CORONERS COURT OF QUEENSLAND

FINDINGS OF INQUEST

CITATION:	**Inquest into the death of James Lewis Cummins**
TITLE OF COURT:	Coroners Court
JURISDICTION:	TOWNSVILLE
FILE NO(s):	2021/4042
DELIVERED ON:	24 October 2023
DELIVERED AT:	BRISBANE
HEARING DATE(s):	24 October 2023
FINDINGS OF:	Terry Ryan, State Coroner
CATCHWORDS:	Coroners: inquest, death in custody, natural causes

REPRESENTATION:

Counsel Assisting:	Ms D Palmer
Queensland Corrective Services:	Mrs C Scott-Hunter

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Introduction

1. James Cummins was aged 48 when he passed away at the Townsville Correctional Centre (TCC) on 2 September 2021. Mr Cummins was serving a term of imprisonment for property offences. He died of natural causes as a result of a subarachnoid haemorrhage.

The investigation

2. The investigation into Mr Cummins' death was led by Detective Senior Constable Sampson of the Queensland Police Service (QPS) Corrective Services Investigation Unit.

3. After being notified of Mr Cummins' death, Police attended the scene and observed Mr Cummins lying on his back in prison issue clothing which had been cut by QAS paramedics in treating him. Scenes of Crime Officers searched the scene and Mr Cummins' cell but did not locate anything suspicious.

4. A coronial investigation report was prepared and provided to the Coroners Court in November 2022 by DSC Sampson. She concluded there were no suspicious circumstances surrounding Mr Cummins' death, and that he was provided with appropriate care and treatment while incarcerated. I am satisfied that the investigation was suitably comprehensive, having regard to the circumstances of the death.

The inquest

5. At the time of his death, Mr Cummins was a prisoner in custody pursuant to the *Corrective Services Act 2006* (Qld). His death was a 'death in custody' and an inquest was required by the *Coroners Act 2003* (Qld) (the Act).

6. The inquest was held at Brisbane on 24 October 2023. All statements, medical records, photographs and materials gathered during the investigation were admitted into evidence. No witnesses were called to give oral evidence. Counsel Assisting made submissions in respect of the facts and the sufficiency of the evidence.

7. The issues considered at the inquest were the findings required by s45(2) of the Act, and whether Mr Cummins had access to, and received appropriate medical care, while he was in custody.

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

9. The role of the coroner is to independently investigate reportable deaths to establish, if possible, the identity of the deceased, the medical cause of death, and the circumstances surrounding the death – how the person died. Those circumstances are limited to events which are sufficiently connected to the death. The purpose of a coronial investigation is to establish the facts, not to cast blame or determine criminal or civil liability.

The evidence

Social and medical history

10. Mr Cummins was born on 30 April 1973 in Sydney, New South Wales. He was one of ten children, with eight sisters and one brother, born to Czeslaw Bak and Suzanne Cummins. He had one son and was a very much-loved member of his family.

11. At the time of his death Mr Cummins identified as a First Nations man. However, his mother has maintained that Mr Cummins is Caucasian. Records held by the QPS indicate that Mr Cummins identified as Caucasian until 8 September 2013. His sister said he was mentored by a First Nations artist while in custody and developed a connection to First Nations culture.

12. Mr Cummins' criminal history dates back to 1999, when he was 26 years of age, with convictions relating to behaving in a disorderly manner, obstructing police and breaching bail undertakings.

13. By the end of 2002 he had been sentenced to a term of imprisonment following convictions in relation to offences including enter premises and commit indictable offence, stealing, dangerous operation of a motor vehicle as well as robbery and attempted robbery with actual violence. He was sentenced to six years imprisonment. An application for leave to appeal against sentence was refused in 2004.

14. Over the following nearly two decades Mr Cummins continued to commit further property and dishonesty related offences sporadically. He was sentenced to further terms of imprisonment.

15. On 16 August 2019, Mr Cummins was hospitalised. He was transferred from the Ayr Hospital to the Townsville Hospital with a diagnosis of septic shock. Mr Cummins had symptoms including headaches with no photophobia and chronic neck and back pain.

16. While admitted to hospital Mr Cummins had a CT head scan which did not find any pathology to explain the headaches. Mr Cummins was discharged on 18 August 2019 with a 7-day course of antibiotics.

17. On 19 December 2019, Mr Cummins had a lumbar spine MRI performed. The MRI showed:

    Moderate to severe L4/5 and L5/S1 level spondylosis, with L4/5 moderate to severe canal stenosis. There is possible compression of the left sided cauda equina structures, including the left descending L5 and S1 nerve roots. No other site of suspected neural compression.[1]

18. Mr Cummins was prescribed Lyrica (Pregabalin) for his back pain caused by the spondylosis (wear and tear of discs) and possible nerve compression.

19. On 13 September 2020, Mr Cummins was arrested and remanded at the Ayr Watch House in relation to property offences. Mr Cummins was transferred to the TCC on 17 September 2020. He was originally housed in the mainstream part of TCC.

20. However, an application for protection was granted on 19 October 2020 after it was found that was being stood over by other prisoners for his Lyrica. Mr Cummins' prison medical records indicate that he frequently complained of chronic lower back pain which radiated down his legs.

21. Mr Cummins was sentenced for the property offences on 23 February 2021 to 3 years and 6 months in custody. His parole eligibility date was set at 13 November 2021, and his fulltime release date was 12 March 2024.

22. On 2 December 2020, Mr Cummins was reviewed by a doctor at the Townsville University Hospital outpatient clinic. At this appointment it was recommended that his prescription for Lyrica increase to 150 mg twice daily, and then to 300mg twice daily after one week.

23. On 26 February 2021, Dr Anson Chan reviewed Mr Cummins in the Neurosurgery clinic. Dr Chan noted that Mr Cummins' lumbar spine MRI on 15 December 2019[2] "*demonstrated L4/5 lumbar canal stenosis and L4/5, L5/S1 disc bulges*".[3]

24. Mr Cummins reported to Dr Chan that he had "*nerve pain in his back* and *down his left leg, radiating to the plantar aspect of his foot.*"[4] He confirmed his pain was managed with a prescription of "*pregabalin 300 mg twice daily and tramadol sustained-release 200 mg twice daily*."[5]

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[1] Exhibit D2 – Cummins J C18327 PHS COR-F25 220417, page 68.
[2] Exhibit D2 – Cummins J C18327 PHS COR-F25 220417, page 68 - 69.
[3] Exhibit B1 – Statement of Dr Anson Chan, page 1.
[4] Exhibit B1 – Statement of Dr Anson Chan, page 1.
[5] Exhibit B1 – Statement of Dr Anson Chan, pages 1 – 2.

25. Dr Chan issued further prescriptions for Pregabalin and Tramadol to manage Mr Cummins' symptoms and another telehealth neurosurgery appointment was made for 13 October 2021. Mr Cummins was advised to seek urgent medical attention if he experienced issues using his legs, bladder or bowels.

26. Dr Chan noted in his post-appointment correspondence that an up-to-date MRI could be arranged if required for Mr Cummins at the next review, after six months. Mr Cummins passed away prior to his next scheduled appointment.

27. Following the appointment Dr Chan wrote to the Prison Health Services (PHS) advising of Mr Cummins' diagnosis, treatment plan and next appointment. Dr Chan noted that while Mr Cummins was experiencing ongoing back and leg pain, he was "*able to walk around the prison yard without problems*."[6]

<u>*Day of death*</u>

28. On the morning of 2 September 2021, inmate Kayle Finn took part in a resilience course with Mr Cummins at which time he "*was completely normal and fine*."[7]

29. At approximately 2:30pm on the afternoon of 2 September 2021, Mr Cummins and other residents of Harold Gregg 3 (HG3) Unit at the TCC were let out of their cells and spent some time in the exercise yard.

30. Following muster, which was called a short time later and attended by Mr Cummins, a number of prisoners continued to exercise in the yard where fellow inmate Shaun Baker saw Mr Cummins walking and doing dips. He observed that "*he looked fine*."[8]

31. CCTV footage of the exercise yard shows Mr Cummins walking around the yard and exercising before he eventually walked towards the back wall at approximately 3:14pm. The angle of the footage does not clearly show Mr Cummins beyond this point. While in the exercise yard Mr Cummins is not observed to interact with any other prisoners.

32. Mr Baker heard a "*groaning sound*" coming from Mr Cummins who he saw was slumped against the wall in a sitting position.[9]

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[6] Exhibit B1 – Statement of Dr Anson Chan, page 4.
[7] Exhibit B6 – Statement of Kayle Finn at [17].
[8] Exhibit B2 – Statement of Shaun Baker at [9].
[9] Exhibit B2 – Statement of Shaun Baker at [10].

33. Mr Finn also saw Mr Cummins against the brick wall and heard "*snoring noises*."[10] He and another inmate moved Mr Cummins onto a yoga mat. As he did so he heard Mr Cummins make noises as though he was gasping for air. Mr Finn also saw yellow bile dripping from Mr Cummins' nose, and observed that he was otherwise unresponsive.

34. Mr Baker ran inside the unit and alerted Custodial Correctional Officer (CCO) James Edwards by yelling, "*Boss, Boss he's collapsed and foaming at the mouth*."[11]

35. Mr Cummins' cellmate, Shannon Damms, also ran out towards the exercise yard where he saw Mr Cummins lying on the ground "*up towards the back left corner of the exercise yard*."[12] He saw that "*his head was facing towards the right wall and his legs were towards the back fence*."[13] He heard Mr Cummins making a groaning sound and tried to comfort him.

36. CCO Edwards entered the exercise yard and observed Mr Cummins in the recovery position in the far back left side with Mr Damms and two other prisoners. CCO Edwards immediately called a code blue medical emergency over the radio and directed prisoners in the exercise yard to come inside.

37. In accordance with prison protocol, CCO Edwards waited for another officer to arrive before approaching Mr Cummins. Mr Damms waited with Mr Cummins and comforted him during this period. CCO Justin Corbett arrived and they responded to Mr Cummins.

38. Upon reaching Mr Cummins, CCO Edwards knelt down and saw "*orange kind of frothy discharge*" coming from his mouth and that his breathing was laboured "*like he was taking in big quick gargling, gasps of air*."[14] Mr Cummins was unresponsive to CCO Edwards and CCO Corbett also gave a verbal direction to prisoners to leave the exercise yard.

39. CCO Edwards commenced chest compressions as the nursing staff and CCO Tegan Menegazzo, Correctional Emergency Response Team Leader, arrived and took control of the scene.

40. QAS paramedics arrived at 1536hrs and continued CPR, but Mr Cummins could not be revived. He was declared life extinct at approximately 1600hrs.[15]

41. The QPS was notified of Mr Cummins' death at approximately 1605hrs.

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[10] Exhibit B6 – Statement of Kayle Finn at [6] – [7].
[11] Exhibit B2 – Statement of Shaun Baker at [13]; Exhibit B5 – Statement of James Edwards at [4].
[12] Exhibit B4 – Statement of Shannon Damms at [11] – [12].
[13] Exhibit B4 – Statement of Shannon Damms at [13].
[14] Exhibit B5 – Statement of James Edwards at [14] – [15].
[15] Exhibit B5 – Statement of James Edwards at [33]; Exhibit B3 – Statement of Justin Corbett at [19] – [21]; Exhibit C5 – CCO scribe, page 3; Exhibit C3 – Incident Report, page 2.

Autopsy results

42. On 8 September 2021, Forensic Pathologist, Dr Paull Botterill, conducted an autopsy consisting of an external and full internal examination of Mr Cummins' body and noted that:

    In plain terms, post mortem examination showed bleeding over the surface of the brain associated with a ruptured blood vessel over the bottom of the left side of the brain, an excess of fluid in the lungs, some lung scarring, some hardening and narrowing of the arteries of the heart, and changes in keeping with the vigorous attempts at resuscitation. No significant injuries were identified.[16]

43. Dr Botterill's opinion was that:

    …the cause of death was most probably subarachnoid haemorrhage complicating a left middle cerebral artery aneurysm but the possible contribution of concurrent drug intoxication and/or the effects of undiagnosed coronary artery disease were difficult to exclude at the time of autopsy examination.[17]

44. A microscopic examination also showed "*lung congestion and early scarring, patchy heart muscle, kidney and testis scarring, as well as bleeding over brain surfaces*."[18]

45. Dr Botterill also noted that:

    The cause of death was subarachnoid haemorrhage, most probably associated with a naturally occurring weakness/balloon-like thinning of one of the brain blood vessels. Although bleeding from such a vessel abnormality is more likely in the presence of elevated blood pressure, there were no features to any significant trauma, and certainly no features indicative of facial or neck trauma.[19]

46. Dr Botterill noted that the neurosurgical review in February 2021 did not identify of any symptoms that might suggest any intracranial lesion.

47. The toxicology results showed the following medications were present in Mr Cummins's system:

    a. Amitriptyline (anti-depressant) (prescribed)
    b. Nortriptyline (metabolite of Amitriptyline)
    c. Buprenorphine (opioid)
    d. Norbuprenorphine (metabolite of Buprenorphine)
    e. Paracetamol (prescribed)
    f. Tramadol (pain management) (prescribed)

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[16] Exhibit A7 – Form 8 autopsy report, page 8.
[17] Exhibit A7 – Form 8 autopsy report, page 8.
[18] Exhibit A7 – Form 8 autopsy report, page 8.
[19] Exhibit A7 – Form 8 autopsy report, page 8.

g. 0-desmethyltramadol (metabolite of Tramadol)
h. Pregabalin (pain management) (prescribed)

48. None of these substances were at toxic or potentially lethal concentrations.

49. As at 2 September 2021, Mr Cummins had been prescribed the following medications:

a. Tramadol 100mg bd
b. Amitriptyline 75mg bd
c. Paracetamol SR 1.33gm bd
d. Paracetamol 500mg nocte
e. Pregabalin 300mg bd

50. On 18 May 2023, Dr Milns provided a statement in which he confirmed that Mr Cummins had not been prescribed the Buprenorphine noted in the toxicology report. It is assumed that he obtained this illicitly in prison.

51. It was also found that Mr Cummins had a blood alcohol level of 36mg/100ml. Dr Milns also noted in his statement that Mr Cummins was not prescribed Ethanol, but that it could be found in the prison. The toxicology analyst noted that "*due to decomposition processes, some or all of the alcohol may have been produced after death*."[20] It is also noted that alcohol was located in the femoral blood and not in the vitreous humour or urine sample. It is likely, in these circumstances, that the alcohol was produced in the decomposition process.

Conclusions

52. After considering the material gathered in the coronial investigation, I am satisfied that Mr Cummins died from natural causes. I find that none of the inmates, correctional or health care staff at the Townsville University Hospital or the Townsville Correctional Centre caused or contributed to his death. There were no suspicious circumstances.

53. It is an accepted principle that the health care provided to prisoners should not be of a lesser standard than that provided to other members of the community. Mr Cummins had been regularly reviewed by health practitioners during his period of incarceration, including specialists at the Department of Neurosurgery, Townsville University Hospital.

54. Mr Cummins was scheduled for a further neurological review in October 2021 but died before it could take place. Importantly, he had not complained of symptoms in the lead up to his death such as acute headache or neck pain that might have flagged the need for a more urgent neurological review.

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[20] Exhibit A8 – Toxicology Certificate of Analysis report, page 1.

55. As Dr Botterill noted, "*it is difficult to know whether a subsequent neurological review would have led to the identification of the underlying brain blood vessel abnormality, and if so whether this would have resulted in treatment or a change in management that may have reduced the possibility of death from such an abnormality*".

56. The primary issue for consideration was whether Mr Cummins had access to, and received, appropriate medical treatment while he was incarcerated. From the medical records and the statements provided, I am satisfied that Mr Cummins received appropriate health care.

Findings required by s. 45

57. I am required to find, as far as possible, the medical cause of death, who the deceased person was and when, where and how he came to his death. After considering all of the evidence, including the material contained in the exhibits, I am able to make the following findings:

Identity of the deceased – James Lewis Cummins

How he died – Mr Cummins was serving a term of imprisonment for property related offences. He had a history of chronic pain related to spinal stenosis. He was prescribed medication to manage the pain. He also accessed illicit drugs in prison. On the afternoon of his death Mr Cummins was in the prison exercise yard when he collapsed and became unconscious. He could not be revived.

Place of death – Townsville Correctional Centre 22 Dwyer Street STUART QLD 4811 AUSTRALIA

Date of death– 2 September 2021

Cause of death – Subarachnoid Haemorrhage

Comments and recommendations

58. Section 46 of the *Coroners Act 2003* enables a coroner to comment of 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.

59. In the circumstances, I accept that there are no comments or recommendations to be made that would assist in preventing similar deaths in future, or that otherwise relate to public health or safety or the administration of justice.

60. I extend my condolences to Mr Cummins' family and friends.

61. I close the inquest.

Terry Ryan
State Coroner
BRISBANE