CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of William Berger
Hearing dates:	24 June 2021
Date of findings:	24 June 2021
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, cause and manner of death
File number:	2020/201875
Representation:	Mr H Mullen, Coronial Advocate Assisting the Coroner Ms D Lekakis for the Commissioner of Corrective Services New South Wales Ms N Szulgit for Justice Health & Forensic Mental Health Network
Findings:	William Berger died on 7 July 2020 at Cessnock District Hospital, Cessnock NSW 2325. The cause of Mr Berger's death was acute exacerbation of chronic airways disease, with carcinoma of prostate being a significant condition contributing to the death, but not relating to the disease or condition causing it. Mr Berger died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication orders:	See Annexure A

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1. Introduction

1.1 At the time of his death, William Berger was 74 years old and was being held in lawful custody at Cessnock Correctional Centre. Mr Berger had a lengthy history of physical health conditions, including chronic obstructive pulmonary disease and metastatic prostate cancer. He had been admitted to hospital on a number of occasions in the 18 months preceding his death for treatment of these conditions.

1.2 During Mr Berger's most recent hospital admission in July 2020 it was found that his condition had deteriorated significantly. On 7 July 2020 Mr Berger was found in his hospital bed to be unresponsive, and showing no signs of life. Mr Berger was subsequently pronounced life extinct.

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 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. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Berger was not appropriately cared for and treated whilst in custody.

3. Mr Berger's life

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. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr Berger's personal history prior to his incarceration.

3.2 Mr Berger was born and raised in the United States. Mr Berger's parents separated when he was approximately two years old. Mr Berger was raised by his aunt and uncle, but remained in regular contact with his mother, although he had little contact with his biological father until he was about 17 years old.

3.3 Mr Berger completed high school in the United States before joining the United States Navy where he was stationed in San Francisco for four years. During his service Mr Berger acquired qualifications as an electrician and was deployed to Vietnam and the Marshall Islands. Mr Berger was reportedly honourably discharged at the end of his service and later took on contract work in both the United States and Pacific Islands.

3.4 In 1969 Mr Berger migrated to Australia and formed a relationship. Mr Berger also commenced work in the electrical trade. In 1972, Mr Berger's son was born. In 1981 Mr Berger gained employment with a construction company involved in the construction of powerlines in the Snowy Mountains region of New South Wales. He also formed a new relationship at this time.

3.5 In 1983, Mr Berger was transferred by his company to Orange. In the same year, Mr Berger married his then partner. In 1985 Mr Berger and his wife took over the lease of a tavern near Orange, where they commenced working.

3.6 Sometime later Mr Berger returned to Sydney and formed a new relationship.

4. Mr Berger's custodial history

4.1 In October 1986 Mr Berger was convicted and sentenced in relation to the manslaughter of his first wife and his stepdaughter. After spending approximately five years in custody, Mr Berger was release to parole on 6 May 1991.

4.2 In 1993 Mr Berger was charged with an offence of murder involving his then de facto partner. Mr Berger was later found guilty by a jury of this offence and convicted. On 21 March 1995 Mr Berger was sentenced in the Supreme Court to a term of imprisonment of 28 years commencing on 10 November 1993, with a non-parole period of 21 years that was to expire on 9 November 2014.

4.3 Mr Berger was initially housed at Maitland correctional centre before later being transferred to a number of other correctional centres including Lithgow, Bathurst, Wellington and Grafton. In 2019 Mr Berger was transferred to Cessnock correctional centre where he remained until his death.

4.4 In 2014 Mr Berger made an application for parole. On 4 September 2014 the State Parole Authority refused parole on the basis that it was considered that Mr Berger was "*unlikely to adapt to normal community life*" and that "*it is not appropriate for [Mr Berger] to be considered for release on parole*". As a result Mr Berger remained in custody, with his overall sentence due to expire on 9 November 2021.

4.5 In March 2020 Mr Berger made a further application for parole. However this application was later withdrawn in April 2020 due to the COVID-19 pandemic.

5. Mr Berger's medical history

5.1 Mr Berger had a history of chronic obstructive pulmonary disease (**COPD**), asthma, acute myocardial infarction, metastatic prostate cancer and urinary system disorder.

5.2 In 2019 and 2020 Mr Berger was transferred and admitted to hospital on a number of occasions for management of his COPD, after presenting with coughing and shortness of breath.

What happened in June/July 2020?

6.1 On the morning of 30 June 2020 Mr Berger presented to the Justice Health & Forensic Mental Health Network (**Justice Health**) health centre at Cessnock correctional centre, complaining of shortness of breath. Mr Berger was found to have a moist sounding cough, chest congestion and reduced oxygen saturation levels (though consistent with his usual levels). Following consultation with a primary care doctor, arrangements were made to transfer Mr Berger to Cessnock Hospital for further medical review. Following assessment, Mr Berger was deemed suitable for transfer back to Cessnock correctional centre and he was later discharged on the same day.

6.2 On 4 July 2020 Mr Berger was reviewed by Justice Health nursing staff for a routine COVID-19 quarantine check. He was found to have developed a productive cough and rigors overnight. The on-call medical officer was consulted and Mr Berger was prescribed antibiotic medication.

6.3 On the morning of 5 July 2020 Mr Berger was again reviewed by Justice Health nursing staff after complaining of breathing difficulties and difficulty sleeping due to coughing and hot and cold sweats. Mr Berger also reported having to use his salbutamol inhaler frequently during the night, and that he had difficulty walking across his cell to use the toilet. On examination Mr Berger was found to be showing signs of increased work of breathing, together with crackles of his left lower lung and a right-sided wheeze. Arrangements were subsequently made to transfer Mr Berger by ambulance to Cessnock Hospital for assessment, ongoing management and treatment of his condition. Whilst at hospital Mr Berger was diagnosed with pneumonia and commenced on intravenous antibiotic therapy and salbutamol, which appeared to improve his symptoms.

6.4 During the evening of 6 July 2020 Mr Berger's condition deteriorated overnight, as it was noted that he had been complaining of left-sided chest pain and was diaphoretic. Investigations on 7 July 2020 revealed an elevated troponin level together with blood test derangement. Due to Mr Berger's deteriorating condition arrangements were initiated with a retrieval team at John Hunter Hospital in Newcastle to transfer Mr Berger to an intensive care unit for a higher level of care.

6.5 Later that morning Mr Berger was assessed by a retrieval team from John Hunter Hospital. He was found to be slightly drowsy, tachypnoeic, hypoxic and with respiratory cachexia. It was also noted that Mr Berger had worsening respiratory acidosis. Following this assessment it was determined that Mr Berger was unsafe to transfer due to his current clinical status. It was considered that intubation and invasive ventilation would be required in order to conduct a transfer safely. However as Mr Berger's baseline lung function was poor, intubation was not considered to be a feasible option, and also considered to carry significant risks.

6.6 Following consultation with Mr Berger's son, his treating team and the intensive care team at John Hunter Hospital a decision was made to not transfer Mr Berger and to instead provide him with ward-based care at Cessnock Hospital.

6.7 Mr Berger continued to be provided with care at hospital and was found to be unresponsive at 11:55am. Mr Berger was later formally pronounced life extinct at 12:32pm.

7. What was the cause of Mr Berger's death?

7.1 Mr Berger was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Allan Cala, forensic pathologist, on 9 July 2020. Dr Cala noted that Mr Berger had a well-documented history of chronic airways disease and prostate cancer. Further, Dr Cala opined that it was clearly apparent that Mr Berger had an acute exacerbation of chronic airways disease resulting in his death at hospital.

7.2 Ultimately, in the autopsy reported dated 15 April 2020, Dr Cala opined that the cause of Mr Berger's death was acute exacerbation of chronic airways disease, with carcinoma of prostate noted to be a significant condition contributing to the death, but not relating to the disease or condition causing it.

8. Conclusions

8.1 Having regard to the relevant records from Corrective Services NSW (**CSNSW**) and Justice Health regarding Mr Berger's period in custody, and the findings from the postmortem examination, it is evident that Mr Berger died as a result of a significant pre-existing natural disease process.

8.2 The evidence establishes that Mr Berger's presentations in June and July 2020 were appropriately assessed and investigated. When it became evident that Mr Berger's condition had deteriorated significantly, appropriate arrangements were made to transfer Mr Berger to hospital for further assessment and management. Given Mr Berger's clinical status and the need for intubation and invasive ventilation, and associated risks, in order to effect a transfer from Cessnock to Newcastle an appropriate decision was made to keep Mr Berger at Cessnock for ward-based care.

8.3 Overall, the available evidence establishes that Mr Berger was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Berger's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

9. Findings

9.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Mr Howard Mullen, Coronial Advocate, for his excellent assistance both before, and during, the inquest. I also thank Senior Constable Regina Stoker for her role in the police investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was William Berger.

Date of death
Mr Berger died on 7 July 2020.

Place of death
Mr Berger died at Cessnock District Hospital, Cessnock NSW 2325.

Cause of death
The cause of Mr Berger's death was acute exacerbation of chronic airways disease, with carcinoma of prostate being a significant condition contributing to the death, but not relating to the disease or condition causing it.

Manner of death
Mr Berger died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

9.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Berger's family for their loss.

9.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
24 June 2021
Coroners Court of New South Wales

Inquest into the death of William Berger
File Number: 2020/201875

Annexure A

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), I direct that the following material contained within Exhibit 1 is not to be published:

(a) The names, addresses, phone numbers, Visitor Index Numbers and other personal information that might identify any family member, friend or person who visited Mr Berger while in custody (other than legal representatives or visitors acting in a professional capacity).

(b) The names, personal information, and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales (CSNSW), other than Mr Berger.

(c) The direct contact details, including telephone numbers and email addresses, of CSNSW Officers, staff and offices not publicly available.

(d) The electronic file management reference numbers at page 6 of the Corrective Services NSW Investigation Serious Incident Report contained in tab 21.

(e) The document titled 'inmate classification and placement review of security rating – objective assessment' contained in tab 27.

(f) Information relating to Corrective Services NSW security equipment, including the specifications of equipment and serial numbers assigned to security equipment, contained in the document titled 'OIC Escort Journal' in tabs 24, 27 and 28.

Pursuant to section 65(4) of the *Coroners Act 2009:*

1. A notation is to be placed on the Court file that if an application is made under s 65(2) of the Act for access to CSNSW documents in the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
24 June 2021
Coroners Court of New South Wales