QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Paul Robert WISE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Rockhampton
FILE NO(s):	2016/3504
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
Queensland Corrective Services:	Ms Vanessa Price

Contents

Introduction

1. Paul Robert Wise was 48 years of age when he was found deceased in his cell at the Capricornia Correctional Centre (CCC) at North Rockhampton on the morning of 17 August 2016. He was serving a term of imprisonment for drug possession and driving offences. Mr Wise had been returned to the CCC on 13 July 2016 for breaches of his parole conditions after he tested positive for drugs including methamphetamine. Mr Wise died of natural causes as a result of insufficient blood supply to his heart due to severe narrowing of his right main coronary artery.

The investigation

2. Detective Senior Constable Brendan Anderson from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) oversaw a targeted investigation into the circumstances leading to Mr Wise's death.

3. Upon being notified of Mr Wise's death, officers from the Rockhampton CIB attended the CCC at 9:23am on 17 August 2016. An examination of Mr Wise's body at the scene revealed no concerning marks or injuries. Mr Wise was in bed laying on his right side and he was covered by a blanket. A police photographer took photographs of the scene and medication from inside the cell was secured. Mr Wise was the only occupant of the cell.

4. The investigation was informed by statements from the relevant custodial correctional officers, together with a statement from Mr Wise's mother. These statements were tendered at the inquest. On the basis of the evidence obtained Detective Senior Constable Anderson provided a report to the Coroner in June 2017. DSC Anderson arrived at the following conclusions in his report:

    1. *The deceased died of natural causes as a result of a heart attack.*
    2. *The prisoner was provided with adequate medical care whilst a prisoner in the care of Queensland Corrective Services.*
    3. *The death was unavoidable and there is no act or omission by any person which resulted in the death.*
    4. *There are no suspicious circumstances surrounding this death.*[1]

Autopsy results

5. On 19 August 2016, Dr Nigel Buxton conducted an autopsy consisting of an external and full internal examination of the body. Dr Buxton found that Mr Wise's heart was enlarged due to left ventricular hypertrophy. The left coronary artery showed mild to moderate atherosclerosis (50% narrowing) and the right main coronary artery showed 85% narrowing proximally.

[1] Exhibit A6, p 6.

6. The cause of death was given as “a) Coronary artery occlusion *due to, or as a consequence of* b) Coronary artery atheroma”. Dr Buxton concluded that Mr Wise died of natural causes, and that there were no suspicious circumstances in relation to his death.[2]

7. The toxicology results were negative for alcohol and illicit drugs, and showed only low levels of paracetamol and Quetiapine, which is an antipsychotic.[3]

Social and medical history

8. Mr Wise was born on 9 August 1968 at the Gladstone Hospital. He had an older brother, Devlin, and a younger brother, Jodi. Mr Wise had one son, who was born in 1992. Mr Wise was diagnosed with chronic asthma as a child, and used a Ventolin spray throughout his life.[4]

9. Mr Wise lived with his father, Robert Wise, for much of his life, and became involved in criminal activities at a very early age. His mother said he was in and out of prison for the rest of his life.[5] Mr Wise’s father passed away in June 2015 and Mr Wise was deeply affected by his death. His father suffered from Alzheimer’s disease and Mr Wise had been his full time carer for 18 months. He subsequently had little contact with other members of his immediate family.[6] His mother reported that she had not had any contact with Mr Wise since 2008.

10. Mr Wise’s contact with the justice system began when he had just turned 11. He was subsequently placed under supervision orders and admitted to juvenile detention in Queensland and New South Wales.

11. As an adult, Mr Wise served prison sentences in Queensland, New South Wales, Western Australia and South Australia. The majority of his offending related to driving and vehicle offences such as driving unlicensed and/or disqualified, driving under the influence, dangerous driving and unlawful use of motor vehicles. He also had convictions for property offences, possession of drugs and drug utensils, and low level assaults. He had also been remanded in custody or imprisoned on occasion for breaching bail conditions or probation orders.[7]

12. On 26 February 2015, Mr Wise was convicted in the Gladstone Magistrates Court of possessing dangerous drugs, unlawful use of a motor vehicle, possession of a knife in a public place and possessing drug utensils. He was convicted and sentenced to 18 months imprisonment. As he had already served 116 days on remand, his earliest parole release date was set at 3 April 2015.

---

[2] Exhibit A3, p 4.
[3] Exhibit A4
[4] Exhibit B1, paras 1 – 5.
[5] Exhibit B1, paras 7 & 8.
[6] Exhibit B1, paras 15 & 16.
[7] Exhibits C1.

13. Mr Wise was returned to custody on 29 July 2015 after his parole was suspended. He was subsequently sentenced to a further 18 months in prison on 14 September 2015 for driving while disqualified.[8] Mr Wise obtained released on parole on 14 April 2016 under reporting and drug testing conditions. However, on 2 June 2016, Mr Wise tested positive to illicit substances. His parole was suspended for an indefinite period and warrants were issued for his arrest. Mr Wise was apprehended by police on 11 July 2016 and returned to custody.[9]

14. At the time of his last admission into custody, Mr Wise suffered from arthritis in both hips, and had an old injury to his right knee which meant that he needed to use a walking stick. He was still being treated for asthma as necessary. Mr Wise had been prescribed two inhaler medications for his asthma (Seretide and Ventolin), and Panadol Osteo for his arthritis and knee pain.[10]

15. At the CCC, Mr Wise was known by staff and other inmates as 'Wisey' and got along with everyone.[11] Mr Wise was in Secure Unit (SU) 6, and was assigned to Cell 9, a single occupant cell. Cells in SU6 have electronically operated doors which cannot be opened by prisoners once they are locked. The cell doors have a glass window in them through which Custodial Correctional Officers (CCOs) can conduct visual checks on the inmates. The cells are locked each night and then unlocked each morning following a visual inspection and headcount.[12]

Circumstances of the death

16. At around 6:00pm on 16 August 2016, CCO Richard Meilland commenced securing the inmates in SU6 into their cells. CCO Meilland was responsible for ensuring Mr Wise was in his cell, and does not recall Mr Wise saying that he felt ill or had any injuries.[13]

17. On the morning of 17 August 2016, CCO Meilland was working with CCOs Matthew Luck and Jason Warcon. The normal procedure was that inmates were given a wake-up call at 6:30am, and then the CCOs unlocked the cells at 7:30am. On this day, however, there was an incident with another inmate at 7:28am which CCO Luck responded to. CCO Luck returned at around 7:45am, at which time he and CCO Meilland commenced a visual 'apparent good health check' on each cell prior to unlocking the cells.[14]

[8] Exhibit C6, p50
[9] Exhibit C6 pp 4 and 7 – 8.
[10] Exhibit B4, p 1.
[11] Exhibit B2, paras 10 & 14
[12] Exhibit B2, paras 7 - 25.
[13] Exhibit B3.2, paras 3 – 5.
[14] Exhibit B3, paras 6 - 8

18. When CCO Luck looked through the window into Mr Wise's cell, he saw that Mr Wise was still in bed with his eyes shut, and that his face was a blue-grey colour. CCO Luck banged on the cell door and called Mr Wise's name, but Mr Wise did not move. CCO Luck radioed a 'Code Blue' medical emergency, and Mr Wise's cell was opened by central control.[15]

19. CCO Meilland had joined CCO Luck by this stage, and both officers entered the cell. CCO Luck placed his hand on Mr Wise's left forearm, and Mr Wise felt cold to the touch. CCO Meilland felt for a pulse but was unable to detect one. Both officers then attempted to roll Mr Wise from his side to his back to attempt CPR, but were unable to do so as his body was stiff.[16]

20. After a Code Blue was activated, medical staff arrived and Registered Nurse Zoe Reed examined Mr Wise. She advised that he had passed away at 7:54am. All staff were then removed from the cell, and the cell door was locked.[17]

Family concerns

21. On 2 May 2018 Mr Wise's mother, Rosalee Day, expressed concerns to the Coroners Court about Mr Wise's death. She said that, having read the autopsy report, she had some questions which were based on the treatment she had received for blocked arteries, including having a nitrospray with her at all times. Ms Day queried why Mr Wise did not have a nitrospray for his condition. She was also concerned that Mr Wise's symptoms should have been identified if he was seeing a doctor about other matters.[18]

Clinical Review

22. At the request of the Coroners Court, Dr Ian Home, Forensic Medical Officer, Clinical Forensic Medicine Unit (CFMU) examined the autopsy report and Mr Wise's medical records and was asked to comment on the health care which was provided to Mr Wise in the twelve months leading up to his death, as well as the concerns raised by Mrs Wise.[19]

23. In his report dated 9 October 2018 Dr Home noted that "there was no way of predicting the presence of severe coronary artery disease in [Mr Wise] and therefore no opportunity to intervene prior to his death".[20]

[15] Exhibit B2, paras 30 - 38.
[16] Exhibit B2, paras 34 - 41.
[17] Exhibit B2, paras 42 – 44.
[18] CCMS file notes.
[19] Exhibit B4, p 1.
[20] Exhibit B4, p 2.

24. In addition, Dr Home made the following comments in relation to the material provided to him:

    a. Medical records provided for Mr Wise, which went back as far as 1985, showed no mention of cardiovascular disease or any episodes of chest pain;

    b. Mr Wise was admitted to hospital for septic arthritis in April 2015 and reported no known cardiovascular disease;

    c. Mr Wise may not have been entirely forthcoming about his health as he had also denied a history of asthma on several forms in the medical records;

    d. There was no evidence in Mr Wise's medical records that he had been prescribed Quetiapine (detected in the toxicology results). Quetiapine is a frequent drug of abuse due to its euphoric properties but the level detected was well below that associated with overdose.[21]

Inquest

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

26. I also had the benefit of written submissions from QCS, who advised that they were in agreement with the findings of Detective Senior Constable Anderson and the opinion of Dr Home.

Conclusions

27. Mr Wise'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.

28. On the basis of Dr Home's opinion, I am satisfied that Mr Wise was given appropriate medical care by staff at the CCC. Mr Wise's death could not reasonably been prevented.

29. 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 Wise when measured against this benchmark.

[21] Exhibit B4.

Findings

30. 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 - Paul Robert Wise

How he died - Mr Wise had a lengthy criminal history which included periods of incarceration. He had recently been returned to prison after failing a drug test while he was on parole. He died suddenly while alone in his cell from a cardiac arrest caused by coronary artery disease.

Place of death - Capricornia Correctional Centre, Bruce Highway, North Rockhampton in the State of Queensland.

Date of death - 17 August 2016.

Cause of death - Coronary artery occlusion, due to, or as a consequence of; coronary artery atheroma.

Comments and recommendations

31. 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.

32. 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.

33. I close the inquest.

Terry Ryan
State Coroner
20 June 2019