CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Francis McCann
Hearing dates:	31 January 2020
Date of findings:	5 February 2020
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, accidental fall, Metropolitan Special Purpose Centre, Complex Monitor Room
File number:	2017/311913
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Ms A Smith for Corrective Services New South Wales Mr H Norris for Justice Health & Forensic Mental Health Network
Findings:	I find that Francis McCann died on 15 October 2017 at Prince of Wales Hospital, Randwick NSW 2031. The cause of death was complications of a cervical spine injury. Mr McCann sustained the injury following an accidental and unwitnessed fall from his bed whilst sleeping. Mr McCann was in lawful custody, serving a custodial sentence, at the time of his death.
Non-publication orders:	See Appendix A

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1. Introduction

1.1 Francis McCann was in lawful custody serving a custodial sentence. He went to sleep in his cell on the evening of 24 September 2017. At around 10:00pm that evening Mr McCann accidentally rolled out of his cell bed and fell to the floor, suffering a serious spinal injury. Mr McCann remained on the floor, breathing and unable to move his legs, until he was discovered the following morning. He was subsequently conveyed to hospital where interventional surgery was performed. However Mr McCann's condition deteriorated and he was later pronounced deceased on 15 October 2017.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

3. Mr McCann's personal and custodial history

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Regrettably in this case very little is known about Mr McCann's personal history, other than he was born in Queensland on 26 February 1968. Prior to entering custody, Mr McCann had no fixed place of abode and reportedly lived a very transient lifestyle. He had no known family members, and during his time in custody he did not make any telephone calls or receive any social visits.

3.3 Mr McCann had an extensive criminal history dating back to 1994. At the time of his death he was serving a custodial sentence after having been convicted and sentenced at Penrith Local Court on 1 March 2017. Mr McCann was serving a custodial sentence of 16 months, with a non-parole period of 10 months commencing on 15 February 2017. This meant that Mr McCann's earliest release date was 14 December 2017.

3.4 After being received into Corrective Services New South Wales (**CSNSW**) Mr McCann was housed at a number of correctional centres including Amber Laurel Correctional Centre, the Metropolitan Remand and Reception centre (**MRRC**), Junee Correctional Centre and Bathurst Correctional Centre. On 11 May 2017 Mr McCann was transferred from Bathurst to the Metropolitan Special Purpose Centre (**MSPC**).

4. Mr McCann's medical history

4.1 During a reception screening assessment at the MRRC in February 2017 Mr McCann reported a history of schizophrenia, anxiety and self-harm, together with alcohol dependency. He was referred to the Risk Intervention Team (**RIT**), and to a Drug & Alcohol nurse for further assessment. Between February 2017 and March 2017 Mr McCann was assessed further on a number of occasions by the RIT following reported thoughts and threats of self-harm. By April 2017 it was noted that Mr McCann had been compliant with treatment and he was recommended for transfer to Junee Correctional Centre for single cell placement.

4.2 After brief periods at Junee and Bathurst Correctional Centres Mr McCann was referred to the Acute Screening Unit at Long Bay Correctional Complex. On 11 May 2017 Mr McCann was transferred to the MSPC and placed in the Intensive Screening Unit (**ISU**). The ISU is predominantly used to house inmates with medical needs and/or non-association alerts. It contains both assessment and stepdown cells. Mr McCann was placed in a one-out assessment cell (commonly referred to as a "safe cell") with constant electronic CCTV monitoring. Between May 2017 and September 2017 Mr McCann attended 39 separate consultations with the RIT due to his mental health issues and intermittent thoughts of self-harm.

5. What happened on 24 and 25 September 2017?

5.1 At about 7:25am on 24 September 2017 Mr McCann was let go from his cell so that he could access the exercise yard. He was returned to his cell at about 11:00am where he remained until a RIT review was conducted at about 1:10pm. Following the review Mr McCann was again returned to his cell sometime later that afternoon. At about 6:45pm two CSNSW officers and a Justice Health & Forensic Mental Health Network (**Justice Health**) nurse provided Mr McCann with his routine medication. Mr McCann was observed to be standing at the door of his cell, and nothing remarkable was noticed.

5.2 Later that evening Mr McCann lay down on the bed in his cell and fell asleep. The critical period occurred from about 10:00pm onwards and was recorded by the cells CCTV camera. A review of the CCTV footage establishes the following (with all times approximations based on the footage timestamps):

(a) 10:01:17pm: Mr McCann is seen to move his arms in an upward direction and begin to roll his torso towards the right side.

(b) 10:01:22pm: Mr McCann is seen to roll his body towards the right side of the bed and place his left leg out straight. At this stage his left leg and part of his lower body appears to be off the bed.

(c) 10:01:23pm: Mr McCann rolls completely off the bed, with the front of his body and face making contact with the concrete floor. Mr McCann's blanket is seen to be wrapped around

his legs, and around and underneath the lower part of his body. Mr McCann is observed to roll slowly onto his left side with his head facing the bed.

5.3 At about 7:15am on 25 September 2017 CSNSW officers within the ISU were conducting routine head checks and issuing breakfast to inmates. When they opened Mr McCann's cell he was found to be lying on the floor on his blanket, with a pool of blood around his head. One of the officers called out to Mr McCann who did not respond. This was repeated and Mr McCann indicated that he could not feel his legs. An emergency radio call was made for medical assistance. Justice Health staff arrived at Mr McCann's cell at about 7:16am. A further call was made to NSW Ambulance for assistance. Mr McCann was later transported by ambulance to Prince of Wales Hospital at about 7:30am.

5.4 Imaging of the spine and facial bones at hospital showed multilevel degenerative changes, together with a 4th and 5th cervical disc spinal injury with a retropulsion and multilevel canal stenosis with cord signal changes.

5.5 On 27 September 2017 Mr McCann underwent anterior survival discectomy and fusion surgical procedure. The surgery was deemed successful with no complications noted, and Mr McCann was subsequently transferred to the Intensive Care Unit where he remained for the next few weeks. During this period Mr McCann was conscious and communicating, but his injury rendered him quadriplegic. Subsequently, on 30 September 2017, Mr McCann developed pneumonia and continued to deteriorate despite being treated with antibiotics.

5.6 Mr McCann's condition did not improve and on 14 October 2017 a guardianship discussion (because Mr McCann had no known next of kin) resulted in Mr McCann being placed on a palliative care pathway. At about 6:00pm on the same day Mr McCann went into atrial fibrillation which was treated but which resulted in respiratory failure. Mr McCann was utterly pronounced deceased at 12:30pm on 15 October 2017.

6. What was the cause and manner of Mr McCann's death?

6.1 Mr McCann was subsequently taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 17 October 2017. Dr Maistry noted that postmortem imaging revealed evidence of a survival spine fracture fixation with no residual deformity. No acute skeletal trauma was noted. In her subsequent autopsy report Dr Maistry opined that the cause of Mr McCann's death was complications of a survival spine injury.

6.2 The investigation which followed Mr McCann's death revealed that the mattress of his bed was approximately 20 centimetres in height. Further, measurements established that the distance from the base of the mattress to the floor was approximately 50 centimetres. There is no evidence to suggest that any structural feature contributed to Mr McCann's fall from bed. Although it is not possible to precisely understand the mechanism of the fall, the CCTV footage from Mr McCann's cell appears to indicate that Mr McCann's legs and lower part of his body were entangled in his blanket. There is no evidence to suggest that Mr McCann's fall was anything other than entirely accidental and unpredictable.

7. Was McCann appropriately monitored?

7.1 It became evident during the course of the coronial investigation that Mr McCann was subject to both physical and electronic monitoring during the evening of 24 September 2017. As noted already, a CCTV camera recorded video footage from Mr McCann's cell. Further, CSNSW officers performed a routine cell inspection that evening. Therefore, immediate questions arise as to why Mr McCann's fall from his bed was not witnessed, and whether the observation of Mr McCann lying on the floor of his cell should have prompted some action.

Physical monitoring

7.2 First Class Correctional Officer (**FCCO**) Kymm Beer was on duty in the ISU on the evening of 24 September 2017, and performed a Wing Security Check with FCCO Jay Slifer. This type of check is conducted to ensure that cell doors are locked and secured, and to confirm that the inmate cards outside the cell is match information contained in the muster book in order to account for all the inmates.

7.3 At about 10:50pm Officer Beer looked through the window of Mr McCann's cell and saw him lying on the floor with a blanket on, and beside, him. Officer Beer specifically saw the rise and fall of Mr McCann's chest and observed that he was breathing. Officer Slifer walked past Mr McCann cell but did not look through the window into his cell. CCTV footage indicates that officers Beer and Slifer spent approximately four seconds outside of Mr McCann cell before continuing with their duties.

7.4 After completing the check, Officer Beer did not report or discuss the fact that Mr McCann was lying on the cell floor with any other correctional staff. He explained: "*It was a particularly warm night and it is very common for inmates housed in safe cells to set up beds on the floor to remain call in warmer weather as the air circulation in the ISU was quite poor*".[1]

CCTV monitoring

7.5 Senior Correctional Officer Adam Hend was working with FCCO Anthony Van Zyl in the Complex Monitor Room (**CMR**) on the evening of 24 September 2017. Officer Hend's duties included monitoring all the security systems of the entire complex, including monitoring the perimeter security of each centre, staff duress systems, cell call systems, and the assessment cells in the ISU. As part of their duties staff in the CMR are required to manage 17 monitor screens, most of which are divided into a total of 125 multiview image boxes. There are approximately 560 security cameras which broadcast images to these monitor screens.

7.6 Officer Hend observed Mr McCann on the monitor numerous times during the course of his shift which ended at 11:00pm. Mr McCann was seen lying on his bed for the majority of the time, and then observed to be sleeping on the floor shortly before the end of Officer Hend's shift. However Officer Hend did not consider that this to be an unusual occurrence, explaining: "*I would not have commented to other staff about [Mr McCann] appearing to be sleeping on the floor as it is common for inmates to sleep on the floor, especially on warm nights as assessment cells have poor ventilation. From my experience it is very common for inmates asleep on the floor*".[2]

[1] Exhibit 1, Tab 8 at [20].
[2] Exhibit 1, Tab 9 at [16] & [17].

7.7 Officer Hend could not specifically recall whether it was a busy night in the CMR on 24 September 2017. However, he explained that his usual experience is that the period between 9:30pm until 11:30pm is a busy one due to shift change over and movement of staff into and out of the complex. As part of the coronial investigation, attempts were made to ascertain with more precision the number of staff moving in and out of the complex on 24 and 25 September 2017. However, due to the passage of time, that information was not available.

7.8 Officer Hend's duties concluded at about 10:30pm and he conducted a handover with the incoming officer, Senior Correctional Officer Lance Reynolds. Officer Hend could not recall whether he told Officer Reynolds that Mr McCann was sleeping on the floor, but considered that it would have been unlikely because, as already noted, this was a common occurrence. However Officer Reynolds indicated that he believed he was told that Mr McCann was sleeping on the floor. Officer Reynolds also observed Mr McCann lying on the floor during the course of his shift, but did not see any other suspicious activity.

7.9 Throughout the course of his shift in the CMR between 6:30pm on 24 September 2017 and 6:30am, Officer Van Zyl recalled seeing Mr McCann on the floor of his cell and assumed that he was sleeping. Officer Van Zyl similarly indicated that in his experience it was a common practice for inmates in assessment cells to sleep on the floor.

7.10 It should be noted that Governor of the MSPC, Patrick Aboud, also expressed the following views, consistent with those of the CMR staff working overnight on 24 and 25 September 2017: "*From my experience it is well known practice that inmates tend to sleep on the floor of their room/cell during warmer nights. It is cooler on the concrete floor and with the free airflow emitting from under the cell doors, sleeping on the floor is an optimal position for inmates throughout the warmer periods. In my time, I have seen many inmates, both male and female sleep on the floor. It is reasonable from my experience that if an inmate is lying on the floor and appears to be asleep, it may not raise any concern for correctional staff as it is a common practice amongst inmates*".[3]

Conclusions

7.11 The evidence established that approximately 50 minutes after he fell out of his bed Mr McCann was physically seen by Officer Beer to be lying on the floor. Of course, Officer Beer did not witness the fall and assumed that Mr McCann had simply chosen to sleep on the floor. The evidence established, in the experience of both CSNSW officers and the MSPC Governor, that this was not an unusual occurrence within the ICU, particularly on warm evenings. Data collected from the Bureau of Meteorology established that 24 September 2017 "*was part of a series of unprecedented warm days*" for that time of year.[4] In these circumstances the assumption made by Officer Beer was not unreasonable, particularly given that there was nothing about Mr McCann's appearance or positioning which suggested that further enquiry ought to have been made.

7.12 The evidence also established that Mr McCann remained on the floor of his cell for just over nine hours after falling out of bed. During this time, he was captured on video that was depicted on monitor screens in the CMR. It is also evident that Mr McCann's fall, which was approximately six seconds in duration, was recorded on video and displayed on the CMR monitor screens.

[3] Exhibit 1, Volume 2.
[4] Exhibit 1, Volume 2.

7.13 The CSNSW officers working in the CMR at the time of Mr McCann's fall did not witness it. Given the brief duration of the fall, and the multitude of other images which the officers were required to monitor as part of their duties, the failure to observe the fall is also not unreasonable. In the nine hours that followed, there is no evidence to suggest again that there was any aspect of Mr McCann's appearance or positioning on video which indicated to the officers in the CMR that anything was amiss. Similarly, it was not unreasonable for the officers in the CMR to make the assumption that Mr McCann had simply chosen to sleep on the floor. It should be noted that the pool of blood around Mr McCann's head that was observed on the morning of 25 September 2017 could not be seen from either the cell window or on the CCTV footage.

7.14 Finally, for completeness, it should be noted that once it became apparent on the morning of 25 September 2017 that something was amiss and that Mr McCann was in a potentially serious condition, the response from both CSNSW and Justice Health staff was entirely reasonable and timely. Therefore, the evidence established that no action or inaction by CSNSW or Justice Health staff contributed to Mr McCann's death.

8. Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Ms Tina Xanthos, Coronial Advocate, for her assistance both before, and during, the inquest. I also thank Detective Sergeant Joshua Palmer for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was Francis McCann.

Date of death
Mr McCann died on 15 October 2017.

Place of death
Mr McCann died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death
The cause of Mr McCann's death was complications of a cervical spine injury.

Manner of death
Mr McCann sustained the injury following an accidental and unwitnessed fall from his bed whilst sleeping. Mr McCann was in lawful custody, serving a custodial sentence, at the time of his death.

8.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
5 February 2020
Coroner's Court of New South Wales

Appendix A

Pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW), the following information contained in the brief of evidence tendered in the proceedings is not be published:

(a) The names, addresses, phone numbers and other personal information that identifies or tends to identify any members of Mr McCann's family members.

(b) Any information that identifies or tends to identify any of Mr McCann's victims.

(c) The names and Master Index Numbers of other inmates housed in the Metropolitan Special Purpose Centre ('MSPC').

(d) The direct contact details of Corrective Services NSW ('CSNSW') staff and details of external service providers that are not publically available.

(e) The CCTV footage of Mr McCann's cell in the ISU of the MSPC, recorded before and after the incident on 24 September 2017, including still images taken from the footage.

(f) The hand-held camera footage taken in Mr McCann's cell and the MSPC on 25 September 2017.

(g) Still photographs of Mr McCann's cell and Long Bay Correctional Complex Monitor Room.

(h) Sections of the CSNSW Operations Procedures Manual and Custodial Operations Policy and Procedures, dealing with the management of inmates at risk of suicide and self-harm, and procedures for a death in custody, which are not publically available.

(i) The procedures followed by Corrective Services New South Wales staff in testing cell alarms and staff duress alarms at the Long Bay Correctional Complex, contained in the statement of Mr Jeff Schubert, dated 29 March 2019.

(j) The procedures followed by Corrective Services New South Wales staff in conducting perimeter checks at the Long Bay Correctional Complex contained in the statement of Mr Jeff Schubert, dated 29 March 2019; and

(k) The duties conducted by Corrective Services New South Wales staff in the Long Bay Correctional Complex Monitor Room contained in the statement of Mr Jeff Schubert, dated 29 March 2019.