CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign King at Adelaide in the State of South Australia, on the 14th day of May and the 13th day of September 2024, by the Coroners Court of the said State, constituted of David Richard Latimer Whittle, State Coroner, into the death of Gerald Douglas Morrison.

The said Court finds that Gerald Douglas Morrison aged 61 years, late of the Port Lincoln Prison, 222 Pound Lane, Duck Ponds, South Australia died at Duck Ponds, South Australia on the 20th day of March 2022 as a result of ischaemic heart disease with left ventricular hypertrophy. The said Court finds that the circumstances of his death were as follows:

1. Introduction and cause of death

1.1. Gerald Douglas Morrison was born 25 November 1960 and died on the 20 March 2022 at the Port Lincoln Prison at the age of 61 years. Mr Morrison was an Aboriginal person.

1.2. An autopsy was undertaken by senior consultant forensic pathologist, Dr Stephen Wills of Forensic Science South Australia. The cause of death was given as 'ischaemic heart disease with left ventricular hypertrophy',[1] and I so find.

2. Reason for inquest

2.1. As at the time of his death Mr Morrison was in the custody of the Department for Correctional Services (DCS) serving a period of imprisonment, this is a mandatory inquest pursuant to Section 21 of the Coroners Act 2003.

[1] Exhibit C2a

3. Background

3.1. Mr Morrison was born in Adelaide and was the middle of five children. He attended Bowden Brompton School and left at the age of 15 and gained employment making industrial springs.

3.2. Mr Morrison married at the age of 24 and had three children then, after many years, he separated from his wife.

4. Custodial sentence

4.1. Mr Morrison was taken into custody on 25 October 2004 after being arrested and subsequently found guilty at trial in the Supreme Court of South Australia of the offences of murder and wounding with intent to do grievous bodily harm.

4.2. On 13 April 2007 he was sentenced to life imprisonment with a non-parole period of 17 years and 11 months, backdated to 15 January 2006.

5. Mr Morrison's medical history

5.1. Mr Morrison's medical history, according to South Australian Prison Health Service (SAPHS) records, included:

- type 2 diabetes;
- hernia;
- hypercholesterolaemia;
- schizophrenia and major depression with psychotic features with admissions to James Nash House in 2005 and 2006;
- hepatitis C diagnosed in 1994 (treated and not detected since 2014);
- hepatitis B infection 1989.

5.2. At the time of his death Mr Morrison was only taking limited medications; metformin, 1gm twice a day for his type 2 diabetes and paracetamol, 1gm twice a day for pain relief.

5.3. On 31 December 2019 Mr Morrison reported experiencing chest pain and was conveyed to the Port Lincoln Hospital where he was examined and cleared for return to the prison.

5.4. As a result of this episode Mr Morrison was referred to Dr Rufus McLeay, a consultant physician and endoscopist, whom he saw on 13 February 2020.

5.5. SAPHS records contain correspondence dated 13 February 2020 from Dr McLeay to the medical officer at Port Lincoln Prison.

5.6. In that correspondence Dr McLeay reported that Mr Morrison had been having chest pains over the previous month or two, which he did not report until he picked up a crate of onions and the pain was quite severe. This complaint led to him being sent to the Port Lincoln Hospital, at which time troponin testing proved negative.

5.7. Dr McLeay reported that he did not feel that Mr Morrison's pain was cardiac related, but possibly either musculoskeletal or from his gut.

5.8. Dr McLeay also detailed in that letter that Mr Morrison had an ECG which showed a left bundle branch block, meaning it was difficult to diagnose any ischaemic changes in the heart. That presented a difficulty with diagnosis and Dr McLeay expressed that stress testing would not be all that useful in deciding what to do next. As such, the only options for further testing for coronary disease involved a transfer to Adelaide, but Mr Morrison reportedly expressed reluctance for that to occur.

5.9. Dr McLeay detailed in that correspondence that he explained to Mr Morrison that the best way for him to prevent a heart attack was by reducing his risk factors, such as stopping smoking, which he already had, and to continue to take his statin medication.

5.10. In addition to that episode of reported chest pain, Mr Morrison had reported bleeding from his rectum and Dr McLeay recommended a colonoscopy.

5.11. Mr Morrison was subsequently booked for a colonoscopy on 8 May 2020 but his case notes indicate that on the day he refused to attend, stating that he could not venture far from the toilet as he was experiencing liquid bowel action. The notes indicate that staff discussed the importance of the procedure but he did not want to go.

5.12. On 26 May 2020 there is a case note indicating that a new referral for a colonoscopy had been requested by the medical officer at the prison.

5.13. On 23 July 2020 there is a note indicating that Mr Morrison went for further surgical referral for a colonoscopy, but he had refused the procedure despite staff trying to

reassure him. He signed a form indicating that he was refusing treatment against medical advice.

5.14. Dr Turnbull, the current head of SAPHS, who provided an overview of Mr Morrison’s medical treatment during his time in custody, expressed the opinion that any issues that may have been identified via colonoscopy were unlikely to have contributed to his death.

5.15. On 22 August 2020 Mr Morrison was booked for a discussion with a nurse as his cholesterol levels had been elevated. He had previously been prescribed atorvastatin for his cholesterol but there is a case note on this date that Mr Morrison admitted to not taking his cholesterol tablets and that he did not want them, as he had been told by an ambulance officer that they were no good for him. He claimed that he was conscious of the importance of diet and exercise.

5.16. Of note, Mr Morrison’s final cholesterol check prior to his death was done on 24 November 2021 with a ratio of total cholesterol to HDL of 4.4. Normal ratio is up to 5, indicating potentially that statin medication was not essential for him or that he had made dietary changes which had successfully reduced his risk.

5.17. Dr Turnbull explained that any prisoner who has a chronic disease, as in the case of Mr Morrison’s diabetes, was put on a chronic disease management plan. As part of that plan Mr Morrison had yearly ECGs. His last was in December 2021.

5.18. Over the course of time Mr Morrison's ECG results were unchanged and were unremarkable, with nothing indicating any acute intervention was required. All the ECGs in his records show a left bundle branch block.

5.19. Dr Turnbull explained that Mr Morrison had risk factors for cardiac disease being diabetes, his age and being male. Additionally, his father had diabetes and died from a heart attack and his mother had diabetes, so there were family risk factors for ischaemic heart disease. Despite this there was nothing in his medical record to suggest that he was at imminent risk of death from ischaemic heart disease.

5.20. According to Dr Turnbull, if Mr Morrison was complaining of angina symptoms and had an angiogram, it may have shown a narrowing of the arteries and then a stent or other surgical intervention may have been appropriate. However, that never occurred

as Mr Morrison never experienced ongoing chest pain that required that kind of investigation or, if he did have any warning signs subsequent to the chest pains that he experienced in December 2019, he does not appear to have expressed that to others.

5.21. Of note is that Mr Morrison had last seen a SAPHS nurse on 5 March 2022. No complaints of chest pain were made on that occasion. The visit was in relation to an injury to his finger.

6. Circumstances leading to Mr Morrison's death

6.1. Alfred Johannsen provided an affidavit in relation to the days leading up to Mr Morrison's death. Mr Johannsen and Mr Morrison were cellmates for several weeks before Mr Morrison's death. They had been friends for many years in the prison system.

6.2. Mr Johannsen noticed that in the days leading up to his death Mr Morrison appeared more fatigued than usual. Both men worked in the prison garden and on 17 March 2022 after work, Mr Morrison remained in bed which was out of the ordinary.

6.3. On 18 March 2022 both men worked in the garden but Mr Morrison left early, claiming he had a dental appointment. There is no record of Mr Morrison having an appointment that day.

6.4. On Sunday 19 March 2022, Mr Morrison seemed cheerful and stayed awake watching movies while Mr Johannsen went to sleep.

6.5. According to Mr Johannsen, Mr Morrison typically woke around 6am, made coffee and then showered in the eastern shower block where water was unlimited. He usually returned to the cell within about 30 minutes.

6.6. CCTV from the morning of 20 March 2022 indicates that Mr Morrison left his cell at around 6:22am and walked to and entered the shower block.

6.7. At about 7:30am on 20 March 2022, Correctional Officer (CO) Stellios Betsias was conducting a handover count of Bluefin Unit, Port Lincoln Prison.

6.8. CO Betsias' count was one prisoner down and another prisoner informed CO Betsias that there was a prisoner still in the shower in the eastern block.

6.9. CO Betsias entered the ablutions block and saw that the far-right stall door was closed. He looked under the door and saw a prisoner naked in the foetal position. He immediately called a code black over the radio.

6.10. CO Jeffery Lock arrived shortly after while CO Betsias was trying to unlock the door, which he was unable to do as the plastic override switch was worn and could not be turned.

6.11. CO Lock climbed over the door and opened it and then correctional officers dragged Mr Morrison out of the cubicle. It was determined that Mr Morrison was not breathing and was unresponsive to stimuli.

6.12. At about 7:36am Officer in Charge (OIC) Clint Helliar arrived on the scene with SAPHS staff who immediately commenced advanced cardiopulmonary resuscitation (CPR) on Mr Morrison, with assistance from COs Lock and Betsias.

6.13. At about 07:38am OIC Helliar instructed the control room operator to call the SA Ambulance Service (SAAS) and request attendance as a 'Priority 1' response. CO Tracie Tierney was instructed by OIC Helliar to facilitate SAAS access to the prison by opening the gates located at the rear of the Bluefin unit and the gates leading to the oval.

6.14. At about 7:50am, the first SAAS ambulance arrived on the scene and were escorted by correctional staff to the Bluefin east ablutions block. SAAS then took over the medical care of Mr Morrison from SAPHS. COs Lock and Betsias continued to deliver chest compressions to Mr Morrison. Supervisor Cooke, who had just commenced his shift, attended the incident scene where he immediately commenced assisting with the delivery of chest compressions to Mr Morrison.

6.15. At about 7:56am, a second SAAS ambulance arrived and commenced working on Mr Morrison. OIC Helliar directed Supervisor Operations Darren Page to call and advise the Port Lincoln Prison duty manager of the incident.

6.16. At about 8:10am SAAS terminated resuscitation efforts and declared Mr Morrison deceased.

7. <u>SAPHS Critical Incident and Adverse Event Team Review</u>

7.1. Following the death of Mr Morrison, DCS undertook a Critical Incident and Adverse Event Team Review. This review considered the circumstances of Mr Morrison's death

in custody, whether there were any significant issues specific to the incident, and reviewed compliance with relevant policy, procedure, guidelines and instructions.

7.2. The review concluded that Mr Morrison received appropriate cultural support while in custody and that there were no material issues of non-compliance with relevant policy, procedure, guidelines or instructions relating to the death in custody of Mr Morrison.

7.3. One issue identified was that the override mechanism on the stall door lock of the shower cubicle used by Mr Morrison was worn and not functioning. This prevented CO Betsias and CO Lock from opening the stall door to commence administering CPR to Mr Morrison and required CO Lock to climb over the door to access Mr Morrison. As a result of that, all locks from shower doors were removed.

7.4. The review also concluded that Mr Morrison's diagnosed health conditions were being suitably managed and treated by SAPHS while accommodated at Port Lincoln Prison.

7.5. I observe that the review stated that 'Mr Morrison underwent a brief medical escort on 18 March 2022 to see a specialist for a complaint of generalised chest pain'.[2] Given the potential significance of that event in the context of his subsequent death, clarification was sought from DCS via the Crown Solicitor's Office.

7.6. I was subsequently advised that:

> 'Despite the Critical Incident Review Report[3] reporting that the reason for Mr Morrison's medical escort on 18 March 2022 was for generalised chest pain, there is no other record of chest pain being the reason for the medical escort … it is apparent that at 10:30 on 18 March 2022 Mr Morrison attended Pt Lincoln Hospital for a review in the general surgery clinic in relation to an ongoing issue with a discharging cyst from his right middle finger at the nail fold.
>
> …
>
> Accordingly … the entry at paragraph [10] at the top of page 7 of the [report] was made in error and the Department accepts that the reason for the medical escort on 18 March 2022 was finger-related and not related to chest pain.' [4]

[2] Transcript, page 9
[3] CIRR
[4] Exhibit C14

8. Conclusion and recommendation

8.1. By way of concluding remarks, at the time of his death Mr Morrison was in the lawful custody of DCS. The circumstances surrounding the death of Gerald Morrison are not suspicious and do not indicate the involvement of any third party.

8.2. I find that the medical treatment Mr Morrison received while in custody was to be of an appropriate standard.

8.3. I make no recommendations.

Key Words: Death in Custody; Prison; Natural Causes

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 13th day of September, 2024.

____

State Coroner

Inquest Number 22/2024 (0640/2022)