CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Colin Winner
Hearing dates:	10 May 2023
Date of findings:	11 May 2023
Place of findings:	Lidcombe
Findings of:	**Magistrate Kennedy** **Deputy State Coroner**
Catchwords:	CORONIAL LAW – Cause and manner of death, death in custody, natural causes
File number:	202//00261655

Representation:	Mr O’Donnell, Solicitor, Coronial Advocate Ms Guildford, Solicitor, Justice Health and Forensic Mental Health Network NSW Ms Heritage, Commissioner of Corrective Services NSW
Findings:	***The identity of the deceased*** David Winner ***Date of death*** 11 September 2021 ***Place of death*** Long Bay Correctional Centre, Malabar, New South Wales ***Cause of death*** Metastatic Basaloid non-keratinising squamous cell carcinoma ***Manner of death*** Natural causes
Recommendations:	**NIL**

INTRODUCTION

1. This is an inquest into the death of Mr David Winner who was 53 years old when he died while on remand at Long Bay Correctional Centre.

The nature of an inquest

2. An inquest is required and in fact mandatory to be held into Mr Winner's death, because his death occurred while he was in a correctional centre (s. 23(1)(d)(ii) and 27(1)(b) of the *Coroners Act 2009*).

3. This is important because he was not at liberty to make arrangements to address his own physical and mental health and relied instead on the State who is responsible for ensuring that he received reasonable and adequate care and treatment where necessary.

4. I note that it is not the purpose of an inquest to blame or punish anyone for the death. Neither is it any part of the Court's function to make findings about fault or negligence, or to award compensation.

5. The primary function of an inquest is to identify the circumstances of death. At the conclusion of this inquest, I am required by section 81 of the *Coroners Act 2009* to record in writing the fact that a person has died and also to record:
    a. the person's identity;
    b. the date and place of the person's death; and
    c. the manner and cause of death.

6. There are five questions to be answered, however the only matters in issue in this case is manner and cause of death.

7. Another purpose of an inquest is found in section 82 of the Act, and that is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from James' death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances. Without limitation, that includes matters of public health and safety, or that a matter be investigated or reviewed by a specified person or body.

Background to Mr Winner

BACKGROUND

David Colin Winner was born on the 18th of July 1968 to [redacted]. He was the eldest of four children, having two brothers and one sister. David was estranged from his family and so a background history of his time as a child growing up has not been provided.

David had no known children or dependents. His last relationship ended around June 2020. David's best friend and listed Next of Kin is [redacted]. They had known each other since 2011 and stayed in regular contact even when David was in custody.

[redacted] had a long friendship with David. He picked him up from prison when he was released in 2012, he credits David with supporting him as he strove for sobriety. He said that he was supported by his friend, and wrote a letter to him telling his friend what a positive impact he had on his life, and how much he had helped him stay clean. The nurses provided the letter to David before he died, and this had a great impact on him.

His friendship with [redacted] was a strong one, he left his estate to [redacted] and [redacted].

[redacted] reported that David told him that he was very happy with the care he received in prison. He said the doctors and nurses and the guards made his comfort their priority once his condition was known to be terminal. He was looked after, and his pain was managed well.

INCARCERATION

David had an extensive criminal history of 62 charges between 1983 and 2021. In 1992 he served a period of 17 years imprisonment for the charge of murder.

On the 12th of May 2021, David was received into NSW Corrective Services Custody charged with aggravated breaking and intimidation offences against his former domestic partner. He remained in custody on these charges until his death.

HEALTH AND TREATMENT WHILST IN CUSTODY

On the 22nd of July 2021, it was confirmed that David had been diagnosed with oropharyngeal squamous cell carcinoma with metastatic malignancy to a new lung cancer. There was extensive involvement of the lung, liver and skeleton. David received a prognosis of about six months.

David was transferred to the Medical Sub-Acute Unit of Long Bay Correctional Centre and on the 25th of August, he completed an advanced care directive stating his healthcare and treatment decisions, including non-resuscitation. The directive read that David did not want aggressive treatment and wanted the focus of his care to be comfort.

In the morning of the 11th of September 2021. Registered Nurse Dimity Brannon noticed that David's condition was deteriorating. At about 11:30am, Registered Nurses Branon and Thornberry were caring for David and continued to administer medications as per his 'end of life' plan. At about 12pm, they noticed David was breathing intermittently. He passed away at approximately 12:44pm.

INVESTIGATON FOLLOWING DEATH

Upon his death, Corrective Officers locked his cell, began a video recording and a log of persons who had entered and exited. Police were notified and attended soon after. They obtained versions from witnesses, searched David's body and escorted the State Contractors who took David's body to the Lidcombe morgue.

An external post-mortem examination was conducted by pathologist, Dr Rianie Van Vuuren on the 14th of September 2021 who confirmed that the direct cause of death was *Metastatic basaloid non-keratinising squamous cell carcinoma.* There was nothing of note found on the toxicology results and nothing suspicious has been identified in relation to David's death. There is no suggestion it is anything other than a naturally caused death.

CONCLUSION

The officer in charge Detective Senior Constable Jennings investigated fully, and found no concerns with the care and treatment David received while in custody.

Acknowledgements

Thank you to Mr O'Donnell for his careful preparation and presentation of this inquest.

Thanks also extend to Detective Senior Constable Jennings for the important work undertaken to ensure David received appropriate palliative care prior to his death.

Recommendations

There are no recommendations arising from this matter.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

David Winner

Date of death

11 September 2021

Place of death

Long Bay Correctional Centre, Malabar, New South Wales

Cause of death

Metastatic Basaloid non-keratinising squamous cell carcinoma

Manner of death

Natural causes

I extend my sincere condolences to the [redacted] for the loss of his friend.

I now close this inquest.