QUEENSLAND COURTS

OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Michael John Reynolds**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2014/1067
DELIVERED ON:	19 January 2016
DELIVERED AT:	Brisbane
HEARING DATE(s):	19 January 2016
FINDINGS OF:	Mr Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Miss Emily Cooper
Queensland Corrective Services:	Ms Ulrike Fortescue

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Introduction

1. At the time of his death, Michael Reynolds aged 55 years, was an inmate at the Palen Creek Correctional Centre (PCCC). He was serving a sentence of imprisonment for a robbery offence involving stealing an elderly woman's handbag at a shopping centre. He had exhausted his own funds drinking at the Casino on the Gold Coast.

2. Mr Reynolds' medical history including a previous heart attack, alcohol related issues and a head injury in 2010 which led to a decline in his thought process.

3. At 6:00am on Monday 24 March 2014, Mr Reynolds was seen exercising in the grounds of the PCCC by walking around the running track. He returned to his cell in cell block 'A' at about 6:30am. At 7:00am, correctional officers attended cell block 'A' for the purposes of conducting a headcount. Mr Reynolds did not present for the headcount, which resulted in correctional officers attending at his cell.

4. Upon attending the cell, correctional officers saw Mr Reynolds lying on his back and otherwise unresponsive. A 'Code Blue' was called and correctional officers commenced CPR. The prison nurse and shift supervisor immediately attended, and also attempted CPR. Resuscitation efforts were unsuccessful, and Mr Reynolds was pronounced deceased at 7:17am.

The investigation

5. Detective Senior Constable Richard Fry from the Queensland Police Service (QPS) Corrective Services Investigation Unit (CSIU) conducted an investigation into the circumstances leading to Mr Reynolds' death.

6. Upon being notified of Mr Reynolds' death, the CSIU attended PCCC and an investigation ensued. Mr Reynolds' correctional records and his medical files from the PCCC were obtained. The investigation was informed by statements from all relevant custodial officers at PCCC and medical officers at the PCCC. These statements were tendered at the inquest.

7. A full internal autopsy examination was conducted by forensic pathologist, Dr Beng Ong. Dr Ong noted the presence of extensive atherosclerosis in the coronary arteries with the right coronary artery showing almost complete occlusion. The two other major coronary arteries also showed prominent atherosclerotic occlusion. Dr Ong reported that the cause of death was coronary atherosclerosis.

8. At the request of the Office of the State Coroner, Dr Adam Griffin from the Queensland Health Clinical Forensic Medicine Unit (CFMU) examined Mr Reynolds' medical records and reported on them.

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

The inquest

10. As he was in custody when he died, an inquest into Mr Reynolds' death is required by the *Coroners Act 2003.* The inquest was held on 19 January 2016. All of the statements, medical records and material gathered during the investigation was tendered in lieu of oral testimony and submissions were heard from Counsel Assisting.

11. I have also had regard to a letter from Mr Reynolds' partner outlining concerns about the medical care he received in prison, and resuscitation efforts after he was located in his cell on the day of his death.

Circumstances of the death

12. Michael John Reynolds was a 55 year old man. He had been in custody since 28 August 2013, having been convicted of robbery and sentenced to imprisonment for 2 years, 6 months. He was originally incarcerated at Brisbane Correctional Centre, until he was transferred to the PCCC on 22 November 2013. It was his second term of imprisonment, having previously served 28 days in custody in 2012 in relation to unpaid fines under the *State Penalties Enforcement Act 1999*. His parole release date had been fixed by the sentencing judge as 17 April 2014.

13. On his admission to PCCC, Mr Reynolds was noted to have a medical history of:

    - Myocardial infarction in 1991 (at age 32);
    - Hepatitis C infection; and
    - Gout (metabolic disorder resulting in arthritis).

14. Mr Reynolds was also noted to be suffering signs of alcohol withdrawal at the time of his admission.

15. In order to consider his suitability for incarceration, a neuropsychology report was prepared. The report, dated 25 April 2013, describes an acquired brain injury relating to seizure activity associated with the ingestion of ethanol. The brain injury was reported to cause problems with Mr Reynolds' memory, finding and pronouncing some words when he spoke, and with attention and concentration. The psychologist noted that the pattern of cognitive deficits elicited on assessment was consistent with the medical information and brain injury, which had a negative impact on his ability to function independently in the community.

16. On 29 August 2013, a day after his initial admission, an ECG was conducted. It showed abnormalities, with changes indicating a previous myocardial infarction. Subsequent blood tests and urine tests were also conducted with essentially normal results.

17. On 21 November 2013, Mr Reynolds was seen by a registered nurse, Ms Cecily Peters. Ms Peters documented Mr Reynolds' non-compliance with prescribed medication, particularly the anti-epileptic medication Epilim, and medication to treat heart disease. The medication he was taking included Thiamine (Vitamin B supplement) and Indocid (Indomethacin: an anti-inflammatory drug). Mr Reynolds had told Ms Peters he 'did not believe in medicines.'

18. The medical records show that Mr Reynolds had not taken any medication to manage his cardiac condition from about 6 months after his heart attack in 1991 when he was aged 32 years. This decision pre-dated his fall and subsequent head injury, thus demonstrating his desire not to manage his condition with medication was consistent throughout his life. His father died from cardiac arrest at age 35, indicating a genetic predisposition to cardiac disease.

19. This decision by Mr Reynolds did not prevent doctors and nurses from undertaking routine preventative screening of his blood pressure and an attempt to check his cholesterol levels.

20. At 6:00am on Monday 24 March 2014, Mr Reynolds was seen by another prisoner exercising in the grounds of the PCCC walking around the running track. He returned to his cell in cell block 'A' at about 6:30am. At 7:00am, correctional officers attended cell block 'A' for the purposes of conducting the morning muster. Mr Reynolds did not present for the headcount, which resulted in correctional officers attending at his cell. Correctional Officer Robert Houston attended at Mr Reynolds' cell, and saw him on his back on the floor of his cell. His legs were folded back under him as if he had fallen back on them. His arms were straight out by his sides. Officer Houston called a 'Code Blue' at 7:06am, and he and correctional officer Michael Sim commenced CPR.

21. The prison nurse, Ms Peters, and shift supervisor Mark Copson immediately attended, and took over CPR efforts. A defibrillator was used. Resuscitation efforts were unsuccessful, and Mr Reynolds was pronounced deceased at 7:17am.

22. Dr Griffin's report concluded that Mr Reynolds suffered from heart disease which he had decided not to have managed with medication. However, he continued to take medication for gout, indicating that he had some capacity to make decisions relating to his health care.

23. Dr Griffin identified no issues with Mr Reynolds' care in the lead up to his death. He was not confident that extended resuscitation efforts would have affected the outcome, given the severity of the disease noted at autopsy. Dr Griffin noted some concerns not related to the death. These related to clinical documentation and the length of resuscitation efforts, although it was not clear how long Mr Reynolds had been in cardiac arrest when resuscitation started. A copy of Dr Griffin's report has been provided to the

General Manager, PCCC, for consideration and further action as is deemed appropriate.

24. Mr Reynolds' death was the subject of a police investigation by the Corrective Services Investigation Unit. That investigation has been considered by me and I accept that the death was from natural causes with no suspicious circumstances associated with it.

Conclusions

25. I conclude that Mr Reynolds died from natural causes. I find that none of the correctional officers or inmates at the PCCC caused or contributed to his death. I am satisfied that Mr Reynolds was given appropriate medical care by staff at the PCCC while he was in custody. His death could not have reasonably been prevented.

26. It is a recognised principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. The evidence tendered at the inquest established the adequacy of the medical care provided to Mr Reynolds when measured against this benchmark.

Findings required by s. 45

27. 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 Michael John Reynolds.

How he died - Mr Reynolds died after suffering a heart attack. He had a history of heart disease, having previously suffered a heart attack in 1991 at age 32. Approximately 6 months after his first heart attack, he ceased taking any medications to assist with his heart condition, and this situation did not change at any point in the lead up to his death.

Place of death – He died at the Palen Creek Correctional Centre, Rathdowney, Queensland.

Date of death – He died on 24 March 2014.

Cause of death – Mr Reynolds died from natural causes, namely coronary atherosclerosis.

Comments and recommendations

28. 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 to be made that would assist in preventing similar deaths in future.

I close the inquest.

Terry Ryan
State Coroner
Brisbane
19 January 2016