QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Maxwell Ronald Brown**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2014/717
DELIVERED ON:	14 August 2015
DELIVERED AT:	Brisbane
HEARING DATE(s):	14 August 2015
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Townsville Hospital and Health Service:	Ms Lisa Harris, Corrs Chambers Westgarth
Queensland Corrective Services:	Ms Ulrike Fortescue
Aboriginal and Torres Strait Islander Legal Service Qld (Ltd):	Ms Charo Weldon

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Introduction

On 22 February 2014 Maxwell Brown, aged 57 years, was admitted to the Townsville Hospital (TTH) palliative care unit. He had been receiving palliative care for inoperable cholangiocarcinoma since early 2011. An Acute Resuscitation Plan was put in place in December 2013 stating that he was to be treated only with comfort measures and supportive therapies.

By the late hours of 24 February 2014 Mr Brown's death appeared imminent. In the early hours of 25 February 2014 he started coughing up blood, and was pronounced deceased 30 minutes later.

The investigation

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

Upon being notified of Mr Brown's death, the CSIU attended TTH and the Townsville Correctional Centre (TCC) and an investigation ensued. Mr Brown's correctional records and his medical files from TCC, TTH and (Princess Alexandra Hospital) PAH were obtained. The investigation was informed by statements from all relevant custodial officers at TCC and recorded interviews with fellow prisoners Mr Brown resided with. These statements were tendered at the inquest.

An external autopsy examination was conducted by Dr David Williams. At the request of the Office of the State Coroner, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Brown from the PAH, TCC and TTH and reported on them.

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

The Inquest

As he was in custody when he died an inquest into Mr Brown's death was required by the *Coroners Act 2003.* The inquest was held on 14 August 2015. All of the statements, records of interview, medical records, photographs and material gathered during the investigation were tendered, and evidence heard from Detective Senior Constable Fry.

Circumstances of the death

Maxwell Ronald Brown was a 57 year old Aboriginal man. He had been held on remand on a murder charge since 27 April 2004. On 5 December 2005 he was found guilty of that charge in the Supreme Court at Rockhampton and sentenced to life imprisonment. He was transferred from the Maryborough Correctional Centre to the TCC in 2010.

In early 2011, Mr Brown was diagnosed at the PAH in Brisbane with hilar cholangiocarcinoma, a type of cancer arising from the proximal bilary tree,

where the hepatic bile ducts come together (bile ducts carry bile from the liver to the intestine). The PAH records confirm that the cancer was inoperable and that most patients in Mr Brown's condition would not survive more than 12 months. As such, he was referred for palliative care at the Townsville Palliative Care Service (TPCS) at TTH for ongoing treatment of his symptoms, mainly pain relief.

Dr Ofra Fried was Mr Brown's treating doctor at the TPCS. She treated him from July 2011 through to his death on 25 February 2014. I was provided with a statement from Dr Fried which confirmed the slow progression of the disease and the various admissions to TTH. In September 2012, Mr Brown communicated to clinic staff that he no longer wanted to attend the clinic, as he perceived it as of no value. Instead of regular reviews at the clinic, it was agreed that he would be referred by the prison on an 'as needed' basis.

From the end of November 2013, Mr Brown was more fatigued, had lost weight and was not eating well. He was being cared for by the TCC medical clinic, and his application for parole on compassionate grounds had been refused. In December 2013, blood tests confirmed he was starting to deteriorate. He was starting to vomit and was not feeling comfortable. It was agreed that he needed to be admitted to TTH. After he was admitted there for four days, his condition stabilised, and he was released back to the prison. An Acute Resuscitation Plan was completed during this admission, confirming that he should have all comfort measures and supportive therapies but not defibrillation, intubation, advanced life support medication and procedures.

Mr Brown's final admission to TTH was from 22 February 2014. His condition had been deteriorating and he was admitted directly to the palliative care unit. The deterioration was expected and was consistent with the natural progression of the disease. He had poor oral intake, had been vomiting and had suffered a fall three days earlier. By 11:00pm on 24 February his death appeared imminent. Early in the morning on 25 February he began coughing up large amounts of blood. He died at 4:30am.

Dr Home's report concluded that Mr Brown was diagnosed with inoperable cholangiocarcinoma almost four years prior to his death and that such tumours have a poor prognosis (two year survival rate no more than 5.5%). Dr Home identified no issues with Mr Brown's care in the lead up to his death.

Mr Brown'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.

Conclusions

I conclude that Mr Brown died from natural causes. I find that none of the correctional officers or inmates at TCC caused or contributed to his death. I am satisfied that Mr Brown was given appropriate medical care by staff at the TCC and TTH while he was in custody. His death could not have been prevented.

It is a 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 Brown when measured against this benchmark.

In reaching these conclusions, I have also had regard to written submissions from the Townsville Hospital and Health Service.

Findings required

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 I am able to make the following findings:

Identity of the deceased – The deceased person was Maxwell Ronald Brown.

How he died - Mr Brown died at the Townsville Hospital after almost three years of palliative treatment for inoperable liver cancer.

Place of death – He died at the Townsville Hospital, Douglas, Queensland.

Date of death – He died on 25 February 2014.

Cause of death – Mr Brown died from natural causes, namely ascending cholangitis due to or as a consequence of cholangiocarcinoma.

Comments and recommendations

The *Coroners Act 2003* enables a coroner 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. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
14 August 2015