QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Gerry Maxwell COOPER**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2010/1574
DELIVERED ON:	7 December 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	7 December 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Mr Peter De Waard
Queensland Corrective Services:	Ms Fiona Banwell
Queensland Health:	Ms Julie Farr (instructed by Minter Ellison Lawyers)

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The *Coroners Act 2003* (the Act) provides in s 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 Mr Gerry Maxwell Cooper. 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

Mr Cooper was a 57 year old Aboriginal man when he died at the Princess Alexandra Hospital (PAH) on the morning of 12 May 2010. At the time of his death, and for the preceding 23 years, Mr Cooper was a prisoner in the custody of Queensland Corrective Services (QCS).

Mr Cooper had a significant medical history, including liver failure, ischemic heart disease and chronic renal failure. As a result of his chronic renal failure, Mr Cooper was required to undergo regular haemodialysis (dialysis) at the PAH Secure Unit.

At times, Mr Cooper was abusive to medical staff and difficult to manage. He frequently refused recommended medical care, including dialysis, which resulted in complications requiring medical attention.

At the time of his death, Mr Cooper had been an inpatient at the PAH Secure Unit for 29 days. He was admitted suffering an ischemic stroke and intermittent confusion as a result of hepatic encephalopathy.

During Mr Cooper's admission, he suffered two falls. After his last fall it was decided, in consultation with Mr Cooper's family, on 5 May 2010, to withdraw dialysis, commence palliative care and implement a 'not for resuscitation' (NFR) order. Mr Cooper subsequently continued to deteriorate. On 12 May 2010, Mr Cooper was found in his room within the Secure Unit of the PAH without life signs and he was pronounced deceased at 6:50am.

These findings:

- confirm the identity of the deceased person, when, where and how he died and what caused his death; and

- consider the adequacy, at the time of Mr Cooper's death and currently, of the policies and procedures in place at the Secure Unit of the PAH, with respect to the management of patients at risk from suffering injury due to a fall.

QPS investigation

Mr Cooper's death was reported to the Corrective Services Investigation Unit (CSIU). A member of that unit, Detective Sergeant Stephen Carr conducted

an investigation into the circumstances surrounding the death and later compiled a detailed coronial report dated 20 March 2011.

The investigating CSIU officers attended the PAH and arranged for the co-ordination of a Police Photographic Officer and a Police Scientific Officer to take photographs and examine the scene. They obtained statements from various medical and QCS employees, and interviewed the six inmates from the PAH Secure Unit.

Detective Sergeant Carr noted that Mr Cooper had previously raised concerns about his treatment by QCS staff and the priority of treatment he was offered by the PAH Secure Unit. He noted that these concerns were investigated by the Ethical Standards Unit (ESU) at the time and the allegations were found to be unsubstantiated.

Detective Sergeant Carr concluded there were no suspicious circumstances surrounding the death of Mr Cooper and it was considered that he died as a direct result of his medical condition, which he had been suffering for an extended time. He found there were no issues with the care and treatment provided to Mr Cooper.

The QPS investigation report was tendered at the inquest and considered as part of these findings. I am satisfied the QPS investigation was thorough and professionally conducted.

QCS investigation

Pursuant to the *Corrective Services Act 2006*, the Chief Inspector of QCS appointed an internal and external inspector to carry out an investigation into the death of Mr Cooper.

The inspectors formed the view that Mr Cooper was generally non-compliant with his medical treatment and displayed very poor behaviour towards medical and custodial staff at the PAH Secure Unit and Wolston Correctional Centre (WCC). They found that Mr Cooper was frequently critical of his care however, they did not identify any issues with his care. They found that Mr Cooper's concerns had been sufficiently addressed on each occasion.

The inspectors concluded that Mr Cooper died of natural causes on 12 May 2010; the management of Mr Cooper was appropriate in all the circumstances; the PAH and WCC staff and management's response to the incident was timely and appropriate; and all actions taken were consistent with policy and procedure.

The QCS investigation report was tendered at the inquest and considered as part of these findings. The QCS investigation was thorough and professionally conducted.

The inquest

An inquest was held in Brisbane on 7 December 2012. All of the statements, records of interview, medical records, photographs, and materials gathered during the investigation were tendered at the inquest.

The CSIU primary police investigator, Detective Sergeant Stephen Carr; the Acting Clinical Nurse Consultant, Falls, PA Hospital, Ms Louise Griffiths, and the CFMU reviewer, Dr Adam Griffin, gave evidence at the inquest. Mr De Waard proposed that no further oral evidence be heard subject to objection from any other party. My office had been in contact with Mr Cooper's next of kin, explaining that Mr De Waard would make this submission. No objection was received to the proposed course from any party and I agreed that the evidence tendered was sufficient for me to make the requisite findings.

The evidence

Social history

Prior to being incarcerated, Mr Cooper had a history of drug and alcohol abuse. At the time of Mr Cooper's incarceration on 10 May 1996, he was a single man. Mr Cooper had a close relationship with his elderly mother, who resided in a nursing home in Victoria. Mr Cooper's mother passed away shortly prior to Mr Cooper's final admission to the PAH.

Mr Cooper was one of eight children. However, it appears Mr Cooper was only in regular contact with his youngest sister and next of kin, who is a health worker at the Bowen Hospital. Mr Cooper's sister was aware her brother was suffering from kidney failure and that he required regular dialysis. She cannot remember any time when Mr Cooper complained about his treatment when he was receiving medical care in the WCC or the PAH.

In August 2006, Mr Cooper reported that he was regularly visited by the Cherbourg elders and Brisbane elders and saw them as his external support network. He also said he had support from a member of the Church of Jesus Christ and received a monthly subscription magazine from the Church.

During his most recent hospitalisation at the PAH Secure Unit prior to his death, Mr Cooper did not have any family or friends visit. However, the Aboriginal and Torres Strait Islander (A&TSI) Liaison Officer consulted with Mr Cooper during his hospitalisation.

Criminal history

Mr Cooper had an extensive criminal history, with convictions dating back to 1981. On 17 December 1987, Mr Cooper was sentenced to a period of imprisonment of just over 16 years for a range of serious offences. Due to a number of offences whilst in custody and on parole, he had been in custody for over 23 years at the time of his death.

Mr Cooper became eligible for parole on 22 September 2009 and his full time discharge date was 22 April 2014.

The South Australian Department of Corrective Services had requested that Queensland Corrective Services notify them prior to Mr Cooper's release. This was due to Mr Cooper's alleged escape from Mobilong Prison in South Australia in 1994. Mr Cooper was a person of interest and was to be returned to South Australia at the completion of his sentence in Queensland.

Medical history

Prior to his death, Mr Cooper had an extensive medical history with a number of co-morbidities. His medical records from the PAH amount to 14 volumes and his QCS medical records amount to seven volumes.

Dr Stuart McDonald, the Medical Director of the PAH Secure Unit confirmed Mr Cooper had a comprehensive medical history which included: long standing Chronic Renal Failure requiring three weekly dialysis; Hepatitis C; Alcoholic Liver Cirrhosis; Hepatocellular Carcinoma; Hepatic Encephalopathy; Type 2 Diabetes Mellutis; Ischaemic Heart Disease; and a recent Cerebro-Vascular Accident (Stroke).

Mr Cooper's chronic health history dates back sometime. There is evidence Mr Cooper underwent four vessel cardiac artery bypass surgery in March 2002 and that despite being a Type 2 Diabetic, he required the daily administration of insulin. Mr Cooper commenced dialysis in or around January 2006. A potential donor offered his kidney to Mr Cooper in or around August 2007 but Mr Cooper was deemed medically unfit for transplantation due to his significant coronary artery disease.

Mr Cooper had a history of depression and was well known to Prisoner Mental Health Services. In January 2001, Mr Cooper was described by a psychologist as potentially suffering from a significant personality disorder with narcissistic and psychopathic features.

As at 10 July 2009, it was reported by the PAH Emergency Department that Mr Cooper was well known with 178 admissions and numerous presentations to the Emergency Department for chest pain.

Non-compliance and behavioural issues

Mr Cooper frequently refused dialysis, which would result in fluid overload, causing chest pain. He also frequently refused hospitalisation, treatment and medications recommended by medical staff. His voluminous medical records are littered with numerous 'Refuse to Accept Medical Advice/Treatment' reports and examples of him missing or refusing to attend for dialysis.

In terms of his final admission to the PAH prior to his death, medical records indicate that Mr Cooper would often ignore instructions from nursing staff designed to mitigate the risk of him falling.

Mr Cooper also had a history of breaches of discipline and threats made against medical staff and other prisoners.

On 11 January 2010, the PAH Secure Unit Nursing Unit Manager attempted to put in place a 'Health Management Plan' with Mr Cooper to achieve a common understanding in terms of their behavioural expectations and the possible consequences of his behaviour during dialysis treatment. Although nursing, psychiatrist and psychologist notes confirm that Mr Cooper understood the effect his behaviour was having on staff, other patients and his treatment, Mr Cooper refused to sign the Management Plan and claimed that he was being discriminated against. A copy of the plan was left in the dialysis room each day Mr Cooper attended dialysis.

One of Mr Cooper's treating nurses, Ms Noor reported that although his behaviour escalated for two to three sessions after the plan was implemented, the verbal abuse, yelling and kicking stopped and they did not have to take any further action.

I am satisfied that the implementation of a Health Management Plan in the circumstances was appropriate and did not adversely impact on the care and treatment provided by the PAH to Mr Cooper.

Complaint by Mr Cooper

On 7 January 2010, Mr Cooper submitted a hand written complaint to the Director of Health – Department of Community Corrections. Mr Cooper alleged he was being racially discriminated against because other non-aboriginal inmates at the PAH Security Unit had received dialysis before him. He alleged he was being verbally abused and racially vilified by a Corrective Services Supervisor at the PAH Security Unit and that he had been ordered to remove his red/black/yellow (aboriginal) necklace. Mr Cooper was seeking to cease dialysis at the PAH and suggested that he go to the Ipswich or QEII hospitals.

Mr Cooper's complaint triggered a chain of events for the management of Mr Cooper, and investigations by Queensland Health and QCS were commenced. The Deputy Commissioner of QCS requested a risk assessment of Mr Cooper to be undertaken as a priority. This request resulted in Mr Cooper being placed on constant observations in the WCC Detention Unit for a period of eight days on 20 January 2010.

On 25 February 2010, Queensland Health provided a response to Mr Cooper concerning his complaints. They advised Mr Cooper that his treating medical team at the PAH Security Unit categorically denied the allegations. The letter also referred to the management plan developed to assist in delivering care to Mr Cooper.

On 16 March 2010, the Deputy Commissioner of QCS acknowledged Mr Cooper's letter and on 13 April 2010, the Director of the ESU wrote to Mr Cooper seeking additional information concerning his allegations.

On 16 June 2010, a memorandum was prepared by the Principal Investigator from ESU to the Director of ESU recommending closure of the ESU file as the complaints could not be substantiated.

I am satisfied the Queensland Health and QCS investigations into the complaint made by Mr Cooper were satisfactory and Mr Cooper's allegations regarding the quality of his health care were unsubstantiated.

Care at WCC and AGCC Health Unit

Mr Cooper has been in a number of different correctional centres throughout his incarceration. In May 2005, he was transferred from the Townsville Correctional Centre to WCC.

As a result of difficulties in continuing to manage Mr Cooper at the WCC due to his complex health needs, whenever Mr Cooper was unwell and requiring more nursing care than could be provided at the WCC, he was transferred to the Arthur Gorrie Correctional Centre (AGCC) Health Unit.

Mr Cooper was allocated a full time carer at WCC due to his chronic illness and incapacity, however, his carers changed frequently as he either requested a change or the carer resigned.

I am satisfied, based on Mr Cooper's medical records, supporting witness statements, and investigation reports, that Mr Cooper's care and treatment at both the WCC and AGCC Health Unit was adequate and appropriate.

Admission to the PAH prior to death

Mr Cooper was admitted to the PAH Secure Unit on 12 April 2010 with what was thought to be a further episode of hepatic encephalopathy. However, following a CT Scan of the brain, he was diagnosed with an ischemic stroke and commenced on Asasantin (anti platelet drug).

On 14 April 2010 at approximately 9.45pm, Mr Cooper had a fall in which he sustained a laceration above his left eyebrow. This was attended to and sutured. He was assessed to have no new neurological symptoms and was placed on regular neurological observations overnight.

On 18 April 2010, Mr Cooper had a further incident which may have been a fall. He reported to a nurse that his legs had given way while he was using the toilet. Mr Cooper was not injured as a result.

On 29 April 2010, during a ward round, it was suggested Mr Cooper may benefit from palliative care due to a poor prognosis.

On 30 April 2010, Dr Frazier, the renal consultant, noted fluctuating levels of confusion and noted concern regarding resuscitation issues. The medical records concerning the plan of care state: *1. Discuss with pt family (sister next week); 2. Not for Resus – see ARP; 3. Cont. Dialysis*.

On 2 May 2010 at approximately 10.45pm, Mr Cooper had a further fall. He was reviewed by a medical officer who records that nursing staff advised the patient was on the toilet after being assisted there by two nurses but he did not alert them when he was finished. He was found on the bathroom floor with

a decreased level of responsiveness. The medical records state: 1*. Ct Head – exclude bleed – d/w radiology reg. happy to proceed – will r/v results & d/w renal reg; 2. hourly neuro obs overnight; 3. To call code if any deterioration…;4. Close Observation overnight*. The nurse caring for Mr Cooper says she was unaware that Mr Cooper had got out of bed and gone to the toilet and that prior to this he had been compliant by following instructions (i.e. he was to request assistance to mobilise).

The fall resulted in a small left 3x8mm frontal subdural haematoma extending into the subarachnoid space. The Asasantin was ceased due to the intracranial bleeding. Surgical intervention was not warranted. A message was left with Mr Cooper's next of kin (his sister) to advise her of his condition. The doctor reviewed the security tape concerning Mr Cooper's fall and states: *was sitting on commode for at least 30 minutes – stood up and appear to reach out for privacy wall – he then fell sideways to the ground - ?syncopal following sitting on toilet – opening bowels*.

As a result of the third fall, 'fall preventative measures' were put in place. This included reducing clutter from the room; using bed rails; placing the bed in a low position; and placing Mr Cooper under constant observation.

On 5 May 2010, Mr Cooper's condition had not improved and Dr Frazier spoke with Mr Cooper's sister. She agreed to a 'not for resuscitation' order, to withdraw dialysis, and for Mr Cooper to commence palliative care.

At approximately 6am on 12 May 2010, Nurses Vandermer, David McConachy and Phillips entered Mr Cooper's room to implement scheduled pressure area care. He was alive and presenting no immediate issues.

At 6.34am on 12 May 2010, Nurse James entered Mr Cooper's room and found he was not displaying any signs of life. CCO Miles and Acting Supervisor Chris Garth were informed. At 6.36am, Nurse James advised that Mr Cooper was deceased. At 6.46am, Dr Enoka Gonsalkorala entered Mr Cooper's room and pronounced him life extinct at 6.50am.

In the 10 days leading up to Mr Cooper's death there had been an 'open door policy' in the PAH Secure Unit, which meant that Mr Cooper's door was left permanently open, enabling nursing staff to access Mr Cooper at will.

The QCS inspectors advise that within a few hours of Mr Cooper's death, the appropriate notifications were made to his next of kin, contact persons, Cherbourg Elders and the indigenous Chaplain by the Acting Assistant General Manager of WCC. The Aboriginal and Torres Strait Islander Legal Service (ATSILS) was notified of Mr Cooper's death by Detective Sergeant Carr.

Autopsy results

An autopsy was carried out by a forensic pathologist, Dr Katherine Urankar, on 14 May 2010. This incorporated an external examination, toxicological testing, a clinical chart review and a full body CT scan of the deceased.

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

> *1(a) Hepatic encephalopathy*
> *1(b) End stage liver failure*
> *1(c) Alcoholic cirrhosis*
>
> *Other significant conditions:*
> *2. End stage renal failure, diabetic nephropathy, ischaemic heart disease, coronary atherosclerosis, hypertension.*

Conclusions

I conclude Mr Cooper died from natural causes and no other person caused or contributed to his death. I am satisfied the care provided to Mr Cooper by the PAH, the WCC and the AGCC was adequate and appropriate in the circumstances.

There is no evidence that any injury sustained when Mr Cooper fell while at the PAH contributed to his death pathologically. Rather, it was suggested that as a result of the injuries sustained, members of the treating team assumed he would deteriorate to a terminal stage faster than otherwise would have been the case and this influenced their decision to withdraw life sustaining measures and to move to palliation.

However, Mr Cooper's medical records indicate that on 29 April the medical officer on the renal round raised the prospect of palliation, given Mr Cooper's co-morbidities and poor prognosis. Palliation was again raised on 30 April by Dr Frazier on his ward round as Mr Cooper's condition was deteriorating.

It was not until after Mr Cooper's fall on 2 May 2010, that palliative care was implemented. However, it was likely to have been implemented at or around the same time, notwithstanding his fall. His general condition had deteriorated to such a stage the dialysis was of limited benefit.

I am satisfied that whilst Mr Cooper's fall and subsequent head injury on 2 May 2010 may have contributed to clinical decision making with respect to his further treatment, that process was already underway and would have been implemented at about the same time in any event.

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 in relation to the other aspects.

Identity of the deceased – The deceased person was Gerry Maxwell Cooper.

How he died – Mr Cooper died of natural causes while a prisoner in the Princess Alexandra Secure Unit.

Place of death – He died at Buranda in Queensland.

Date of death – He died on 12 May 2010.

Cause of death – Mr Cooper died as a result of hepatic encephalopathy, end stage liver failure, alcoholic cirrhosis, end stage renal failure, diabetic nephropathy, ischaemic heart disease, coronary atherosclerosis, and hypertension.

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.

The only prevention issue which the facts of this case bring into focus is the management of falls risk among hospital patients.

At the time of Mr Cooper's last admission there was a PAH procedure entitled 'Falls Assessment, Identification and Treatment' in place. I have considered the oral evidence of Ms Louise Griffiths, the Acting Clinical Nurse Consultant, Falls, at the PAH and Dr Adam Griffin from the CFMU, regarding the adequacy of that policy and the associated procedures.

I conclude that procedure was largely adequate however, there were some minor deficiencies in its terms and application.

For example, a definition of what constituted a 'fall' was not readily accessible within the policy; and daily falls risk assessments were not always recorded or thoroughly completed. Further, the definition of what constituted a 'low', 'medium' or 'high' risk of falls was not explicitly set out and little guidance was given as to how it should be assessed.

The procedure has been reviewed and amended since Mr Cooper's death. The current PAH falls policy and procedures can be found within the PAH Procedure Manual entitled 'Falls Assessment, Identification and Treatment' (Procedure No. 01309/v3/10/2012), a form entitled 'Falls Risk Management Plan' and another form entitled 'Post Fall Clinical Pathway'. This is now a standardised process implemented across the PAH.

I consider the improvements included in the new set of procedures largely address the deficiencies of the previous regime.

I am satisfied a comprehensive regime of training has been implemented to familiarise nursing staff with its requirements.

Accordingly, I do not consider any comment from me in relation to these issues is necessary.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
7 December 2012