



# CORONERS COURT OF QUEENSLAND

## FINDINGS OF INQUEST

CITATION: **Inquest into the death of Alexander David Aitkenhead**

TITLE OF COURT: Coroners Court

JURISDICTION: BRISBANE

FILE NO(s): 2019/2021

DELIVERED ON: 17 December 2020

DELIVERED AT: Brisbane

HEARING DATE(s): 17 December 2020

FINDINGS OF: Terry Ryan, State Coroner

CATCHWORDS: CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting: Sarah Lio Willie

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## Introduction

1. At the time of his death, Alexander David Aitkenhead was aged 86 years. He was a prisoner hospitalised in the palliative care unit at the Rockhampton Hospital. Prior to his hospitalisation he was an inmate serving a sentence at the Capricornia Correctional Centre (CCC).
2. Mr Aitkenhead suffered from many chronic illnesses. On 21 April 2019, he was admitted to hospital with end stage chronic obstructive pulmonary disease. He died on 10 May 2019.

## The investigation

3. Detective Senior Constable (DSC) Alfred Pritchard from the Corrective Services Investigation Unit conducted a targeted investigation into the circumstances surrounding Mr Aitkenhead's death.
4. The CSIU investigation was informed by statements from relevant custodial correctional officers and nursing and medical staff at the CCC and the Rockhampton Hospital. These statements were tendered at the inquest.
5. DSC Pritchard concluded that Mr Aitkenhead received adequate medical care as a prisoner. He also concluded that his death was unavoidable and there was no act or omission by any person which resulted in the death.

## The inquest

6. As Mr Aitkenhead died while he was in custody, an inquest was required by s 27 of the *Coroners Act* 2003. The inquest was held on 17 December 2020. All the statements, medical records and material gathered during the investigation into Mr Aitkenhead's death were tendered to the court. Counsel Assisting proceeded to submissions in lieu of any oral testimony being heard.

## The evidence

### *Personal History*

7. Mr Aitkenhead had six children with his wife.<sup>1</sup> Mr Aitkenhead's son was listed as his next of kin while he was in custody. His daughter who was a registered nurse had ceased contact with Mr Aitkenhead about five years prior to his death. At that time, she was aware that Mr Aitkenhead was suffering from several chronic illnesses, and his wishes were to cease life prolonging procedures and treatments. His daughter had no concerns about the care her father received while in custody. I extend my condolences to his family.

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<sup>1</sup> Sentencing remarks

### ***Criminal history***

8. Mr Aitkenhead had one entry on his criminal history. On 22 June 2015, he was convicted on his plea of guilty in the District Court at Gladstone of two counts of rape and three counts of indecent treatment of girls under 14 years. Those offences were committed between 1980 and 1986. He was sentenced to eight years imprisonment, and became eligible for parole on 22 December 2017.

### ***Medical history***

9. On Mr Aitkenhead's reception to CCC on 23 June 2015, he was a frail 82 year old man who suffered from:<sup>2</sup>
  - Chronic obstructive pulmonary disease (COPD);
  - Atrial fibrillation (AF);
  - Emphysema;
  - Osteoporosis;
  - Osteoarthritis;
  - Hypertension; and
  - Reflux
10. Mr Aitkenhead had at least ten medications prescribed order to treat his illnesses. Throughout his incarceration at the CCC, Mr Aitkenhead had several admissions to hospital for chest infections. During those admissions, Mr Aitkenhead also had fast atrial fibrillation and would develop congestive cardiac failure.
11. On 16 October 2018, after two successive hospital admissions, Mr Aitkenhead was assessed by the visiting medical officer (VMO) at the health centre of the prison, and confirmed his previously signed 'Not for Resuscitation' (NFR) order was to remain in place while at CCC. He did not wish to be intubated or ventilated.
12. On 18 October 2018, Mr Aitkenhead was admitted to the Rockhampton Hospital Sub Acute Geriatric Evaluation (SAGE) unit for a period of 19 days. This was due to his inability to self-manage safe basic hygiene requirements in the prison environment.
13. When Mr Aitkenhead returned to CCC on 6 November 2018, Assistant in Nursing (AIN) staff were specifically hired to provide activities of daily living (ADL) for him. These included showering, shaving, and continence management. In addition to the daily assistance, Mr Aitkenhead was also regularly reviewed by the VMO. He was seen at least six times by the VMO between 3 July 2018 and 16 March 2019.

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<sup>2</sup> Exhibit B6

14. On 4 April 2019, Mr Aitkenhead was reviewed by a clinical nurse at the CCC health centre and assessed to have increased shortness of breath and wheeze, elevated and irregular heart rate. He was subsequently transferred to the Rockhampton Hospital by ambulance.
15. On 11 April 2019, he returned to residential accommodation at CCC. Assistance with ADLs by AINs was re-instigated at the health centre. Mr Aitkenhead was taken to the health centre daily in a wheelchair by a prisoner carer.
16. Mr Aitkenhead was last seen by the VMO in the health centre on 16 April 2019, who assessed his chronic reflux concerns and planned ongoing International Normalised Ratio (INR) monitoring due to him receiving Warfarin treatment for his chronic AF.

### **Events leading up to the death**

17. On 21 April 2019, Mr Aitkenhead was too weak to mobilise. Correctional officers (CO's) subsequently called a Code Blue. Mr Aitkenhead was assessed by a clinical nurse who documented that he had shortness of breath and tightness in his chest. Mr Aitkenhead also disclosed to the nurse that he had not been eating or taken any fluids in a few days.
18. Mr Aitkenhead was transported by ambulance to the Rockhampton Hospital. He was diagnosed with end-stage COPD, and admitted to a single occupancy room in the Palliative Care Unit.
19. On 29 April 2019, nurses from the CCC made enquiries with local nursing homes and care organisations if they had any availability to provide palliative care for Mr Aitkenhead, if they were able to attain his release on compassionate parole.
20. Mr Aitkenhead's condition deteriorated after that point, and on 10 May 2019 at 6.35pm, he was declared life extinct in his hospital room.

### **Autopsy Results**

21. An external post-mortem examination was performed by Professor David Williams at the Rockhampton Mortuary on 16 May 2019.<sup>3</sup> The examination noted that muscle mass appeared rather wasted.

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<sup>3</sup> Ex A4

22. A review of the medical records, in conjunction with the examination determined that Mr Aitkenhead died of natural causes. The cause of death was found to be ischaemic heart disease. Other significant conditions that contributed to his death, but not related to the underlying cause were, valvular heart disease, prostatic enlargement and chronic obstructive airways disease.
23. The toxicology showed low levels of his medication with no drugs of abuse in his system. The acetone levels reflected a probable period of not eating prior to his death.

## **Conclusions**

24. Mr Aitkenhead' death was the subject of a police investigation. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.
25. Mr Aitkenhead was an elderly man who entered custody with a number of comorbidities. When Mr Aitkenhead's health deteriorated he received daily assistance by staff specifically hired to provide activities of daily living. Staff at CCC made enquiries with nursing homes about the possibility of residence if he was granted compassionate parole. In all the circumstances, no adverse comment could be made about the care and attention Mr Aitkenhead received in custody.
26. None of the CO's involved at CCC contributed to his death. I am satisfied that Mr Aitkenhead was given appropriate medical care by staff at CCC and the Rockhampton Hospital while he was admitted there. His death could not have reasonably been prevented.
27. 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 medical care provided to Mr Aitkenhead when measured against this benchmark.

## **Findings required by s. 45**

**Identity of the deceased** – Alexander David Aitkenhead

**How he died** – Mr Aitkenhead suffered from chronic illnesses on his admission to prison at the age of 82 in June 2015. On 21 April 2019, he was admitted to hospital with end stage chronic obstructive pulmonary disease. He died on 10 May 2019.

**Place of death** – Rockhampton Hospital, Rockhampton, Queensland

**Date of death**– 10 May 2019

**Cause of death** – Ischaemic heart disease on a background of valvular heart disease, prostatic enlargement and chronic obstructive airways disease.

## **Comments and recommendations**

28. The circumstances of Mr Aitkenhead's death do not call for any comment relating to issues of public health and safety or the administration of justice or ways to prevent deaths from happening in similar circumstances.
29. I close the inquest.

Terry Ryan  
State Coroner  
Brisbane  
19 June 2024