QUEENSLAND COURTS

# OFFICE OF THE STATE CORONER

# FINDINGS OF INQUEST

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| CITATION: | **Inquest into the death of Mark William PROBERTS** |
| TITLE OF COURT: | Coroners Court |
| JURISDICTION: | Brisbane |
| FILE NO(s): | COR 2013/478 |
| DELIVERED ON: | 3 November 2014 |
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| HEARING DATE(s): | 3 November 2014 |
| FINDINGS OF: | Mr Terry Ryan, State Coroner |
| CATCHWORDS: | CORONERS: Death in custody, natural causes |
| REPRESENTATION: | |
| Counsel Assisting: | Mr Peter Johns |

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The *Coroners Act 2003* provides in ss. 45 and 47 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various officials with responsibility for the justice system. These are my findings in relation to the death of Mark William Proberts. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of the State Coroner.

# Introduction

Mark Proberts was 52 years of age when he died at the Princess Alexandra Hospital (PAH) on 6 February 2013.

A week prior to his death Mr Proberts had been transferred to hospital from the Arthur Gorrie Correctional Centre (AGCC). He had been returned to that corrective services facility in early January 2013 following the revocation of his parole.

Multiple chronic medical conditions had left Mr Proberts' organs in a weakened state. Although his medical condition was managed by staff at AGCC, the acute onset of more serious symptoms led to his transfer to PAH in late January 2013. There, the source of a severe infection was identified. However, the seriousness of Mr Proberts' co-morbidities limited treatment options when he began suffering cardiac failure.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care adequately discharged those responsibilities; 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

An investigation into the circumstances leading to the death of Mr Proberts was conducted by Detective Sergeant Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). He submitted a report to my Office and this was tendered at the inquest.

CSIU detectives Seery and Anderson attended PAH when notification of Mr Proberts' death was received. They established formal identification of the deceased and organised forensic officers to photograph the body in situ.

Arrangements were made for all medical documentation to be provided to police and statements were obtained from relevant medical staff.

Similar procedures were adopted at AGCC where medical records were seized along with general prison records pertaining to Mr Proberts. A statement was taken from Mr Proberts' brother.

At the request of counsel assisting, Dr Anne-Louise Swain, an independent medical practitioner from the Queensland Health Clinical Forensic Medicine Unit, examined Mr Proberts' medical records from AGCC and PAH and reported on them. Her findings are detailed below.

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

# The Inquest

An inquest was held in Brisbane on 3 November 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from the investigating police officer, Detective Sergeant Andy Seery. Submissions were received from Counsel Assisting and the represented parties.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

# The evidence

## *Personal circumstances and correctional history*

Mark William Proberts was born on 22 January 1961 in Gympie, the eldest of 6 children. He was educated in Brisbane and worked for Queensland Rail and in other short term jobs. In 1985 he was injured in a serious fall on a building site. His family consider that the idleness and boredom that resulted from this injury led to a life of drugs, alcohol and anti-social behaviour.

Mr Proberts' criminal history was comprised of offences associated with alcohol use. It appears to have worsened from 2010. In November 2012 Mr Proberts was imprisoned for the twelfth time. The head sentence was five months though he was released a short time later on parole. A public nuisance offence on New Year's Day 2013 appears to have led to the revocation of this parole, and on 8 January 2013 Mr Proberts was returned to AGCC to serve the remaining months of his November 2012 sentence.

Medical records tendered at the inquest show that Mr Proberts was medically assessed on arrival and the following day commenced treatment for ulceration to his feet. It was known that he had a long history of alcohol abuse and suffered from chronic diabetes, liver disease and hypertension.

Mr Proberts saw a doctor on 14 January 2013 who recommended twice weekly changes to the dressings on his foot ulcers. This was commenced on 17 January 2013, as per the management plan. On 22 January 2013 Mr Proberts refused to attend the medical centre as scheduled. He again refused the following day which prompted a 'case discussion' involving medical and nursing staff. It was agreed that Mr Proberts would be encouraged to attend the medical centre every three days for the dressings on his feet to be changed, though not forced to do so in the short term.

## *Transfer to PAH*

On 29 January 2013 Mr Proberts attended the AGCC medical centre complaining that he felt sick. He looked very unwell to the medical staff and they promptly called an ambulance which transported Mr Proberts to PAH.

On arrival at PAH Mr Proberts was diagnosed as being septic. Triple antibiotic therapy was commenced while investigations took place to identify the source of the sepsis. On 30 January 2013, Mr Proberts was transferred to the Intensive Care Unit and appeared to show some improvement. Blood cultures identified the specific bacteria responsible for the sepsis and the antibiotic treatment was changed to penicillin.

Mr Proberts was experiencing abnormal heart rhythms but refused to have an electrocardiogram and then refused to take his prescribed medication. He was transferred to the coronary care unit on 2 February 2013 where his health remained precarious. He suffered chest pains from 3 February 2013 and on 5 February 2013 a repeat echocardiogram identified mitral valve vegetation and severe mitral valve regurgitation. An ultrasound of the liver was suggestive of cirrhosis.

That evening he suffered further chest pain and an ECG indicated ischaemia, possibly due to an embolic event. In the context of the severe endocarditis and likely cirrhosis it was agreed that Mr Proberts was not suitable for "active invasive" treatment.

Despite treatment over the following 24 hours Mr Proberts' condition deteriorated. Further assessment indicated that he was unlikely to survive surgery and he died at 9:15pm on the evening of 6 February 2013.

## *Autopsy results*

An external autopsy examination was carried out on 8 February 2013 by an experienced forensic pathologist, Dr Philip Storey.

A post mortem CT scan was conducted. Samples of blood were taken and subjected to toxicological analysis. This revealed drugs expected to be prescribed during hospital treatment and all were at therapeutic levels.

Dr Storey examined the PAH records and the offender medical files from AGCC. He noted that bruising on the body corresponded to sites of medical intervention consistent with the treatment described.

Dr Storey noted that the site of infection was not immediately apparent when Mr Proberts arrived at PAH. The echocardiogram showed vegetation on the mitral valve consistent with infective endocarditis. Dr Storey explained:

> "*A particularly ominous form of embolism occurs when a fragment or fragments break off and access the coronary arteries....When infective vegetations embolise into these vessels, there is the potential for an acute heart attack. This is what did eventually occur in this man and was responsible for the symptoms he experienced from 03/02/2013 onwards…"*

Dr Storey issued a certificate listing the cause of death as:

> *1(a) Acute coronary syndrome*
> *1(b) Coronary artery embolus*
> *1(c) Infective endocarditis*
>
> Other significant conditions:
>
> 2. *Coronary atherosclerosis; chronic liver disease*

### *Medical Review*

The medical records pertaining to Mr Proberts were sent by counsel assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Anne-Louise Swain.

Dr Swain submitted a report which was tendered at the inquest. In it she summarises some of the more significant aspects of Mr Probert's medical treatment at both AGCC and PAH. In her opinion the medical care provided at both facilities was appropriate in the circumstances. Dr Swain noted that Mr Proberts had refused medical and nursing assistance on a number of occasions. She agreed with the assessments conducted at the time to the effect that Mr Proberts was competent to make such decisions.

## Conclusions

I conclude that Mr Proberts died from natural causes. I find that none of the correctional officers or inmates at AGCC caused or contributed to his death.

I am also satisfied, based primarily on the opinion of Dr Swain (and in the absence of any criticism) that the medical care provided to Mr Proberts prior to his death was adequate and appropriate.

## Findings required by s. 45

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. 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 Mark William Proberts.

**How he died** - Mr Proberts suffered from multiple chronic health conditions affecting the major organs. These were managed by medical staff at Arthur Gorrie Correctional Centre where he was incarcerated. He was hospitalised a week prior to his death with a history of vomiting and diarrhoea. Investigations showed that he had contracted infective endocarditis. A segment of the vegetations formed by the endocarditis dislodged and travelled into the coronary artery. This led to acute coronary syndrome that could not be treated due to the other serious health problems suffered by Mr Proberts.

**Place of death** – He died at the Princess Alexandra Hospital, Buranda in Queensland.

**Date of death** – He died on 6 February 2013.

**Cause of death** – Mr Proberts died from acute coronary syndrome caused by coronary artery embolus and infective endocarditis.

## *Comments and recommendations*

Section 46, insofar as it is relevant to this matter, provides that a coroner may 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.

Nothing has arisen on the evidence tendered at this inquest which warrants such comment.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
3 November 2014