QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Desmond George Buckby**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/4533
DELIVERED ON:	26 May 2026
DELIVERED AT:	BRISBANE
HEARING DATE(s):	26 May 2026
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody.

REPRESENTATION:

Counsel Assisting:	Margeaux Dillon
Metro South Hospital and Health Service:	Courtney Coyne
Queensland Corrective Services:	My Khuu

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Introduction

1. Desmond George Buckby was 74 years of age when he died at the Princess Alexandra Hospital ('**PAH'**) on the evening of 7 September 2022. Mr Buckby had been transported to the PAH on 24 August 2022 from the Wolston Correctional Centre ('WCC'), where he was detained under a continuing detention order under the *Dangerous Prisoners (Sexual Offenders) Act* 2003, after showing signs of a stroke. Mr Buckby received blood thinning therapy (thrombolysis) on arrival, however made no significant recovery from the stroke and eventually received palliative care after consent was provided by the Public Guardian. Autopsy confirmed Mr Buckby died of natural causes due to a left cerebral ischaemic stroke and cerebral arterial cardioembolism.

Coronial jurisdiction

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

3. In cases such as this, an inquest is mandatory pursuant to s27(1)(a)(i) of the Act.

4. An inquest is intended to provide the public and 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.

The investigation

6. An investigation into Mr Buckby's death was completed by Detective Senior Constable Penelope McEwen of the Queensland Police Service Crime and Intelligence Command.

7. Detective Senior Constable McEwen provided a report to the coroner dated 31 December 2023, which detailed the circumstances of Mr Buckby's custodial history, medical history, his death, and witness statements collected for the purpose of the investigation.[1]

8. Detective Senior Constable McEwen noted the autopsy findings which confirmed that Mr Buckby died from the stroke and concluded in her report that Mr Buckby was in palliative care at the time of his death, and it was highly unlikely that his death was preventable. She further concluded, on the basis of the reports provided by the treating clinicians, that Mr Buckby appeared to have been treated satisfactorily and adequately whilst in custody.[2]

[1] Exhibit A6 – QPS Coronial Report, p 5.
[2] Exhibit A6 – QPS Coronial Report, p 5-6.

The inquest

9. The inquest was held at Brisbane on 26 May 2026. All statements, medical records, reports 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.

10. The issues considered at the inquest were the issues required by s 45(2) of the Act.

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

The evidence

Social and Custodial History

12. Mr Buckby was born on 23 September 1947 and had been in continuous detention since 2007. Little is known of Mr Buckby's pre-custodial history due to his minimal engagement with mental health services in the course of his imprisonment, and estrangement from family and friends since his incarceration in 2004.[3] Mr Buckby had reported to QCS staff that he was in the Australian Army for five years, and had completed three tours of duty in Vietnam.[4] He further reported that he had served in the Corps of Engineers and Royal Australian Electrical Mechanical Engineers (RAEME) and had been awarded an Infantry Combat Badge for his time in combat.[5]

13. Mr Buckby had a long criminal history dating back to 1974 when he was convicted of stealing.[6] His sexual offending began in 1981, and continued with multiple convictions of sexual offending against children (*unlawful carnal knowledge and a range of indecent treatment of a child under 12 offences, indecent treatment offences and offences of attempting to and administering a drug for the purpose of a sexual act)* from 1990.[7]

14. In relation to 1995 offences, Mr Buckby was sentenced to 7 years imprisonment (following an appeal) and was released in 2003. In 2004 Mr Buckby offended against children again and received a head sentence of four years.[8]

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[3] Exhibit B3 – Statement of Andrea Stephens, page 2. Note that the OPG statement in this regard does not provide the source of this information, however, it is consistent with reports made by Mr Buckby's brother and daughter when they were notified of his death (as detailed in QPS documents).
[4] This account is supported by the statement from the OPG however, no records are provided.
[5] Exhibit D4 – IOMS Case Note History, p 3.
[6] Exhibit A6 – QPS Coronial Report, p 3.
[7] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139.
[8] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [5].

15. Mr Buckby was released in 2007 on a supervision order, and, within a matter of months he was taken back into custody after being found with five children under the age of 16 in his unit.[9] As a consequence of that offending, the supervision order was rescinded and an order was made that Mr Buckby be detained in custody for an indefinite term for control, care and treatment pursuant to the provisions of the *Dangerous Prisoners (Sexual Offenders) Act 2003*.[10]

16. The continuing order was reviewed annually pursuant to section 27 of the Act,[11] and, at those reviews it was noted that Mr Buckby had continued to demonstrate minimal insight into his offending and had 'repeatedly reiterated that he had not offended'.[12] In a 2018 review, the Court noted a psychiatrist's opinion that due to Mr Buckby's cognitive decline, should he be released on a supervision order, he would not be able to recall or comply with the conditions of such an order.[13] The Court further noted that Mr Buckby could therefore only be released to a closely supervised and supported aged care facility which was not available.[14]

17. Accordingly, the order was affirmed on each occasion and Mr Buckby continued to be subject to the continuing detention order at the time of his death.[15]

18. In the course of WCC attempting to progress referrals for Mr Buckby to be assessed by the Aged Care Assessment Team whilst he was still in custody, the matter was referred to the Queensland Civil and Administration Tribunal (QCAT) for a determination of his capacity. QCAT found that Mr Buckby had impaired capacity and the Public Guardian was appointed as guardian for Mr Buckby on 4 May 2021.[16]

19. On 15 September 2021, guardianship orders were made for the following matters:

    a. Accommodation.
    b. Provision of Services.
    c. Legal matters not relating to financial or property matters.
    d. Health care to request and obtain clinical assessment and records, including any matters in relation to material required for 'my aged care'.[17]

[9] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [9].
[10] *Attorney-General for the State of Queensland v Buckby* [2007] QSC 370.
[11] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [1].
[12] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [15].
[13] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [37].
[14] *Attorney-General for the State of Queensland v Buckby* [2018] QSC 139 at [40].
[15] Exhibit D2 – Intelligence Profile – p 2.
[16] Exhibit B3 – Statement of Andrea Stephens, page 1.
[17] Exhibit B3 – Statement of Andrea Stephens, page 1.

Medical History

20. Mr Buckby's medical history included hypercholesterolaemia, hypertension, Post Traumatic Stress Disorder, paroxysmal atrial fibrillation, neurocognitive disorder, and prior pericarditis.[18] As of 8 August 2022, Mr Buckby's medications included:[19]

    a. *Pantoprazole 20mg daily (gastro-oesophageal reflux disease)*
    b. *Paracetamol 1g TDS PRN (pain relief)*
    c. *Hydroxocobalamin 1mg 3 monthly (vitamin B supplement)*

Care in custody

21. In 2016, Dr Lars Madsen, Forensic and Clinical Psychologist, provided a report to the QCS High Risk Offender Management Unit ('HROMU') detailing the psychological treatment Mr Buckby was receiving in relation to cognitive assessments. That report indicated that at the time Mr Buckby '*struggl[ed] significantly with his memory'.* Dr Madsen's ultimate opinion was that Mr Buckby '*likely suffers cognitive impairment, possible dementia*'. [20]

22. On 13 October 2021, Mr Buckby was reviewed in the Nurse Practitioner clinic for medication noncompliance. At that time, Mr Buckby denied he had any health issues, and it was noted he had 'very bad memory'. It was reinforced by the nurse practitioner that he needed to take his regular medications and the risks of not taking his medications were explained.[21]

23. On 21 October 2021, Mr Buckby was reviewed by Dr Crystal Pidgeon for medication noncompliance. Mr Buckby reported that "*I don't need meds, nothing wrong with me".*[22] Dr Pidgeon reviewed Mr Buckby's regular medications and ceased his amlodipine, metoprolol and aspirin, noting there was no clear indication for these. Mr Buckby agreed to continue taking his statin at a lower dose, and a plan was made for weekly blood pressure, repeat bloods and review in 2-3 months.[23]

24. On 2 May 2022, Mr Buckby was reviewed by the PHS after complaining of dizziness and confusion. It was queried whether statin should be commenced and it was noted that risks of CVD (cardiovascular disease) were discussed with Mr Buckby, including risk of MI (myocardial infarction) and stroke. Despite this, Mr Buckby was 'not keen' to start medications.[24]

25. Mr Buckby was transferred to the PAH on 20 May 2022 for increased confusion. He was returned to WCC that same day.[25]

[18] Exhibit B2 – Statement of Dr Nadeem Siddiqui, p 2.
[19] Exhibit C2- Medical Records, p 83.
[20] Exhibit C2- Medical Records, p 18.
[21] Exhibit C9- Prison Health Service records, p 58.
[22] Exhibit C9- Prison Health Service records, p 59.
[23] Exhibit C9- Prison Health Service records, p 59.
[24] Exhibit C9- Prison Health Service records, p 64.
[25] Exhibit C9- Prison Health Service records, p 69.

26. On 3 June 2022, Mr Buckby was referred to the Geriatrics service at the PAH for review and opinion regarding possible diagnosis of dementia. It was noted that he had been observed as increasingly confused/ disoriented by corrections staff over the preceding months, and that an MRI brain performed in mid-2021 showed no cause for confusion.[26]

27. On 9 July 2022, nursing staff were approached by Mr Buckby's carer expressing concern over Mr Buckby's behaviour at night. It was noted that he was for medical review for deterioration and also awaiting review by geriatrics.[27]

28. Mr Buckby was reviewed by medical staff on 14 July 2022, where Mr Buckby reported that he was 'completely well'. It was noted that nursing staff reported that Mr Buckby was forgetting to attend to take medications. The treating doctor noted that Mr Buckby's cardiovascular ('CVD') risk was 20% and queried why statin had been ceased. It was noted he had a high risk for deterioration/ increased CVD risk. A plan was made to restart statin and it was noted Mr Buckby was agreeable to this. There was also a plan for monitoring of blood pressure and consideration of antihypertensives.[28]

29. Mr Buckby presented for his medications on two occasions following that appointment, however, following 25 July 2022, he refused, reporting '*there is nothing wrong with me'*.[29]

30. On 8 August 2022, Mr Buckby was reviewed by Dr Paul Varghese, geriatrician, and the impression was that Mr Buckby had mild to moderate Alzheimer's dementia. It was suggested that Mr Buckby would '*likely need lifelong care.*' He was discharged from the geriatric clinic.[30]

31. Throughout the course of 2022, Mr Buckby also had two attendances on medical practitioners at the WCC and PAH in relation to suspicion of upper gastrointestinal bleeding, following instances of reported dark coloured or 'coffee ground' vomits. On each occasion, he was assessed to have no evidence of gastrointestinal bleeding and was treated with pantoprazole and discharged back to WCC for investigation as an outpatient. [31]

Events of 24 August 2022 to 7 September 2022

32. On 24 August 2022 at approximately 10:15 AM, WCC staff were informed by Mr Buckby's carer that Mr Buckby was lying on the floor and having trouble getting up.[32] Following a period of 10 minutes of not being seen by other inmates,[33] Mr Buckby was found with a GCS [Glasgow Coma Scale] of 13 and severe weakness on his right leg.[34]

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[26] Exhibit C2- Medical Records, p 10.
[27] Exhibit C9- Prison Health Service records, p 72.
[28] Exhibit C9- Prison Health Service records, p 74.
[29] Exhibit C9- Prison Health Service records, p 74 – 75.
[30] Exhibit C2- Medical Records, page 84.
[31] Exhibit B2 – Statement of Dr Nadeem Siddiqui, p 4 – 5; Exhibit C2 – Medical Records, pp 90, 98.
[32] Exhibit D8 – WCC Medical Emergency Records, page 1.
[33] Exhibit C5- Medical Records, page 36.
[34] Exhibit C9- Prison Health Service records, p 75.

33. Queensland Ambulance Service arrived at the centre at 10:40AM in response to a category 2 call made at 10:25AM.[35] Mr Buckby was transported to the PAH at 11:15AM and was assessed in the emergency department ('ED') at approximately 12:00 PM.[36] He was noted to be alert but confused with a GCS of 14 and a right sided facial droop and limb weakness. He was reviewed by an ED consultant.[37] Mr Buckby was then updated to a 'Code Stroke'[38] at 12:15 PM and was reviewed by the stroke team at 12:20PM before undergoing a CT Scan of his brain.

34. The stroke team, led by a Neurologist, determined that Mr Buckby met criteria for thrombolysis at 13:00 PM, and alteplase was given with the stroke team in attendance at 13:25 PM[39] with an infusion commencing immediately afterward.[40]

35. Mr Buckby was observed in the ED before being transferred to the ward under the stroke team that afternoon. The neurologist noted in his assessment of Mr Buckby that the Next of Kin should be advised of the severity of the stroke and the expected outcomes, and further noted that he would advocate for ward-based cares only with no provision of ICU admission/ventilation, to be re-reviewed on the basis of clinical recovery from the stroke.[41]

36. The neurologist reviewed Mr Buckby that evening and noted that there was a minimal improvement in his stroke symptoms.[42] The formal diagnosis of the stroke was noted to be a L) ICA occlusion and L) MCA M1 occlusion.[43]

37. On 26 August 2022 Mr Buckby was reviewed by the General Medicine team at the request of the stroke team for consideration of 'take-over of care'.[44] The General Medicine Registrar noted that Mr Buckby would require extensive rehabilitation, and that he was declined by the Geriatric and Rehabilitation Unit ('GARU')[45] for rehabilitation due to his incarcerated status. It was noted that ongoing rehabilitation would have to be provided by General Medicine as this was the 'only feasibly [sic] option currently'.[46]

38. On 27 August Mr Buckby developed a fever and was reviewed by the on-call resident, who commenced IV antibiotics after discussing the case with the on-call registrar and stroke SMO.[47] The antibiotics (Piptaz) were prescribed for a presumption of aspiration pneumonia pending further investigations.[48]

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[35] Exhibit C9- Prison Health Service records, p 76.
[36] Exhibit C5- Medical Records, page 39.
[37] Exhibit C5- Medical Records, page 40.
[38] "Code Stroke" describes an emergency protocol, activated when a suspected stroke is identified, to facilitate rapid assessment and treatment for patients experiencing stroke symptoms.
[39] Exhibit C5- Medical Records, page 163.
[40] Exhibit C5- Medical Records, page 40.
[41] Exhibit C5- Medical Records, page 163.
[42] Exhibit C5- Medical Records, page 161.
[43] Exhibit C5- Medical Records, page 155.
[44] Exhibit C5- Medical Records, page 128.
[45] (PAH).
[46] Exhibit C5- Medical Records, page 129.
[47] Exhibit C5- Medical Records, page 114.
[48] Exhibit B1- Statement of Dr Amgad Said, page 3.

39. On 29 August Mr Buckby was reviewed by the general medicine SMO. Mr Buckby was noted to be non-verbal,[49] with a 'significantly altered consciousness level, severe motor weakness on the right side of the body and ongoing very poor oral intake'.[50]

40. On review by Dr Said on 31 August it was noted that Mr Buckby had deteriorated and was now becoming obtunded, was nonverbal and not following single stage commands and was unable to swallow. He was considered to have a very poor prognosis, and it was noted he would benefit from palliative care and withdrawal of active treatment. He was referred to palliative care for review and it was noted Mr Buckby was under the guardianship with the Public Guardian and that the decision for palliative care would need to be recommended by two physicians.[51]

41. Later that day, social worker Rowanne Wright sought collateral information from Qld Corrective Services and the Office of the Public Guardian regarding statutory health attorneys (SHA's) for healthcare decisions relating to withdrawing life-sustaining measures. A discussion occurred with Andrea Stephens, Principal Guardian, who reported that Mr Buckby had no family or SHAs and that the OPG could be used for these decisions after completing the relevant documentation for consent.[52]

42. The palliative care team reviewed Mr Buckby on 1 September who assessed Mr Buckby as having a residual right-sided deficit and being high risk of aspiration and subsequent deterioration. They noted his pre-morbid cognitive impairment and Alzheimer's which was considered to impact Mr Buckby's ability to engage in rehabilitation.[53]

43. A palliative care consultant reviewed Mr Buckby on 2 September who noted his '*long term prognosis is poor from a survival perspective, and terrible from a morbidity and quality of life perspective*.' He noted that enteric feeding was an option but that it would not eliminate his aspiration risk and will not enhance his quality of life. Therefore, he opined that a comfort care approach would be medically appropriate, and that Mr Buckby's ARP would need to be updated for comfort cares.[54]

44. Later that day the general medicine team spoke with the OPG and were advised that executive approval would be required for updating the ARP to reflect the decision to proceed down the palliative pathway and withdrawal/withholding of life sustaining measures.[55]

45. That evening, Shayna Smith, Public Guardian, provided consent for provided consent for the withholding of life-sustaining treatment and provision of palliative care measures in accordance with section 12(1)(f) of the *Public Guardian Act 2014* and section 66A(2), Schedule 2 sections 5A and 5B of the *Guardianship and Administration Act 2000.*[56]. Mr Buckby's ARP was updated to reflect this.[57]

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[49] Exhibit C5- Medical Records, page 114.
[50] Exhibit B1- Statement of Dr Amgad Said, page 3.
[51] Exhibit C5- Medical Records, page 94.
[52] Exhibit C5- Medical Records, page 91.
[53] Exhibit C5- Medical Records, page 80.
[54] Exhibit C5- Medical Records, page 74.
[55] Exhibit C5- Medical Records, page 73.
[56] Exhibit B3 – Statement of Andrea Stephens, page 6.
[57] Exhibit C5- Medical Records, page 68.

46. Mr Buckby continued to be cared for with ongoing input from palliative care. He was noted to have minimal symptoms of concern and appeared comfortable.[58] On 7 September Mr Buckby was reviewed by a palliative care SMO who assessed Mr Buckby to be dying with a prognosis of hours to short days. He was given morphine and midazolam and it was noted that it was appropriate that Mr Buckby have end of life cares at the PAH as an inpatient as he was too unstable to transfer to PCU.[59]

47. On the afternoon of 7 September Mr Buckby was given further morphine and midazolam and was commenced on a continuous infusion of these medications. Nursing staff were notified at around 18:00 by a corrective services officer with Mr Buckby that he had stopped breathing. Ward call was requested[60] and declared Mr Buckby deceased at 20:49 PM.[61]

48. Nursing staff noted that a Next of Kin was not informed as there was none on record, and that the police were also having difficulty locating one.[62]

Forensic Medicine Queensland advice

49. I sought an opinion from Forensic Medicine Queensland ('FMQ') regarding Mr Buckby's medication management and non-compliance with his statin (cholesterol lowering drug) in the context of his known hypercholesterolaemia (high cholesterol) and cognitive decline, noting he died of an embolic stroke.

50. Dr Mitchell Shaw, Forensic Physician, provided an opinion on Mr Buckby's care to the Court on 5 November 2025.

51. Dr Shaw noted Mr Buckby's history including his cognitive decline and repeated assertions that there was 'nothing wrong' with him, and observed that his treating doctor at WCC highlighted the risk of heart attack or stroke, and that despite this, Mr Buckby was not keen to take medication.[63]

52. In summary, Dr Shaw provided advice that:[64]

> *"In the absence of atrial fibrillation, Mr Buckby's stroke risk related predominately to his cardiovascular risk factors (blood pressure and cholesterol specifically). Mr Buckby was repeatedly put on medications to control blood pressure and cholesterol (which was only modestly elevated) and he was recurrently non-compliant with these medications. This non-compliance would seem to have preceded any substantial loss of decision making capacity.*

[58] Exhibit C5- Medical Records, page 56.
[59] Exhibit C5- Medical Records, page 46. PCU is presumed to be Prison Corrections Unit but this is not defined in the notes.
[60] It was noted that there was a delay in the ward call review due to clinical requirements in the hospital.
[61] Exhibit C5- Medical Records, page 41.
[62] Exhibit C5- Medical Records, page 44.
[63] Exhibit E1 – Forensic Medicine Queensland opinion, paragraph 17.
[64] Exhibit E1 – Forensic Medicine Queensland opinion, paragraph 34 – 36.

Even if it is assumed that Mr Buckby had ongoing atrial fibrillation, blood thinning medication to prevent a cardioembolic stroke was not clearly indicated in the months prior to death most notably due to concerns about gastrointestinal bleeding. Mr Buckby's risk of stroke per year was perhaps 4%, and the risk of serious bleeding was perhaps 6%.

Overall, the care provided to Mr Buckby appears to have been of an acceptable standard with no obvious opportunities for outcome changing care."

53. Dr Shaw further observed that the decision to transition Mr Buckby to palliation was made in consultation with the Public Guardian and agreed by multiple clinicians.

54. I accept the advice of Dr Shaw.

Autopsy results

55. On 12 September 2022, Dr Nathan Milne conducted an autopsy consisting of an external only post-mortem examination of the body, whole body CT Scans and toxicology testing. He concluded that:

In my opinion, the cause of death is a left sided ischaemic stroke. This resulted from blockages in the arteries in the base of the brain, clinically considered to [be] *the result of cardioemboli.*[65]

Conclusions

56. I am satisfied that Mr Buckby died from natural causes. I find that none of the inmates, correctional or health care staff at the PAH or WCC caused or contributed to his death. There were no suspicious circumstances.

57. 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 Buckby when measured against this benchmark.

[65] Exhibit A4 – Autopsy report, p 5.

Findings required by s. 45

58. 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:

(a) Who the deceased person is:	Desmond George Buckby
(b) How the person died:	Mr Buckby had been detained since December 2007 under the *Dangerous Prisoners (Sexual Offenders) Act* 2003. Mr Buckby had a large cardioembolic stroke on 24 August 2022 and was transferred to the Princess Alexandra Hospital where he made no meaningful recovery and died following palliative care measures.
(c) When the person died:	07 September 2022.
(d) Where the person died:	Princess Alexandra Hospital.
(e) What caused the person to die:	1(a) Left cerebral ischaemic stroke 1(b) Cerebral arterial cardio embolism.

Comments and recommendations

59. 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.

60. 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.

61. I close the inquest.

Terry Ryan
State Coroner
BRISBANE