CORONERS ACT, 2003

SOUTH *AUSTRALIA*

FINDING OF INQUEST

An Inquest taken on behalf of our Sovereign Lady the Queen at Adelaide in the State of South Australia, on the 9th day of February 2006, and the 1st day of May 2006, by the Coroner's Court of the said State, constituted of Elizabeth Ann Sheppard, a Coroner for the said State, into the death of Michael John Hulsinga.

The said Court finds that Michael John Hulsinga aged 27 years, late of 4 Millhouse Street, Millicent died at Yatala Labour Prison, 1 Peter Brown Drive, Northfield, South Australia on the 4th day of October 2004 as a result of left temporal intracerebral haemorrhage due to arteriovenous malformation. The said Court finds that the circumstances of his death were as follows:

1. Introduction and reason for Inquest

1.1. Michael John Hulsinga was an inmate of Yatala Labour Prison at the time of his death. He had been in custody since 30 May 2004 following his arrest concerning an assault of a man in Millicent. He had also been arrested nine days earlier for an alleged assault against his mother. Mr Hulsinga suffered from schizophrenia. There is a suggestion that Mr Hulsinga may have been exhibiting a psychotic episode at the time of the second alleged assault which resulted in his incarceration. (Exhibit C12a) On 31st May 2004, Mr Hulsinga was refused bail in the Mount Gambier Magistrate's Court and was remanded in custody.

1.2. Mr Hulsinga was designated a high security risk inmate during his initial security assessment, documented on 31 May 2004. (Exhibit C12e) Between the time he was taken into custody and the day he died, Mr Hulsinga had been transferred between Yatala Labour Prison and Mount Gambier Prison on several occasions to enable him

to attend the Mount Gambier Magistrates Court concerning outstanding criminal charges. At the time of his death, Mr Hulsinga was housed in 'B' Division of Yatala Labour Prison lower east, in cell 210. Because Mr Hulsinga's death on 4 October 2004 was a "death in custody" within the meaning of the provisions of the Coroner's Act 2003, an Inquest is therefore mandatory pursuant to Section 21(1)(a) of that Act.

2. Events of 4 October 2004

2.1. Correctional Services Officer Ian Burner was on day shift on 4th October 2004, commencing at 7:30 am, completing his shift at 4:30 pm. He was the Unit Manager in charge of the B Division lower east where Mr Hulsinga was housed. He described the day as being fairly quiet and at 3:45 pm he commenced lock down of the prisoners into their cells for the night. It was his practice at that time to do a head count and phone that through to the control room. He said that while doing this count and lock down, the prison servers issued the night meal to the prisoners in the unit. Mr Burner confirmed that on this afternoon he checked prisoner Hulsinga and saw that he was sitting at his table and appeared fine. He described Mr Hulsinga from his knowledge of him as a very quiet prisoner who stayed in his cell most of the time and kept to himself.

2.2. At about 4pm, prisoners Marc Fortunato and Robert Wagner were working as "food servers," delivering meals to each cell in B Division. Mr Fortunato served Mr Hulsinga his main meal, but couldn't remember if he spoke with him. Mr Wagner looked through the trap and passed him the dessert, after Mr Hulsinga confirmed that he wanted it. (Exhibits C12h & c12i)

2.3. At about 8:15 pm on 4 October 2004, registered nurse Sheryl Hartwell and Officer Henry Burzynski were conducting a routine medical round in B Division lower east at Yatala Labour Prison. This process involved a nurse accompanied by a Correctional Services Officer for the purpose of dispensing medication to those inmates due to receive it. (Exhibit C3a)

2.4. Nurse Hartwell was employed as a registered nurse by the South Australia Prison Health Services at the time. When she approached cell 210, she checked the prisoner's identification card on the cell door in accordance with her usual practice to ensure that the medication due to be dispensed was correctly identified. Officer

Burzynski opened the trap of the cell door through which the medication was to be passed to the prisoner. Nurse Hartwell described what she saw as follows:

> 'I looked through the trap and saw the prisoner on the floor. He was lying flat on his back. He did not move, his mouth was open and his head was tilted back. I noticed what appeared to be froth around his mouth, collected on his moustache. There was no chest movement and he appeared to have poor colour.'

The nurse alerted Officer Burzynski to the prisoner on the floor in the cell. (Exhibit C3a)

2.5. Mr Burzynski also saw the prisoner lying on his back between the bed and the toilet basin. He called a 'Code Black' on the radio which is an alert to a medical emergency. Neither the registered nurse nor Mr Burzynski was able to gain immediate access to Mr Hulsinga's cell and needed to wait for a master key to be brought to them by another officer.

2.6. Brian Rogers was the officer in charge of the prison when at 8.21 pm he was alerted to a 'Code Black'. He proceeded with Officer Foreman to cell 210 and watched Mr Foreman unlock the cell. He heard one of the staff member's say words to the effect "It's too late, he's gone."

2.7. When the cell was opened, nurse Hartwell entered and noticed a mottled appearance on Mr Hulsinga's arms. She subsequently recorded her observations as follows:

> 'Whilst doing pm drug round, DCS officer lowered trap to enable CN to give client medications. CN noted, after looking into trap that Prisoner was lying on floor (time approx 2015 hrs). Officer alerted to this fact immediately. Prisoner was lying on his back between toilet and bed. His head was tilted back and he had what appeared (from that distance) to be froth around his mouth. He was extremely pale, eyes closed and mouth open. His chest was still and he did not appear to have any chest movement. DSC Officer called Prisoner's name and no response. Two officers then opened the cell door and entered cell to look at Prisoner. He was not moved in any way. The officers asked CN (Hartwell) to check if Prisoner was deceased. CN attempted to reach for carotid pulse but this was difficult due to position of body. There was no radial pulse detected. The Prisoner's skin was quite cold and there was marked stiffness of body. It was also noted that the Prisoner's right arm was mottled in colour. CN Hartwell informed Officers that Prisoner was deceased. Officers called a Code Black.'
> (Exhibit C12f)

2.8. It must have been apparent to Nurse Hartwell that Mr Hulsinga had been dead for such a period that any attempt to perform cardio-pulmonary resuscitation would be futile. Consequently, no resuscitation efforts were made and no documentation exists

to specifically explain the decision taken not to commence CPR. Whilst it is not being suggested that the decision taken was wrong, the lack of documentation about this important decision is disturbing.

2.9. A subsequent examination of Mr Hulsinga's cell suggested that he probably collapsed without warning, whilst eating the meal provided to him by Mr Fortunato and Mr Wagner.

2.10. Mr Hulsinga's body was taken to the Royal Adelaide Hospital and examined by Dr Truc Huynh who certified life extinct at 11:50 pm on Monday 4 October 2004.

3. Post mortem examination

3.1. A post mortem examination was conducted by Forensic Pathologist, Dr John Gilbert on 5 October 2004. Dr Gilbert concluded that Mr Hulsinga died from natural causes when he suffered a spontaneous brain haemorrhage. Dr Gilbert described the following observations at autopsy:

> '..death was found to be due to an intracerebral haemorrhage in the left temporal lobe. Detailed neuropathological examination identified a vascular malformation (arteriovenous malformation) as the source of the haemorrhage. There were old cortical contusions attributable to previous head injury occurring months to years previously. These were apparently unrelated to the haemorrhage that caused death.'
> (Exhibit C16)

3.2. Dr Gilbert viewed photographs taken of the scene. He said that it was reasonable to conclude that Mr Hulsinga had commenced his evening meal and then vomited some of the meal before collapsing on the floor of the cell. He considered that Mr Hulsinga would have collapsed and succumbed very quickly. A fresh abrasion noted on Mr Hulsinga's right knee, in Dr Gilbert's opinion may have been caused by a simple fall when he collapsed. Dr Gilbert's examination confirmed that the partly eaten meal had not been in Mr Hulsinga's stomach for very long before died. (T23)

3.3. Dr Gilbert explained that arteriovenous malformation (AVM) is relatively rare, but he had come across it as incidental findings in autopsies conducted over a number of years. He said that they sometimes remain asymptomatic in one person and yet in another person may bleed spontaneously for no apparent reason. He said that it is possible that a temporary increase in blood pressure caused through day-to-day activities may initiate a bleed in a person with this particular defect. (T20) He

described the malformation as a type of tumour, in the sense that it presents as a collection of abnormal blood vessels having the potential to bleed spontaneously.

3.4. Dr Gilbert said that in Mr Hulsinga's case, he observed a massive haemorrhage which would have raised intracranial pressure producing a fairly rapid onset of symptoms leading to loss of consciousness. He said that a rapidly bleeding AVM may produce symptoms including headache, nausea and vomiting. According to Dr Gilbert, the bleeding seen in this case was of such a nature, that even if Mr Hulsinga was found in a timely fashion, it was unlikely that a surgeon would elect to intervene surgically. Regardless of the nature of the intervention, Dr Gilbert considered that if Mr Hulsinga did manage to survive the incident and was successfully resuscitated, he was likely to had suffered a very severe disability due to cerebral damage. (T21, T23)

3.5. As to the decision taken not to attempt CPR, Dr Gilbert concluded that if the body was "cold and stiff", as described by Nurse Hartwell, this would imply that rigor mortis was present, in which case, "CPR would have been futile". Dr Gilbert confirmed that the presence of rigor mortis indicates that Mr Hulsinga had been dead for at least a few hours when he was discovered. (Exhibit C16a)

3.6. I accept Dr Gilbert's opinion, and find that the cause of death was as he described.

3.7. Dr Gilbert's opinion was confirmed by a neuropathological examination of Mr Hulsinga's brain conducted by Dr Grace Scott, Pathologist with the IMVS. Dr Scott's examination revealed an arteriovenous malformation adjacent to a left temporal intracerebral haemorrhage, which in her opinion was the likely origin of the haematoma. (Exhibit C5b)

4. <u>Toxicology</u>

4.1. Toxicological analysis of a sample of Mr Hulsinga's blood revealed therapeutic concentrations of Sertraline and Olanzapine, consistent with the medications prescribed and administered to him prior to his death. Alcohol, amphetamines, cannabinoids, opiates, cocaine and metabolites, benzodiazepines and other common drugs were not detected in his blood. (Exhibit C6a)

4.2. In Dr Gilbert's opinion, the medications being prescribed to Mr Hulsinga would not have played any role in his death. (T25) I accept Dr Gilbert's opinion and find it unnecessary to comment further about this.

5. Police Investigation

5.1. An investigation was conducted into Mr Hulsinga's death by Detective Senior Constable Stephen Denton of Holden Hill CIB. He attended at Yatala Labour Prison at 9:05 pm and arranged for Crime Scene Officer Peter McKenzie to examine the scene and take photographs. (Exhibit C13b) There were no detectable signs of violence on the body and there was no apparent explanation for the death. Upon searching a pair of jeans on top of the single bed in the cell, Detective Denton located in the front pocket, a packet of matches which contained four tablets. After discussing the tablets with the nursing staff at the prison hospital, Detective Denton was informed that they were the same tablets that were being given by nursing staff each evening to Mr Hulsinga. Presumably these tablets were provided on a previous evening but were not consumed.

5.2. Whilst it appears Mr Hulsinga may not have been ingesting his medication strictly when it had been administered to him, he must have been taking sufficient to create a therapeutic concentration of his prescribed drugs for treatment of his schizophrenia at the time of death. (Exhibit C6a)

5.3. Officer McKenzie described the scene within cell 210 as follows:

> 'The deceased was lying on his back at the eastern end of the cell, between the bed and the toilet. His head was resting against the east wall with his legs stretched outwards towards the cell door. The only clothing on the deceased was a pair of underpants. Vomit was evident around his mouth and on the floor to the right of his head. There was no vomit splash on the wall immediately to the east of the deceased or on the side of the toilet which was immediately to the north. The lid on the toilet was down and there was no indication that the deceased had vomited into the toilet bowl. These observations appeared to indicate that the deceased was already lying on the floor when he vomited. I checked the body of the deceased for any injuries and located a small abrasion on his right knee which appeared to be recent. No other injuries were located.
>
> An examination of the table in the cell indicated the deceased may have been eating his dinner when the incident occurred. A dinner plate on the table had a partially eaten meal of mashed potatoes and corned beef still on the plate with a plastic knife and fork resting on either side of the plate. There was still mash potato on the end of the fork. The dessert and a cup of water were also on the table along with bread and tobacco. … A

> brown plastic chair was pushed under the table in its correct position and I was advised that this was the location of the chair when the deceased was first discovered.'
> (Exhibit C13a)

I have since been informed that the cell intercom was in working order.

5.4. Correctional Services Officer Henry Burzynski told Denton that he commenced his shift at 4:30 pm on this day. His duties required him to conduct two hourly patrols to sight prisoners and check on their welfare. He explained that the process "involves looking through a peep hole only to confirm nobody has hung themselves or slashed themselves." Mr Burzynski went on to say the following:

> 'My patrol commenced at about 1750 hours. I believe I sighted prisoner Michael Hulsinga lying on his bed without covers on. I can't be 100% sure I sighted him though, because I do check on 140 prisoners on each patrol at the moment. What I do is a slow walk by each peep hole and it's difficult to notice any problems unless they are very obvious. After this round of patrol the nurse came through at 1910 hours and dispensed the prisoners medication. Myself and the nurse arrived at the prisoner's cell for dispensing the medication at 2020 hours. I opened the trap for dispensing the medication and noticed with the nurse that the prisoner was lying on the floor.'
> (Exhibit C4a)

5.5. During the course of the investigation into Mr Hulsinga's death, Mr Burzynski acknowledged that he did not conduct the check which he claimed previously to have conducted and recorded in the prison Log Book as occurring at 6pm. On Monday 20 December 2004, Mr Burzynski participated in an interview with Detective Denton during which he acknowledged that what he had stated about performing his patrol at 5:50 pm was incorrect. He admitted to falsely recording in the Correctional Services Log Book that he commenced his patrol of 1750 hours at 1800 hours and also falsely recorded that all prisoners had been sighted. (Exhibits C4c, C12g) When Detective Denton asked why Mr Burzynski lied about checking on Mr Hulsinga, Mr Burzynski stated:

> 'I'm not really sure, it could be panic, could be…
> It could be I was totally confused at the time...
> …the bottom line is I stuffed up.'

5.6. I find that the revised position as explained by Mr Burzynski in his interview in December 2004 represents what occurred. Mr Burzynski was subsequently disciplined in relation to his misconduct. (Exhibit C4c)

5.7. It is disturbing that a period of approximately four hours passed between the time Mr Hulsinga was last seen alive and the time when his body was discovered at approximately 8:15 pm. Whilst I am satisfied that a more timely check of Mr Hulsinga is unlikely to have altered the fatal outcome in this case, the absence of regular checks in accordance with the Local Operating Procedures, reflects poorly upon Officer Burzynski in particular and upon Correctional Services Officers generally. It does tend to undermine public confidence in the determination of Correctional Services Officers entrusted with general welfare of prisoners in their care, to comply with procedures that have been developed for sound reasons.

5.8. It is at least to Officer Burzynski's credit that he has frankly recognised the seriousness of his error and came forward to admit his misconduct.

6. General behaviour whilst incarcerated at Yatala Labour Prison

6.1. Detective Denton interviewed a number of prisoners at Yatala Labour Prison in relation to Mr Hulsinga's behaviour in the period leading to his death on 4 October 2004. Whilst some prisoners made observations about Mr Hulsinga being agitated and distressed about being in prison (Exhibit C12n), others described Mr Hulsinga as a quiet person who kept pretty much to himself and didn't associate with other prisoners. He was rarely seen out of his cell. (Exhibits C12j, C12k, C12l and C12m)

7. Background

7.1. During the course of Detective Denton's investigation, he obtained background information from Mr Hulsinga's mother, Lynette Hulsinga. He summarised the information as follows:

> 'Michael Hulsinga was a single man. He did not have children of his own and before his arrest was unemployed, living with his mother in Millicent. He was a heavy user of cannabis and alcohol and when he was drunk, he became violent. His mother believed that he suffered with schizophrenia, but was unwilling to seek medical treatment. After the death of a friend, he was admitted to Glenside when he threatened suicide.'
> (Exhibit C12a)

8. Offender history

8.1. Mr Hulsinga had an extensive criminal history including offences of building break and felony, larceny, unlawful possession, unlawfully on premises offences, possessing equipment to administer cannabis and possessing a controlled substance, and driving under disqualification. These convictions were dealt with in the Children's Court. His offending continued as an adult and included assaults and property offences. (Exhibit C12b)

9. Psychiatric status

9.1. Mr Hulsinga's offender health care service notes were received into evidence. Amongst the material is a summary prepared by consultant psychiatrist Dr Craig Raeside, which touches on Mr Hulsinga's psychiatric status in June 2004, approximately 16 months before his death. Dr Raeside recorded Mr Hulsinga's presentation as follows:

- 'Depressed "all my life" but bit better since incarcerated.
- Sleeping poorly with intermittent waking. Appetite improved since back on Olanzapine. Recent loss of 3 stone from 14 stone down to 11 stone last few years.
- No suicidal thoughts. No anxiety or panic attacks
- Still problems with temper outbursts, but not angry at present.
- Main problem that feels he has nothing in life but himself.
- No voices, still ideas of speaking through nose, but not so sure.'

9.2. Dr Raeside summarised his assessment by noting that the presentation suggested schizophrenia together with a major depressive disorder. He also noted that he had recently been non compliant, which I understand to mean was not taking prescribed medication. Dr Raeside noted that the situation had deteriorated due to recent alcohol abuse. He prescribed Olanzapine and Zoloft and advised that he be reviewed in one week. (Exhibit C12f). There is no need to elaborate upon the subsequent management of his psychiatric condition in the absence of any causal link with Mr Hulsinga's death. I find that there is no evidence to suggest that Mr Hulsinga's psychiatric status had any role to play in his untimely death.

10. Recommendations

10.1. The final issue to consider is whether the circumstances surrounding Mr Hulsinga's death, justify making recommendations pursuant to Section 25 (2) of the Coroner's Act 2003 which might prevent, or reduce the likelihood of, a recurrence of an event similar to the event that was the subject of the inquest.

10.2. A question arose during counsel submissions, as to whether a recommendation should be made concerning a requirement for prison officers to check that prisoners have swallowed medications issued to them. In Mr Hulsinga's case, for instance, he may have been hoarding his medication and was in danger of a possible overdose. Alternatively he might have been tempted to trade drugs amongst other prisoners. Mr Keane, acting for the Department for Correctional Services (DCS), submitted that if I made a recommendation along those lines, it would have significant staffing and resource implications for the Department. I accept Mr Keane's submission about this. In the absence of a relevant causal connection between this issue and Mr Hulsinga's death, I decline to make any recommendation on this topic.

10.3. A letter, dated 23 January 2006, was received into evidence from Chief Executive Officer, Peter Severin of the DCS in which he outlined the steps taken following Mr Hulsinga's death, to remind officers of the requirement to conduct 2 hourly checks of prisoners in accordance with Local Operating Procedure. I am satisfied that that the existing procedure does not require further clarification and I therefore decline to make any recommendation that changes me made. (Exhibit C15)

Key Words: Death in custody;

In witness whereof the said Coroner has hereunto set and subscribed his hand and

Seal the 1st day of May, 2006.

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Coroner