QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Hayward Rasmussen**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2019/3992
DELIVERED ON:	10 March 2023
DELIVERED AT:	BRISBANE
HEARING DATE(s):	23 September 2022
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, cirrhosis, splenomegaly, ruptured spleen, health care.

REPRESENTATION:

Counsel Assisting:	Ms Sarah Lio-Willie
Queensland Corrective Services:	Ms Vanessa Price
West Moreton Health:	Ms Prudence Fairlie

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Introduction

1. Hayward Rasmussen was aged 45 years when he died at the Ipswich Hospital after being transferred by Ambulance from the Borallon Training and Correctional Centre (BTCC).

2. Mr Rasmussen had a number of significant comorbidities. On 28 August 2019, he collapsed while working in the prison's computer laboratory. He was transported to hospital for treatment, where he ultimately died from intra-abdominal haemorrhage caused by a ruptured spleen. He had been in custody since 5 May 2019.

The investigation

3. Detective Sergeant Carr and Detective Sergeant Jones from the Corrective Services Investigation Unit (CSIU) were advised of Mr Rasmussen's death and attended the Ipswich Hospital on 28 August 2019, together with a Scenes of Crimes Officer from Ipswich Police.

4. I subsequently issued a direction for a full investigation into the death. This included seeking medical records, interviewing family members, and obtaining statements from relevant treating medical officers and corrective services officers.

5. Detectives attended the computer laboratory where Mr Rasmussen first collapsed. Nothing was located to assist in the investigation. Photographs of the computer room and Body Worn Camera (BWC) footage from Correctional Officers attending the computer room to assist Mr Rasmussen were seized.

6. Investigators also spoke with prisoners who were present when Mr Rasmussen collapsed. They were not prepared to assist the Police investigation.

7. A Coronial Report was prepared and provided to the Coroners Court in August 2020. The investigation concluded that there appeared to be no insufficiency of care, and there were no suspicious circumstances in relation to Mr Rasmussen's death. The Office of the Chief Inspector (OCI) also investigated Mr Rasmussen's death.

8. Professor Leggett, a Specialist in Gastroenterology and Hepatology, and Professor Wullschleger, General and Trauma Surgeon, also examined Mr Rasmussen's medical records and reported on them for the Coroners Court.

The inquest

9. At the time of his death, Mr Rasmussen was a prisoner in custody under the *Corrective Services Act 2006*. His death was a 'death in custody' and an inquest was mandatory under the *Coroners Act 2003*.

10. The inquest was held at Brisbane on 23 September 2022. All statements, records of interview, medical records, photographs and materials gathered during the investigation were admitted into evidence. Counsel Assisting proceeded to submissions on the investigation material in lieu of any oral evidence.

11. The issues considered in the inquest were the findings required by s45(2) of the *Coroners Act 2003,* and whether Mr Rasmussen had access to, and received appropriate medical care, while he was in custody.

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

13. The role of a 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.

14. Under the *Coroners Act 2003*, coroners also have functions of helping to prevent deaths, promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

The evidence

Personal history

15. Mr Rasmussen worked as a tradesman until 2010, when his illnesses resulted in an inability to work. He then received Newstart Allowance. Immediately prior to his imprisonment, he lived with his mother. His mother, sisters and daughters were his main supports in the community. Sadly, his mother passed away on 14 September 2021.

16. At the inquest, Mr Rasmussen's daughter read a family statement to the court. She said that her father was well educated, intelligent, kind, and sensitive. He raised his children with love, and was a much loved member of his extended family. Unfortunately, trauma in the early stages of his life led him to drug use and he developed multiple serious health conditions as a result. Mr Rasmussen was optimistic and had plans for the future. He was only 45 years when he died, and his family miss him greatly. His family feel he might still be alive if his health was more closely monitored while he was in custody.

17. Mr Rasmussen had a lengthy history of polysubstance use, including intravenous drug use. He had become dependent on opioids, including morphine and heroin. In a Queensland Corrective Services (QCS) Benchmark Assessment on 24 September 2018, Mr Rasmussen reported cannabis use from age 16, mainly between the ages of 17 and 25 years. He also reported sporadically using methamphetamine from age 21. Heroin was reported as his 'drug of choice' and he said he was using heroin daily until the end of February 2018, when he was sentenced to a community order. Mr Rasmussen had been treated on the methadone program by his general practitioner.[1]

[1] Ex C18 – OCI Report, para 26

18. Mr Rasmussen had an extensive Queensland criminal history commencing in 1991. This consisted primarily of drug and property offences, breaches of orders and suspended terms of imprisonment. His first custodial period was in 2000 and he was undertaking his fourth custodial sentence at the time of his death.

19. At the time of his death, Mr Rasmussen had been in custody following his arrest on 5 May 2019. He was remanded to the Arthur Gorrie Correctional Centre on 8 May 2019. He was subsequently convicted on 20 June 2019 for drug and property offences. He was sentenced to a head sentence of six months imprisonment. As he was already on parole at the time of these offences, he was given a parole eligibility date of 20 June 2019.[2] His full-time discharge date was 7 April 2020.

20. On 25 June 2019, Mr Rasmussen was transferred to the Brisbane Correctional Centre. On 4 July 2019, Mr Rasmussen was transferred to the BTCC. He was accommodated in the Secure Unit B12 in cell 27, a cell occupied solely by him. Mr Rasmussen was not involved in any known altercations, conflicts or assaults. He had no listed enemies or associates that were in custody at the same time. [3]

21. At the time of his death he had a parole application pending.[4]

Medical history

22. Mr Rasmussen had a complex medical history, including:

    a. Hepatitis C with development of liver cirrhosis,
    b. Portal hypertension with oesophageal varices (episodes of bleeding/banding) and gastropathy,
    c. Splenomegaly and hypersplenism,
    d. Pancytopenia,
    e. Infective endocarditis,
    f. Cardiomyopathy / cardiomegaly,
    g. Pulmonary hypertension,
    h. Thiamine deficiency,
    i. Poly-substance abuse and dependency (including intravenous use), and
    j. Smoking

23. Mr Rasmussen had no significant surgical history and no previous abdominal surgery. During his third custodial episode, Mr Rasmussen spent considerable time in hospital. On 30 December 2014, he was transported by ambulance to the Princess Alexandra Hospital Secure Unit because he was vomiting blood, which was thought to be connected to a pre-existing condition. He was hospitalised on 29 January 2015 for a sore spleen and on 24 February 2015 for further treatment.

24. In later years, he had been treated by several specialists from PAH, Logan Hospital and the Royal Brisbane and Women's Hospital (RBWH). Mr Rasmussen also had a mental health history involving depression, anxiety, self-harm and suicide attempts.

[2] Ex C17 – Qld criminal history
[3] Ex C18 – OCI Report, para 37
[4] Ex C18 – OCI Report, para 20

25. On admission to QCS custody on 8 May 2019, a Notice of Concern was raised on intake and Mr Rasmussen was assessed for risk of self-harm. He reported experiencing auditory command hallucinations three weeks earlier, as well as poor sleep, reduced appetite and a recent plan to end his life by overdose. He was subsequently placed on 60-minute visual observations.

26. Although Mr Rasmussen was depressed and withdrawing from substances when admitted to custody in May 2019, he settled in well. By June he was reporting that he had no thoughts of self-harm. There were no reports of hallucinations during the current custodial episode. However, he still struggling with sleep, mental health and family concerns in the context of the death of a former partner in late May 2019.[5]

27. On 2 June 2019, Mr Rasmussen was at Arthur Gorrie Correctional Centre (AGCC). He received Cephalexin 1g BD and Phisohex daily for five days for "pustules on his back", later diagnosed as impetigo (a bacterial skin infection) after a consultation with a DOCTO contracted clinician (an out of hours private healthcare provider to AGCC).

28. On 13 June 2019, Mr Rasmussen was reviewed by a nurse practitioner at AGCC and requested to recommence on his past medications. He was recommenced on Venlafaxine 150mg mane, in addition to Quetiapine 25mg XR nocte.

29. On 25 June 2019, Mr Rasmussen transferred to Brisbane Correctional Centre (BCC).

30. On 4 July 2019, Mr Rasmussen transferred to BTCC. Due to his extensive medical history, including oesophageal varices, a referral to the prison medical officer was generated. He was also referred to the optometrist. His medical chart had been lost in the transfer and a new chart had to be created. At BTCC he was seen by nursing staff on 5, 16, 24, 26 and 28 July 2019 for a range of concerns. He was also seen on 6,7 and 8 August 2019.

31. Mr Rasmussen expressed an interest in training and employment and requested placement at BTCC. He was assessed as suitable for industry employment and started work at the “Barbed Design” graphic design computer training classroom on 13 August 2019.

Circumstances of the death

32. On 27 August 2019, Mr Rasmussen presented to the Health Service with the complaint of nightmares and was assessed by the medical officer. He mentioned that he had some left-sided lower chest pains, since ‘mucking around’ with other inmates three days prior.[6] He denied that he had been assaulted.

33. The clinical assessment revealed tenderness over the left lower anterior chest, possibly a rib fracture. His vital signs (pulse and blood pressure) were within normal limits, and pain management with Panadol and Tapentadol was commenced. A referral to hepatology review at the PAH gastroenterology Department was also made for an endoscopy and surveillance with regard to his cirrhosis, portal hypertension and oesophageal varices. The prison medical officer felt the possible rib fracture would heal naturally.

[5] Ex C18 – OCI Report, para 41
[6] His father reported that he was training with an ex-professional boxing friend each day.

34. At approximately 7:30am on Wednesday, 28 August 2019, Mr Rasmussen received his prescribed pain medication of Tramadol and Panadol. At 8:30am, Mr Rasmussen was in the Barbed Design computer lab in F Block, where he was being trained in Graphic Design. He was returned to his unit for a lunch break between 12:00pm and 1:00pm.

35. At about 1:45pm, while working on the computer in the Barbed Design room, Mr Rasmussen collapsed and fell to the ground. Another prisoner supported Mr Rasmussen in the recovery position, while the Education Instructor Rolls ran to the security desk at the entrance to F Block to alert Custodial Correctional Officer (CCO) Byrne.

36. Another prisoner had also run to alert CCO Byrne that Mr Rasmussen had collapsed. CCO Byrne ran towards the Barbed Design room and as he got closer, he heard prisoners yelling that someone had collapsed in the room. CCO Byrne immediately called a *Code Blue* medical emergency over the QCS internal radio network.[7]

37. CCO Byrne entered the Barbed Design room and saw Mr Rasmussen being supported on the floor. He saw that Mr Rasmussen had a yellow complexion, his facial features were displaying cyanosis, with obvious blue and white lips which also appeared dry. Mr Rasmussen told CCO Byrne that he had felt weak and collapsed. He told CCO Byrne he thought he had a fractured rib and was given tramadol in the morning by medical staff for the pain. He would not say how he sustained the rib fracture and denied taking any illicit drugs.[8]

38. Nursing staff arrived at approximately 1:47pm. Mr Rasmussen told the nurses that he had pain in the rib area since Sunday, and that he had seen the doctor about it on 27 August and was prescribed Tramadol, which helped with the pain.

39. More CCOs responded to the *Code Blue* and upon entering the Barbed Design room directed the other prisoners to move to one side of the room to make space for Mr Rasmussen to be treated.[9]

40. In body worn camera footage Mr Rasmussen is clearly jaundiced. When CCO Turned tried to assist him to the stretcher, Mr Rasmussen lost consciousness and collapsed.[10] He was lifted onto the stretcher and taken to the medical centre.

41. At 2:01pm, once at the medical centre, the Queensland Ambulance Service (QAS) was called as a Category 1. Mr Rasmussen repeatedly denied taking any illicit substances, but nurses administered Naloxone as a precautionary measure.[11]

42. At 2:20pm, QAS paramedics arrived and took over his care. Mr Rasmussen was visibly scared and voiced his fears to the CCOs in the medical centre.[12] CCO Philp and CCO Weaver escorted Mr Rasmussen in the ambulance.

[7] Ex B2 – Officer Report, S Byrne
[8] Ex B2 – Officer Report, S Byrne
[9] Ex B5 – Officer Report, A Hernandez
[10] Ex F2 – BWC of CCO Turner, at 9.28mins
[11] Ex C18 – OCI Report, p16
[12] Ex F2 – BWC of CCO Turner

43. At 2:40pm, the ambulance departed for the PAH. At about 2:50pm, the ambulance exited the Warrego Highway onto the Kholo Road exit and was met by Critical Care Paramedic who provided urgent treatment.[13]

44. Due to Mr Rasmussen's condition, the decision was made to divert to the Ipswich Hospital, and arrived at 3:14pm. At about 4:26pm, Mr Rasmussen was urgently transferred to Theatre for an Upper Gastro-Intestinal scope, but he arrested en-route. On arrival to Theatre, the Anaesthetic and Theatre team took over resuscitation efforts. Mr Rasmussen was pronounced life extinct at 4:55pm.

Autopsy results[14]

45. On 30 August 2019, Dr Nadine Forde conducted an autopsy consisting of an external and full internal examination of the body.

46. The internal examination showed more than 5 litres of blood and clot in the abdomen. The spleen was markedly enlarged with a thickened fibrous capsule showing a 60mm tear. There were large subcapsular and intraparenchymal haematomas. No other source of bleeding was identified. CT scans showed intrabdominal blood and haemorrhage around and within the spleen.

47. The heart was mildly enlarged and two of the valves were thickened. The liver was cirrhotic. The coronary arteries showed mild atherosclerosis.

48. There were anterior rib fractures, consistent with CPR. There were some healed/healing rib fractures in the left posterior chest wall, with no disruption of the pleura or diaphragm and no associated residual bruising. There was a small focus of soft tissue haemorrhage on the left lateral chest wall adjacent to rib 9.

49. The posterior rib fractures were in an advanced phase of healing, with an age estimate favouring weeks to months. There was haemorrhage but no inflammation in the left lateral chest wall haemorrhage, suggesting recent injury. This may or may not be related to the splenic injury, and may be related to medical treatment. Dr Forde concluded that the age estimation of the left posterior rib fractures made it unlikely that they were related to any recent trauma or the splenic rupture.

50. The toxicology analysis detected fentanyl, lignocaine, paracetamol, venlafaxine, ondansetron and Tapentadol, all of which were recorded as having been administered medically on the day of death.

51. Dr Forde concluded that the cause of death was intra-abdominal haemorrhage due to a ruptured spleen. This was listed as:

    1(a) Intra-abdominal haemorrhage, *due to, or as a consequence of*;
    1(b) Ruptured spleen, *due to, or as a consequence of*;
    1(c) Splenomegaly, *due to, or as a consequence of;*
    1(d) Cirrhosis, *due to, or as a consequence of*;
    1(e) Hepatitis C

    Other significant conditions:
    2 Cardiomyopathy

[13] Ex B7 – Officer Report, A Philp
[14] Ex A10 – Autopsy report

52. Dr Forde considered that the underlying cause of Mr Rasmussen's splenomegaly was most likely related to portal hypertension from liver cirrhosis, which causes congestion and subsequent expansion of the spleen. Dr Forde further explained that the liver is also responsible for producing many blood clotting factors. Therefore, liver dysfunction increases the risk of haemorrhage.

53. Dr Forde also noted that Mr Rasmussen had known cardiomyopathy and would have been at increased risk of cardiac decompensation in the setting of blood loss. However, the amount of haemorrhage present is likely to have been lethal even in the absence of the cardiac disease.

54. Dr Forde commented that the underlying cause of his cardiomyopathy may be related to his other medical conditions (including previous endocarditis), however some cardiomyopathies have a genetic basis.

Investigation findings

Office of the Chief Inspector Report[15]

55. Section 305 of the *Corrective Services Act 2006* requires that an inspector be appointed to investigate an incident[16] and present a written report to the Chief Executive. The investigation was conducted by internal inspectors and an external inspector from the private bar. The Office of the Chief Inspector (OCI) Report was finalised in November 2020.

56. The OCI investigation found that:

- there was no information to suggest that Mr Rasmussen's death was occasioned by another person, or the result of suicide.
- his cause of death was related to his general state of ill health.
- one of the CCOs who responded to the incident commented, without reasonable basis for doing so, that Mr Rasmussen had overdosed on Subutex. There was no evidence of this and the theory of illicit drug use contributing to his death was dismissed.

57. The OCI investigators concluded that the response of BTCC officers was largely prompt and consistent with relevant Custodial Operations Practice Directives (COPDs). There were a number of issues identified in relation to debriefing post the incident, but those issues did not relate to the cause of Mr Rasmussen's death.

HEAPS Review[17]

58. The West Moreton Hospital and Health Service's Prison Health Service conducted a Human Error and Patient Safety (HEAPS) review of Mr Rasmussen's medical care in prison, leading up to and at the time of his collapse. The review concluded that Mr Rasmussen's collapse could not have been predicted or prevented, as there were no signs or symptoms leading up to the collapse.

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[15] Ex C18 – OCI Report
[16] "Incident" includes a death (other than by natural causes) of someone who is in a corrective services facility.
[17] Ex D2 – HEAPS Review

59. The review concluded that Mr Rasmussen's management by West Moreton Health Prison Health Staff to have been of a good standard and clinically appropriate.

Family concerns

60. Mr Rasmussen's mother said she had communicated frequently with her son while he was in custody, as did his sister and daughter. They had regular telephone contact and exchanged letters each week. Mr Rasmussen's mother said the family had many concerns as her son had a lot of serious health issues and had received poor treatment in custody, before the incident resulting in his death. She said that he was physically assaulted on occasions in custody resulting in serious injuries.

61. Mr Rasmussen's mother believed her son sustained broken ribs while at the Brisbane Correctional Centre just prior to his transfer to BTCC and sustained further broken ribs and injury four days prior to his death. He had told his family that he was boxing and exercising intensively and had put on a significant amount of weight.

62. Mr Rasmussen's father was also concerned that his son's death was caused by injuries he sustained in prison. He said that "*spleens don't rupture themselves*" and that his son had "*severe liver disease and as part of this disease his other organs (including the spleen), were compromised and under immense pressure to function properly, hence the need for ongoing medical supervision and check-ups."*[18]

63. Mr Rasmussen's father reported that his son had communicated in a letter dated 26 August 2019:

> *"Hello again, how are you? I hope the answer is good!! Well I'm shit. I had to go to hospital today and I've got a broken rib?? Oh God I hate broken ribs! I think it is like my 5th or 6th broken rib!! OMG it's sore, and (page 4) if you have ever had one it gets worse, much worse before it gets better. So much for looking a million bucks if I get out in a few months hey! I can't do anything for 2 months…….".*

64. Following the inquest, Mr Rasmussen's family submitted a range of further concerns in writing. These are summarised as follows:

> <u>Prison Health and QCS did not have access to his extensive medical file.</u>
>
> - They were not equipped to deal with his extensive health issues. They had no idea how to manage his condition and the dangers of his condition.
> - His health was not managed and his subsequent death from a treatable injury was the result.
> - He was not adequately cared for and his personal risk was not assessed. His extreme boxing and physical exercise were not managed. He should never have been allowed to box, spar, exercise, weightlift vigorously every day for hours at a time.
> - Splenic rupture is most commonly caused by an injury to the spleen.

[18] Ex B13

Red flags leading to the death

- He was unwell for about a week or so prior to his death. Dizzy, lethargic, unable to pass urine and chest pain.
- He had blood noses on and around 8 August 2019.

- He had been unable to pass urine on 19 and 20 August 2019 and been breached for being unable to provide a urine sample.
- Cirrhosis of the liver affects urine output. In cirrhotic patients that reach the stage of predisposition to acute renal dysfunction, urine output is usually significantly reduced compared with patients without cirrhosis. Splenomegaly also presents with frequent difficulty with urination.
- Rather than medical assistance and investigation on why he could not pass urine, he was given two major breaches.
- He complained to prison staff about his health.
- A medical officer saw him again on 27 August 2019 - the day before he died. He was in pain on the left-hand side of his chest and he described around the T6 region – right near the spleen and near the area of the rupture.
- He was passed off as having broken ribs and given Panadol and tramadol up until the morning he collapsed. He was scheduled for some haematology work but this was not made urgent. His heart rate and blood pressure were not in the normal range when he saw medical. He had high blood pressure and was hypertensive (150/102 – 140/90 is considered high and hypertensive) – also very dangerous for his pulmonary and portal hypertension and varices.
- He was not examined properly in accordance with his liver cirrhosis. Diagnosis of an enlarged spleen is done via imaging of the abdomen and blood tests. Doctors may suspect that the spleen is enlarged when people complain of fullness or pain in the upper left portion of the abdomen or back. Usually, doctors can feel an enlarged spleen during a physical examination. Visually he was yellow and had " a bulging abdominal mass" clear, simple signs.

65. Mr Rasmussen's family submitted that he "*ultimately died from an intrabdominal haemorrhage from a ruptured spleen because his ill health was not managed. There is common link between cirrhosis and splenomegaly. Hayward was not examined properly and was not diagnosed even though the link should have been apparent. He already had Portal Hypertension and had been treated for it in the past.*"

Expert reports

66. Given the concerns raised by Mr Rasmussen's family, the Coroners Court engaged Professor Martin Wullschleger, Director of Trauma at the Royal Brisbane and Women's Hospital to provide an expert report.[19] A report was also obtained from Professor Barbara Leggett, Specialist in Gastroenterology and Hepatology, Royal Brisbane and Women's Hospital and Professor of Medicine, University of Queensland.[20]

[19] Ex F2 - Report of Professor Wullschleger, 29 June 2022.
[20] Ex F1

67. Professor Leggett said that when Mr Rasmussen was taken into custody in late 2018, he had several severe chronic illnesses. The illnesses relevant to his death were liver cirrhosis and splenomegaly. He had been known to have cirrhosis due to chronic hepatitis C for many years. He was cared for by Associate Professor Macdonald at the PAH.

68. Professor Leggett noted that there was a letter in his Offender Health Service record for his previous period of custody which was written in 2015 by Associate Professor Macdonald summarising his serious liver condition. In 2016 new and much more effective treatment for Hepatitis C became available and Mr Rasmussen was treated with this through PAH liver services. This treatment would not reverse his cirrhosis but aimed to stop it worsening.

69. Mr Rasmussen was last seen at PAH liver services on 15 August 2017 to assess his progress, but he subsequently failed to attend several appointments and was discharged to the care of his GP Dr Dunne.

70. Professor Leggett said that a complication of Mr Rasmussen's cirrhosis was portal hypertension, which caused oesophageal varices and these varices caused life threatening gastrointestinal bleeding in 2014. He underwent a course of banding to treat the varices, and this was successful in controlling them. The usual subsequent management is to perform endoscopies approximately annually. If large varices recur, further banding is undertaken.

71. When Mr Rasmussen was last seen in the liver clinic on 15 August 2017 a surveillance endoscopy was requested, and this was performed at the PAH on 7 February 2018. The results were reassuring, showing only very small (Grade 1) varices with a low risk of bleeding. Further endoscopy was not organised because he failed to attend subsequent liver clinic appointments, but he was likely aware that it would have been usual care to have another surveillance endoscopy in 2019.

72. However, Professor Leggett said that the delay in this occurring did not change the outcome because Mr Rasmussen did not bleed from varices in 2019 and varices were not related to his death.

73. Another complication of Mr Rasmussen's portal hypertension was splenomegaly and pancytopaenia. He was referred to the RBWH Haematology clinic where he was seen on 26 February 2018. His bone marrow biopsy was consistent with a diagnosis of cytopenias due to peripheral destruction of platelets because of his portal hypertension and splenomegaly. He was noted to have moderate to massive splenomegaly on examination. This would lead to an increased risk of splenic rupture from lesser degrees of trauma than would typically rupture a normal spleen. A letter from RBWH Haematology was sent to his GP, Dr Dunne.

74. Professor Leggett said that when Mr Rasmussen was taken into custody in late 2018, the pathway to communicate these medical issues to the prison nursing and medical staff was not clear. While the assessment and management of his mental health issues was thoroughly documented, Professor Leggett was not able to find a clear plan for the provision of care for his liver disease. She said that in retrospect, it is clear that his splenomegaly was associated with a risk of rupture from contact sports such as boxing.

75. However, Professor Leggett noted Mr Rasmussen clearly derived much positive benefit from his fitness regime as evidenced in his letters. He may have chosen to avoid boxing and other contact sport if the risks of splenic rupture had been discussed. Professor Leggett also said it is not standard care to discuss risks of splenic rupture in patients with portal hypertension unless the topic of contact sport is raised.

76. Professor Leggett said that following his collapse on 28 August 2019 management at the prison was entirely appropriate. The difficulty in establishing IV access greatly hampered his resuscitation and would have been a contributing factor to the adverse outcome. Once he arrived at Ipswich Hospital, his assessment could perhaps have given more consideration to causes of shock other than bleeding varices given there was a history of vomiting without haematemesis, and examination documented normal faeces not blood or melaena. Nonetheless, his very rapid deterioration would have made medical imaging and surgical splenectomy very difficult to achieve before he arrested. The autopsy showed that death was from a ruptured spleen and there was no evidence of gastrointestinal bleeding.

77. Professor Leggett's opinion was that, in general, Mr Rasmussen's treatment was appropriate, but it could have been improved by a clearer pathway to transmit his known serious medical history to Offender Health Services, and for them to have then organised regular medical review of his liver disease and associated problems at least every six months. In her opinion, to prevent similar events happening in the future, medical review of the risks of contact sport in individuals with splenomegaly or other serious illness could be implemented.

78. Professor Leggett said that the delay in gastroscopy was not outcome changing since the bleeding site was not in the gastrointestinal tract. She said that if he had been having regular medical review with staff well informed of his cirrhosis and splenomegaly, medical staff may have been aware of his participation in contact sport including boxing and may have been able to advise of his increased risk of splenic rupture from this activity.

79. Professor Leggett said that she could not provide any more detail of the incident on 24 August 2019 and from the medical findings it cannot be certain when the splenic injury occurred.

80. Professor Wullschleger explained that splenomegaly is an enlarged pathological spleen from portal hypertension, and consists of more fragile tissue consistency with larger blood vessels. These spleens are, due to that changed nature, more prone to sustain damage, with smaller amounts of force or impact, even without known impact (spontaneous rupture through intrinsic growth and tissue distortion).[21] Professor Wullschleger said that once rupturing occurs, these spleens tend to bleed more heavily due to the larger blood vessels feeding into the spleen and within the splenic organ itself, as well as the more fragile tissues.

[21] Report of Professor Wullschleger, 29 June 2022, p2

81. Splenic injuries can occur in two stages. There is the initial primary impact and damage to the spleen. In some cases secondary damage with rupture of the spleen can occur within a timeframe of a few days from the initial trauma to up to two weeks after. The mechanism and reasoning for the 'secondary rupture' is not well understood and happens to pathological and normal-tissue spleens.

82. Professor Wullschleger said that in terms of higher risk activities to cause potential splenic damage, medical specialists recommend avoiding any direct or even indirect (shearing, pulling, deceleration) forces to enlarged, pathological spleens as well as in the recovery phase after splenic injuries.

83. Professor Wullschleger considered that the treatment by Offender Health Services' medical officers and nurses was appropriate. Mr Rasmussen was appropriately assessed in relation to his left-sided rib cage tenderness and pains on chest compression and possible clinical rib fracture, and was correctly treated with analgesia and breathing exercises, which Mr Rasmussen complied with.

84. Professor Wullschleger also considered that further examinations with a chest x-ray would not have made any difference to the recovery from the possible rib fracture, nor recognition of a potential splenic injury. Mr Rasmussen did not disclose having abdominal pains. Therefore, an abdominal ultrasound was not indicated. Even if an ultrasound was performed on the day he was assessed (27 August 2019) at the medical centre, the splenic injury may have been missed.

85. Professor Wullschleger said Mr Rasmussen's collapse on 28 August 2019 was due to the rupture of his enlarged spleen with massive haemorrhage causing hypotensive shock. The reason for the splenic rupture was either spontaneous in nature or, more likely, a secondary delayed rupture from a minor/silent splenic injury in the days or weeks prior to the collapse.

86. Professor Wullschleger commented that the boxing exercises undertaken by Mr Rasmussen may have been the trigger for the minor injury, but this was not necessarily the case. Professor Wullschleger noted the left-sided rib fractures were identified at autopsy as more than 2-3 weeks old, and were possibly unrelated to the splenic event. As minor or silent splenic injuries might not cause any symptoms, it was not a case of a missed diagnosis.

87. Professor Wullschleger made no criticism of the medical treatment provided to Mr Rasmussen upon his collapse from nursing staff, QAS or the Emergency Department at Ipswich Hospital. Professor Wullschleger stated that a Focused Abdominal Assessment in Trauma ultrasound (FAST scan) could have been performed at the hospital. This may have shown the abdominal bleeding, but would not have identified the exact origin. An urgent transfer to the operating theatre for potential laparotomy could have resulted from a positive FAST scan. However, this would not have changed the outcome of the cardiac arrest on arrival to the operating theatre.

88. In terms of any missed opportunities to prevent Mr Rasmussen's death, Professor Wullschleger noted that he could not see in the medical records that medical officers had informed Mr Rasmussen of the risks of physical training in the context of his splenomegaly. He suggested that regular conversations between Mr Rasmussen and the medical officers could have happened to inform and discuss the risk of physical activities including boxing, in the context of his splenomegaly and bleeding risk.

Conclusions

89. Mr Rasmussen's death was the subject of a police investigation, together with investigations by the Office of the Chief Inspector and a HEAPs review by West Moreton Health.

90. I accept that his death was from natural causes and that there were no suspicious circumstances associated with it. His death was not related to the use of illicit substances within the prison.

91. On the basis of the opinions of Professor Wullschleger and Professor Leggett, I am satisfied that Mr Rasmussen was given generally appropriate health care by staff from West Moreton Health while he was at BTCC and at the Ipswich Hospital.

92. As the splenic rupture may have been spontaneous or a secondary delayed rupture from a minor/silent splenic injury in the days or weeks prior to the collapse, it was not a case of missed diagnosis. His death could not reasonably have been prevented.

93. It is a recognised principle that the health care provided to prisoners should not be off a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Rasmussen when measured against this benchmark.

94. It is important to note that, apart from the period between 4 December 2018 and 27 February 2019, Mr Rasmussen was living in the community for over three years from 1 December 2015 until his final term of imprisonment commenced on 8 May 2019. He died less than three months after his return to prison.

95. Mr Rasmussen was last seen at the PAH on 15 August 2017 but subsequently failed to attend appointments. In February 2018, the RBWH noted he had moderate to massive splenomegaly. The PAH and RBWH had both communicated these matters to his GP, Dr Dunne.

96. Mr Rasmussen's family were particularly concerned that he may have sustained a broken rib from an assault while in custody, and that it was undiagnosed. They were also concerned that Mr Rasmussen's medical history was not properly appreciated by Prison Health Services. Both independent experts retained by the Coroners Court have addressed these concerns and it is clear that Mr Rasmussen received appropriate care and treatment in custody, and at the time of his collapse.

97. As Professor Leggett noted, the Prison Health Service had Associate Professor Macdonald's 2015 letter advising that Mr Rasmussen had very advanced liver disease. Blood tests on 8 August 2019 showed findings consistent with cirrhosis and hypersplenism. The visiting medical officer's notes confirmed they were aware of his cirrhosis and splenomegaly. A referral was made for hepatology review at the PAH at that time on 27 August 2019.

98. Professor Leggett's primary concern was that she was could not find a clear plan for the provision of care for Mr Rasmussen's liver disease. While she considered his treatment by the Prison Health Service was appropriate, it could have been improved by a clearer pathway to transmit his known serious medical history to Offender Health Services, and for them to have then organised regular medical review of his liver disease and associated problems at least every six months.

99. Professor Leggett noted that she was able to base her report on the documentation accessed by the Coroners Court and on what is recorded in the integrated electronic Medical Record (ieMR) about Mr Rasmussen's care at the PAH and RBWH.

100. Prison Health Services only gained access to read ieMR in October 2020 and did not have access during their care of Mr Rasmussen. As far as Professor Leggett could determine, they only had access to Associate Professor Macdonald's letter from 2015 and were otherwise reliant on history from Mr Rasmussen.

101. West Moreton Health confirmed that at the time of Mr Rasmussen's incarceration in 2019, PHS did not have access to ieMR. PHS gained 'read only' access in late 2020. Since then all PHS staff are provided the training module for 'read only' access to ieMR at orientation.

102. This allows all medical and nursing staff to be able to access ieMR for updates regarding a prisoners treatment, plan of care, recommendation, test results for those returning to the correctional centres from other hospitals, like the PAH following presentations to Emergency Departments, outpatients appointments or admission.

103. In my May 2021 findings in relation to the death of Scott Hambly I noted:

> *West Moreton Health confirmed that correctional facilities do not operate using an Electronic Medical Records Management system. A project is underway under the auspices of the Office for Prisoner Health and Well-Being to develop this capacity. This will assist with information sharing of consumer health issues across all prison health services, Prison Mental Health Service, general practitioners, and other health service providers. Read only access for ieMR and CIMHA records has also been provided to nursing staff, enabling faster access to discharge summaries from the PAH including for mental health admissions and other specialist medical appointments.*

104. West Moreton Health advised in October 2022 that this project is being led of EHealth Queensland. The Office of Prisoner Health and Wellbeing had advised it is expected that implementation will occur throughout 2023.

105. West Moreton Health has Nurse Practitioners who specialise in blood borne viruses (BBV) like Hepatis C and liver cirrhosis. In addition, recruitment has commenced for a BBV Clinical Nurse and Clinical Nurse Consultant health promotion and screening positions. The Clinical Nurse role will directly support the BBV Nurse Practitioner with the review, education and application of care to the BBV patient cohort. The Clinical Nurse Consultant Health Promotion and screening will also support the BBV practitioners in addition to the greater prisoner patient cohort with health promotion and screening.

106. Although Professor Leggett said it is not standard care to discuss risks of splenic rupture in patients with portal hypertension unless the topic of contact sport is raised, West Moreton Health plans to create an information sheet detailing the risks associated with contact sports, such as boxing, for individuals with conditions including liver disease and splenomegaly.

107. This information sheet can be included with BBV information provided to identified prisoners at the time of reception screening into correctional facilities. In addition, the information sheet can be provided to prisoners identified through the BBV screening program and as part of "Focus of the Month" (a rotational information session provided through the health centres at the correctional centres, operated by WMH).

Findings required by s. 45

108. 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 – Hayward Rasmussen

How he died – Mr Rasmussen had severe chronic illnesses including liver cirrhosis and splenomegaly. He was remanded in custody for property and drug offences on 8 May 2019. He was convicted of those offences on 20 June 2019.

On 28 August 2019 he collapsed in the Borallon Training and Correctional Centre's computer laboratory. He was given first aid treatment and transferred to the Ipswich Hospital.

Unfortunately, he died from an intra-abdominal haemorrhage caused by a ruptured spleen before he could undergo surgery. Mr Rasmussen's collapse on 28 August 2019 was due to the rupture of his enlarged spleen with massive haemorrhage causing hypotensive shock. The reason for the splenic rupture was either spontaneous in nature or, more likely, a secondary delayed rupture from a minor/silent splenic injury in the days or weeks prior to the collapse.

Place of death – Ipswich General Hospital, Ipswich in the State of Queensland

Date of death– 28 August 2019

Cause of death –	1(a) Intra-abdominal haemorrhage, *due to, or as a consequence of*; 1(b) Ruptured spleen, *due to, or as a consequence of;* 1(c) Splenomegaly, *due to, or as a consequence of*; 1(d) Cirrhosis, *due to, or as a consequence of*; 1(e) Hepatitis C Other significant conditions: 2 Cardiomyopathy

109. Section 46 of the *Coroners Act 2003* 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.

110. Having regard to the circumstances of Mr Rasmussen's death, the evidence of Professors Wullschleger and Leggett, and the response from West Moreton Health, I accept that there are no comments or recommendations to be made under s 46.

111. I extend my condolences to Mr Rasmussen's family and friends. I close the inquest.

Terry Ryan
State Coroner
BRISBANE