CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Peter Matthew Bernard**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2016/843
DELIVERED ON:	24 January 2018
DELIVERED AT:	Brisbane
HEARING DATE(s):	24 January 2018
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes
REPRESENTATION:	
Counsel Assisting:	Daniel Bartlett
Queensland Corrective Services:	Robert Vize, Department of Justice and Attorney-General

Introduction

1. On 26 February 2016, Peter Matthew Bernard, aged 42 years, was seen exercising for an extended period. Afterwards, inmates reported he was pale, sweating and had complained of feeling unwell. However, he did not seek or receive any medical review, and was assisted back to his cell by another inmate, late in the afternoon.

2. On the morning of 27 February 2016, Mr Bernard did not exit his cell for the morning muster. He was discovered by correctional officers on his bed in his cell, face down, with the bed covers over his head. He was unresponsive, and cold to touch. A Code Blue was called, but it was agreed resuscitation efforts would be futile. Paramedics from the Queensland Ambulance Service were called, and pronounced Mr Bernard deceased.

The investigation

3. An investigation into the circumstances leading to the death of Mr Bernard was conducted by Detective Sergeant Andy Seery from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU). Detective Sergeant Seery was assisted by a local detective from the Mareeba Criminal Investigation Branch, Detective Sergeant Anthony Moynihan.

4. After being notified of Mr Bernard's death, QPS officers attended Lotus Glen Correctional Centre (LGCC). Mr Bernard's correctional records and his medical files from the LGCC were obtained. The investigation was informed by statements from the relevant custodial correctional officers and inmates at LGCC and the clinical nurse at LGCC. CCTV footage of Mr Bernard's unit at the time of the cell lockdown and the discovery of his body was also obtained. These materials were tendered at the inquest.

5. A full internal autopsy examination with associated CT scans and toxicology testing was conducted by Dr Paull Botterill. At the request of the Coroners Court of Queensland, Dr Ian Home from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined the medical records for Mr Bernard from the LGCC and reported on them.

6. I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed.

The Inquest

7. Although Mr Bernard died from natural causes, an inquest into his death was mandated by the *Coroners Act 2003* as he was in custody when he died. The inquest was held on 24 January 2018. All of the statements, medical records and material gathered during the investigation was tendered. Counsel Assisting proceeded immediately to submissions in lieu of oral testimony.

Circumstances of the death

8. Peter Matthew Bernard was a 42 year old Indigenous man from Kowanyama. English was his second language. Mr Bernard was the third of seven siblings. He is survived by his daughter who resides with extended family in Kowanyama.[1] I extend my condolences to his family and community.

9. On 25 January 2016, Mr Bernard was arrested and remanded in custody at LGCC for offences including trespass, disorderly conduct and numerous assaults. He had a lengthy custodial history, dating back to his childhood.

10. Mr Bernard had a diagnosed acquired brain injury, resulting in a very significant level of impairment. From 23 April 2014, he was the subject of a Guardianship Order appointing the Public Guardian to make decisions regarding accommodation, health care, provision of services and legal matters. The Public Trustee was appointed to manage financial matters. His medical history while in custody related mostly to his mental health, episodes of seizures associated with epilepsy, and the clinical care provided to him as a result of regular altercations with other prisoners.

11. Information provided by various inmates during the course of the investigation confirmed that Mr Bernard would exercise for up to an hour on most days. However, on 26 February 2016, he was observed to train for an extended period of time. He had been doing chin ups, push ups and exercises on the stairs.

12. Towards the afternoon, Mr Bernard was observed by other inmates to be pale, sweating and he complained that he was feeling unwell. Inmate Che Furlong walked Mr Bernard back to his cell at about 5:40pm, and shut his cell door for him. Nothing further was heard from Mr Bernard over the course of the evening.

13. On the morning of 27 February 2016, the morning muster was called at 7:20am. Mr Bernard failed to exit his cell. In a statement to the inquest, Custodial Correctional Officer Marlene Wilds confirmed that she looked through the cell window and could see Mr Bernard on his bed covered by a doona, apart from his feet. She then entered the cell, called out to Mr Bernard and touched his foot with her finger. He did not respond. She thought Mr Bernard was still sleeping, and called CCO William Ryan for assistance.

14. After pulling the doona off, it was noted there were wet patches on the bed. Mr Bernard was lying on his stomach, with his left arm hanging off the bed. CCO Ryan touched him to try and get a response, but there was none. CCO Ryan then called a Code Blue.

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[1] Exhibit C8

15. Registered Nurse Michael Thomas attended in response to the Code Blue. He discerned immediately that Mr Bernard was deceased. He was in a stage of rigor mortis, he had a grey coloured haze over his face and blood was running from his mouth. Upon checking for vital signs, Nurse Thomas noticed that Mr Bernard was cold to touch, and there were no signs of life. Paramedics from the Queensland Ambulance Service attended, and Mr Bernard was pronounced deceased at 8:16am.

16. Dr Home assisted the inquest by reviewing the available medical records and the autopsy report completed by Dr Botterill. Dr Home confirmed that Mr Bernard had a past medical history of acquired brain injury, epilepsy, neurosyphilis, alcohol abuse and behavioural issues. His medications at the time of his death were:

- Sodium valproate (anti-epileptic medication);
- Phenytoin (anti-epileptic medication);
- Risperidone (anti-psychotic medication);
- Thiamine (B vitamin); and
- Paracetemol.

17. The autopsy report completed by Dr Botterill indicated that the cause of death was most likely an irregular heart rhythm (arrhythmia) complicating severe single vessel coronary artery disease.[2] Dr Botterill noted that in plain terms, post-mortem examination showed severe (90%) narrowing of one of the arteries of the heart with some narrowing of other arteries, an excess of fluid in the lungs, some scarring over the lung services, enlargement of the prostate and bladder. There were no features to suggest any recent assault or evidence of recent restraint. Subsequent microscopic examination showed severe heart artery narrowing, lung congestion and some kidney scarring. Toxicology testing showed the presence of anticonvulsants and a painkiller at therapeutic levels. No alcohol was detected.

18. Dr Home explained that an arrhythmia is a recognised cause of sudden cardiac death and, in many cases, the first and only manifestation of cardiovascular disease. Dr Home confirmed that there was no recorded history of any cardiovascular disease and no mention of any episodes of chest pain in Mr Bernard's medical records.

19. Dr Home noted that although Mr Bernard was described as pale, sweaty and felt unwell following a vigorous work out the day before his death, he did not seek any medical assistance. Dr Home confirmed that *"there was no way of predicting the presence of severe coronary artery disease in this man and no opportunity to intervene prior to his death."*[3]

[2] Exhibit A5.
[3] Exhibit B9, page 2.

Conclusions

20. Mr Bernard's death was the subject of a police investigation by the CSIU. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

21. I conclude that Mr Bernard died from natural causes. I find that none of the correctional officers or inmates at LGCC caused or contributed to his death. Having regard to Dr Home's opinion, I am also satisfied that Mr Bernard was given appropriate medical care by staff at LGCC while he was in custody and that his death could not have reasonably been foreseen, or prevented.

22. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Bernard while in custody was not of a lesser standard than that provided to other members of the community.

Findings required

23. I am required to find, as far as is possible, the medical cause of death, who the deceased person was and when, where and how he came by his death. After considering all of the evidence I am able to make the following findings:

Identity of the deceased – The deceased person was Peter Matthew Bernard.

How he died - Mr Bernard died alone in his cell after a sudden arrhythmia complicating severe single vessel coronary artery disease.

Place of death – He died at the Lotus Glen Correctional Centre, Chettle Road, Arriga, in the State of Queensland.

Date of death – He died on or about 27 February 2016.

Cause of death – Mr Bernard died from coronary artery atheroma.

Comments and recommendations

24. The *Coroners Act 2003* 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. In the circumstances, I accept that there are no comments or recommendations I could make that would assist in preventing similar deaths in future.

25. I close the inquest.

Terry Ryan
State Coroner
Brisbane
24 January 2018