QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Edgar Hugh Sandow (aka Conlon)**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2021/3246
DELIVERED ON:	5 July 2023
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 May 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes.

REPRESENTATION:

Counsel Assisting:	Ms Jessica Lambert
West Moreton Health:	Ms Prudence Fairlie
Metro South Health:	Ms Myla Ruttan
Queensland Corrective Services:	Ms Josephine Villanueva
ATSILS:	Ms Angela Taylor

Contents

Introduction 1
The investigation 1
The inquest 1
The evidence 2
Circumstances of the death 5
Autopsy results 6
Conclusions 7
Findings required by s. 45 8
    Identity of the deceased 8
    How he died 8
    Place of death 8
    Date of death 8
    Cause of death 8
Comments and recommendations 9

Introduction

1. Edgar Hugh Sandow[1] (also known as Conlon) was aged 75 years at the time of his passing on 17 July 2021 at the Princess Alexandra Hospital Secure Unit (PAHSU).

The investigation

2. The investigation into Mr Sandow's passing was led by Plain Clothes Senior Constable Joshua Barlow of the Corrective Services Investigation Unit (CSIU).

3. After being notified of the passing PCSC Barlow attended the PAHSU. Police observed no signs of trauma to Mr Sandow, and made no observations which suggested the death was suspicious. Mr Sandow had minor marks on his arms covered with band aids, which appeared consistent with routine medical care. There was no medical equipment attached to Mr Sandow, and no personal property in the room.

4. Photographs of the scene and the body were taken a Police Scenes of Crime officer. A statement of formal identification was completed by Correctional Supervisor Warren, who had known Mr Sandow for about five years.

5. Police obtained CCTV recordings which depicted events relating to the care of Mr Sandow on 17 July 2021 from 17:00 hours to 23:59 hours as well as correctional and medical staff response to the Code Blue in relation to Mr Sandow. A review of these recordings did not reveal any issues of concern.

6. A direction for a targeted coronial investigation was issued by the Coroners Court. This included seeking medical records, interviewing the next of kin about any concerns, and obtaining statements from relevant medical staff and custodial correctional officers. A Coronial Report was prepared and provided to the Coroners Court in July 2022.[2]

7. PCSC Barlow conducted a thorough investigation in response to the targeted direction. He concluded that there were no suspicious circumstances surrounding Mr Sandow's passing, and he was provided with appropriate care and treatment while incarcerated. He also considered that the death was not preventable.

The inquest

8. At the time of his passing, Mr Sandow was a prisoner in custody under the *Corrective Services Act 2006*. As Mr Sandow's passing was a 'death in custody' an inquest was required by the *Coroners Act 2003*.

9. The inquest was held at Brisbane on 17 May 2023. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence. No witnesses were called to give oral evidence.

[1] Mr Sandow's daughter asked that he be referred to as Sandow. He was also known as Kimble Freeman.
[2] Ex A5.

10. The issues considered in the inquest were the findings required by s45(2) of the *Coroners Act 2003,* together with suggested recommendations under s 46 of the Act proposed by ATSILS. I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal History

11. Mr Sandow was a First Nations man who had lived at Wujul Wujul and other communities in far North Queensland. His daughter said that he was an artist who had travelled widely across Australia before he was imprisoned.

12. Mr Sandow had a three-page criminal history commencing in 1961.[3] His history consistent mostly of property offending, with convictions for stealing and unlawful use of a motor vehicle. He was sentenced to his first term of imprisonment in 1964 for unlawful use of a motor vehicle. He was subsequently convicted of offences such as breaking and entering, wounding, assaults, going armed in public, and animal cruelty.

13. On 9 September 2006, Mr Sandow was arrested for very serious historical sexual offences involving children. This offending spanned 10 years and commenced in 1980 when he was aged 34. He pleaded guilty in the Cairns District Court the week before trial was due to commence and was sentenced on 14 counts. One count was later quashed in the Court of Appeal.

14. Mr Sandow was sentenced on 15 May 2008 in the Cairns District Court for nine counts of rape, one count of assault occasioning bodily harm, and three counts of carnal knowledge against nature. He was initially placed at Lotus Glen Correctional Centre before being moved to Townsville Correctional Centre. He was transferred to Wolston CC on 18 February 2011 and remained there until his passing at the PAHSU on 17 July 2021.[4]

15. Mr Sandow's correctional history included minor breaches of discipline and non-compliance.[5]

16. Mr Sandow had a significant medical history with multiple comorbidities, and was being treated for the following:[6]

    - End stage kidney disease (haemodialysis 3x per week)
        - Secondary to diabetic nephropathy and hypertension
        - Anaemia of chronic renal disease
    - Brachio-cephalic fistula stenosis requiring regular angioplasty/fistuloplasty (every 3 months)
    - Idiopathic Thrombocytopaenic Purpura
    - Ischaemic Heart Disease
        - Acute Myocardial Infarction with stent insertion in 2003
        - Mitral, tricuspid and aortic valve disease
    - Atrial Fibrillation

[3] Queensland Criminal History.
[4] Movement History.
[5] Breach Incidents Contravention History pg. 69, 209.
[6] Ex B3, Statement of Dr Pidgeon [9]; PAH medical records.

- Cholecystitis with choledocholithiasis (gallstones)
  - Managed with cholecystostomy and pig tail drainage from January 2014 until July 2016
  - Endoscopic Retrograde Cholangiopancreatography ('ERCP'), sphincterotomy and biliary stent insertion in July 2016
  - ERCP, removal of gallstones and removal of stent in October 2016
  - Laparoscopic cholecystectomy in July 2018
- Left subclavian/brachiocephalic thrombus, on warfarin
- Hypertension
- Type 2 Diabetes Mellitus
- Depression
- Anxiety
- Macular degeneration
- Chronic obstructive airway disease
- Gastro-oesophageal reflux disease
- Inguinal hernia
- Cataracts
- Chronic Hepatitis B

17. Mr Sandow was taking the following medications:[7]

- Aspirin, isosorbide mononitrate, and bisoprolol for heart disease
- Calcitriol and cinacalcet for calcium levels
- Coloxyl with senna for constipation
- Iron injection during dialysis
- Magnesium for muscle cramps
- Novasource renal and Sustagen as supplements
- Pantoprazole for reflux
- Perindopril for blood pressure
- Sertraline for anxiety and depression
- Umeclidinium-vilanterol, salbutamol, and ipratropium inhalers for Chronic Obstructive Airways Disease.

18. The Australia and New Zealand Dialysis and Transplant Registry records indicate that Mr Sandow commenced peritoneal dialysis on 27 May 2005 in Townsville.[8] This was prior to his arrest and subsequent incarceration. Given his numerous complex medical conditions, following his incarceration Mr Sandow was managed between various specialist teams at the PAH, as well as the primary care team at WCC.[9]

19. From the records provided, it was apparent that he received regular, appropriate, and timely medical treatment throughout his lengthy sentence. His multidisciplinary management included nursing and specialist care, regular hospital admissions, assignment of a prisoner carer, various medical treatments and testing, and referrals to outpatient services when prison services were lacking.[10]

[7] Ex B3, Statement of Dr Pidgeon [10]; PAH medical records.
[8] Ex B1, Statement of Dr Foat [9].
[9] Ex B3, Statement of Dr Pidgeon [12]; PAH medical records.
[10] Ex B3, Statement of Dr Pidgeon.

20. Mr Sandow's records indicate he was the subject of at least eleven Code Blues between March 2011 and March 2021.[11] This was in addition to numerous presentations to the prison health centre and calls for nurse attendance. It is evident from the records that Mr Sandow experienced a steady and consistent decline in health over his period of incarceration as a result of his multiple conditions. In the months prior to his passing, he was observed to be very frail with significant weight loss.[12]

21. An Advanced Resuscitation Plan was discussed with Mr Sandow on 28 April 2021, and it was agreed that the use of cardiopulmonary resuscitation would not be in his best interests.[13]

22. At the time of his passing, Mr Sandow was in the process of applying for exceptional circumstances parole. On 15 July 2021, WMH received a request from the Parole Board seeking a summary of his medical conditions. On that day, a response was prepared by Dr Pidgeon which advised of Mr Sandow's end of life care.[14]

23. Dr Pidgeon expressed concern about the current process of discharging prisoners into alternate accommodation when granted exceptional circumstances parole. She said there was a lack of social work or discharge planning services, and the burden of this work works fell upon nursing staff. Efforts to locate accommodation for Mr Sandow commenced in January 2021 and were ongoing until his last hospitalisation.[15]

24. Dr Pidgeon said a register of vulnerable prisoners had since been developed in the context of Covid-19. An annual health check was also being implemented for those on the vulnerable list. While Mr Sandow's care was centred around dialysis and specialist care at the PAH, this would assist in monitoring frail and infirm prisoners. An interagency project had been established to address the issue of sourcing aged care accommodation in the West Moreton region.

25. Dr Pidgeon also noted that as prisoners are not able to access Medicare subsidised medication, the choices of treatment can be limited due to budget constraints. The cost of certain special access medicines otherwise accessible under the Pharmaceutical Benefits Scheme needs to be met out of local budgets. The outcome may be differential treatment for prisoners. Similar considerations apply to the provision of other services in prison that would be subsidised by Medicare in the community, such as GP services, physiotherapy and occupational therapy.[16]

26. Police engaged with Mr Sandow's adult daughter during the coronial investigation. She provided a draft statement but could not be contacted again.[17]

27. The draft statement from Mr Sandow's daughter reported that she was provided the opportunity to say goodbye to him via videocall on 16 July 2021.[18] She did not have any concerns about his medical treatment in custody. She

[11] Ex B3, Statement of Dr Pidgeon [15] - [156]; Breach Incidents Contravention History.
[12] Ex B1, Statement of Dr Foat[15].
[13] Ex B1, Statement of Dr Foat[15]; Advanced Resuscitation Plan PA60340 DH8INPT 2021 pg. 2.
[14] Ex B3, Statement of Dr Pidgeon [186]; Attachment 1.
[15] Ex B3, Statement of Dr Pidgeon [185].
[16] Ex B3, Statement of Dr Pidgeon, Ex B3.1.
[17] DIC Conlon Final Report pg. 8.
[18] Statement of daughter [24].

acknowledged he had serious renal issues for many years and had been on dialysis, which was why she was opposed to an internal autopsy examination. Mr Sandow's daughter reported she had been kept informed by hospital staff and found the medical team to be helpful.

Circumstances of the death

28. On 12 July 2021, Mr Sandow was transferred to PAH for his routine five-hour haemodialysis. There were no records to indicate he was unwell prior to transfer. Hospital records do note he was lethargic prior to dialysis.[19] Dr Foat was the Nephrology unit registrar and the primary treating doctor involved in Mr Sandow's care during this period.

29. Fifteen minutes into dialysis, after only 150mL of fluid had been ultrafiltrated (i.e., fluid removed on dialysis), Mr Sandow suffered an acute loss of consciousness.[20] He was observed to have slurred speech, drowsiness, hypotension, and unrecordable oxygen saturations.[21] Staff ceased dialysis, administered oxygen therapy, and called for the Rapid Response Team (RRT).[22] Mr Sandow was noted by the RRT to be hypothermic with oxygen saturations of 85%, his Glasgow Coma Score was 10 and blood sugar level 2.1mmol/L. He appeared peripherally shutdown with poor circulation.

30. Treatment was commenced and he was transferred to the Emergency Department, where his blood pressure fluctuated but repeatedly fell, and haematochezia was noted.[23] Examinations were undertaken, including blood tests and CT imaging. There was no evidence of infection and the cause of Mr Sandow's deterioration at this point was uncertain. Dr Lazarus, the consultant medical officer, re-discussed and confirmed Mr Sandow's Advanced Resuscitation Plan with him.[24]

31. On 13 July 2021, Mr Sandow was noted to be in decompensated heart failure with ongoing recurrent hypotension.[25] The decision was made that dialysis should be withheld on the basis that it was unsafe in his current condition. That evening, his case was reviewed by Dr Foat and Dr Lazarus, in consultation with A/Prof Campbell and A/Prof Francis. A provisional diagnosis of shock from a lower respiratory tract infection in the context of heart failure and frailty was made.[26]

32. On 14 July 2021, Dr Foat and Dr Lazarus decided to attempt dialysis as Mr Sandow's blood pressure had improved. On commencement, his blood pressure immediately dropped, and dialysis was ceased. According to Dr Foat, it was clear

[19] Ex B3, Statement of Dr Pidgeon [174]; PA60340 DH8INPT 2021 pg. 98.
[20] PA60340 DH8INPT 2021 pg. 98; Ex B1, Statement of Dr Foat[20].
[21] Ex B1, Statement of Dr Foat[20].
[22] Ex B1, Statement of Dr Foat[20]; PA60340 DH8INPT 2021 pg. 98.
[23] Ex B1, Statement of Dr Foat[21]; PA60340 DH8INPT 2021 pg. 99.
[24] Ex B1, Statement of Dr Foat[22].
[25] Ex B1, Statement of Dr Foat[23].
[26] Ex B1, Statement of Dr Foat[24].

at this point that Mr Sandow was too hypotensive to tolerate any further haemodialysis.[27]

33. After further consultation with Mr Sandow's next of kin, it was determined that end of life care, focusing on symptom relief and comfort, was the most appropriate treatment option. Mr Sandow was subsequently transferred back to the PAHSU for treatment consisting of pain management only.[28] Dr Foat noted that at this stage, Mr Sandow was no longer able to engage in decisions relating to his care.[29]

34. Between 15 July 2021 and 17 July 2021, Dr Foat reviewed Mr Sandow daily to ensure that he was comfortable and receiving appropriate palliative care.[30]

35. On 17 July 2021, Mr Sandow was accommodated within the PAH Secure Unit, with two Custodial Correctional Officers (CCOs) assigned to monitor him. At around 5:20pm, the CCOs observed Mr Sandow's breathing to become heavy, and he was moaning as if in pain.[31]

36. The CCOs alerted PAHSU nurses who immediately attended and attempted to make Mr Sandow comfortable. His breathing was noted to rapidly deteriorate and then cease. The on-call resident, Dr Truong, attended and declared Mr Sandow deceased at 7:00pm on 17 July 2021.[32]

Autopsy results

37. Mr Sandow's adult daughter raised strong objections to an internal autopsy taking place for cultural reasons. She believed it to be unnecessary as she was well informed of Mr Sandow's medical conditions.[33] On 20 July 2021, an external only post-mortem examination was conducted by Forensic Pathologist, Dr Kedziora, at Queensland Health Forensic and Scientific Services.[34]

38. Dr Kedziora reported no injuries to Mr Sandow. Post-mortem CT scan revealed bilateral pleural effusions, severe generalised atherosclerosis, and severely atrophic kidneys. Dr Kedziora noted Mr Sandow's well-documented deterioration of end-stage renal disease on the background of type 2 diabetes mellitus, hypertension, ischaemic heart disease, and chronic obstructive pulmonary disease. Toxicology samples (blood and urine) were taken and held, but not tested.

39. In the circumstances, Dr Kedziora concluded that the cause of death was end-stage renal disease, with hypertension, ischaemic heart disease, and diabetes mellitus listed as other significant conditions.

40. Mr Sandow's treating doctor from PAH, Dr Foat, was given an opportunity to review the Autopsy Certificate. Dr Foat had concluded and remained of the view that heart failure was the disease or condition directly leading to Mr Sandow's

[27] Ex B1, Statement of Dr Foat[25].
[28] DIC Sandow Final Report pg. 5.
[29] Ex B1, Statement of Dr Foat[25].
[30] Ex B1, Statement of Dr Foat[28].
[31] Form 1 pg. 10.
[32] Life Extinct Form.
[33] DIC Sandow Final Report pg. 5; Statement [28]; Supp Form 1.
[34] Form 30 Autopsy Certificate.

death. He considered this occurred in the context of kidney failure, hypertension, ischaemic heart disease, cardiomyopathy, and diabetes mellitus.[35]

41. In response, Dr Kedziora noted that Mr Sandow suffered from more than 15 natural conditions at the time of his death. Many of these conditions were interrelated. He said that in such circumstances, it is often difficult to determine which disease - independently of others - has caused the death, as it is the combination of several pathologies ("combined effect") which at some stage become unmanageable and lead to the final outcome.

42. Dr Kedziora said that towards the end of his life Mr Sandow was dependent on haemodialysis. During his last hospital stay he experienced hypotension at the onset of haemodialysis. This led to the conclusion that haemodialysis was no longer a viable option and led to initiation of end-of-life cares. Mr Sandow died three days later. In this situation, Dr Kedziora interpreted end-stage renal disease as the cause of death because its efficient treatment could not be continued.

43. Dr Kedziora agreed that heart failure may have been the mechanism of hypotension at the onset of haemodialysis. However, intradialytic hypotension may have other causes, including e.g. autonomic neuropathy related to diabetes mellitus. Nevertheless, cardiomyopathy may have been the most important of several conditions responsible for intradialytic hypotension and indirectly the death.

44. In these circumstances the determination whether end-stage renal disease caused the death (when its further treatment became impossible), or whether the condition which made the treatment of end-stage renal disease impossible caused the death (possibly cardiomyopathy, but likely multifactorial) is difficult.

45. In view of the complexity of the situation, Dr Kedziora's opinion was that the underlying cause of death was end-stage renal disease, whereas other diseases contributed to it through various mechanisms.

Conclusions

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

47. It is 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 evidence tendered at the inquest established the adequacy of the health care provided to Mr Sandow when measured against this benchmark.

48. Mr Sandow was suffering from end-stage renal disease, having been on dialysis for many years. As noted by Dr Foat, heart failure in people with kidney disease progressively worsens over time. In Mr Sandow's case, heart failure was not

[35] Ex B1, Statement of Dr Foat[29]-[31].

unexpected when considering his long-term kidney failure and multiple other serious comorbidities.[36]

49. There was a difference of opinion between the Forensic Pathologist and treating doctor regarding Mr Sandow's most likely cause of death. In circumstances where a full autopsy was not conducted, I accept the Pathologist's conclusion that Mr Sandow's ultimate cause of death was end-stage renal disease, with hypertension, ischaemic heart disease, and diabetes mellitus listed as other significant conditions.

50. The primary issue for consideration was whether Mr Sandow had access to, and received, appropriate medical treatment while he was incarcerated. From the medical records and statements provided, I am satisfied that Mr Sandow received regular, timely, and appropriate medical care.

51. Due to the complexity of his conditions, he was managed by specialist teams at PAH with regular reviews by the nursing staff at Wolston CC. His passing was expected and managed according to his ARP.

52. I also note that as a First Nations man, the Cultural Liaison Officer at PAH was regularly engaged in the care and decisions relating to Mr Sandow.[37] Staff were conscientious in providing culturally appropriate care and support, locating his daughter's contact information, facilitating contact with his daughter and other extended family members, and engaging with his daughter and family around care decisions.

Findings required by s. 45

53. 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 am able to make the following findings:

Identity of the deceased – Edgar Hugh Conlon (aka Sandow)

How he died – Mr Sandow was a first nations man who was serving a lengthy prison sentence for serious sexual offences. He had a number of comorbidities. He experienced a steady decline in health in the months preceding his death as a consequence of end-stage renal disease. He died after he had been transferred to the PAHSU for regular dialysis.

Place of death – Princess Alexandra Hospital Secure Unit WOOLLOONGABBA QLD 4102 AUSTRALIA

Date of death– 17 July 2021

Cause of death – 1(a). End-stage renal disease

[36] Ex B1, Statement of Dr Foat[29].
[37] Ex B1, Statement of Dr Foat[27].

Other significant conditions

2. Hypertension, ischaemic heart disease; diabetes mellitus.

Comments and recommendations

54. The concerns expressed by Dr Pidgeon regarding the process of securing alternative accommodation for infirm prisoners did not directly relate to Mr Sandow's health care in custody or his passing. Mr Sandow was not granted parole prior to his passing. However, there was an application in progress and accommodation enquiries were underway.

55. This issue which has been explored in other inquests and has been the subject of coronial recommendations.[38] In the Inquest into the death of Jay Maree Harmer it was recommended that:

> *The Queensland Government comprehensively review the current model for the provision of palliative care to prisoners with a view to improving how and where palliative care is delivered, including the provision of a range of post-release supported accommodation options for infirm prisoners eligible for parole, including exceptional circumstances parole.*

56. ATSILS was given leave to appear in this inquest under s 36(2) of the *Coroners Act.* The following submissions were made by ATSILS in relation to possible coronial recommendations to assist in preventing deaths of elderly and terminally ill prisoners in a custodial setting:

    1. That positions be created for support workers to work with prisoners identified under the interagency aged care accommodation project in West Moreton, the Prison Health Service, Queensland Corrective Services, and other relevant stakeholders.

    2. That a register of accommodation and care facilities be established approved by relevant departments and stakeholders to permit easier transition for these prisoners into more appropriate accommodation.

    3. That relevant departments and stakeholders work towards establishing a memorandum of understanding to facilitate better and more efficient information sharing and collaboration to improve the processes involved with obtaining placements for these prisoners.

57. ATSILS noted that recommendation 150 from the Royal Commission into Aboriginal Deaths in Custody provides that the health care available to prisoners should be of an equivalent standard to that available in the community. The exclusion of prisoners from Medicare limits the services Queensland Health can provide. On occasion, prisoners are unable to access the same medical care and services as they would in the community.

58. The Director of the Officer for Prisoner Health and Wellbeing in Queensland Health, Mr Kraak, provided an update on recommendation one from the Jay Harmer inquest and commented on the matters raised by ATSILS.

[38] Inquest into the death of Jay Harmer; Inquest into the death of Barry Haynes

59. Mr Kraak advised that the Office for Prisoner Health and Wellbeing (OPHW), has developed and published a Statement on the provision of end of life care.[39] This Statement is intended to assist people in prison and community corrections with the identification of substitute decision makers, advanced care planning and to share knowledge about options for palliative care.

60. Mr Kraak said that Queensland Health has examined the long-term options for people in prison who require personal care, including palliative care. Very few providers are willing to provide these services. However, Queensland Health is developing an arrangement with a provider with expertise in aged and palliative care. This provider has been identified as being willing to provide a service outside the custodial environment. The service is expected to be in place in the second half of 2023.

61. With respect to ATSILS proposed recommendation 1, Mr Kraak said that Queensland Health routinely gathers information about people in prison who may be nearing end of life to inform the Parole Board, and to facilitate release and appropriate placement where possible. Clinical staff also provide relevant information to support individual parole applications where required. These processes are intended to ensure that people are supported to access the care that they require in a comparable way to that available in the wider community. Health staff also liaise closely with Queensland Corrective Services staff to find accommodation and care arrangements that best meet the needs of people in custody and in preparation for release.

62. Mr Kraak did not support a register of accommodation and care facilities. He said that Queensland Health is working to develop a solution with a suitable vendor to provide personal care (e.g. assistance with toileting, showering, dressing, mobility) for people in the custody of QCS and has recently undertaken a market scan to identify suitable providers of aged and personal care services for people in prison. This market scan identified very few providers willing to accept people directly from a correctional setting.

63. In relation to the ATSILS proposal for a memorandum of understanding to facilitate better and more efficient information sharing and collaboration to improve the processes involved with obtaining placements for prisoners at suitable accommodation and care facilities, Mr Kraak noted there is an existing Confidential Information Sharing Agreement between the Parole Board and Queensland Health prescribed under regulation.

64. This is underpinned by Operating Guidelines. The guidelines specify the timeframes in which information should be provided to the Parole Board, how requests for information are made by the Parole Board and provide a non-exhaustive schedule of the types of information which may be shared under the Agreement.

65. In addition, Queensland Health established a Memorandum of Understanding with QCS to guide the provision of health services for people in the custody of QCS.[40]

[39] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/service-improvement/offender-health-project/end-of-life-care-prison-community-corrections.pdf
[40] https://clinicalexcellence.qld.gov.au/sites/default/files/docs/priority-area/service-improvement/offender-health-project/prisoner-health-service-mou.pdf

66. Mr Kraak said that Queensland Health will continue to advocate for all prisoners to have full access to the subsidies available via the Medical Benefits Schedule, the Pharmaceutical Benefits Scheme and to appropriate supports under the National Disability Insurance Scheme, noting that the decision rests with the Federal Government.

67. Having regard to the information supplied by Queensland Health in relation to the matters identified by ATSILS, including efforts to secure supported accommodation for infirm prisoners eligible for parole, I do not consider that the circumstances of Mr Sandow's death give rise to any further recommendations or comments in relation to the matters set out under s 46 of the *Coroners Act 2003*.

68. I extend my condolences to Mr Sandow's family.

69. I close the inquest.

Terry Ryan
State Coroner
BRISBANE