STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ivan CHRISTOV
Hearing Dates:	12 January 2022
Date of Findings:	1 February 2022
Place of Findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Joan Baptie, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File Number:	2020/00194015
Representation:	Ms K Mackay, Coronial Advocate Assisting the Coroner Ms K Wiltshire for the Commissioner of Corrective Services, New South Wale Ms N Szulgit for Justice Health and Forensic Mental Health Network
Findings	Ivan Christov died on 30 June 2020 at the Prince of Wales Hospital, Randwick, New South Wales. The cause of Mr Christov's death were complications of chronic obstructive pulmonary disease and ischemic heart disease. Mr Christov died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication order	See Annexure A

1. Introduction

1.1 At the time of his death, Mr Ivan Christov was 70 years of age and was in lawful custody, serving a sentence of imprisonment.

1.2 Mr Christov had a medical history which included Chronic Obstructive Pulmonary Disease (COPD), Ischaemic Heart Disease, obstructive sleep apnoea, pharyngeal squamous carcinoma and hypothyroidism.

1.3 At 7.30am on 30 June 2020, Mr Christov was heard by correctional officers calling from his cell. He was found by Correctional Officers and Justice Health nursing staff lying on his right side in the bathroom area of his cell. He was somewhat confused, disoriented and unable to explain what had precipitated his fall. He denied that he was experiencing pain, however was unable to weight bear independently. Ambulance officers attended on Mr Christov at 8.05am and undertook an initial assessment, noting that he was confused with shortness of breath, but no obvious trauma. He was transported by ambulance and shortly before arriving at the hospital there was a change in his presentation, with an increased respiratory rate. The ambulance arrived at the hospital some 30-60 seconds later and the Nurse Unit Manager was spoken to by the ambulance officers indicating that he needed to be triaged urgently. Immediate attempts were made by the Emergency Department staff to resuscitate him by supporting his airway and placing him on Bipap (bi-level positive airway pressure) ventilation. This continued for 40 minutes with no clinical improvement, when the team became aware of the "not for resuscitation" and "not for intubation" directive and he was removed from the bipap and palliated. He died within ten minutes of the withdrawal of active treatments.

2. The legislative requirement for an Inquest

2.1 Pursuant to the Coroner's Act 2009 ("the Act"), a Coroner is required to investigate all reportable deaths to determine the identity of the person that has died, when and where they died, and the cause and manner of their death.

2.2 A person can be detained in lawful custody either as a result of the refusal of bail pending the determination of alleged criminal charges, or as a sentenced prisoner after conviction. Section 23 of "the Act" requires the Court undertake a mandatory inquest when a person dies within a custodial setting, to ensure that a person deprived of their liberty, is adequately cared for within that custodial setting, by the State.

2.3 The coronial investigation and inquest provides an independent inquiry into the circumstances surrounding a person's death in custody to assess issues of accountability, transparency and to ensure that the State has discharged its duty of care to an individual.

3. Mr Christov's life

3.1 Mr Christov was born on 26 July 1950 in Czechoslovakia, (now the Czech Republic) to his parents, Mr Jordan Christov and Ms Irena Nagyoua. He had two siblings, Irena and Franctiser. His parents are deceased and his siblings are presumed to be domiciled overseas.

3.2 Mr Christov migrated to Australia on 15 November 1970. He was granted Australian citizenship in 1994.

3.3 Mr Christov was known to reside in "various states across Australia with information suggesting that in 1971 he was in New South Wales, 1975 he was in South Australia, 1976 in Western Australia, in 1979 returning to New South Wales where he resided for most of his life."

3.4 Mr Christov was also known as Mr Jan Strbak and Mr Stan Boran. He had a number of entries on his criminal antecedents both in NSW and in South Australia and had served a number of periods of time in custody.

3.5 Mr Christov was reported to have formed several intimate relationships with women, although these appeared to have been marred by his propensity for violence to these women. In approximately 1982-83, Mr Christov formed a relationship with Noelene and they had one son, Michael from that union, born on 18 November 1984. In 1986, Mr Christov was sentenced to a period of imprisonment and Noelene moved to Western Australia with Michael and her other children (from a previous relationship), just prior to his release from custody on the advice of NSW Police. Noelene changed her name to avoid Mr Christov's attempts at detection, however continued to remain hypervigilant and protective of her young family.

3.6 Mr Christov had a long history of illicit substance abuse, particularly amphetamines and cocaine. He was a heavy smoker of cigarettes, at least 1-2 packets per day, until he was diagnosed with Chronic Obstructive Pulmonary Disease, approximately three years prior to his death.

3.7 In 2003, Mr Christov met his victim and they formed a relationship for a three month period. The victim ended this relationship and subsequently reported Mr Christov's stalking behaviour to NSW Police. The victim provided at least two statements to police and an interim apprehended violence order was sought on her behalf by the police. Attempts to serve Mr Christov with the interim order were unsuccessful. On 10 January 2004, the victim returned to her home at around 10pm and was confronted by Mr Christov who had earlier concealed himself within her house without her consent or knowledge. She was strangled by Mr Christov. He was subsequently arrested after a police pursuit. At trial, he relied on self-defence and impairment, however, both were rejected by the trial Judge. He was sentenced to a period of imprisonment of 23 years to date from 12

January 2004, with a non-parole period of 17 years. His earliest release date to parole would have been 11 January 2021.

4. Medical Interventions whilst in custody

4.1 Justice Health medical records disclose that Mr Christov was generally unwell during his last period of incarceration, most significantly with his known heart condition and COPD. In relation to COPD, he was provided with an oxygen tank with a mask to assist with his breathing. Mr Christov was also observed to be morbidly obese and was assessed as presenting with a risk of falls and was assisted with a walking stick for mobility and support.

4.2 In the months leading up to his death, Mr Christov was housed in a single cell in the Long Bay Hospital Aged Care Rehabilitation Unit (ACRU). Prison medical records confirm that he frequently attended the Prince of Wales Hospital for medical appointments and treatment for his numerous ailments. He was also seen by Justice Health nursing staff on a daily basis, as well as frequent assessments by a general practitioner.

4.3 By 29 January 2019, Mr Christov was under the care of the Senior Staff Specialist at the Respiratory Medicine Clinic at the Prince of Wales Hospital, due to his severe COPD, respiratory failure and obstructive sleep apnoea.

4.4 On 3 July 2019, a Registrar at the Respiratory Clinic commented in medical records that "Ivan and I had a long discussion today regarding the need for a sleep study or even empiric treatment with CPAP or BIPAP therapy. He continues to decline further investigation or treatments despite my assurance that unfortunately it is only a matter of time before he has another exacerbation with severe respiratory failure".

4.5 On 30 August 2019, he collapsed and was transported to the Prince of Wales Hospital, again receiving treatment for his respiratory diseases. During this admission, he was transferred to the Intensive Care Unit, until 3 September 2019, and then remained on a general ward until his discharge back to custody seven days later.

4.6 In January 2020, Mr Christov came under the care of an Associate Professor at the Cancer and Haematology Service at the Prince of Wales Hospital in relation to a six month history of right-sided pharyngeal pain on swallowing with some voice change and was diagnosed with squamous cell carcinoma arising in the right base of his tongue, with ipsilateral lymphadenopathy. He was treated with radiotherapy until 16 March 2020. He was last seen for a follow up consultation on 11 June 2020, at which time there was no visible or palpable evidence of a malignancy.

4.7 His cancer specialist provided a report after Mr Christov's death concluding that the "malignancy was a most unlikely cause of this patient's subsequent events."

4.8 On 25 March 2020, Mr Christov consulted with a geriatrician at the Prince of Wales Hospital, and provided him with a "not for resuscitation" and "not for intubation" directive.

5. Events on 29 June 2020

5.1 Justice Health records note that Mr Christov appeared pale and confused on 29 June 2020. His breathing was described as being noisy on exhaling but without signs of difficulty with his breathing. He was monitored closely and provided with oxygen at various intervals. It is noted that "Patient is refusing hospital care, wants to stay in ACRU. (Geriatrician) rung and is aware. ANUM (Acting Nurse Unit Manager) also aware patient is NFR."

6. Events on 30 June 2020

6.1 At 6.39am on 30 June 2020, a Correctional Officer was conducting the morning head count in the ACRU and saw Mr Christov in cell 10 on the toilet and responsive. At 6.44am, a temperature was conducted on Mr Christov who remained in situ on the toilet.

6.2 At 7.30am, two correctional officers were accompanying Justice Health Nursing staff for the morning pill parade and upon entering Mr Christov's cell found him on the ground in the shower area. A Registered Nurse (RN) on the unit was called and together they assisted Mr Christov onto a chair within the shower recess area. At the time, Mr Christov was unable to recount what had caused his fall. He denied any pain or injuries, but was confused, thinking that the year was 2002 and could not identify in which ward he was currently housed. It was also noted that he was breathing rapidly.

6.3 Due to the fall, his confusion and rapid breathing, the RN then contacted his geriatrician at 7.40am. His geriatrician requested that Mr Christov be transferred to the Prince of Wales Hospital emergency department for further investigations and treatment. The RN then contacted the NSW Ambulance Service and continued to monitor Mr Christov until he was in the care of ambulance officers. Mr Christov was then transported by ambulance to the Prince of Wales Hospital.

6.4 The Emergency Staff Specialist at the Prince of Wales Hospital provided a statement in these proceedings. The ED specialist confirmed that Mr Christov was brought to the Emergency Department in respiratory distress. Her team were informed that he had a "background of end-stage COPD, pharyngeal squamous cell carcinoma for which he was receiving radiotherapy, ischaemic heart disease, and obstructive sleep apnoea."

6.5 The ED specialist confirmed that "He was semi-conscious and had an obstructed airway. We attempted to resuscitate him by supporting his airway and placing him on Bipap (bi-level positive airway pressure)

ventilation. We gave steroids and bronchodilators for the treatment of COPD.

6.6 The ED specialist confirmed that "During this time I ascertained further information about ceiling of care for Ivan, given his history of end-stage COPD. I noted paperwork signed by (geriatrician from POWH) from March 2020 which indicated that he was not for resuscitation and not for intubation. By this stage we have been attempting resuscitation for 40 minutes with no clinical improvement. I called (his geriatrician) to discuss the case and we were in agreement that he should be taken of the bipap and palliated. He died within 10 minutes of withdrawal of active treatments, and was pronounced dead at 10.45am."

6.7 The ED specialist was of the opinion that the "cause of death was type 2 respiratory failure (hours), secondary to COPD (years), secondary to smoking (years). Co-morbidities of Ischaemic heart disease, pharyngeal squamous carcinoma and obstructive sleep apnoea."

7. Cause of Death

7.1 Mr Christov was later transported to the Department of Forensic Medicine where a postmortem examination was performed by Dr Kendall Bailey, forensic pathologist on 3 July 2020.

7.2 Dr Bailey noted that at the "postmortem external examination the deceased was found to be a morbidly obese adult male with external signs (barrel chest) of significant chronic obstructive pulmonary disease (COPD). In addition, signs of remote cardiothoracic surgery were noted."

7.3 Dr Bailey concluded that "Based on external examination and toxicology only, as directed by the Coroner, including review of the medical records provided, the cause of death is complications of chronic obstructive pulmonary disease and ischaemic heart disease. While respiratory failure may be the precipitant factor in this case, the underlying cardiac disease would predispose the deceased to cardiac arrest."

8. Conclusions

8.1 Considering the relevant records from CSNSW and Justice Health documenting Mr Christov's time in custody, together with the postmortem examination, it is clear that Mr Christov died from a natural disease process, which had been anticipated since at least March 2020.

8.2 It would appear that Mr Christov's medical condition was monitored closely on 29 June 2020, and his refusal to receive hospital treatment at this time was consistent with a pattern of declining medical advice and interventions.

8.3 On 30 June 2020, Mr Christov was transferred to hospital, in accordance with Departmental protocols, for treatment. It is noted that a "not for

resuscitation or intubation" directive was current and consistent with Mr Christov's stated wishes from March 2020.

8.4 Overall, it would appear that Mr Christov was provided with appropriate medical care to deal with a number of significant medical conditions while he was in custody. It is clear that no medical intervention would have changed the outcome experienced by Mr Christov on 30 June 2020, nor did any staff employed by CSNSW of Justice Health, contribute to his death.

8.5 I note that Mr Christov's son, Michael, provided a statement dated 17 December 2021. In his statement he speaks of the long term impact of significant and serious domestic violence perpetrated on his mother, himself and his half siblings. He speaks of the terror his mother exhibited over many years, fearing that her children may be found and further exposed to violence for 32 years. It is a stark reminder of the short-term and long-term consequences of violence and controlling behaviour and the associate physical, emotional and psychological sequelae of such abuse.

8.6 I would like to acknowledge and thank Ms Karissa Mackay, Coronial Advocate for her assistance in the preparation and presentation of the evidence in this case. I would also like to acknowledge and thank the Officer in Charge of this case, Plain Clothes Senior Constable Alesandar Gallina for his investigation and collation of the brief of evidence.

9. Findings

9.1 The findings I make under section81(1) of the Act are:

Identity

The person who died was Ivan Christov

Date of Death

Mr Christov died on 30 June 2020

Place of Death

Mr Christov died at the Prince of Wales Hospital, Randwick

Cause of Death

The cause of Mr Christov's death was complications of chronic obstructive pulmonary disease and ischaemic heart disease

Manner of Death

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

9.2 I now close this inquest

Magistrate Joan Baptie
Deputy State Coroner
1 February 2022
Coroners Court of New South Wales

Inquest into the death of Ivan Christov

File Number 2020/00194015

ANNEXURE "A"

Pursuant to section 74(1)(b) of the Coroner's Act 2009 (the Act), the following material contained within Exhibit 1 is not to be published:

a. Photographs, stills and CCTV of the Long Bay Hospital and of Ivan Christov,

b. Portions of the section 24 transfer order that describes security practices performed by CSNSW staff when escorting inmates,

c. Portions of Watch OIC's Journal dated 29 and 30 June 2020 that describe security checks performed by CSNSW staff,

d. Portions of the Inmate Accommodation Journal dated 29 and 30 June 2020 that describe security checks performed by CSNSW staff,

e. Portions of the checklist outlining the protocol surrounding reporting and investigation of deaths in custody

f. Portions of documents displaying the names, Visitor Index Numbers, contact numbers and addresses of family, friends and/or visitors, other than legal or professional visitors

g. Portions of documents displaying Ivan Christov's address, including addresses in Auburn, Riverwood or Mortdale prior to his imprisonment,

h. Portions of documents that might reveal the identity of Ivan Christov's victims

i. Portions of documents displaying the names, Master Index Numbers, locations and other identifying information of inmates other than Ivan Christov; and

j. Portions of documents displaying personal contact information of CSNSW, New South Wales Police Force, Metropolitan Special Programs Centre, Long Bay Hospital and Prince of Wales Hospital staff.

2. Pursuant to section 65(4) of the Coroner's 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.

Magistrate Joan Baptie
Deputy State Coroner
1 February 2022
Coroner's Court of New South Wales