CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Khaled DIB
Hearing dates:	14 February 2022
Date of findings:	14 February 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Brett Shields, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2019/00278264
Representation:	Ms. K. Mackay, Coronial Advocate Assisting the Coroner
Findings:	Identity: Khaled Dib Date of death: 5 September 2019 Place of death: Dawn De Loas Correction Centre, Silverwater, New South Wales Cause of death: Cardiomegaly and myocardial bridging of the left anterior descending coronary artery Manner of death: Natural Causes
Recommendations	Nil
Non-publication orders:	See Annexure A

1. Introduction

1.1. At the time of his death, Khaled Dib was 42 years old and in lawful custody at the Dawn De Loas Correctional Centre ('DDCC') within the Silverwater Correctional Complex, Silverwater, New South Wales, serving a term of imprisonment.

1.2. On 5 September 2019 Mr. Dib was seen by his cell mate to collapse at approximately 20.32 and strike his head on a cupboard as he fell to the floor. Emergency services attended however Mr. Dib could not be revived and he was pronounced deceased at the scene.

2. Reason for the inquest

2.1. The *Coroners Act* 2009 ('the Act') requires a Coroner to investigate a 'reportable death', as that term is defined in the Act, to enable a Coroner to the make the findings required by sec. 81 of the Act. The findings concern the identity of the person who died, when and where they died, and the cause and the manner of their death. In this context the manner means the circumstances in which they died.

2.2. A person charged with a criminal offence, or who is sentenced to a term of imprisonment upon conviction, can be detained in lawful custody and, in so doing, the State assumes responsibility for the care of that person. Sec. 23 of the Act makes an inquest mandatory in cases where a person dies while in the custody of the State. The open administration of justice requires, and the community appropriately expects, that the death of a person in the custody of the State will be properly and independently investigated to ensure that the State met its responsibility for the care of that person.

2.3. The coronial investigation into the death of Mr. Dib did not identify any evidence to suggest that he was not appropriately cared for and treated while in custody.

3. Mr. Dib's life and background

3.1. Mr. Dib was born in Sydney on 9 July 1977 and was aged 42 at the time of death. Mr. Dib came from a large family and he had 10 siblings. Both of his parents are deceased and it is reported, although not confirmed, that his mother died from a cardiac condition.

3.2. Mr. Dib was religiously married and with his spouse had 5 children born between 2001 and 2013. Prior to his incarceration Mr. Dib worked for 18 years as a self-employed taxi driver.

4. Mr. Dib's custodial history

4.1. In November 2015 Mr. Dib was arrested and charged with supplying prohibited drugs and related matters. He was bail refused and entered Corrective Services New South Wales ('CSNSW') custody on 7 November 2015 and was thereafter held on remand until he was sentenced.

4.2. Mr. Dib appeared before the District Court on 20 November 2017 and again on 12 December 2017 when he was sentenced to a term of imprisonment of 7 years with a non-parole period of 4 years commencing on 6 November 2015. Mr. Dib's earliest possible date for release was on 5 November 2019. At the date of his death Mr. Dib had served the majority of the non-parole period of his sentence and he would have been eligible for release in 2 months.

4.3. After sentence Mr. Dib was classified as 'C1 Minimum Security' inmate and he was held in a number of CSNSW correctional centres until he was transferred to DDCC in January 2018. In July 2018 Mr. Dib was reclassified as 'C2 Minimum Security' and in February 2019 he was again reclassified at 'C3 Minimum Security'. During his time in custody Mr. Dib had 2 minor breaches of discipline with minimal or no sanction. He received many visits from family.

5. Mr. Dib's medical history

5.1. Mr. Dib underwent a Reception Screening Assessment when he first entered custody on 7 November 2015 which included a mental health assessment. Mr. Dib reported he was seeing a specialist at Westmead for skin and eye irritations, and he was commenced on medication. Mr. Dib reported no other medical conditions although he did report regular use of Cocaine.

5.2. After initial assessment the evidence shows that Mr. Dib had the following further contacts with Justice Health:

5.2.1. Between November 2015 and November 2017 Mr. Dib was seen by primary care nurses for recurrent heartburn and headaches, neck pain and hay fever, and he was treated appropriate medications;

5.2.2. Between January 2016 and September 2017 Mr. Dib completed a patient self-referral from requesting consultations with a medical practitioner for severe heart burn, recurrent migraine headaches, cold and flu symptoms, severe back pain and hay fever, although on 4 occasions he failed to go to the health centre when called concerning his self-referrals;

5.2.3. On 12 October 2016 Mr. Dib saw a medical practitioner about the above conditions;

5.2.4. On 18 January 2017 Mr. Dib was reviewed by a medical practitioner who reported Mr. Dib had no health concerns;

5.2.5. On 30 March 2019 Mr. Dib and he disclosed certain matters relating to his childhood and past drug use. He denied any thoughts of self-harm and requested a counselling to manage the sequelae from the disclosed childhood matters;

5.2.6. On 31 July 2019 Mr. Dib was seen by a primary care nurse for severe back pain and migraines and was prescribed medication; and

5.2.7. On 5 September in the circumstances described below.

6. 5 September 2019

6.1. On 3 September 2019, Mr. Dib spent the morning exercising. He attended the midday muster and again exercised for a short time before socialising. Mr Dib made no complaints of feeling unwell. Starting at 20.00 Mr Dib played cards with other inmates until 20.21 when he returned to his cell, which he shared with one other inmate.

6.2. Mr. Dib's cell has no internal CCTV coverage however external CCTV partially views the interior of the cell when the door is open. Seemingly for this reason, Mr. Dib had erected a curtain to cover the doorway. On returning to his cell Mr Dib changed his clothes and then socialised with his cell mate and other inmates who entered the cell.

6.3. At approximately, 20.32 Mr. Dib was seated on his cell mate's bed when his head dropped slowly to his chest and he fell forwards off the bed onto the floor, striking his head on an adjacent cupboard as he fell. Another inmate activated the 'Knock Up' button in the cell and spoke by intercom to CSNSW Staff informing them of the situation, and he then provided assistance to Mr. Dib, who was making noises but was otherwise unresponsive.

6.4. The first CSNSW staff entered the cell at 20.34 and they were joined by Justice Health nurses in the cell at 20.36. CPR was commenced while awaiting the arrival of Ambulance. A '000' call was made at 20.40 and an ambulance was tasked at 20.44, arriving at the DDCC at 20.50. The Ambulance paramedics arrived at the cell at 20.54 and they continued the CPR and treatment until 21.26. Mr. Dib was pronounced deceased at 20.28.

7. The cause Mr. Dib's death

7.1. Mr. Dib was taken to the Department of Forensic Medicine in Sydney where a post-mortem examination was performed by Dr. K. Bailey, forensic pathologist, on 10 September 2019.

7.2. In the autopsy report dated 28 July 2020 Dr. Bailey opined that the direct cause of death is cardiomegaly and myocardial bridging of the left anterior descending coronary artery.

8. Conclusions

8.1. The evidence establishes on the balance of probabilities that the cause of Mr. Dib's death was Cardiomegaly and myocardial bridging of the left anterior descending coronary artery.

8.2. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health to alter the outcome or that any aspect of the medical care provided to Mr. Dib while in custody contributed in any way to his death.

9. Findings

9.1. The findings I make under sec. 81(1) of the Act are:

Identity	Khaled Dib
Date of death	5 September 2019
Place of death	Dawn De Loas Correctional Centre, Silverwater, New South Wales
Cause of death	Cardiomegaly and myocardial bridging of the left anterior descending coronary artery
Manner of death	Natural Causes

10. Closing

10.1. I acknowledge and express my gratitude to Ms. K. Mackay, Coronial Advocate, for her assistance both before and during the inquest. I also thank Plain Clothes Senior Constable Joel Swales for conducting the Police investigations and for compiling the initial brief of evidence.

10.2. On behalf of the Coroners Court of New South Wales, I offer condolences to Mr. Dib's family.

10.3. I close this inquest.

Magistrate Brett Shields
Deputy State Coroner
Coroners Court of New South Wales