CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Fennell
Hearing dates:	19 May 2022
Date of findings:	19 May 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Erin Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody - cause and manner of death
File number:	2020/308509
Representation:	Mr Kai Jiang, Coronial Advocate assisting the Coroner Ms Sian Pickard for Commissioner for Corrective Services New South Wales Ms Natalie Szulgit for Justice Health and Forensic Mental Health Network
Findings:	I make the following findings pursuant to Section 81 of the Coroners Act 2009 NSW: Mr Robert Fennell died on 27 October 2020 in Cell 30 of the Medical Sub-Acute Unit of Long Bay Hospital within the Long Bay Correctional Facility. Mr Fennell died of natural causes while in lawful custody serving a sentence of imprisonment.
Recommendations	Nil
Non-publication orders:	See annexure A

FINDINGS

1. Mr Fennell had been diagnosed with metastatic colorectal carcinoma and was in palliative care at Long Bay Hospital. He had a complex medical history. He was serving a sentence of imprisonment at the time. He was found unresponsive by staff on the evening of 27 October 2020. Hospital staff, Corrective Services staff and police attended and Mr Fennell was declared life extinct.

2. Mr Fennell had previously made a decision to cease treatments and receive palliative care at Long Bay. Prior to that time he had received extensive medical treatment over his years of incarceration.

Why was an inquest held?

3. A Coroner is required to investigate reportable deaths. The Coroner must attempt to answer questions in accordance with the Act. This involves an investigation to determine the identity of the person, when and where they died, and what was the cause and manner of their death.

4. A person who is detained at law in lawful custody on remand or sentenced to a term **of imprisonment for any reason falls into the category of persons for whom an inquest** must be held. This is an important process to ensure the protection of such people while they are in the care of the State. It generally will be the case that the conduct of staff from Corrective Services New South Wales (Corrective Services) and Justice Health and Forensic Mental Health Network (Justice Health) will be examined carefully to ensure the State properly played its part in the care of the individual.

Reflection on the life of Mr Robert Fennell

5. Robert Fennell was born on 26 November 1942 in Newcastle. He worked as an electrician in coal mines before he stopped working in 2012.

6. In 1963, Mr Fennell married his first wife and had two daughters and one son from that relationship. However, the marriage broke down at a later stage, and he was estranged from this family.

7. In 1991, Mr Fennell remarried and gained two stepdaughters as a result of that union. Mr Fennell had a close relationship with his family and is loved and missed by his stepdaughters.

8. On 25 June 2013, Mr Fennell was arrested and charged with a number of serious offences. On 13 August 2015, he was convicted at Newcastle District Court and was sentenced to a term of imprisonment of 18 years commencing on the same day with a non-parole period of 8 years and 6 months. The earliest possible release date was 12 February 2025.

9. Throughout his time in custody, Mr Fennell was transferred to multiple correctional centres due to his health needs. His last transfer was on 20 October 2019, when he was moved to the Long Bay hospital within the Long Bay Correctional Complex. At the time of his death, Mr Fennell was in lawful custody as a result of his sentence. He was an inmate housed in Cell 30 of the Medical Subacute Unit at the Long Bay Hospital. Pursuant to Section 23 of the Coroners Act 2009 NSW an inquest is mandatory.

Medical History of Mr Fennell

10. Mr Fennell suffered poor health due to multiple serious health conditions and was described to be an elderly frail man who required assistance with his mobility upon reception into custody. He was a smoker but stopped around 2006.

11. Mr Fennell has an extensive list of health conditions. He had a tonsillectomy in his childhood. He suffered from chronic obstructive airways disease, peripheral vascular disease and osteoarthritis and osteoporosis. In the 1980s, Mr Fennell was diagnosed with systemic lupus erythematosus (autoimmune disease). He had a right shoulder reconstruction in 2011. He was diagnosed with coeliac disease in 2013. In March 2019, Mr Fennell was diagnosed with iron deficiency anaemia and he also underwent limited fasciectomy to treat dupuytren's contracture in his right little finger. Further medical records indicate that he suffered from conditions such as dyslipidaemia, congestive cardiac failure, mild asthma and hypertension.

12. Since November 2003, regular surveillance colonoscopies were conducted after the detection of pre-malignant polyps. Since July 2013, colonoscopy was required every 2 years. Since Mr Fennell's incarceration, according to the records held by Justice Health, colonoscopies were conducted in November 2016 and November 2017. In November 2018, Mr Fennell was admitted to the Prince of Wales Hospital Orthopaedic Clinic for left shoulder arthroplasty. There was no record of colonoscopies at the same time.

13. In March 2019, Mr Fennell was referred to the Prince of Wales Hospital Department of Haematology due to right hip discomfort and weight loss. On 20 March 2019, a CT abdomen scan was performed which demonstrated findings consistent with Primary Bowel Malignancy. This was confirmed in May 2019 after elective colonoscopy and Mr Fennell was subsequently diagnosed with Colorectal Cancer.

14. On 13 June 2019, Mr Fennell underwent an elective open right hemicolectomy at the Prince of Wales Hospital. He recovered well without complications. However, he was admitted back to the hospital soon after due to gradually increasing pain and swelling to his left knee. On 24 October 2019, Mr Fennell was diagnosed with metastatic (spreading of cancer cells to other parts of body) colorectal cancer. Due to his multiple medical co-morbidities and poor performance status, palliative radiotherapy was preferred as the treatment method. This was completed in November 2019 and the pain in his knee was significantly reduced. Palliative chemotherapy was to be considered if his clinical conditions improved. However, this did not eventuate due to ongoing deterioration of Mr Fennell's health.

15. On 19 November 2019 Mr Fennell authorised an Advanced Care Directive and elected not to be resuscitated in the event of a cardiopulmonary arrest. On 12 December 2019, Mr Fennell was seen by Professor David Goldstein at the Department of Medical Oncology where it was explained that he has incurable, advanced colon cancer and he was provided a prognosis of less than 12 months. The follow-up treatment plan was focused on "reconditioning, pain optimisation, nausea optimisation, and if performance status improves, then palliative intent chemotherapy could be considered". On 9 January 2020, after further review with Dr Goldstein, Mr Fennell conditions did not improve.

16. After discussion of his treatment options, Mr Fennell decided to return to Long Bay Correctional Centre and not to receive systemic anti-cancer therapy. He wanted the treatment to focus on having his symptoms tended to and maintain his overall comfort during his end-of-life care. Mr Fennell understood that he was likely to die from his malignancy in the coming months.

Events leading up to Mr Fennell's death

17. Over the following months, Mr Fennell continued to experience generalised pain in his body, and was described to be cachectic. He was regularly reviewed by the Department of Palliative Care at the Prince of Wales Hospital using telehealth. He also had regular contact with his family who were aware of his conditions. In June 2020, regular observations, weight monitoring and blood tests ceased.

18. By August 2020, due to COVID restrictions, Mr Fennell was unable to receive visits from his family, however he was able to maintain regular and daily contact with them using video conference and telephone. On 21 October 2020, a request was put through for family visitation in person due to Mr Fennell's limited life expectancy, however the application was denied by the Correctives Services. On 23 October 2020, according to records held by Corrective Services, Mr Fennell received family visit for the last time using video conference.

19. I should comment here on the difficult times faced by all during COVID restrictions. The heartbreaking decisions that separated families in such sad times were made in attempt to protect all. These decisions were not limited to prison with a highly susceptible and vulnerable population. It was also occurring in nursing homes and hospitals. This in no way diminishes the terrible sadness experienced by Mr Fennell's family at their inability to be physically with him during the end stages of his life.

20. About 10pm on Tuesday 27 October 2020, routine checks were conducted by Corrective officers and Mr Fennell was observed to be responsive at the time. However, about one hour later on the same day, he was found by Justice Health nurses during their medical rounds in his cell to be unresponsive and without any signs of life.

21. About 11:10pm on Tuesday 27 October 2020, Mr Fennell was declared life extinct.

Investigation following the death of Mr Fennell

22. Following Mr Fennell's death, as is appropriate, Police were notified and attended the location at about 1am on 28 October 2020. A crime scene was established, and Cell 30 was secured. Police spoke to and obtained statements from the Justice Health nurses and Corrective officers present. Cell 30 was searched and forensically examined with a number of photographs taken. After the attendance and examination of the scene by Police Detectives, Mr Fennell's death was not treated as suspicious.

23. Police spoke to Mr Fennell's family and informed them of his unfortunate passing. His family raised two concerns firstly in relation to whether he received appropriate colonoscopies while in custody. Investigations as set out above disclosed that he did in fact receive them as medically recommended.

24. The second issue raised was that the family had concern that Mr Fennell did not have adequate access to chaplaincy services. In the case management report it was noted that Mr Fennell was "encouraged to self-refer to the chaplaincy service as he required", however it would seem that no formal procedure or policy was in place at the time regarding access to chaplaincy service by inmate patients in palliative care. It was especially important to his family that he received some comfort where available. They also were concerned that as a very unwell person it would be difficult to self-refer.

25. As a result of this concern enquiries were made with Corrective Services. Evidence was obtained that disclosed that in February 2021, a special project was commenced to initiate a "strong partnership between Justice Health network palliative care team and CSNSW Chaplaincy services to provide holistic care to inmates receiving palliative care" which intends to provide a stronger framework for better access and engagement by inmates in palliative care to chaplaincy services. This is a very

important issue raised but it appears Corrective Services are taking steps to make access easier for those in palliative care in the future.

Identification and Investigation outcome

26. An identification statement was completed by a Justice Health nurse who had been treating and caring for Mr Fennell for a significant period of time whilst he was housed at the Long Bay Hospital Medical Sub-Acute Unit. The relevant CCTV footage from the Medical Sub-Acute Unit was provided and reviewed. No issues were identified, and the content of the footage was consistent with reports from Corrective officers and Justice Health staff. The case file kept by Correctives Services was obtained and reviewed. Mr Fennell was cared for and treated appropriately whilst in custody and in accordance with relevant policies and procedures of the Corrective Services. There is no evidence that any aspect of Mr Fennell's medical care or the care provided by CSNSW and Justice Health contributed in any way to his death.

Conclusion

27. The process could not proceed without the investigating officer Detective Senior Constable David Murphy and in this case Coronial Advocate Mr Kai Jiang who both have contributed a great deal of work in assisting this inquiry for which the Court is grateful.

Findings

Pursuant to section 81(1) of the Coroners Act (2009)

a. Identity: Mr Robert Fennell

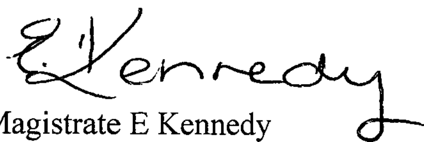
b. Date: 27 October 2020

c. Place: Cell 30 of the Medical Sub-Acute Unit of Long Bay Hospital, Long Bay Correctional Facility,1300 Anzac Pde Malabar NSW

d. Cause: Complications of Metastatic Colorectal Carcinoma

e. Manner: Natural Causes

To the family and friends of Mr Fennell, I offer my sincere and respectful condolences for their loss.



Magistrate E Kennedy
Deputy State Coroner
19 May 2022

ANNEXURE A

Short Minutes of order

19 May 2022

SHORT MINUTES OF ORDER

COURT DETAILS	
Court	State Coroner's Court of NSW
Registry	Lidcombe NSW
Case number	2020/308509
PROCEEDINGS	
Inquest into the death of	**Robert FENNELL**
DATE OF ORDER	
Date made or given	19 may 2022

TERMS OF ORDER

1. Under section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published as it is information that is not available to the public and, if released, has the potential to jeopardise CSNSW security arrangements and the safety of staff, inmates and visitors:

   a. CCTV footage and any stills of that footage, handheld video camera (**HHVC**) footage and offender telephone system (**OTS**) call audio; and

   b. The project briefing at Tab 22.

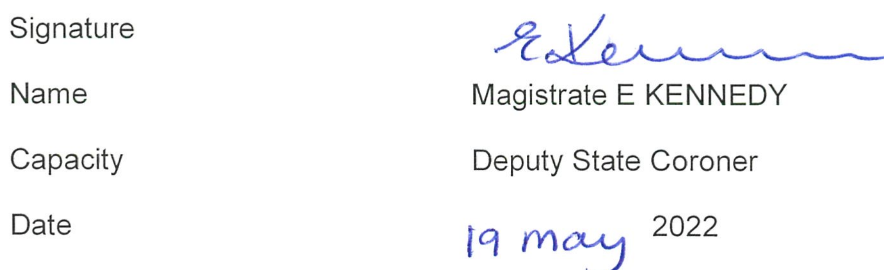
   c. Names, addresses, phone numbers and other personal information that could tend to identify:

      i. Any member of Robert FENNEL's family (including any addresses listed); and

      ii. Any person who visited Robert FENNELL while in custody (other than legal representatives or visitors acting in a professional capacity).

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.

SIGNATURE



Signature	[signature]
Name	Magistrate E KENNEDY
Capacity	Deputy State Coroner
Date	19 may 2022