CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr James Brown
Hearing dates:	14 March 2023
Date of findings:	14 March 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, care and treatment
File number:	2020/91972
Representation:	Mr Kai Jiang, Advocate Assisting Ms Katharine Guilford, for Justice Health Ms Ally Pettitt, for Corrective Services NSW (CSNSW)

Findings:	I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW): **The identity of the deceased** The deceased person was Mr James Brown **Date of death** Mr Brown died on 23 March 2020 **Place of death** Mr Brown died at John Hunter Hospital, New Lambton Heights, New South Wales **Cause of death** Mr Brown died as a result of hemopericardium due to ruptured aortic dissection contributed to by hypertension **Manner of death** Mr Brown died as a result of natural causes.
Recommendations:	I make the no recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW)

1. This is an Inquest into the death of Mr James Brown, who was 70 years of age when he died at the John Hunter Hospital on 23 March 2020. This is a mandatory inquest pursuant to section 27 of the Coroners Act 2009, as Mr Brown was in custody at the time of his death. The legislation requires the State Coroner or a Deputy State Coroner to hold an inquest to ensure that proper care and treatment is extended to those who are not free to make their own choices, and are reliant on the State to provide medical treatment for them.

Coroner's Role

2. Inquests are not adversarial, but inquisitorial. The purpose of an Inquest is not to attribute blame or punish anyone, but rather to investigate how and why a person died, and to find mechanisms, if possible, to stop preventable deaths.

3. It is the role of the Coroner to investigate and make findings about sudden, violent, suspicious or unnatural deaths. Those findings are to be made in relation to

    - the identity of the person who has died,
    - the date and place of the person's death,
    - the cause of death,
    - and the manner (or circumstances) of the person's death.
    - Recommendations may also be made in relation to any matter connected with the person's death where appropriate.

Background to the life of Mr Brown

4. Mr James Brown was born on 12 January 1950 and was aged 70 when he died. He was one of six siblings, including his elder sister, Mrs Mary Lawson. They grew up in the suburb of Stanford Merthyr and eventually moved to live in Weston with their father. Mr Brown moved out when he was 21 and lived in various locations before moving to Mallabula. He was never married and had no children. He was schooled at the Kurri Kurri high school after which he attended a local art school. He was a talented artist and musician. He was part of the Irish Celtic Group in Newcastle where he played drums and pipes. He was also part of the Christian motorcycle club and had an interest in classical cars.

5. On 24 November 2011, Mr Brown was arrested and charged with multiple child sex related offences. On 2 March 2012, he was convicted and was initially sentenced to 10 years imprisonment. However, on 18 September 2012, following an appeal by the DPP, the sentence was increased to 20 years, with a non-parole period of 12 years. The earliest eligible release date was 23 November 2023. As a result of the length of imprisonment sentence, Mr Brown was classified as maximum security and was transferred to Goulburn Correctional Centre. On 28 May 2016, he was re-classified to medium security due to his compliance in custody and was transferred to the Junee Correctional Centre. On 5 April 2019, Mr Brown's classification progressed to minimum security.

6. On 10 April 2019, he was charged with further offences and was subsequently bail refused on those matters by the Newcastle District Court pending finalisation of the related criminal proceedings. Consequently, he was reclassified as maximum security and was housed in Hunter Correctional Centre and was allocated to work as a painter.

7. Whilst in custody, Mr Brown was reviewed by the Serious Offenders Review Council and participated in the Sex Offenders Program. He was first placed in protective

custody at his own request due to the nature of his offending. Since 12 December 2012, a special management area placement order was initiated by Mr Brown due to his fear for safety. He remained in protection or special management placement until his transfer to Hunter Correctional Centre where it was revoked voluntarily on 19 March 2018.

Medical History of Mr Brown

8. Mr Brown had a history of hypertension since 1968 and atrial fibrillation since 2014. He was treated with Prazosin and Amlodipine for high blood pressure; and Propranolol and Pradaxa for his atrial fibrillation. He also had a history of haematuria and osteoarthritis. Justice health records noted that he had difficulty walking, cellulitis and other skin irritations. Whilst in custody, his health was regularly checked and monitored by Justice Health staff and GP.

9. On 20 February 2015, Mr Brown received treatment at the Goulburn Base Hospital due to his complaint of chest pains. On 30 July 2019, he was seen at the Cessnock District Hospital for painless haematuria and eye irritation. A referral was made for renal CT scan. On 6 February 2020, Mr Brown attended the clinic for a respiratory illness. It was noted that the initial symptoms were resolved apart from some chest congestion. However, his vital signs at the time were normal and there were no further concerns raised when reviewed at the clinic again on the following day.

Events leading up to the death of Mr Brown

10. On 23 March 2020, at the completion of mustering at around 11:30am, Mr Brown experienced chest pains and he sat on a lounge within pod C1. He was attended to by corrective officers. Justice Health staff attended when medical assistance was requested. Mr Brown was observed to be pale and during treatment he was unresponsive for about 20 seconds. Oxygen was administered. Upon regaining consciousness, Mr Brown complained about crushing central left sided chest pain radiating into the neck area. An ambulance was called, and he was transferred to the Cessnock District Hospital. Mr Brown's condition worsened. He felt numbness in his right leg and had extreme lower back pain. At 12:30pm, upon arrival at the hospital, he was unable to move his right leg. A bedside ultrasound indicated possible aorta dissection. After consultation with a vascular surgeon at the John Hunter Hospital, it was decided for Mr Brown to be transported there for further treatment.

11. Mr Brown was taken by ambulance to the John Hunter Hospital and arrived at 2:24pm on the same day. The diagnosis of Type A Aortic Dissection was confirmed after an urgent CT scan. Mrs Lawson was contacted and attended the hospital. She had the opportunity to briefly speak to Mr Brown and hugged him before he was transferred to the operating theatre at 3:55pm for emergency surgery. Anaesthetics were administered at 4pm. Mr Brown was moved into the theatre at 4:23pm. However, whilst being transferred onto the operating table, he went into cardiac pulmonary

arrest and was unable to be resuscitated. He was declared deceased at 4:32pm on 23 March 2020.

Investigation by police following the death of Mr Brown

12. An investigation was commenced following Mr Brown's death. Police were contacted and arrived shortly after. The scene was forensically examined and searched. Photographs were taken. Staff from the hospital, CSNSW, and Justice Health were spoken to by police. Mr Brown's identity was confirmed by corrective staff. Importantly, no suspicious circumstances were identified by Police in relation to Mr Brown's death at the conclusion of the investigation.

13. A statement was obtained from Mrs Lawson who stated that Mr Brown did not express any real complaints regarding his medical treatment and care whilst in custody. However, a concern was raised regarding Mr Brown's placement in custody where it appears that he complained about being assaulted and threatened by other inmates. In response to the concern, a statement was requested from the director of the CSNSW investigation branch. A review of the statement and the supporting documents produced confirmed that Mr Brown was appropriately classified and placed in accordance with applicable policies at the time. It is noted that at no time did Mr Brown make a report of assaults or of being a fearful inmate whilst at the Hunter Correctional Centre, which was a centre that housed mainly aged and frail inmates who were previously subjected to either protective custody or special management placement orders.

14. An external postmortem examination was conducted. No injuries of concern were identified which confirms that Mr Brown was not assaulted prior to his death. The cause of his death was found to be Hemopericardium due to ruptured aortic dissection with hypertension noted as a significant contributing disease.

15. CSNSW records and associated incident reports were reviewed. No breaches of any relevant policies current at the time were identified. Relevant CCTV footages were obtained and captured events consistent with officer reports of the incident leading up to Mr Brown's complaint of chest pain and eventual hospitalisation. No issues were found regarding the responses by corrective officers and justice health nurses. Mr Brown received appropriate care and treatment in custody.

16. Justice health records, including health screening assessments and clinical notes were obtained and reviewed. Relevant medical records from NSW Ambulance, Cessnock District Hospital, and John Hunter Hospital were also obtained in relation to Mr Brown's terminal admission and treatment after his complaint of chest pain on 23 March 2020.

17. It appears after a thorough investigation by police that no issues were identified of concern. I am satisfied that Mr Brown was provided with adequate and sufficient medical care to address Mr Brown's health issues.

Acknowledgements

18. Thank you firstly to the family of Mr Brown, for raising concerns that could be addressed through the preparation of the inquest in obtaining the necessary evidence.
19. Thank you to Mr Jiang, Coronial Advocate assisting for a thorough and careful preparation, attention to detail and appropriate submissions made to assist in this inquest.

20. I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased
The deceased person was Mr James Brown

Date of death
Mr Brown died on 23 March 2020

Place of death
Mr Brown died at John Hunter Hospital, New Lambton Heights, New South Wales

Cause of death
Mr Brown died as a result of hemopericardium due to ruptured aortic dissection contributed to by hypertension

Manner of death
Mr Brown died as a result of natural causes.

I make no recommendations pursuant to Section 82 of the *Coroners Act 2009* (NSW)

Conclusion

21. I extend my sincere condolences to the family and friends of Mr James Brown.

22. I now close this inquest.