to be given a job while in prison because working was good for him. Mr Mallie obtained a job in the tailor's workshop. In 2009, he also completed an 'Ending Offending Program' which offered prisoners a series of courses designed to help them gain insight into the reasons for their offending.[9]

13. Mr Mallie worked in the tailor shop until 2012, when he had problems with his feet which meant he could no longer operate the machine pedal. He had a number of toes amputated after they became gangrenous. His toes did not heal well, and ongoing infections and pain often left Mr Mallie confined to a wheelchair.[10]

14. At the end of 2013, Mr Mallie made a number of applications to the Parole Board for release on an exceptional circumstances parole order. His twin brother Henry, younger brother Amoy, and his niece Melissa provided letters of support with his applications. The Parole Board did not accept these applications on the ground that Mr Mallie would present an unacceptable risk to the community, but advised that his case would be considered again is his medical condition significantly deteriorated or he was likely to be offered a palliative care bed.[11].

15. In early 2014, Mr Mallie began making enquiries with the Office of the Health Ombudsman (OHO) and the Health Quality and Complaints Commission (HQCC) about a number of problems he was having with the health care provided to him at the LGCC medical centre. Mr Mallie was advised by both organisations that he would need to exhaust any internal complaints avenues before coming to them.

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[8] Exhibit 6.1, *R v Mallie; ex parte A-G (Qld)* [2009] QCA 109.
[9] Exhibit D1, pp 370 - 398.
[10] Exhibit D1
[11] Exhibit D1, pp 316

16. Mr Mallie then sought help from the Deaths In Custody Watching Group, Far North Queensland, and on 12 October 2014 Margaret Barstow of that organisation made a formal complaint to the OHO on Mr Mallie's behalf. Ms Barstow's complaint raised a number of issues which, essentially, fell into two main categories: that the medical centre did not have adequate services to properly provide treatment for Mr Mallie's various serious health conditions; and that Mr Mallie's cultural needs were not able to be met by the LGCC.[12]

17. After assessing the complaint, considering Mr Mallie's medical records, a response from the complaint by the Cairns and Hinterland Hospital and Health Service (CHHHS) and obtaining an expert opinion from Associate Professor Harry Jacobs, the OHO advised Ms Barstow that it would not take further action in respect of the complaint as it was satisfied that the care provided to Mr Mallie, both medical and cultural, was appropriate and sufficient in the circumstances.[13]

18. In April 2015, Mr Mallie's liver disease had progressed to the point that he was in end-stage renal failure, and he was started on haemodialysis. At this stage, his feet had healed and he was again fully mobile, but two of his fingers had become necrotic and required amputation. His heart problems were stable and he saw the visiting optometrist regularly about his eyesight. His hypertension was managed with multiple medications, he was also on medication for gout and attended the LGCC medical clinic twice a day to self-administer insulin.[14]

19. In June 2015, Mr Mallie continued working on his rehabilitation by undertaking an Alcohol and Drugs Intervention program with the Salvation Army.[15]

Circumstances of the death

20. On 14 May 2016 Mr Mallie attended the LGCC medical centre for his regular dialysis treatment at around 10:00am. Observations of dialysis patients were taken by the clinic nurses at 11:00am, 12:00pm and 1:30pm.[16]

21. Mr Mallie's observations were normal and he was watching television.[17] However, about five minutes after the last observations were taken a nurse heard irregular breathing and returned to the dialysis room to find Mr Mallie in respiratory distress. He then he became unresponsive. Registered Nurse (RN) Alan Snelson called for assistance, and began attempting to

[12] Exhibit D2.
[13] Exhibit D2.
[14] Exhibit B3.1.
[15] Exhibit D1, p 419.
[16] The coronial report has this time as 1:05pm but the relevant chart appears to read 13:30, and this time appears in keeping with other evidence.
[17] Exhibit C2.5, p 127.

revive Mr Mallie and performed CPR on him. The Queensland Ambulance Service (QAS) was called at 1:37pm.[18]

22. At 1:56 pm QAS arrived and took over Mr Mallie's resuscitation. Paramedics worked on Mr Mallie in the medical centre for just over an hour, but unfortunately, he did not recover. Ambulance Officer Alan Clough declared Mr Mallie deceased at 3:03pm.[19]

Clinical Review

23. At the request of the Coroners Court, Dr Natalie MacCormick, forensic medical officer, Clinical Forensic Medicine Unit (CFMU) examined the autopsy report and Mr Mallie's medical records and was requested to comment on the healthcare which was provided to Mr Mallie in the twelve months leading up to his death, as well as the concerns raised by Ms Barstow.[20]

24. Dr MacCormick noted in her report that she had reviewed the complaint to the OHO by Ms Barstow. She considered that the OHO's decision in respect of that complaint was "well informed and reasonable". Dr MacCormick also noted that she agreed with the expert opinion given to the OHO by Associate Professor Jacobs that the health care provided to Mr Mallie was appropriate and sufficient.[21]

25. Dr MacCormick also noted that:

> *Patients with end-stage renal disease have a 30 times higher risk of cardiovascular death as compared with the general population. For patients with end-stage renal disease including those on haemodialysis, sudden cardiac death is the most common cause of death. The proportionate cardiovascular mortality ratio for dialysis patients is more than a quarter (28%). The chances of survival following sudden cardiac death in dialysis clinics is only 8%.* (References omitted)[22]

26. Dr MacCormick gave the following opinion in relation to the material provided to her:

> *Mr Mallie had significant morbidity due to his long history of poorly controlled type 2 diabetes that preceded his incarceration (since 1985). At the time of his incarceration, he had evidence of both macrovascular and microvascular complications which were life-limiting. Unfortunately, once established, these complications were not reversible. The development of end-stage renal disease and requirement for*

[18] Exhibit B1 and Exhibit C.1.
[19] Exhibit C.1.
[20] Exhibit B5, p 1.
[21] Exhibit B5, p 5.
[22] Exhibit B5, p 8.

haemodialysis placed him at very high risk of sudden cardiac death. This is a well-recognised risk in this patient population.

The drugs present on the certificate of analysis at their respective levels would not have contributed to Mr Mallie's death.

I am in agreement with the clinical advice provided to the Health Ombudsman. I am satisfied that Mr Mallie received appropriate medical care for his chronic and complex health conditions.

Overall, I have no concerns with the health care provided to Mr Mallie.[23]

Inquest

27. As Mr Mallie's death was a death in custody, an inquest was required by s27(1)(a)(i) of the *Coroners Act 2003*. The inquest was held on 20 June 2019. All of the statements, medical records and material gathered during the investigation into Mr Mallie's death were tendered to the court. Counsel Assisting proceeded immediately to submissions in lieu of an oral testimony being heard.

28. In considering this matter, I also had the benefit of written submissions from QCS, which advised that it agreed with the findings of Detective Sergeant Carr and the opinion of Dr MacCormick.

Conclusions

29. Mr Mallie'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. On the basis of Dr MacCormick's opinion and the conclusions reached by OHO, I am satisfied that Mr Mallie was given appropriate medical care by staff at LGCC. Mr Mallie's death could not reasonably have been prevented.

31. It is a recognised principle that the health care provided to prisoners should not be off 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 Mallie when measured against this benchmark.

[23] Exhibit B5 – MacCormick, Natalie – CFMU, p 9.

Findings

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, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased - William Michael Mallie

How he died - Mr Mallie died in custody after a lengthy term of imprisonment. He had been imprisoned for almost nine years. He died from natural causes after an extensive history of significant kidney disease which led to significant morbidity and irreversible complications. The requirement for haemodialysis placed him at very high risk of sudden cardiac death.

Place of death - Lotus Glen Correctional Centre, Chettle Road, Mareeba in the State of Queensland.

Date of death - 14 May 2016.

Cause of death - Atherosclerotic cardiovascular disease.

Comments and recommendations

33. The *Coroners Act 2003* enables a corner 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
20 June 2019