CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of William MacDonald
Hearing dates:	9 June 2016
Date of findings:	9 June 2016
Place of findings:	State Coroner's Court, Glebe
Findings of:	**Deputy State Coroner Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody Aged Care in custody Natural Causes Resuscitation Plans in End of Life Decisions
Non-publication order:	Non-publication of Attachment 11, Exhibit 1 s.74(1)(b) Coroners Act 2009
File number:	2015/141687
Representation:	**Sgt Durand Welsh, Coronial Advocate** **Steven Griffiths, Commissioner for Corrective Services** **Michael Sterry, Justice Health and Forensic mental Health Network**

Findings:	**Identity of deceased**: The deceased person was William MacDonald **Date of death**: Mr MacDonald died on 12 May 2015 **Place of death**: He died at Prince of Wales Hospital, Randwick, NSW **Manner of death:** Natural causes **Cause of death:** The medical cause of the death was complications arising from a gastrointestinal obstruction. An incarcerated inguinal hernia was an antecedent cause

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of William MacDonald.

Introduction:

Mr William MacDonald was born on 17 June 1924 in the United Kingdom. At the time of his death he was serving a custodial sentence at the Long Bay Correctional Centre. At 90 years of age, he was the oldest inmate in NSW.

As Mr MacDonald was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The Inquest:

The role of a Coroner, as set out in s 81 of the Coroners Act, is to make findings as to:

(a) the identity of the deceased;
(b) the date and place of the person's death;
(c) the physical or medical cause of death; and
(d) the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

The Evidence:

Background:

Mr Macdonald was born in Liverpool, England. He had discipline issues at school and in his mid to late teens was being treated by a psychiatrist who certified him as an erratic schizophrenic.

He was conscripted into the British Army at the age of 18 and it appears he served during World War 2. At the termination of the war, he received an honourable discharge with exemplary conduct.

In 1948, Mr MacDonald immigrated to Canada but soon found himself in dire circumstances and his family had to forward money so as he could return to England.

Upon returning to England, he started to display erratic behaviour. He was admitted as a voluntary patient to the Crichton Mental Home in Scotland, however, his mother arranged for him to be returned home from Crichton shortly after admission.

Mr MacDonald migrated to Australia and arrived in Brisbane in 1954. He worked numerous jobs before finding himself in Adelaide. On 18 April 1955 he was charged with 'indecent assault on a male person' and 2 counts of gross indecency. He received a two-year good behaviour bond with orders he submit himself to treatment. He did not comply with these orders and left Adelaide immediately.

After leaving Adelaide, Mr MacDonald spent time in Ballarat, and Perth. He changed his name to Alan Edward Brennan before travelling onto Hobart and later to New Zealand in 1959.

He returned to Australia and in 1961 and gained employment with the Postmaster-General's Department in Sydney. Mr MacDonald's behaviour was noticed to be odd and he was examined by a doctor who reported, *"There is little doubt that Mr Brennan (as he was then known) is an unusual personality, best described as schizoid."*

Not much is known of Mr Macdonald's family. As at 1963, his father was deceased, however records mention that his mother and a brother were alive at that time. Their names are not revealed in the brief.

To date, Police have been unable to locate any next of kin or known relatives of Mr MacDonald. Mr MacDonald has never disclosed a next of kin or emergency contact to Police or Corrective Services. He continually stated to authorities he had no living relatives. Enquiries with the United Kingdom Consulate have proved fruitless.

Custodial History:

On 24 September 1963 Mr MacDonald was sentenced at the NSW Supreme Court in relation to four charges of murder. The matter was sensational at the time, and Mr MacDonald gained notoriety as *'the Sydney mutilator'*, due to his modus operandi of removing the genitals of his male victims.

Mr MacDonald received a sentence of penal servitude for life. He was initially held at Long Bay Gaol, before being committed to Callan Park Mental Hospital by the then Minister for Health. He was certified medically and legally insane.

In 1964, Mr MacDonald was transferred to Morisset Hospital where he was diagnosed and treated for depression and schizophrenia.

In 1976 Mr Macdonald was admitted into the prison system proper, his schizophrenic and depressive illnesses considered to be in remission.

On 30 December 2004, Mr MacDonald was admitted to the Old Long Bay Hospital due to increasing age and associated health problems.

On 8 August 2007, Mr MacDonald was transferred to a section of the Metropolitan Special Programs Centre set aside for older inmates.

On 2 July 2008, Mr Macdonald was transferred to the new Long Bay Hospital's Medical Sub Acute Unit and then later transferred to the Aged Care Rehabilitation Unit (ACRU) on 5 January 2009.

Medical history:

Soon after entering custody, Mr Macdonald was certified as 'Mentally Ill' under section 27 of the Mental Health Act 1958 as it was then. He was transferred to an appropriate secure facility where he received treatment for his illnesses. It was only when his illnesses were considered to be in remission that he was admitted into the general prison system.

On 30 December 2004, Mr Macdonald was admitted to the Old Long Bay Hospital due to increasing age and associated health problems.

On 8 August 2007, Mr MacDonald was transferred to a section of the Metropolitan Special Programs Centre set aside for older inmates. He was 85 years old and suffering from clots in his legs, cellulitis, peptic ulcer, hernias, decreased mobility, declining memory and dementia.

On 2 July 2008, Mr Macdonald was transferred to the new Long Bay Hospital's Medical Sub Acute Unit. He was later transferred to the Aged Care Rehabilitation Unit (ACRU) on 5 January 2009.

Whilst in the ACRU, the medical records reveal Mr Macdonald was regularly assessed by the nursing staff and the Clinical Director of Aged Care. Mr MacDonald suffered leg pain, hernias and occasional episodes of diarrhoea, however he was self-caring, and relatively mobile around his ward. All of his conditions were consistent with advancing age.

The Fatal Incident:

On the evening of 11 May 2015, Mr MacDonald complained of severe abdominal pain. He had nausea and was vomiting. He was transferred from Long Bay to the Prince of Wales Hospital that evening, where he was diagnosed with a gastrointestinal obstruction due to an incarcerated section of bowel in an inguinal hernia.

A surgical consultation occurred that night between specialists at the Hospital. It was considered Mr Macdonald's condition was not survivable and he was deemed not for operative management.

Mr MacDonald's resuscitation plan was marked 'No CPR' because CPR was only likely to result in negligible clinical benefit. A palliative care plan was initiated. Mr Macdonald's condition did not improve and he died the next morning. He was pronounced dead on 12 May 2015 at 0814am.

End of Life Care:

Mr Macdonald had previously discussed "end of life care' with his regular doctor, Dr Sim. He indicated end of life care to include full resuscitation and intubation. This conversation occurred in 2014.

NSW Health has guidelines and policies regarding resuscitation. The NSW Health Guideline 'End of Life Care and Decision-Making Guidelines' provides that:

A primary goal of medical care is preservation of life, however when life cannot be preserved, the task is to provide comfort and dignity to the dying person, and to support others in doing so.

It goes on:

Appropriate end-of-life care should intend to provide the best possible treatment for an individual at that time. It recognises that if the goals of care shift to primarily accommodate comfort and dignity, then withholding or withdrawal of life-sustaining medical interventions may be permissible in the best interests of the dying patient.

The applicable NSW Health Policy Directive is PD 2014_030 "*Using Resuscitation Plans in End of Life Decisions."* This Directive provides that one of the rationales for withholding resuscitation is:

2.2.3 Where the Attending Medical Officer judges that resuscitation offers no benefit or where the benefits are small and overwhelmed by the burden to the patient.
• Given that judgments about the benefits or otherwise of a therapy ultimately reflect the values, beliefs and hopes/goals of the patient, any decision to withhold resuscitation on clinical grounds alone must be carefully considered, properly justified and documented

• Focussing on patient comfort also entails withholding life-sustaining measures sometimes considered to be of negligible benefit (for example, where the ability to restore spontaneous rhythm or circulation with CPR is highly unlikely)

• A medical practitioner does not need to obtain agreement from the patient or family to withhold interventions considered to be of negligible benefit, but it is still good clinical practice to discuss why these are not being offered in the context of broader end of life goals of care conversation. This includes scenarios that may present at an Emergency Department. If consent is not sought, the reasons why should be documented in the patient record. It is also the case that engaging patients in such discussion does not obligate the treating team to provide treatments that they believe are considered to be of negligible benefit.

Mr MacDonald's Resuscitation Plan was made in consultation with Drs Sim, Muhlmann, Kaplin and authorised by the Attending Medical Officer, Dr Ann-Marie Cheshire. The medical records indicate that "*The patient's condition is such that CPR is likely to result in negligible clinical benefit."*

The decision to withhold CPR from Mr MacDonald was appropriate in the circumstances and complied with the NSW Health Guidelines and applicable Policy Directive.

Care and Treatment:

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes, an inquest is required to independently assess whether the State has discharged its responsibility.

The Corrective Services records indicate that Mr MacDonald's care and treatment was appropriate.

Mr MacDonald's death is not suspicious and he died of natural causes.

Autopsy Report

On 13 May 2015, Dr Kendall Bailey conducted an autopsy upon Mr MacDonald. Dr Bailey issued a report recording Mr MacDonald's cause of death as complications of gastrointestinal obstruction. An incarcerated inguinal hernia was listed as an antecedent cause.

Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it:

The identity of the deceased

The deceased person was William MacDonald.

Date of death

Mr MacDonald died on 12 May 2015.

Place of death

Mr MacDonald died at Prince of Wales Hospital, Randwick, New South Wales.

Cause of death

The cause of death was complications arising from a gastrointestinal obstruction. An incarcerated inguinal hernia was an antecedent cause.

Manner of death

Mr MacDonald died of natural causes whilst serving a custodial sentence.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date 9 June 2016