CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Phillip Graeme Abell
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2023/4477
DELIVERED ON:	8 July 2026
DELIVERED AT:	BRISBANE
HEARING DATE(s):	8 July 2026
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody, hepatocellular carcinoma

REPRESENTATION:

Counsel Assisting:	Ms Danielle Palmer
Metro North Health	Mr Hal Quin
Queensland Corrective Services	Ms Josephine Villanueva

Contents

Introduction

1. Phillip Graeme Abell was 51 years of age when he died in palliative care at Caboolture Hospital on 17 September 2023. Mr Abell had been transferred from the Woodford Correctional Centre ('WCC'), where he was serving a term of imprisonment imposed in relation to one count of murder, two counts of robbery with circumstances of aggravation, one count of deprivation of liberty, one count of enter dwelling with intent with circumstances of aggravation, and two counts of armed robbery in company. Mr Abell died of natural causes as a result of complications of stage 4 hepatocellular carcinoma. Mr Abell's conditions of Cirrhosis and Hepatitis C were considered to have contributed to his death.

Coronial jurisdiction

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

> *But reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer…In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*[2]

[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.
[2] *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J).

6. In adjudicating the significance of the evidence, the impact of hindsight bias and affected bias must also be considered.[3] 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.*
> *…*
> *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.*[4]

The investigation

7. The investigation into Mr Abell's death was led by Plain Clothes Senior Constable (PCSC) Catherine Boles of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

8. After being notified of Mr Abell's death on 17 September 2023, DSC Peta Shenk and PCSC Catherine Boles of the QPS CSIU attended bed 10 at Caboolture Hospital. PCSC Boles observed Mr Abell to be covered with a sheet up to his chest and not breathing. He had some medical equipment still connected to his body. Mr Abell had no injuries or marks indicative of a suspicious death.

9. On 18 September 2023, I made a direction for a targeted police investigation to occur. A Coronial Investigation Report was prepared and provided to the Coroners Court on 19 February 2024.

10. PCSC Boles conducted a thorough investigation in response to the targeted direction and concluded that there were no suspicious circumstances in relation to Mr Abell's death.

The inquest

11. The inquest was held at Brisbane on 8 July 2026. 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.

[3] Findings of the inquest into the death of Pasquale Rosario Giorgio, [140] – [142].
[4] Hugh Dillon and Marie Hadley, *The Australasian Coroner's Manual* (The Federation Press, 2015) 10.

12. The issues considered at the inquest were the issues required by s 45(2) of the Act, and whether Mr Abell 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 Abell was born on 29 June 1972 in Brisbane, Queensland. Prior to entering custody on 3 June 2011, Mr Abell was in a relationship with Ms Janaya Daley, with whom he shared a son. They maintained contact with him during his time in custody.

15. Mr Abell had a lengthy criminal history in Queensland commencing in 1988 at 15 years of age. He continued to commit offences, predominantly comprised of property and violent offences, over the following two decades.

16. On 8 October 2013, Mr Abell was sentenced in the Supreme Court of Queensland at Brisbane in relation to one count of murder, one count of robbery with circumstances of aggravation and one count of deprivation of liberty. He was sentenced to life imprisonment with a parole eligibility date set at 29 May 2031 in relation to the count of murder[5] and to lesser concurrent terms of imprisonment for the remaining offences.[6]

17. On 6 November 2013, Mr Abell was sentenced in the District Court of Queensland at Brisbane in relation to one count of enter dwelling with intent with circumstances of aggravation, one count of robbery with circumstances of aggravation and two counts of armed robbery in company. He was sentenced to a head sentence of 8 years imprisonment in relation to the offence of enter dwelling with intent and lesser concurrent terms of imprisonment for the remaining offences. His new parole eligibility date was set at 29 May 2032.[7]

18. Prior to his final transfer from WCC to Caboolture Hospital on 31 August 2023, Mr Abell was prescribed the following medications:[8]

    a. *Oxycontin CR* *30mg BD (to treat severe pain)*
    b. *Endone* *5mg nocte (to treat severe pain)*
    c. *Lactulose* *30ml BD (to treat encephalopathy)*
    d. *Spironolactone* *125mg mane (to remove excess fluid)*
    e. *Furosemide* *40mg mane (to remove excess fluid)*
    f. *Rifaximin* *550mg BD (to treat hepatic encephalopathy)*
    g. *Metoclopramide* *10mg BD (to treat nausea)*
    h. *Domperidone* *10mg BD (to treat nausea)*

[5] Ex C2, p 5.
[6] Ex C2, p 6.
[7] Ex C2, p 6.
[8] Ex E2, pp 234 – 235.

i. *Pantoprazole* *40mg mane (to treat reflux disease)*
j. *Magnesium Aspartate* *500mg BD (Magnesium Supplement)*
k. *Carvedilol* *6.25mg BD (to improve heart function)*
l. *Multivitamin* *mane*
m. *Oxycontin CR* *10mg nocte (to treat severe pain)*
n. *Dexamethasone* *4mg main (to treat pain)*

19. Between June and August 2023, Mr Abell was transferred to the Caboolture Hospital on four occasions to receive medical treatment.

Care in custody

20. Mr Abell was initially held in custody at Arthur Gorrie Correctional Centre from 3 June 2011, and Brisbane Correctional Centre from 9 October 2013, before he was transferred to WCC on 18 November 2013. While at WCC Mr Abell was reviewed Dr Rajendra Prakash[9] who opined that Mr Abell's diagnosis of liver cirrhosis was most likely attributed to an historical hepatitis C infection.[10]

21. On 18 January 2016, Mr Abell was admitted to the Princess Alexandra Hospital[11] where he underwent an ultrasound of his liver which showed cirrhosis of the liver and portal hypertension, but did not identify any focal hepatic lesions indicative of Hepatocellular carcinoma.[12] Between June 2016 and September 2017, Mr Abell had Grade 2 and 3 oesophageal varices identified and treated with banding.[13]

22. Mr Abell underwent surveillance ultrasounds on a six-monthly basis to monitor for hepatocellular carcinoma, with ultrasounds between 2017 and May 2020 failing to identify any lesions of concern.[14]

23. In November 2020, a suspicious lesion in segment VIII of his liver was identified in an ultrasound,[15] however, a CT scan liver multiphase the following month did not identify a focal liver lesion.[16]

24. In September 2021, a further ultrasound showed Mr Abell had a cirrhotic liver with an area of increased echogenicity, however, it was noted that his previous CT scan did not reveal any abnormality.[17]

[9] Ex B2 at [10].
[10] Ex B2 at [11].
[11] Ex B2 at [11].
[12] Ex B2 at [11].
[13] Ex B2 at [14] – [17].
[14] Ex B2 at [17] – [18].
[15] Ex B2 at [20].
[16] Ex B2 at [21].
[17] Ex B2 at [22].

25. That month Mr Abell was placed under the care of Consultant Hepatologist and Gastroenterologist, Dr Enoka Gonsalkorala, at the Royal Brisbane and Women's Hospital.[18] During an initial consultation on 2 November 2021,[19] Dr Gonsalkorala observed that Mr Abell showed signs of serological liver decompensation with treated hepatitis C as "*there were early signs that his liver was not able to perform routine function, which is a complication of cirrhosis*."[20] Mr Abell also had elevated Alpha-fetaprotein (AFP) levels and an MRI was ordered to exclude liver cancer or hepatocellular carcinoma.[21]

26. In December 2021, Mr Abell underwent a liver contrast ultrasound which did not show any hepatic lesions.[22] That month Mr Abell also underwent an MRI which showed there was "*no liver cancer present and there were features of fibrosis, splenomegaly and portosystemic collaterals on imaging*."[23] At a Multi-Disciplinary Team (MDT) meeting on 12 January 2022, it was recommended that Mr Abell continued to be monitored with alternating CT and MRI scans.[24]

27. On 8 March 2022, a CT scan of Mr Abell's abdomen showed "*cirrhotic liver with no focal arterial enhancement/portal venous washout to suggest HCC*."[25]

28. On 12 April 2022, during a consultation with Dr Gonsalkorala, it was noted that while CT scan results from 8 March 2022 showed that Mr Abell did not have hepatocellular carcinoma, his AFP levels were still elevated.[26] A follow up blood test showed a reduction in his AFP levels and no lesions were identified on an ultrasound.[27]

29. By December 2022, Mr Abell's AFP level had increased significantly during the intervening six month period and Dr Gonsalkorala advised Mr Abell that it was likely to be indicative of liver cancer.[28] Mr Abell was scheduled to undergo an urgent MRI that month, however, he had declined to wait after arriving late to his appointment and was returned to WCC.[29]

<u>Diagnosis of infiltrative Hepatocellular Carcinoma</u>

30. On 27 January 2023, Mr Abell underwent a rescheduled MRI scan of his liver at Caboolture Hospital.[30]

[18] Ex B2 at [23].
[19] Ex B5 at [13] – [15]; Ex E7, pp 46 – 48.
[20] Ex B5 at [14].
[21] Ex E4, p 237; Ex B5 at [15].
[22] Ex B2 at [24].
[23] Ex B5 at [17] – [18].
[24] Ex E7, pp 53 – 54.
[25] Ex E1, p 107.
[26] Ex B5 at [22]; Ex E7, pp 45 - 46.
[27] Ex B5 at [23]; Ex E7, pp 45 – 46, 59.
[28] Ex B2 at [26].
[29] Ex E4, p 93.
[30] Ex E4, p 83; Ex E1, p 105.

31. On 7 February 2023, during an MDT meeting, it was determined that "*the MRI scan showed that there was infiltrative HCC with tumour invasion into the portal vein branch supplying Mr Abell's liver*." Mr Abell's prognosis was poor and it was noted that "*based on accepted hepatology practice, surgery or local regional therapy (with chemotherapy beads) was not an option for this disease due to the infiltrative nature of the tumour*." As Mr Abell's platelets were too low for immunotherapy, it was recommended that he undergo systemic therapy in the form of Lenvatinib[31] which he commenced taking later that month.[32]

13 June 2023: Transfer to Caboolture Hospital

32. On 13 June 2023, a code blue was called after Custodial Correctional Officers (CCO) located Mr Abell in a "*barely responsive*" condition in his cell.[33] He was transferred to Caboolture Hospital where he was admitted with hepatic encephalopathy secondary to liver failure.[34]

33. On 14 June 2023, Mr Abell completed an Acute Resuscitation Plan (ARP) in which he indicated that he did not want to have CPR, intubation and ventilation, ICU or defibrillation.[35]

34. At the time of discharge on 16 June 2023, Mr Abell's hepatic encephalopathy had resolved[36] and it was recommended that his electrolytes be rechecked in a repeat blood test, with further liaison regarding disease progression to take place with the Royal Brisbane and Women's Hospital liver nurse.[37]

35. On 19 June 2023, Mr Abell completed another ARP in consultation with Dr Prakash at WCC. It was recorded that Mr Abell "*expected to be offered all treatments that would resolve or improve the acute conditions he will encounter during the progression of his liver cancer*."[38]

20 June 2023: Transfer to Caboolture Hospital

36. On 20 June 2023, Mr Abell was transferred to the Caboolture Hospital after he was found in bed with reduced consciousness.[39] Mr Abell was admitted with hepatic encephalopathy.[40]

37. On 22 June 2023, Mr Abell underwent a palliative care review and advised that while he was happy for Ms Daley to be his statutory health attorney, his

[31] Ex B5 at [27]; Ex E7, pp 51 - 52.
[32] Ex B5 at [29]; Ex E7, p 39.
[33] Ex D2, p 1.
[34] Ex B2 at [30]; Ex E4, pp 81 – 82.
[35] Ex E2, p 3.
[36] Ex E4, p 80.
[37] Ex E4, p 82.
[38] Ex B2 at [31].
[39] Ex E1, p 28.
[40] Ex E1, p 326.

preference was to make his own decisions.[41] It was recommended that he complete an Advanced Health Directive.[42]

38. During a ward round the following day, it was noted that Mr Abell was at maximal therapy with a prognosis in the range of 6 – 12 months.[43] That day he underwent a liver MRI which "*showed progression of the tumour*".[44] During an MDT meeting on 27 June 2023, it was recommended that Mr Abell cease taking Lenvatinib and be transferred to palliative care.[45]

39. That day, Dr Gonsalkorala explained to Mr Abell that "*his liver tumour had progressed despite treatment and that the priority was now to manage his symptoms once they appeared*." He was advised that he would undergo a palliative care review. He was also removed from liver cancer treatment and discharged from Dr Gonsalkorala's clinic.[46]

40. On 28 June 2023, Mr Abell underwent a palliative care review, at which time he was experiencing overall deterioration in the setting of hepatocellular carcinoma.[47] Mr Abell was discharged back to WCC the following day.[48]

4 July 2023: Transfer to Caboolture Hospital

41. On 4 July 2023, a code blue was called in response to reports Mr Abell was showing signs of agitation, and confusion and was unable to take evening medications. He was transferred to Caboolture Hospital[49] where it was noted that he was a palliative patient but that WCC did not "*have the current level of palliative support to avoid med admission*."[50]

42. Mr Abell was admitted under the care of Dr Rahman who noted a progression of his hepatocellular carcinoma and that he was to cease taking Lenvatinib. Dr Rahman requested a palliative care review and that Mr Abell's care be transferred to the Princess Alexandra Hospital Secure Unit for future admissions.[51]

43. On 6 July 2025, Mr Abell underwent a palliative care review which found that he was unsuitable to return to WCC.[52] That day a transfer to the PAHSU was declined,[53] and he was not eligible for transfer to Redcliffe Hospital without special circumstances parole.[54]

[41] Ex E1, p 335.
[42] Ex E1, p 335.
[43] Ex E1, p 336.
[44] Ex B5 at [32].
[45] Ex B5 at [33]; Ex E7, pp 49 – 50.
[46] Ex B5 at [34] – [36]; Ex E7, p 35.
[47] Ex E1, p 356.
[48] Ex E1, p 357.
[49] Ex B2 at [33]; Ex E6, p 40; Ex E1, p 16.
[50] Ex E1, p 3.
[51] Ex E1, p 139.
[52] Ex E1, p 143.
[53] Ex E1, p 144.
[54] Ex E1, p 168.

44. By 13 July 2023, Mr Abell's prognosis had reduced to the range of weeks to months.[55] On 19 July, Mr Abell raised concerns in returning to WCC where "*codes/lock downs prohibit access to timely [and] consistent medication dosage*."[56] Mr Abell's dosage of Oxycontin was increased to 30mg twice daily.[57]

45. Nurse Practitioner (NP) Toni Bradley discussed the supply of Mr Abell's medication with the WCC Nurse Unit Manager who advised that the timeliness of medication dispensation can be challenged by restrictions in the correctional facility.[58]

46. On 25 July 2023, Mr Abell was reviewed by Palliative Care Consultant, Dr Win who advised Mr Abell that he was unable to be admitted to the PAHSU as he was currently stable.[59] Mr Abell also reported his concerns relating to the timeliness of medication dispensation at WCC to Dr Win.[60]

47. On 28 July 2023, Mr Abell was considered medically stable and was discharged back to WCC with a palliative care appointment scheduled in four weeks.[61]

48. On 30 July 2023, a code blue was called after Mr Abell's cellmate reported he was unconscious. On arrival Mr Abell was laying bed and refused to answer questions. Mr Abell asked whether he would be transferred to hospital and was advised that he would be monitored only, which angered him.[62]

49. On 2 August 2023, Mr Abell complained that his pain was not being controlled and that he felt that it was "*not being taken seriously*".[63] The palliative care team advised that Endone should be given as needed for pain relief. At that time Mr Abell stated "*that he is refusing all his medication bar his pain relief medication until all issues are resolved*."[64]

50. On 3 August 2023, Mr Abell continued to refuse to attend the medical unit for medications. NP Bradley was contacted and advised that Mr Abell was not required to return to hospital and to dispense Endone as needed.[65] Mr Abell stated that "*he will no longer be taking his medication until he goes to hospital*."[66]

51. That day, Dr Avelino advised that Mr Abell could have 5mg of Endone every 4 hours as needed to a maximum of 30mg a day and was to be monitored for pain and bowel motions.[67] This was also discussed with NP Bradley, who confirmed that there was no need for Mr Abell to return to hospital at that time. NP Bradley

[55] Ex E1, p 161.
[56] Ex E1, p 178.
[57] Ex E1, p 179.
[58] Ex E1, p 190.
[59] Ex E1, p 192.
[60] Ex E1, p 191.
[61] Ex E1, p 114.
[62] Ex E6, p 42.
[63] Ex E6, p 43.
[64] Ex E6, p 43.
[65] Ex E6, pp 43 – 44.
[66] Ex E6, p 44.
[67] Ex E8, p 45.

advised that while Mr Abell could have Endone as needed but not to increase his dose of Oxycontin.[68] Mr Abell was not happy with that approach and stated that he still wanted to return to hospital for pain management, maintaining that he would not take his medication pending a return to hospital.[69]

52. That evening a code blue was called following reports of abdomen pain. Mr Abell's observations were within the normal limits, and he was noted to be "*belligerent but able to follow directions*".[70] When Mr Abell requested Endone, there was initially a misunderstanding as the nurse did not see his script and advised him of same, to which he became abusive. Mr Abell had refused to take his oxycontin dose that day.[71]

53. On 9 August 2023, Mr Abell was spoken to about diverting his Endone, he denied doing so and advised staff that it was stuck on his plate. He was advised that if he diverted the medication then it would be ceased for safety reasons.[72]

54. On 15 August 2023, Mr Abell was reviewed by Dr Avelino and reported that he was not given enough pain relief at night. Dr Avelino prescribed additional Oxycontin and Oxycodone at night.[73]

55. On the morning of 21 August 2023, Mr Abell's pain relief was reviewed by Dr Avelino. Mr Abell reported that his pain level was 7-8/10. As he did not meet the criteria for palliative care at that time, Dr Avelino recommended dispensing Endone as required.[74]

56. The following day Dr Avelino spoke with NP Bradley about Mr Abell's reported ongoing pain and he was commenced on Dexamethasone 4mg and Pantoprazole 40mg each morning.[75]

<u>31 August 2023: Final transfer to Caboolture Hospital</u>

57. On 31 August 2023, a code blue was called following reports of Mr Abell experiencing increased pain and feeling generally unwell. He was examined in the medical unit and his evening medications were not given due to aspiration concerns.[76] Mr Abell was transferred to Caboolture Hospital with increasing lower right quadrant abdominal pain.[77]

[68] Ex E8, p 46.
[69] Ex E8, p 46.
[70] Ex E8, p 49.
[71] Ex E8, pp 49 – 50.
[72] Ex E8, p 50.
[73] Ex E8, p 51.
[74] Ex E8, p 55.
[75] Ex E8, p 56.
[76] Ex E8, p 63.
[77] Ex B2 at [35]; Ex E2, p 21.

58. Mr Abell was examined in the Caboolture Hospital Emergency Department where it was noted "*palliative pain being undertreated in correctional facility*."[78] Contact was made with medical staff at WCC to ensure Mr Abell was given Endone. It was reported that he was given Oxycontin CR 30mg twice a day, Oxycontin CR 10mg at night and Endone as needed.[79]

59. An ultrasound of Mr Abell's abdomen showed, "*Chronic gallbladder wall thickening*" with "*progressive intrahepatic malignancy with marked interval increase in size of the segment 5 lesion.*"[80]

60. A CT scan of his abdomen and pelvis showed "*a marked interval enlargement of the intrahepatic metastatic disease, with the largest lesion measuring 5.5cm, previously indistinct*" with the portal vein "*progressively narrowed and indistinct at the porta hepatis*." It was also noted that there was "*upper abdominal lymphadenopathy*" and a "*diffusely thickened gallbladder wall*."[81]

61. Mr Abell was admitted under Dr Rahman[82] and by the following day, he reported that he was feeling improved.[83]

62. On 4 September 2023, during a Palliative Care review, NP Bradley noted the challenges of timely dispensation of medications and access to PRN medications at WCC.[84] Mr Abell's Oxycontin dose was increased to 50mg twice daily.[85]

63. On 7 September 2023, Mr Abell was reviewed by Dr Win, who noted that his encephalopathy was resolving and increased his oxycontin to 60mg twice daily.[86]

64. On 9 September 2023, an intravenous course of Metoclopramide was commenced with hydromorphone as needed. Mr Abell continued to report excruciating abdominal pain, nausea and dry retching.[87] Mr Abell's hepatocellular carcinoma had progressed rapidly and had suspected spontaneous bacterial peritonitis.[88]

65. During a ward round on the morning of 13 September 2023, Mr Abell reported that his pain had slightly improved.[89] It was noted that he had grade 3 hepatic encephalopathy and that his ex-partner would be visiting that evening, at which time they would discuss Mr Abell's "*ceiling of care/likely terminal admission*."[90]

[78] Ex E2, p 9.
[79] Ex E2, p 10.
[80] Ex E2, p 98.
[81] Ex E2, pp 99 – 100.
[82] Ex E2, p 108.
[83] Ex E2, p 116.
[84] Ex E2, p 118.
[85] Ex E2, pp 118, 127.
[86] Ex E2, p 130.
[87] Ex E2, pp 133 – 134.
[88] Ex E2, pp 134 – 135.
[89] Ex E2, p 154.
[90] Ex E2, p 155.

66. That afternoon Dr Moiyad recommended continuing Mr Abell's current pain management and noted, *"ceiling is ward based cares. Pt is aware of diagnosis and prognosis, is keen on pursuing active tx despite multiple discussions. We will respect his wishes and continue IV Abox. If deteriorates will be palliated.*"[91]

67. On 15 September 2023, Dr Moiyad spoke with Ms Daley and explained that Mr Abell's prognosis was in the range of hours to days. Ms Daley stated that Mr Abell's wishes were to continue active treatment and Dr Moiyad explained that his condition was not reversible with the current ceiling of care being ward based cares.[92]

68. Following their discussion, it was agreed that his intravenous therapy would continue with further discussions to take place after the weekend, however, Dr Moiyad warned Ms Daley that Mr Abell could pass away over the weekend.[93]

16 – 17 September 2023: Events leading to the death

69. In the early hours of 16 September 2023, Medical Registrar, Dr Hughan observed that Mr Abell was deteriorating and noted, "*Treating team feel Phillip is dying. It seems from the documentation that family are not accepting of this and are wanting to continue active management."* Dr Hughan also noted:[94]

> *Discussions by TT 14/9 with Phillip about his poor prognosis and he has opted to continue active treatments. Phillip currently asleep, looks comfortable. Encephalopathic on waking. Unable to make his own decisions.*
>
> *I feel that we can continue to respect Phillip and family's wishes by continuing active treatment consisting of IV abx, IVF. There comes a time when continuing active management would be inconsistent with best medical practice. That time is approaching for Phillip, but that decision should be made during daylight with consultant input and family discussion.*

70. At that time hospital staff were unable to locate any next of kin details, with enquiries also made with QCS to obtain details. Dr Hughan was unable to contact *"any substitute decision-maker*"[95] and strongly recommended ceasing active management in favour of palliation.[96]

71. That morning, Mr Abell was reviewed by Dr Brusasco who noted he was unconscious and minimally responsive to touch but appeared comfortable. By that time Mr Abell had entered the terminal phase and Dr Brusasco phoned WCC regarding guardianship and withdrawal of care.[97]

[91] Ex E2, p 149.
[92] Ex E2, p 156.
[93] Ex E2, p 157.
[94] Ex E2, pp 158 – 159.
[95] Ex E2, p 160.
[96] Ex E2, p 160.
[97] Ex E2, p 162.

72. Dr Brusasco was later advised by the WCC General Manager that Mr Abell did not have a formal next of kin or decision-maker. In light of this, Dr Brusasco recommended that Mr Abell's intravenous fluids and antibiotics be ceased.[98]

73. That morning Ms Daley visited Mr Abell with their son and were visibly upset by Mr Abell's condition. Ms Daley requested that she be notified of Mr Abell's death.[99]

74. By 12:15pm Mr Abell was unresponsive to both voice and touch.[100]

75. At approximately 5:40am on 17 September 2023, Dr Hughan attended following reports Mr Abell was groaning while unconscious. He spoke with Dr Win who approved increasing both driver and PRN doses as charted.[101] By approximately 7:05am Mr Abell appeared to be "*a lot more settled and comfortable*."[102]

76. At approximately 12:50pm, Mr Abell was observed by CCOs to "flatline"[103] and reported this to nursing staff who checked Mr Abell and called for a doctor to attend.[104]

77. Mr Abell was declared deceased at 1:10pm by Dr Laver.[105]

78. QPS CSIU were advised of Mr Abell's death and at approximately 3:20pm DSC Shenk and PCSC Boles attended Mr Abell's bedside at Caboolture Hospital and commenced a Death in Custody investigation.[106]

Failure to contact Ms Daley prior to withdrawing cares

79. During the investigation, Ms Daley raised a concern that Mr Abell's treatment was ceased without prior consultation, despite a request that his medications continue over the weekend.

80. I sought a response from Metro North Hospital and Health Service in relation to Ms Daley's concern. Acting Executive Director of the Caboolture, Kilcoy and Woodford Clinical Directorate, Dr Theodore Chamberlain advised that "*had the treating team been able to contact Mr Abell's next of kin, the expected clinical practice would have been to advise that antibiotics and intravenous fluids were being ceased on the basis that they were clinically futile in light of Mr Abell's deterioration caused by HCC and liver failure*."[107]

81. It was acknowledged by Dr Chamberlain that Ms Daley "*should have been contacted as part of the withdrawal of antibiotics and intravenous fluids, and that*

[98] Ex E2, p 163.
[99] Ex E2, p 164.
[100] Ex E2, p 164.
[101] Ex E2, p 167.
[102] Ex E2, p 167.
[103] Ex D6, p 1.
[104] Ex E2, p 168.
[105] Ex E2, p 168.
[106] Ex A1, p 11; Ex A4, p 4.
[107] Ex B6, p 3.

Ms Daley's contact details should have been readily available to the treating team at the time of his clinical deterioration."[108]

Office of the Health Ombudsman

82. On 11 August 2023, Mr Abell made a complaint to the Office of the Health Ombudsman (OHO) regarding the dispensation of his medications at WCC. In particular, he complained that his medication to control his cancer and to provide pain relief was not given on time or sometimes not at all, and that he was wrongly diagnosed with the cancer five years earlier.[109]

83. Mr Abell's complaint was investigated by the OHO, with enquiries made with Metro North Hospital and Health Service, who manage Offender Health Services at WCC.[110] On 4 September 2023, a decision by the OHO not to take any further action in relation to the complaint for the following reasons:[111]

- *Mr Abell received medications at different times of the day and all appeared to be given on time as documented;*
- *He was palliative with liver cancer and, while concerned about access to PRN and regular medication, he accessed medication many times a day as required;*
- *The provider has worked with the complainant to assist with the administration of pain medications;*
- *The MO had reviewed the complainant and recently increased his medication doses.*

Forensic Medicine Queensland advice

84. As Mr Abell had been under HCC surveillance for some time prior to death, and given his background of cirrhosis and hepatitis C, I sought advice from Forensic Medicine Queensland as to the appropriateness of the medical treatment provided to Mr Abell in custody, and whether the frequency of cancer surveillance and monitoring was adequate.

85. On 6 March 2026, Dr Mitchell Shaw, provided advice that "*there were no obvious deficiencies in the medical treatment provided to Mr Abell identified within the reviewed materials*"[112] and concluded:[113]

> *Mr Abell appeared to receive appropriate and judicious screening and targeted evaluation for the development of hepatocellular carcinoma. It is notable that in 2021-2022 CT scanning, ultrasound scanning and MRI scanning did not identify any lesion suspicious for hepatocellular carcinoma.*

[108] Ex B6, p 3.
[109] Ex F3.
[110] Ex F2, p 1 – 2.
[111] Ex F2, p 2.
[112] Ex F1 at [22].
[113] Ex F1 at [23] – [25].

> *When Mr Abell had an elevation in his alpha fetoprotein, this was investigated promptly but a solid detectable tumour was not present. Had there been more screening or more imaging performed, this would not have changed the outcome for Mr Abell. I agree with the medical oncologist, that despite there being a small rise in the AFP preceding the rapid increase, this was non-diagnostic for HCC. Instituting treatment at this stage is unlikely to have changed the outcome, noting in particular that Mr Abell had an aggressive and multifocal cancer unlikely to have been amenable to surgery.*
>
> *The American Association for the Study of Liver Diseases has previously produced guidance on the management and screening of hepatocellular carcinoma. (1) The advice was for 6 monthly ultrasound of the liver, which Mr Abell in general exceeded in terms of screening intervals. AFP was checked alongside imaging, in accordance with guidelines.*

86. I accept the advice of Dr Shaw.

Autopsy results

87. On 19 September 2023, Forensic Pathologist, Dr Rohan Samarasinghe conducted an autopsy consisting of an external examination of Mr Abell's body.[114]

88. In the autopsy report, Dr Samarasinghe noted that Mr Abell had yellow discolouration in his skin and eye which was consistent with chronic liver disease and hepatic failure.[115]

89. It was opined by Dr Samarasinghe that Mr Abell's death *"was due to complications of stage 4 hepatocellular carcinoma developed on the background of hepatitis C infection and cirrhosis. His condition was deemed to be not amenable to resection and was considered to be an aggressive form of hepatocellular carcinoma with infiltrative disease. Overall, with this condition there is a life expectancy of less than 12 months and, in this case, it may have been considerably less than 12 months*."[116]

90. Dr Samarasinghe concluded that the cause of death was 1(a) *Complications of stage 4 hepatocellular carcinoma* with 2(a) *Cirrhosis* and 2(b) *Hepatitis C* listed as other significant conditions.[117]

[114] Ex A3, p 1.
[115] Ex A3, p 6.
[116] Ex A3, p 6.
[117] Ex A3, p 7.

Conclusions

91. I am satisfied that Mr Abell died from natural causes. I find that none of the correctional or health care staff at Caboolture Hospital or WCC caused or contributed to his death. There were no suspicious circumstances.

92. 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 Abell when measured against this benchmark.

Findings required by s. 45

93. 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 the evidence, including the material contained in the exhibits, I am able to make the following findings:

(a) Who the deceased person is:	Phillip Graeme Abell (DOB: 29 June 1972).
(b) How the person died:	In February 2023, Mr Abell was diagnosed with infiltrative hepatocellular carcinoma. Following progression of his hepatocellular carcinoma Mr Abell entered palliative care at Caboolture Hospital. On 17 September 2023 Mr Abell died from complications of stage 4 hepatocellular carcinoma with cirrhosis and hepatitis C listed as other significant conditions.
(c) When the person died:	17 September 2023.
(d) Where the person died:	Caboolture Hospital.
(e) What caused the person to die:	1(a) Complications of stage 4 hepatocellular carcinoma *Other significant conditions* 2(a) Cirrhosis (b) Hepatitis C

Comments and recommendations

94. 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.

95. 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.

96. I extend my condolences to Mr Abell's family and friends.

97. I close the inquest.