OFFICE OF THE STATE CORONER

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of Donald Mervyn HAY**
TITLE OF COURT:	Coroner's Court
JURISDICTION:	Brisbane
FILE NO(s):	COR 2011/3923
DELIVERED ON:	5 September 2012
DELIVERED AT:	Brisbane
HEARING DATE(s):	5 September 2012
FINDINGS OF:	Mr Michael Barnes, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Mr Peter Johns
Queensland Corrective Services:	Ms Fiona Banwell
West Moreton Hospital & Health Service:	Mr Kevin Parrott (Crown Law)

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The *Coroners Act 2003* provides in s47 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 Donald Mervyn Hay. 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

Donald Hay had been in prison for more than three years and at Wolston Correctional Centre (WCC) for seven months when, on 15 November 2011, he became suddenly and seriously ill. He went into cardiac arrest while being treated by nursing staff and was taken by ambulance to Princess Alexandra Hospital (PAH). Extensive resuscitation attempts there were partially successful, however Mr Hay never regained consciousness and died the following day.

These findings:

- confirm the identity of the deceased person, the time, place and medical cause of his death and how he died;
- consider whether any third party contributed to his death;
- determine whether the authorities charged with providing for the prisoner's health care needs 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 Hay was conducted by Detective Senior Constable Rudi Knaggs from the QPS Corrective Services Investigation Unit (CSIU).

Once Mr Hay died in his hospital bed the room was appropriately secured. A QPS officer took a series of photographs of the room and the body in situ. DSC Knaggs and another CSIU officer attended the hospital and made their own observations of the scene before liaising with hospital staff in order to access relevant medical records. Two other officers attended the WCC, conducted a search of Mr Hay's cell and seized all documentation relating to him. They took statements from several corrective services officers (CSO's) and nursing staff. The CSIU officers conducted interviews with those inmates who had been domiciled in the same residence as Mr Hay.

A statement was obtained from the doctor at PAH who declared Mr Hay deceased and from the two paramedics who had transported him from the WCC to PAH.

I am satisfied that the investigation was thoroughly and professionally conducted and that all relevant material was accessed. I commend DSC Knaggs on his endeavours.

The Inquest

An inquest was held in Brisbane on 5 September 2012. All of the statements, records of interview, medical records, photographs and materials gathered during the investigation were tendered at the inquest.

The investigating officer gave evidence and Mr Johns proposed that no further oral evidence be heard subject to objection from any other party. Mr Johns had earlier written to Mr Hay's daughter, enclosing a copy of the police investigation report and explaining that he would make this submission. No objection was received to the proposed course from any party and I agreed that the evidence tendered was sufficient for me to make the requisite findings.

The evidence

Personal circumstances

Donald Hay was born on 24 January 1944, making him 67 years of age at the time of his death.

On 22 July 2008 he was sentenced to eight years imprisonment having been found guilty in the Emerald District Court of 17 charges of indecent treatment of children and one of common assault. He was initially accommodated at Capricornia Correctional Centre but moved to the WCC on 11 April 2011.

Medical history

Medical records from the WCC show Mr Hay had a lengthy history of heart disease with numerous admissions to hospital throughout his three years in prison. These records also note him having suffered a heart attack and being treated at Blackwater Base Hospital in 1994.

At the time of his death he was taking the following medication:

- Atenelol
- Micardis
- Aspirin
- Metformin
- Simvastatin
- Glicazide
- Iron supplements

In combination, these drugs had been prescribed to treat his chronic heart disease, high cholesterol levels and diabetes.

Events of 15 November

At about 12:40am on 15 November 2011, inmate Robert Long heard banging coming from the cell of Mr Hay. Inmates in residential care at the WCC are able to exit their cells (though not their particular unit) and so Mr Long investigated the noise. He found Mr Hay vomiting into a wastepaper basket and noticed him to be clammy and sweaty. He assisted Mr Hay to the toilet and then, at 12:50am, called for assistance. This resulted in a “Code Blue” being called and several CSO’s and a nurse attending on Mr Hay.

The nurse, Simone Blakeman, assessed Mr Hay and noted him to be dehydrated. After a short period she ordered him to be transported to the WCC medical unit on a trolley. In the course of transporting him to the medical unit she noticed a gasping sound and then observed that Mr Hay had ceased breathing. A defibrillator was attached and CPR commenced.

Queensland Ambulance Service (QAS) records show that they were contacted at 1:22am and paramedics were with Mr Hay at 1:40am. Those records also reflect extensive ongoing resuscitation attempts including the administration of adrenaline on numerous occasions. The paramedics transported Mr Hay to the PAH arriving at 2:20 AM. The paramedics were still attempting to resuscitate Mr Hay when they arrived at the PAH and this process was taken over by emergency department staff. After more than two hours of attempts to resuscitate and stabilise him Mr Hay was transferred to the intensive care unit (ICU) at 4:56am.

Hospital records note that Mr Hay had been electrically cardioverted at least twelve times by the time he arrived in ICU. An echocardiogram showed very poor cardiac function.

A further infusion of adrenaline was required in the ICU in order to maintain Mr Hay’s blood pressure. He suffered two further episodes of loss of pulse and required CPR and one further electrical defibrillation.

A review by a cardiologist established that the arrhythmias being experienced by Mr Hay were due to a ventricular scar from a previous myocardial infarct. That cardiologist did not believe that acute myocardial ischaemia was causing the arrhythmias and recommended medical management and supportive care. He did not believe that there was any intervention he could perform that would alter the prognosis for Mr Hay.

On 16 November 2011 Mr Hay had evidence of multi-organ failure with cardiac, neurological and renal dysfunction. His severe heart failure was not responding to therapy and an assessment was made that the treatment available would not save him. After consultation with family members who had congregated at the hospital, supportive therapy was ceased and Mr Hay died at 1:35pm that day. Dr Brigit Weld signed the death certificate and the CSIU was notified.

Autopsy results

An external autopsy examination was carried out on 7 December 2010 by an experienced forensic pathologist, Dr Philip Storey. He supplied a very detailed report of his findings which was tendered at the inquest.

Samples were taken for toxicological testing. Dr Storey had access to all medical records relating to Mr Hay. After considering these, the toxicological results and his own observations he issued a certificate listing the cause of death as:

> *1(a) Acute Myocardial Infarction;* due to or as a consequence of
>
> *1(b) Coronary Atherosclerosis*
>
> Other significant conditions:
>
> *2. Diabetes Mellitis; Hypertension*

Investigation findings

None of the other inmates at the WCC provided information to the investigating officer suggestive of foul play or of any deficiency or inappropriateness with regard to the treatment received by Mr Hay while in custody.

The examination of Mr Hay's room at PAH revealed no signs of violence.

The investigating officer, DSC Knaggs, told the inquest that the CSIU investigation into Mr Hay's death did not lead to any suspicion that the death of Mr Hay was anything but natural.

Medical Review

Mr Hay's medical records were sent by Counsel Assisting to the Clinical Forensic Medicine Unit where they were independently reviewed by Dr Robert Hoskins. He expressed the following view in relation to the treatment afforded to Mr Hay at the WCC:

> "*There is nothing in the process that gives me any cause for major concern. Given the requirements to attempt to assess and stabilise, not to mention the security obstacles that have existed in the past, it is impressive that QAS had Mr Hay on board and en route to the PA less than an hour and a quarter after the CSO's were first called.*
>
> *If Mr Hay was sick enough to require stretchering to the medical centre then there may be an argument that he was sick enough to call an ambulance before he arrested on his way there at the time difference means that there would have been no practical change in the final outcome"*

He went on to express the following opinion in relation to the treatment received by Mr Hay by QAS staff and at PAH:

> "*QAS did not administer thrombolytic drugs but were correct in their decision as there were several reasons not to do so using the published criteria.*
>
> *From that point on, and having regard to the clinical picture throughout and the autopsy finding, there was nothing additional that could be done, nothing that ought not to have been done and nothing that could have been done differently that would have been likely to affect the outcome."*

Conclusions

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

I am satisfied that Mr Hay was given adequate medical treatment at the WCC in the 7 months of his stay there prior to the cardiac event on 15 November 2011. I also consider the emergency response by staff when he did collapse was appropriate.

Having considered the opinion of Dr Hoskins I am also satisfied that the care afforded to Mr Hay by staff at the Princess Alexandra Hospital in the short period prior to his death was adequate and appropriate.

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 in relation to the other aspects.

Identity of the deceased –	The deceased person was Donald Mervyn Hay
How he died -	Mr Hay died of natural causes while in custody at the Princess Alexandra Hospital having been transferred there when he suffered a heart attack in the Wolston Correctional Centre.
Place of death –	He died at Buranda in Queensland.
Date of death –	He died on 16 November 2011.
Cause of death –	Mr Hay died from an acute myocardial infarction.

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.
In the circumstances of this case there is no basis on which I could make any useful preventative recommendations.

I close the Inquest.

Michael Barnes
State Coroner
Brisbane
5 September 2012