OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Robert Hayes MYERS**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2548/05(4)
DELIVERED ON:	16 December 2009
DELIVERED AT:	Brisbane
HEARING DATE:	15 May 2009 & 03 December 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
Queensland Health:	Mr Terence Gardiner (instructed by Minter Ellison Lawyers)
Department of Community Safety:	Mr Michael Nicolson

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 officials with responsibility for the justice system. These are my findings in relation to the death of Robert Hayes Myers. 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

On Friday 14 October 2005 Robert Myers collapsed and died in his cell at the Wolston Correctional Centre (WCC). The sixty three year old Caucasian prisoner was serving an eleven year term of imprisonment for child sex offences. He had a long history of heart disease and had been discharged from the secure unit at the Princess Alexander Hospital only three days before.

Because his was a "death in custody" within the terms of the Act Mr Myers' death was reported to the State Coroner for investigation and inquest.

These findings:-

- confirm the identity of the deceased, the circumstances, time, place, and medical cause of his death;

- consider whether the medical treatment afforded him while he was imprisoned was adequate and reasonable; and

- consider whether there is a need to review the protocols for managing critically ill prisoners to reduce the likelihood of deaths occurring in similar circumstances.

The investigation

Police from the Oxley District were advised of the death and attended the scene. Members of the Queensland Police Service, Corrective Service Investigation Unit (CSIU) were also advised and Detective Sergeant Robert Wildin assumed responsibility for the investigation.

Mr Myers' cell was searched and photographed and interviews were undertaken with all prisoners in the unit.

Enquiries revealed no basis to suspect any third party had been involved in the death.

His medical records were seized but no expert medical review was undertaken.

The investigators raised concerns about two post death matters, namely: the interference with the crime scene; and a critical incident de-brief of staff during the investigation. I will refer to those matters subsequently.

I am satisfied the investigation was thorough and competently undertaken. I commend Detective Sergeant Wildin on his endeavours.

The inquest

A pre inquest conference was convened on 15 May 2009 and Mr M. Le Grand was appointed as counsel to assist me. Leave to appear was granted to the Department of Community Safety (the successor to the Department of Corrective Services) and Queensland Health. Counsel assisting persuaded me further inquiries were necessary and the matter was adjourned to allow those to be undertaken. They were resolved by the obtaining of further expert reports and statements from senior officers within Offender Health Services.

All of the statements, records of interview, photographs and materials gathered during the investigation were tendered into evidence. The evidence was reviewed and submissions were made to the Court by counsel assisting and counsel for each of the other parties granted leave to appear without the need to call oral evidence.

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.

Medical history

Mr Myers had been imprisoned since 2001. During that period he had suffered six medical emergencies requiring transfer to the PA Hospital. All related to Mr Myers' heart condition.

Medical records show that he had been suffering from ischaemic heart disease since at least the mid 1970's and had regularly suffered heart attacks in the intervening period.

No doubt his persistent smoking contributed to this.

In 1995 Mr Myers received four coronary artery bypass grafts during open heart surgery at the Prince Charles Hospital.

On 5 October 2005 Mr Myers suffered an acute cardiac arrest. He was resuscitated by use of a defibrillator at the prison medical centre and was again transferred by ambulance to the Princess Alexandra Hospital (PAH) secure unit.

An x-ray taken at the hospital showed a lung complaint which was treated. He also had other medication adjusted and was transferred back to the Wolston Correctional Centre on 11 October to await a dobutamine stress echocardiogram as an out-patient and a follow up examination in due course.

Upon his return to the correctional centre he was interviewed by the health services coordinator, Registered Nurse Griffiths, about the seriousness of his illness. She said that she stressed with Mr Myers the seriousness of his illness and the desirability of his giving up smoking. She said she also advised him that the only form of exercise he should undertake was to walk around the exercise yard. She drafted a dietary plan in consultation with Mr Myers and submitted it to the general manager for consideration.

The circumstances of death

Mr Myers was housed in secure unit 3. Correctional Services Officers (CSOs) working in that unit were aware of his medical condition. In their statements two indicate that they were advised to "*keep observations on Myers due to a heart condition*". They indicated the observations were not required to be recorded in a medical sense; rather it was a case of checking on him regularly.

Early in the afternoon of 14 October one of the CSO's saw Mr Myers playing table tennis in a very active fashion. The CSO called out to Mr Myers to "*give it up*" because he thought Mr Myers was overly exerting himself having regard to his precarious health.

Mr Myers apparently took this advice and returned to his cell.

A short time later another CSO came to the officer station and said that Mr Myers "*was down*". Both officers went to the cell and saw the prisoner lying on the floor on his left hand side. His head was nearer the cell door and his feet were pointing towards the rear wall of the cell. Mr Myers appeared unconscious and was not moving. One of the officers checked and could not detect breathing or a pulse at the prisoner's wrist. His face appeared flush. A code blue was called and medical staff quickly arrived.

Resuscitation attempts commenced and it was decided by the nurses to move Mr Myers out of the cell so they had more room to work on him in the hallway. A visiting medical officer also attended. They were soon joined by Queensland Ambulance Service paramedics.

Mr Myers was not able to be revived and at about 3.05pm the VMO pronounced life extinct. Mr Myers was then moved back into his cell at the direction of the

prison manager. He was placed in a position which he had apparently originally been found. The cell was locked and police were notified.

Investigation results

The investigation detailed earlier was then commenced.

Fingerprints were taken from My Myers to confirm his identity.

On 18 October an autopsy was performed by a forensic pathologist, Dr Nathan Milne. Doctor Milne reported his examination showed a severely abnormal heart that was enlarged, dilated and had extensive evidence of old infarctions. He also noted evidence of recent myocardial infarction which he estimated to be seven to ten days old. There was severe blockage (coronary atherosclerosis) in one of his bypass graphs. Dr Milne concluded

> *In my opinion the cause of death is ischaemic heart disease caused by coronary atherosclerosis. In this case the death appears to be sudden. There was evidence of infarction that was hours old and it was therefore likely that he died from ongoing infarction. It is also possible that he died from an abnormal rhythm (arrhythmia) which can result from coronary atherosclerosis. There were no suspicious findings.*

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 Robert Hayes Myers, who was born in Tasmania on 10 December 1941.

How he died

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

Date of death

Mr Myers died on 14 October 2005.

Where he died

He died at the Wolston Correctional Centre in Queensland.

Cause of death

Mr Myers died from a myocardial infarction as a result of long standing ischaemic heart disease and atherosclerosis.

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.

I have found that Mr Myers died of natural causes and that no other person in any way contributed to his death. However the circumstances of the death raise two issues for consideration from a prevention perspective. They are:-

- Was Mr Myers' discharge from PAH three days before his death appropriate; and

- Does the Department of Community Safety have appropriate protocols for monitoring chronically, seriously ill prisoners?

Quality of health care provided to Mr Myers

Tendered into evidence was a letter from Professor Tom Marwick, Professor of Medicine Department of Cardiology at the PAH. He had provided treatment to Mr Myers and is aware of the circumstances of his death. He advised the court that although Mr Myers was critically ill when he presented to the hospital on 5 October, his condition had been stable for approximately a week after that admission. He was not a good candidate for further surgery having previously had bypass surgery and given his cardiac dysfunction. Most importantly Professor Marwick advised that "*a public patient would have been discharged in similar circumstances*".

In those circumstances I am satisfied that the treatment given to Mr Myers while he was at the PAH was of an adequate standard and the decision to discharge him back to the WCC while awaiting the echocardiogram was appropriate.

Once he was at the prison I am satisfied the consultation with the health services coordinator and the monitoring by the CSOs was an adequate response to his on-going health risks. It is apparent that in consultation with hospital doctors adjustments were made to Mr Myers' medication and the need to avoid strenuous exercise was discussed with him. In the circumstances no comments from me are necessary in relation to this issue.

Protocol for managing seriously ill patients

During the course of the inquest concern was raised as to whether health services in correctional centres had sufficient procedures in place for managing the ongoing care and support of chronically, seriously ill patients.

In response to that concern Queensland Health through its Director Nursing, Offender Health Services has provided information to the Court about the policy relevant to such issues. In particular I was advised the relevant policy provides:-

On return to the correctional facility the offender must present to the health centre with all accompanying medication, completed health referral form and any other relevant documentation.

The health service staff are required to assess the offender regarding ongoing health care needs and action and advise any follow up such as appointments and referrals.

Further I was advised consideration is being given to developing a pro-forma document to comprehensively document offenders follow up and ongoing health management requirements.

In view of that information I do not consider any further comment by me is necessary in relation to that issue.

Issues impacting the integrity of the investigation

The investigator raised two issues that had the potential to negatively impact upon the integrity of the investigation. They are:-

- the movement of Mr Myers body; and
- the de-briefing of correctional centre staff before they were interviewed.

It is readily acknowledged that as events have transpired, neither of these aspects has caused any evidence to be lost or otherwise negatively impacted upon the integrity of the investigation. However as a matter of principle they raise concerns.

Crime scene preservation

When the nursing staff attended to Mr Myers after he was found collapsed in his cell, they asked for him to be moved into the corridor outside so they had more room to undertake first aid. After Mr Myers was pronounced dead, the general manager of the correctional centre directed his body be returned to the cell and the cell secured. It was kept in that condition until handed over to the investigating police.

The investigating officer expressed the view Mr Myers' body should not have been returned to the cell until such time as the investigators had examined the scene and were satisfied there were no suspicious circumstances.

The policy dealing with incident management provides; *"The body of the deceased prisoner must not be moved from the scene of death until an officer of the CSIU has provided authorisation."*

The policy dealing with crime scene management provides; "C*rime scene preservation must override any other consideration at the scene except the provision of first aid or CPR*".

A crime scene is defined as "*the area associated with a suspected crime from/in which physical evidence may be obtained."*

The Department of Community Safety advised the WCC general manager considered Mr Myers's cell was the crime scene and by moving Mr Myers body back into the cell they were restoring it to the crime scene. They said this was necessary to preserve the dignity of the dead man and to avoid undue distress to other prisoners who might have been able to view the body had it remained *in situ*.

While the significance of those sensitivities cannot be ignored, I am of the view that returning the body to the cell was a contravention of the relevant policy. Removing it from the cell for CPR was in accordance with the policy; returning it was not. Any unnecessary entry to the cell had the potential to contaminate evidence. The suggestion that it was appropriate because the experienced general manager was able to determine the death was not suspicious is, with respect, unconvincing. Such a determination cannot be made until the matter is investigated and interfering with a crime scene can conceivably interfere with such an investigation.

I trust this will be brought to the general manager's attention.

Timing of stress de-briefing

The department's incident management policy in force at the time of the death provided for critical incident stress debriefing for all staff involved in responding to a death in custody. The policy provided; *"operational debriefing or counselling cannot commence until such time as the police have interviewed the staff or prisoner directly involved in the incident."*

In this case the investigator raised concern that while police were in the process of obtaining witness accounts and statements from staff and prisoners it was determined by centre management that a critical incident stress de-brief should occur for all staff involved before they completed their shifts of duty. Apparently management of the correctional centre were advised that this was not practicable because police interviews were continuing but the relevant manager was insistent that staff be allowed to attend the de-briefing. The investigating police officers apparently reluctantly consented to this request only because the death appeared to be of natural causes and was not suspicious.

In the circumstances, the request and the acquiescence of the investigators were understandable, but not in accordance with best practice.

Since Mr Myers' death the relevant policies have been revised. Two policies now provide for at least three types of de-briefing.

The policy entitled "Operational de-briefing" is designed to ensure an opportunity to review the application and suitability of a facility's procedures and staff responses to a particular incident. It provides all employees who were directly or indirectly involved in the incident be given the opportunity to discuss it to identify issues which worked well and any deficiencies. Importantly and appropriately, general managers are instructed by the policy to ensure all employees involved in the incident have been interviewed by the CSIU prior to participating in operational de-briefing.

The policy entitled "Managing traumatic events at work" provides for critical incident stress de-briefing and incident de-briefing to minimise the effects of traumatic events on employees. Both may involve the sharing of information about an incident between those involved in it. Both obviously therefore pose a risk of recall contamination which could negatively impact upon an investigation.

The policy provides an incident de-brief is to commence as soon as practicable after the incident and "*is to be held within three hours of the incident occurring"*. Critical incident stress de-briefing is to be conducted between three and 24 hours after the incident.

While the policy in part 7 notes that officers of the CSIU will often be called to the scene of the incident to investigate, it makes no provision for ensuring employees are interviewed by these officers prior to participating in incident de-briefing or critical incident stress de-briefing.

Recommendation: Review of "Managing traumatic events at work".

I recommend that the Department of Community Safety review its policy "Managing traumatic events at work" to ensure that when CSIU officers are investigating an incident, staff undertake interviews with those officers prior to participating in critical incident stress de-briefing or incident de-briefing

I close this inquest.

Michael Barnes
State Coroner
Brisbane
16 December 2009