QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	Inquest into the death of Clifford Raymond Grogan
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2023/2261
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, atherosclerotic cardiovascular disease, pacemaker.

REPRESENTATION:

Counsel Assisting:	Ms D Palmer
Queensland Corrective Services:	Ms J Villanueva
Cairns and Hinterland Hospital and Health Service:	Ms H Price

Contents

Introduction

1. Clifford Raymond Grogan, a First Nations man, was 68 years of age when he passed at Lotus Glen Correctional Centre (LGCC) on the morning of 11 May 2023. He was held there on remand pending trial. Mr Grogan had a significant cardiac history and passed of natural causes as a result of atherosclerotic cardiovascular disease.

Coronial jurisdiction

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

[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 Grogan's death was led by Plain Clothes Senior Constable (PCSC) Simon Rowe of the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU).

8. After CSIU investigators were notified of Mr Grogan's death on 11 May 2023, local police attended holding cell 4 at LGCC. Police observed Mr Grogan to be wearing green shorts, laying on his back and covered with a white sheet. Mr Grogan did not have any signs of trauma or indications of a suspicious passing.

9. On 12 May 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 27 September 2023.

10. PCSC Rowe conducted a thorough investigation in response to the targeted direction. He concluded that there were no suspicious circumstances in relation to Mr Grogan's passing.

The inquest

11. The inquest was held at Brisbane on 7 July 2026. All statements, medical records, photographs, CCTV 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 Grogan 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 Grogan was born on 5 April 1955 in Cairns, Far North Queensland. His sister, Valerie Grogan, remembered him as, "*...a really protective big brother to his young siblings and also his nieces and nephews*".[5]

15. Mr Grogan's first interaction with the criminal justice system commenced at the age of 18 years, when he was convicted and fined for disorderly conduct.[6]

16. Mr Grogan's final custodial episode commenced on 9 June 2022[7] after he was arrested and remanded in custody in relation to multiple sexual, violence and drug related offences, several of which were alleged to involve children.[8] He was transferred from the Cairns Watchhouse to LGCC on 13 June 2022.[9]

17. Mr Grogan's medical history was not insignificant. He had a history of cardiac issues, commencing in 2005 with a diagnosis of ischaemic heart disease following an angiogram which showed triple vessel coronary artery disease. Mr Grogan had declined to undergo a recommended coronary artery bypass graft at that time.[10]

18. In 2015, Mr Grogan suffered a non-ST-elevation myocardial infarction requiring a coronary artery bypass operation.[11] This was complicated by a complete heart block (which required the implantation of a permanent pacemaker), and heart failure, as a consequence of his coronary artery disease, with severe impairment of the left ventricular systolic function.[12]

19. Mr Grogan also suffered from a number of comorbidities that increased his risk of sudden cardiac passing, including type 2 diabetes mellitus requiring insulin, hypertension treated with medication, chronic obstructive lung disease and chronic kidney disease.[13] He also had a history of untreated Hepatitis C, intravenous drug use[14] and smoking.

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[5] Ex B5, at [20].
[6] Ex C1, p 1.
[7] Ex A6, p 2.
[8] Ex C1, pp 2 – 4.
[9] Ex D16, p 2.
[10] Ex B3 at [10].
[11] Ex B3 at [9] & [11].
[12] Ex B3 at [12] – [13].
[13] Ex B2, page 1.
[14] Ex B3 at [15]; Ex B5 at [9] – [10].

Care in custody

20. Mr Grogan was first received into custody at LGCC on 13 June 2022.[15] He was classified as a high security prisoner[16] and was accepted for Prisoner of Concern management.[17] He was seen twice daily for medication and insulin rounds, and was reported to have, "*...excellent compliance with his medication*".[18]

21. On 17 June 2022, Mr Grogan declined to attend a scheduled medical review and was rebooked for review on 20 June 2022.[19]

22. The following day, Mr Grogan complained of central chest pain and a code blue was called. He was able to speak in full sentences and it was noted he had a pacemaker. He reported feeling anxious the past two days and was moved to a cell on the lower floor due to his heart condition[20] and "*anxiety of going up and down stairs*."[21]

Transfer to Mareeba Hospital: 18 June – 19 June 2022

23. On 18 June 2022, Mr Grogan was transported to the Mareeba Hospital Emergency Department following complaints of central chest pain on and off over the preceding couple of days that had worsened that night.[22] He reported that he had last used intravenous drugs a couple of weeks before entering custody.[23]

24. Mr Grogan reported that his central chest pain level was 2/10[24], and was slightly relieved by using Glyceryl Trinitrate (GTN) spray. He also advised that he had previously experienced shortness of breath, but did not have any fevers, leg pain or radiation of pain.[25]

25. Mr Grogan was admitted "*for possible central cardiac chest pain*" and was able to mobilise independently from the Emergency Department.[26] He was due for a repeat ECG which "*showed no new changes*" and his troponin level was 0.00.[27]

26. At that time Mr Grogan was prescribed the following medications:[28]

Ramipril	*2.5mg mane*
Spironolactone	*25mg mane*
Aspirin	*100mg mane*

[15] Ex B1 at [8].
[16] Ex D7.
[17] Ex D9, p 1.
[18] Ex B1 at [10].
[19] Ex E4, p 19.
[20] Ex E4, p 19.
[21] Ex E4, p 20.
[22] Ex E5, p 1; Ex D23.
[23] Ex E5, p 1.
[24] Ex E5, p 291.
[25] Ex E5, p 1.
[26] Ex E5, p 291.
[27] Ex E5, p 291.
[28] Ex E5, p 1.

Atorvastatin	*20mg daily*
Bisoprolol	*5mg mane*
Furosemide	*20mg mane*
Metformin XR	*1g mane*
Panadol osteo	*BD*

27. The following evening, Mr Grogan was discharged back to LGCC with a Cardiology Clinic appointment scheduled on 20 June 2022.[29]

28. On 20 June 2022, Mr Grogan was reviewed by visiting medical officer Dr Copson who noted that his Cardiology Clinic appointment that day had been rescheduled. He was dispensed GTN to treat his chest pain, his dose of Atorvastatin was increased to 80mg,[30] and his blood sugar level was noted to be high. Mr Grogan reported that he was feeling "*stressed, anxious, shame*" and had been having difficulty sleeping. He was prescribed a two-week trial of melatonin.[31]

29. On 10 July 2022, Mr Grogan was taken to the medical centre in a wheelchair after complaining of shortness of breath. He reported that he did not have any pain, and a clinical nurse listened to his chest.[32]

30. On 12 July 2022, Mr Grogan attended the medical centre with shortness of breath and was given information regarding anxiety management.[33]

31. On 22 July 2022, Mr Grogan reported further shortness of breath. On examination his chest was clear and was he was examined by a medical officer. It was considered Mr Grogan was experiencing nasal congestion, and he was given a Symbicort inhaler for his COPD and a nasal spray.[34]

32. On 27 August 2022, a code blue was called in response to Mr Grogan experiencing shortness of breath. He was provided with education on the use of Ventolin with a spacer and his anxiety issues were also discussed. Mr Grogan advised that he wanted to have a cellmate.[35]

33. On 29 August 2022, Mr Grogan was reviewed by Dr Purcell and reported feeling shortness of breath and agitation regarding his health concerns. Mr Grogan told Dr Purcell that he gets "*worked up*" about being in custody and showed Dr Purcell the intravenous drug use scars on his arm.[36]

[29] Ex E5, p 169.
[30] Ex E4, p 21.
[31] Ex E4, p 21.
[32] Ex E4, p 25.
[33] Ex E4, p 23.
[34] Ex E4, p 27.
[35] Ex E4, pp30 - 31.
[36] Ex E4, p31.

Transfer to Mareeba Hospital: 29 August 2022

34. On 29 August 2022, Mr Grogan was transported to Mareeba Hospital following complaints of shortness of breath, back pain and chest pain.[37] On examination Mr Grogan did not appear unwell and had intermittent shortness of breath that had improved with intravenous fentanyl and SL GTN.[38] A chest x ray showed "nil obvious collapse or consolidation."[39]

35. Mr Grogan's condition was discussed with the on-call Cardiologist, Dr April, who advised to "*add on formal troponin, rediscuss in morning with results and treat pain with GTN*."[40]

36. The following morning, Mr Grogan was observed to be sitting up in bed and reported his shortness of breath and back pain had improved. While his ECG showed a "*paced, ventricular rhythm*" with no peripheral oedema, his chest was noted to be wheezy.[41] He did not report any chest pain.[42]

Transfer to Cairns Base Hospital: 30 August 2022

37. On 30 August 2022, Mr Grogan was discharged from Mareeba Hospital and transferred to Cairns Base Hospital[43] for treatment for elevated troponin level on a background of significant cardiac history, and shortness of breath.[44] He was diagnosed with an "*infection of unestablished etiology*" and was treated with intravenous antibiotics.[45] He did not have a fever and was not considered to be clinically unwell.[46]

38. The following day, Mr Grogan reported that he had an infection in his back over the preceding two weeks and had experienced pain in his back when breathing.[47] He also reported dark green phlegm when coughing over the course of a week.[48] It was considered that there was "*no clinical focus for infection*" and required a cardiology review. His antibiotics would be ceased, and his SGLT2 inhibitors and nephrotoxics were withheld.[49]

39. During a Cardiology review, Dr Elder considered whether Mr Grogan had a Type 2 Myocardial Infarction or Non-ST-elevation myocardial infarction and recommended that he remain on telemetry surveillance for cardiac issues and to undergo a Transthoracic Echocardiogram.[50]

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[37] Ex E5, p 66; Ex E4, p 32; Ex D24.
[38] Ex E5, p 3.
[39] Ex E5, p 3.
[40] Ex E5, p 259.
[41] Ex E5, p 259.
[42] Ex E5, p 260.
[43] Ex E5, p 257.
[44] Ex E2, p 87; Ex E5, p 261.
[45] Ex E2, p 86 – 87.
[46] Ex E2, p 83.
[47] Ex E2, p 83.
[48] Ex E2, pp 81, 83.
[49] Ex E2, p 84.
[50] Ex E2, p 82.

40. During a ward round the following day, Mr Grogan had symptoms consistent with bronchitis and was commenced on an oral dose of antibiotics "*for possible chest infection*" with regular medications to recommence the following day. He was noted to be a "*high risk for cardiac event given trop rise and history*."[51]

41. Mr Grogan was reviewed by Cardiologist, Dr Sutcliffe, who considered that Mr Grogan had Non-ST-elevation myocardial infarction. His care was transferred to the Coronary Care Unit and he was to undergo a transthoracic echocardiogram and angiogram.[52]

42. On 1 September 2022, Mr Grogan had a Transthoracic Echocardiogram which found:[53]

> *Left ventricle mild-moderately dilated with mild-moderate regional and dyssynchronous impairment of systolic function, EF 44%, wall thickness upper limits of normal, grade I diastolic dysfunction with elevated filling pressures and LAD/LCx regional wall abnormalities.*
> *Right ventricle – normal size with mildly reduced systolic function.*
> *Atria – mild-moderately dilated left atrium. Valves – no significant valve abnormalities.*

43. The following day, during a Cardiology ward round, Mr Grogan reported "feeling alright" and no chest pain. The transthoracic echocardiogram findings were explained to Mr Grogan as was the plan for him to undergo a coronary angiogram.[54]

44. Mr Grogan underwent a coronary angiogram which showed that "his bypass grafts were patent."[55]

45. On 3 September 2022, Mr Grogan was discharged back to LGCC with a follow up appointment with Dr Sutcliffe scheduled.[56]

46. On 5 September 2022, Mr Grogan attended a telehealth appointment with Dr Sutcliffe who confirmed that he had a pacemaker appointment scheduled the following February.[57] Following the appointment, Dr Sutcliffe wrote to Wuchopperen Health Service and advised that Mr Grogan had "remained well following his hospital discharge" and that would have a further Cardiology Outpatient Clinic appointment in one year.[58]

47. Two days later, a code blue was called following reports that Mr Grogan had shortness of breath and chest pain. He had reported running out of Beconase spray and this was given on the PM medication round.[59]

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[51] Ex E2, p 74.
[52] Ex E2, pp 71 – 72.
[53] Ex E2, p 72.
[54] Ex E2, p 64.
[55] Ex B3 at [16].
[56] Ex E2, p 60.
[57] Ex E4, p 33.
[58] Ex E3, p 158.
[59] Ex E4, p 34.

48. On 22 September 2022, staff responded to a code blue following reports of shortness of breath. Mr Grogan reported that he had misplaced his puffer and spray during a unit move that day. His reported shortness of breath was "*consistent with previous presentations*" and he was given new puffers.[60]

49. The following day, Mr Grogan presented to the medical centre again in relation to breathing difficulties and reported that his Beconase spray was not helping.[61]

Transfer to Mareeba Hospital: 23 September 2022

50. In the early hours of the morning, Mr Grogan was transported to Mareeba Hospital following reported shortness of breath over a two-week period.[62] He had negative troponins and was given 50mg of tramadol with no effect on his pain level. It was noted that there was "*no clear cause for [shortness of breath] except that patient states it is made worse by being in a cell*."[63]

51. He was returned to LGCC later that afternoon[64] and was commenced on a trial of mirtazapine to treat his shortness of breath and claustrophobia, and a short course of meloxicam to treat his pain.[65]

Transfer to Mareeba Hospital: 26 October 2022

52. On 26 October 2022, Mr Grogan was transported to Mareeba Hospital in relation to reported central chest pain, shortness of breath and headaches.[66] He was commenced on 60mg of isosorbide mononitrate daily.[67]

53. It was determined that his reported pain "*may be musculoskeletal in nature*". His troponins were negative and he was discharged back to LGCC.[68]

Transfer to Mareeba Hospital: 2 November 2022

54. On 2 November 2022, Mr Grogan was transported to the Mareeba Hospital following complaints of chest pain which had lasted several hours and was relieved with the use of GTN spray.[69]

55. Mr Grogan was commenced on the chest pathway, with a normal initial and 6-hour troponin and was diagnosed with acute ischaemic heart disease. He was discharged back to LGCC and commenced on Nicorandil 10mg BD.[70]

[60] Ex E4, p 34.
[61] Ex E5, pp 56, 60; Ex D25.
[62] Ex E5, pp 56, 60; Ex D25.
[63] Ex E5, page 158.
[64] Ex E4, page 35.
[65] Ex E5, page 159.
[66] Ex E5, page 52; Ex E4, p 37; Ex D26.
[67] Ex E5, p 156.
[68] Ex E4, p 37; Ex E5, p 156.
[69] Ex E5, p 6; Ex D27.
[70] Ex E3, p. 191.

56. The following evening, Mr Grogan reported that he was having trouble breathing and his Symbicort was replaced. He did not report any pain.[71]

57. On 5 November 2022, nursing staff responded to a code blue called following reports that Mr Grogan was having trouble breathing. On review, Mr Grogan was able to speak in full sentences and did not show any signs of respiratory distress. He was taken to the medical centre for further examination and a headache was treated with Panadol.[72] Mr Grogan did not report new chest symptoms and did not want to attend the Emergency Department as he felt that his chest pain was not changing.[73]

Transfer to Mareeba Hospital: 13 November – 14 November 2022

58. On 13 November 2022, Mr Grogan was transported to the Mareeba Hospital following reports of sharp central chest pain without shortness of breath, light-headedness or excessive sweating or fevers.[74] It was considered to be "*possibly cardiac chest pain; however, unlikely given no obstruction on recent [coronary angiogram]*."[75] It was concluded the source of his pain was likely musculoskeletal or costochondral in nature.[76]

59. On the morning of 14 November 2022, Mr Grogan was discharged back to LGCC.[77]

60. On 22 November 2022, a code blue was called following reported chest pain and difficulty breathing. Mr Grogan requested and was provided with a Ventolin puffer. He reported that he had given an empty puffer to an officer.[78]

61. The following day a code blue was called in relation to Mr Grogan reporting further chest pain. On examination he was no longer short of breath and his chest was clear.[79]

62. On 8 February 2023, a code blue was called in response to Mr Grogan having shortness of breath. During an examination in his cell Mr Grogan was noted to be "*very anxious*." He was taken to the clinic where he also reported a headache and cramping in his hands. His chest sounded "*clear with equal air entry*" and he was treated with Panadol.[80]

[71] Ex E4, p 40.
[72] Ex E4, p 40.
[73] Ex E4, p 42.
[74] Ex E5, p 173; Ex D28.
[75] Ex E5, p 174.
[76] Ex E5, p 174.
[77] Ex E4, p 43.
[78] Ex E4, p 44.
[79] Ex E4, pp 44 – 45.
[80] Ex E4, p 48.

63. On 23 February 2023, Mr Grogan refused to attend a medical appointment.[81] On 13 March 2023, following several refusals to attend the medical clinic, he was removed from the medical officer list and would be required to submit a new Health Services Request Form to secure an appointment.[82]

64. On 17 March 2023, Mr Grogan refused to attend a Cardiology and Permanent Pacemaker telehealth appointment and was rebooked for 11 May 2023.[83]

Transfer to Mareeba Hospital: 16 April 2023

65. On 16 April 2023, a code blue was called following reported difficulty breathing and vomiting. Mr Grogan was transported to Mareeba Hospital[84] where it was noted that he been short of breath after being in air conditioning at the correctional centre.

66. His shortness of breath was treated with "*salbutamol burst therapy*" and it was noted that his "*chest was clear, abdomen soft and there was no other focus of infection*." Mr Grogan was diagnosed with influenza[85] and was treated with a five-day course of Tamiflu.[86] He was discharged back to LGCC that evening.[87]

Day of Passing: 11 May 2023

67. Early in the morning of 11 May 2023, Mr Grogan attended the medical centre for his medication prior to a transfer to Cairns Base Hospital Cardiology Clinic to attend an 8:30am appointment.[88] At that time Mr Grogan did not appear unwell and did not complain of any health issues. He was then placed in holding cell 4 with other prisoners prior to his escort to Cairns Base Hospital.[89]

68. At approximately 5:58am prisoners alerted Custodial Corrections Officers (CCO) that Mr Grogan had collapsed in the holding cell and a code blue was called.[90] Nursing staff arrived at approximately 6:02am. He was placed in the recovery position and Queensland Ambulance Service was called.[91] He was given oxygen and defibrillator pads were applied while CPR was commenced.[92]

[81] Ex E4, p 49.
[82] Ex E4, p 49.
[83] Ex E4, p 49; Ex B1 at [12].
[84] Ex E4, p 50; Ex D29.
[85] Ex E8, p 1.
[86] Ex E5, p 13.
[87] Ex E5, p 14.
[88] Ex E4, p51; Ex D30, p 1.
[89] Ex D30, p 1.
[90] Ex D30, p 1.
[91] Ex D30, p 1.
[92] Ex D31, p 1; Ex C2, p 1.

69. By 6:07am Mr Grogan had stopped breathing and did not have a cardiac rhythm.[93] He continued to be given oxygen and CPR and by 06:12am Mr Grogan was noted to be breathing by himself again for a short time. A nasopharyngeal tube was inserted, and a shock was administered, however no cardiac rhythm was present.[94]

70. CCO Carberry, who assisted with administering CPR recalled that Mr Grogan *"aspirated via the throat and nose and airway bag compressions were performed in conjunction with chest compressions*."[95]

71. CCOs continued to perform CPR with three shocks delivered between 6:26am and 06:28am.[96] At 6:32am Queensland Ambulance Service officers arrived and took over. At 06:32am a phone call was also made to Mareeba Hospital to advise of Mr Grogan's cardiac arrest and arrangements were made to have medical staff on standby for his arrival via QAS.[97]

72. At 06:49am QAS staff consulted with Dr Stephen Rashford who provided advice to "*administer 300mg amiodarone, continue CPR for 15 minutes then call back*." QAS Officers administered four shocks.[98]

73. At 07:13am QAS Officers called Dr Rashford again and were advised to stop CPR.[99]

74. QAS officer Sara Blake declared Mr Grogan deceased at 07:14am.[100]

Morbidity and Mortality Review

75. On 14 June 2023, a Morbidity and Mortality Review of Mr Grogan's passing was held.[101]

76. During the meeting, it was noted that no nursing staff at LGCC were trained in advanced life support and it was proposed that consideration be given to arranging training for interested staff.[102]

Forensic Medicine Queensland advice

77. Given Mr Grogan's significant cardiac history, I sought advice from Forensic Medicine Queensland in relation to whether management of Mr Grogan's cardiovascular risk factors and known heart disease was appropriate, and whether Mr Grogan's collapse and deterioration was responded to promptly and treated appropriately.

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[93] Ex D40, p 1.
[94] Ex D40, p 1.
[95] Ex D31, p 1.
[96] Ex D31, p 1; ExC2, p 1.
[97] Ex E5, p 15.
[98] Ex C2, p 1.
[99] Ex C2, p 1.
[100] Ex D30, p 1.
[101] Ex B1 at [13]; Ex E8.
[102] Ex E8, p 1.

78. On 26 May 2026, Forensic Physician, Dr Jessica Page provided some advice in which she opined that "*Mr Grogan's cardiovascular risk factors and known heart disease were managed in accordance with expected medical practice, and there were no missed outcome changing opportunities identified*."[103]

79. In relation to the response to Mr Grogan's deterioration, Dr Page was of the view that "*recognition and response to Mr Grogan's deterioration was appropriate and consistent with expected medical practice*."[104]

80. In her advice, Dr Page also referred to the recommendation made in the Morbidity and Mortality Review that consideration be given to providing interested nursing staff at LGCC with Advanced Life Support (ALS) training. Dr Page noted that "*while this is a sensible recommendation, provision of ALS to Mr Grogan at the time of his cardiac arrest on 11/05/2023 is unlikely to have been outcome changing*."

81. I accept the advice of Dr Page.

Autopsy results

82. On 19 May 2023, Forensic Pathologist Dr Paull Botterill conducted an autopsy consisting of an external and internal examination of the body.[105]

83. Dr Botterill concluded that "*at the time of autopsy, the cause of death was a heart rhythm disturbance due to atherosclerotic cardiovascular disease, but the possible contribution of valvular heart disease, chronic lung disease and kidney damage associated with diabetes were difficult to quantitate, and the possibility of drug toxicity was difficult to completely exclude at the time of autopsy examination."*[106]

84. It was noted that "*Further investigations were subsequently performed. Microscopic examination showed heart muscle scarring and heart cell enlargement, lung congestion, liver fatty change and early scarring, and some kidney and testicular scarring.*"[107]

85. Toxicology results confirmed that medications were below individually toxic ranges.[108]

86. Dr Botterill concluded that Mr Grogan's cause of passing was Atherosclerotic cardiovascular disease.

[103] Ex E9 at [34].
[104] Ex E9 at [38].
[105] Ex A3; Ex A4, pp 4 – 7.
[106] Ex A4, p 7.
[107] Ex A4, p 7.
[108] Ex A4, p 7.

Conclusions

87. I am satisfied that Mr Grogan died from natural causes. I find that none of the health care staff at LGCC, Mareeba Hospital or Cairns Base Hospital caused or contributed to his death. There were no suspicious circumstances.

88. 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 Grogan when measured against this benchmark.

Findings required by s. 45.

89. 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:	Clifford Raymond Grogan
(b) How the person died:	Mr Grogan suffered several co-morbidities that increased his risk of sudden cardiac passing including Ischaemic Heart Disease, Type 2 Diabetes Mellitus requiring insulin, Hypertension treated with medication, Chronic Obstructive Lung Disease, and Chronic Kidney Disease. On the morning of 11 May 2023, Mr Grogan was in a holding cell pending transfer to Cairns Base Hospital to attend the Cardiology and Permanent Pacemaker Clinic. Whilst in the holding cell Mr Grogan suffered a cardiac arrest and was unable to be revived. He was declared deceased at 7:14am.
(c) When the person died:	11 May 2023.
(d) Where the person died:	Lotus Glen Correctional Centre.
(e) What caused the person to die:	1(a) Atherosclerotic cardiovascular disease.

Comments and recommendations

90. 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.

91. 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.

92. I extend my condolences to Mr Grogan's family and friends.

93. I close the inquest.

Terry Ryan
State Coroner
BRISBANE