OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	Inquest into the death of Anthony Kenneth HANSEN
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 03/1505
DELIVERED ON:	22 December 2005
DELIVERED AT:	Brisbane
HEARING DATE(s):	09 December 2005
FINDINGS OF:	Mr Michael Barnes, State Coroner

CATCHWORDS: **CORONERS: Inquest, death in custody, Maryborough Correctional Centre, transfer to hospital, death from natural causes**

REPRESENTATION:

Counsel:

Counsel Assisting the State Coroner:	Ms Jo-Anne Dickson
Department of Corrective Services:	Ms Annie Little

1. *The Coroners Act 1958* provides in s43(1) that after considering all of the evidence given before a coroner at an inquest the coroner shall give his or her findings in open court. What follows are my findings in the inquest held into the death of Anthony Kenneth Hansen.

Introduction

2. Mr Hansen was an inmate at the Maryborough Correctional Centre serving a sentence of 17 years imprisonment. On 24 August 2003 he was admitted to the medical ward at the correctional centre with flu-like symptoms. He remained in the centre and was reviewed by the Visiting Medical Officer on 26 August. In the late evening of 27 August Mr Hansen's condition deteriorated and he was transported by ambulance to the Maryborough Base Hospital where he was treated in the intensive care unit. Mr Hansen died some eleven hours later of diffuse alveolar damage – otherwise known as adult respiratory distress syndrome.

3. These findings seek to explain how that occurred and consider whether the care given to Mr Hansen by correctional authorities and the Maryborough Base Hospital was adequate.

The Coroner's Jurisdiction

4. Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The Basis of the Jurisdiction

5. Although this inquest was opened on 09 December 2005, as the death being investigated occurred before 01 December 2003, the date on which the *Coroners Act 2003* was proclaimed, it is a "*pre-commencement death*" within the terms of s100 of that Act and therefore the provisions of the *Coroners Act 1958* (the Act) are preserved in relation to it.

6. Because the police officer who first became aware of this death considered "*that the person had died within the State while detained in any prison or psychiatric hospital*"[1] he was obliged by s12(1) to report it to a coroner. S7(1) confers jurisdiction on a coroner to investigate such a death and s7B authorises the holding of an inquest into it.

Scope of the Coroner's Inquiry and Findings

7. The Act, in s24, provides that where an inquest is held, it shall be for the purpose of establishing as far as practicable:-
   - the fact that a person has died;
   - the identity of the deceased;
   - when, where and how the death occurred; and
   - whether anyone should be charged with a criminal offence alleging that he or she caused the death.

[1] s7(1)(b)

8. After considering all of the evidence presented at the inquest, findings must be given in relation to each of those matters to the extent that they are able to be proven.

9. An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [2]

10. The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations,[3] referred to as "*riders*" but prohibits findings or riders being framed in a way that appears to determine questions of civil liability or suggests a person is guilty of any criminal offence.[4]

The Admissibility of Evidence and the Standard of Proof

11. Proceedings in a coroner's court are not bound by the rules of evidence because s34 of the Act provides that "*the coroner may admit any evidence the coroner thinks fit"* provided the coroner considers it necessary to establish any of the matters within the scope of the inquest.

12. This flexibility has been explained as a consequence of an inquest being a fact-finding exercise rather than a means of apportioning guilt; an inquiry rather than a trial.[5]

13. A coroner should apply the civil standard of proof, namely the balance of probabilities, but the approach referred to as the *Briginshaw* sliding scale is applicable.[6] This means that the more significant the issue to be determined, the more serious an allegation or the more inherently unlikely an occurrence, the clearer and more persuasive the evidence needed for the trier of fact to be sufficiently satisfied that it has been proven to the civil standard.[7]

14. Of course, when determining whether anyone should be committed for trial, a coroner can only have regard to evidence that could be admitted

[2] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625
[3] s43(5)
[4] s43(6)
[5] *R v South London Coroner; ex parte Thompson* per Lord Lane CJ, (1982) 126 S.J. 625
[6] *Anderson v Blashki* [1993] 2 VR 89 at 96 per Gobbo J
[7] Briginshaw v Briginshaw (1938) 60 CLR 336 at 361 per Sir Owen Dixon J

in a criminal trial and will only commit if he/she considers an offence could be proven to the criminal standard of beyond reasonable doubt.

15. It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[8]This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[9] makes clear that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The Investigation

16. I turn now to a description of the investigation.

17. The death was immediately reported to the police and officers from the Maryborough Criminal Investigation Branch attended. The local coroner and I were both notified of the death.

18. Police immediately began to investigate the circumstances surrounding Mr Hansen's death. Detective Sergeant Hayden Lenz from the Corrective Services Investigation Unit was appointed as the Investigating Officer. He was assisted in the investigation by other officers from the CSIU and the Maryborough CIB.

19. On 29 August 2003 Detective Sergeant Lenz attended the hospital mortuary and observed the body of Mr Hansen. He saw no signs of injury.

20. On the same day Detective Sergeant Lenz, in company with other officers, attended the Maryborough Correctional Centre and conducted a search of the medical ward and Mr Hansen's cell. Detective Sergeant Lenz considered there was nothing suspicious about either the ward or the cell. He directed a series of photographs be taken of both rooms.

21. Investigating officers compiled 20 statements during the investigation including statements from police officers involved in the investigation, custodial services officers and nursing staff from the Maryborough Correctional Centre as well as medical practitioners involved in Mr Hansen's care.

22. The investigating officer noted in his statement that all medical staff at both the Maryborough Correctional Centre and the Maryborough Base Hospital were forthright and willing to cooperate with the investigation.

[8] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13

[9] (1990) 65 ALJR 167 at 168

23. A comprehensive report outlining the circumstances of the death was subsequently forwarded to the local Coroner. The matter was then transferred to me in March 2004.

24. This office then arranged for an independent thoracic physician to review the medical records of Mr Hansen to assess the quality of the health care provided to him by the Department of Corrective Services and the Maryborough Base Hospital.

25. I am satisfied that the investigation was competent and thorough.

The Inquest

26. An inquest was held in Brisbane on 09 December 2005. Ms Jo-Anne Dickson was appointed to assist me during the inquest. Leave to appear was granted to the Department of Corrective Services. Mr Hansen's family advised that they did not wish to attend the inquest and had no matters they wished to raise at the inquest. A copy of the evidence was provided to the family prior to the inquest.

27. All of the statements, medical records and photographs were tendered.

28. I determined that the evidence contained in them was sufficient to enable me to make the findings required by the Act and that there was no other purpose which would warrant any witnesses being called to give oral evidence. The family indicated that they did not wish to challenge or examine any of the witnesses' versions as contained in the documents which had been tendered.

Particulars of Imprisonment

29. Mr Hansen was remanded into custody at the Arthur Gorrie Correctional Centre on 02 November 1999 for child sex offences. He was immediately afforded protective custody status.

30. On 05 January 2000 he was transferred to the Wolston Correctional Centre. He was sentenced on 29 January 2001 to 17 years imprisonment. He was eligible for parole on 07 June 2013 and his earliest discharge date was 01 November 2016.

31. Mr Hansen was then transferred to the Maryborough Correctional Centre on 29 April 2003.

32. He did not further offend or commit any breaches during his period of incarceration.

Medical History

33. Mr Hansen's recorded medical history included the following conditions:-

- epilepsy;
- an hiatus hernia;

- asthma; and
- a personality disorder with schizophrenia traits.

34. Mr Hansen was also reported to have been a heavy smoker and to have abused drugs.

35. In 1998/99 Mr Hansen had two admissions to the Beaudesert Hospital to investigate his history of fitting and heart complaints. No cause was found.

36. He was also reported to have twice collapsed at the Wolston Correctional Centre – first in January 2000 and then in February 2003. There was also a report of an attempted self-harm by hanging in April the same year.

Circumstances Surrounding the Death

37. On 24 August 2003 Mr Hansen presented to the medical ward at the correctional centre complaining of shortness of breath and chest pain when breathing. He stated that he began to feel ill on 23 August. He reported that he had been coughing up phlegm. Nursing staff admitted Mr Hansen to the centre and then contacted the Visiting Medical Officer Dr Cotton at about 3.30pm. Dr Cotton recollects a history of high temperature, shivering and a productive cough. Dr Cotton prescribed an antibiotic (Augmentin Duo) as well as Ventolin 4 hourly if required and a simple analgesia.

38. Mr Hansen's symptoms continued on 25 August. Dr Cotton was again contacted by telephone and he instructed that the same treatment continue. In the early afternoon of 25 August, Mr Hansen vomited his breakfast and lunch. He was administered panadol and settled to bed. He reported feeling much better.

39. At about 3.30pm on 26 August Mr Hansen was reviewed by another Visiting Medical Officer, Dr Lethbridge. Dr Lethbridge noted his history consisted of symptoms of fever, cough, some shortness of breath, pleuretic chest pain, lethargy and some vomiting. He noted that his observations were stable and that he appeared to be suffering from a febrile respiratory illness with symptoms of possible lower respiratory infection or pleurisy, although when the doctor examined his chest there were no specific signs to confirm this diagnosis.

40. Dr Lethbridge prescribed maxalon to alleviate the vomiting and recommended improving his fluid intake but otherwise did not alter his treatment plan.

41. Mr Hansen remained in the medical centre throughout 27 August where he was monitored by nursing staff. At 6.15pm Clinical Nurse Heather Hancock-Toohey commenced her shift at the centre. He was reviewed by nurse Hancock-Toohey and provided with nebulised ventolin at 7.30pm. His observations were also taken at this time. His

blood pressure was 145/80, his pulse was 120, his respiration was 24, his temperature was 38.5 degrees, and his oxygen saturations were at 95%. He was then administered two panadol tablets.

42. At 10.30pm Correctional Services Officer Wendy Dale requested nurse Hancock-Toohey to review Mr Hansen as he was asking to see her. Nurse Hancock-Toohey reviewed him at 10.35pm. Mr Hansen stated to the nurse that he was short of breath and asked if he could use the nebuliser. Nurse Hancock-Toohey suggested he have a hot shower instead, which Mr Hansen agreed to, because the nebuliser had been ordered at 6 hourly intervals by Dr Lethbridge.

43. Nurse Hancock-Toohey reviewed Mr Hansen again at 11.00pm and administered his nebuliser. His observations at that time were blood pressure 160/100, pulse 150, respiration 30, temperature 39.9 degrees, oxygen saturations were 85% and his blood sugar level was 11.3 millimoles. Nurse Hancock-Toohey commenced oxygen therapy via a rebreather mask which improved his saturations to 91%. Mr Hansen then informed nurse Hancock-Toohey that he had been coughing up blood.

44. Nurse Hancock-Toohey says she contacted Dr Cotton and updated him on Mr Hansen's condition at 11.22. Dr Cotton contends that he was contacted at 12.30am. However as the Queensland Ambulance Service report records they were called to attend the correctional centre at 12.08am, Dr Cotton is clearly mistaken.

45. During Nurse Hancock-Toohey's conversation with Dr Cotton she advised him that Mr Hansen's condition had deteriorated, that his oxygen saturations had decreased, that he was short of breath, clammy, febrile and had coughed up some blood. He agreed that Mr Hansen should be transferred to the Maryborough Base Hospital by ambulance forthwith. Nurse Hancock-Toohey then notified the hospital accident and emergency department to expect the arrival of Mr Hansen.

46. Nurse Hancock-Toohey says she contacted correctional supervisor Carl Jespersen at 11.44pm and informed him of Mr Hansen's deteriorating condition and that an ambulance transfer to the Maryborough Hospital was needed. Correctional supervisor Jespersen says he was contacted shortly after midnight. The statements of correctional services officers Wendy Dale and Mervyn Rasmussen however support nurse Hancock-Toohey's version as to time.

47. Correctional supervisor Jespersen and correctional services officers Rasmussen and Buenen then attended the medical centre. Rasmussen states that nurse Hancock-Toohey and Jespersen then had a conversation which he could not hear but following that conversation Jespersen issued instructions to himself and Buenen to escort Mr Hansen to the hospital. Correctional services officer Buenen

then went to the gatehouse to draw weapons, handcuffs and legcuffs for the escort.

48. Correctional services officer Dale states that she was contacted by officer May at 12.05am and directed to contact master control at the gatehouse to request an ambulance for the transfer. The Queensland Ambulance Service report indicates that the call from correctional centre to attend was received at 12.08am and a car dispatched at 12.09am, arriving on the scene at 12.20am. Nurse Hancock-Toohey remained with Mr Hansen and continued treatment until the ambulance service arrived.

49. Ambulance officer Leslie Maidment states that they rendered assistance and then departed the correctional centre at 12.37am and transferred Mr Hansen to the Maryborough Base Hospital accident and emergency department at 12.45am. Dr John Ting, a Principal House Officer at the hospital then took over the care of Mr Hansen.

Treatment at Hospital

50. Dr Ting recalls that Mr Hansen reported a 5/6 day history of worsening fever, rigors, shortness of breath, wheezy and anorexic with haemoptysis, some yellow/green sputum and pleuritic chest pain upon coughing. Dr Ting considered the history and clinical examination were consistent with severe (bilateral) pneumonia with initial severe Type 1 Respiratory Failure. Dr Ting commenced IV antibiotics and discussed Mr Hansen's care with respiratory physician Dr Berglind. The initial respiratory failure rapidly deteriorated to severe Type 2 Respiratory Failure requiring intubation and ventilation at around 7.00am in the intensive care unit.

51. The on-call anaesthetist for the intensive care unit was consulted and he instructed the patient be transferred out of the Maryborough Hospital as there were no intensive care beds available within the Fraser Coast District. Mr Hansen was accepted for transfer to the Nambour Hospital however because his condition was so unstable, he was unable to be transferred. Dr Ting and other medical staff continued to treat Mr Hansen however he eventually succumbed to severe respiratory failure. Dr Ting pronounced life extinct at 11.40am.

52. Mr Hansen's mother, Ms Marlene Nygaard, was notified of her son's death at approximately 2.10pm that day by the General Manager of the correctional centre.

Autopsy Findings

53. An autopsy was conducted by Dr Eric Donaldson on 29 August 2003. Detective Sergeant Lenz was also present at the autopsy. Dr Donaldson noted that there were no signs of violence or trauma. He also informed Detective Sergeant Lenz that Adult Respiratory Distress Syndrome can be a result of a virus and can rapidly accelerate causing death.

54. Dr Donaldson noted at autopsy that samples taken from the upper and lower lobes of both lungs show marked abnormality. Many of the alveoli were coated with a thin hyaline membrane. The alveolar capillaries were congested. The alveoli contained varying amounts of red blood cells, fibrin and haemosiderin-laden macrophages. Focally there were areas of recent haemorrhage associated with increased numbers of intra-alveolar polymorphs. The features of the latter were consistent with superimposed areas of early pneumonia.

55. Dr Donaldson also noted that samples taken of the coronary arteries confirm severe atherosclerosis with 70% luminal narrowing.

56. Dr Donaldson considered the cause of death to be as follows:-

    1. Diffuse Alveolar Damage (Adult Respiratory Distress Syndrome) as a consequence of or due to;
    2. Bilateral Early Lobar Pneumonia;

    Other Major Findings
    3. Severe Coronary Atherosclerosis.

Expert Medical Review

57. Upon assuming responsibility for the coronial investigation I requested a review of the treatment and care provided by the jail medical centre and Maryborough Hospital staff be undertaken by Dr Robert Boots, a Respiratory Physician at the Royal Brisbane and Women's Hospital. Dr Boots was provided with a copy of the police investigation report and Mr Hansen's medical records.

58. Dr Boots' notes in his report that the admission of Mr Hansen to the medical ward at the correctional centre was appropriate for his presentation and the clinical illness was consistent with bronchitis for which timely medical advice was sought and appropriate antibiotics were prescribed. When medically assessed there was no clinical evidence of pneumonia or respiratory distress and the oxygenation recorded was not of clinical concern. The recorded clinical signs made initial treatment of lower tract respiratory infection with oral antibiotics and bronchodilators a responsible clinical decision.

59. The deterioration of Mr Hansen's condition was rapid and could not have been anticipated or prevented. The assessment and action taken at the correctional health centre was rapid, timely and appropriate as was the transfer to hospital.

60. Dr Boots also opined that the assessment at the Maryborough Hospital was clinically appropriate and the severity of the respiratory infection was immediately recognized. Dr Boots stated that the rapid deterioration was consistent with the severity of the pneumonia as documented at admission. Dr Boots considered that without being able

to improve Mr Hansen's oxygenation to an arterial oxygen saturation of greater than 90% (which was never attained after commencing mechanical ventilation) transfer to another intensive care unit although appropriate was not possible because death would have occurred in transport. No intensive care unit would have accepted the transfer of a patient under such clinical circumstances until stable clinical improvement in the oxygenation had occurred.

61. Dr Boots considers that the mechanism of death was typical, predictable but not preventable in this case due to the severe prolonged hypoxaemia.

62. Dr Boots concludes that Mr Hansen developed a rapidly progressive bilateral respiratory infection despite appropriate and timely therapeutic decisions and care. The aetiology of this inciting infection was not elucidated which is the case in 50% of such pneumonias often reflecting either a viral aetiology for which there are very limited therapeutic options. Progression of the pulmonary inflammation (Adult Respiratory Distress Syndrome) occurred despite appropriate therapy. The rapidity of the progression and severity of the condition did not allow for transfer to occur to a higher-level intensive care facility.

63. I am satisfied given Dr Boots' opinions that all that could have been done for Mr Hansen was done and his treatment and care was appropriate in the circumstances.

Apparent Delay in Hospital Transfer

64. Counsel Assisting in her submissions raised a concern about the apparent delay in Mr Hansen's transfer to hospital. Ms Dickson submitted that the evidence indicated that it was decided to transfer the patient at about 11.30pm but the ambulance was not called until 12.08am. It was noted however that a number of other witnesses recorded different times in their statements so the delay may have been more in the vicinity of 20 minutes.

65. Counsel Assisting noted that Dr Boots' opinion was sought in relation to this issue of apparent delay. In Dr Boots' opinion the delay would not have made any difference, or very little difference, to the outcome given the severity of Mr Hansen's pneumonia and the number of hours he was treated at the hospital before he succumbed to the illness. However Dr Boots did say that it might have made a significant difference if Mr Hansen had been suffering from asthma or something similar.

66. The Department of Corrective Services was invited to provide submissions addressing this issue.

67. I am grateful for the prompt written submissions provided by the Department enclosing three departmental policies for managing medical emergencies entitled: 'Emergencies', 'Ambulance Services',

and ‘Code Blue’ in addition to two supplementary statements: one from nurse Hancock-Toohey and the second from correctional supervisor Carl Jespersen.

68. The Department submitted that in all instances, it is the medical staff who have dominion for determining whether a hospital transfer is necessary. The correctional staff will be consulted concerning the method of transport and the level of security required, but they will be guided by medical staff as to the urgency of the transfer.

69. In Mr Hansen’s case, his transfer to hospital was classified as an unscheduled medical transfer and not a Code Blue Medical Emergency. A Code Blue Medical Emergency would have precipitated a more urgent response.

70. All staff questioned in relation to the issue of apparent delay have refuted any suggestion of delay and consider that the response to the transfer was one of the swiftest they have been involved with at the correctional centre.

71. Nurse Hancock-Toohey states in her supplementary statement that there was no excessive delay between the time she first contacted correctional supervisor Jespersen and requested his attendance at the medical centre, then his subsequent arrival at the medical centre, her briefing on Mr Hansen’s condition, the request for an ambulance and the attendance of the ambulance. Nurse Hancock-Toohey confirms in her supplementary statement that she cannot provide exact times for the events as she did not note them at the time; rather the times were extracted from the medical centre log.

72. Nurse Hancock-Toohey also states that following Mr Hansen’s transfer to the hospital, she was contacted by one of the clinical nurse’s there asking whether the correctional centre had the capability to provide intravenous antibiotics as the hospital was considering returning Mr Hansen to the prison.

73. Correctional supervisor Jespersen also asserts that there was no delay in Mr Hansen’s transfer to hospital. He reports that he obtained the times for his statement from his watch which he sets 8 minutes ahead of time. He noted that the officers concerned in this transfer will almost certainly not have noted the time contemporaneously but estimated the times after the events. He does note however that if a Code Blue had been declared an officer would have been appointed to record all times in a running log.

74. Correctional supervisor Jespersen advised the Department’s representative at the inquest that he did not consider that Mr Hansen was in urgent need of medical attention or in imminent danger of death because he was ambulatory and that Mr Hansen had had a conversation with him while they awaited the arrival of the ambulance.

Correctional supervisor Jespersen states that he did not have any indication from nurse Hancock-Toohey that Mr Hansen's transfer was urgent.

75. Other officers involved in Mr Hansen's transfer also confirm that he was variously sitting up in bed, walked to the ambulance stretcher and talked to them whilst waiting for the ambulance to arrive.

76. CSO Wendy Dale who was rostered to perform duty in the medical ward on the evening of 27 August 2003 states she was shocked to learn Mr Hansen had died because she didn't think his condition was that serious.

77. However custodial officers who relieved at the Maryborough Hospital at 6.00am on the morning of 28 August (CSOs Colin Kurtz and Kevin Maude) both describe Mr Hansen as appearing seriously unwell at that time.

78. I am satisfied on the evidence available that Mr Hansen's transfer to the Maryborough hospital occurred within a reasonable timeframe given the presentation of his condition and the classification of transfer.

Findings

79. On the evidence available and in accordance with section 43(2) of the *Coroners Act 1958* I find as follows:-

- **Identity of the deceased:** Anthony Kenneth Hansen
- **Place of death:** Maryborough Base Hospital, Queensland
- **Date of death:** 28 August 2003
- **Cause of death:** Diffuse Alveolar Damage (Adult Respiratory Distress Syndrome) as a consequence of or due to Bilateral Early Lobar Pneumonia.

80. I find that there is no evidence to suggest that anyone should be committed to stand trial for causing the death.

Recommendations

81. Pursuant to section 43(5) of the Act I am authorised to make riders or recommendations designed to reduce the occurrence of similar deaths to the one investigated by this inquest. The circumstances of this matter are such that it is not necessary for me to consider any riders or recommendations as I do not consider the death was preventbale.

Michael Barnes
State Coroner
22 December 2005