STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of James Sampson Doran
Hearing dates:	18 November 2021
Date of findings:	18 November 2021
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody, natural causes
File numbers:	2018/314209
Representation:	Mr Howard Mullen (Sergeant) coronial advocate assisting Ms K McKinlay, solicitor, Department of Communities and Justice(DCJ) Legal, for the Commissioner of Corrective Services NSW (CSNSW) Mr H Norris, solicitor for the Justice Health & Forensic Mental Health Network

Findings

Identity

The person who died was James Sampson Doran

Date of death

He died on 13 October 2018.

Place of death

He died at Prince of Wales Hospital, Randwick NSW.

Cause of death

He died of metastatic prostate cancer

Manner of death

He died of natural causes, in custody.

Non-Publication orders

I make the following 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 That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):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. The names, master index numbers ('MINs') and other identifying information of inmates other than James Doran;
    b. The names, Visitor Index Numbers, contact numbers and addresses of any member of James Doran's family, friends and/or visitors, other than legal or professional visitors;
    c. The direct contact details of CSNSW staff and staff from external service providers that are not publicly available;
    d. Portions of CSNSW accommodation journals that detail security checks conducted by CSNSW staff; and
    e. Portions of documents that may reveal the identity of James Doran's victims.

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 Corrective Services NSW documents on the Court file, that material shall not be provided until Corrective Services NSW has had an opportunity to make submissions in respect of that application.

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Introduction

1. James Sampson Doran was 85 years of age at the time of his death on 13 October 2018. He was serving a custodial sentence and had most recently been living at the Metropolitan Special Programs Centre (MSPC), within the Long Bay Correctional Complex before being transferred to hospital for palliative care.

2. In the early hours of 13 October 2018, he was discovered by nursing staff, unconscious. He was cold and had no signs of life.

3. A post mortem examination was conducted on 16 October 2021. The forensic pathologist conducting the examination recorded the cause of death as "metastatic prostate cancer."[1]

4. Whilst in custody, it is reported that Mr Doran kept in touch with some members of his family. They did not wish to be involved in the inquest.

The role of the coroner

5. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] In addition, the coroner may make recommendations, arising from the evidence, in relation to matters that may have the capacity to improve public health and safety in the future.[3]

6. In this case there is no dispute in relation to Mr Doran's identity, or to the date, place or medical cause of his death.

7. Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner[4]. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care.

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[1] Autopsy Report, Exhibit 1, Tab 3
[2] Section 81 *Coroners Act* 2009 (NSW)
[3] Section 82 *Coroners Act* 2009 (NSW)
[4] See sections 23 and 27 Coroner's Act 2009 (NSW)

8. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of James Doran.

Scope of the inquest

9. The inquest took place on 18 November 2021. A comprehensive police brief was tendered including police statements and photographs, as well as prison and medical records. The officer in charge of the investigation, Senior Constable Timothy Bujeia gave brief oral evidence by video link

Background

10. Mr Doran was born was born on 25 April 1933, to parents C and L, in Manly NSW. Mr Doran was the second eldest child and had three brothers.

11. Mr Doran grew up in Campsie NSW and attended De La Salle College in Marrickville for the entirety his Schooling. At the age of 18, Mr Doran was enrolled in National Service and travelled to Korea for an unknown amount of time to assist in the activities following the end of the Korean War.

12. Upon returning to Australia, Mr Doran taught as an English teacher at St Patricks School in Fairfield NSW and became a Patrician Brother. However, he did not make his final vows and decided to leave the Patrician Brotherhood community.

13. After leaving the Patrician Brothers, Mr Doran married P and had three children, M, C and J. During this time, Mr Doran lived in Campsie with his family whilst running a general store with his wife.

14. Around 1980, Mr Doran and his family moved to Inverell NSW, where he was a teacher at Holy Trinity Catholic School.

15. Around 1983, Mr Doran moved with his family to Lismore NSW where he was a teacher at St Johns College, Woodlawn, an all-male boarding school operated by the Marist Brother's Organisation.

16. Around 1988, Mr Doran moved his family to far North Queensland where he was a teacher at St Teresa's Catholic College, Abergowrie QLD. Mr Doran retired as a teacher.

17. Around 1994, Mr Doran moved to Brisbane and then to Kingscliff NSW, where he and his wife lived together until they separated soon before he was sentenced.

Custodial History

18. Initially Mr Doran had minimal recorded criminal history. In 1950, he was charged with wilful and obscene exposure.

19. On 16 September 2014, Mr Doran was charged with 81 Sequences of historical child sex offences. A vast number of these charges related to incidents that occurred at St Johns College, Woodlawn between 1980 and 1988. During this time, Mr Doran was appointed the dormitory master on various occasions. He was also charged with an offence relating to his time at St Patricks and one during his time at Holy Trinity College.

20. On 29 May 2015, Mr Doran was charged with a further 11 sequences relating to sexual offences against children. Mr Doran was also charge with multiple sexual offences against a male student whilst employed at St Patricks Patrician Brothers School, in Fairfield, NSW. The offences for which he was charged related to children between the ages of 15-17 years of age. Ultimately, on 6 April 2017, Mr Doran was sentenced by Judge R Toner, in the District Court of NSW, for a total of 30 offences. He received a term of 13 years imprisonment with a non-parole period of 6 years, due to expire on 5 April 2023. Mr Doran was 83 years old at the time of his sentence.

Medical History prior to Custody

21. As a part of his sentencing submissions, Mr Doran was examined by Dr John Obeid. Dr Obeid prepared an extensive report and detailed Mr Doran as suffering from the following medical conditions, including but not limited to - Ischaemic Heart Disease, Hypertension Hyperlipidaemia, Non-insulin dependent diabetes mellitus, Peripheral neuropathy, Muscular degeneration, Depression, Chronic Obstructive Pulmonary disease, Obstructive sleep apnoea, Carcinoma of the left kidney, Carcinoma of the thyroid, Chronic lower back pain Chronic vasomotor rhinitis, Prostatism, Possible gastrointestinal bleeding, Suspected benign essential tremor, Gout and abdominal aortic aneurysm. It is clear that prior to entering custody Mr Doran was already infirm and unwell.

Time in Custody

22. On 6 April 2017 Mr Doran entered custody. He was always active in requesting assistance in relation to his care and treatment. He was assessed by Justice Health & Forensic Mental Health Network (JH) at various times in relation to his ongoing risks in custody. A risk of falls and depression was noted. He was described as a frail, elderly and hearing impaired man who had mobility issues and used a CPAP machine at night.

23. He was initially housed at the Metropolitan Remand and Reception Centre.

24. On 7 April 2017, Mr Doran was reviewed by a doctor and referred to a number of specialists. He was then referred to the Aged Care Unit at Long Bay Hospital.

25. Mr Doran remained in the Age Care Unit until 15 April 2017, when he was discharged and transferred to the Metropolitan Special Programs Centre (MSPC) within Long Bay Correctional Centre. Mr Doran remained here until he was transferred to the Prince of Wales Hospital on 2 October 2018, where he remained until he died.

Medical History whilst in custody

26. During Mr Doran's time in custody, he was transferred between the Metropolitan Special Programs Centre, Long Bay Hospital and the Correctional Health Unit, Secure Annexe at the Prince of Wales Hospital on multiple occasions for treatment and specialist appointments.

27. On entry into custody he was reviewed by a doctor and referred to specialists in cardiology, ear nose and throat medicine, ophthalmology, gastroenterology, physiotherapy and respiratory medicine. There was a request for pathology and an abdominal ultrasound was completed.

28. On 14 June 2017, Mr Doran was reviewed by Doctor Weerakoon at the Prince of Wales Urology outpatient clinic. Dr Weerakoon recorded that a renal tract ultrasound was performed revealing an enlarged prostate. Extensive discussion between Dr Weerakoon and Mr Doran took place, regarding investigations for prostate cancer and recorded "James himself does not want any investigation or treatment for a possible prostate cancer."

29. On 6 February 2018, Mr Doran was diagnosed with Metastatic Prostate Cancer following a biopsy. Upon discovery the cancer rated a 9 on the Gleeson scale. As a result of this, Mr

Doran was referred to palliative care and treated on prostate cancer drug zoludex and bicalutamide. To assist with pain, Mr Doran was administered Fentanyl and Endone.

30. Mr Doran was discharged from the Prince of Wales Hospital, back to the care of Long Bay Hospital. During his time at Long Bay Hospital, Mr Doran suffered from two falls. One in April 2018, which resulted in a fracture of the neck of the left femur, requiring surgery. The records reflect that the surgery went well, and he was discharged back into the care of Long Bay Hospital 7 days later.

31. The second fall occurred on 1 October 2018, as a result of this fall, he was again transferred to the Prince of Wales Hospital. The fall resulted in a fractured hip. Due to his ill health, Mr Doran remained at the Prince of Wales Hospital.

32. Upon his admission, Dr Welkee Sim, a Geriatrician, noted that Mr Doran was delirious and in pain. His prostate cancer was confirmed to be progressing aggressively, with the cancer marker rising from 691 in July 2018, to 8642 on 5 October 2018, despite treatment.

Events leading to his death

33. While at the Prince of Wales Hospital, Mr Doran's health deteriorated. The Justice Health medical notes reflect that while his condition was stable, he was noted as being disoriented and confused. Given his deteriorating health, Mr Doran remained at the Prince of Wales Hospital for Palliative care only.

34. On 12 October 2018, Mr Doran was seen by Geriatrician, Dr McGregor-Wood, who noted that Mr Doran had slightly rapid and shallow breathing and ordered 1.5mg of Hydromorphone.

35. About 9:00am on 12 October 2018, palliative care doctor, Dr Clark-Dickson attended and noted laboured breathing.

36. About 11:10am on 12 October 2018, nurses provided comfort measures, sedating Mr Doran. His family was informed.

37. About 10:00pm on 12 October 2018 nursing staff were turning Mr Doran, in order to prevent pressure sores and noted that he was non-responsive with rapid breathing. About 10:45pm that night, the night staff were advised that Mr Doran was expected to pass away during the night.

38. About 11:50pm on 12 October 2018, nursing staff moved Mr Doran, again noting that he was non-responsive with rapid breathing.

39. About 1:30am on 13 October 2018, Registered Nurse Medina Beremo attended to Mr Doran and discovered he was unconscious, cold, and with no signs of life. Dr Hannah Corbett entered the room and pronounced life extinct.

What was the cause and manner of Mr Doran's death?

40. On 16 October 2021, a post mortem was conducted by Dr Istvan F Szentmariay. He stated that Mr Doran's death was caused by metastatic prostate cancer, in accordance with the medical records he had reviewed.

41. I am satisfied that Mr Doran's death was due to natural causes and that he was provided with appropriate care for his pre-existing conditions whilst in custody. I did not identify any issues with the attempts made at resuscitation by correctional or medical staff.

Conclusion

42. I thank those assisting me in the investigation and in preparation of this inquest.

43. I close this inquest.

Formal findings

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

Identity

The person who died was James Sampson Doran

Date of death

He died on 13 October 2018.

Place of death

He died at Prince of Wales Hospital, Randwick NSW.

Cause of death

He died of metastatic prostate cancer

Manner of death

He died of natural causes, in custody.

Magistrate Harriet Grahame
Deputy State Coroner
18 November 2021
NSW State Coroner's Court, Lidcombe