CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jeffrey Ellington
Hearing dates:	18 March 2022
Date of findings:	18 March 2022
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:	2020/00245234
Representation:	Ms S Williams, Solicitor Assisting, instructed by Ms H Nicholls (Crown Solicitor's Office) Ms D Lekakis for the Commissioner of Corrective Services New South Wales Ms N Szulgit for Justice Health & Forensic Mental Health Network Ms H Webb for Ms C Ellington
Findings:	Jeffrey Ellington died on 21 August 2020 at Long Bay Correctional Complex, Malabar NSW 2036. The cause of Jeffrey's death was subarachnoid haemorrhage due to ruptured cerebral aneurysm. Jeffrey 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, Jeffrey Ellington was 32 years old and in lawful custody at the Long Bay Correctional Complex, serving a sentence of imprisonment. On the morning of 21 August 2020 Jeffrey was attending to some work duties with another inmate when he was seen to suddenly collapse to the ground. Medical assistance was immediately sought, and resuscitation efforts were initiated by nearby bystanders, and later continued by NSW Ambulance paramedics. Despite these efforts, Jeffrey could not be revived and was, tragically, later 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 be answered 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 seek 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. Typically, this responsibility rests with the government organisations which assume the care of a person whilst in lawful custody: Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**). It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Jeffrey was not appropriately cared for and treated whilst in custody.

3. Jeffrey'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 Jeffrey's personal history prior to his incarceration.

3.2 Jeffrey was born in May 1988 and was the youngest of four siblings. As a young child, Jeffrey was raised in the St Peters area in Sydney by his mother, Colleen Ellington, and lived in a house with his mother, uncle and two sisters, Shalee-Nicole and Ashley. When Jeffrey was about five or six years old, he was separated from his sisters and went to live with his aunty whilst Colleen dealt with

issues relating to alcohol and substance use. Approximately six months later, Jeffrey was reunited with Colleen and his sisters, and the family moved to Hillsdale.

3.3 Several years later, the family moved to Macquarie Fields. Jeffrey was involved in many activities with other children in his local neighbourhood, and was well liked amongst his peers. He had a particular interest in lizards and snakes and, according to Shalee-Nicole, was known as the "Steve Irwin of Mac Fields". Jeffrey was also interested in rugby league and played for local teams in Matraville and Macquarie Fields. Shalee-Nicole describes Jeffrey as a "happy, funny, happy-go-lucky kid".

3.4 Jeffrey was also interested in his Aboriginality, with much of this interest coming from his grandmother, Yvonne. As a result, according to Colleen, Jeffrey would often learn about the bush and his heritage. Regrettably, later in his childhood, Jeffrey was exposed to aspects of racism and appeared to lose interest in his culture.

3.5 Jeffrey approached his years at school with a positive attitude but struggled academically due to issues with literacy. This resulted in Jeffrey attending a non-mainstream school until Year 9 to assist with his learning challenges.

3.6 There is no doubt that Jeffrey's passing has been deeply felt by his family members and loved ones, and that they continue to miss him enormously.

4. Jeffrey's custodial history[1]

4.1 On 25 July 2019, Jeffrey entered lawful custody and was later convicted and sentenced to a term of imprisonment of two years and nine months in relation to a number of dishonesty and property offences. Jeffrey was due to be eligible for statutory parole on 23 June 2021.

4.2 Jeffrey had previously spent time in juvenile detention, and significant periods of his adult life were also spent in lawful custody between 2006 and 2019.

4.3 At the time of his death, Jeffrey was housed at the Long Bay Correctional Complex, Metropolitan Special Programs Centre (**MSPC**) Area 3, which is a low security wing.

5. Jeffrey's personal and medical history

Physical health

5.1 Jeffrey had a history of hepatitis C, facial cysts, acne, a heart murmur diagnosed in childhood, chronic lower back pain following a workplace injury in 2006, and treatment for injuries sustained whilst in custody. Jeffrey was also a smoker and had a history of asthma.

5.2 Upon Jeffrey's admission into custody on 27 July 2019 he was noted to have a "*large haematoma*" on his central forehead. However, Jeffrey declined any treatment in relation to it.

[1] Much of this background material has been drawn from the helpful and comprehensive opening address of the Solicitor Assisting.

5.3 On 11 December 2019, Jeffrey was reviewed by a visiting medical officer who referred him for surgical intervention. However, Jeffrey eventually decided not to proceed with the referral. It was noted that the matter was "*non-urgent at this stage and non-complicated lesion as per the examination*".

5.4 On 8 July 2020, Jeffrey reported to a Justice Health nurse that the lump had increased in size, that it was tender to the touch, and that he was experiencing ongoing headaches. Jeffrey disclosed that the lump was a result of head-butting another person three years previously. Jeffrey was placed on a waitlist for review by a general practitioner (**GP**).

5.5 On 13 July 2020, Jeffrey was reviewed by a GP who noted that the lump was not tender. A lipoma[2] was suspected, and an ultrasound was ordered with a referral to plastic surgery for further management.

5.6 On 13 August 2020, Jeffrey was reviewed by another GP who also suspected that the lump was a lipoma. Jeffrey was advised to seek further review if he noticed any changes.

History of complaints of headaches

5.7 Whilst in custody, Jeffrey complained of headaches on a number of occasions:

(a) On 21 September 2007, Jeffrey presented to Justice Health staff complaining of daily migraine headaches. He was referred to a GP for follow-up, although no records exist as to the nature of this follow-up.

(b) On 21 February 2015, 14 March 2015, 30 December 2016 and 29 August 2018, Jeffrey was administered paracetamol following complaints of a headache.

(c) On 4 December 2016, Jeffrey again complained to Justice Health staff of a headache.

(d) On 3 December 2018, Jeffrey presented to Justice Health staff complaining of a headache and a burst facial cyst on the right lower side of his lip.

(e) On 8 July 2020, Jeffrey again reported to Justice Health staff that he was experiencing ongoing headaches.

(f) Whilst at the MSPC, Jeffrey complained of frequent, severe headaches to other inmates, including MB. Mr MB reported that Jeffrey associated these headaches with the lump on his forehead, and that they disrupted his sleep on a nightly basis. According to Mr MB, Jeffrey reported experiencing migraines and sensitivity to light approximately three weeks prior to his death.

(g) Jeffrey also reportedly complained of headaches to his family members. Shalee-Nicole reports that Jeffrey told her that he was experiencing a headache on one occasion although the date of this event is not known. Further, prior to entering custody, Jeffrey reported to Colleen that he

[2] A relatively common, and usually harmless, growth of fatty tissue that develops under the skin of largely unknown cause(s) but often associated with injury and genetic factors.

was hearing voices which caused what he described as a burning pain in his head. As a result, Jeffrey had to lie down and used Panadeine for pain relief. After entering custody, Jeffrey continued to complain of hearing voices and experiencing headaches each time that he spoke to Colleen.

Episodes of violence whilst in custody

5.8 Jeffrey was also involved in three recorded episodes involving violence whilst in custody:

(a) On 29 November 2016, Jeffrey presented to the health centre at Parklea Correctional Centre after disclosing that he had been struck on the head five times with a heavy object. Jeffrey was transferred to Blacktown Hospital where he was found to be complaining of a headache, and with lacerations to his forehead, eyebrows and scalp, and swelling to his left cheek. Imaging investigations revealed no evidence of intracranial bleeding. The lacerations required stitches and Jeffrey was given medication for pain relief before being discharged on the same day. A follow-up appointment was booked at Westmead Hospital on 4 January 2017; however, Jeffrey later cancelled this appointment citing his reason as "*[D]on't want to go*".

(b) On 3 November 2018, Jeffrey was treated at Junee Correctional Centre after reportedly being punched in the mouth. This resulted in the loss of one tooth, whilst another tooth was displaced. An x-ray two days later showed no displaced nasal fracture, and it was noted that a computed tomography (**CT**) scan would provide better evidence of any potential facial bone fractures. Ultimately, no CT scan was conducted and the GP treating Jeffrey at the time noted that no further investigation was clinically indicated.

(c) On 7 February 2020, Jeffrey was involved in a physical altercation which resulted in him being charged with an offence occurring whilst in custody. There is no record of Jeffrey sustaining any injuries as a result of this event.

History of substance use

5.9 Jeffrey had a history of illicit drug use, commencing at age 12. After entering custody, Jeffrey disclosed that he was using amphetamines and heroin while in the community, and had been taking part in opioid substitution therapy by way of a methadone program. Jeffrey was subsequently diagnosed with Primary Opioid Use Disorder.

5.10 On 25 May 2020, Jeffrey self-referred for assistance regarding his drug use, stating that he had been using "*everything I can*" whilst in custody, and injecting substances into his neck. On 23 June 2020, Justice Health staff observed new track marks on Jeffrey's neck.

5.11 In June 2020, Jeffrey was assessed for suitability for the Buvidal program[3] and commenced on weekly depot injections of buprenorphine on 30 June 2020. Jeffrey disclosed that he had previously been using non-prescribed buprenorphine intravenously whilst in custody.

[3] A maintenance program for treatment of opioid dependence in patients who are also receiving medical, social and psychological support.

5.12 At the time of his death, Jeffrey's cellmate, Mr MB, reported that Jeffrey had also been drinking methadone, which had been diverted and obtained from other inmates. Mr MB indicated that Jeffrey reported drinking methadone a couple of days prior to his death.

Mental health

5.13 Jeffrey had a history of mental illness, including schizophrenia and bipolar disorder, with a history of self-harm. After entering custody, Jeffrey was commenced on olanzapine[4] in September 2019, after having ceased this medication whilst in the community.

5.14 On the 4 May 2020, Jeffrey was transferred from Parklea Correctional Centre to the emergency department at Blacktown Hospital after using a razor blade to make a 10 centimetre laceration to his right forearm. Jeffrey denied any suicidal ideation, and stated that he acted in order to avoid being transferred to Long Bay Correctional Complex (with the reason for Jeffrey's reluctance to be transferred being unclear). In hindsight, Jeffrey acknowledged that it had not been a good idea to act in this way. He was discharged the same day and referred to Westmead Hospital for review by the plastic surgery team. On 5 May 2020, Jeffrey underwent surgery at Westmead Hospital to repair the laceration.

5.15 As a result of his actions, Jeffrey was placed in a 24-hour camera cell under observation as part of a Risk Intervention Team protocol. On 6 May 2020, Jeffrey was returned to a shared cell placement.

5.16 It should be noted that at some stage Jeffrey reported to Colleen that on an unspecified date he was taken, whilst unconscious, from Parklea Correctional Centre to Long Bay Correctional Complex. No event consistent with Jeffrey's report has been documented in his medical records. However, this may be related to the 4 May 2020 self-harm event described above, although it is noted that there is no record of Jeffrey losing consciousness.

6. What happened on 21 August 2020?

6.1 On the evening of 20 August 2020, Jeffrey complained of being tired to his cellmate and went to bed an hour earlier than usual.

6.2 On 21 August 2020, Jeffrey reported for work duties between 6:30am and 7:00am in accordance with usual routine. Jeffrey and a fellow inmate, RM, were tasked with painting fire hydrants within the Long Bay Correctional Complex as part of grounds maintenance work. At approximately 7:45am Jeffrey and Mr RM collected their necessary work equipment and made their way towards Brian Phemister Avenue to commence work. The work site is located outside the perimeter wall of Long Bay Hospital but still within the Long Bay Correctional Complex.

6.3 Jeffrey began to jog while pushing a wheelbarrow containing some work equipment. As he was doing so, Jeffrey suddenly appeared unsteady, stopped jogging and said to Mr RM, "*I'm going to faint*", before collapsing to the ground. Mr RM flagged down a passer-by and asked for an ambulance to be called. At approximately 8:00am CSNSW Officer Heather Ferguson drove along

[4] Antipsychotic medication primarily used to treat schizophrenia and bipolar disorder.

Brian Phemister Avenue and saw Jeffrey lying on the ground. Officer Ferguson pulled over and used her mobile phone to call the Long Bay Hospital gate for assistance.

6.4 As this was occurring, a CSNSW officer located at a nearby tower also noticed Jeffrey lying on the ground and similarly called for assistance. CSNSW Officer Ashley Phillips responded to the call and made his way to the scene, arriving a short time later. Jeffrey was noted to be unconscious, in the recovery position and gasping for air. Officer Phillips felt Jeffrey's neck and detected a weak pulse. Senior CSNSW Officer Julie Lyle also responded to the request for assistance and after arriving at the scene made a radio call to the MSPC for medical assistance. An ambulance was called at 8:03am.

6.5 Justice Health personnel arrived on the scene a short time later, by which time Jeffrey had stopped breathing. Resuscitation efforts were commenced at 8:05am and oxygen was administered to Jeffrey. NSW Ambulance paramedics arrived on the scene at 8:13am, with a second paramedic crew arriving six minutes later. Defibrillation efforts commenced at 8:16am and Jeffrey was administered adrenaline. Resuscitation efforts continued for a further 13 minutes with no return of spontaneous circulation. Following this, the senior paramedic on scene directed that resuscitation efforts cease. Jeffrey was, tragically, pronounced life extinct.

7. What was the cause of Jeffrey's death?

7.1 Jeffrey was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 25 August 2020. Postmortem CT scan examination showed an acute event within the cranium, with bilateral subarachnoid haemorrhage along with haemorrhage noted in the ventricles. No evidence of trauma to the skull or the neck was identified.

7.2 Internal examination confirmed bilateral subarachnoid haemorrhage over the surfaces of both hemispheres. Further examination showed the presence of haemorrhage in the cerebral ventricles with a ruptured, round 0.9 centimetre aneurysm found over the anterior communicating arteries. It was noted that the vertebral arteries were unremarkable and that no trauma involving the head was identified.

7.3 In the autopsy report dated 5 January 2021, Dr Szentmariay opined the cause of Jeffrey's death to be subarachnoid haemorrhage with ruptured cerebral aneurysm being an antecedent cause.

8. Expert evidence

8.1 Given the sudden and expected nature of Jeffrey's collapse on the morning of 21 August 2020, the coronial investigation essentially sought to clarify three matters, namely whether:

(a) the events of 21 August 2020 could have been predicted;

(b) there was any opportunity to prevent the eventual outcome; and

(c) Jeffrey was provided with appropriate care and treatment following his collapse.

8.2 To assist with the above matters an independent expert, Professor Michael Besser AM, consultant neurosurgeon, was briefed to examine the circumstances leading up to, and surrounding, the events of 21 August 2020 and to provide an expert report.

8.3 In his report Professor Besser expressed the following views:

(a) Jeffrey's medical history included a number of known risk factors for the development of a cerebral aneurysm, including cigarette smoking and illicit drug use. Professor Besser also noted that Jeffrey's history of hepatitis C with significant liver fibrosis can lead to a deficiency in coagulation factors resulting in coagulopathy. In addition, Professor Besser noted that if a coagulopathy was present (despite a coagulation study from March 2018 being within normal limits), even to a mild degree, this would have made Jeffrey's subarachnoid and intraventricular haemorrhage "*very much worse*".

(b) As to the question of whether Jeffrey's cerebral aneurysm was diagnosable prior to death, Professor Besser opined that Jeffrey was "*entirely asymptomatic*". Professor Besser noted that although Jeffrey had previously complained of headaches, these were non-specific in nature and never accompanied by nausea, vomiting or collapse which are the classical symptoms for subarachnoid haemorrhage. Further, Professor Besser noted that there was no indication to perform any of the necessary investigations to arrive at a diagnosis of a cerebral aneurysm. More particularly, Professor Besser explained that that on the basis of Jeffrey's presentations to, and interactions with, Justice Health staff "*there was no indication of intracranial pathology or the need for any further investigation in this regard*".

(c) Professor Besser also considered the reports of headaches that Jeffrey had made to both Colleen and Mr MB. Professor Besser expressed the view that Jeffrey's report of loss of consciousness on an unspecified date did not correlate with the medical records, and may have been related to Jeffrey's history of schizophrenia and hearing of voices. Further, Professor Besser noted that Jeffrey's reports of headaches to Mr MB were non-specific and not associated with any symptoms suggestive of intracranial haemorrhage. In particular, Professor Besser noted that whilst Jeffrey associated these headaches with the cyst on his forehead, the cyst was benign and would not have contributed to such headaches.

(d) Professor Besser considered the medical treatment provided to Jeffrey following his collapse to be "*prompt, appropriate and of a high standard*" and that Jeffrey "*received the best care that could be given under the circumstances*". Professor Besser opined that no other medical treatment on 21 August 2020 could have prevented the eventual tragic outcome. Professor Besser described the ruptured anterior communicating cerebral aneurysm as being so overwhelming as to cause immediate collapse and cardiorespiratory arrest within minutes due to a massive increase in intracranial pressure resulting in agonal brain stem herniation.

8.4 Ultimately, Professor Besser concluded as follows:

> Jeffrey was in the unfortunate 60% of patients who die in the community from massive intracranial haemorrhage due to a ruptured cerebral aneurysm. They simply do not live long

enough to be admitted to hospital and half of these patients are asymptomatic prior to their [sudden event].

9. Conclusions

9.1 All of the evidence gathered as part of the coronial investigation, and in particular the independent expert evidence provided by Professor Besser, establishes that:

(a) The tragic events of 21 August 2020 could not have been predicted. Jeffrey was entirely asymptomatic in the period leading up to his sudden and unexpected collapse. Whilst Jeffrey had previously reported experiencing headaches to his family members, fellow inmates and Justice Health staff, these reports were non-specific in nature. Further, these reports were not accompanied with any of the usual symptoms associated with the possibility of a cerebral aneurysm.

(b) There was no opportunity to prevent the eventual tragic outcome. Whilst a cerebral aneurysm may be diagnosed with appropriate medical investigations, there was no feature of his previous presentations to, or interactions with, Justice Health staff which provided a clinical indication for any investigations of this kind to be performed.

(c) Jeffrey was provided with prompt and appropriate care and treatment following his collapse, and no other care or treatment could have averted the eventual outcome.

9.2 Overall, the available evidence indicates that Jeffrey was provided with appropriate medical care and treatment whilst in custody. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual devastating outcome. There is also no evidence to suggest that any aspect of Jeffrey's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

9.3 One final matter should be noted. Colleen explained that following Jeffrey's death she was, without warning, given a cardboard box (labelled with Jeffrey's name and inmate number) containing his belongings. The circumstances in which this occurred likely and understandably caused Colleen some distress. Relevant CSNSW policies exist to allow for the administrative process of returning property belonging to a deceased inmate to the family of that inmate. It is hoped that in the future this process can be undertaken with appropriate sensitivity and empathy, without adding to the trauma that a family is already experiencing.

10. Findings

10.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Sophie Williams, Solicitor Assisting, and Ms Hermione Nicholls of the Crown Solicitor's Office their excellent assistance both before, and during, the inquest. I also thank them for the sensitive and compassionate way in which they have approached this matter.

10.2 I also thank Detective Senior Constable Kelly Gatt, the police officer-in-charge, for her role in the investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Jeffrey Ellington.

Date of death

Jeffrey died on 21 August 2020.

Place of death

Jeffrey died at the Long Bay Correctional Complex, Malabar NSW 2036.

Cause of death

The cause of Jeffrey's death was subarachnoid haemorrhage due to ruptured cerebral aneurysm.

Manner of death

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

10.4 There is no doubt that Jeffrey is greatly missed by his family and loved ones. The sudden and unexpected nature of Jeffrey's death, and his untimely death at a young age, have surely only added to the trauma and grief experienced by those who miss Jeffrey the most. On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Jeffrey's family and loved ones for their tragic loss.

10.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
18 March 2022
Coroners Court of New South Wale

Inquest into the death of Jeffrey Ellington

File Number: 2020/00245234

Annexure A

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), 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 identifies or might identify any family member, friend or person who visited Jeffrey while in custody (other than legal representatives or visitors acting in a professional capacity).

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

   (c) The direct contact details, including telephone numbers and email addresses, of CSNSW officers, employees and offices that are not publicly available.

   (d) The following CSNSW policy material:

      i. Death in Custody Checklist

         i. Lines 7 and 8 under the sub-heading 'Crime Scene Preservation' on page 1

         ii. Line 2 on page 3: telephone number of duty officer

      ii. COPP 13.1 Serious Incident Reporting

         i. At [2.6] on page 6 of 12 and [4.1] on page 9 of 12: email address of CSNSW

         ii. At [2.5] on page 5 of 12 and [3.1] on page 7 of 12: telephone number of duty officer

         iii. At [2.5] on page 5 of 12: after hours telephone number

      iii. COPP 13.3 Death in Custody

         i. At [2.4] on page 6 of 17: third sentence

         ii. At [6.1] on page 12 of 17: telephone number of the ASPU.

      iv. COPP 13.8 Crime Scene Preservation

         i. At [4.1] on pages 10-11 of 14: whole sub-section other than the sentence beginning 'For forensic evidence on victims…'

   (e) Photographs of Metropolitan Special Programs Centre

(f) Paragraph 9 of the statement of ST, from line 5 after the words 'I relation…'

(g) Body worn camera footage.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on 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
18 March 2022
Coroners Court of New South Wales