OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Martin Heywood**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2063/06(9)
DELIVERED ON:	03 December 2009
DELIVERED AT:	Brisbane
HEARING DATE:	8 October 2009
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes, adequacy of health care.

REPRESENTATION:

Counsel Assisting: Mr Mark Le Grand

Department of Community Safety: Ms Melinda Zenner

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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 John Martin Heywood. They will be distributed in accordance with the requirements of the Act and posted on the web site of the Office of State Coroner.

Introduction

Mr John Martin Heywood, a 68 year old prisoner, died at the Secure Unit of the Princess Alexandra Hospital at approximately 4.00am on 20 July 2006.

Because his death was a "death in custody" within the terms of the Act[1] it was reported to the State Coroner for investigation and inquest.

These findings

- confirm the dead man's identity, and the time, place, circumstances and medical cause of his death;
- consider whether the actions or inactions of any person contributed to his death;
- consider whether the medical treatment afforded to him at the Secure Unit of the Princess Alexandra Hospital (PASU) was adequate and reasonable; and
- consider whether any changes to procedures or policies could reduce the likelihood of deaths occurring in similar circumstances or otherwise contribute to public health and safety or the administration of justice.

The investigation

The investigation was conducted by officers from the QPS Corrective Services Investigation Unit (CSIU). As detailed below, there were certain inadequacies with the initial investigation which has unnecessarily prolonged the consideration of this matter and which required supplementary investigations to be undertaken to enable findings to be made to the appropriate level of satisfaction.

Persons in custody in general, and persons in custody as a result of the commission of certain crimes in particular, for example, crimes against young

[1] 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

persons, are at high risk of violence. Consequently the consideration of possible foul play by third party involvement will play a significant role in any such inquest.

The Coroners Act 2003 refers to the recommendations of the Royal Commission into Aboriginal Deaths in Custody. It mandates an inquest be held into all deaths in custody. It is important these matters are rigorously investigated and assumption do not lead to shortcuts being taken.

In this case the following shortcomings were observed in the police report when it was received by this office:-

- There were no statements from the nurses who found Mr Heywood dead, nor from the doctor who issued the life extinct certificate

- There was no statement from the nurse who did the routine check at approximately 3:00am detailing her observations which enables the conclusion to be drawn that the deceased was alive and sleeping at that time.

- There was no statement from the first police officer to arrive at the scene her detailing her observations about its state upon her arrival.

- The four other prisoner/patients who were in the unit at the time were not interviewed as to anything they heard or saw at the time of Mr Heywood's death.

These matters were remedied at the request of counsel assisting and as a result when considered with the other steps that were taken at the time of the death, I am confident the material enables me to make the findings I have. It transpires that the investigating officer's assumption that the death was from non suspicious natural causes was correct, and I can understand why he quickly came to that conclusion. However for the reasons mentioned earlier this should not lead to essential inquiries not being undertaken and/or documented.

The inquest

An inquest was held in Brisbane on 8 October 2009. Mr M. Le Grand was appointed as counsel to assist me. Leave to appear was granted to Ms M. Zenner for the Department of Community Safety (the successor to the Department of Corrective Services).

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered at the inquest. The evidence was reviewed and submissions were made to the Court by counsel assisting.

The evidence

I turn now to the evidence. Of course, I cannot summarise all of the information contained in the exhibits but I consider it appropriate to record in these reasons, the evidence which I believe is pertinent and relevant to the findings I have made.

Personal background

John Martin Heywood was born in Townsville on the 10th August 1937 under the name of Morris John Hudson. By the time he was 11 he commenced appearing in the Children's Court and quickly accumulated an unenviable criminal history. In total he was dealt with by various courts on fourteen occasions, on five occasions in his birth name of Morris John Hudson, and on nine occasions under the name of John Martin Heywood, for various offences of stealing, breaking and entering, arson and, finally, for wilful murder.

Mr Heywood was 29 years of age at the time of his last conviction for the killing of a schoolboy at Nudgee College, Brisbane. He was sentenced to life in prison on the 6th October 1967.

Mr Heywood spent eleven years at The Park Centre for Mental Health, which is a secure mental hospital at Wacol, before returning to secure custody. I am unaware of his psychiatric diagnosis but it is apparent from the length of his admission to the Park he was seriously ill.

Mr Heywood was released on parole on 18 April 1985, but this parole was revoked 5 months later after information was received that he was interstate in company with a teenage boy. Mr Heywood was located and returned to custody in September 1985 where he remained until his death on 20th July 2006.

The deceased died just prior to his 69th birthday having been incarcerated in secure custody for 38 years (except for a 5 month period in 1985). He was appraised by a psychologist shortly prior to his death as *"institutionalised with no community support".*

He was born into a family of four children with an older brother and sister, and a younger sister Dallas Stevens. Apart from Ms Stevens, none of his relatives kept in contact with Mr Heywood. He never married and had no children.

Ms Stevens states that she used to visit the deceased in prison but not much after he was moved to the Borallon Correctional Centre. He occasionally wrote letters, but he called her frequently on the telephone and they would talk.

Ms Stevens said she last visited the deceased two months before his death when he told her he had lost a lot of weight, couldn't eat and couldn't keep his food down.

Circumstances of death

At the time of his death Mr Heywood was usually accommodated at the Borallon Correctional Centre. He had been in deteriorating health and was undergoing medical assessment and treatment. This involved attendance at the Princess Alexandra Hospital Secure Unit (PASU). Mr Heywood's last transfer to that unit occurred on 7 July 2006 and was to address anorexia (loss of appetite), weight loss and elevated adrenal hormones. The medical assessment was that these symptoms were suggestive of phaeochromocytoma (a tumour of the adrenal gland).

While at PASU each prisoner/patient is segregated from other prisoners in their own single bed room. The room is a standard single bed hospital room except that it remains locked while occupied by a prisoner/patient.

At about 4:18am on 20 July 2006, the room occupied by Mr Heywood was unlocked and opened by Queensland Correctional Services Officer (QCS) Alan Miles, to allow Nurse Robertson and Nurse Alexis to conduct a routine nursing check. It appeared to both nurses that the prisoner was dead, so the room was re-locked and a doctor was called to attend.

Upon the arrival of Dr Elisabeth Marsden, the room was again unlocked at 4:53am and Dr Marsden issued a life extinct certificate. The room was then re-locked until investigating police attended.

Investigations at the scene

The first police officer to arrive at the scene was Detective Senior Constable Melanie Cooper. Officers of the Corrective Services Investigation Unit (CSIU) arrived at 5:30am. A list of the four other prisoner/patients was obtained. Each was isolated in individual rooms while at PASU.

The deceased's medical file indicated that he had last been checked shortly after 3.00am and that he was breathing and asleep at that time.

The last medication was recorded as having been given at 10.00pm on the previous evening.

A police photographer was called to record the scene. The police report states that there were no signs of disorder and there did not appear to be any unexplained marks on the body of the deceased. The body was conveyed to the John Tong Centre and an autopsy conducted the following day.

A right thumb fingerprint was obtained from the body of Mr Heywood was then sent to QPS fingerprint analysts in Brisbane. It matched an official fingerprint form bearing the name Maurice John Hudson with a date of birth of 10/8/1937.

Medical history

Hospital medical records show Mr Heywood had two in patient admissions in the months before his death: 22 May to 6 June 2006 and 7 July until his death on the 20 July 2006. Both of these admissions were in relation to the investigation of weight loss, loss of appetite, weakness and shortness of breath. Mr Heywood had lost about 20kg of weight over the 4-5 months prior to May 2006. His medical history indicates that he suffered from chronic obstructive lung disease, arthritis, depression and diabetes that was diet-controlled.

A malignancy was suspected and a number of tests were performed during these admissions including:

- Chest X-ray – minor changes but no evidence of malignancy;

- Gastroscopy – inflammation due to a bacterial infection (helicobacter pylori), but no malignancy;

- Ultrasound liver – two cysts identified, but no definite malignancy;

- CT scan of abdomen – liver cysts and a 15mm nodule on the right adrenal gland;

- Bone scan – lesion in right adrenal glad;

- Echocardiogram (ultrasound scan of heart) – moderate enlargement (hypertrophy) of the left ventricle but otherwise normal;

- A number of blood and urine tests were performed – the most significant result was that the hormones normally produced by the adrenal gland were elevated; and

- A colonoscopy was also planned but was not performed prior to his death.

It would appear clear from the medical records that the deceased has received a high standard of medical care.

Throughout the deceased's admission, medical staff noted that he was weak and frail. He would have episodes of shortness of breath and his blood pressure was noted to fall significantly when he went from sitting to standing (postural hypotension). On the 10 July he had a fall. On the 18 July he had another fall in which he hit his head. The deceased was later given some intravenous fluid to try to improve his blood pressure.

There was a notation in the medical file made by Dr Lisa Gemmell on 18 July 2006 that Mr Heywood was "Not for Resuscitation." This is a medical directive obtained from the deceased to the effect that should a defined event occur and

he is unable to convey his intentions at that time, he did not want to be resuscitated in the event of a cardiac arrest and that he did not want to be fed intravenously.

The deceased was an elderly person suffering a progressive deterioration in his health. The last treating doctor, Dr Stuart McDonald, stated that the deceased had several medical conditions:

- Coronary artery disease;
- Phaeochromocytoma;
- Chronic depression; and
- Non-insulin Dependant Diabetes Mellitus.

Pathology

An autopsy was conducted at the John Tong Centre on the 21st July 2006 by forensic pathologist, Dr R Williams, Registrar, which was observed by Senior Constable A Manson of the Coronial Support Unit.

The post-mortem examination showed a thin Caucasian male with signs of recent medical intervention. Internal examination confirmed a 17mm tumour in the right adrenal gland. The arteries supplying blood to the heart were severely narrowed (coronary atherosclerosis).

Histology showed the lesion in the right adrenal gland to be a phaeochromocytoma. Serology could not be performed as the blood sample had clotted. Dr Williams concluded that the cause of death was a combination of coronary arteriosclerosis and phaeochromocytoma.

Findings required by s45(2)

As a result of considering all of the information contained in the exhibits I am able to make the following findings:-

Identity of the deceased

The deceased was John Martin Heywood aka Maurice John Hudson, who was born at Townsville in the State of Queensland on 10 August 1938.

How he died

Mr Heywood died of natural causes while in the custody of the Department of Correctives Services.

Date of death

Mr Heywood died on 20 July 2006.

Where he died

He died at the Princess Alexander Hospital Secure Unit (PASU). PASU is a declared prison under the schedule to the Corrective Services Regulations 2001.

Cause of death

Mr Heywood died from an abnormal heart rhythm (arrhythmia) precipitated by coronary atherosclerosis and phaeochromocytoma.

Comments and recommendations

Section 46 provides that a coroner may comment on anything connected with a death that relates to public health and safety, the administration of justice or ways to prevent deaths from happening in similar circumstances in the future.

In this case I have found that Mr Heywood died of natural causes and that no other person in any way contributed to his death. I also find he received high standard health care in the days and months preceding his death.

In the circumstances I am of the view there are no issues that warrant any comment by me from a prevention perspective.

I close this inquest.

Michael Barnes
State Coroner
Brisbane
3 December 2009