QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Maureen Ann Weazel**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Murgon
FILE NO(s):	2010/1309
DELIVERED ON:	10 May 2013
DELIVERED AT:	Kingaroy
HEARING DATE(s):	23 September, 24 December 2010, 31 January, 8 & 9 August 2011
FINDINGS OF:	Barry Barrett, Coroner
CATCHWORDS:	CORONERS: Inquest – Whether there was an unreasonable denial of access to, and as a result treatment at, Cherbourg Hospital

REPRESENTATION:

Counsel Assisting:	Mr Justin Harper
Queensland Health	Ms S Miller, i/b Crown Law
ATSILS	Mr AW Korovacz

The *Coroners Act 2003* provides in section 45 that when an inquest is held, the coroner's written findings must be given to the family of the person who died, and to each of the persons or organisations granted leave to appear at the inquest. These are my findings in relation to the death of Maureen Ann Weazel. The said findings will be distributed in accordance with the requirements of the said act and on the website of the Office of the State Coroner.

As the deceased died in 2006, and these findings are delivered nearly seven years after the death, I will add a preamble.

The death of Maureen Ann Weazel was reported to the resident coroner at Kingaroy on the 10 July 2006. On that date, the coroner ordered an autopsy, and again on the same date, Dr P Ruscoe issued his autopsy certificate and the body of the deceased was released for burial.

In September 2006, the interest of Aboriginal & Torres Strait Islander Legal Services was noted, and about this time the coroner was aware of an impending investigation into the quality of health services at Cherbourg Hospital, by the Queensland Health Quality and Complaints Commission. In February 2007 the said commission was granted permission to access all coronial investigation documents relating to Maureen Ann Weazel.

On 21 August 2007, Coroner Guttridge decided that there would be no inquest and he made findings into the death of Ms Weazel.

As events transpired, on 15 September 2007, Michael Barnes, State Coroner, directed that an inquest was necessary in relation to Ms Weazel's death.

My reading of the coroner's file indicates that from 15 September 2007 until 23 September 2010, when the first of two pre-inquest conferences were held, there was an exchange of material between the commission aforementioned, and counsel assisting the coroner. Also, it appears at one stage the office file, or part of that file, was missing or incomplete.

A second pre-inquest conference was held by me on 24 December 2010. That conference was my first dealing with this matter, and I then presided over inquest hearings on 31 January 2011, 8 August 2011 and 9 August 2011. Following the last hearing date, further hearing was adjourned awaiting preparation of Professor Rashford's report. Such report was finalised on 29 October 2012.

After Professor Rashford's report was received it was distributed to all parties appearing at the inquest hearings. Consensus was reached that no further witnesses were required for cross-examination and parties were directed to supply any written submissions within set time frames. The complexity of such submissions, and in part counsel's pre-arranged court commitments, resulted in the last of such submissions being received in March 2013.

It now falls to me to conclude the inquest by making my findings.

Ms Weazel was just 25years old when she died at Cherbourg on 8 July 2006.

An inquest was directed by the State Coroner pursuant to his powers under the said Coroners' Act. I deliver the findings of such inquest which confirm:

A. The identity of the deceased person, how she died, and the date, place and medical cause of such death, and

B. Whether there was an unreasonable denial of access to, and as a result treatment at, Cherbourg Hospital in the period immediately prior to the death of the deceased person; and if so

C. Whether any unreasonable denial of access to treatment at Cherbourg Hospital contributed to the death of the deceased person.

The inquest

Maureen Ann Weazel was born on 7 July 1981 at Cherbourg. Maureen was of aboriginal origin.

During her short life, Maureen did not endure the best of health. There was a family history of heart disease, and she suffered, and in fact was receiving treatment for diabetes at the time of her death.

In addition, it is known that the deceased smoked cigarettes, and on occasion consumed alcohol in excessive quantities.

In fact, in the week prior to her death, on 2 July 2006, Maureen presented at the Cherbourg Hospital complaining of chest pain, and after admission for some hours, was discharged.

Again on 7 July 2006, Maureen presented at the Cherbourg Hospital for checks in relation to her diabetes and elevated cholesterol.

It has been established that the deceased was in attendance at a party at 17c Barambah Avenue, Cherbourg on the evening of the 7 July 2006 and into the early hours of the 8 July 2006.

It was at this party that Maureen and Henry Thomas Geyemore became acquainted. The couple had known each other for many years and some six years prior had a sexual relationship.

As events transpired, after the party ended, Maureen and Henry Geyemore parted company with others, and the deceased drove a vehicle with themselves as the sole occupants, first to the Cherbourg cemetery where the couple talked, and then later, to a paddock in the vicinity of the reservoir on Murray Road, Cherbourg, where the pair engaged in a consensual act of sexual intercourse in the rear seat of the vehicle.

After intercourse, Henry Geyemore witnessed Maureen sit up and hold her hands on her chest. As Henry drove the vehicle to a vacant tractor shed in an

area known as ‘the farm’ in Stan Mickelo Drive, Cherbourg, whereas the deceased remained in the back seat during the journey, she informed Henry Gyemore that she was okay and that he should continue the journey.

Upon arrival at the shed, Henry Geyemore alighted from the vehicle, and after Maureen declined water, he went and located some tap water. Upon Mr Gyemore’s return to the vehicle, he observed that the deceased was grasping at her chest and making snoring like noises.

This prompted Henry Geyemore to drive the vehicle to the Cherbourg Hospital to seek medical assistance for the deceased.

After parking the vehicle in the hospital carpark, near the entrance of the emergency section, and seeing Maureen still in a distressed state in the rear seat of the car, Henry Gyemore tried to lift her out of the vehicle. This attempt failed.

Henry Gyemore then went to the emergency door and tried to alert hospital staff by banging on that door, and later the back door of the hospital. Henry Gyemore has stated that whereas he was observed by a hospital staff member at each door, after no person allowed him entry, he again banged on the front door.

At this point in time Henry Gyemore states that Maureen was quiet and he could not find her pulse.

Others joined Henry Gyemore at the emergency door and it was not until the arrival of Murgon police officers that the deceased received attention.

CCTV footage, exhibit no.5, depicts all events from when Henry Geyemore first went to the emergency door until police arrived and others became involved.

The evidence provided by nursing staff at the Cherbourg Hospital, Hayley Stuart, Laureen Wolfe and Deborah Anderson, and also in-patients Tina Douglas and Merna Compton, provides a satisfactory explanation, in the circumstances that prevailed in the vicinity of 4:00am on the morning of 8 July 2006 at the Cherbourg Hospital, as to why Henry Gyemore was denied access to the hospital.

It is factual that Henry Gyemore did bang on the emergency door, that he activated a red buzzer and that it was observed by Hayley Stuart on an observation monitor that door communication with Mr Gyemore was not possible due to a broken intercom. Hayley Stuart did not observe any injury to Henry Gyemore and formed the opinion that he was under the influence of liquor, and those factors, coupled with the ferocity of his banging, led her to call Murgon police. At this point in time, there existed a documented history of verbal and physical abuse, by potential patients and others, directed at staff of the Cherbourg Hospital. Formulated guidelines dictated that if concerns were held for staff or their patients, police were to be notified.

The initial decision to deny Henry Gyemore access to the hospital was then fortified by Tina Douglas who initially identified Henry Gyemore as her partner, and that she feared injury at the hands of her partner if he was allowed admission. Ms Douglas' concerns prompted Hayley Stuart to again contact Murgon police, and at this time Ms Douglas, after viewing the monitors at the nurse's desk, informed Ms Stuart that Mr Gyemore was not her partner.

By this point in time, Henry Gyemore's emotions had reached the stage where he pulled a railing from the hospital walls. Nursing staff and in-patients alike were in fear of Henry Gyemore's unexplained actions, and it was reasonable in the circumstances to hold such fear and deny Mr Gyemore access to the hospital until police officers arrived.

Upon the arrival of police officers, Sgt Colin Bruce Jackson and Constable Bradford, the situation was defused, nursing staff attended Maureen, in the car, and then the hospital, however all attempts to revive her failed and Dr Prasad Satyasiv later pronounced life extinct at approximately 4:00am on 8 July 2006.

This inquest required scrutiny of all evidence extracted. That took place in the cold, calm and sterile atmosphere of the courtroom, as opposed to the emotion charged rapid chain of happenings that unfolded at Cherbourg on the night the deceased died.

I was called upon to consider Mr Gyemore as a witness who gave a credible and reliable account of what unfolded before him on the night in question.

That was not the case, as he was in fact vague, unsure and not reliable. Consumption of alcohol, on the night and in the days prior, obviously played its part, to the point, that with few exceptions, no final conclusion in this inquest is, or could be, reached by reliance on Mr Gyemore's evidence alone.

Conversely, I had no reason to doubt the reliability and accuracy of all other witnesses called at this inquest, and of course, that included the unchallenged documentary exhibits tendered as evidence.

Much was made of the time lapse, per the CCTV footage at the Cherbourg Hospital, exhibit 5, when Mr Gyemore undoubtedly tried to attract attention of hospital staff. This time period exceeded ten minutes but was not more than fourteen minutes. It must be borne in mind that in the opinion of Dr Satyasiv that the deceased had suffered cardiac arrest 30 -120 minutes prior to his examination of her, and whereas I accept Professor Rashford's conclusion that such an assessment was fraught with difficulty, equally, I accept Professor Rashford's further conclusion that the deceased had a cardiac arrest at 3:55am or earlier. On balance of probability, I defer to the patently sound and reliable conclusion of Professor Rashford that the deceased's cardiac arrest, at an indeterminate time at or before 3:55am when Mr Gyemore arrived at the Cherbourg Hospital, coupled with her pre-existing established medical history, resulted in a medical situation that any medical treatment she may have received, such as immediate attention of nursing staff, would not have prevented her unfortunate demise.

For absolute clarity, I reject Mr Gyemore's contention that he detected a pulse of the deceased, at any time, especially after arrival at the Cherbourg Hospital on the ill fated night the deceased died.

In the early hours of the morning of the 8 July 2006 there was no unreasonable denial of access for treatment of the deceased at the Cherbourg Hospital, and on balance of probability, any treatment after the time she was taken to the hospital would have been futile.

Findings required by s. 45

I am required to find, as far as is possible, who the deceased was and when, where and how she died, as well as the medical cause of death. As a result of considering all of the material contained in the exhibits, and the oral evidence given at the inquest, I am able to make the following findings.

Identity of the deceased:

Maureen Ann Weazel

How she died:

See within findings

Place of death:

The evidence before me does not justify a finding beyond that Ms Weazel was certified dead on arrival at the Cherbourg Hospital

Cause of death:

Ms Weazel died from severe coronary atherosclerosis and liver cirrhosis was a contributing factor but not related to her underlying aforementioned primary cause of death

Comments and recommendations:

Section 46 provides that a coroner may 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.

It is highly unlikely, even allowing for the fragile vagaries of human beings, that during the future course of human conduct within the Cherbourg community, a situation will occur at the hospital that will not be appropriately addressed by staff at the said hospital. It is factual that the death of Maureen Ann Weazel was the subject of an investigation by the Health Quality and Complaints Commission. Such investigation was indeed the catalyst for the implementation of improved security and after-hours access measures at the Cherbourg Hospital

In that regard, changes implemented, as witnessed during the inquest court inspection of the Cherbourg Hospital, fortify my belief that there will not be a repetition of the tragic and unfortunate events that occurred at the Cherbourg Community Hospital in the early hours of the morning of the 8 June 2006.

I do not make any recommendations within the ambit of section 46 of the act.

This inquest is closed.

Barry Barrett
Coroner
Kingaroy
10 May 2013