CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Walter Clough
Hearing date:	8 November 2021
Date of findings:	8 November 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person in lawful custody – adequacy of custodial health care
File number:	2019/117552
Representation:	Coronial Advocate assisting the inquest: Sergeant A Chytra, NSW Police. The Commissioner, Corrective Services NSW: M Smith, Department of Communities and Justice, Legal GEO Group Australia: T Berberian of Counsel i/b Sparke Helmore Lawyers.

Findings:	**Identity** The person who died is Walter Clough. **Date of death**: Walter Clough died on 14 April 2019. **Place of death**: Walter Clough died at Junee Correctional Centre, NSW. **Cause of death:** Walter Clough died as a result of complications of chronic obstructive pulmonary disease. A significant contributing condition was cardiomegaly. **Manner of death:** Walter Clough died as a result of natural causes, while he was in lawful custody.

Non-publication orders

The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009.*

Details of these orders can be found on the Registry file.

1. Section 81(1) of the *Coroners Act 2009* (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. These are the findings of an inquest into the death of Walter Clough.

Introduction

3. Walter Clough was aged 66 years when he died at Junee Correctional Centre on 14 April 2019.

4. On 5 April 2017 Mr Clough was sentenced to a term of imprisonment. He received a further term of imprisonment on 6 September 2019, and would not be eligible for release until 12 February 2021. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

5. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

6. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

7. Walter Clough was born in Narrandera on 3 March 1953, the fifth of twelve children born to his parents. As an adult he was employed as a truck driver. He married and had four children. He suffered two serious traffic accidents which caused significant injuries to his chest, lungs and back. These resulted in a condition known as right hemidiaphragm paralysis, involving a loss of lung function causing shortness of breath, headaches, fatigue and breathing difficulties. After the second accident Mr Clough was no longer able to work.

8. Mr Clough also had a medical history of hypertension, sleep apnoea and depression. He used prescribed medication for some of these conditions, including opioid medications for chronic back pain. He had also been a heavy smoker but had ceased smoking some years previously.

Mr Clough's health care in prison

9. Junee Correctional Centre is operated by the company GEO Group Australia [GEO]. During his time in custody Mr Clough received regular treatment for his medical issues from nursing staff, general practitioners and psychiatrists.

10. On a number of occasions Mr Clough attended the Health Clinic at Junee Correctional Centre complaining of shortness of breath. This was a longstanding problem due to his loss of lung function following his traffic accidents. For this he was prescribed Spriva, a long acting bronchodilator used for chronic obstructive pulmonary disease. On other occasions Mr Clough complained of dizziness and chest pain, but despite medical investigations no cause could be found for these. On a number of occasions Mr Clough was seen by Dr Darren Corbett, a General Practitioner employed by Junee Correctional Centre.

11. On 25 March 2019 Mr Clough was again examined by Dr Corbett, who concluded that Mr Clough's breathing difficulties were worsening, and that his paralysed diaphragm was creating further breathing difficulties. Dr Corbett added the inhaler Seretide to Mr Clough's medication regime.

Mr Clough's admission to Wagga Wagga Rural Referral Hospital

12. On 8 April 2019 Mr Clough was again short of breath, with low oxygen saturations. He was transferred to Wagga Wagga Rural Referral Hospital, where he remained for three days. There he was found to have type 2 respiratory failure due to respiratory acidosis. He was also diagnosed with a lower respiratory tract infection for which he was treated with antibiotics. When he was discharged back to Junee Correctional Centre on 11 April 2019, the plan was for him to continue antibiotics and to use a different inhaler in addition to his usual medications.

Mr Clough's return to Junee Correctional Centre

13. When Mr Clough returned to prison he did not have a formal health review. However he briefly saw Dr Corbett in the Health Centre and told him he was feeling better. Dr Corbett prescribed the antibiotics advised by the hospital, and changed Mr Clough's inhaler to the recommended one. His other medications were continued. Mr Clough received his prescribed medications that day and on 12, 13 and 14 April 2019, in accordance with his discharge instructions from hospital.

14. A member of the nursing staff, Endorsed Enrolled Nurse Tracie Cudmore, dispensed Mr Clough's medication on 13 April. She noted that he was short of breath, although no more than was usual for him.

15. EEN Cudmore gave Mr Clough his medication the following day as well. This time she did think he was more out of breath than usual. She asked him if he was okay and he replied that he was. She advised him to buzz for help if he needed assistance.

16. When EEN Cudmore checked Mr Clough's health record, she could find no entry that Mr Clough had received a health care assessment on his return from hospital. For this reason, she made an appointment for him to be seen for a check up by a Primary Health Nurse later that day.

17. At about 1.31pm that day a correctional officer came to Mr Clough's cell to collect him for his appointment. As Mr Clough and the officer approached the exit to his

wing, Mr Clough collapsed face forward onto the ground. CPR was immediately commenced and Mr Clough was carried to the Health Centre. Despite these efforts and those of ambulance paramedics, Mr Clough could not be revived. He was pronounced deceased at about 2.30pm.

The cause of Mr Clough's death

18. Forensic pathologist Dr Alison Ward performed an autopsy. She found that the cause of Mr Clough's death was complications of chronic obstructive pulmonary disease. A significant contributing condition was cardiomegaly, which is an enlarged heart. This is usually due to an increased workload on the heart, likely caused in Mr Clough's case by his underlying hypertension and chronic obstructive pulmonary disease.

Since Mr Clough's death

19. Following Mr Clough's death, GEO has issued a directive to all Junee Correctional Centre health staff that when an inmate returns from a hospital admission he is to receive a review, during which the inmate's hospital discharge papers are to be reviewed and the discharge plan implemented. This may involve prescribing new medications and making recommended appointments for the inmate.

20. In Mr Clough's case it appears this did not happen. However I note that on his return from hospital Mr Clough had an informal attendance on Dr Corbett, who proceeded to prescribe the antibiotics advised by the hospital, and to change Mr Clough's inhaler as recommended. Mr Clough received these medications and treatments that day and the following days.

21. In Mr Clough's case the evidence at inquest established that the medical and psychiatric care and treatment which he received while he was an inmate was appropriate. The evidence did not disclose any basis for making recommendations.

Conclusion

22. I express to Mr Clough's family my sincere sympathy for their loss.

23. I thank Coronial Advocate Sergeant Amanda Chytra for her assistance in the preparation and conduct of this inquest. I thank also the Officer in Charge of the coronial investigation, Detective Sergeant Joshua Broadfoot for his preparation of the brief of evidence.

<u>Findings required by s81(1)</u>

24. 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.

Identity
The person who died is Walter Clough.

Date of death:
Walter Clough died on 14 April 2019.

Place of death:
Walter Clough died at Junee Correctional Centre, NSW.

Cause of death:
Walter Clough died as a result of complications of chronic obstructive pulmonary disease. A significant contributing condition was cardiomegaly.

Manner of death:
Walter Clough died as a result of natural causes, while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

8 November 2021