QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Reginald Wright**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/5479
DELIVERED ON:	11 August 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	11 August 2025
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody.

REPRESENTATION:

Counsel Assisting:	Ms Danielle Palmer
Metro South Hospital and Health Service	Ms Rosalie Grace
Queensland Corrective Services	Ms Ellen Limerick

West Moreton Hospital and Health Service

Ms Emily McDonald

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Introduction

1. John Reginald Wright was seventy-nine years of age when he died in Palliative Care at the Princess Alexandra Hospital (PAH) Secure Unit (SU) on 1 November 2022. Mr Wright was a remand prisoner at the Brisbane Correctional Centre (BCC). He was transferred to the PAHSU on 24 May 2022 with peripheral vascular disease. Mr Wright died of natural causes as a result of complications of peripheral vascular disease with Type 2 diabetes mellitus, atrial fibrillation, cardiomyopathy and delirium listed as other significant conditions.

Coronial jurisdiction

2. At the time of his death, Mr Wright was a prisoner in custody as defined in Schedule 4 of the *Corrective Services Act 2006* (Qld). Mr Wright'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. 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 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.

4. 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.

5. 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.

The investigation

6. The investigation into Mr Wright's death was led by Detective Senior Constable (DSC) Trudi Flintham of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

7. After being notified of Mr Wright's death on 1 November 2022, officers from the QPS CSIU attended the PAHSU and observed Mr Wright laying on his hospital bed. Mr Wright had an infusion pump connected to his body. There were no injuries or indications of a suspicious death.

8. On 2 November 2022, I made a direction for a targeted police investigation to occur. A Coronial Investigation Report was prepared and provided to the Coroners Court in July 2023.

[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.

9. DSC Flintham conducted a thorough investigation in response to the targeted direction. She concluded that there were no suspicious circumstances in relation to Mr Wright's death and that he was provided with adequate medical care while incarcerated.

The inquest

10. The inquest was held at Brisbane on 11 August 2025. All statements, medical records 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.

11. The issues considered at the inquest were the issues required by s 45(2) of the Act, and whether Mr Wright 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.

The evidence

Social and Medical History

13. Mr Wright was born on 24 February 1943 in Sydney, New South Wales. Mr Wright was a retired swimming coach and horse trainer. He had no contact with his immediate family.

14. On 21 October 2021, Mr Wright was extradited to Queensland from Western Australia in relation to nine charges of Indecent Treatment of Boys under seventeen and one charge of common assault, alleged to have been committed between 1980 and 1985.

15. Mr Wright appeared before the Brisbane Magistrates Court on 23 October 2021 and was remanded in custody. On 27 October 2021 Mr Wright was transferred from the Brisbane Watchhouse to the Brisbane Correctional Centre (BCC).

16. On 14 March 2022, Mr Wright was charged with an additional twenty offences of indecent assault on males and indecent treatment of boys under 17, alleged to have been committed between 1982 and 1986.

17. Mr Wright's Queensland criminal history is dated and contains two entries. On 15 September 1971 Mr Wright was sentenced at the Mackay Magistrates Court in relation to an offence of stealing for which he was convicted and fined $30.

18. On 20 June 1986, Mr Wright appeared before the Cleveland Magistrates Court and was placed on a $500 recognisance for a period of 18 months in relation to two offences of assault occasioning bodily harm and assault on a female.

19. Mr Wright's medical history included diabetes related peripheral vascular disease, type 2 diabetes, gastro-oesophageal reflux (GORD), glaucoma, atrial

fibrillation[2] and prostate cancer.[3] At the time of his nursing intake on reception at BCC Mr Wright was noted to have pressure ulcers on his right big toe and also between the fourth and fifth toes on his left foot.[4]

20. Mr Wright was prescribed several medications at the time reception to BCC:[5]

    a. *Glicazide and Metformin for diabetes*
    b. *Pantoprazole for GORD*
    c. *Atorvastatin for lowering cholesterol*
    d. *Rivaroxaban for preventing blood clots*
    e. *Azarga eye drops for glaucoma.*

21. The movement history received from Queensland Corrective Services (QCS) showed that Mr Wright was transported to the Princess Alexandra Hospital Secure Unit on multiple occasions to receive medical treatment during his period of incarceration.[6]

Care in custody

22. Following his initial nursing intake at BCC on 27 October 2021, Mr Wright was booked for daily dressings of his pressure ulcers and weekly blood sugar monitoring. Mr Wright was also referred to see a diabetic wound specialist at the PAH.

23. From 2 December 2021, Mr Wright was to have his daily dressings completed in his unit due to mobility concerns and being considered a falls risk.

8 December 2021: Transferred to PAH

24. On 8 December 2021, while Mr Wright's wound was being dressed, it was noted he had a "*deteriorating, oedematous leg with necrotic tissue*"[7] and was transferred to the PAH.

25. At the PAH it was noted that Mr Wright's diabetic foot ulcers were "*mildly cellulitic*" with "*no evidence of systemic response*".[8] Mr Wright was prescribed a course of antibiotics and his atrial fibrillation was controlled with anticoagulants.

26. On 9 December 2021, Mr Wright was referred to the Vascular Surgery High Risk Foot Clinic for review. It was recommended that Mr Wright's wounds be kept clean and dry with betadine applied twice daily.

27. Mr Wright was transferred back to BCC where he continued to have his wound dressed. By 12 December 2021, while Mr Wright's infection was improving, his left foot had redness and swelling which was tender to touch.

28. On 16 December 2021, Mr Wright declined to attend a podiatry review at the PAH due to previous wait times, notwithstanding being advised of the importance of attending appointments and the risk of amputation of his toe.

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[2] Exhibit B3 – Statement of Dr Nadeem Siddiqui, [10] – [11].
[3] Exhibit D6 – PAH DH Inpatient, page 1679.
[4] Exhibit B3 – Statement of Dr Nadeem Siddiqui, [13].
[5] Exhibit B3 – Statement of Dr Nadeem Siddiqui, [14].
[6] Exhibit E14 – QCS Movement History, pages 1 – 2.
[7] Exhibit B3 – Statement of Dr Nadeem Siddiqui, [22].
[8] Exhibit D6 – PAH DH Inpatient, page 1682.

29. By 19 December 2021 Mr Wright's ulcer was necrotic with "*swelling, erythema, poor vasculature, unpalpable pulses*".[9] On review Mr Wright's foot was red, slightly swollen and warm to touch and he was referred for medical review.

20 December 2021: Transferred to PAH

30. On 20 December 2021, Mr Wright was transferred back to the PAH for further treatment as his foot had deteriorated and was "*red, warm to touch, shiny to just above ankles then discovered up to mid shin area*"[10] with pain while walking. He was treated with intravenous antibiotics.

31. On 22 December 2021, following a Vascular Surgery review, no recommendation was made for vascular intervention at that time. However, Mr Wright was placed on oral antibiotics with a review by the vascular wound clinic scheduled for two months.

32. On 24 December 2021, Mr Wright was transferred back to BCC with wound management instructions to treat the ulcers with betadine paint twice daily and to use toe spacers until his scheduled vascular wound clinic review.

33. On 27 December 2021, RN Simpson made the following Prison Health Services (PHS) progress note regarding Mr Wright's wound management:[11]

> *Nursing: During PM med run was advised by pt, fellow inmate and a correctional officer that nursing staff during the AM shift had twice told the pt that they were unable to attend to his dressing as they were "too busy". Supposedly they also advised pt that he had to "do the dressing himself on the unit." Pt had another inmate helping him to change the dressing whilst I was there. Pt has complex wound and has been on regular clinic list since hospital discharge. Advised that I would follow up on this. Discussed with shift coordinator. Info to be passed on to AM staff tomorrow*.

34. Over the following days PHS progress notes indicate that while Mr Wright's dressings were changed daily, it is not clear whether Mr Wright was seen twice a day for betadine treatment on the big toe with toe spacers as recommended by the PAH.

6 January 2022: Transferred to PAH

35. On 6 January 2022, Mr Wright's right foot showed signs of increased cellulitis and pain and he was again transferred to the PAH for treatment.

36. On 8 January 2022, Mr Wright was reviewed by Vascular Surgery. A treatment plan was made consisting of continued intravenous antibiotics, the application of betadine paint, daily blood tests and orthotic shoes. Mr Wright showed signs of improvement.

37. On 14 January 2022, Mr Wright was discharged and transferred back to BCC and at 2:32pm a code blue was called after Mr Wright complained of abdomen pain, however, his observations were within normal limits.

[9] Exhibit D1 – Prison Health Records, page 29.
[10] Exhibit D1 – Prison Health Records, page 30.
[11] Exhibit D1 – Prison Health Records, page 30.

38. Another code blue was called on 17 January 2022 following complaints of chest, abdomen and kidney area pain. Mr Wright later indicated "*he feels more unsteady than in pain,*" and an ECG confirmed "*nil changes noted*".[12]

39. On 25 January 2022, Mr Wright experienced increased foot pain and a medical appointment was made for the following Monday. On 28 January 2022, it was noted that the dressing on Mr Wright's right toe had been inappropriately applied with the right toe "*very sloughy & oozing*."[13]

1 February 2022: Transferred to PAH

40. By 1 February 2022 Mr Wright's toe was "*visibly worse, purulent liquid leaking from wound, infection present*"[14] and he was transferred back to the PAH and admitted under Vascular Surgery.

41. The management of Mr Wright's wounds at PAH included continued application of betadine, and a diagnostic angiogram to which Mr Wright consented. By 3 February 2022, Mr Wright reported that the pain in his right foot was ongoing but less severe.

42. On 7 February 2022, Mr Wright underwent a right lower limb angiogram and angioplasty/stent. A follow up was scheduled at six weeks with repeat ultrasound.

43. On 8 February 2022, Mr Wright was discharged to BCC with PHS progress notes confirming Mr Wright's wound management was to continue with betadine swabs and nil dressing.

44. On 15 February 2022, during a medical review, Dr Della Bosca observed the ulcer on Mr Wright's right big toe was necrotic. Mr Wright declined any specialist involvement, including via video conferencing facilities and told Dr Della Bosca "*he understands he may die from his toe ulcer, but this is preferable to him returning to hospital*."[15] Dr Della Bosca also noted that Mr Wright's left foot appeared swollen and infected and prescribed oral antibiotics.

45. On 17 February 2022, Mr Wright appeared confused and reported visual hallucinations to nursing staff. Mr Wright told nursing staff that he would not return to hospital.

19 February 2022: Transferred to PAH

46. On 19 February 2022, Mr Wright refused medications and was transferred back to the PAH for investigation of his cognitive decline following continued confusion and visual hallucinations. At the PAH it was noted that Mr Wright's right leg was warm and "*without objective evidence of infection otherwise*"[16] and he showed signs of delirium.
47. On 22 February 2022, Mr Wright was assessed by Consultant Psychiatrist, Dr Wallace, who diagnosed Mr Wright with "*delirium psychotic features*" with "*possible background cognitive impairment*"[17] and placed Mr Wright on a low dose of risperidone.

[12] Exhibit D1 – Prison Health Records, pages 33 – 35; 38.
[13] Exhibit D1 – Prison Health Records, page 41.
[14] Exhibit D1 – Prison Health Records, pages 41 – 42.
[15] Exhibit D1 – Prison Health Records, pages 42 – 43.
[16] Exhibit D6 – PAH DH Inpatient, page 1563.
[17] Exhibit D6 – PAH DH Inpatient, page 1541; Exhibit D3 – PAH – CIMHA, page 6.

48. An MRI confirmed Mr Wright had an infection of the bone potentially requiring amputation to which Mr Wright was deemed competent to consent as his delirium was resolving. At that time Mr Wright did not have an Advance Health Directive or Enduring Power of Attorney. On 2 March 2022, Mr Wright underwent an amputation of his ulcerated toe at the metatarsophalangeal joint.

49. On 9 March 2022, Mr Wright was again reviewed by Dr Wallace, who noted Mr Wright had "*worsening confusion/agitation in context of ongoing delirium, pain and potential cognitive decline on background of recent infection/long term diabetes complications and recent amputation of right hallux*"[18] and adjusted Mr Wright's risperidone dose. Dr Wallace reviewed Mr Wright again on 11 March 2022, noting he had "*resolving delirium in postoperative setting*" and "*likely vascular cognitive decline*."[19]

50. By 15 March 2022, Mr Wright had developed two small sores on his second and fifth toes. The following day it was noted that a blister observed on the outside of Mr Wright's foot on 8 March 2022 had deteriorated and now extended to the base of the fifth toe. By 19 March 2022, the blister had broken and revealed an "*underlying superficial pressure injury*."[20]

51. On 21 March 2022, neither the amputation wound nor lateral wound were showing signs of infection and a plan was made to discharge Mr Wright the following day. Consultant Psychiatrist, Dr Wallace, confirmed there were "*no barriers from a mental health perspective to discharge*."[21]

52. On 22 March 2022, Mr Wright was discharged from the PAH with a telehealth follow up scheduled for two weeks and a medical review at BCC. On 24 March 2022, Dr Della Bosca reviewed Mr Wright and noted continued confusion and queried whether he had dementia or delirium.

53. On 21 April 2022, Dr Della Bosca reviewed Mr Wright who appeared alert and orientated. Dr Della Bosca reported "*sloughy debris*" [22] on Mr Wright's amputation wound without any surrounding redness.

1 May 2022: Transferred to PAH

54. On 1 May 2022, Mr Wright was transferred to the PAH where it was noted that while Mr Wright was systemically well, the areas of chronic ulceration on his left foot required ongoing monitoring and dressing changes. Mr Wright was transferred back to BCC that day.

55. On 3 May 2022, a phone call was received from RBWH podiatry in relation to Mr Wright's feet. Nursing staff photographed Mr Wright's feet and received instructions from the podiatrist to apply betadine daily to Mr Wright's left foot. It was also advised that Mr Wright should been seen daily at a minimum.

[18] Exhibit D6 – PAH DH Inpatient, page 1433 – 1434.
[19] Exhibit D6 – PAH DH Inpatient, page 1420.
[20] Exhibit D6 – PAH DH Inpatient, page 1366.
[21] Exhibit D6 – PAH DH Inpatient, page 1350.
[22] Exhibit D1 – Prison Health Records, pages 53; 181 - 183.

56. On 6 May 2022, Mr Wright was referred to the Prison Mental Health Service after reporting visual hallucinations while in hospital. Mr Wright underwent an intake assessment on 10 May 2022 with clinician Michelle Morrison who noted "*significant depressive features, passive death wish and refusing necessary hospitalisation*." [23] It was recommended that Mr Wright undergo an urgent review.

57. On 19 May 2022, Mr Wright was reviewed by Psychiatric Registrar, Dr Dennis Yin, who noted Mr Wright's mental state was stable but recommended input be obtained from psychology in relation to capacity and memory.

58. That day it was also noted that the third and fourth toes on Mr Wright's left foot were "*almost completely black*" and were "*cold to touch*."[24]

59. On 24 May 2022, Dr Della Bosca transferred Mr Wright to the PAH for the final time, noting "*he is currently alert and orientated but his toes are frankly necrotic and he is likely to develop infection/delirium/sepsis without tertiary care*."[25]

24 May 2022 – 1 November 2022: Final transfer to PAH Secure Unit

60. On 24 May 2022, Mr Wright was admitted under Vascular Surgery and under the care of Dr Ian Campbell, with left third and fourth toe necrosis and peripheral vascular disease of the left leg. Mr Wright was treated with intravenous antibiotics.

61. On the afternoon of 27 May 2022, Mr Wright underwent an angiogram of his left leg, angioplasty and the amputation of his third, fourth and fifth toes. He also had rapid atrial fibrillation that was treated with digoxin loading.[26]

62. On 2 June 2022, during a Vascular Surgery review it was observed that there was a necrotic edge on the base of the left foot that did not appear to be healing, however, there was no overt infection to the area. By 8 June 2022, Mr Wight's right foot hallux was slowly improving, his right foot lateral wounds had formed an eschar covering and his left foot wounds were improving.

63. On 13 June 2022, Mr Wright had a chest x-ray that showed "*the cardiac shadow is enlarged. There is minor atelectasis or scarring at the left lung base but there is no pulmonary consolidation or pleural effusion*."[27]

64. By 18 June 2022, Dr Truong explained to Mr Wright during a Vascular Surgery ward round that further deterioration may require further procedures to save his life, including above knee amputation. Mr Wright declined any further surgery, even if lifesaving.

65. On 21 June 2022, Mr Wright underwent a Geriatric review to assess his capacity to consent to "*complex operation vs withdrawal of life saving measures*."[28] On assessment it was determined that Mr Wright possessed "*adequate capacity to make a decision re whether to have surgery or not*" and did not display signs of delirium at the time.[29] Mr Wright also had a Mini-Mental State Examination score

[23] Exhibit D2 – WMHHS – CIMHA, page 12.
[24] Exhibit D5 – PAH DH Outpatient, page 63.
[25] Exhibit D5 – PAH DH Outpatient, page 64.
[26] Exhibit B2 – Statement of Dr Juanita Muller, [16].
[27] Exhibit D6 – PAH DH Inpatient, page 2237.
[28] Exhibit D6 – PAH DH Inpatient, page 1198.
[29] Exhibit D6 – PAH DH Inpatient, page 1196.

of 20/30 which suggested "*possible underlying cognitive impairment in keeping with previous MRI head showing atrophy, vascular changes and an old lacunar infarct*."[30]

66. During the assessment it was noted that Mr Wright possessed an understanding of the potential medical outcomes of his decisions.[31] Mr Wright indicated that he would like two female friends to make decisions on his behalf if required but did not nominate them and was aware that he did not have an Enduring Power of Attorney at that time. Mr Wright advised that he would consider speaking to his solicitor about appointing one.[32]

67. The following day a VI Leg Peripheral Artery Duplex Left ultrasound showed a "*left superficial femoral artery false aneurysm*"[33] and on 27 June 2022, Mr Wright underwent a "*left posterior tibial artery stent and repair of left superficial femoral artery false aneurysm with covered stent. Further local amputation, debridement of wound and surgical closure of wound*."[34]

68. On 26 June 2022, Mr Wright had a chest x-ray in a septic screen that showed "*the bibasal atelectasis has worsened with possible developing consolidation in the left lower lobe*."[35] A further chest x-ray on 2 July 2022, following reports of chest tightness and discomfort, noted "*the bibasal atelectasis persists and is stable*."[36]

69. On 3 July 2022, Mr Wright reported abdominal pain and had an ultrasound on 5 July 2022 that confirmed the presence of gallstones which was managed with pain relief. Over the following days Mr Wright exhibited agitated behaviour, which limited the ability to examine his gallbladder for inflammation. A non-contrast CT of Mr Wright's abdomen on 7 July 2022 confirmed inflammation with "*no evidence of colitis or any other acute intra-abdominal pathology*."[37]

70. On 11 July 2022, Mr Wright had a MET call following a drop from 15 to 13 on the Glasgow Coma Scale, with reduced urine output. A septic screen chest x-ray found "*bilateral pleural effusions have developed and there is consolidation in the left lung*",[38] since the prior x-ray on 2 July 2022.

71. That day blood tests also indicated that Mr Wright had acute kidney failure stage 4 with kidney function reducing since 7 July 2022 and type 2 respiratory failure. Consultant General Physician, Dr Suzana Milosevic opined that "*Mr Wright's acute kidney injury (AKI) was multifactorial due to: 1. presumed sepsis 2. Cardiac failure 3. Nephrotoxic medications*."[39]

[30] Exhibit B2 – Statement of Dr Juanita Muller, [18].
[31] Exhibit D6 – PAH DH Inpatient, page 1195.
[32] Exhibit D6 – PAH DH Inpatient, page 1195.
[33] Exhibit D6 – PAH DH Inpatient, page 2261; Exhibit B2 – Statement of Dr Juanita Muller, [19].
[34] Exhibit B2 – Statement of Dr Juanita Muller, [20].
[35] Exhibit D6 – PAH DH Inpatient, page 2236.
[36] Exhibit D6 – PAH DH Inpatient, page 2235.
[37] Exhibit D6 – PAH DH Inpatient, page 1103 and 1105.
[38] Exhibit D6 – PAH DH Inpatient, page 2234.
[39] Exhibit B1 – Statement of Dr Suzana Milosevic, [13].

72. On 13 July 2022, Dr Milosevic changed Mr Wright's antibiotics to Meropenem and stopped Pregabalin and Oxycodone, citing that "*at the time he was receiving Piptaz antibiotics which were potentially nephrotoxic in the setting of lower kidney function*."[40]

73. Mr Wright's blood tests showed "*worsening of his liver function tests in the setting of heart failure*."[41] An echocardiogram that day indicated Mr Wright had severe heart failure.

74. Mr Wright was reviewed by Intensive Care Unit (ICU) Registrar, Dr Benjamin Gardiner who noted Mr Wright's condition resembled a "*decompensated heart failure in multi-organ dysfunction; no overtly reversible pathology; likely represents terminal event*." Following a discussion with ICU Consultant, Dr Laurie, regarding Mr Wright's prognosis it was concluded, "*Escalation to ICU level support would not change trajectory of patients illness and there would be inappropriate – not a candidate for intubation/ventilation, inotropic support or Dialysis. Would suggest transition to care focused on patient comfort*."[42]

75. On 15 July 2022, Mr Wright was also reviewed by Renal Registrar, Dr Saskia Leibowitz who noted that Mr Wright had multifactorial acute kidney injury with poor prognosis and concluded he "*would not be a good candidate for dialysis in view of age, comorbidities and multiple active issues*."[43]

76. Dr Milosevic noted that between 13 – 23 July 2022 "*Mr Wright's blood results were seen to be improving and his kidney function was recovering, however he still remained delirious*" which impacted his appetite and in turn his blood sugar levels.[44] Between 26 August and 12 September Mr Wright experienced three episodes of hyperglycaemia.

77. On 25 July 2022, during a Cardiology Consult, Dr Harte noted Mr Wright's atrial fibrillation was rate controlled with digoxin and anticoagulated with apixaban.[45] However, his apixaban was withheld from 2 August 2022, during an episode of passing blood clots in his urine.

78. On 18 August 2022, a MET call was made following an aspiration event during breakfast with a subsequent chest x-ray confirming "*improvement in the bilateral pleural effusions*" and improvement in "*the left lower lobe consolidation*."[46]

79. During the medical ward round it was noted that Mr Wright had experienced "*profound clinical functional decline over previous several weeks*"[47], however it was considered that Mr Wright had capacity to make medical decisions with his recurrent delirium and agitation largely resolved.

80. On 31 August 2022, during a Vascular Surgery review, it was noted that the wound on Mr Wright's right foot appeared healed with a dry scab while the left had a small cavity with a healthy base. It was recommended that treatment with dressings and betadine paint continue.

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[40] Exhibit B1 – Statement of Dr Suzana Milosevic, [14].
[41] Exhibit B1 – Statement of Dr Suzana Milosevic, [14].
[42] Exhibit D6 – PAH DH Inpatient, pages 1039 and 1042.
[43] Exhibit D6 – PAH DH Inpatient, page 1022.
[44] Exhibit B1 – Statement of Dr Suzana Milosevic, [21].
[45] Exhibit D6 – PAH DH Inpatient, page 938.
[46] Exhibit D6 – PAH DH Inpatient, pages 774 and 2230.
[47] Exhibit D6 – PAH DH Inpatient, page 771.

81. On 3 September 2022, Mr Wright had a further aspiration event with a chest x-ray showing "*persistent consolidation in the left lower lobe*" [48] with no other changes and resolved pleural effusions.

82. In the weeks preceding 26 September 2022, Mr Wright's wounds deteriorated further with a "*lateral wound with cavity, expressing purulent discharge*."[49] Mr Wright's wound progress and management was discussed with Dr Campbell who did not recommend any further vascular intervention but recommended palliative care input, noting the Mr Wright had been clear that he did "*not want major limb amputation in the event of sepsis*".[50]

83. On 29 September 2022, Dr Milosevic referred Mr Wright to Palliative Care as his condition had not improved with antibiotics and was not for surgical intervention.

30 September 2022: Mr Wright transferred to Palliative Care

84. On 30 September 2022, Mr Wright was reviewed by Dr Sumbal Shahid who recommended a formal capacity assessment be undertaken, and in the event that Mr Wright did not have capacity to contact the Public Guardian. Mr Wright was commenced on hydromorphone, haloperidol and midazolam.

85. On 6 October 2022, Dr Milosevic contacted the Public Guardian for consent to withdraw life sustaining measures as Mr Wright in the absence of a next of kin. Consent was granted to withhold *Cardiopulmonary resuscitation; Assisted ventilation* and *Artificial hydration*. [51] Dr Milosevic was of the view that, "*Mr Wright did not have capacity at that time to understand the complexity of the health decisions regarding his care, progress and prognosis*."[52]

86. Over 10 and 11 October 2022, Mr Wright's hydromorphone infusion was increased, and Dr Shahid requested that medications be rationalized and for Mr Wright's Acute Resuscitation Plan be updated to reflect the comfort care approach taken.

87. On 19 October 2022 Mr Wright's insulin was ceased and he was reviewed by Dr Kate Gibson who noted he had ongoing delirium and hypoglycaemia as well as increasing agitation. Mr Wright's condition was discussed at the Palliative Care Multidisciplinary Team meeting the following day, when it was noted that he had "*limb threatening ischaemia, not for surgical intervention*" and was actively deteriorating.[53]

88. On 24 October 2022 Dr Gibson recommended that Mr Wright "*would be most appropriate for comfort cares, with focus on symptomatic control and quality of life*" and recommended that this course be discussed with the Public Guardian.[54] Palliative Care Consultant Dr Gunawan also recommended that Mr Wright be "*be transitioned to a comfort care approach, focusing on his comfort and dignity*" with further discussion to take place with the Public Guardian.[55]

[48] Exhibit D6 – PAH DH Inpatient, page 2229.
[49] Exhibit D6 – PAH DH Inpatient, page 530.
[50] Exhibit D6 – PAH DH Inpatient, page 458.
[51] Exhibit D6 – PAH DH Inpatient, page 455.
[52] Exhibit B1 – Statement of Dr Suzana Milosevic, [32].
[53] Exhibit D6 – PAH DH Inpatient, page 382.
[54] Exhibit D6 – PAH DH Inpatient, page 361.
[55] Exhibit D6 – PAH DH Inpatient, page 359.

89. On 26 October 2022 Dr Gunawan noted that he anticipated a "*more rapidly deteriorating trajectory*" and reiterated that it would be appropriate to transfer Mr Wright to comfort cares.[56] Consent was obtained from the Public Guardian to transition Mr Wright to comfort cares.

1 November 2022: Day of Mr Wright's death

90. By 1 November 2022, Mr Wright had entered the terminal phase. During nursing checks conducted that afternoon Mr Wright appeared to be sleeping and comfortable. By approximately 1635hrs nursing staff were advised Mr Wright was unresponsive and observed nil signs of life.[57]

91. At approximately 1640hrs Dr Hinde was informed of Mr Wright's death via phone at attended the secure unit at 1650hrs. Dr Hinde declared Mr Wright deceased.[58]

92. The Corrective Services Investigation Unit was advised of Mr Wright's death.[59]

Forensic Medicine Queensland advice

93. As there were multiple missing entries in the PHS progress notes relating to Mr Wright's wound management at BCC, I sought advice from Forensic Medicine Queensland as to the impact, if any, this may have had on Mr Wright's prognosis. On 3 June 2025, Dr Jessica Page provided the following advice:[60]

> *Mr Wright was a man with multiple medical comorbidities, including severe peripheral vascular disease. The nature of peripheral vascular disease is such that wound healing is slow, challenging, and frequently complicated. It is not uncommon for patients to develop chronic, non-healing wounds, even with the highest level of medical and surgical intervention being offered. Wounds such at this place these patients at high risk of complications such as infection, sepsis, and ultimately death.*
>
> *I note that Mr Wright at various times declined to attend hospital for appointments, including an appointment with the vascular surgery outpatient team in December 2021. It is also reported that he on several occasions expressed that he did not want major limb amputation in the event of sepsis (presumably from wound infection). In the setting of limited surgical options, the chance of complete healing of Mr Wright's wounds would have been limited again.*
>
> *In light of all of this, it is in my view unlikely that lapses in wound/dressing management in the correctional facility would have been significantly outcome changing for Mr Wright. I note that he was admitted to hospital from May until his death in November, where he presumably was receiving the highest possible level of wound care and yet his condition deteriorated. In my opinion his death would have occurred at about the same time, and from the same or similar complications of his underlying natural diseases, even had different wound care been provided in the correctional facility.*

94. I accept the advice of Dr Page.

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[56] Exhibit D6 – PAH DH Inpatient, page 346.
[57] Exhibit D6 – PAH DH Inpatient, page 309
[58] Exhibit D6 – PAH DH Inpatient, page 310.
[59] Exhibit D6 – PAH DH Inpatient, page 310.
[60] Exhibit [insert #] – Advice from Dr Jessica Page, 3 June 2025.

Autopsy results

95. On 7 November 2022, Dr Nadine Forde conducted an autopsy consisting of an external examination of the body and compiled an autopsy report.

96. CT scans showed signs of vascular calcification and Dr Forde observed, in the external examination, that Mr Wright had undergone amputations of toe and partial forefoot "*with ongoing healing wounds, some four months since surgery*."[61]

97. In the autopsy report Dr Forde stated, "*the cause of death is multifactorial given his numerous comorbidities, however his admission and deterioration as an inpatient was subsequent to the development of necrotic toes and lower limb ischaemia from peripheral vascular disease. Therefore, the cause of death is attributed to complications of peripheral vascular disease with his other conditions as significant contributing factors*." [62]

98. Dr Forde concluded that the cause of death was 1(a) *complications of peripheral vascular disease* with (2) *Type 2 diabetes mellitus, atrial fibrillation, cardiomyopathy and delirium* listed as other significant conditions.[63]

Conclusions

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

100. 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 Wright when measured against this benchmark.

Findings required by s. 45

101. 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:	John Reginald Wright
(b) How the person died:	Mr Wright, who had a number of comorbidities, including type 2 diabetes mellitus, died from complications of peripheral vascular disease following a lengthy admission at Princess Alexandra Hospital Secure Unit.
(c) When the person died:	1 November 2022.

[61] Exhibit A5 – Autopsy Report, page 6.
[62] Exhibit A5 – Autopsy Report, page 6.
[63] Exhibit A5 – Autopsy Report, page 7.

(d) Where the person died:	Princess Alexandra Hospital Secure Unit.
(e) What caused the person to die:	1(a) Complications of peripheral vascular disease. 2 Type 2 Diabetes Mellitus; atrial fibrillation; cardiomyopathy; delirium.

Comments and recommendations

102. 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.

103. 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.

104. I extend my condolences to Mr Wright's family and friends.

105. I close the inquest.

Terry Ryan
State Coroner
BRISBANE