QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Kenneth Draney**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2012/3955
DELIVERED ON:	09 October 2013
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 September 2013
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Antonietta Kersten

Table of Contents

The *Coroners Act 2003* provides in s. 47 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 Kenneth Draney. 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

At the time of his death, Kenneth Draney, 80, was an inmate at the Wolston Correctional Centre (WCC). In early May 2012 Mr Draney underwent a chest biopsy at the secure unit of the Princess Alexandra Hospital (PAH). That chest biopsy revealed metastatic mesothelioma which had spread throughout his chest and metastasised to his bones.

On 29 October 2012 Mr Draney's condition deteriorated and he was transferred to PAH. Palliative measures were put in place. In the early hours of 30 October 2012, it was noted that Mr Draney was not breathing. In accordance with his express wishes, cardio-pulmonary resuscitation was not attempted and he was pronounced deceased.

These findings:

- confirm the identity of the deceased person, how he died, and 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 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

An investigation into the circumstances leading to the death of Mr Draney was conducted by Detective Senior Constable David Caruana from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

Upon being notified of Mr Draney's death, the CSIU attended PAH and an investigation ensued. Photographs were taken of the scene at PAH. The investigation obtained Mr Draney's correctional records and his medical files from both WCC and PAH. The investigation was informed by statements from the relevant custodial officer at PAH and Mr Draney's carer at WCC, recorded interviews with fellow prisoners who Mr Draney resided with and a statement from his son, Allan Draney. These statements were tendered at the inquest.

An external autopsy examination was conducted by Dr Alex Olumbe. Further photographs were taken during this examination.

At the request of the Office of the State Coroner, Dr Ian Mahoney from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Draney from PAH and WCC and reported on them.

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

The Inquest

An inquest was held in Brisbane on 24 September 2013. All the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Counsel assisting, Miss Cooper, proposed that all evidence be tendered and oral evidence be heard only from Detective Senior Constable Caruana. I agreed that the evidence tendered in addition to the oral evidence of Detective Senior Constable Caruana was sufficient for me to make the requisite findings.

The evidence

Personal circumstances and correctional history

Kenneth Draney was born in Toowoomba on 13 March 1932 making him 80 years of age when he died. He was a married man, and together he and his wife had spent many years providing full time care to intellectually impaired persons at their home north of Bundaberg. He had no criminal history up until he was 77 years of age.

On 16 April 2009, Mr Draney was charged with rape and unlawful exposure of an intellectually impaired person to an indecent act. On 10 February 2010 he was sentenced to a head term of eight years imprisonment for these offences.

He was initially incarcerated at the Maryborough Correctional Centre until 25 March 2011, at which time he was transferred to WCC.

Mr Draney had been eligible to apply for parole since 15 April 2011. An application for parole was created within the Queensland Corrective Services information management system on 18 September 2012. Mr Draney was interviewed by a psychologist in relation to his parole application in the weeks prior to his death but the application was not finalised.

Medical history

Mr Draney had been receiving ongoing respiratory treatment from the respiratory clinic at PAH. The medical records from PAH confirm that Mr Draney's last admission before his death was from 1 May 2012 – 18 May 2012. Progressive shortness of breath was the trigger for this admission. It

was during this admission that the mesothelioma was diagnosed and discussed with Mr Draney.

On 24 May 2012 it was noted the mesothelioma had spread throughout his chest and had metastasised to his bones. The prognosis was poor. It was agreed in the days following this admission that he was to be treated symptomatically and provided with supportive care.

Mr Draney was reviewed at PAH in the months leading up to his death, specifically on 18 June 2012, 30 July 2012 and 10 September 2012. On 18 September 2012 Mr Draney signed an Acute Resuscitation Plan (ARP) which confirmed he was to be provided with palliative care only, and he was not to be resuscitated.

His condition deteriorated significantly in the lead up to his final admission to PAH on 29 October 2012 and his eventual death in the early hours of 30 October 2012.

Events leading to death

Mr Draney's carer was a fellow inmate at WCC, Jason Wilton. Mr Wilton confirmed to police that in the early hours of 29 October 2012 he was awoken by another inmate due to Mr Draney being quite ill and moaning. Mr Wilton asked Mr Draney if he was alright, to which Mr Draney said he was. Mr Draney was assisted back to his bed.

For the next few hours, Mr Wilton checked on Mr Draney every 15 minutes and he was noted to be lying in bed, but not asleep. Later in the morning Mr Wilton informed the Health Unit nurses that Mr Draney was not well. Two nurses attended Mr Draney's cell with a stretcher, a quick assessment was conducted and he was subsequently transferred to PAH.

Palliative care measures were put in place and his observations were taken every two hours. At about 4am on 30 October 2012 it was noted Mr Draney was not breathing. In keeping with the ARP, cardio-pulmonary resuscitation was not attempted. Mr Draney was subsequently pronounced deceased.

Autopsy results

An external examination was conducted by senior forensic pathologist Dr Alex Olumbe on 1 November 2012.

A computed tomography (CT) scan showed circumferential pleural thickening throughout the right thoracic cavity with large right loculated pleural effusion and extensive collapse of the right lung which was minimally aerated. There was marked leftward mediastinal displacement with a small left pleural effusion and diffuse air space change/layering oedema within the left upper and lower lobes.

There was also extensive peritoneal thickening extending inferiorly along the right paracolic gutter with diffuse omental thickening throughout the abdomen in keeping with transcoelomic spread of disease.

Dr Olumbe opined that metastatic mesothelioma had developed and predisposed Mr Draney to multi-lobular pneumonia leading to sepsis.

The cause of death was determined as sepsis, as a consequence of lobar pneumonia, as a consequence of the mesothelioma. Ischaemic heart disease and diabetes mellitus were considered to be other significant conditions contributing to the death.

Investigation findings

None of the other inmates at WCC provided information to the investigating officer suggesting foul play or any deficiency or inappropriateness in the treatment received by Mr Draney while in custody.

The examination of Mr Draney's body and his room at WCC revealed no signs of violence.

The CSIU investigation into Mr Draney's death did not lead to any suspicion that his death was anything but natural.

Medical Review

The medical records pertaining to Mr Draney were sent by the Office of the State Coroner to the CFMU where they were independently reviewed by Dr Ian Mahoney.

Dr Mahoney opined that Mr Draney received appropriate medical care whilst at WCC and PAH. The standard of care provided to Mr Draney was in line with the standard of treatment which would be available to a member of the general community. In coming to that conclusion, Dr Mahoney noted the following:

- Mr Draney had mesothelioma that had spread into his chest wall and metastasised to his bones. It was a highly malignant incurable condition and, at the time of diagnosis, his life expectancy was only a few months;
- Medically, there was nothing that could be done for him;
- Even if the diagnosis had been made at an earlier time, the nature of the cancer coupled with Mr Draney's age meant the prognosis was always going to be poor.

Conclusions

I conclude Mr Draney died from natural causes. I find that none of the correctional officers or inmates at WCC or PAH caused or contributed to his death.

I am satisfied Mr Draney was given appropriate medical care by staff at PAH and while he was in custody at WCC. His death could not have been prevented.

It is a well 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 Draney when measured against this benchmark.

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 Kenneth Draney.

How he died - Mr Draney died at the secure unit of the Princess Alexandra Hospital from metastatic mesothelioma which had predisposed him to multi-lobular pneumonia leading to sepsis.

Place of death – He died at Brisbane in Queensland.

Date of death – He died on 30 October 2012.

Cause of death – Mr Draney died from natural causes, namely sepsis, due to lobar pneumonia, due to metastatic mesothelioma.

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.

In this matter the adequacy of the medical care afforded to Mr Draney was examined by Dr Mahoney. Dr Mahoney found that no person had contributed to Mr Draney's death. His life expectancy was only a few months and, medically, there was nothing further that could have been done for him that ought to have been investigated.

In the circumstances I accept the submission of counsel assisting that there are no comments or recommendations to be made that would likely assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane