CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ronald Turner
Hearing dates:	5 April 2022
Date of findings:	5 April 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:	2020/26597
Representation:	Ms A Chytra, Coronial Advocate Assisting the Coroner Ms C Moore for the Commissioner of Corrective Services New South Wales Ms N Szulgit for Justice Health & Forensic Mental Health Network
Findings:	Ronald Turner died on 26 January 2020 at Prince of Wales Hospital, Randwick NSW 2031. Mr Turner died from the consequences of bowel obstruction. Mr Turner 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 On 23 January 2020, Ronald Turner experienced a sudden medical episode suggestive of an acute abdominal condition which required urgent medical treatment. At the time, Mr Turner was in lawful custody at a correctional centre serving a sentence of imprisonment. Arrangements were made to transfer Mr Turned to hospital where interventional surgery was performed on 24 January 2020.

1.2 Despite showing initial signs of improvement and stability on 25 January 2020, Mr Turner's condition subsequently deteriorated. In accordance with Mr Turner's wishes, no further surgical intervention was performed and no advanced life support was provided. Mr Turner was later pronounced life extinct on the afternoon of 26 January 2020.

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 answer 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 seeks 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. This type of examination typically involves consideration of, where relevant, the conduct of staff from 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 Mr Turner was not appropriately cared for and treated whilst in custody.

3. Mr Turner'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.

3.2 Mr Turner was born in Fremantle, Western Australia in July 1938, and was one of six children. Mr Turner married on two occasions, with the first marriage resulting in three children, and the second marriage resulting in two children.

3.3 In around 1979, Mr Turner his wife and two of his daughters moved to Hong Kong due to his wife's work. However, whilst in Hong Kong, the marriage broke down, resulting in Mr Turner returning to Australia and moving to the NSW Central Coast.

3.4 Regrettably, little else is known about Mr Turner's personal history prior to his incarceration. However, there can be little doubt that those loved ones most affected by Mr Turner's passing still feel his loss most deeply.

4. Mr Turner's custodial history

4.1 On 30 November 2012, Mr Turner was arrested and charged with a number of offences. He was later convicted of some of these offences on 2 March 2013 and subsequently sentenced to an effective term of imprisonment of 16 years, with a non-parole period of seven years. Mr Turner's earliest release date to parole was 25 June 2020.

4.2 Following his convictions, Mr Turner was housed at a number of different correctional centres including at Parklea, Junee, the South Coast, and Long Bay. Whilst in custody, Mr Turner worked in the laundry and library of correctional centres at various times. At the time of his death Mr Turner was housed within the Aged Care Rehabilitation Unit (**ACRU**) at Long Bay Correctional Complex, having been transferred there from the Medical Subacute Unit. The ACRU is a specialist unit which caters for older inmates in need of medical care and attention.

5. Mr Turner's medical history

5.1 Mr Turner had a complex history of insulin-dependent type II diabetes mellitus, chronic psychosis, hypertension, pseudo-obstruction, cellulitis, hypothyroidism, hyperlipidaemia, osteoarthritis and functional decline. In 2011, Mr Turner suffered a stroke causing him to suffer a fall resulting in a broken hip. This was later repaired during surgery at hospital. However, in 2016, Mr Turner displaced the repair to his hip and was stood down from work duties in the laundry at Long Bay Correctional Complex. Following this, Mr Turner experienced mobility issues and was provided with a walking stick and offered a wheel trolley on request. In June 2018, following surgical consultation at hospital, Mr Turner underwent a full hip replacement at the Prince of Wales Hospital (**POWH**).

5.2 In May 2018, Mr Turner was diagnosed with sigmoid volvulus[1] and large bowel obstruction. He was admitted to POWH for further treatment. In September 2018, Mr Turner underwent a flexible sigmoidoscopy[2] and reduction of his sigmoid volvulus. The following month, Mr Turner was returned to POWH and diagnosed with recurrent sigmoid volvulus. He subsequently underwent a laparoscopic high anterior resection of the bowel[3].

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[1] This occurs when part of the colon twists on itself, causing obstruction and compromising blood supply to the colon.
[2] A medical examination, using a flexible, narrow tube with a light and small camera, to evaluate the lower part of the colon.
[3] A type of surgery, using a slender tube inserted through a small incision, to remove sections of the bowel.

5.3 In June 2019, Mr Turner was admitted to the psychiatric unit within Long Bay Hospital due to concerns that a decline in his mental health pose a risk to himself, and to others. However, by August 2019, these concerns were resolved and Mr Turner was transferred to the ACRU.

6. What happened in January 2020?

6.1 On 22 January 2020, Registered Nurse (**RN**) Aarati Bhandari was completing the night time medication round within the ACRU. At around 7:30pm, RN Bhandari spoke with Mr Turner who reported feeling a lump in his stomach for the previous two weeks. Mr Turner described experiencing intermittent pain, and denied any nausea, vomiting or constipation. RN Bhandari examined Mr Turner's abdomen and found it to be distended but with nil palpable lump. Following this assessment, Mr Turner was provided with his regular medications and advised to use a call alarm button if in need of medical assistance.

6.2 After completing the medication round, RN Bhandari checked on Mr Turner again at around 8:30pm and found him to be asleep and breathing normally. During the remainder of her shift, RN Bhandari checked on Mr Turner at hourly intervals and found him to still be asleep, with no apparent issues.

6.3 At the completion of her shift on the morning of 23 January 2020, RN Bhandari provided a handover regarding Mr Turner's presentation to the incoming nursing staff, including RN Catherine Ross. RN Bhandari advised RN Ross that Mr Turner was due for review by a medical officer later that day due to his abdominal concerns.

6.4 Between around 6:45am and 7:00am , Mr Turner was checked on and found to be resting in bed and breathing normally. However, later that morning, Mr Turner was found to be incontinent of faeces and to have vomited. On assessment, Mr Turner reported experiencing abdominal pain and requested analgesic pain relief. Following consultation with Dr Welkee Sim, a specialist in geriatric medicine, nursing staff obtained an order for an intramuscular antiemetic (medication effective against vomiting and nausea) to treat Mr Turner's vomiting. However, Mr Turner refused the injection after ceasing vomiting, and was able to tolerate oral analgesia.

6.5 At around 9:25am Mr Turner's blood pressure was noted to be 74/45, placing it outside what is known as the "Between the Flags" range for vital signs observations. At around 9:55am, a repeat blood pressure was performed showing some moderate improvement. Nursing staff made a phone call to Dr Sim, reporting Mr Turner's refusal of the intramuscular antiemetic and his low blood pressure. Dr Sim advised the nursing staff to make arrangements for Mr Turner to be conveyed to the POWH emergency department.

6.6 An ambulance arrived at around 10:05am and Mr Turner was transferred to POWH, where he was admitted under the care of Dr Francis Lam, consultant colorectal surgeon. Mr Turner was diagnosed with recurrent sigmoid volvulus and large bowel obstruction.

6.7 On 24 January 2020, a flexible sigmoidoscopy was performed with successful decompression of the sigmoid volvulus and resolution of the bowel obstruction. Following surgery, it was noted that Mr Turner's abdomen was significantly less distended, and there was no ongoing clinical evidence of

bowel obstruction. As Mr Turner appeared to be recovering well, a plan was formulated for him to be discharged back into the custody of CSNSW.

6.8 However, on 25 January 2020, Mr Turner experienced unexpected episodes of vomiting. Consideration was given to the recurrence or persistence of sigmoid volvulus, but it was noted that Mr Turner's abdomen was soft and he showed no clinical signs consistent with this presentation. A nasogastric tube was inserted to decompress the stomach, and a number of further investigations were planned (chest x-ray, abdominal CT scan and repeat blood tests). Before these investigations could be completed, Mr Turner experienced respiratory distress secondary to aspiration pneumonia[4]. He was subsequently admitted to the intensive care unit for management and respiratory support. Due to Mr Turner's poor prognosis, his family were advised that his condition was deteriorating.

6.9 Prior to the events of January 2020, Mr Turner had indicated to medical staff during his previous admissions to hospital that he did not wish for advanced life support, or resuscitation efforts, to be provided. On 25 January 2020, following discussion with the medical team and his family, Mr Turner confirmed that he did not wish for any further surgical intervention. As a result, the ceiling of care for Mr Turner was determined and he was transitioned to a comfort care, rather than active treatment, pathway. Mr Turner's condition continued to decline and he was later pronounced life extinct at 2:18pm on 26 January 2020 in the company of one of his daughters and son-in-law.

7. What was the cause of Mr Turner's death?

7.1 Mr Turner was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Rianie Van Vuuren, forensic pathologist, on 30 January 2020. Postmortem imaging showed coronary artery calcification and calcific atherosclerotic vascular disease[5]. Distended bowel loops with air fluid levels were noted in the abdomen, and the lungs showed extensive infiltrates/consolidation[6]. It was noted that there was no toxicological contribution to Mr Turner's death.

7.2 In the autopsy report dated 13 August 2020, Dr Van Vuuren opined the cause of death to be the consequences of bowel obstruction.

8. Care and treatment provided to Mr Turner

8.1 The coronal investigation primarily focused on whether Mr Turner was provided with appropriate care and treatment in the immediate period preceding 26 January 2020. Dr Alan Meagher, a colorectal surgeon, was briefed to provide an independent expert report which considered aspects of Mr Turner's care and treatment.

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[4] Inflammation or infection of the lungs which occurs when food, saliva, liquids or vomit is breathed into the lungs, or airways leading to the lungs, instead of being swallowed into the stomach.

[5] The build up of fats, cholesterol and other substances (called plaque) in the artery walls, causing arteries to narrow and block blood flow.

[6] When the air that typically fills the small airways in the lungs is replaced with fluid or a solid (such as stomach contents), commonly caused by pneumonia.

8.2 In his report, Dr Meagher, relevantly, expressed the following views:

(a) It was reasonable for Mr Turner's treatment not to have been escalated as a result of his presentation on the evening of 22 January 2020. Dr Meagher noted that Mr Turner had not been experiencing nausea, vomiting or constipation, and that he was observed overnight with adequate plans for possible escalation if his symptoms changed.

(b) The management of Mr Turner on the morning of 23 January 2020 was entirely reasonable. When Mr Turner was assessed by RN Ross, he was noted to be sitting out of bed, alert and compliant with instructions, with no apparent reason for immediate concern regarding his blood pressure at that stage. However, once Mr Turner's low blood pressure was noted, his care was appropriately escalated with a review sought from Dr Sim, and his transfer to hospital effected.

Further, Dr Meagher noted that whilst it is "*entirely conceivable*" that Mr Turner had some degree of abdominal symptoms and distension in the two weeks preceding 26 January 2020, it is "*very likely*" that Mr Turner made no mention of the symptoms to any Justice Health nursing staff. Specifically, Dr Meagher noted that when Mr Turner did mention these symptoms on the evening of 22 January 2020, "*he did not have any alarming symptoms or signs that would indicate that his condition was about to deteriorate over the next 12 to 24 hours*", suggesting that he required immediate transfer to hospital. Similarly, Mr Turner's episodes of vomiting and diarrhoea with incontinence on the morning of 23 January 2020, also did not indicate that he required transfer to hospital at that time.

(c) Even if Mr Turner had been transferred to hospital prior to 10:10am on 23 January 2020, it is unlikely that this would have materially altered the eventual clinical course.

(d) The care and treatment provided to Mr Turner at POWH was reasonable and appropriate. Relevantly, Dr Meagher explained that it is only possible in retrospect to consider that there were possible signs that Mr Turner was not making a normal recovery following colonoscopic decompression. Further, once Mr Turner began vomiting, and it became clear that he was aspirating, the treatment provided to him was entirely reasonable.

(e) Overall, Dr Meagher expressed this opinion: "*Essentially Mr Turner had become increasingly medically frail over the previous years […] At the age of 81 it is not rare for patients in a situation to be at very high risk of aspiration pneumonia during vomiting - no matter the cause of the vomiting. The main cause of death and Mr Turner was in fact his inability to vomit in a coordinated fashion so that he avoided aspiration and impatience in a situation that is actually not rare*".

9. Conclusions

9.1 Having regard to the relevant records from CSNSW and Justice Health regarding Mr Turner's period in custody, and the findings from the postmortem examination, it is evident that Mr Turner died from progression of a natural disease process. Dr Meagher noted that it is not rare for patients to

suffer recurrent sigmoid volvulus despite already having undergone previous surgical intervention to treat the condition.

9.2 Having regard to the opinions expressed by Dr Meagher, the evidence establishes that the care and treatment provided to Mr Turner on the evening of 22 January 2020 was appropriate. In particular, there was no clinical indication at that stage for Mr Turner's care to be escalated. When Mr Turner's condition suddenly deteriorated on the morning of 23 January 2020, appropriate action was taken by nursing staff to seek medical review and advice, resulting in Mr Turner's appropriate transfer to hospital.

9.3 Overall, the available evidence indicates that Mr Turner was provided with appropriate medical care, to address and treat his various chronic medical conditions, 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 outcome. There is also no evidence to suggest that any aspect of Mr Turner's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

8. 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 Amanda Chytra, Coronial Advocate, for her assistance both before, and during, the inquest. I also thank Plain Clothes Senior Constable Valentin Roukchan for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity
The person who died was Ronald Turner.

Date of death
Mr Turner died on 26 January 2020.

Place of death
Mr Turner died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death
Mr Turner died from the consequences of bowel obstruction.

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

10.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Turner's family and loved ones for their loss.

10.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
5 April 2022
Coroners Court of New South Wale

Inquest into the death of Ronald Turner

File Number: 2020/26597

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, Master Index Numbers ('MINs') and any other identifying information of inmates other than Ronald Turner.

    (b) The names, Visitor Index Numbers ('VINs'), telephone numbers and residential addresses of any member of Mr Turner's family, friends and/or visitors, other than legal or professional visitors.

    (c) The names, telephone numbers, residential addresses, and any other identifying information of any victim of Mr Turner's offences.

    (d) The direct contact details of Corrective Services NSW ('CSNSW') staff and staff from external service providers that are not publicly available.

    (e) The OIC Watch Journal dated 24 January 2020 contained in attachment 5 of tab 15 of the brief of evidence.

    (f) Hospital Escort Journals dated 23 January 2020 – 25 January 2020 contained in attachment 10 of tab 15 of the brief of evidence.

2. Pursuant to section 65(4) of the Act, a notation is placed on the Court file that if an application is made under section 65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

Magistrate Derek Lee
Deputy State Coroner
5 April 2022
Coroners Court of New South Wales