QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Errol George Radan**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/5372
DELIVERED ON:	15 July 2025
DELIVERED AT:	BRISBANE
HEARING DATE(s):	15 July 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 Nadia El Moslemani
Queensland Corrective Services	Ms Jennifer Capper
West Moreton Hospital and Health Service	Ms Jennifer Davis

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Introduction

1. Errol George Radan was 83 years of age when he died in palliative care at the Princess Alexandra Hospital (PAH) Secure Unit (SU) on 26 October 2022. Following a stroke on 19 October 2022, Mr Radan was transferred to the PAHSU from the Wolston Correctional Centre (WCC) where he had been serving a term of imprisonment for sexual offences. Mr Radan died of natural causes as a result of a left middle cerebral artery cerebrovascular accident. Mr Radan's conditions of atrial fibrillation, hypertension and cerebrovascular accident were also considered to have contributed to his death.

Coronial jurisdiction

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

6. In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[2] As outlined in 'The Australasian Coroners Manual':

> *Hindsight bias is the tendency after the event to assume that events are more predictable or foreseeable than they really were. What is clear in hindsight is rarely as clear before the fact…It is an obvious point, but one that nonetheless bears repeating, particularly when coroners are considering assigning blame or making adverse comments that may damage a person's reputation.*
> *…*
> *Coroners should attempt first to understand the circumstances as they appeared at the relevant time to the people who were there.*
> *…*

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

> *Hindsight, of course, is a very useful tool for learning lessons from an unfortunate event. It is not useful for understanding how the involved people comprehended the situation as it developed. This distinction needs to be understood and rigorously applied.*[3]

The investigation

7. The investigation into Mr Radan's death was led by Detective Sergeant (DS) Tunny of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

8. After being notified of Mr Radan's death on 26 October 2022, Detective Acting Sergeant (D/AS) Hamilton from the QPS CSIU attended the PAHSU. D/AS Hamilton observed Mr Radan lying supine on the hospital bed wearing a hospital gown. He had an infusion pump connected to his body as well as a catheter. Mr Radan was pale and had no injuries, marks or indications of a suspicious death. D/AS Hamilton took photographs of Mr Radan and the scene.

9. On 27 October 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 May 2024.

10. DS Tunny conducted a thorough investigation in response to the targeted direction. He concluded that there were no suspicious circumstances in relation to Mr Radan's death and that he was provided with adequate medical care while incarcerated.

The inquest

11. The inquest was held at Brisbane on 15 July 2025. All statements, medical records, photographs and materials gathered during the investigation were admitted into evidence. No witnesses were called to give oral evidence. Counsel Assisting proceeded to submissions on the investigation material in lieu of any oral evidence.

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

13. 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

14. Mr Radan was born on 12 February 1939 in Adelaide, South Australia. Mr Radan used a number of aliases including David Evans, Alan Hanson and Alan West.

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

15. Mr Radan had a lengthy criminal history across South Australia, New South Wales, Victoria and Queensland. His interaction with the criminal justice system spanned 70 years, commencing in Adelaide in 1952 when he was 13 years of age. Mr Radan's offences were predominately sexual in nature and he had multiple convictions for offences including gross indecency, indecent assault, indecent interference, assault with intent to rape, indecent dealing, abduction and carnal knowledge.

16. On 31 May 1984, Mr Radan was sentenced in the District Court at Brisbane to a total of 12 years imprisonment in relation to seven offences of indecent dealing with a girl under the age of 14 years and one offence of carnal knowledge against the order of nature. In relation to the offences of indecent dealing with a girl under the age of 14 years, Mr Radan was sentenced to 3 years imprisonment with hard labour to be served concurrently in relation to counts 1 to 3, and 3 years imprisonment to be served cumulatively in relation to counts 4 to 7. Mr Radan was also sentenced to 9 years imprisonment to be served concurrently in relation to the offence of carnal knowledge against the order of nature. At the time of sentence, a ruling was made that at the end of his sentence Mr Radan was to be detained in an institution during Her Majesty's pleasure.

17. On 28 August 1984, the Court of Appeal allowed an appeal against sentence to the extent that the sentence was set aside and Mr Radan was re-sentenced to three years imprisonment and then admitted to an institution during Her Majesty's pleasure. On 17 September 1990, the Court of Appeal dismissed an appeal against conviction.

18. In 2014, the High Court of Australia dismissed an appeal by Mr Radan and another prisoner contesting the validity of s 18 of the *Criminal Law Amendment Act 1945* (Qld) with respect to indefinite sentencing orders.[4] Consequently, Mr Radan had been in the custody of QCS for approximately 39 years at the time of his death.

19. During his incarceration, Mr Radan had no visitors or telephone calls in more than 20 years. A number of attempts were made by both QCS and QPS to contact a family member however these were unsuccessful.

20. Mr Radan's medical history included a left middle cerebral artery cerebrovascular accident in 2017, atrial fibrillation, hypertension, epilepsy and left inguinal hernia repair in 2016.[5]

21. Mr Radan was prescribed several medications at the time of his death including:

    a. *Levetiracetam (500mg, twice a day) to treat epilepsy*
    b. *Lamotrigine (50mg, mane) to treat epilepsy*
    c. *Dabigatran (Pradaxa) (110mg, twice a day) to prevent blood clotting*
    d. *Atorvastatin (80mg, nocte) to prevent heart attacks, strokes, lowers cholesterol*
    e. *Metoprolol (25mg, twice a day) to regulate heart rate.*[6]

[4] *Pollentine v Bleijie* (2014) 253 CLR 629
[5] Exhibit A3 – Autopsy Report, page 6.
[6] Exhibit B2 – Statement of Dr Nadeem Siddiqui, [10]

22. The movement history received from QCS, dating back to 2013, showed that Mr Radan was transported to the PAH Secure Unit on multiple occasions to receive medical treatment. In the 12 months before his death there was no recorded movement of Mr Radan from WCC.[7]

Care in custody

23. On 5 April 2020, Mr Radan made the following Prison Health Service (PHS) request:

> *I do not wish to be provided with Dabigatran Capsules, Atorvastatin Tablets or Metoprolol Tablets.*
> *I will not enter into any discussion concerning my decision.*[8]

24. On 2 July 2020, Mr Radan attended PAH following an "*unwitnessed seizure in prison, secondary to medication non-compliance*."[9] A CT scan of his brain showed "*significant atrophy particularly frontally*."[10] The discharge summary noted that whilst at PAH Mr Radan had refused cares and initially medications, however, started to agree to medications during his admission.

25. On 12 July 2020, Mr Radan's previous written refusal for medications was reversed by making the following PHS request:

> *To be provided with:*
> *Dabigatran*
> *Atorvastatin*
> *Levetiracetam* *2 in morning*
> *Metoprolol*
> *Lamotigine* *1 in evening*
> *No sleeping tablet.*[11]

26. On 19 October 2020, Mr Radan requested to speak with the nurse unit manager regarding not being administered four doses of his medication. The nurse unit manager clarified that Mr Radan had only missed one dose on 15 October 2020.

27. On 5 March 2021, Dr Pidgeon, Senior Medical Officer at the PHS, made the following note following Mr Radan refusing to be seen for a medical review that day:

> *He has written several letters stating he wishes not to receive further treatment for epilepsy or stroke @ the PAH. Mr Radan is competent and does not appear to have any signs of altered mental state. Mr Radan states he does not want to have any further treatment for epilepsy or stroke but is happy to be treated for any other condition, if required.*
>
> *Mr Radan's reasoning for refusing further treatment for stroke & epilepsy is that he is 82, has receptive aphasia from prev stroke and he finds this very frustrating. He understands that refusing treatment fir epilepsy and stroke may result in his death*.

[7] Exhibit C6 – QCS Movement History, pages 1 – 4.
[8] Exhibit D5 – PHS – IM Vol 7, page 130.
[9] Exhibit D5 – PHS – IM Vol 7, page 150 (PAH Discharge Summary)
[10] Exhibit D5 – PHS – IM Vol 7, page 151.
[11] Exhibit D5 – PHS – IM Vol 7, page 126.

Mr Radan has previously completed an AHD that wasn't signed by a JP. I have asked him to complete a new AHD & I will go through this with him next week. The we can arrange for a JP to sign & this will become a legally binding document.[12]

28. On 30 March 2021, Mr Radan prepared an Advance Health Directive (AHD) and Dr Pidgeon recorded in the PHS progress notes at that time that "*Mr Radan is of sound mind and competent*."[13]

29. On 7 June 2021, Mr Radan made the following written PHS request refusing medications:

> *I do not wish to be provided with the following medications:*
> *Dabigatran*
> *Atorvastatin*
> *Metoprolol*.[14]

30. On 27 August 2021, Mr Radan made a written PHS request to revoke his AHD as it contained information he "*did not wish for*".[15] Mr Radan was advised this would be achieved by completing an updated AHD.

31. On a number of occasions in September and October 2021 Mr Radan requested to see a doctor regarding his AHD and specified that he did not want to see Dr Pidgeon. He had declined to attend his previous two medical reviews.

32. Mr Radan was placed on Dr Della Bosca's review list. However, on 20 December 2021, 27 June 2022 and 25 July 2022 Mr Radan declined to attend medical review appointments with Dr Della Bosca. Had Mr Radan attended those appointments he would have had the opportunity to amend his AHD.

33. On 27 February 2022, Mr Radan made the following written PHS Health Services Request:

> *To be provided with*
> *In the evenings:*
> *1 Dabigatran*
> *2 Atorvastatin*
> *3 Levetiractam*
> *4 Metopolol*
>
> *In the mornings:*
> *1 Dabigatran*
> *2 Levetiractam*
> *3 Metoprolol*
> *4 Lamatrigine*
> *2 x Coloxyl*.[16]

34. On 28 March 2022, Mr Radan refused to take medications, stating that he "*does not want to take it*".[17] The PHS progress notes indicate that this refusal continued until 4 April 2022 when Mr Radan accepted medication.

35. On 11 April 2022, Dr Pidgeon made the following note in the PHS progress notes after Mr Radan refused a medical review:

> *Went down to S3 to see prisoner Radan w/ CN [indistinct].*
> *Mr Radan declined to be seen.*
> *Has been predominantly refusing meds but has taken them on occasion.*

[12] Exhibit D5 – PHS – IM Vol 7, page 42.
[13] Exhibit D5 – PHS – IM Vol 7, page 44.
[14] Exhibit D5 – PHS – IM Vol 7, page 112.
[15] Exhibit D5 – PHS – IM Vol 7, page 99.
[16] Exhibit D5 – PHS – IM Vol 7, page 84.
[17] Exhibit D5 – PHS – IM Vol 7, page 54.

Has declined to attend MO review in medical on several occasions in past 6 months.
I have previously discussed w/ Mr Radan his increased risk of dying by refusing medication & medical review.
Please continue to offer medication.
Will list for review again next month.
I wonder if QCS psych could conduct a welfare check, QCS officers did not express any concerns today.[18]

36. On 14 April 2022, Mr Radan also refused Atorvastatin in addition to Dabigatran and Metoprolol. Mr Radan continued to decline to take his prescribed medications of Dabigatran and Metoprolol and on 26 April 2022 the consequences of not taking the medication was explained to Mr Radan. His response was, "*No is no*."[19]

37. On 12 May 2022, Mr Radan declined a Mental Health review.

38. On 24 and 25 May 2022, PHS progress notes indicate that Mr Radan refused to take Dabigatran and Metoprolol despite education provided.

39. On 25 August 2022, PHS progress notes indicate Mr Radan "*still refusing Dabigatran and Metoprolol AM*."[20] It is unclear whether Mr Radan was compliant with taking his medication on the remaining days or if it was sporadically refused at this point.

40. On 4 and 5 October 2022, Mr Radan refused medications. However, on 6 October 2022 he received his medications and complained that staff had not attended with his medications during the prior three-day period. When reminded that he had been offered his medication those days he told staff to leave and was adamant that staff had not attended.

41. On 8 October 2022, Mr Radan made the following written PHS request:

To be provided with:
Epilepsy medication only
Coloxyl
Hernia medication only
Twice daily.[21]

Events of 19 October 2022 – 26 October 2022

42. At 7:30am on 19 October 2022, Mr Radan was seen breathing during a head count. At approximately 8:50am Mr Radan was found by QCS staff lying on the floor of his cell. He was conscious but unable to stand. He had minor cuts on his arm and some blood on his face, indicative of a fall. A Code Blue medical emergency was activated and Mr Radan was assisted to the WCC medical centre.

[18] Exhibit D5 – PHS – IM Vol 7, page 56.
[19] Exhibit D5 – PHS – IM Vol 7, page 57.
[20] Exhibit D5 – PHS – IM Vol 7, page 58.
[21] Exhibit D5 – PHS – IM Vol 7, page 80.

43. QAS Officers arrived on scene at 9:40am and noted Mr Radan was able to maintain his own airway and had sustained bruising on the bridge of his nose and his right cheek bone. The Code Stroke was not activated in light of Mr Radan's AHD in which he requested no life-saving interventions.

44. Mr Radan was transported by Queensland Ambulance Service (QAS) to the PAHSU for treatment, arriving at 10:33am. Mr Radan presented with "*dense right hemiparesis and aphasia*."[22] It was noted that Mr Radan had not been compliant with his medications for some months prior.

45. Upon arrival at the PAH a Code Stroke was activated and an urgent CT Brain, CT perfusion and CT angiogram were completed. The CT Brain showed "*a left Middle Cerebral Artery anterior M2 branch acute infarct on a background of established left posterior frontal and right frontal infarct*", the CT perfusion showed "*matched perfusion deficit*" and the CT angiogram showed "*a filling defect within the anterior branch of left M2 segment consistent with acute thrombus with non-opacification of distal anterior M2 branches*."[23]

46. Mr Radan was diagnosed with "*Left MiddIe Cerebral Artery Ischaemic stroke, secondary to Chronic Atrial Fibrillation in the setting of non-compliance to anticoagulant therapy for secondary stroke prevention in Atrial Fibrillation*."[24] It was determined Mr Radan would not benefit from endovascular clot retrieval as an established Ischaemic stroke had been established on CT and acute thrombolysis was also not recommended as there was a risk of haemorrhagic transformation.

47. On 21 October 2022, Mr Radan rapidly deteriorated over a period of hours and was minimally responsive. In accordance with Mr Radan's wishes outlined in his AHD and ARP it was determined that in the event of further deterioration, Mr Radan would be transitioned to comfort cares.

48. During a medical review Mr Radan was confirmed to have a reduced level of consciousness and it was noted that he "*had sustained a large dominant sphere ischaemic stroke with significant neurological deficits with limited neurological recovery on Day 3 post the event*."[25] In light of Mr Radan's poor prognosis it was determined that palliative care would be appropriate following an independent assessment undertaken by the Stroke Team.

49. Mr Radan was reviewed by Stroke Registrar, Dr Jane McAuliffe, who confirmed that Mr Radan had sustained significant neurological deficits and recommended that he receive palliative care in accordance with his AHD. The Public Guardian was contacted in relation to Mr Radan's prognosis and his wishes outlined in his AHD and agreed to palliative care being provided to Mr Radan.

50. That afternoon Mr Radan was reviewed by a Palliative Care Consultant who ceased his current mediation and commenced him on Morphine, Midazolam and Haloperidol. Over the following days Mr Radan continued to receive comfort cares only in Palliative Care.

[22] Exhibit B1 – Statement of Dr Yassmin Khadra at [7].
[23] Exhibit B1 – Statement of Dr Yassmin Khadra at [8].
[24] Exhibit B1 – Statement of Dr Yassmin Khadra at [9].
[25] Exhibit B1 – Statement of Dr Yassmin Khadra at [14].

51. On 25 October 2022, QCS made enquiries with the Parole Board Queensland (PBQ) in relation to making an application on behalf of Mr Radan for exceptional circumstances parole. QCS completed the relevant form on behalf of Mr Radan and forwarded it to the PBQ[26].

52. In response, the PBQ requested a report about Mr Radan's current condition. Dr Mao wrote a letter to the PBQ confirming that Mr Radan was receiving terminal/end of life cares with input from the Palliative Care Team.[27] However, as Mr Radan had been detained under section 18 of the Criminal Law Amendment Act 1945 (Qld), s18C precluded him from both applying for or being granted an exceptional circumstances parole order.

53. On 26 October 2022, at 11:30am Dr Mao was contacted by nursing staff to advise that Mr Radan had no signs of life.

54. Dr Mao attended Mr Radan's room and confirmed his death at 12:55pm.

Forensic Medicine Queensland advice

55. Given Mr Radan's persistent refusal to take medications in the months preceding his stroke, I sought advice from Forensic Medicine Queensland as to the impact Mr Radan's of refusal to take medication. On 15 May 2025 Dr Jessica Page provided the following advice:

> *Mr Radan's refusal of dabigatran would have contributed significantly to his cause of death. Dabigatran is an anticoagulant (a blood thinning medication) prescribed to reduce the risk of blood clots developing when someone has atrial fibrillation. It does not eliminate this risk, however it is more likely than not that had Mr Radan taken his dabigatran as prescribed he would not have developed the stroke seen on CT angiogram on 19 October 2022.*[28]

56. I accept the advice of Dr Page.

Autopsy results

57. On 31 October 2022, Forensic Pathology Registrar, Dr McCourt, conducted an autopsy consisting of an external examination of the body and compiled a report that was peer reviewed by Forensic Pathologist, Dr Forde.

58. CT scans showed a left sided intracerebral lesion with an appearance in keeping with recent stroke and coronary artery calcification as evidence of significant natural disease. The external post-mortem examination showed signs of recent medical therapy, minor bruises and abrasions on the head, torso and limbs and no sign of major trauma.

59. Dr McCourt concluded that the cause of death was 1(a) *left middle cerebral artery cerebrovascular accident* with (2) *atrial fibrillation, hypertension and cerebrovascular accident* listed as other significant conditions.[29]

[26] Exhibit A5 – Coronial Report, pages 5 – 7.
[27] Exhibit D3 – PAH – DH, page 58; Ex A5 – Coronial Report, page 6.
[28] Exhibit A6 – Advice from Dr Page, dated 15 May 2025.
[29] Exhibit A3 – Autopsy Report, page 7.

Conclusions

60. I am satisfied that Mr Radan 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.

61. 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 Radan when measured against this benchmark.

Findings required by s. 45

62. 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:	Errol George Radan
(b) How the person died:	Mr Radan was found on the floor of his cell on 19 October 2022 at the Wolston Correctional Centre after refusing to take prescribed medications for over a year. He had a decreased level of consciousness and right sided neurological deficits suggestive of a stroke. He was transferred to the Princess Alexandra Hospital Secure Unit. It was identified Mr Radan had suffered a stroke and had a subsequent severe neurologic deficit. Mr Radan further deteriorated and died in palliative care.
(c) When the person died:	26 October 2022.
(d) Where the person died:	Princess Alexandra Hospital Secure Unit, Woolloongabba.
(e) What caused the person to die:	1(a). left middle cerebral artery cerebrovascular accident *Other significant conditions* 2. atrial fibrillation, hypertension and cerebrovascular accident

Comments and recommendations

63. 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.

64. 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.

65. I close the inquest.

Terry Ryan
State Coroner
BRISBANE