QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Mirko Civic**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2018/4154
DELIVERED ON:	25 January 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 January 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, health care, provision of Aspirin and anti-hypertensive medication to prisoner with history of cardiac illness.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lane
Queensland Corrective Services:	Ms Vanessa Price
Metro South Health Metro North Health:	Ms Myla Ruttan

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Introduction

1. Mirko Civic was aged 70 at the time of his death on 16 September 2018 in cell 21 of the B Block at Palen Creek Correctional Centre (Palen Creek). Mr Civic had served over seven years of a 10 year sentence for manslaughter.[1]

2. On 16 September 2018, Mr Civic attended the lunch-time muster at 12:10pm before returning to his room. At 3:43pm, the afternoon muster was commenced by custodial correctional officers (CCOs) Williams, Wilson and Pratt in the common area of Block B.

3. Another prisoner, Mr McMeekin, noted that Mr Civic was not present at the line-up. He went to his cell to tell him the muster was beginning. Mr McMeekin found Mr Civic lying in bed, unresponsive. He returned to the common area to notify CCO Williams, and they returned to Mr Civic's cell.

4. CCO Williams observed Mr Civic was unresponsive, with no pulse and cold to the touch. He was lying supine, fully clothed and his glasses were on the floor under his desk. CCO Williams told Mr McMeekin to notify another officer, and Mr McMeekin retrieved CCO Wilson. CCO Wilson entered the cell and began resuscitation. CCO Williams called a Code Blue (medical emergency) at approximately 3:52pm before commencing cardiopulmonary chest compressions (CPR).

5. At 3:55pm, CCOs Walker, Stanford, Copson and Vautin and Registered Nurse (RN) Kristy Baldwin responded to the Code Blue. At approximately 4:00pm, RN Baldwin attached a defibrillator to Mr Civic and used an air bag to deliver rescue breaths. The Queensland Ambulance Service arrived at 4:29pm and QAS Officer Neaum issued a life extinct certificate.

The investigation

6. On 16 September 2018 at 5:42pm, Senior Constable Woodberry and Constable Lambie from Beaudesert Police attended Palen Creek and commenced the investigation by arranging Scenes of Crime (SOCO) attendance and advising necessary personnel.

7. Senior Constable Arnold (SOCO) examined the scene and observed cell 21 to contain a desk, single bed and an open wardrobe which contained clothing and food. There was an empty box of pantoprazole (Somas) 20mg tablet issued on the 1 August 2018 by Beaudesert Hospital. No other medication was located in the cell.

8. The attending police officers did not observe any signs of trauma, puncture wounds or blood on Mr Civic.

[1] Including time served on remand.

9. The Corrective Services Investigation Unit (CSIU) was notified that afternoon and Detective Sergeant Johns and Detective Senior Constable Anderson attended Palen Creek at 9:30pm.

10. A targeted direction for investigation was issued by the Coroners Court. Mr Civic's correctional records and his medical files from Palen Creek were obtained.

11. The investigation was informed by statements from the relevant custodial correctional officers, medical and nursing staff. These statements were tendered at the inquest. I was provided with annexures including witness statements, recordings, Corrective Services records and photographs.

12. Senior Constable Pritchard from the Corrective Services Investigation Unit (CSIU) finalised the investigation into the circumstances surrounding Mr Civic's death. A Coronial Report was provided dated 6 March 2020.

13. The CSIU investigation concluded that Mr Civic passed away from natural causes, and that he was provided with adequate medical care in prison. It also found that there were no suspicious circumstances associated with the death.

14. Dr Aran Thillainathan from the Clinical Forensic Medicine Unit (CFMU) subsequently examined Mr Civic's medical records and reported on them as part of the coronial investigation.

The inquest

15. As Mr Civic died in custody, an inquest was required by s 27(1)(a)(i) of the *Coroners Act* 2003. As the police investigation concluded that the death was due to natural causes, the primary issue for consideration was whether Mr Civic's medical treatment was appropriate and sufficient.

The evidence

Offending and correctional history

16. Mr Civic's limited criminal history began in 1994 when he was found guilty of five drug and weapons offences. He was sentenced to 2 years' probation and 240 hours community service. Later that year, he was found guilty of a further three drug and weapons offences and fined $750. In 2008, he was fined $1350 after being found guilty of obtaining a controlled drug, obstructing police and possessing tainted property.

17. In January 2011, Mr Civic was owed $300 by an associate. On 17 January 2011, after drinking a large quantity of alcohol, he attended the man's residence to recover his debt. Another man, Jonathan Turner, exited the residence and ran towards Mr Civic. A fight ensued and Mr Civic stabbed Mr Turner five times. Mr Turner died following this altercation and Mr Civic

fled the scene. He was located in his home later that day, arrested and charged with murder. He was remanded in custody in the Southport Watchhouse before being transported to the Arthur Gorrie Correctional Centre (AGCC) on 19 January 2011.

18. On 29 April 2013, a jury found Mr Civic guilty of manslaughter. On 21 May 2013, he was sentenced to 10 years imprisonment and declared a serious violent offender. Between his arrest and his sentence, Mr Civic was admitted for treatment to the Princess Alexandra Hospital (PAH) on eight occasions.

19. On 23 May 2013, Mr Civic was moved from AGCC to Brisbane Correctional Centre (BCC) due to accommodation requirements. Following a meeting with Sentence Management on 1 July 2013, Mr Civic was approved to transfer to Woodford Correctional Centre (WCC) on 20 August 2013. His case notes indicate throughout this time he was highly distressed, complaining about his charges and the system at large and focused on his own victimisation and appeal process.

20. Mr Civic appealed against his conviction and sentence. On 5 December 2014, the Court of Appeal dismissed his application for leave to appeal.

21. On 10 May 2017, Mr Civic was approved to be classified as a low security prisoner and he was transferred to Palen Creek on 30 May 2017.

22. Mr Civic was a qualified electrician and worked in the industrial workshop while in Woodford CC. He later worked as a groundsman and in the wheelchair area at Palen Creek, making wheelchairs from unwanted bicycles. He was noted to work well with staff and other inmates. On 30 November 2017, Mr Civic was approved to commence work as a landscaper and was noted to be "surprisingly knowledgeable" while employed in the nursery.

23. On 23 July 2018, a parole application was lodged by Mr Civic. On 30 August 2018, a parole assessment recommended he was suitable for parole with multiple conditions upon release. On 3 September 2018 this recommendation was endorsed. The Parole Board had not determined his application at the time of his death.

24. In the four years preceding his death, there were eight instances of Mr Civic applying for a change of classification from a 'High' security classification to 'Low', and six instances of Mr Civic requesting a transfer between correctional centres. Mr Civic's prison transfer history was as follows:

    - January 2011 – May 2013 – AGCC;
    - May 2013 – July 2013 – Brisbane Correctional Centre
    - July 2013 – May 2017 – Woodford Correctional Centre; and
    - May 2017 – date of death – Palen Creek.

Personal and medical history

25. Mr Civic was born in Croatia on 30 August 1948. He moved to Australia in 1966 and became a dual citizen. Mr Civic had four children and over a dozen grandchildren. He told CCOs during his time in custody that he felt supported by his mother and children.

26. Mr Civic's medical history included ischaemic heart disease, a self-reported myocardial infarction, hypertension, asthma, dormant tuberculosis, prostate carcinoma, post-traumatic stress disorder and depression.

27. On admission to the AGCC, Mr Civic reported a history of several myocardial infarctions dating back to the 1960s. He said that he was not taking any heart medication. When seen by the visiting medical officer (VMO) on 20 January 2011 he reported a history of a "mild heart attack" in 1999 or 2000 and prostate cancer.

28. Mr Civic had frequent appointments with medical and mental health practitioners during his time in custody. Some treating practitioners had difficulty with Mr Civic refusing medication, which would have had an impact on the effectiveness of any medical treatment given.

29. On 17 February 2011, Mr Civic was sent to the Arthur Gorrie medical centre after becoming emotional about his living situation. After talking to the nurse and discussing his situation, he was discharged. He was noted in the first years of his incarceration to complain about his health, the healthcare he received, and become tearful and upset very easily. He would refuse medication often and was demanding and abusive to staff.

30. Mr Civic had sporadic bouts of blood in his urine throughout the early years of his incarceration which he verbalised to staff. Mr Civic also suffered from sporadic bouts of lower abdominal pain, or 'kidney pains'. While he would often complain to Correctional Officers about these conditions, he would refuse to attend the Medical Centre.

31. His records indicate attendance at approximately twenty psychology and mental health appointments from 2011, where he expressed attitudes of pessimism and self-persecution.

32. On 18 May 2011, Mr Civic was admitted to the Princess Alexandra Hospital (PAH) after feeling pain in his abdomen. He was discharged two days later. A CT scan was conducted on his chest with no further action required. The pain in Mr Civic's right upper quadrant was found to be caused by faecal loading.

33. The AGCC VMO, Dr Pham, reviewed Mr Civic's chart following this hospital admission and he was maintained on a pain relief regime of Tramadol. Collateral information was obtained from the Ashmore Medical Centre. Mr Civic later became argumentative with staff and refused to take his medications after demanding 'decent' pain killers.

34. On 3 January 2012, Mr Civic was seen by the AGCC Mental Health Nurse who noted Mr Civic as being "oppositional and obstructive to any solutions or suggestions". Due to his personality and behaviour, it was difficult to ascertain if he suffered from an acute illness from a psychiatric perspective. It was noted he had refused to take his medication for over two months.

35. On 12 August 2013, Mr Civic was seen by VMO, Dr Lethbridge, and asked for more pain relief, stating he had been given morphine previously. Dr Lethbridge was reluctant to move to a stronger opiate when Mr Civic would not agree to further investigation, but agreed to a change to Amitriptyline to help night pains.

36. On 6 August 2016, Mr Civic was reported to have fallen on his wrist and was sent to the Medical Unit. No follow up was required. On 20 December 2016, Mr Civic presented again to the Medical Unit complaining of pain in his right shoulder. He was already prescribed Celebrex for pain relief and was not prescribed anything further. He continued to present to the Medical Unit for the right shoulder pain and on 4 January 2017, he was prescribed 10mg Piroxicam, which was increased to 20mg on 16 January 2017.

37. On 5 July 2017, the Palen Creek SMO saw Mr Civic for X-ray results, and found moderate degenerative joint disease of the hips, severe degenerative disease in his L5-SI (lumbosacral joint) and moderate arthritic changes in his facet joints. He was told to perform exercises and trial amitriptyline.

38. On 6 July 2017, Mr Civic attended the Medical Unit complaining of abdominal distension. The pain ceased on examination by a nurse and Mr Civic declined pain relief. On 12 July 2017, Mr Civic again presented to the Medical Unit for abdominal pain. His medication was subsequently changed from amitriptyline 20mg to Piroxicam 20mg.

39. On 27 September 2017, Mr Civic attended the Palen Creek psychologist for a general follow up, and was reported to have no notable concerns with regards to his mental health or circumstances.

40. On 11 October 2017, Mr Civic presented to a nurse complaining of chest pains, pins and needles and sweating. He told nurses that it felt the same as his previous heart attack fifteen years ago. He was transported to

Beaudesert Hospital for assessment and returned to Palen Creek the next day.

41. On 22 November 2017, Mr Civic was assessed by the SMO after presenting with intermittent paraesthesia (pins and needles) and weakness in his left hand. Mr Civic stated that he would "wait and see" how the pain went in the next couple of weeks. No further medical treatment was required.

42. During 2018, Mr Civic attended the Medical Unit sporadically for complains of skin rashes. There were no other issues raised prior to his death on 16 September 2018.

43. Mr Civic's Offender Health records and his 2011 and 2012 medication charts show that:

- From 5 to 21 July 2011 he refused all charted medications, which at that time included Amlodipine (hypertension and angina) Somac (heartburn), Tramadol (pain); Coloxyl with senna (constipation), Panadol and Citalopram (antidepressant). Mr Civic complained that he wanted "decent" pain killers and accused a nurse of calling him a "junkie";

- Prazosin was commenced on 28 July 2011;

- Amlodipine was ceased and Prazosin was increased on 7 September 2011;

- From 4 November 2011 to 6 March 2012 Mr Civic refused all his charted medication (Prazosin, Somac, Tramadol, Coloxyl and senna and Citalopram) alleging the doctors had been telling him he was a "junkie".

- After 6 March 2012 Mr Civic took Tramadol, Diazepam and Celecoxib (pain – arthritis) as charted, but no medication for hypertension or depression was charted;

- Prazosin was ordered again from 17 October 2012 but refused;

- On 25 November 2012 Mr Civic saw a doctor. He reported that the prazosin "always gives him nausea & vomiting". The doctor noted "prazosin – hypersensitivity can be ceased".

- From then on, the medication charts show that Mr Civic was largely compliant with his charted medications, which included various pain medications and an anti-depressant, but for periods of a few days at a time in September 2013 and May 2014.

CFMU Review

44. The review by Dr Thillainathan of the CFMU considered all the evidence obtained by the Coroners Court, including the hospital records and medication charts. Dr Thillainathan provided a report giving a chronology of the dates Mr Civic had attended the medical clinic, whether his blood pressure was recorded, the outcome of the attendance and notes which were recorded.

45. Dr Thillainathan quoted medical literature which reported that:

- Aspirin use reduces the risk of serious vascular events by about 25% in high-risk patients (those with existing occlusive vascular disease such as coronary atherosclerosis with a prior occlusive vascular event);
- There is ample evidence linking hypertension and coronary heart disease. Hypertension accelerates the development of atherosclerosis, and it can precipitate acute coronary events; and
- Hypertension is one of the most preventable causes of premature death – blood pressure (BP) control is of paramount importance in decreasing the risk of cardio-vascular death.

46. Based on this information, Dr Thillainathan gave the following opinion:

Mr CIVIC was a 70-year-old male who was first admitted into a correctional facility on 19 January 2011. At the time of admission, he displayed a significant elevation in his blood pressure and was known to have Ischemic Heart Disease.

When he was first seen by the MO on 20 January 2011 a very brief history was taken, and he was commenced on Amlodipine for his BP and Prazosin for his prostate.

It was likely the Amlodipine was ceased after approximately 8 months due to Mr CIVIC experiencing side effects (swelling of the feet). The Prazosin was likely ceased after 3 months as Mr CIVIC was refusing the medication. At the time he was already experiencing dizziness which is a well-known side effect of the Prazosin.

At no time was Aspirin commenced or medical records obtained from Chermside Hospital or his treating GP to elicit further information of Mr CIVIC's Ischemic Heart disease.

The chronology clinic dates of Mr CIVIC demonstrated significant elevation of his BP at various times.

It was finally on 17 July 2017, 6 years and 6 months later did a MO become aware of Mr CIVIC's cardiac status and commenced him on Aspirin and 2 antihypertensive medications. Despite the request for the BP to be followed up in 1 week, Mr CIVIC's BP was checked on 8 September 2017.

No further follow up of the BP was undertaken until Mr CIVIC passed away on 16 September 2018.

The failure to prescribe Mr CIVIC Aspirin for approximately 6 years and 6 month falls below the acceptable standard of care. Although antihypertensive medications were prescribed for the first 8 months from the first admission, there was a failure to prescribe antihypertensive medications for approximately 5 years and 6 months. The failure to prescribe Aspirin, antihypertensive medications, ordering of blood tests and regular follow up of Mr CIVIC contributed to the acceleration of the coronary atherosclerosis.

The medical care provided to Mr CIVIC was of a lesser standard than that is provided to the members of the community.[2]

Metro South HHS Response

47. On 1 October 2021, Dr Brian Bell, Executive Director Medical Services at the PAH, provided a response to the CFMU report by way of a letter written by Professor Michael Stowasser, Director of Hypertension at the PAH since 2000. Professor Stowasser has over 30 years' experience in the clinical management of hypertension. Professor Stowasser had been provided with Dr Thillainathan's report and chronology as well as Mr Civic's PAH medical chart.

48. Professor Stowasser noted Mr Civic's presentation history, recorded blood pressures and autopsy report and observed that:

- Of the 19 blood pressure readings that were recorded while he was off all antihypertensive medications, the average blood pressure was 151.8/87.0. The range of blood pressure levels was large (from 121/75 to 198/102) and it is unknown whether some of the higher readings were recorded during periods of stress caused by factors such as anxiety, emotional turmoil or pain which are well known to acutely raise blood pressure*;*

- Mr Civic's blood pressure appeared to be adequately controlled when he was taking amlodipine or prazosin;

- Mr Civic ceased taking prazosin from 1 November 2011 because of the side effects, and the clinic notes indicate on 24/11/11, 3/1/12, and on 4 occasions between 3/9/13 and 26/5/14 that he was "refusing to take medications", which at 30/09/13 included Tramadol, Panadol, piroxicam, Losec and Valium;

- The autopsy report described moderate to severe coronary atheroma and the cause of death was listed as coronary atherosclerosis. No information is available as to whether there was

[2] E7, CFMU Report, paras 14 – 21.

other evidence to suggest inadequately controlled hypertension such as left ventricular hypertrophy or renal glomerulosclerosis.

49. On the basis of that information, Professor Stowasser concluded:

- Mr Civic's hypertension was at most mild (Grade 1) and appeared readily controlled with a single agent.
- Ideally, in the setting of a previous myocardial infarct, hypertension should be treated with antihypertensive agents.
- After he ceased antihypertensive agents, his blood pressure remained only modestly elevated.
- There is insufficient evidence to state that management of his hypertension by his treating team was suboptimal.
- The degree to which hypertension contributed to his death is uncertain, but the evidence is insufficient to state that it played a major role.

50. After being provided with a missing 2012 Medication Chart Professor Stowasser provided the following clarification of his opinion:

> *According to the Medication Charts now available to me (in addition to the previously supplied CMFU statement), Mr Civic refused prazosin from 1/11/2011 until 6/3/2012, after which the prazosin order was discontinued. It was then recommenced at a dose of 2mg bd for lower urinary tract symptoms on the 19/10/2012, but the patient again refused to take it until the order was again discontinued on 29/10/2012. Importantly, I note that his recorded BP levels throughout this time period off all antihypertensives were all normal (130/70 on 21/11/2011, 138/78 on 17/10/2021, 140/70 on 25/11/2021). Subsequently, he did have some high BP levels measured but they appeared to be short lived and settling to normal over a matter of days, and usually in the setting of stress or illness (e.g. on 31/8/2013, blood pressure 170/90 when stressed and upset settling to 139/81 by 3/9/2013; on 19/10/2015, BP 158/89 while suffering bronchitis). At other times BPs were again normal (e.g. on 30/9/2013, BP 121/75). There were no further orders made on the medication chart for antihypertensives until 7/6/2017 when he was commenced on ramipril and metoprolol. Based on the above, I remain of the opinion that Mr Civic's BP status was a minor problem only, and that the evidence is insufficient to state that it played a major role in his death.*[3] *(emphasis added)*

[3] E9, pp 1 – 2.

Cardiology opinion

51. An opinion was subsequently sought from Dr Gregory Starmer, Interventional Cardiologist and Director of Cardiology at the Cairns Hospital. Dr Starmer was asked to provide an opinion on the appropriateness of the medical care and treatment provided to Mr Civic while at the Palen Creek Correctional Centre. Dr Starmer concluded that:

> *Mr Civic was a 70 year old male with cardiovascular risk factors and a history of a possible heart attack from 18 or 19 years prior to his ultimate passing from another cardiovascular event. Demographic and population data from the United States suggests that people suffering from a first heart attack at the age of 50 can expect to live 18 more years despite good therapy. Mr Civic was therefore highly likely to have a second cardiovascular event at approximately this age if not sooner despite medical therapy if indeed he had a first cardiovascular event in 1999 or 2000. Cardiovascular risk factor control to prevent second events is important. The control of hypertension and daily Aspirin have been shown to reduce the chance of a second event and improve life expectancy. Despite this events do occur and the ongoing requirement for further therapies highlights the difficulty in addressing blood pressure/hypertension control. Medication side effects are common and limiting and have clearly contributed to some of the difficulties in controlling Mr Civic's hypertension. Similarly, while Aspirin reduces cardiovascular events, it is documented to increase bleeding events and while the net clinical benefit is in favour of its use, this is based on large scale clinical trials and does not mean each individual will have the same risk/benefit profile. Mr Civic did have an episode of rectal bleeding in 2014, and was ultimately on Aspirin therapy in the months leading up to his passing. I would therefore suggest that while the secondary preventative care of Mr Civic was imperfect, it was acceptable.*[4]

52. With respect to the treatment of Mr Civic's hypertension in the setting of his medical history, Dr Starmer noted that:

> *Mr Civic had cardiovascular risk factors including hypertension and was on medication to treat this. Management of this was complicated by Mr Civic having dizziness, which may reflect "white coat" hypertension, a condition whereby a patient may have an elevated blood pressure when checked by a health care practitioner, however outside of this setting the blood pressure may be normal and therefore when blood pressure lowering medications are added, the blood pressure becomes low and side effects become evident and are typically in the form of light-headedness/dizziness. Management of hypertension is important however the ongoing need for further treatments for refractory or difficult to control hypertension highlights the ongoing difficulties in management of this cardiovascular risk factor globally. Whilst one can question the intent and comprehensiveness of investigation and management of*

[4] E10, p 3.

hypertension, it should be noted that attempts were made in the form of prescribed medical therapy to manage the hypertension and documented difficulties were encountered in the form of light-headedness. I therefore find it difficult to draw a parallel between this and Mr Civic's ultimate demise, as hypertension control is very often imperfect in the real world setting.

Ultimately Mr Civic died of complications relating to cardiovascular disease, a common cause of sudden cardiac death particularly in an elderly male as highlighted by Dr Li Ma, the anatomical pathologist that performed the autopsy for Queensland Health.[5]

53. Dr Starmer was also asked to respond to Dr Thillainathan's opinion that Mr Civic should have been prescribed aspirin. He noted that:

Mr Civic seems to have been intermittently prescribed Aspirin over the years. Certainly it appears as though in the final year of his life he was prescribed Aspirin. I agree Aspirin is an important therapy for secondary prevention after a cardiovascular event such as a myocardial infarct and therefore Mr Civic should preferentially have been on this from the time of his myocardial infarct in 1999 or 2000. Once again there are some important confounding factors. Firstly, the details and clarity of Mr Civic's event from nearly 20 years prior to his demise are not clear. Secondly, Mr Civic seems to have been prescribed Aspirin leading up to and at the time of his cardiovascular event and based on the mechanism of action of Aspirin, this should have provided the clinical benefit that has been discussed.[6]

Metro North Health and Metro South Health Responses

54. In October 2022, Metro North Health (MNH) conducted a review of the circumstances of Mr Civic's death. The review found that, in relation to Mr Civic's underlying heart condition and blood pressure, it appeared little monitoring occurred across multiple prison health services and that no consistent long term management plan was put in place until his transfer to Palen Creek. Factors that contributed to this included Mr Civic's highly emotional state when he presented to Health Clinic at WCC, aggression and intermittent refusal of medication. Staff were focussed on his presenting issue rather than chronic conditions.

55. As a result of the review, it was recommended that Woodford Correctional Health Service adopt the Primary Clinical Care Manual (PCCM), which includes a guideline for nursing staff regarding high or low blood pressure readings, including an identified escalation process.

[5] E10, p 2.
[6] E10, pp 2 - 3.

56. MNH has advised that the recommendations from the review were fully implemented at Woodford Correctional Centre Prison Health Services (PHS) in November 2022.

57. PHS staff have been informed and made aware of the requirement to use the PCCM guidelines to support clinical decision making regarding high blood pressure management in the context of patients with complex co-morbidities. In addition, staff have been encouraged to access the PCCM online training module.

58. Metro South Health (MSH) advised that it also incorporates the PCCM in clinical decision making for management of patients with history of heart attack at Palen Creek Prison Health Centre (Palen Creek PHC). Staff at Palen Creek PHC follow the PCCM to support clinical decision making for patients with previous history of heart attack or presenting with chest pain. Staff at Palen Creek PHC regularly monitor patients against their baseline, undertake ECG, escalate concerns to a medical officer, and contact the QAS if patients require transport to hospital for further management if clinically indicated.

59. In addition, MSH has documented procedures relating to chest pain management, clinical escalation between the Prison Health Centre and Beaudesert Hospital, and a standing order for prescribing Aspirin.

Autopsy results

60. On 19 September 2018, Dr Li Ma conducted an autopsy consisting of an external and full internal examination of the body, toxicology, a full body CT scan and a review of the medical records from Prison Health.

61. The external examination showed a well-nourished, elderly male with no significant injuries. Toxicology analysis revealed metoprolol and paracetamol below the therapeutic range, as well as Piroxicam. No other drugs or alcohol were detected.

62. The full internal examination and CT scan showed severe coronary atherosclerosis and changes in the lungs consistent with past tuberculosis infection. Histology analysis demonstrated a focus on plaque rupture and early thrombus formation in the section from the left circumflex artery. There were chronic ischaemic changes in the heart muscles (from a lack of blood supply). Sections of lung tissue showed features consistent with previous tuberculosis infection, without evidence of an active infection.

63. The mechanism of death was found to be cardiac arrythmia (irregular/abnormal heart rhythm) and Mr Civic's cause of death was determined as coronary atherosclerosis.

64. Dr Ma noted that coronary atherosclerosis is a condition characterised by the build-up of fatty deposits (plaque) in the wall of blood vessels that supply the heart, and when that plaque is disrupted, it may rapidly form a clot that blocks the blood vessel and cause a heart attack. It is a common cause of sudden death.

Conclusions

65. After considering the material gathered in the coronial investigation, I am satisfied that Mr Civic died from natural causes. I find that none of the inmates, correctional or health care staff at Palen Creek caused or contributed to his death. There were no suspicious circumstances.

66. An accepted 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 inquest considered the adequacy of the health care provided to Mr Civic when measured against this benchmark.

67. Dr Thillainathan raised a concern that the medical care provided to Mr Civic was of a lesser standard than that provided to the members of the community. His opinion was based on the fact that, despite Mr Civic's self-reported history of ischaemic heart disease and hypertension, Aspirin was not prescribed until over six years after he was first admitted to a correctional facility in January 2011.

68. In addition, although he was initially prescribed antihypertensive medications, these were ceased in November 2011, when Mr Civic refused them because of adverse reactions, and were not recommenced. Dr Thillainathan's view was that these failures, combined with an ongoing failure to order blood tests and regular follow-up in respect of his blood pressure contributed to the acceleration of the heart condition which caused his death.

69. In my view, Dr Thillainathan's concerns have been adequately addressed in the opinions given by Dr Starmer and Professor Stowasser. While Dr Starmer agreed that "Aspirin is an important therapy for secondary prevention after a cardiovascular event such as a myocardial infarct" and that "management of hypertension is important", he noted 'confounding factors' in Mr Civic's case, and 'ongoing difficulties' in the treatment of hypertension generally.

70. Dr Starmer's expert opinion was that the secondary preventative treatment of Mr Civic's cardiovascular risk factors while he was in custody was imperfect but acceptable. I agree with that opinion. As Dr Starmer noted, Mr Civic had been prescribed Aspirin leading up to his death and this should have provided the clinical benefits noted in the CFMU review.

71. The response from Professor Stowasser on behalf of MSH also concluded that Mr Civic's blood pressure levels were not a significant issue in terms of risk of a secondary event. I agree that it is not possible to conclude that hypertension played a major role in his death. Reasonable attempts were made to treat Mr Civic's hypertension, which were thwarted by Mr Civic's regular refusal to take his medication because of the side effects he experienced.

72. I also note that the VMO at AGCC, Dr Pham, sought collateral information from Mr Civic's General Practitioner at Ashmore in May 2011. No indication was provided that he was prescribed aspirin or other medication to manage his risk of heart disease while he was in the community.

Findings required by s. 45

73. 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 make the following findings:

Identity of the deceased – Mirko Civic

How he died – Mr Civic was nearing the end of a lengthy prison sentence for manslaughter. His medical history included ischaemic heart disease, myocardial infarction, and hypertension. He died suddenly following a cardiac arrest at the prison

Place of death – Palen Creek Correctional Centre, Palen Creek

Date of death– 16 September 2018

Cause of death – Coronary atherosclerosis

74. The circumstances of Mr Civic's death have been reviewed death by MNH. Changes to clinical practice have been implemented as a result of that review to ensure that prisoners with a history of cardiac illness and elevated blood pressure are monitored and managed. Similar practices have been established as Palen Creek in conjunction with the Beaudesert Hospital.

75. I am satisfied that there are no comments or recommendations to be made which would assist in preventing similar deaths in future, or that otherwise relate to public health or safety or the administration of justice.

76. I extend my condolences to Mr Civic's family.

77. I close the inquest.

Terry Ryan
State Coroner
BRISBANE