OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Edward Arthur Anthony RAWLINS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR2010/1299
DELIVERED ON:	01 June 2011
DELIVERED AT:	Brisbane
HEARING DATE(s):	18 May 2011
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Department of Community Safety:	Ms Fiona Banwell

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The *Coroners Act 2003* provides in s47 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 Edward Arthur Anthony Rawlins. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Edward Rawlins had spent more time in custody than anyone else in Queensland when he died at the age of 81 on 17 April 2010. He suffered deteriorating health in the early months of 2010 and had been hospitalised on several occasions. At the time of his death he was accommodated in a special needs unit at Wolston Correctional Centre (WCC) and was being assisted in his daily routine by another prisoner. His death brought to an end more than 54 years of continuous imprisonment.

These findings

- confirm the identity of the deceased person, 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 needs 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

Mr Rawlins' death was reported to the Corrective Services Investigation Unit (CSIU) and the investigation carried out by Detective Senior Constable Greg Lucre.

Senior Constable Lucre travelled to WCC with other CSIU officers and QPS forensics and photographic officers. They arrived at Mr Rawlins' cell two hours and 45 minutes after his death. In the interim, Queensland Corrective Service (QCS) staff secured the cell and recorded a log of events. Senior Constable Lucre was satisfied with the arrangements put in place by QCS staff and I am content the integrity of evidence at the scene was maintained. The QPS officers conducted a thorough examination of Mr Rawlins' cell. That cell was sealed off as a crime scene pending the outcome of the autopsy examination.

All records relating to Mr Rawlins were seized from WCC together with rosters, transfer forms and plans relating to the unit where Mr Rawlins was accommodated. Medical records from the Princess Alexandra Hospital and

the Queensland Ambulance Service (QAS) were later obtained and provided to the Office of the State Coroner. Details of Mr Rawlins' criminal and custodial history were also supplied by Senior Constable Lucre.

Statements were obtained from corrective service officers (CSO's), prison medical staff and other prisoners who had dealt with Mr Rawlins in the lead up to his death.

Mr Rawlins' body was transported to the Queensland Scientific Services Centre where a post mortem examination was conducted. Samples were taken for histological and toxicological testing. A QPS photographer recorded this process.

I find the investigation into this matter was thoroughly and professionally conducted. I commend Detective Senior Constable Lucre for his efforts.

The Inquest

An inquest was held in Brisbane on 18 May 2011. Mr Johns was appointed as counsel to assist me with the inquest. Leave to appear was granted to the Department of Corrective Services and Queensland Health.

All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

Mr Rawlins' sister was notified of the inquest and, while requesting a copy of these findings, did not raise any issues of concern on behalf of the family of the deceased.

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.

Custody

On 29 December 1955 Mr Rawlins fatally strangled an 11 year old girl after luring her to an isolated area near The Strand in Townsville. The attack was sexually motivated.

As recently as 2009, after more than half a century in prison and aged 80, Mr Rawlins was denied parole on the basis he posed an unacceptable risk to the community. He had refused to undertake prison based sexual offender programs and a 2005 psychological assessment found he was a high risk of recidivism if released from custody.

Medical history and treatment

Mr Rawlins was housed in Residential Accommodation block 13A of WCC in the period leading up to his death. This block caters specifically for those prisoners requiring constant care and assistance in attending to even basic

needs such as eating and personal hygiene. The practice is for an able bodied prisoner, in this case an inmate called Simon Von Pearson, to be assigned as a carer to the other infirmed prisoners in that block.

Prison transfer records show multiple transfers over the latter years of his life from the low security facility at Palen Creek to WCC ostensibly for the purpose of receiving medical care. Medical records tendered at the inquest show Mr Rawlins had suffered multiple strokes including a large left middle cerebral artery territory infarct in 2006 that left him wheelchair-bound and with some right sided paralysis.

In the years leading up to his death Mr Rawlins suffered from Chronic Obstructive Airways Disease, Peripheral Vascular Disease, Atrial Fibrillation, asthma, hypertension, reflux and Diabetes Mellitus. In addition to his previous strokes he also had a history of myocardial infarct. He was taking 11 different medications on a regular basis.

In the period from December 2009 to April 2010 Mr Rawlins had multiple admissions to the Princess Alexandra Hospital secure unit for a variety of complications arising from his chronic conditions. These included urinary tract infection, unexpected drug reactions, chest infections and multiple episodes of rapid Atrial Fibrillation.

His last period of hospitalisation was from 2 to 8 April 2010. The hospital records provided to the inquest do not raise any concerns as to the adequacy of the care provided to Mr Rawlins. The event leading to his death, while not unexpected, was sudden and causally linked to the very narrow lumens in three of his coronary arteries. There is no evidence to suggest his death might have been prevented by different medical treatment, nor that the medical treatment he did receive was otherwise deficient or inappropriate.

Events leading to death

On the evening of 16 April 2010 Mr Rawlins was locked in his cell at 6:15pm as was usual. Mr Von Pearson noted Mr Rawlins was already in his bed at this time, again this being consistent with usual practice. Mr Von Pearson conducted several checks of the infirm prisoners during the evening, the last being at 11:30pm. He says he observed Mr Rawlins moving and grunting in his sleep at that time.

At 6:10am on the next morning Mr Von Pearson took a cup of tea to Mr Rawlins. He says Mr Rawlins acknowledged this and Mr Von Pearson left the room. At 6:30am Mr Von Pearson returned to cell 5 where Mr Rawlins was housed with the intention of giving him a shower. He noted Mr Rawlins was too weak to pull himself up by the handle suspended over the bed. He then attempted to roll Mr Rawlins over to change his incontinence pad but Mr Rawlins was too weak to assist. Mr Von Pearson left the room to have a cigarette while he considered his options.

One option was to wait until 7:30am when the door to the unit was unlocked and assistance would be available to help move Mr Rawlins. After a short

period, though, Mr Von Pearson decided to have another attempt at rolling Mr Rawlins by himself and returned to cell 5. He noted Mr Rawlins was not responsive despite his eyes being open. Mr Von Pearson returned to his room and notified CSO's via the intercom. He did this in the form of calling a 'code blue' which signifies a medical emergency and four CSO's responded. Two nurses also responded to the code blue, attending the cell a short time later. As the CSO's began assembling the Oxyviva equipment they were advised by the nurses that any resuscitation attempt would be futile. The observations conducted by the two nurses indicated there was no sign of life.

QAS records show they were contacted at 7:05am and ambulance officers arrived at WCC at 7:12am and were with Mr Rawlins at 7:18am. It was clear to them after an initial examination that Mr Rawlins was deceased and no resuscitation was attempted.

Autopsy results

An autopsy examination was carried out on 20 April 2010 by an experienced forensic pathologist, Dr Urankar. After considering toxicology and histology results she stated in her report:

> *Arcus senilis (a white ring around the iris of the eyes) were noted suggesting underlying coronary artery disease. This was confirmed on examination of the heart with severe narrowing of the lumen of all three major coronary arteries supplying blood and hence vital oxygen to the heart. This would have led to sudden death.*

Dr Urankar also found evidence of previous strokes while conducting a specialist neuropathological examination. She said this would account for the right-sided paralysis experienced ante-mortem.

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

> *1(a). Coronary atherosclerosis*
>
> Other contributory findings:
>
> *2. Emphysema; Hypertension; Diabetes Mellitus.*

Investigation findings

No information obtained from other prisoners was inconsistent with the account of Mr Rawlins' death as given by Mr Von Pearson.

Toxicology results were consistent with the contents of the prescribed medication taken by Mr Rawlins. No illicit drugs or alcohol were present.

No signs of trauma were noted on the body of the deceased. No signs of a struggle or anything indicating involvement in the death by a third party were detected at the scene.

Conclusions

I find that Corrective Services staff appropriately followed “death in custody” and medical emergency protocols. Corrective Services staff and Queensland Ambulance Service paramedics did all within their power to provide assistance to Mr Rawlins although the circumstances meant that was very little. Treatment was carried out in an appropriately timely manner.

A comprehensive police investigation has been conducted into this death in custody. The investigation, coupled with the autopsy, reveal Mr Rawlins passed away relatively suddenly from the acute effects of his coronary atherosclerosis while in his cell at WCC. There is no evidence of violence or the involvement of another person in the death.

The autopsy report of Dr Urankar provides sufficient evidence to find the death was sudden and unexpected. There is no suggestion therefore that CSO’s or medical staff at WCC should have conducted themselves any differently.

Findings required by s45

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 Edward Arthur Anthony Rawlins
How he died -	Mr Rawlins died of natural causes while he was a prisoner being held in a correctional centre.
Place of death –	He died whilst in the custody of the Department of Corrective Services at Wolston Correctional Centre, Wacol.
Date of death –	He died on 17 April 2010.
Cause of death –	Mr Rawlins died from natural causes, namely coronary atherosclerosis.

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.

I find that none of the correctional officers or inmates at Wolston Correctional Centre caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr Rawlins, who passed away

suddenly from natural causes. I am satisfied the care afforded to Mr Rawlins by staff at the Princess Alexandra Hospital in the months prior to his death was adequate and appropriate.

In those circumstances there is no basis on which I could make any preventative recommendations.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
1 June 2011