QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Reynold David HORACE**
TITLE OF COURT:	Coroners Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2012/2914
DELIVERED ON:	17 December 2014
DELIVERED AT:	Brisbane
HEARING DATE(s):	8 August 2014
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services: (Department of Justice & Attorney-General)	Ms Ulrike Fortescue
West Moreton Hospital and Health Service:	Ms Holly Ahern
Family of Mr Horace:	Mr Simon Burgess (Instructed by ATSILS)

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Introduction

Reynold Horace (also known as Reynold Luke) was 51 years of age when he died on the morning of 15 August 2012. At that time he was an inmate at the Wolston Correctional Centre (WCC). He had spent the last 26 years of his life in prison or secure psychiatric care.

In the preceding two years Mr Horace had been treated on multiple occasions for chest pains and shortness of breath. He was twice diagnosed with having suffered a heart attack during this period. However, he remained reluctant to accept medical treatment and continued to smoke cigarettes until close to his death.

Mr Horace was last seen alive in his cell at 7:15am on 15 August 2012. By 7:38am he was unconscious and could not be revived by prison medical staff or ambulance officers.

These findings:

- confirm the identity of the deceased person, how he died, and the time, place and medical cause of his death;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care adequately discharged those responsibilities; 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

An investigation into the circumstances leading to the death of Mr Horace was conducted by Detective Sergeant Lisa Jacks from the Queensland Police Service Corrective Services Investigation Unit (CSIU). She submitted a report to my Office and this was tendered at the inquest.

DS Jacks attended WCC with other CSIU investigators after Mr Horace's death and oversaw a forensic examination of his cell. A series of photographs were taken of the cell, and the unit in which Mr Horace was housed, with his body in situ.

Statements were taken from relevant correctional and medical staff at WCC. All custodial and medical records pertaining to Mr Horace were seized and made available to my Office along with CCTV footage from the prison. Queensland Ambulance Service (QAS) records were obtained and a number of other inmates were interviewed in relation to their observations of Mr Horace prior to his death.

At the request of counsel assisting, an independent medical practitioner from Queensland Health's Clinical Forensic Medicine Unit, Dr Sally Jacobs, examined Mr Horace's medical records and reported on them. Her findings are detailed below.

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

The Inquest

An inquest was held in Brisbane on 8 August 2014. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest. Oral evidence was heard from the investigating officer Detective Sergeant Jacks. Submissions were made by counsel assisting and the representative for the family.

I am satisfied that all the material necessary to make the requisite findings was placed before me at the inquest.

The evidence

Personal circumstances and correctional history

Reynold David Horace was born in Cairns on 23 January 1961. He resided in Kowanyama and other parts of far north Queensland until early adulthood. Mr Horace's family continue to reside in Kowanyama.

In 1986, at the age of 25, Mr Horace was sentenced to life imprisonment for the offence of rape. This was reduced to 18 years following an appeal. A series of offences in prison, including escape from custody and the attempted murder of a corrections officer, led to further cumulative periods of imprisonment resulting in a total prison term of 31 years and 10 months. His parole eligibility date was 1 October 2008 and his full time discharge date was to be 24 July 2018.

He had been denied parole one month prior to his death, largely because he lacked accommodation and community support.

Mr Horace was initially imprisoned at the Lotus Glenn Correctional Centre in far north Queensland. However, in 2009 he was relocated to WCC to enable the treatment of his psychiatric conditions at the John Oxley Hospital, a secure mental health facility.

This effectively limited the amount of contact he was able to have with his family. His extended imprisonment, illness and death clearly caused his family considerable distress. I extend to them my sincere condolences

Medical History

In September 2009 Mr Horace had a cardiorespiratory arrest and had to be resuscitated. He was admitted to the Princess Alexandra Hospital ("PAH") where an ECG showed decreased blood supply to the heart.

By this time Mr Horace already had an extensive medical and psychiatric history. He was first diagnosed with cardiovascular disease in 1996. His risk factors at that time included non-insulin dependent diabetes, obesity, high cholesterol, high blood pressure and smoking.

In 1999 he was diagnosed with severe left ventricular dysfunction. This, combined with his other risk factors, led to a decision to manage his heart disease medically rather than surgically.

Mr Horace had also been subject to an Involuntary Treatment Order under the *Mental Health Act* while imprisoned due to the symptoms of his diagnosed schizophrenia. These included his repeatedly hearing voices that urged him to self harm. He was transferred to the John Oxley Hospital for treatment on a number of occasions between 1995 and 2005.

These chronic issues were managed by various prison officials and health personnel over many years, although often with difficulty due to Mr Horace failing to engage with the treatments offered.

After recovering from his cardiac arrest in 2009 Mr Horace continued to suffer symptoms which were likely cardiac in origin. He was transported to the PAH on seven occasions from 2010 until his death in 2012. Documentation from these attendances shows that he is thought to have suffered heart attacks in July 2011 and again in May 2012. In June 2012, Mr Horace became unresponsive and had to be resuscitated by QAS officers before being transferred to PAH. He refused treatment at PAH and returned to WCC where he continued to suffer episodes of chest pain over the months leading to his death.

In 2011, and again in 2012, cardiologists assessed Mr Horace and determined that medical treatment, rather than surgery, continued to be the appropriate way of managing his condition. It is evident that surgery carried with it significant risks with limited benefits. No criticism has been made of the course of treatment recommended for Mr Horace during these two independent cardiology consultations.

Events of 15 August 2012

Shortly after 7:00am on 15 August 2012 Custodial Corrections Officers Verner Hughes and Darryl Kiepe arrived at unit S8 at WCC to commence duty. This unit accommodated 44 prisoners and Mr Horace was housed in Cell 1.

At 7:15am CCO Hughes conducted a visual check on all inmates. He observed Mr Horace sitting on the end of his bed with an unremarkable appearance.

At 7:35am all cell doors within unit S8 were remotely and simultaneously unlocked. This was a prompt for prisoners to present at the door of their cell. When Mr Horace failed to do so, CCO Kiepe went to investigate. He found Mr Horace lying on the floor of his cell between the desk and bed. There were no signs of violence and no blood was visible. Mr Horace was unresponsive and CCO Kiepe called a "*code blue*" over the prison radio system.

CCO Hughes came to Cell 1 and was unable to detect a pulse when he checked Mr Horace. CCO Hughes commenced CPR compressions.

At 7:38am nurses Tanya Shaw and Sandra Karner heard the "*code blue*" and arrived at unit S8 at 7:41am. Mr Horace was moved into a more open area outside his cell and the two nurses took over CPR. At 7:43am a defibrillator arrived and when applied to Mr Horace it indicated "*no shock advised*". CPR continued and at 7:46am the defibrillator indicated "*shock advised*". This was given and CPR continued until further shocks were again advised, and given, at 7:52am, 7:55am and 7:58am.

QAS officers arrived at unit S8 at 7:56am and attached their own defibrillator at 7:59am. An IV cannula was attached and adrenaline administered while ongoing attempts were made to revive Mr Horace. It became apparent that Mr Horace could not be saved and life extinct was declared at 8:28am. At this point the scene was appropriately guarded and sealed off until the arrival of police.

Autopsy results

A full autopsy examination was carried out on 17 August 2012 by an experienced forensic pathologist, Dr Philip Storey.

A post mortem CT scan was conducted. Nail scrapings were collected and portions of tissue subjected to histological examination. Samples of blood were taken and subjected to toxicological analysis. These revealed the presence of prescribed drugs at non-toxic levels.

Dr Storey had access to nine volumes of medical information concerning the deceased from WCC. In his autopsy report which was tendered at the inquest he stated:

> "*There was evidence of ongoing damage to the heart muscle because of the combination of coronary atherosclerosis and small vessel disease. This ongoing damage would provide the basis for his persistent symptomatology and repeated presentations to hospital, sometimes with cardiac arrest…The constellation of findings in the cardiac muscle are best described as representing an ischaemic cardiomyopathy and this man's heart would have been prone to the development of abnormal rhythms.*"

After considering all of the available information Dr Storey issued a certificate listing the cause of death as:

1(a) Coronary atherosclerosis.

Medical Review

The medical records pertaining to Mr Horace were sent by counsel assisting to the Queensland Health Clinical Forensic Medicine Unit where they were reviewed by Dr Sally Jacobs. At the end of her very detailed report Dr Jacobs concluded:

> "*From reviewing the material provided to me it appears that Mr Horace was seen regularly by nursing, medical and psychiatric staff in regard to his medical issues. The care and treatment he received seemed appropriate, although at times Mr Horace was not willing to participate in treatment regimens advised."*

Dr Jacobs was not critical of any aspect of the treatment received by Mr Horace.

Family concerns

At the inquest, Mr Horace's family submitted that, because of his comorbidities, it would have been more appropriate for him to have been placed in a hospital setting rather than a prison setting.

A statement was obtained from Dr Andrew Aboud, Clinical Director of the Prison Mental Health Service (PMHS). He indicated that priority in the allocation of beds in the High Secure Inpatient Service (HSIS) was given to individuals who were the subject of forensic orders from the Mental Health Court. Mr Horace was on a waiting list for admission to HSIS in late 2011 for one month, and in late 2012 for 2.5 months, but was not prioritised for admission on either occasion.

Mr Horace's family also identified concerns in relation to his capacity to make his own decisions regarding health care given his psychiatric illness. However it appeared from the evidence that his capacity fluctuated. While the Adult Guardian was eventually engaged to make decisions in relation to health care matters, there was no evidence that Mr Horace was incapable of making appropriate decisions about his health care during periods when he was not suffering from psychotic symptoms.

Submissions made at the inquest on behalf of Mr Horace's family also raised concerns about the general health status of Aboriginal and Torres Strait Islander (ATSI) prisoners, as reflected in Mr Horace's particular circumstances. These included the fact that he continued to smoke cigarettes throughout his term of imprisonment despite specialist advice to the contrary. He also regularly discharged himself from hospital against medical advice in order to be able to resume smoking. It was submitted that I should consider broader issues for ATSI prisoners with respect to the prevention of chronic illness, including factors such as diet, lifestyle, exercise and the cessation of smoking.

In response to the concerns identified on behalf of Mr Horace's family at the inquest I requested that information be provided in relation to the employment of ATSI staff and health workers within correctional centres and programs related to ensuring compliance with medication regimes, diet, exercise and general health and well-being.

A statement from Michael Stubbins, Director, Aboriginal and Torres Strait Islander Unit, outlined that there are over 151 ATSI staff working in QCS. These officers are employed in particular roles such as corrective services officers or supervisors. However, these officers will make themselves available to ATSI prisoners where a prisoner wishes to engage with them.

Mr Stubbins noted that there are 19 identified positions across Queensland prisons, with each prison having a minimum of one cultural liaison officer or cultural development officer. The roles of these officers include assisting with case management, counselling, and ensuring that cultural and social needs are met for ASTI prisoners. Cultural liaison officers have a particular focus on the health and well-being and cultural strengths of ATSI prisoners.

Mr Stubbins also noted that over the past two years there has been a focus on the "quit smoking" campaign prisons in association with Queensland Health. From 5 May 2014 QCS facilities have become tobacco and smoke free. Smoking cessation has the potential to significantly reduce the risk of chronic illnesses such as heart and vascular disease among prisoners. Mr Stubbins indicated that QCS also works with sporting bodies and organisations to deliver healthy living messages to prisoners.

A statement was provided from Vincent Dodd, a cultural liaison officer at the WCC. Mr Dodd's evidence was that he had frequent contact with Mr Horace, and facilitated contact with his mother. Mr Horace was generally unwell but was compliant with his medication regime. The role of the cultural liaison officer was to ascertain the reasons for non-compliance where this occurred.

A statement was provided from Trudy Sheffield, Manager, Offender Intervention Unit, Offender Rehabilitation and Management Services within QCS. Ms Sheffield's statement indicated QCS did not offer stand-alone healthy lifestyle choices programs. These would be considered where relevant to the development of a relapse prevention plan or as part of other programs. However, as adults, prisoners are regarded as capable of making their own decisions about lifestyle choices and can access information via prison health services operated by Queensland Health.

A statement was also provided from Laura Dyer, Nursing Director of Prison Health Services (PHS) at the West Moreton Hospital and Health service. Ms Dyer's statement noted that the provision of health services is a primary health care model, with an emphasis on encouraging self-management wherever possible. However, the PHS uses screening tools to identify health risks and early intervention strategies for identified offenders.

The PHS also identifies offenders who are at a higher risk of developing chronic diseases and conducts health promotion activities and provides health education to prisoners in conjunction with QCS.

Conclusions

I conclude that Mr Horace died from natural causes. I find that none of the staff or inmates at WCC caused or contributed to his death.

I conclude that the medical care provided to Mr Horace while he was an inmate at WCC and a patient at PAH was, at the very least, adequate and reasonable.

I am also satisfied that when he was found unconscious on 15 August 2012 the response by prison staff was prompt and all appropriate efforts were made to revive him.

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. As a result of considering all of the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – The deceased person was Reynold David Horace.

How he died - Mr Horace was found unconscious in his cell at Wolston Correctional Centre and could not be resuscitated. He had experienced cardiac arrest after suffering from a chronic cardiac illness for many years.

Place of death – He died at the Wolston Correctional Centre, Wacol in Queensland.

Date of death – He died on 15 August 2012.

Cause of death – Mr Horace died from coronary atherosclerosis.

Comments and recommendations

Section 46, insofar 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.

Mr Horace's family were concerned with respect to the health challenges for Aboriginal and Torres Strait Islander prisoners serving lengthy sentences, and access to culturally appropriate education programs to prevent the development of chronic health conditions.

There is a considerable body of research to support the family's concerns. Prisoners in Australia experience relatively high rates of chronic disease, communicable disease and mental health issues[1]. Rates of the major mental illnesses, such as schizophrenia and depression, are between three and five times higher in offender populations than those expected in the general community[2] [3].

I am satisfied on the basis of the supplementary material provided by QCS and Queensland Health that some positive steps have been made in relation to measures to improve the general health and well-being of ATSI prisoners. These include the employment of cultural liaison officers and ATSI staff within correctional centres, the cessation of smoking in prisons and access to comprehensive health care through Prison Health Services.

While these measures alone cannot overcome the disadvantage experienced by ATSI prisoners prior to entry to prison, which contributes to the development of chronic illness, it is clear that opportunities exist for interventions to improve the health of offenders after they are incarcerated. Indigenous prisoners are more likely to access health services in prison than in the community. Health intervention in prison has the capacity to reduce the impact of chronic disease and mental health issues.

I also note that the wellbeing of people in contact with the criminal justice system has been identified as a priority area in the recently launched Queensland Mental Health Drug and Alcohol Strategic Plan. The research cited above demonstrates that there is a pressing need for "culturally capable" mental health services for Indigenous prisoners.

I encourage the Queensland Government to continue to invest in health services that are culturally appropriate and accessible to those in custody. Nothing has arisen from the evidence collected in this matter which would allow me to make any other comments or recommendations.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
17 December 2014

[1] The health of Australia's prisoners 2012, AIHW (Australian Institute of Health and Welfare) 2013. Cat. No. PHE 170. Canberra: AIHW.
[2] Prevalence of mental illness among Aboriginal and Torres Strait Islander people in Queensland prisons E B Heffernan, K C Andersen, A Dev and S Kinner, Med J Aust 2012; 197 (1): 37-41
[3] The Identification of Mental Disorders in the Criminal Justice System. Trends and Issues in Crime and Criminal Justice, no. 334. Canberra: Australian Institute of Criminology. Ogloff, J.R.P., Davis, M.R., Rivers, G. & Ross, S. (2007).