



**CORONER'S COURT  
OF NEW SOUTH WALES**

**Inquest:** Inquest into the death of Michael Murphy

**Hearing dates:** 30 November 2020

**Date of findings:** 30 November 2020

**Place of findings:** Coroner's Court of NSW, Lidcombe

**Findings of:** State Coroner, Teresa O'Sullivan

**Catchwords:** CORONIAL LAW – death in custody, mandatory inquest, manner of death

**File number:** 2019/59022

**Representation:** Mr T O'Donnell, Coronial Advocate Assisting the Coroner  
Mr R Schmidt, Solicitor, Department of Corrective Services NSW  
Mr H Norris, Legal Advisor, Justice Health & Forensic Mental Health Network

**Findings:** The findings I make under section 81(1) of the Act are:

***Identity***

The person who died was Michael Murphy

***Date of death***

Michael Murphy died on the 21<sup>st</sup> of February 2019

***Place of death***

Michael Murphy died at Long Bay Correctional Centre, 1300 Anzac Parade, Malabar NSW

***Cause of death***

The cause of Michael Murphy's death was 'complications of chronic viral liver disease'.

***Manner of death***

Michael Murphy died of natural causes whilst in custody

**Non-publication orders:**

1. That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):
  - a. Names, addresses, phone numbers and other personal information that might identify:
    - i. Any member of Michael Patrick Murphy's family or his friends;
    - ii. Any person who visited or otherwise contacted Michael Patrick Murphy whilst in custody (other than legal representatives or other persons acting in a professional capacity); and
    - iii. Any victim of an offence committed by Michael Patrick Murphy who is not publicly known.
  - b. Names, personal information, locations and Master Index Numbers (MINs) of any persons in the custody of Corrective Services NSW (CSNSW) other than Michael Patrick Murphy.
  - c. Direct contact details of CSNSW staff that are not publicly available.
  - d. Information concerning criminal proceedings against Michael Patrick Murphy conducted in the Children's Court of NSW.
  - e. Photographs and hand-held video camera footage of the Medical Subacute Unit of Long Bay Hospital and of the deceased Michael Patrick Murphy.
  - f. Portions of the following sections of the CSNSW Custodial Operations Policy and Procedures which have not been made publicly available:
    - i. Section 13.3 – Deaths in Custody; and
    - ii. Section 13.8 – Crime Scene Preservation.
  - g. Portions of the Inmate Accommodation Journals that describe security checks performed by CSNSW staff.
  - h. Portions of section 24 transfer orders and accompanying documents that describe security practices performed by CSNSW staff when escorting inmates.
  - i. Information concerning the CCTV coverage within the Medical Subacute Unit of Long Bay Hospital.
2. Pursuant to section 65(4) of the *Coroners Act 2009* (NSW), a notation be placed on the Court file that if an application is made under section 65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

## Table of Contents

1. Introduction .....	1
2. The role of the Coroner and the purpose of the inquest.....	1
3. Evidence at Inquest .....	1
4. Background .....	1
5. Medical History .....	2
6. Criminal History.....	2
7. Medical Treatment in Custody.....	2
8. Events leading up to the death .....	3
9. Investigation following death.....	4
10. Findings pursuant to section 81 of the <i>Coroners Act 2009</i> .....	4

## Introduction

1. This is an inquest into the death of Michael Murphy, who passed away on the 21<sup>st</sup> of February 2019 at Long Bay Correctional Centre.
2. Mr Murphy was born in 1952. At the time of his death he was serving a custodial sentence and had been transferred to Long Bay Hospital due to deteriorating health. He had a lengthy medical history and was in palliative care at the time of his death. No issues have been raised in relation to his care or treatment.
3. Michael Murphy was in the lawful custody of Corrective Services NSW (“CSNSW”) at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009 (“the Act”).

## The role of a Coroner and purpose of this inquest

4. Under s81 of the Act a Coroner, 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.
5. Pursuant to s 82 of the Act a Coroner is empowered to make recommendations concerning matters such as public health or safety issues arising out of the death in question.
6. There is no controversy in this case as to Mr Murphy’s identity, the date or place of his death. No outstanding questions have been raised in relation to the medical cause or death or in relation to the circumstances surrounding Mr Murphy’s death.

## **Evidence at Inquest**

7. A short inquest was held on 30 November 2020. The only witness called in the inquest was Detective Senior Constable Lisa Imisides who is the Officer in Charge of the investigation. The brief of evidence compiled by Detective Imisides was tendered (Ex.1).

## **Background**

8. Michael Patrick Murphy was born in Sydney on the 31<sup>st</sup> of October 1952, to Leslie Murphy and Dolcie Croft. He is the eldest of nine children, and they resided together in various suburbs of Sydney.
9. Mr Murphy moved out of the family home when he was 18 years old and lived with his maternal grandparents in Maroubra. He began a relationship and had a child, born in 1977.

## **Criminal History**

10. Mr Murphy's offending commenced in the early 1970's. He was sentenced for break and enter and stealing offences in 1972 and spent time in custody. In 1973 he was convicted for robbery and break and enter offences and was sentenced to a total term of 12 years with a non-parole period of four years. He was released on parole on the 28<sup>th</sup> of May 1976. Mr Murphy breached his parole in 1978 and was ordered to serve the rest of his sentence, expiring on the 24<sup>th</sup> of August 1985. He was also charged with additional matters and an additional 8 years was added to his sentence, making his release date not until January 1993.
11. Mr Murphy escaped lawful custody on the 27<sup>th</sup> of December 1985 after being approved for work release.
12. On the 26<sup>th</sup> of February 1986, Mr Murphy was arrested and charged for offences relating to the assault, abduction and murder of Anita Cobby on the 2<sup>nd</sup> of February 1986. On the 10<sup>th</sup> of June 1987, Mr Murphy was found guilty of all charges and on the 16<sup>th</sup> of June, was sentenced to life in prison, never to be released.
13. Mr Murphy was placed in protective custody during his incarceration, mostly in relation to threats that had been made against him due to the nature of his offences. He also spent time placed in segregation due to threats he had made, including threats to contaminate food and threats of physical violence towards other inmates and corrective services staff.
14. Whilst in custody, he was subjected to random and targeted drug testing. He failed to comply with testing on the 8<sup>th</sup> of November 2011 and 20<sup>th</sup> January 2014. He had positive results on the 4<sup>th</sup> of August 2012 with Beta Blockers detected, and the 8<sup>th</sup> of February 2014 with Mirtazapine detected.

## **Medical Treatment in Custody**

15. During his incarceration, Mr Murphy received treatment for numerous health-related issues. Between 1986 and 2014, he received treatment for asthma, drug use, epigastric pain, bleeding peptic ulcer, hiatus hernia, hearing loss, Hepatitis C, anxiety, self-harm and suicidal ideation.

16. Whilst in custody in Goulburn between 2014 and 2017, Mr Murphy cancelled numerous ultrasound and CT scans that were booked in Sydney. Between 2017 and 2018, he was admitted to hospital for management of ascites, requiring regular percutaneous drainage at Goulburn Hospital and Prince of Wales Hospital.
17. On the 23<sup>rd</sup> of March 2018, Mr Murphy was reviewed in a teleconference by two liver specialists. He was advised that he had a well differentiated Hepatocellular Carcinoma with smaller ones present in the left lobe and metastatic spread. He agreed to be transferred from Goulburn to Long Bay Correctional Centre for ongoing medical oncology review.
18. On the 5<sup>th</sup> of April 2018, Mr Murphy was reviewed, and advised that he had decompensated liver failure with Child-Pugh B, secondary to liver cirrhosis and Hepatitis C. He understood that his prognosis was poor, and comfort measures would be provided should he deteriorate.
19. On the 17<sup>th</sup> of May 2018, Mr Murphy was reviewed at Prince of Wales Hospital and was advised that Transcatheter Arterial Chemoembolization (TACE) may be an option, but was not a curative treatment and only aimed at managing symptoms. He was also advised that, due to his likely poor hepatic reserve, the procedure could put him into liver failure which could potentially be fatal. Nevertheless, Mr Murphy consented to the treatment. He underwent this procedure on the 29<sup>th</sup> of May and the 12<sup>th</sup> of June 2018, with no complications.
20. On the 9<sup>th</sup> of August 2018, Mr Murphy was again reviewed by oncology at Prince of Wales, who advised that, given recent drainage of ascites and good disease control, the TACE procedures should cease.
21. On the 16<sup>th</sup> of August 2018, Mr Murphy agreed that he was not for cardiopulmonary resuscitation in the event of a cardiac arrest.

#### **Events leading up to the death of Mr Murphy**

22. Between December 2018 and February 2019, Mr Murphy was regularly reviewed by the medical team and received comfort care and symptomatic treatment. His condition was noted to be deteriorating.
23. On the 21<sup>st</sup> of February at 10:45pm, Mr Murphy was reported to be agitated, distressed, unable to communicate and moaning. He was administered 2.5mg of Midazolam subcutaneously and placed on his left side. At 11:55pm, nursing staff attended his cell to administer his regular medication, but he was not responsive, not breathing and had no pulse. He was subsequently pronounced life extinct.

#### **Investigation following Mr Murphy's death**

24. Police from Eastern Beaches Police Area Command attended, and a crime scene was established. Photographs were taken, and Mr Murphy's body was transferred to the Department of Forensic Medicine, in Lidcombe.
25. A post-mortem external examination was conducted by Pathologist Dr Rebecca Irvine on the 27<sup>th</sup> of February 2019, along with a full body CT scan. Dr Irvine found the direct cause of

death to be “complications of chronic viral liver disease”. Dr Irvine commented that the external examination revealed a chronically ill older man with ascites and that there was no significant acute injuries or evidence of neglect or maltreatment.

### **Findings pursuant to section 81 of the *Coroners Act 2009***

26. The findings I make under section 81(1) of the Act are:

***Identity***

The person who died was Michael Murphy

***Date of death***

Michael Murphy died on 21<sup>st</sup> of February 2019.

***Place of death***

Michael Murphy died at Long Bay Correctional Centre, 1300 Anzac Parade, Malabar NSW.

***Cause of death***

The cause of Michael Murphy’s death was complications of chronic viral liver disease.

***Manner of death***

Michael Murphy died of natural causes while serving a life sentence in custody.

Teresa O’Sullivan

State Coroner

30 November 2020