CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Maxwell John Beever
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2022/3335
DELIVERED ON:	7 July 2026
DELIVERED AT:	BRISBANE
HEARING DATE(s):	7 July 2026
FINDINGS OF:	T Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, natural causes, death in custody, metastatic melanoma, delay in diagnosis, refusal of treatment.

REPRESENTATION:

Counsel Assisting:	Ms D Palmer
Queensland Corrective Services:	Ms A Myatt

Contents

Introduction

1. Maxwell John Beever was 83 years of age when he died in palliative care at Robina Hospital on 8 July 2022. Mr Beever had been held on remand at Gold Coast University Hospital and Robina Hospital in relation to the death of his wife. Mr Beever died of natural causes as a result of metastatic melanoma.

Coronial jurisdiction

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

> *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]

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':

[1] *Briginshaw v Briginshaw* (138) 60 CLR 336.
[2] *Briginshaw v Briginshaw* (138) 60 CLR 336, 362 – 363 (Dixon J).
[3] Findings of the inquest into the death of Pasquale Rosario Giorgio, [140] – [142].

> *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 Beever's death was led by Detective Senior Constable (DSC) Lea-Ann Matthews of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

8. Following notification of Mr Beever's death on 8 July 2022, officers from Palm Beach Police Station attended Room 44 of the Palliative Care Unit at Robina Hospital. Mr Beever, who was in a hospital gown, was laying on his back on his hospital bed, and was covered with a white sheet. Mr Beever did not have any medical equipment attached to him and had no signs of trauma indicative of suspicious circumstances. Attending police officers took photographs and Correctional Officers maintained security at the entrance to the room.

9. On 11 July 2022, I made a direction for a targeted police investigation to occur. A Coronial Investigation Report was prepared and provided to the Coroners Court on 15 May 2023.

10. DSC Matthews conducted a thorough investigation in response to the targeted direction. She concluded that there were no suspicious circumstances in relation to Mr Beever's death.

The inquest

11. The inquest was held at Brisbane on 7 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.

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

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

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 Beever was born on 27 August 1938 in New Zealand.[5] He had been married to Robyn Beever, with whom he had been in relationship for approximately 60 years[6] prior to her death on or about 25 February 2021.[7]

15. Mr Beever had been employed as a salesman,[8] and had worked in a timber yard attached to a sawmill, eventually attaining the position of foreman.[9]

16. On 25 February 2021, Mr Beever was arrested and charged with the murder of his wife,[10] and was transported to the Gold Coast University Hospital.[11] At no stage following arrest did Mr Beever spend any time in either the Southport Watch House or Brisbane Correctional Centre. He was held in custody in hospital until his death.

Care in custody

17. On 25 February 2021, following his arrest in relation to his wife's death, Mr Beever was examined in the Gold Coast University Hospital Emergency Department. He had a background of known Parkinson's disease[12] and reported that he had fallen and hit his head causing him to momentarily lose consciousness.[13]

18. His daughter, Ms Brown reported to staff that she had noticed a decline in Mr Beever's baseline level of function during the preceding couple of months, including hallucinations and increased confusion.[14]

19. On 26 February 2021, Mr Beever was again reviewed and diagnosed with "*Acute Kidney Injury and Rhabdomyolysis with a medical background significant for Parkinson's disease*"[15] Mr Beever was also reviewed by consultant Psychiatrists, Professor Stapelberg and Dr Patist and was also diagnosed with delirium "*with a background of mental impairment*."[16]

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[5] Ex C14, p 1.
[6] Ex E1, p 10.
[7] Ex C13, p 2.
[8] Ex A1, p 5.
[9] Ex E1, p 14.
[10] Ex C13, page 3.
[11] Ex C13, page 3.
[12] Ex E3, page 615.
[13] Ex E3, page 616.
[14] Ex E3, page 616.
[15] Ex B3 at [10].
[16] Ex E1, p 1; Ex B3 at [11].

20. Mr Beever also underwent a Consultation Liaison Psychiatry Consultant Review with Consultant Psychiatrists Professor Stapelberg and Dr Boyes who opined that Mr Beever "*currently presents with ongoing delirium given his fluctuating agitation and orientation to TPP (time, place and person).*"[17] He was also assessed as being delirious by Staff Specialist Geriatrician Dr Subakumar.[18]

21. During an examination that day, it was noted *"reports lesion ? melanoma on back"*. [19] However, no further investigation took place in relation to the lesion at that time.

22. On 27 February 2021, Mr Beever was diagnosed with a urinary tract infection after E Coli was detected in his urine, and he was treated with antibiotics.[20]

23. On 2 March 2021, Mr Beever was assessed by Psychiatrist, Dr Patist, who diagnosed him with delirium and concluded that he did not have an acute mental illness.[21]

24. On 3 March 2021, Geriatrician, Dr Michael Leihy conducted a chart review and noted that Mr Beever had "*resolving delirium in the context of UTI, rhabdomyolysis, acute liver injury and acute kidney injury*."[22]

25. On 22 March 2021, during a Multidisciplinary Team (MDT) meeting, it was noted that Mr Beever had been medically cleared of any ongoing delirium or acute medical issues and did not display any ongoing suicidal ideation or clinical depression. He was closed to Consultation Liaison Psychiatry. [23]

26. On 26 March 2021, General and Acute Medicine Specialist, Dr Siddharth Sharma took over Mr Beever's care. He assessed him as "*having episodes of hypoactive delirium*" and requested a further Geriatric review "*for consideration of Lewy Body Dementia*." Dr Ilango conducted a geriatric assessment and opined that Mr Beever "*was not delirious at this point and his behaviour was appropriate for someone in his situation*."[24]

Identification of the melanoma

27. During a skin check on 26 June 2021, a mole with a "*dark, irregular shape*" was noted on Mr Beever's upper back.[25] The mole was reviewed by Dr Yip who recommended that his Treating Team review the mole on a weekday and to consider a dermatology review.[26]

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[17] Ex E1, p 2; Ex E3, pp 3271 – 3272.
[18] Ex B3 at [10], [12].
[19] Ex E3, p 3292. An earlier entry by a registered nurse had noted -"*Skin intact on back, a ? small melanoma*"
[20] Ex B3 at [12].
[21] Ex B3 at [14].
[22] Ex E3, page 3222.
[23] Ex E1, p 35.
[24] Ex B3 at [20].
[25] Ex E3, p 2748.
[26] Ex E3, pp 2746 – 2747.

28. On 1 July 2021, Dermatology Consultant, Dr Peters, reviewed the mole and recommended that it be removed.[27] A shave biopsy that day confirmed it to be a melanoma.[28]

29. On 2 July 2021, Mr Beever had a brain MRI which found "*mild parietal lobe atrophy is noted, however findings are not entirely convincing for Alzheimer's disease*."[29]

30. On 14 July 2021, Mr Beever had a whole body FDG-PET/CT scan which found:[30]

    1. *No focal FDG avid cutaneous lesion in the back*
    2. *No FDG avid nodal or distant metastatic disease*
    3. *Focal moderate FDG update within the lower right abdominal cavity correspond to a ? small bowel diverticulum which appears thickened with adjacent fat stranding possibly representing an inflamed diverticulum*
    4. *Short segment of apparent mural thickening involving the ascending colon extending for approximately 4 cm immediately superior to the ileocecal valve. This is a nonspecific finding and whilst may be seen in bowel peristalsis, an underlying colonic lesion would require exclusion. Consider colonoscopy for further evaluation if clinically appropriate.*

31. That day, Mr Beever also underwent a brain FDG-PET/CT scan which showed:[31]

    Asymmetric mild to moderate reduction in FDG uptake in the posterior cingulate gyri, left temporal, occipital and parietal lobes raises the possibility of dementia with lewy bodies in the correct clinical context.

32. On 16 July 2021, it was noted that there was no evidence of metastatic disease at that time and that the Melanoma Institute Calculator estimated an 8% risk of Sentinel Node Metastasis.[32] Mr Beever was spoken to about the findings and a recommendation was made that he undergo a wide local excision with 1-2cm peripheral margins within one month. He advised that he would speak with his daughter, Ms Brown, before consenting.[33]

33. That day, Medical Oncology Registrar, Dr Burnett conducted a chart review and noted Mr Beever to have a stage 1B invasive melanoma with a high mitotic rate and high risk of metastatic disease.[34] Dr Burnett recommended a surgical review for re-excision as there was "*no role for systemic [treatment] for stage 1b disease*." It was also recommended that Mr Beever undergo a colonoscopy.[35]

[27] Ex E3, p 2727.
[28] Ex E3, p 2653.
[29] Ex E3, p 3720.
[30] Ex E3, p 3726.
[31] Ex E3, p 3724.
[32] Ex E3, p 2653.
[33] Ex E3, p 2653.
[34] Ex E3, p 3311.
[35] Ex E3, p 3311.

34. On 19 July 2021, Dr Saito Millan contacted Mr Beever's daughter, Ms Brown, who was also his Enduring Power of Attorney (EPOA), to discuss his melanoma diagnosis and the recommendation for a wide local excision with potential sentinel lymph node biopsy. Ms Brown indicated that she would sign a consent form.[36]

35. On 22 July 2021, the Melanoma MDT met and considered that the melanoma had a Breslow Depth of at least 1.4mm with a 12mm mitotic count[37] and recommended wide local excision.[38]

36. On 2 August 2021, Dr Saito Millan contacted Ms Brown, and explained the recommendation made by the MDT that he undergo a wide local excision. Dr Saito Millan also explained that excision would not include a biopsy of the sentinel lymph node as it was not considered beneficial. Dr Saito Millan also explained the risks, Mr Beever's expected outcome and the potential complications. Ms Brown consented over the phone.[39]

37. On 3 August 2021, Mr Beever underwent the wide local excision[40] without a sentinel lymph node biopsy.[41] On 19 August 2021, the Melanoma MDT met again following the melanoma excision and recommended surgical follow up.[42]

38. On 1 September 2021, an Acute Resuscitation Plan (ARP) was prepared in consultation with Ms Brown.[43] At that time Dr Hourn was of the view that Mr Beever did not have capacity to consent to or refuse medical treatment, in particular, noting that he "*has Parkinson's dementia. Can understand simple questions but retaining information is difficult and complex decisions are also too difficult*."[44] Ms Brown advised Dr Ellen Hourn that she would email the EPOA documents to the hospital.[45]

39. During their discussion regarding Mr Beever's ARP it was noted that Mr Beever had previously stated that "*he has had a good life and is ready to die*" and "*does not want to be resuscitated*."[46] Dr Hourn explained that "*due to [Mr Beever's] age and frailty in event of arrest it is extremely unlikely [they] would be able to successfully resuscitate him*" and "*would likely cause significant harm*." The completed ARP reflected that Mr Beever would not receive CPR, defibrillation, intubation, ICU level cares, dialysis or bi-level ventilation.[47]

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[36] Ex E3, pp 2631 – 2632.
[37] Ex E3, p 554.
[38] Ex E3, p 554.
[39] Ex E3, p 2552.
[40] Ex E3, pp 2545; 3307.
[41] Ex E3, p 3307.
[42] Ex E3, p 552.
[43] Ex E3, p 2416.
[44] Ex E3, p 9.
[45] Ex E3, pp 2411, 2416.
[46] Ex E3, p 2416.
[47] Ex E3, pp 9, 2416.

40. On 2 September 2021, Mr Beever's family was present during a review regarding his confusion during which it was noted that Mr Beever did not appear "*acutely confused*" and it was requested that his treating team be notified of any acute changes.[48]

41. On 8 September 2021, Mr Beever's daughter, Ms Brown forwarded a copy of the EPOA to the hospital.[49]

42. Dr Sharma noted that prior to his transfer to the Complex Management Unit (CMU) at Robina Hospital, Mr Beever had Aged Care assessments that had been "*initiated with Social Work and Mr Beever's EPOA, his daughter*." Dr Sharma also noted that "*Due to slow recovery from delirium, underlying cognitive impairment and possibility of Lewy Body Dementia, Mr Beever's capacity to make medical decisions about his health and living arrangements was questionable and decision support with EPOA was utilised*."[50]

16 September 2021 – 4 July 2022: Complex Management Unit, Robina Hospital

43. On 16 September 2021, Mr Beever was transferred to the CMU and placed under the care of Staff Specialist, Dr Sarah Leeder.[51] Dr Leeder noted Mr Beever's medical conditions included Parkinson's disease, mild cognitive impairment associated with Parkinson's disease, hypertension, gout, nephrolithiasis, prostatism, and treated melanoma.[52]

44. During a CMU MDT meeting on 3 November 2021, it was noted that Mr Beever had capacity.[53] During meetings between 17 November 2021 and 29 June 2022, it was noted that Mr Beever "*does have capacity for health and lifestyle decisions, benefits from supported decision making*."[54]

45. On 2 February 2022, a surveillance FGT-PET/CT scan, which revealed a recurrence of the melanoma, found: [55]

> *Disease recurrence with interval development of intensely FDG avid left axillary lymphadenopathy.*
> *Skin thickening with mild associated FDG uptake (SUV Max 2.3) posterior to the spinous processes, favoured to represent inflammatory change at the resection site. No corresponding focal lesion.*
> *Focal moderate FDG uptake within the right lower abdominal cavity may relate to an incidental inflamed diverticulum with adjacent thickening.*

[48] Ex E3, pp 2411 – 2412.
[49] Ex E3, p 2386.
[50] Ex B3 at [22].
[51] Ex B1 at [9].
[52] Ex B1 at [10].
[53] Ex E3, p 2102.
[54] Ex E3, pp 709, 2030.
[55] Ex E3, pp 544, 3722 – 3733.

46. On 17 February 2022, the MDT met and, noting that the melanoma was a T3a with 2.5mm Breslow Depth, recommended surgical follow up and potential radiotherapy.[56]

47. On 24 February 2022, the Melanoma MDT met again and recommended Mr Beever undergo an axillary lymph node dissection.[57]

48. On 18 March 2022, Mr Beever underwent an axillary lymph node dissection that showed a metastatic malignancy compatible with metastatic melanoma.[58]

49. On 31 March 2022, the Melanoma MDT met to discuss Mr Beever's axillary lymph node dissection and associated histopathology.[59] It was noted that there was "*extensive nodal involvement*"[60] and a recommendation was made to refer him to medical oncology and potential radiotherapy.[61] However, Mr Beever declined to undergo any further treatment relating to the melanoma following consultation with specialists and his family.[62]

50. On 8 April 2022, Medical Oncologist, Dr Robert Mason, spoke with Mr Beever about his diagnosis of stage 3C cutaneous melanoma and available adjuvant therapy with immunotherapy. Mr Beever declined to undergo any adjuvant therapy. This was also discussed with Ms Brown, who agreed with Mr Beever's decision.[63]

51. On 20 April 2022, Mr Beever and Ms Brown attended an outpatient Oncology-Radiation appointment with Dr Wen Giok Wong. Dr Wong explained the role of post-operative radiotherapy as treatment to reduce the risk of locoregional recurrence by approximately 50%. Mr Beever indicated that he understood but that he did not want to undergo treatment.[64]

52. On 23 May 2022, Mr Beever had an ultrasound of his left axilla which found:[65]

> *The subcutaneous tissue of the left axilla demonstrates extensive oedema and hyperaemia in keeping with inflammatory change. Due to the this there is a fluid collection demonstrating some fine internal septations measuring 5.5 x 2.2 x 5.6 cm (35 ml). Differentials for this appearance include abscess or seroma, and less likely organised haematoma.*

[56] Ex E3, p 547.
[57] Ex E3, pp 542, 531.
[58] Ex E3, p 3307.
[59] Ex E3, p 533.
[60] Ex E3, p 532.
[61] Ex E3, p 533.
[62] Ex E3, p 1122; Ex B1 at [12].
[63] Ex E3 3308; Ex B2 at [10].
[64] Ex E3, p 11522.
[65] Ex E3, p 3718.

53. The following day, Mr Beever had an unsuccessful drainage ultrasound, which noted, "*ovoid hypoechoic collection/focus deep to the left axillary surgical scar unable to be aspirated despite multiple passes, favoured to be reflective of phlegmon or complex collection*."[66]

54. On 25 May 2022, Mr Beever underwent a chest CT scan with contrast, with new swelling and redness, which found:[67]

> *Multiple soft tissue densities and lymphadenopathy favouring disease progression demonstrated throughout the left axilla with surrounding oedema. Further soft tissue density/nodal disease within the left infraclavicular region. Ovoid hypodensity within the left axilla lateral to the chest wall suggestive of a complex collection.*
> *Multiple new area large nodular densities throughout lungs bilaterally concerning for metastatic deposits. No confluent consolidation.*
> *No destructive osseous lesions.*

55. That day, Mr Beever underwent a Plastic Surgery review with Dr Rhys Youngberg who noted that while the results of the CT scan were not reported yet, that it was likely Mr Beever had a recurrence of metastatic melanoma. It was noted that Mr Beever declined further surgery, however, recommended that he have a core biopsy and would likely be palliative.[68]

56. On 26 May 2022, during a CMU ward round, Mr Beever was spoken to regarding the recommendation by Plastic Surgery that he undergo a core biopsy to which he initially refused, stating "*no, I've had enough*." It was clarified that it was not an operation and it was required to determine if there had been a recurrence to the left axilla and symptom control, not as a curative means. He advised that he would think about it.[69]

57. Following this, Dr Shenoda spoke with Ms Brown who advised that she had visited her father the day prior. Ms Brown confirmed she was aware of Mr Beever's decision not to undergo radiotherapy or chemotherapy but would speak to him about how he feels about having a core biopsy.[70]

58. The following day, during a CMU review Mr Beever was spoken to again regarding undergoing the recommended core biopsy. Mr Beever advised that he would discuss it with Ms Brown first.[71]

59. On 31 May 2022, Mr Beever was reviewed by CMU Consultant, Dr Prasad, at which time the discussion regarding a core biopsy to determine if there was a malignancy recurrence and if radiotherapy would assist with pain relief was revisited. Mr Beever indicated he was happy to have a biopsy pending Ms

[66] Ex E3, p 3717.
[67] Ex E3, p 3697; Ex B1 at [13].
[68] Ex E3, p 3325 – 3326.
[69] Ex E3, p 949.
[70] Ex E3, p 950.
[71] Ex E3, p 941.

Brown's agreeance.[72] Ms Brown was contacted by phone and confirmed her agreement.[73]

60. That day, Mr Beever underwent a targeted left axilla ultrasound, with the findings "*likely consistent with extensive metastatic disease*" and showed:[74]

> *Large, heterogenous, predominantly hypoechoic region with peripheral vascularity located in the superficial aspect of the left axilla. The size of this region is difficult to measure. Surgical clips noted.*
> *No drainable collection identified.*

61. On 1 June 2022, Mr Beever had a left axilla core biopsy, the results of which were consistent with metastatic melanoma.[75]

62. On 2 June 2022, during a CMU ward round, Mr Beever was advised that the Melanoma MDT would meet on 9 June 2022 and discuss his recent test results. He was informed of the results of the CT scan and ultrasound results regarding the presence of suspicious lesions on his lungs that were concerning for cancer metastases. Following the ward round, Ms Brown was contacted and updated regarding the CT scan results and upcoming MDT meeting. At that time the core biopsy results were not available.[76]

63. On 9 June 2022, the Melanoma MDT confirmed Mr Beever's diagnosis of metastatic melanoma and recommended that he undergo a palliative care review.[77] Dr Leeder discussed the diagnosis with Mr Beever and his family and explained that he had a limited life expectancy. However, Mr Beever declined treatment targeting his melanoma.[78]

64. On 13 June 2022, Mr Beever was referred to Palliative Care for symptom management.[79]

65. On 16 June 2022, Mr Beever underwent a targeted left axilla ultrasound, which was compared to his prior ultrasound on 31 May 2022, and his core biopsy on 1 June 2022, and found the following:[80]

> 1. *No discrete fluid collection is demonstrated*
> 2. *Extensive incompressible heterogenous vascular mass is demonstrated in the left axilla, too large to measure on ultrasound, in keeping with metastatic disease.*

[72] Ex E3, pp 918 – 919.
[73] Ex E3, p 920.
[74] Ex E3, p 3716.
[75] Ex E3, p 832.
[76] Ex E3, p 903.
[77] Ex E3, p 532.
[78] Ex B1 at [13].
[79] Ex B1 at [14].
[80] Ex E3, p 3713 – 3714.

66. On 20 June 2022, following a ward round with Dr Leeder, advice was obtained from a Palliative Care Consultant regarding Mr Beever's pain management. It was advised that Mr Beever be prescribed 40mg of Oxycontin and 75mg of Lyrica twice daily and recommended that he undergo palliative radiotherapy. Dr Leeder indicated that she would speak about this with Mr Beever.[81]

67. Mr Beever's condition had continued to deteriorate over the preceding week, and by 21 June 2022, Dr Leeder was of the view that it had become "*evident that Mr Beever was dying, and the cardiopulmonary resuscitation would not be in his interests*."[82] Dr Leeder wrote to Queensland Corrective Services and requested that Mr Beever have unrestricted visiting hours for compassionate reasons given his deterioration and entering the end stages of his life.[83]

68. Dr Leeder spoke with Ms Brown to update her regarding the recommendation for palliative radiotherapy. Ms Brown advised that she would consent if it helped ease his pain. In the interim, Mr Beever's pain management was to continue.[84]

69. On 24 June 2022, Dr Lambkin provided Ms Brown with a clinical update while Dr Leeder was on leave. Ms Brown was advised of Mr Beever's need for increased pain relief and she noted his visible deterioration during recent visits.[85]

70. On 30 June 2022, Mr Beever's ARP was updated by Dr Lambkin following a discussion with Mr Beever and Ms Brown. It was updated to reflect that he would receive comfort cares only in the case of deterioration.[86]

71. On 1 July 2022, Staff Specialist Palliative Care Consultant Physician Dr Nicola Morgan, assessed Mr Beever as being at an end-of-life stage,[87] and recommended that he commence on Hydromorphone and Midazolam.[88]

4 July 2022 – 8 July 2022: Palliative Care Ward, Robina Hospital

72. By 4 July 2022, Mr Beever had further deteriorated and was prescribed a Rotigotine patch to treat the rigidity caused by his Parkinson's disease. He was transferred the Palliative Care Ward at Robina Hospital.[89]

73. While his condition continued to deteriorate over the following days he remained comfortable.[90] By 7 July 2022, Mr Beever was considered to be "*actively dying*" with medications ensuring he remained comfortable in his final days.[91]

[81] Ex E3, p 781.
[82] Ex B1 at [14].
[83] Ex E3, p 764.
[84] Ex E3, p 764.
[85] Ex E3, p 739.
[86] Ex E3, p 8.
[87] Ex B2 at [13].
[88] Ex B2 at [13].
[89] Ex B2 at [14].
[90] Ex B2 at [17].
[91] Ex B2 at [18].

8 July 2022: Day of Death

74. On the afternoon of 8 July 2022, Mr Beever was visited by his family and his daughter requested to be contacted in the event of decline.[92]

75. That evening, Custodial Correctional Officers were stationed outside Mr Beever's room[93] and observed his breathing change. Nursing staff were informed and attended Mr Beever.[94] However, no signs of life were observed.[95]

76. Dr Conor Crowley attended and declared Mr Beever deceased at 7:45pm.[96]

77. Ms Brown was advised of her father's passing.[97]

Forensic Medicine Queensland advice

78. Given the delay between the initial identification of a potential melanoma on Mr Beever's back on 26 February 2021 and subsequent identification and investigation from 26 June 2021, I sought advice from Forensic Medicine Queensland in relation to the delay and whether it led to a missed opportunity to provide outcome changing care.

79. On 19 June 2025, Forensic Physician, Dr Mitchell Shaw provided an advice and was of the view that while there was insufficient information regarding what lesion was at that time, "*regardless of the ability of the doctor to identify a melanoma, it remains unexplained as to why they documented their concern but the concern failed to result in meaningful action."*

80. In relation to the delay in managing the suspicious lesion, Dr Shaw concluded:[98]

> *Mr Beever had a possible delay of over 4 months until biopsy that confirmed the lesion to be a melanoma of a nodular and superficial spreading type. While there is limited information to confirm the lesion at 26/02/2021 was indeed suspicious for melanoma, it would be reasonable given the histopathology in July to suspect that had dermatological evaluation been performed earlier than 01/07/2021 that melanoma could have been identified and more promptly surgically excised, offering a more favourable prognosis.*

[92] Ex E3, p 629.
[93] Ex C7, p 1; Ex C8, p 1.
[94] Ex C7, p 1; Ex E3, p 629.
[95] Ex E3, p 626.
[96] Ex E3, p 626; Ex C7, p 1; Ex C8, p 1.
[97] Ex E3, p 629.
[98] Ex B5 at [54].

Expert opinion

81. I subsequently sought an expert report from Consultant Medical Oncologist at Metro North Hospital and Health Service, Associate Professor Melissa Eastgate, in relation to whether early intervention following the identification of the melanoma on 26 February 2021 would have been outcome changing for Mr Beever's prognosis.

82. On 30 April 2026, Associate Professor Melissa Eastgate, provided an expert report in which she noted that "*there is no information available regarding how long the pigmented lesion had been present prior to the patient's initial presentation or hospital or whether its nature had changed over time*."[99]

83. Associate Professor Eastgate also noted that "*there is no suggestion it was itchy or bleeding which would be symptoms that would suggest a rapidly growing melanoma" and that "the initial pathology report showed that the lesion was arising in a pre-existing nevus, suggesting that there may have been a pigmented lesion present prior to the development of the melanoma*."[100]

84. In relation to Mr Beever's outcome, Associate Professor Eastgate noted that if Mr Beever had "*agreed to undergo systemic treatment for his melanoma his outcome may have been significantly different*." However, her ultimate view was that "*it is not possible to say categorically that an earlier identification of the melanoma would have been outcome changing for Mr Beever however it is possible*."[101]

85. Regarding the level of care provided to Mr Beever on diagnosis, Associate Professor Eastgate concluded that treatment "*was consistent with clinical guidelines and appropriate*."[102]

86. I accept the advice of Associate Professor Eastgate.

Autopsy results

87. On 12 July 2022, Forensic Pathologist Dr Andrzej Kedziora conducted an autopsy consisting of an external examination of the body.[103]

88. In the autopsy report Dr Kedziora noted Mr Beever's previous diagnosis of a '*malignant melanoma of upper back, resected in August 2021, which metastasised to left axilla*'.[104]

89. Dr Kedziora concluded that Mr Beever's cause of death was *1(a) Metastatic melanoma*.

[99] Ex F1, p 2.
[100] Ex F1, p 2.
[101] Ex F1, p 2.
[102] Ex F1, p 2.
[103] Ex A2, p 1.
[104] Ex A2, p 5.

Conclusions

90. I am satisfied that Mr Beever died from natural causes. I find that none of the health care staff at Gold Coast University Hospital or Robina Hospital caused or contributed to his death. There were no suspicious circumstances.

91. 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 Beever when measured against this benchmark.

92. Dr Lau[105], who saw Mr Beever in the Medical Assessment Unit following his referral from the Emergency Department at the GCUH noted that his presenting complaints were:

    a. Right sided abdominal pain/ bruising;
    b. Bruising to knees;
    c. Right sided cervical spine pain;
    d. Incontinent of urine; and
    e. Dehydration.

93. On examination of Mr Beever, Dr Lau noted in the medical records "*reports lesion ? melanoma on back*", which she believed had been reported to her by the forensic physician at handover. Dr Lau was unsure if it was self-reported by Mr Beever, however, noted that she did not visualise or diagnose the lesion at the time of examination.[106] It follows that it is unclear whether any medical staff at GCUH visualised the lesion on Mr Beever's back at the time of his initial presentation, or whether its appearance in the medical records was based on his self-report.

94. It is not possible to conclude that the suspicious lesion noted in the medical records on 26 February 2021 was a melanoma. While earlier surgical excision may have offered a more favourable outcome for Mr Beever, it is not possible to conclude that earlier intervention would have been outcome changing when Mr Beever declined to undergo further treatment following the diagnosis of metastatic melanoma.

95. I accept that attempting to manage a suspicious skin lesion on Mr Beever's back would have been difficult during the early course of his admission as his cognitive function, mood and capacity to make appropriate health decisions was still being evaluated and managed. The primary assessment and management plan were appropriately focused on the presenting complaints following his arrest for his wife's death. Given the involvement of police, there was no certainty he would have remained an inpatient at the GCUH.

[105] Ex B4
[106] Ex B4 at [13(j)-(m)].

Findings required by s. 45

96. 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:	Maxwell John Beever
(b) How the person died:	Mr Beever was admitted to Gold Coast University Hospital on 25 February 2021 following his arrest and remand in custody in relation to a charge of murder. The following day a notation was made in the medical records that he had a suspicious lesion on his back. No further action was taken until 26 June 2021, when it was noted during a skin check. The following month Mr Beever was diagnosed with melanoma. In February 2022, there was a recurrence of the melanoma and Mr Beever underwent an axillary lymph node dissection but declined to undergo radiotherapy. Mr Beever was later diagnosed with metastatic melanoma. Mr Beever's condition continued to deteriorate and on 8 July 2022, Mr Beever's breathing was observed to change. Nursing staff observed no signs of life and following a medical examination he was declared deceased.
(c) When the person died:	8 July 2022.
(d) Where the person died:	Robina Hospital.
(e) What caused the person to die:	1(a) Metastatic melanoma.

Comments and recommendations

97. 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.

98. 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.

99. I extend my condolences to Mr Beever's family and friends.

100. I close the inquest.

Terry Ryan
State Coroner
BRISBANE