QUEENSLAND COURTS

CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of John Francis Alex Martyn**
TITLE OF COURT:	Coroners Court
JURISDICTION:	BRISBANE
FILE NO(s):	2017/1720
DELIVERED ON:	11 December 2020
DELIVERED AT:	Brisbane
HEARING DATE(s):	17 June 2020 (written submissions June-July 2020)
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	CORONERS: Death in custody, natural causes, terminally ill prisoner, palliative care, parole.
REPRESENTATION:	
Counsel Assisting:	Ms Sarah Lio Willie
SERCO:	Nick Rowe, Prison Director, Southern Queensland Correctional Centre
ATSILS:	Ms Kate Greenwood
QCS:	Ms Megan Lincez

Contents

Introduction

1. John Francis Alex Martyn was a prisoner at the Southern Queensland Correctional Centre (SQCC) at the time of his death. He was an Indigenous man aged 75 years. Mr Martyn was convicted of murder on 6 June 1987 and sentenced to life imprisonment with hard labour.

2. In 2012, Mr Martyn was diagnosed with bony lesions from metastatic prostate cancer. He also suffered from haemophilia A[1], ischaemic heart disease, hypertension, gout and multiple curable vascular accidents that left him wheelchair bound with a dense left hemiparesis.[2]

3. On 25 April 2017, Mr Martyn was moved to the ambulance bay within the Acute Care Unit (ACU) at SQCC. At 2:35pm, Corrective Services Officers (CSO's) observed that Mr Martyn was not breathing. At 2:37pm he was declared life extinct. He died from metastatic prostate cancer.

The investigation

4. Detective Sergeant (DS) Greg Bishop of the Corrective Services Investigation Unit (CSIU) investigated the circumstances surrounding Mr Martyn's death. He provided a Coronial Report with various annexures, including witness statements and medical records.

5. The CSIU investigation was informed by statements from relevant corrective services officers and nursing and medical staff at SQCC and the Princess Alexandra Hospital (PAH).

6. On the basis of the evidence obtained, DS Bishop's report concluded that Mr Martyn was provided with adequate medical care and attention while he was in the custody of SQCC.[3] There were no suspicious circumstances surrounding his death, nor any omission by any person which may have contributed to or caused it.

The inquest

7. At the time of his death, Mr Martyn was a prisoner in custody, as defined in Schedule 4 of the *Corrective Services Act 2006.* Pursuant to s 8(3)(g) of the *Coroners Act* 2003 Mr Martyn's death was a 'death in custody' and an inquest was required. The inquest was held on 17 June 2020. All of the statements, medical records and material gathered during the investigation into Mr Martyn's death were tendered. Counsel Assisting proceeded to submissions in lieu of any oral testimony being heard.

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[1] Haemophilia A is an inherited bleeding disorder in which individuals, predominantly males, are deficient in an essential clotting protein called factor eight, hence it is also known as Factor VIII deficiency
[2] Weakness of the entire side of the body
[3] Exhibit C1

8. On the day of the inquest, Aboriginal and Torres Strait Islander Legal Service (ATSILS) sought and was given leave to make written submissions under s 46(3) of the *Coroners Act* 2003. The other parties were asked to provide written responses to the ATSILS' submissions.

The evidence

Personal circumstances

9. Mr Martyn was the second of six children. Mr Martyn's next of kin was his sister, Kathleen Lawnton. Ms Lawton provided a statement explaining that the last contact she had with her brother was in 1996 after their mother's funeral. Ms Lawnton told police that she was made aware of his death by his stepdaughter, 'Terry'.[4] Ms Lawnton was aware that Mr Martyn was born with haemophilia A, but only found out about his cancer after his death.

10. Registry of Births, Deaths and Marriages records indicate that Mr Martyn married on 28 June 1980. No record of any children born to Mr Martyn could be located throughout Queensland.[5]

11. Mr Martyn's fellow inmates told investigators he did not speak about his family, nor did he have any visitors while at SQCC. He told one inmate that he had a son in the Australian Federal Police, but the inmate said that Mr Martyn was "reckless with what he would say".[6] Another inmate told investigators that in the nights prior to his death, Mr Martyn called out the name 'Maureen' and told this inmate that Maureen was his sister. Records confirmed that Mr Martyn had a younger sister named Maureen.

12. A review of Mr Martyn's ARUNTA phone calls reveal that he called a friend, Christine, while at SQCC. The phone calls varied from 30 seconds to 15 minutes. The phone calls were initially sporadic but increased to nearly every week after December 2016.[7]

Criminal history

13. Mr Martyn's criminal history consisted of two offences.[8] He was first convicted on 24 April 1964 for a breach of the *Racing and Betting Acts* and fined 150 pounds, and order to pay the costs of the court.

14. On 5 June 1987, Mr Martyn was convicted of murder and sentenced to life imprisonment with hard labour. Mr Martyn had administered methadone and temazepam to a young woman with the intent to rape her. His victim suffered from an overdose and subsequently died.

[4] There was no confirmation of Terry's identity.
[5] Ex F1
[6] Ex G5
[7] Ex D1
[8] Ex C2

Parole History

15. Mr Martyn's parole eligibility date was 31 May 2000. Queensland Corrective Services (QCS) records indicate that he was released on parole on five occasions[9] but was subsequently returned to custody as a result of parole violations.

16. Mr Martyn was granted exceptional circumstances parole on 16 October 2003 due to his ill health at the time. On 31 July 2006, he appeared in the Ipswich Magistrates Court after being arrested for the offences of rape and procuring a sexual act by administering a drug. The circumstances of the alleged offending were like those attaching to Mr Martyn's murder conviction. His parole was revoked, and he was returned to custody on 1 August 2006. Mr Martyn was subsequently not convicted in relation to those charges.

17. On 26 September 2007, Mr Martyn was released on parole. On 23 November 2007, his parole was suspended indefinitely after he breached a parole condition by having alcohol in his accommodation.

18. On 6 January 2009, Mr Martyn was released on parole to an aged care facility. Special conditions had been added by the Queensland Parole Board (the Board) to reduce his risk of recidivism, including that he would not cohabit with any individual without the permission of his CSO Officer. Notwithstanding that condition, Mr Martyn started to cohabit with a vulnerable young woman. He disregarded a direction that he was not allowed to reside with that person. His parole was suspended on 31 August 2009 and he was returned to custody on 4 September 2009.

19. On 9 May 2011, Mr Martyn was released on his fourth period of parole. Following complaints about comments made by Mr Martyn to neighbouring children his parole was suspended on 16 November 2012 and he returned to custody on 19 November 2012.

20. On 19 March 2013, Mr Martyn was released on parole for the fifth and final time. His release was subject to strict conditions relating to contact with children and young women, close monitoring and supervision. A 17 August 2015 search of his property revealed a woman and her son hiding in a room. The woman advised police that she had stayed with Mr Martyn on several occasions with her two children. Mr Martyn reportedly told police that 'he did not care for his parole conditions' as he was dying man. On 17 August 2015, a warrant was issued for Mr Martyn for failing to comply with his parole order and he was returned to custody on 19 August 2015.

[9] Ex D4 – Offender Violation Record; Ex D5 – Cautions and Warnings

Medical and custodial history 2016-2017

21. The medical records provided detailed Mr Martyn's treatment in 2016 and 2017, when he was a prisoner at Wolston Correctional Centre (W CC) and SQCC. The history referred to Mr Martyn suffering a stroke. Other inmates also told investigators about this but there was no date attributed to when this occurred. It is also unclear how long Mr Martyn was bed bound.

22. In 2012, Mr Martyn was diagnosed with bony lesions from metastatic prostate cancer. His other past medical history included haemophilia A, ischaemic heart disease, hypertension, hepatitis C, severe osteoarthritis and several cerebrovascular accidents, with a dense left hemiparesis.

23. On 7 March 2016, Mr Martyn submitted an exceptional circumstances parole application. On 7 June 2016, the Nurse Unit Manager (NUM) at Wolston Prison Health Services (WPHS) outlined the following limitations in relation to the care that could be provided to Mr Martyn at that centre:

- He had been diagnosed with incurable prostate cancer and referred to a palliative care specialist for pain/palliative management;
- He required pain management and regular pain management review from the visiting medical officer;
- Multiple organ failure had been caused by the metastases;
- He required assistance with care and medications. Although he had been assigned a carer to assist, the correctional centre could not provide adequate nursing care for his daily needs;
- His profound left-sided weakness meant that he should be regularly repositioned to prevent bedsores. 24-hour care was not available at WCC; and
- Patients such as Mr Martyn should have a properly trained carer and equipment such as a transfer hoist to manage safe transfer to bathroom facilities and avoid skin tears and bruising that he was susceptible to as a haemophiliac.

24. The NUM noted that Mr Martyn's "prognoses are not good however his illness had not yet progressed to a stage where death is imminent". This report was provided to the Board.

25. On 24 June 2016, the Board wrote to Mr Martyn and informed him that it was continuing to assess his matter and had requested a home assessment to a palliative care facility. He was encouraged to provide the name and address of a suitable sponsor to the Sentence Management Unit at his custodial centre to enable the home assessment to be conducted. He was advised that the Board would further consider his matter upon receipt of the requested information.

26. On 6 July 2016, Mr Martyn was transferred to SQCC because the facility was better equipped to support his palliative care needs. SQCC put in place measures to supplement the care it could provide at its medical unit, including a carer drawn from the prison population and a pole and other devices to assist with mobility.

27. Mr Martyn required all daily living cares to be attended to. However, on most occasions Mr Martyn was reported to have declined care and medication, allowing only basic care to be provided. At times, Mr Martyn was verbally abusive and threatening towards correctional and nursing staff who cared for him. On 15 April 2017, he was sanctioned for threats he made to staff.[10]

28. On 9 August 2016, the Board wrote to Mr Martyn noting that the Board had been informed that his medical conditions could be managed in a custodial facility. The Board informed Mr Martyn that it had formed the preliminary view that his application for exceptional circumstances parole should be declined.

29. On 24 August 2016, a letter was sent from ATSILS to the Board nominating two possible nursing home placements for the Board's consideration. Both required an assessment by an Aged Care Assessment Team (ACAT). The ACAT assessment had to be facilitated by custodial staff. The letter reiterated the views of the NUM at WCC that Mr Martyn could not be cared for within a correctional centre. However, it went on the state that while the Palliative Care Unit PCU at the SQCC provided 24 hour nursing care, to endeavour to properly manage Mr Martyn's chronic illness it would be in his best interests if he were released to an aged care facility.

30. An ACAT assessment requires the consent of the person who is being assessed and there was conflicting evidence in relation to whether Mr Martyn did want to be assessed for a nursing home placement. An email from a Diversional Therapist to the NUM at WCC dated 25 July 2016 indicates that Mr Martyn expected to be released to public housing, as he had been on previous occasions, and insisted that he could live independently without support.

31. However, the letter from ATSILS to the Board and a statement from Mr Downey of ATSILS indicated that Mr Martyn said that he would be happy to live in a nursing home.[11] Mr Downey said that Mr Martyn was unhappy about the transfer to SQCC from WCC as he was no longer able to access the services of an Aboriginal doctor from the Indigenous Medical Centre at Inala. Mr Downey also said that Mr Martyn had little confidence in the prisoner carers who were allocated to assist him at WCC.

[10] Ex D4 – From 1993 – 2017 he had 22 medical emergencies and was sanctioned 5 times for making threats/ offensive behaviour towards staff and/or prisoners, and once for assaulting staff.
[11] Affidavit of Rory Downey dated 22 June 2020.

32. Mr Martyn's Integrated Offender Management System (IOMS) records indicate that on 29 September 2016 he was informed by the Sentence Management Officer that his exceptional circumstances parole application had been declined and was given a copy of the relevant correspondence. His response was that he did not need assistance with care on release and was not applying for palliative care accommodation options. He indicated that he still had a special circumstances parole application on foot and was advised he could apply for parole at any time. The IOMS entry records "*prisoner appeared to have some problems understanding the information although it was provided twice to the prisoner."*

33. The submission from QCS indicated that it did not have any records to suggest that Mr Martyn ever consented to an ACAT assessment, nominating a palliative care facility to the Board. There were also no records to suggest that the Board assessed a palliative care facility for Mr Martyn.

34. Mr Martyn was hospitalised three times in the 12 months leading up to his death. On 3 April 2016, he was admitted to the Emergency Department at the Princess Alexandra Hospital (PAH) for 24 hours, under clinical toxicology following an accidental/iatrogenic administration of 80mg of OxyContin. He was placed on a naloxone infusion (200mcg/hr) which was ceased the following morning. Based on the low dose required and the time since ingestion, he was medically cleared to return to his usual accommodation at WCC.[12]

35. On 13 June 2016, Mr Martyn was admitted to the PAH Emergency Department (ED) with abdominal/pelvis/perineal pain.[13] While at the PAH he refused treatment, refused a cannula and blood tests. He was subsequently discharged later that day against medical advice.

36. Mr Martyn's final hospital admission was to the PAH ED for rectal bleeding on 4 March 2017. During this admission, despite repeated attempts by medical staff to engage with Mr Martyn, he refused any assessment and treatment. Hospital staff were advised by SQCC nurses that Mr Martyn's behaviour at the PAH was normal and longstanding. It was therefore determined that there were no issues with his capacity to make the decision to refuse treatment. He told PAH staff he wanted to return to prison. He was subsequently discharged and returned to SQCC on 5 March 2017.[14]

37. On 14 April 2016, Mr Martyn had completed an Advance Health Directive (AHD) indicating he did not want any treatment that might obstruct his natural death, the only exception was administration of Factor VIII (a blood clotting protein) in the event of bleeding.

[12] Ex E4, pg13
[13] Ex E3, pg157
[14] Ex B1; Ex E3, pg11 and 26

Events leading up to the death

38. Upon his return from the PAH on 5 March 2017, Mr Martyn resided in the SQCC Acute Care Unit (ACU). Mr Martyn was bed bound and required all daily cares to be attended to. Notwithstanding, his challenging behaviour towards nurses persisted. He was, at times, verbally abusive, declined medication, and refused basic cares including measures to prevent/treat bed sores.

39. On 24 April 2017, the Assistant Director of Operations at SQCC notified the CSIU that Mr Martyn's condition had 'deteriorated significantly' and it was anticipated he would 'not survive the coming days' and that he was 'nil by mouth and measures for care are palliative only.'[15]

40. On the morning of 25 April 2017, Mr Martyn was moved to the ambulance bay at SQCC. This allowed constant observations by CCTV and included 15-minute physical observations by CSOs. The first physical observations check at 8:15am recorded that Mr Martyn had gargled breathing. The same observation was made up until the final check at 2:15pm, at which time he was also observed to have his eyes open.[16]

41. At 2:35pm corrections staff conducted a physical check and found Mr Martyn had stopped breathing. At 2:36pm a *Code Blue* (medical emergency) was initiated and corrections officers commenced CPR. SQCC Nurses also responded to the *Code Blue.* When they arrived at the ambulance bay, they requested corrections officers stop CPR as they held Mr Martyn's signed AHD. Clinical Nurse Melinda Evans checked for vital signs and he was declared life extinct at 2:37pm.[17]

42. The ambulance bay was secured at 2:40pm until the Statewide Operations Manager and CSIU were advised of his death and attended later that afternoon.

43. Investigators interviewed prisoners who either worked in the ACU or resided with Mr Martyn. All prisoners commented that the nurses and staff in the ACU "really looked after him"[18]; that he was well cared, as if he were in hospital; and "the nurses were very caring, even though he was abusive to them."[19]

[15] Ex D6
[16] Ex E7
[17] Ex B5; Ex B6; Ex A2
[18] Ex G4
[19] Ex G5

Clinical Forensic Medicine Unit Review

44. Dr Ian Home of the Clinical Forensic Medicine Unit conducted a review of the medical treatment provided to Mr Martyn while he was in custody.

45. Dr Home provided a report detailing his conclusions.[20] His observations can be summarised as follows:

- When Mr Martyn was first diagnosed with cancer in 2012, the cancer initially responded well to hormone therapy.
- Mr Martyn often declined assistance from nurses, thus aggravating pressure areas (bed sores) and refused medication.
- Mr Martyn's death was imminent. On the day of his death he was moved to the ambulance holding bay to not cause undue stress for his fellow inmates. He was monitored constantly via CCTV along with regular physical observations.
- Mr Martyn made it clear he did not want treatment, which was reflected in his AHD.

46. Dr Home saw no reason to be critical of the care provided to Mr Martyn by Offender Health Services.

Autopsy results

47. An external post-mortem examination was performed by forensic pathologist, Dr Beng Ong, on 28 April 2017 at Queensland Health Forensic and Scientific Services at Coopers Plains. A CT scan and toxicology testing were also undertaken.

48. The external examination noted there was wasting of the muscles of the upper and lower limbs. There was shortening of the left forearm with mild fixed flection deformity of the left elbow and fixed flection deformity with swelling of the left wrist joint. There was a soft lump on the back of the right elbow. There were several sores on the back of the left hand, slightly swollen index and middle finger. There was also a weeping ulcer on the back of his left thigh associated with erythema of the surrounding tissues. Several bruises and areas of erythema were also located on his chest, abdomen, elbow, knee and leg.

49. Also noted were irregular areas of hypodensity in the inferior right occipital lobe with associated atrophic change most in keeping with areas of dystrophic calcification related to previous insult/ infarction.

[20] Ex I1

50. The CT scan confirmed metastatic lesions in the skeletal system. There were also multiple foci of metastases in the lungs, peritoneum (abdominal cavity) and possibly the liver. There were changes in the brain indicating previous cerebral pathology (history of cerebrovascular accident or stroke). The liver showed changes indicating cirrhosis in addition to metastatic lesions.

51. The toxicology analysis detected the presence of diazepam, morphine and metoclopramide in the blood. All the levels were within therapeutic range.

52. Dr Ong found the cause of death to be metastatic prostatic cancer.[21]

Submissions under section 46

ATSILS

53. Public interest submissions were provided by ATSILS on 22 June 2020. The submissions noted that although steps had been taken at Wolston CC to identify nursing and palliative care for Mr Martyn those efforts had to recommence on his transfer to SQCC on 6 June 2016.[22]

54. ATSILS submitted that neither WCC nor SQCC contained a palliative care centre suitable to support Mr Martyn's medical needs. He needed a 24-hour system of professional nursing. Due to the combined complications of his haemophilia and left-sided incapacity, he needed a centre with appropriate hoists to avoid bruising and skin tearing.

55. ATSILS noted the additional measures provided at SQCC but submitted that the sum of those measures was inadequate, and that he should not have been placed there.

56. ATSILS submitted that a humane common sense approach should be taken to all prisoners with complex nursing and palliative needs. Where on site 24-hour nursing services and appropriate facilities are not available within the prison grounds, the prisoner should be treated in a community setting with appropriate care and facilities.

57. ATSILS referred to criticisms of transfers to the PAH which likely contributed to Mr Martyn's reluctance to remain at that facility. These included long transit times and the practice of handcuffing prisoners to beds within the hospital.

[21] Ex A4

[22] Palliative care was distinguished from 'end of life care' to mean multidisciplinary care that is provided when a patient has little or no prospect of cure where the goal is to optimise quality of life.

58. It was submitted that Mr Martyn's express desire to return to SQCC should not have been be interpreted as a lack of desire for medical treatment in an environment other than his prison cell. ATSILS submitted that it was inhumane to keep Mr Martyn in conditions that fell below an adequate standard of palliative care.

59. ATSILS noted that Mr Martyn had been incarcerated for around 29 years. After being returned to prison following parole breaches, he lost his accommodation. One of the ongoing factors preventing his future release from prison was the lack of suitable accommodation. ATSILS had identified two possible nursing home placements for the Board's consideration. Both required an assessment by an ACAT team. The ACAT assessment had to be facilitated by custodial staff.

60. ATSILS also submitted that prisoners were often eligible for both parole and exceptional circumstances parole, but if they chose to apply for exceptional circumstances parole, they had a higher threshold to meet. They asserted that the practice of the Board was to consider and refuse exceptional circumstances parole, without going on to consider the merits of a parole application.

61. It was submitted the Board should also consider if a prisoner was eligible for parole under normal parole eligibility when the person submits an exceptional circumstances parole application, and prisoners should routinely be given a parole application form[23] to submit at the same time as an application for exceptional circumstances parole.

QCS

62. QCS' submission noted that it does not provide medical care to prisoners. Its submission was confined to the practice of handcuffing prisoners to a hospital bed. The QCS policy overseeing escorts to the PAH secure unit stipulates that "the General Manager of a correctional facility must ensure the appropriate method of escort is undertaken, with due regard to the safety and security of the prisoner and the community".

63. Mr Martyn was on a high security classification from 2 August 2006 until the time of his death. A high risk prisoner requires the use of handcuffs, but restraints may be removed once the prisoner is in a secure holding cell. This would include the PAH secure unit.

[23] Form 29

64. The QCS submission was that Mr Martyn's periods of incarceration reflected an ongoing pattern of bullying, abusive, inappropriate and threatening behaviour directed towards fellow prisoners, carers, QCS and medical staff. His demonstrated and persistent behaviour would have been a consideration when assessing his transfer and the restraints required. There were numerous examples of such conduct recorded in his records. However, if restraints were interfering with Mr Martyn's medical treatment, medical staff could request they be removed.

Conclusions

65. The medical records and statements from SQCC nurses confirmed Mr Martyn's diagnosis while in custody and his significant deterioration in the weeks immediately prior to his death. There was no concern that the death was anything other than non-suspicious.

66. Detective Sergeant Bishop confirmed that there were no concerns in relation to the care and treatment of Mr Martyn. He identified no concerns in relation to SQCC or Queensland Health staff responsible for the care and custody of Mr Martyn. He considered that SQCC and its staff complied with policies and procedures in relation to the death of Mr Martyn.

67. After considering the police investigation and other evidence, I accept that Mr Martyn's death was from natural causes with no suspicious circumstances associated with it.

68. Based on Dr Home's opinion, I am satisfied that Mr Martyn was given appropriate medical care by staff at SQCC and at the PAH while he was admitted there. His death could not reasonably have been prevented.

69. It is a recognised principle that the health care provided to prisoners should not be off 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 Martyn when measured against this benchmark.

70. I do not accept the submission from ATSILS that the measures provided at SQCC to support Mr Martyn's care were inadequate. He was appropriately transferred to the PAH secure unit when the SQCC was unable to manage his health care. Although he expressed a desire to return to WCC it was clear that facility was not well suited to look after his needs. I also note the Board had assessed that his medical needs could be met at SQCC.

71. ATSILS submitted that prisoners who are approaching the end of their life would ideally be treated in a community setting. That aspiration could only apply to prisoners who are subject to an appropriate risk assessment. The wishes of the prisoner must be balanced against community safety.

72. Mr Martyn was in prison for the murder of a young woman. He had been paroled on five occasions and was returned to custody following serious breaches on each occasion. The weight of evidence indicates that Mr Martyn did not accept that if he was to be released into the community, he would have to be accommodated in a facility that would provide him with nursing care. In the absence of his consent to live in a nursing home, QCS staff cannot be said to have failed to facilitate the required ACAT assessments in 2016.

73. With respect to the ATSILS' submission that the Board should also consider if a prisoner was eligible for parole under normal parole eligibility after the prisoner submitted an exceptional circumstances parole application, there does not appear to be anything to prevent the concurrent consideration of applications.

74. The November 2020 findings of the Inquest into the death of Mr Barry Haynes contain a recommendation related to the provision of personal and health care for prisoners who are ageing and/or requiring palliative care.

75. In the circumstances of Mr Martyn's death, I consider that there are no additional comments or recommendations that I can usefully make connected to his death that relate to public health or safety or the administration of justice.

Findings required by s. 45

Identity of the deceased – John Francis Alex Martyn

How he died – Mr Martyn was convicted of murder in 1987. Apart from five periods on parole, Mr Martyn had spent almost 29 years in custody. He was diagnosed with prostate cancer in 2012. In the lead up to his death he declined any treatment that might obstruct his death. An application for exceptional circumstances parole was unsuccessful in 2016. He died from natural causes while accommodated in the prison's Acute Care Unit.

Place of death – Southern Queensland Correctional Centre, Millers Road Spring Creek, Queensland.

Date of death– 25 April 2017

Cause of death – Metastatic prostatic carcinoma

76. I extend my condolences to Mr Martyn's family. I close the inquest.

Terry Ryan
State Coroner
Brisbane
11 December 2020