QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Shane Anthony May**
TITLE OF COURT:	Coroners Court
JURISDICTION:	ROCKHAMPTON
FILE NO(s):	2022/2139
DELIVERED ON:	16 December 2024
DELIVERED AT:	BRISBANE
HEARING DATE(s):	16 December 2024
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody, multiorgan failure, metastatic lung cancer, palliative care.

REPRESENTATION:

Counsel Assisting:	Ms N Macregeorgos
Queensland Corrective Services:	Ms M Lincez

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Introduction

1. Shane Anthony May was sixty-one years of age when he died in palliative care at the Rockhampton Base Hospital (RBH) on the evening of 11 May 2022. Mr May had been transported from the Capricornia Correctional Centre (CCC), where he was serving a term of imprisonment for historical sexual offences, to the RBH on 6 May 2022. Mr May died of natural causes as a result of multiorgan failure due to metastatic lung cancer.

Coronial jurisdiction

2. At the time of his death, Mr May was a prisoner in custody as defined in Schedule 4 of the *Corrective Services Act 2006* (Qld). As such, Mr May's death is a reportable death under section 8(3)(g) of the *Coroners Act 2003* (Qld) (the Act) as it is a '*death in custody*'.

3. *Death in custody* is defined in section 10 of the Act to include the death of a person who died while detained under the authority of an Act of the State

4. In cases such as this, an inquest is mandatory pursuant to s27(1)(a)(i) of the Act. An inquest is intended to provide the public and, most importantly, the family of the deceased, with transparency regarding the circumstances of the death, and to answer any questions which may have been raised following the death.

5. The role of the coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death – how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability. Those are matters for other courts.

6. The relevant standard of proof is that of the balance of probabilities, with reference to the *Briginshaw*[1] standard. Accordingly, the more significant the issue for determination, the clearer and more persuasive the evidence must be for the coroner to be sufficiently satisfied on the balance of probabilities that the issue has been proven:

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*[2]

7. In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[3] As outlined in 'The Australasian Coroners Manual':

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in*

[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.
[2] *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J).
[3] Findings of the inquest into the death of Pasquale Rosario Giorgio, [140] – [142].

> *hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation.*
> *…*
> *Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.*
> *…*
> *Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[4]

The investigation

8. The investigation into Mr May's death was led by Detective Senior Constable Jason O'Halloran of the Queensland Police Service (QPS) Corrective Services Investigation Unit.

9. After being notified of the passing on 6 May 2022, Senior Constable Matt Dominick from North Rockhampton Police Station, attended the Medical Ward of the RBH.

10. Senior Constable Dominick attended upon Bed 3, where he observed Mr May to be laying supine on the bed. A cannula was attached to the left arm of Mr May, as well as a small bandage covering a previous wound from a syringe. No injuries or marks inconsistent with medical treatment were identified.

11. On 12 May 2022, I made a direction for a targeted police investigation to occur. A Coronial Investigation Report was prepared and provided to the Coroners Court on 1 November 2023.

12. Detective Senior Constable O'Halloran conducted a thorough investigation in response to the direction. He concluded that there were no suspicious circumstances surrounding Mr May's death, and Mr May was provided with appropriate care and treatment while incarcerated.

The inquest

13. The inquest was held in Brisbane on 16 December 2024. 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. Counsel Assisting proceeded to submissions on the investigation material in lieu of any oral evidence.

14. The issues considered at the inquest were the issues required by s 45(2) of the Act, and whether Mr May had access to, and received appropriate medical care, while he was in custody.

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

[4] Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (The Federation Press, 2015) 10.

The evidence

Social and Medical History

16. Mr May was born on 20 December 1960 in Merredin, Western Australia. When he was approximately six years of age, he was placed in a boys' home, where he reportedly suffered physical abuse. Mr May was educated to a year nine standard and went on to complete an apprenticeship as a baker.

17. Mr May worked a number of jobs throughout his lifetime, including as a fisherman and a sawmill worker. In 1995, he obtained qualifications in Workplace Health and Safety, and worked as an assessor for a commercial builder and more recently, for Blue Care.

18. In or around 1983, Mr May fathered a child, a daughter. Mr May did not maintain a close relationship with this child during her younger years.

19. In or around 1989, Mr May met Julie May, whom he went on to marry in the early 1990s. Together, they had two daughters. Mr May's daughter from a previous relationship came to reside with Mr and Mrs May and their children in the late 1990s.

20. Mr May had a history of smoking approximately twenty packs per year, however he quit in 2010. He consumed alcohol occasionally and was allergic to penicillin.

21. In 2014, Mr May underwent chemotherapy and radiation therapy for tongue cancer.

22. In 2020, Mr May had a stage one melanoma removed from his back.

23. On 24 March 2022, Mr May was convicted of two counts of sexual assault of a child the Rockhampton District Court after a trial by jury.

24. Mr May was sentenced to a head sentence of three years imprisonment for the first count, and two years and six months imprisonment for the second count, to be served concurrently, with a parole eligibility date of 24 September 2023.

25. Mr May had a number of comorbidities, including:

    (a) Hypothyroidism;
    (b) Hypertension;
    (c) Dyslipidaemia;
    (d) Depression, with a previous incident of self-harm.

26. Whilst incarcerated at the CCC, Mr May was prescribed the following medications:

    (a) Amlodipine 5mg tablet mane;
    (b) Ezetimibe 10mg tablet nocte;
    (c) Fenofibrate 145mg tablet nocte;
    (d) Levothyroxine 100mcg tablet and 50mcg tablet (total 150 mcg) mane;
    (e) Liothyronine 10 mcg (half-tablet) mane;
    (f) Loperamide 2mg capsule twice per day when required;
    (g) Metoclopramide 10mg tablet twice per day when required;

(h) Pantoprazole 40mg tablet mane; and
(i) Rivaroxaban 15mg tablet twice per day; and
(j) Mirtazapine 30mg.

27. Mr May was received into the CCC on 28 March 2022, however his reception assessment was delayed due to him testing positive for COVID-19. As a result, he was placed in isolation.

28. While in isolation, Mr May's COVID-19 symptoms worsened and on 2 April 2022, the Visiting Medical Officer (VMO) was consulted and Mr May was prescribed oral antibiotics, an anti-emetic and antidiarrhea medications.

29. On 3 April 2022, Mr May's cough, nausea and diarrhea had not improved. Mr May was observed to appear weaker, was breathing heavier, and he advised that he was unable to eat and drink properly as a result of the nausea and diarrhoea. Given this, nursing staff consulted the Medical Officer and it was advised that Mr May should be transferred to hospital. Accordingly, Mr May was transferred to the RBH via Queensland Ambulance Service (QAS) at approximately 1150 hours.

30. Mr May was admitted to the RBH and a number of investigations were carried out, including blood tests, urine tests, an electrocardiogram, a chest X-Ray and a chest CT scan with contrast. Mr May was provided intravenous fluids and antibiotics (to continue upon his return to CCC). Results from the chest X-Ray noted:

> *A fairly well-defined rounded up slightly irregular density in left upper zone is suggestive of a mass lesion. Slightly rounded lobulated appearance of left hilum suggests lymphadenopathy. These lesions need further assessment with CT chest.*[5]

31. The CT scan was undertaken, which identified, *"…an enlarged mediastinal node in the prevascular region measuring 1.9 cm*" and, *"…a 6.1 x 5.5 opacity noted in the left upper lobe posteriorly with lobulated borders. This was not present on the prior study, and the appearances are concerning for a primary bronchogenic malignancy*".[6] It was recommended that Mr May undergo a CT lung biopsy to determine whether the nodules were metastatic or non-small cell or small cell lung cancer, to which he consented. It was also recommended that he undergo a CT scan of his brain, abdomen and pelvis due to his previous history of cancer.

32. On 4 April 2022 at approximately 1630 hours, Mr May returned to the CCC. It was noted that no discharge summary or handover was received from the RBH. He stated that he was still feeling nauseous and coughing, and nursing staff advised him that his COVID-19 symptoms would take some time to resolve. Mr May understood this, and nursing staff ordered his continuing oral antibiotic.

33. On 7 April 2022, the discharge summary was received from the RBH and Mr May was scheduled as a matter of priority to attend the nurse-led clinic the following day.

34. On 8 April 2022, Mr May was cleared to leave isolation and the reception process was re-commenced. Mr May's vitals were taken, he underwent an ECG and a

[5] Exhibit E1 – PHS Records - Part 1, 84.
[6] Exhibit E1 – PHS Records – Part 1, 83.

psychological assessment. Due to Mr May's history of tongue cancer, he was referred to the dentist for a clean and check-up (Category 2). He was also referred as Category 1 to the VMO as a result of the recent lung findings.

35. On 11 April 2022, Mr May failed to attend the scheduled VMO clinic. As a result, he was re-listed for another appointment.

36. On 15 April 2022, Mr May attended the nurse-led clinic, however refused to undergo pathology testing, stating that he did not require it. He signed a refusal form confirming this. He did, however, request Sustagen as he reported feeling lethargic. Mr May was advised to discuss this with the VMO when he was next reviewed.

37. On 18 April 2022, Mr May attended the VMO clinic where he was reviewed by Dr Sheraz Dost. His medical history was noted, Sustagen was charted and Dr Dost advised that he would follow up with the RBH respiratory clinic in relation to the lung biopsy. Mr May also consented to pathology being collected on this occasion.

38. On 21 April 2022, a Code Blue Medical Emergency was called after Mr May was found on the floor of his cell coughing and complaining of excessive fatigue. His vitals were taken and it was recorded that his blood pressure was 128/89, pulse rate was 113 and oxygen saturation levels were 99%. A Rapid Antigen Test was performed and returned a negative result for COVID-19. Mr May was transferred to the health centre and ECG was performed which returned an abnormal result. The VMO was consulted and requested that Mr May be transferred to the RBH Emergency Department (ED) via QAS.

39. At approximately 1900 hours, Mr May was admitted to the RBH. He again underwent investigations including an electrocardiogram, pathology (including T3 and tumour markers), a CT pulmonary angiogram, and a CT scan of his brain and abdomen with contrast, which revealed a provoked segmental right pulmonary embolism. The CT scan of the brain and abdomen revealed a liver lesion and possible sigmoid lesion. Mr May was commenced on Clexane and indefinite Xarelto (to prevent clots from enlarging or forming). His Crestor tablets were withheld following deranged liver function results and after improving clinically, Mr May was discharged on 22 April 2022, with a CT guided lung biopsy scheduled to occur on 13 May 2022.

40. Upon discharge, Mr May was accommodated in the CCC medical unit for observation as he stated that he was still feeling unwell. He returned to his cell the following day after requesting to return to his usual accommodation.

41. On 30 April 2022, Mr May presented to the health centre with shortness of breath and fatigue. He complained of a rash on his lower legs and feeling nauseous and vomiting after meals. It was also recorded that Mr May had lost nine kilograms of weight in two months. Accordingly, he was accommodated in the medical unit for observations and was scheduled for review with the VMO the following day.

42. The Prison Health Service records indicate that Mr May remained in the CCC medical unit until 6 May 2022, when he was reviewed by the VMO and it was advised that he be transferred to the RBH for further management.

Circumstances of Death

43. At 1428 hours on 6 May 2022, Mr May was admitted to the Medical Ward at the RBH under the care of Dr Kieth Tiong. During the entirety of his admission, two Custodial Correctional Officers (CCOs) remained present with Mr May. Mr May presented with left-sided abdominal pain that was radiating to his back, which would reportedly increase on movement and palpation. He also complained of intermittent dizziness and was observed to be fatigued and jaundiced.

44. On review, he also complained of shortness of breath, his heart racing and having vomited twice that day. Dr Camila Moreira formed the initial impression that Mr May may have been suffering from sepsis, with an abdominal infection most likely the source. The following treatment plan was formulated:

    (a) Mr May to undergo pathology (including blood cultures and blood and urine testing);
    (b) Mr May to undergo a chest X-RAY and an abdominal CT scan;
    (c) Mr May to be provided intravenous fluids and antibiotics (as per the sepsis pathway);
    (d) Mr May to be administered ondansetron and 25mcg of fentanyl.

45. Results from the abdominal CT scan revealed extensive hepatic metastatic disease, with an enlargement of the liver since the previous CT scan on 22 April 2022. The colon showed signs of diverticular disease, including muscle hypertrophy within the sigmoid. Mr May's lower chest demonstrated lymphadenopathy associated with the primary malignancy identified on 21 April 2022. The radiologist opined a progression of Mr May's liver metastases since April, presumed to be secondary to the bronchogenic malignancy.

46. Mr May was reviewed by the Medical Registrar at approximately 2100 hours, where it was assessed that his presentation (extensive pain, jaundice and blood results) was in keeping with acute liver failure secondary to liver metastases with a severely poor prognosis. The Registrar discussed Mr May's condition with Dr Shiromeli who advised that:

    (a) Mr May was suffering from an aggressive progression of disease;
    (b) He was unlikely to have benefit from discussing care with a tertiary centre for transfer; and
    (c) Biochemical and liver metastases between bordering on palliation.

47. They also agreed to withhold hepatoxic medications and consider administering Vitamin K to Mr May.

48. Mr May was updated in relation to the results and was advised that his prognosis was guarded and he may deteriorate very quickly. It was explained to Mr May that analgesia would accelerate hepatic dysfunction/failure but there was little other option to control his metastatic pain. Mr May acknowledged the risk and advised that he would rather be comfortable and not in pain. It was recorded that Mr May was amicable to be palliated if he deteriorated and wanted his wife to be updated. The following treatment plan was formulated:

    1. *VBG to track progress;*
    2. *Oxycodone, morphine as needed;*
    3. *Consider liver screen (but low utility tomorrow);*
    4. *Cease lincomycin (hepatoxicity);*
    5. *Withhold rivaroxaban, ezetimibe, amlodipine;*
    6. *If deteriorates, will be for palliation;*

7. *IV fluids.*[7]

49. On this date, Mr May completed an Acute Resuscitation Plan (ARP) which outlined that in the event of an acute deterioration or critical event, he consented only to ward-based cares, IV fluids and antibiotics. Mr May did not consent to ICU level care, including mechanical ventilation, CPR, defibrillation or METs.

50. Mr May's condition continued to deteriorate between 7 May to 9 May 2022; he was complaining of increasing pain, had periods of being hypotensive and was unable to tolerate food due to vomiting. He suffered confusion as to time and later to orientation.

51. On 10 May 2022, the treating team had a discussion with Mr May and his next of kin and it was agreed that they would commence care of the dying pathway. As such, Mr May's scheduled lung biopsy was cancelled, and all interventions but for oxygen therapy was discontinued. Mr May was commenced on a syringe driver to control his pain, shortness of breath and secretions. Mrs May was approved to attend the hospital and visit Mr May.

52. On 11 May 2022, Mr May was again visited by his wife. Later that afternoon at approximately 1447 hours, Mr May signed paperwork to apply to the Parole Board of Queensland for Exceptional Circumstances Parole.

53. At approximately 1715 hours, CCOs Steven Baker and Matthew Bradshaw observed Mr May shaking and his breathing slow. They informed nurses, who, in turn, attended upon Mr May and informed doctors.

54. Dr Binod Guatam attended upon Mr May; proof of life checks were undertaken and at 1740 hours, Mr May was declared life extinct.

Next of Kin Concerns

55. As part of the coronial investigation, Mr May's wife provided a statement to QPS on 31 May 2022. Mrs May did not raise any concerns in relation to her husband's treatment by Correctional staff or medical staff, and stated the following:

> *16. Shane was not at the Capricornia Correctional Centre for that long and I had no problems with the way he was treated by Correctional Staff while he was there, he was treated well by the medical staff at the Correctional Centre and Hospital Staff at the Rockhampton Hospital as well.*
>
> *17. I know Shane had no concerns in the Correctional Centre and while he was there, he was safe and looked after well.*[8]

Forensic Medicine Queensland Preliminary Opinion

56. While the next of kin did not raise any concerns, a preliminary opinion was sought from Dr Ian Home, Senior Forensic Physician and Acting Director of Forensic Medicine Queensland (FMQ), to determine whether the short delay in obtaining

[7] Exhibit E2 – PHS Records – Part 2, p 31.
[8] Exhibit B6 – Statement of Julie May, paras 16 – 17.

the CT scan would have been outcome changing for Mr May, and whether any delay would have caused or hastened his death.

57. On 20 August 2024, Dr Home provided his preliminary opinion to the Court. He stated that:

> *The timeline indicates Mr MAY passed away within 44 days of his incarceration.*
>
> *On 04/04/22 Mr MAY underwent a CT scan that showed a likely lung cancer. On 21/04/22 he underwent further imaging that revealed liver metastases. Further imaging performed roughly two weeks later showed progression.*
>
> *Once a suspicious lesion is identified, there is a workup and specialist referral process that should ideally occur within 2-4 weeks depending on associated symptoms.*
>
> *Given the short interval it is highly likely Mr MAY was suffering metastatic disease at the time of his incarceration. Earlier confirmation and commencement of treatment (if he were amenable) would likely not have altered the outcome in this case.*
>
> *Whilst we don't know the type of lung cancer, metastatic non-small cell lung cancer has just a 7% survival rate at 5 years.*[9]

58. Dr Home concluded that he, "*…did not believe a delay of less than three weeks to obtain additional imaging was outcome changing in this case*".[10]

59. I accept the opinion of Dr Home.

Autopsy results

60. On 18 May 2022, Dr Beng Ong conducted an autopsy consisting of an external examination of the body, full body CT scan and a review of the medical records. The CT scan showed, "*…a prominent lobulated opacity in the left upper lobe of the lung consistent with the site of primary lung cancer"* and, "*Increased opacity of the lung fields with features suggestive of chronic obstructive pulmonary disease*".[11]

61. Dr Ong concluded that the cause of death was:

> *1(a) Multiorgan failure, due to, or as a consequence of*
> *1(b) Metastatic lung malignancy (suspicious of bronchogenic carcinoma left lung).*[12]

Conclusions

62. After considering the material gathered in the coronial investigation, I am satisfied that Mr May died from natural causes. I find that none of the inmates,

[9] Exhibit G3 - Email dated 20 August 2024 at 11:08am from Dr Ian Home.
[10] Exhibit G3 - Email dated 20 August 2024 at 11:08am from Dr Ian Home.
[11] Exhibit A5 – Autopsy Report, 3.
[12] Exhibit A5 – Autopsy Report, 5.

correctional or health care staff at the RBH or the CCC caused or contributed to his death. There were no suspicious circumstances.

63. 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.[13] Mr May had been regularly reviewed by health practitioners in the CCC and had been admitted to the RBH and reviewed by medical staff. His passing was expected and the final stages of his illness were managed in accordance with his ARP in consultation with his family.

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

Findings required by s. 45

65. I am required to find, as far as possible, the medical cause of death, who the deceased person was and when, where and how he came to 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 – Shane Anthony May

How he died – Mr May was serving a term of imprisonment for sexual offences. At the time of his death, he had only been in custody for forty-four days. Mr May had a number of comorbidities, including hypothyroidism, hypertension and dyslipidaemia, as well as a previous history of cancer.

Upon his receipt into custody, Mr May tested positive for COVID-19, was placed into isolation and prescribed oral antibiotics, amongst other things. Despite treatment, he did not improve and was transferred to the RBH via QAS on 3 April 2022. During his admission, investigations identified an enlarged mediastinal node and an opacity in the left upper prevascular region and an opacity in the left upper lobe posteriorly. Mr May was to undergo a CT lung biopsy to determine whether the nodules were metastatic or non-small cell or small cell lung cancer, as well as a CT scan of his brain, abdomen and pelvis due to previous history of cancer.

[13] *Human Rights Act 2019* (Qld), s 37; *Reducing barriers to health and wellbeing: The Queensland Prisoner Health and Wellbeing Strategy 2020-2025.*

	Mr May returned to the CCC, was later cleared to leave isolation and underwent his reception process. His condition did not improve throughout April and by early May 2022, was admitted again to the RBH for further management due to complaints of shortness of breath, fatigue, nausea, vomiting and reported weight loss. During this admission, investigations revealed extensive hepatic metastatic disease. His presentation was in keeping with acute liver failure, secondary to liver metastases with a severely poor prognosis. In light of the findings, a decision was made in consultation with his next of kin to commence palliation. Mr May died of natural causes.
Place of death –	Rockhampton Base Hospital, 2 Canning Street, Rockhampton QLD 4700 AUSTRALIA
Date of death –	11 May 2022
Cause of death –	Multiorgan failure, *due to, or as a consequence of* metastatic lung cancer (suspicious of bronchogenic carcinoma left lung).

Comments and recommendations

66. Section 46 of the Act enables a coroner to 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.

67. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in the future, or that otherwise relate to public health or safety or the administration of justice.

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

69. I close the inquest.

Terry Ryan
State Coroner
BRISBANE