OFFICE OF THE STATE CORONER

FINDING OF INQUEST

CITATION:	**Inquest into the death of Albert William HENDY**
TITLE OF COURT:	**Coroner's Court**
JURISDICTION:	Brisbane
FILE NO(s):	COR 560/05(7)
DELIVERED ON:	**24 February 2006**
DELIVERED AT:	Brisbane
HEARING DATE(s):	16 February 2006
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: Inquest, Death in Custody, Natural Causes
REPRESENTATION:	

Counsel Assisting: Detective Inspector Gil Aspinall
Department of Corrective Services: Ms Annie Little

Findings of the inquest into the death of Albert William Hendy

Table of contents

The *Coroners Act 2003* provides in s45 that when an inquest is held into a death in custody, the coroner's written findings must be given to the family of the person who died, each of the persons or organisations granted leave to appear at the inquest and to various specified officials with responsibility for the justice system. These are my findings in relation to the death of Albert William Hendy. They will be distributed in accordance with the requirements of the Act.

Introduction

Albert William Hendy, a prisoner, was found dead on his bed in Room 30, Block D at the Department of Corrective Services' Western Outreach Centre (WORC) at Wacol on Saturday, 12 March 2005.

These findings seek to explain how that occurred.

The Coroner's jurisdiction

Before turning to the evidence, I will say something about the nature of the coronial jurisdiction.

The basis of the jurisdiction

Because when he died, Mr Hendy was in the custody of the Department of Corrective Services under the *Corrective Services Act 2000*, his death was a "*death in custody*"[1] within the terms of the Act and so it was reported to the State Coroner for investigation and inquest.[2]

The scope of the Coroner's inquiry and findings

A coroner has jurisdiction to inquire into the cause and the circumstances of a reportable death. If possible, the coroner is required to find:-

- whether the death in fact happened
- the identity of the deceased;
- when, where and how the death occurred; and
- what caused the person to die.

An inquest is not a trial between opposing parties but an inquiry into the death. In a leading English case it was described in this way:-

> *It is an inquisitorial process, a process of investigation, quite unlike a criminal trial where the prosecutor accuses and the accused defends… The function of an inquest is to seek out and record as many of the facts concerning the death as the public interest requires.* [3]

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[1] See s10
[2] s8(3) defines "*reportable death*" to include deaths in custody and s7(2) requires that such deaths be reported to the state corners or deputy state coroner. S27 requires an inquest be held in relation to all deaths in custody
[3] *R v South London Coroner; ex parte Thompson* (1982) 126 S.J. 625

The focus is on discovering what happened, not on ascribing guilt, attributing blame or apportioning liability. The purpose is to inform the family and the public of how the death occurred with a view to reducing the likelihood of similar deaths. As a result, the Act authorises a coroner to make preventive recommendations concerning public health or safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in future[4]. However, a coroner must not include in the findings or any comments or recommendations or statements that a person is or maybe guilty of an offence or civilly liable for something.[5]

The admissibility of evidence and the standard of proof

Proceedings in a coroner's court are not bound by the rules of evidence because s37 of the Act provides that the court "*may inform itself in any way it considers appropriate".* That doesn't mean that any and every piece of information, however unreliable, will be admitted into evidence and acted upon. However, it does give a coroner greater scope to receive information that may not be admissible in other proceedings and to have regard to its provenance when determining what weight should be given to the information.

It is also clear that a coroner is obliged to comply with the rules of natural justice and to act judicially.[6] This means that no findings adverse to the interest of any party may be made without that party first being given a right to be heard in opposition to that finding. As *Annetts v McCann*[7] makes clear, that includes being given an opportunity to make submissions against findings that might be damaging to the reputation of any individual or organisation.

The investigation

Once it was apparent that Mr Hendy was dead, Plain Clothes Senior Constable Tammy Durre-Bauer of the Queensland Police Service's Corrective Services Investigation Unit was directed to conduct a "death in custody" coronial investigation.

The scene was photographed and forensically examined. All relevant witnesses were interviewed and statements obtained. On 15 March 2005, an autopsy was conducted on Mr Hendy's body by Dr Nathan Milne, a Forensic Pathologist from the John Tonge Centre. Permission was also granted for Dr Byron Collins, a Forensic Pathologist from Melbourne to conduct an independent second autopsy at the request of lawyers representing Mr Hendy's family.

I am satisfied that the investigation was competent and thorough.

The Inquest

An inquest was held in Brisbane on Thursday, 16 February 2006. Detective Inspector Aspinall was appointed to assist me. Leave to appear was granted to the Department of Corrective Services. Mr Hendy's de-facto wife, Leanne Richters, and Mr Hendy's

[4] s46
[5] s45(5) and 46(3)
[6] *Harmsworth v State Coroner* [1989] VR 989 at 994 and see a useful discussion of the issue in Freckelton I., "Inquest Law" in *The inquest handbook*, Selby H., Federation Press, 1998 at 13
[7] (1990) 65 ALJR 167 at 168

mother, Mrs Nancy Hendy, were advised of the inquest and provided with a copy of the police investigation report. They chose not to attend. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered into evidence.

I determined that the evidence contained in this material was sufficient to enable me to make the findings required by the Act and that there was no other purpose, which would warrant any witnesses being called to give oral evidence. The family indicated that they did not wish to challenge any of the witnesses' versions as contained in those documents or hear oral evidence in relation to any issue.

The evidence

I turn now to the evidence. Of course, I cannot even summarise all of the information contained in the exhibits, but I consider it appropriate to record here, the evidence I believe is necessary to understand the findings I have made.

Background

Albert Hendy was born on 4 June 1964 at Brisbane. He was 41 years of age at the time of his death.

Mr Hendy's family consisted of his mother, Nancy Isobel Hendy, his father, Lionel Sennet Hendy, his two brothers, Eddie and Barry and a sister, Lorna. His father, Lionel, passed away when Albert was 18 years of age.

Records held by the Department of Corrective Services show that Mr. Hendy declared on admission that Leanne Richters was his de-facto wife. This is confirmed by Ms Richters, who indicated she had been in a de-facto relationship with him for some twelve (12) years. Ms Richters regularly visited Mr Hendy whilst he was in custody and he was planning to reside with her when released from custody.

Mr Hendy and Ms Richters are the parents of a six year old girl, Samantha Richters. Mr Hendy also had a son, Levi Aaron Hendy, from an earlier relationship.

Medical issues

Mr Hendy suffered a heredity blood disorder called spherocytosis. The condition did not seem to negatively affect him, provided he took folic acid daily. Corrective Services records show that this medication was appropriately dispensed to him.

Mr Hendy had his spleen removed 13 years ago.

Records also show that he suffered from depression, constipation and back pain and that he also received prescribed medication for these medical ailments.

Ms Richters advises that in 2001, Mr Hendy experienced chest pains and was admitted to the Royal Brisbane Hospital for several days whilst doctors conducted numerous medical tests. He was released after several days, when the tests proved inconclusive. She claims he frequently suffered from indigestion and chest pains, but refused to attend a doctor, as he was using illicit drugs.

Custody

Mr Hendy had a moderately serious criminal history. He had been sentenced to an earlier term of imprisonment in 1989.

On 26 March 2003, Mr Hendy was sentenced in the Brisbane Supreme Court to 6 years imprisonment for drug related offences. He was due for release on 26 March 2005. Unfortunately, he died fourteen days before this date.

Events leading up to the incident

At about 12.30pm on 12 March 2005, Mr Hendy was visited by Leanne Richters at the WORC Program at Wacol. During this visit, he indicated to her that he had sustained a laceration to his head above the hairline. He advised her that the injury occurred when he accidentally hit his head on the toilet roll holder in the bathroom at the WORC Program.

At 2.25pm, after Ms Richters had left, Mr Hendy attended the Administration Office of the WORC Program and advised Corrective Services Officers of his injury. On this occasion, he claimed that the injury had occurred as a result of him hitting his head against the metal frame of the double bunk ensemble in his room.

Mr Hendy was transported under guard by Corrective Services Officers to the emergency department of the Princess Alexander Hospital, where he received treatment for the injury from Dr. Jason Dawson. The wound was considered minor and only necessitated three sutures.

Dr Dawson provided Mr Hendy with advice on how to care for the sutured wound and the need to consult with a doctor in four days to remove the sutures. He also advised Mr Hendy to return to hospital, if he experienced any infection, increased pain, swelling, discharge or fever. I note that during this consultation, Dr. Dawson records no mention of Mr Hendy complaining of indigestion or chest pains.

Ms Richters advises that at about 4.15pm, Mr Hendy telephoned her from the Princess Alexandra Hospital. He was angry and stated that he “wasn’t feeling really well”.

After treatment, Mr Hendy returned to the WORC Program at Wacol at approximately 6pm and partook of an evening meal. At about 6.15, he again telephoned Ms Richters to advise her that he was back at the WORC program, that he was feeling sick and that was going to lie down.

Soon after this call, at about 6.30pm Mr Hendy told inmates Dexter and Lavender that he had a headache and indigestion and he went and lay down on his bunk. There is no record that he complained to any correctional officer of any health concerns.

The incident

At approximately 7.50pm corrective services officers commenced a muster. At 7.55pm, CSO Bloomfield was advised by inmate Geoffrey Dexter that Mr Hendy was asleep on his bed and could not be woken.

Mr Bloomfield attended Mr Hendy’s room and observed him lying on the top level of his bunk. He appeared to be sleeping, so Mr Bloomfield commenced shaking and shouting at Mr Hendy. However there was no response. Mr Bloomfield touched Mr Hendy’s neck but he was unable to find a pulse and he was cold to the touch. Mr Bloomfield established that Mr Hendy was not displaying any vital signs and had been incontinent of urine.

Mr Bloomfield and inmate Lavender lifted him from his bed and placed him on the floor of the room. Mr Bloomfield turned him on his side and checked his airway and breathing. Mr Bloomfield and inmate Lavender commenced cardio-pulmonary resuscitation (CPR). Corrective Service Officer Maxwell also arrived on scene.

Messrs Maxwell and Bloomfield commenced two operator CPR. This was continued for approximately 15 minutes, until the ambulance officers arrived at 8.14pm.

The ambulance report notes that Mr Hendy was unconscious and the pupils were fixed and dilated. He had saliva in his airway, which was cleared by suctioning. The ambulance report also noted "*nil pulse present*" and "*nil heart sounds present."*

An ambulance officer connected up a Heart Start 4000 defibrillator which confirmed that Mr Hendy had no electrical activity within the heart. The ambulance officers discontinued CPR at 8.24pm when they were convinced that Mr Hendy could not be revived.

A Forensic Medical Officer, Dr Liz Christensen soon after attended the WORC Program and announced life was extinct.

A crime scene was established and the circumstances of the death were investigated by detectives from the Corrective Services Investigation Unit as a "death in custody" situation.

Specialist police attended the scene and conducted forensic examinations.

Autopsy results

Mr Hendy's body was taken to the John Tonge Centre where, at the conclusion of the autopsy examination, forensic pathologist, Doctor Nathan Milne advised that, in his opinion, Mr Hendy died as a result of natural causes namely "*coronary artery thrombosis due to or as a consequence of coronary atherosclerosis."*

Dr Milne advised that the head injury was minor, involving the scalp only. There was no evidence of fracture of the skull, injury to the brain or any complication related to the treatment received in hospital. He confirmed that there is no evidence to suggest that the head injury contributed to death.

The second autopsy undertaken by the forensic pathologist retained by the family, Dr. Byron Collins, confirmed Dr Milne's view that death was due to natural causes namely, heart failure and that the head injury was not a contributing factor to Mr Hendy's death.

Conclusions

Whilst Mr Hendy gave differing versions of how he sustained the minor head injury on the day of his death, he has always maintained it occurred accidentally. There is no evidence to the contrary.

In any case, I find that the head injury suffered by him was given appropriate attention by Corrective Services staff once it was brought to their attention. He was promptly transported to the Princess Alexandra Hospital, where he was provided with an appropriate level of care and treatment. It played no part in Mr Hendy's death.

Significantly, while being treated for this injury, Mr Hendy did not complain of indigestion, chest pain or any other ailments. Consequently, once his wound was dressed, he was returned to the WORC camp.

I find that Corrective Services staff followed medical emergency and death in custody protocols. Corrective Services staff did all within their power to provide assistance and resuscitation to Mr Hendy upon his being located unconscious in his room. I commend Correctional Services Officers Bloomfield and Maxwell for their efforts in endeavouring to resuscitate Mr Hendy.

A comprehensive police investigation has been conducted into the circumstances of Mr Hendy's death. That investigation, coupled with the autopsy, revealed that Mr Hendy passed away peacefully from natural causes namely heart failure, whilst resting on his bed.

Findings required by s45

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. I have already dealt with this last aspect of the matter, the manner of the death. As a result of considering all of the material contained in the exhibits, I am able to make the following findings in relation to the other aspects of the matter.

Identity of the deceased – The deceased person was Albert William Hendy

Place of death – He died whilst in the custody of the Department of Corrective Services at the Western Outreach Centre (WORC) at Wacol, Queensland.

Date of death – Mr Hendy died on 12 March 2005

Cause of death – He died from natural causes namely, coronary artery thrombosis due to or as a consequence of coronary atherosclerosis.

Comments and recommendations

Section 46, in so far as it is relevant to this matter, 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.

I find that none of the correctional officers, inmates or medical personnel at the Princess Alexandra Hospital caused or contributed to the death and that, under the circumstances, nothing could have been done to save Mr Hendy, who passed away suddenly from natural causes not previously diagnosed.

After considering the available evidence, I am of the view that the Correctional Services staff involved in this incident acted appropriately. I do not consider Correctional Services staff could reasonably been expected to have handled the

matter in any other way. I consider the Correctional Services staff did their best to try to revive Mr Hendy, when he was found unconscious on his bed.

There is therefore, no basis on which I could make any preventative recommendations.

I close the inquest.

Michael Barnes
State Coroner
Brisbane
24 February 2006