CORONERS COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of JM**
Hearing dates:	6 March 2023
Date of findings:	6 March 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death, Section 27 Coroners Act 2009, death in custody, natural causes
File number:	2022/96193
Representation:	Inspector Xanthos and Sergeant Chytra, Coronial Advocate assisting

Findings:	**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*** The deceased person was JM ***Date of death*** *3 April 2022* ***Place of death***, Long Bay Correctional Facility, Malabar, New South Wales ***Cause of death*** Complications of metastatic adenocarcinoma. ***Manner of death*** Natural Causes
Recommendations:	NIL

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

INTRODUCTION

1. Introduction

1.1. Section 23 of the *Coroners Act* NSW grants jurisdiction to the Coroner to hold an inquest, where a person has died:

(a) While in the custody of a police officer or in other lawful custody.

1.2. In fact, pursuant to section 27 of the Act, an inquest in these circumstances is mandatory, and must be heard by the State Coroner or a Deputy State Coroner.

1.3. The primary function is to make findings as to:

(a) The identity of the deceased;
(b) The date and place of the person's death;
(c) The manner and cause of the person's death.

1.4. Guided by these five aspects, an inquest investigates the facts and circumstances of a death, places them on the public record and in certain cases will examine changes that could be made to prevent similar deaths in the future. An inquest is not a forum for the laying of blame or the attribution of guilt. Nor is it a vehicle for civil litigation. It is not a trial, but an inquiry. In this case, there is no controversy as to JM's identity, date or place of his death, nor the cause or manner of his death. It is further not disputed that JM was lawfully in custody at the time of his death.

1.5. In this context it should be recognised that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. Families often wish to grieve and deal with their loss in private. That grieving, and loss does not diminish significantly over time. Unfortunately, the coronial process can compel a family to re-live distressing memories of a death and do so in a public forum.

1.6. As JM was in custody and his liberty was not his own, the State maintains a responsibility to ensure that his medical treatment was provided in an appropriate and timely manner. This is a mandatory inquest, and for that reason it is important to carefully consider the circumstances of his death, importantly looking closely at his diagnosis, treatment and general nursing care.

2. Background

2.1. JM was born on 10th December 1960 at Bankstown District Hospital. He was the youngest of 3 children and raised in Riverwood. By the time JM was of school age, the family had moved to La Perouse. He completed his education in year 10 and worked as a chef. Sometime in the 1980's, the family moved to Nowra where JM met his first wife. However, that relationship ended in 1997 when JM met his second wife. They subsequently married in September 1998, 10 days after her 18th birthday.

2.2. JM and his second wife had four children between 1998 and 2006. During this they lived at Nambucca Heads on the North Coast before moving to the Central Coast in 2000. Following the family's move to Erina, JM remained unemployed and received Centrelink payments. He first came under police notice in 2000 where he was charged with historical sexual offences. He was acquitted of these charged in 2001.

2.3. On 18th November 2010, JM and his wife were charged with 47 sexual offences. Both were subsequently convicted and JM was sentenced to a cumulative term of imprisonment for a total of 21 years. His earliest possible release date was 17th November 2025.

2.4. When JM first entered custody, his medical issues included anxiety and migraines. He was a heavy smoker and disclosed that he had a pneumothorax 25 years earlier that was treated with intercostal tube/drain. He also disclosed in his first interview with a psychologist at MRRC, a self-harm history where he slashed himself about 15 years earlier. However, he denied any suicidal thoughts at the time and there were no subsequent reports of self-harm ideation or attempts. He continued with scheduled psychology appointments and his depression and anxiety was managed through medication. Overall, he was described as a '*compliant and polite inmate*' and employed as a textile worker.

2.5. JM spend the majority of his incarceration as a Special Management Area Placement (SMAP) on his own request due to the nature of his criminal convictions. He was housed at various locations throughout the state where his SMAP status remained.

3. Circumstances of death

3.1. On 4th February 2022, JM tested positive to COVID-19 pneumonitis as a part of the cluster of cases at Junee Correctional Centre at the time. However, on 12th February 2022, he was admitted to Wagga Wagga Base Hospital where he was hypotensive and tachypnoea on admission. He had lost a significant amount of weight and struggled with breathing. A chest x-ray was ordered showing significant right pleural effusion. A chest drain was inserted as tests continued until it was confirmed he had advanced stage 4 lung cancer. He was officially diagnosed as having a '*malignant pleural effusion in the context of newly diagnosed metastatic adenocarcinoma with lung and liver lesions*.'

3.2. JM remained in Wagga Hospital where he refused treatment telling staff he did not want to "*prolong the inevitable*." In consultation with oncology and palliative care services locally, it was determined that JM would not be for active management and would benefit from a symptom oriented approach. JM also signed a DNR on 14th March 2022. He was subsequently discharged and transferred by air to Long Bay Correctional Centre. He was housed in cell 30, a single room cell in the Medical Sub-Acute Unit (MSU) and managed on an Advanced Care Directive.

3.3. Once he was admitted into palliative care, his medication was monitored as his condition deteriorated. By 31st March 2022, JM was on oxygen via nasal prongs and he had ongoing issues of nausea and drowsiness.

3.4. Between 11:00pm and midnight on Saturday 2nd April 2022, JM was captured on CCTV being checked by correctional and Justice Health staff. Subsequently, four (4) cell alarm activations from cell 30 were made by JM on 3rd April 2022 between 12:22am and 3:57am requesting help.

3.5. Following the last alarm, CO Gauchan alerted JH nurses Owens and Donati who went into JM's cell and found him sitting on the edge of the bed with laboured breathing holding on to his walking frame. He then collapsed forward and was

helped back onto the bed where he was provided medical assistance. He continued to be monitored until RN Owens pronounced life was extinct at 4:05am.

3.6. Police were called and they reported JM's death to the coroner pursuant to s.23 of the Act.

3.7. A limited post-mortem examination was performed by Dr. Pokorny. A CT scan showed a large right sided loculated pleural effusion, with a mass seen in the right upper lobe. Multiple lesions were also seen in the liver. The cause of death was determined to be from '*complications of metastatic adenocarcinoma*.'

3.8. The investigation into the death of JM shows that the diagnosis and treatment of JM was conducted in an appropriate manner. His wishes were taken into account after the diagnosis, and he was cared for palliatively until he died. It is also of note that he had nurses with him who responded to his call for help and stayed with him to care for him until he passed away.

Acknowledgements

Thank you to Inspector Xanthos and Sergeant Chytra who has carefully prepared and presented this matter respectfully for the family of JM.

Thank you also to Detective Sergeant Daley for the thorough investigation and preparation of the matter.

Recommendations

After hearing the matter, there are no additional recommendations that now arise from the death of JM.

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:

The identity of the deceased

The deceased person was JM

Date of death

3 April 2022

Place of death,

Long Bay Correctional Facility, Malabar, New South Wales

Cause of death
Complications of metastatic adenocarcinoma.

Manner of death
Natural Causes

I extend my sincere condolences to the family and friends.

I now close this inquest.

Deputy State Coroner E Kennedy, Magistrate.

6 March 2023