QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Anthony Gayle COSTELLOE**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR/02 2636
DELIVERED ON:	26 November 2009
DELIVERED AT:	Brisbane
HEARING DATE(s):	30 October 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in prison custody, natural causes, quality of health care, Indigenous prisoner, cross cultural awareness

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Family of Mr Costelloe:	Ms Maria Rinaudo-Lewis (ATSILS)
Department of Community Safety:	Mr Michael Nicholson
Queensland Health:	Mr Kevin Parrott (Crown Law)

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These are the findings of the inquest into the death of Anthony Gayle Costelloe. They will be distributed in accordance with the requirements of sections 44 and 45 of the *Coroners Act* 1958 (the Act) and posted on the web site of the Office of the State Coroner.

Introduction

Anthony Gayle Costelloe was playing touch football with fellow prisoners at the Wolston Correctional Centre (WCC) shortly before 10:00am on the morning of 25 October 2002, his 37th birthday. He became unwell and sat down next to the goal posts. He quickly lapsed into unconsciousness and despite prompt medical attention from prison staff and the Queensland Ambulance Service he was unable to be revived.

Less than 24 hours earlier Mr Costelloe had attended the WCC health centre complaining of chest pains. Arrangements were made for him to see a doctor four days later on 28 October 2002, but no other treatment was provided.

These findings:-

- confirm the identity of the deceased man, the time, place and how he came by his death;

- consider the adequacy of the medical treatment afforded to the deceased while in custody at WCC and in particular on the day before his death; 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

Immediately after it became evident Mr Costelloe had died, police from the Corrective Services Investigation Unit (CSIU) were notified. Detectives from that unit attended the scene at 11:00am and were later assisted by uniformed police from Mount Ommaney.

Mr Costelloe's body remained in situ and scientific officers conducted examinations of the immediate area and of Mr Costelloe's cell. Personal property including Mr Costelloe's diary were seized and photographs of the relevant locations taken.

No physical injuries or abnormalities were observed on the body of Mr Costelloe and police later accompanied the body to the John Tonge Centre for lodgement.

At the time of Mr Costelloe's death there were 40 other inmates on the football oval and all except one were interviewed. All Corrective Service Officers (CSOs) involved immediately before or in the aftermath of Mr Costelloe's death were interviewed and statements obtained.

All records pertaining to Mr Costelloe were seized from WCC and investigations conducted in relation to Mr Costelloe's attendance at the WCC medical centre on 24 October 2002. This included interviews with the nurse whom Mr Costelloe consulted as well as witnesses to his condition on that date. An independent report was obtained from Dr Robert Hoskins, then Deputy Director of GMO Services for Brisbane and Ipswich, in relation to the medical care afforded to Mr Costelloe.

Fingerprints from the body matched QPS fingerprint records for Anthony Gayle Costelloe and his body was also identified by his half brother, Gavin Costelloe.

A post mortem examination took place on 26 October 2002 and blood and urine samples were taken for analysis.

I find that the investigation into this matter was thoroughly and professionally conducted. It was pointed out during the inquest that many of the interview transcripts contained material the typist was not able to reproduce. I accept that the investigator who undertook those interviews made an assessment they contained nothing of much significance and so I accept that seeking to clarify the unintelligible passages was probably not warranted.

I thank Detective McCartney for his considerable efforts in collating the large number of witness statements and the voluminous records. I am also satisfied the procedures adopted by staff at WCC immediately after the death appropriately preserved the integrity of the evidence.

An investigation into the incident was also commissioned by the then Department of Corrective Services pursuant to the provisions of the *Corrective Services Act 2000*. I have had regard to the findings made in that report and am largely in agreement with them, although I am less inclined to so readily concede the adequacy of the care provided to Mr Costelloe at the WCC medical centre on 24 October 2002.

The Inquest

An inquest was opened in Brisbane on 30 October 2009 in accordance with the requirements of s.7B of the Act. Mr Johns was appointed as counsel to assist me with the inquest and leave to appear was granted to the family of the deceased, the Department of Community Safety and Queensland Health. Submissions were made as to the issues to be investigated and the witnesses to be called.

The inquest reconvened on 19 November. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered into evidence and one witness gave oral evidence.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence I believe is necessary to understand the findings I have made.

Personal History

Mr Costelloe, who liked to be known as "Tony", was born in Brisbane on 25 October 1965. He is the middle child of a family of six.

Tony spent very little time with his biological family and had minimum contact with them until he reached his late teenage years when he formed a close attachment to his older half-brother, Gavin, and his aunty, Sharon who currently live on North Stradbroke Island.

The majority of Tony's biological family lives on North Stradbroke Island, and Tony apparently expressed a keen desire to return to the island when he was released from custody.

He attended *St Peter's Lutheran College* until the end of grade eight. He completed his junior studies through *BoysTown*. Apparently, Tony did well at school, excelling in English.

Tony possessed a rather limited vocational history. However, he had worked in a number of casual positions over the years, including at various meatworks, and as a traditional Aboriginal dancer at the *Currumbin Sanctuary*.

Apparently, Tony had a troubled youth, and this contributed to his offending, which resulted in frequent periods of incarceration from approximately twenty years of age.

Tony's main passion was playing touch football, and he always looked forward to a game with other inmates at whatever correctional facility he was placed. Tony also enjoyed eating seafood, and Fridays, when the majority of correctional centres in Queensland serve fish and seafood meals, was one of his favourite days of the week.

Tony kept a detailed diary for most of his life where he would record the significant events of each day. Pages of the last one were tendered into evidence in these proceedings.

He has been described by Corrective Service's staff as a friendly, easy-going, happy, and easy to manage inmate. He had many friends among the inmates who spoke highly of him.

Custody

At the time of his death Mr Costelloe was serving a sentence of 5 years imprisonment for indecent assault imposed by the District Court at Brisbane on 8 October 1999. His earliest release date was 8 December 2003. Mr Costelloe had been transferred to WCC on 28 August 2002 to participate in the Sex Offenders Treatment Program.

Events of 24 October

A review of the extensive medical documentation concerning Mr Costelloe's periods of imprisonment reveals no reference to chest pain other than a brief entry made in 1989. Since then, in two further reception medical assessments he apparently ticked the "no" box next to a question inquiring as to whether he suffered from chest pain.

Mr Costelloe's diary notes that on 24 October 2002, he woke "*with a very sore chest*". This is consistent with the observations of CSO Samone Jackson at 8:30am on that day. She noticed Mr Costelloe appeared listless and she described his complexion as a dull, yellowy colour. To her, he didn't look well. At about 10.00am Mr Costelloe approached Ms Jackson and another CSO and complained of chest pains.

The other officer made arrangements for Mr Costelloe to go to the prison's medical centre.

At the medical centre, Mr Costelloe was attended to by registered nurse Lesley Wright, who at that time had been a registered nurse for 41 years, had been working in correctional centres for 9 years and had some undefined experience in indigenous communities. Nurse Wright's hand written notes of the consultation are very brief:-

> *To HC at 10.30am*
> *c/o pain in the sternum area on inspiration*
> *to see VMO Monday 28th Oct.*

The nurse said Mr Costelloe told her the prison officers "*had sent him up here"*. In response to her question about his ailment, he tapped his sternum and said, "*It hurts when I take a big deep breath.*" She also said she asked him to do that and in response to her inquiry "*Does it hurt now?*" he said, *"No it's gone now.*"

Nurse Wright says in her statement that she took Mr Costelloe's temperature, blood pressure and pulse and all were normal. She says Mr Costelloe did not appear pale or flushed. She says she asked Mr Costelloe about his family history and says he told her his mother had died "*from the grog".* She says she cannot remember what he said about his father's cause of death.

Nurse Wright said from the information Mr Costelloe gave her about his condition she had no reason to suspect he might have been suffering from a cardiac event. She thought he might have a chest infection, although he denied he'd had a cold of late.

She also said there was no doctor at the WCC on the day in question, and although one was scheduled to visit the next day, secure section inmates could only see the doctor then if it was an emergency. For that reason she made an appointment for Mr Costelloe to see the doctor on the next scheduled visit to the secure section which was Monday 28 October.

The internal inspectors report that Mr Costello logged into the medical centre at 10.42am and logged out at 10.45am. When regard is had to the time it must have taken for the nurse to find his file and review it, it is apparent the time she spent with Mr Costelloe must have been very brief.

When he came back from the medical centre Mr Costello again spoke to CSO Jackson. She recalls Mr Costelloe gave her the impression he considered his health complaint had not been taken seriously.

Morning of 25 October

The next day, at around 9:30am, Mr Costelloe was one of approximately 40 inmates escorted to the WCC oval for outdoor activities. The unit officer for unit S7 where Mr Costelloe was housed noted nothing unusual prior to this time.

Once on the oval the majority of the inmates commenced a game of touch football. Other prisoners state that Mr Costelloe was seen to be in some physical distress at around 9:50am. They suggested he lie down and he did so near a set of goal posts. He quickly became unconscious. The other prisoners began calling out and waving to the CSOs who were under some trees on the other side of the oval.

Two CSOs ran to the scene. They say when they got there it was apparent Mr Costelloe was unconscious and various inmates were crowding around attempting to assist their friend. One of the CSOs saw that Mr Costelloe's arms were shaking and he thought he was having a seizure. These CSOs said some of the inmates were upset and agitated and resentful of being told to move away from Mr Costelloe.

After checking he was breathing and had a detectable pulse, they put Mr Costelloe into the recovery position, secured his airway and called a "code blue" over the radio.

In the ensuing minutes, other CSOs arrived and moved the other prisoners to another area. The first two CSOs had continued to monitor Mr Costelloe and noticed his breathing pattern change and pulse become weaker. After a few minutes two nurses arrived with an emergency trolley. CSO Drinkeld says at about this time he noticed he could no longer feel a pulse on Mr Costelloe's neck and told the nurse. The nurses then took control and commenced CPR. A 'Life Pack 500' machine was attached to Mr Costelloe and he was defibrillated in accordance with the instructions given. The nurses also began an intravenous infusion of 1000ml of saline solution and undertook CPR.

The Queensland Ambulance Service officers were contacted at 10:01am. The first unit arrived at WCC at 10:10am and were with Mr Costelloe at 10:14am. The officers attached their own equipment and took over medical treatment although it was apparent within minutes there was no prospect of reviving Mr Costelloe.

Some concern was expressed at the inquest that inmates with first aid training were not allowed to assist with attempts to revive Mr Costelloe but it is easy to understand why this would be so. The CSOs would have no way of knowing if the prisoners were competent. There was also oblique criticism of the failure of the officers to commence CPR but on their uncontradicted versions, Mr Costelloe was breathing and had a detectable pulse until just before the nurses arrived with the emergency trolley. In those circumstances the officers did all that was necessary by placing Mr Costelloe in the recovery position and maintaining his airway.

In the circumstances, I am satisfied the response to Mr Costelloe's collapse was prompt and professional. The post mortem findings confirm that nothing could have been done to revive Mr Costelloe once he lapsed into unconsciousness.

Autopsy results
An autopsy examination was carried out on 26 October 2002, by an experienced pathologist, Dr Lampe. It revealed severe coronary atherosclerosis along with the formation of a long intra-luminal blood clot in the right coronary artery. This had caused an area of posterior myocardial infarction.

Dr Lampe found the severely narrowed blood vessel had caused previous death of heart muscle cells. He found evidence of infarction having occurred over a period some weeks earlier and clear evidence of a more recent cardiac event some 24-36 hours before death. No other causes of sudden death were evident.

Dr Lampe stated the cause of death was directly related to the clot formed in the right coronary artery. In his report, Dr Robert Hoskins, the deputy director of the Clinical Forensic Medicine Unit, posited that the event leading to death may in fact have been a fatal arrhythmia resulting from the inability of the substantially decayed heart muscle to cope with the physical activity undertaken by Mr Costelloe in the minutes prior to his death.

In any case this is consistent with the cause of death as listed by Dr Lampe on his autopsy certificate.

Findings required by s43

I am required to find who the deceased person was and when, where and how he died. 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 Anthony Gayle Costelloe.

Place of death – He died at Wolston Correctional Centre at Wacol in Queensland.

Date of death – Mr Costelloe died on 25 October 2002.

Cause of death – He died from the effects of a posterior myocardial infarct consequent upon a right coronary artery thrombosis and coronary atherosclerosis while a prisoner in the custody of the Department of Corrective Services.

Adequacy of medical care

Section 45(3) of the *Coroners Act 1958* authorises a coroner at an inquest to make riders designed to reduce the likelihood of deaths occurring in similar circumstances in future. The circumstances of this case suggest the adequacy of the health care given to Mr Costelloe on the day before his death, warrant consideration from that perspective.

It is highly likely that when Mr Costelloe went to the medical centre of the prison on the day before his death, he was suffering a myocardial infarction. His diary records he woke with "*a very sore chest*" and prisoners and a prison officer noted he appeared unwell. He sought medical attention but left the health centre without

receiving any treatment and without a firm diagnosis being made as to the cause of his complaint. This raises concerns about the quality of the health care provided to him.

Morality, the criminal law and government policy require prisoners be given health care equivalent to that which the government makes available to members of the public. There is no basis to conclude that if Mr Costelloe's condition had been correctly diagnosed he would not have been transferred to the Princess Alexandra Hospital where care of that standard would have been made available to him. It was the failure to diagnose the event that led to it being untreated.

I was advised during the inquest there was at the health centre the equipment to enable an electrocardiograph, an ECG, to be undertaken. This is likely to have detected the malfunctioning of Mr Costelloe's heart. It seems it was not used because Nurse Wright did not consider any of his presenting symptoms indicated a cardiac cause for his pain. In my view this conclusion was based on flawed information about the patient's history and a lack of understanding as to how to deal with patients presenting with such symptoms.

When critiquing the care given to Mr Costelloe, it is appropriate to acknowledge the evidence of the expert cardiologist who, in his review of this case commented that more than half of those in the general community who die from heart attacks do not get appropriate medical treatment due to a failure to recognise symptoms.

Mr Costelloe's close family history of fatal heart disease, his aboriginality, gender and age made him a high risk of having heart disease and meant when he presented with chest pain a differential diagnosis of angina should have been made and acted on until it could be excluded.

Nurse Wright said she was given no information about a family history of heart disease either in the patient's medical file or in her debriefing of him. Further, she said Mr Costelloe's description of his symptoms did not cause her to suspect he may have been experiencing a cardiac event. One wonders how thorough her questioning of him could have been when, according to the report of the departmental inspectors, he spent only three minutes in the medical centre. During that time the nurse said she had to find his file and acquaint herself with his recent history, take a family history, ascertain his clinical symptoms, examine him and make an appointment for him to see a doctor four days hence.

Health care in publicly operated correctional institutions is now provided by Queensland Health. Its Nursing Director, Offender Health Services, Ms Lawrence gave evidence that reforms being implemented will remedy shortcomings that may have contributed to the failure to diagnose Mr Costelloe's heart attack.

She said improved reception screening of new prisoners will ensure they are asked opened ended questions designed to illicit all known, relevant information and the forms used to gather it will make it harder for the staff undertaking those assessments to "tick and flick". She said all staff will undergo cultural awareness training on a regular basis, designed among other things to make communicating with Indigenous prisoners more effective.

As part of the review of all medical policies, the management of chest pain by prison health staff will be reformed. I was told it will result in enhanced emergency response packs being readily available and flow charts or clinical pathways being used to assist nurses make better informed diagnoses when a prisoner presents with chest pain. It will need to be more inclusive than the current flow chart which requires staff to first recognise that chest pain should be treated as an emergency.

These proposed reforms would appear to address the shortcomings that may have contributed to Mr Costelloe receiving inadequate care. They are an appropriate response to some of the recommendations made by the Royal Commission into Aboriginal Deaths in Custody 18 years ago. It may be instructive for the managers of Offender Health Services to investigate how many of the prisoners who have died since those recommendations were made, may have been saved had the current reforms been undertaken in a more timely manner.

It was submitted that I should monitor the implementation of the proposed changes but I don't consider that to be a coroner's role. One would assume the Department will understand the necessity to do this.

In the circumstances I do not consider there are any other recommendations I could make that would assist reduce the likelihood of similar deaths occurring.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
26 November 2009