CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of JAY LEE CRICH
Hearing dates:	25 January 2023
Date of findings:	1 February 2023
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes
File number:	2022/126719
Representation:	Coronial Advocate Assisting, Inspector Tina Xanthos Ms Deborah White, Solicitor, DCJ Legal for the Commissioner of Corrective Services, NSW
Findings:	Identity: The person who died is Jay Lee Crich Date: Jay Crich died on 30 April 2022 Place: Jay Crich died at Clarence Correctional Centre, Lavidia New South Wales Cause: Jay Crich died as a result of the effects Cardiomegaly and Coronary Artery Disease. Significant contributing conditions were Emphysema and Obesity Manner: Jay Crich died as a result of natural causes whilst in lawful custody
Non-publication orders:	A Non-publication order was made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) on application by the Commissioner of Corrective Services NSW : Refer Annexure "A". A copy of is Annexure order can be requested from the Coroner's Court registry if required.

Introduction

1 An Inquest was held on 25 January 2023 into the death of Mr Jay Lee Crich, who died at Clarence Correctional Centre (Clarence) on 30 April 2022.

2 Because Jay died while in custody, an inquest is required by the Coroners Act 2009 NSW (the Act).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The role of a Coroner

4 An inquest is a public examination of the circumstances of a death. It provides an opportunity to closely consider what led to the death. It is not the purpose of an inquest to blame or punish anyone for the death. The fact of holding an inquest does not imply that anyone is guilty of wrongdoing.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of the person’s death.

6 Another purpose of an inquest 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 the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding an Inquest a detailed coronial investigation is undertaken. Investigating Police compile a brief of evidence and a report by a forensic pathologist as to the cause of death is obtained. Given that Jay’s death occurred in a correctional facility, it was actively and thoroughly investigated by Police, who obtained all correctional centre records, including medical records and incident reports as well as CCTV footage. Police also interviewed various witnesses including Correctional Officers, other inmates, and family members and associates of Jay. Witness statements and summaries of conversations are contained in the brief of evidence prepared by Police.

8 The Coronial investigation also obtained all relevant policy documents relating to management of inmates in correctional facilities to ascertain that the policies were complied with, and so as to consider whether any recommendations for change should be made.

9 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered to the Inquest. Given the thoroughness of the coronial investigation, the detailed Police brief provided evidence which answered a number of matters which the inquest was required to address. For this reason the only witness required to give evidence at the inquest was one of the officers involved in the investigation, Detective Senior Constable Waddell.

10 All of the material, and the evidence at the Inquest, has been considered in making the findings detailed below.

Background

11 Jay was born on the 25 of February 1981 in Muswellbrook where he was raised. Jay's father left the family home when Jay was young leaving behind his mother and two younger siblings. His mother later remarried and had two more children. Jay had little contact with his natural father but enjoyed a good relationship with his step-father Errol

Bates. Mr Bates attended the Inquest, his brother Dean kept in contact throughout the investigation process and his sister Kelly provided helpful background and family details to the investigating Police. Jay's brother Mitchell was in custody at the time of Jay's death.

12 Jay left school at the beginning of year 7 and around that time he first started using cannabis. Jay was fourteen when he left home and having travelled to Canberra, he found himself homeless and was soon introduced to heroin. Jay had a battle with drug addiction throughout the balance of his life.

13 Jay had a number of relationships and fathered a number of children during his life. At the time of his death Jay was in a relationship with Nicole Donna Mason. Ms Mason was in custody at the time of Jay's death. Jay and Ms Mason did not have any children together however, Jay had three children with Ruth Athrop one of whom had tragically passed away. In late March 2022 Jay confided in David Paul, a psychologist at Clarence, that he attributed, in part, the poor sleep he was experiencing to the trauma of having lost his 5 year old son in 2009. In that conference Jay also referred to the passing of his mother within the preceding 12 months. Jay also had a child, Koby, with Gemma Standing.

14 Jay first entered custody in March 2002 and thereafter was in and out of prison up until the time of his death. In March and July of 2021 Jay was sentenced to terms of imprisonment. In August 2021 the July sentence was confirmed on appeal to the District Court with the result that Jay's earliest release date would have been 3rd February 2023.

15 On the 9 of July 2021 Jay was transferred to Clarence and he remained at Clarence until the date of his death other than for short term transfers to Kariong and Long Bay hospital for health purposes.

16 Whilst at Clarence Jay was gainfully employed within "Male Minimum Industries" doing metal fabrication where it was reported he was polite and cooperative. Jay had also been enrolled to complete a Certificate 2 in engineering through TAFE.

Medical History

17 Throughout his adult life Jay had heart, lung, mental health and substance abuse issues.

18 Jay was prescribed medication for high blood pressure, asthma and his mental health issues. He was taking the prescribed medication whilst at Clarence.

19 Jay was due for a review of his mental health medication in early May 2022. It was clear that traumatic events from his past continued to trouble Jay, impacting upon his sleep. It was in the context of these discussions that arrangements had been made for a medication review.

20 Jay reported that he was a light and controlled drinker but that he smoked 30 cigarettes a day. Smoking was banned in NSW prisons in August 2015. On the evidence in the Inquest there was nothing to suggest that Jay was able to access smokes of any description whilst at Clarence.

21 To manage his heart issues, in addition to his medication for high blood pressure, Jay was examined by ECG (electrocardiograph) from time to time and correctives officers were advised to look for symptoms such as swelling, difficulty breathing, sweating, wheeze and fatigue.

22 In relation to Jay's lung or breathing issues the medical records refer to "asthma" however, post-mortem examination revealed marked emphysema. Smoking is one of the well identified causes of emphysema. Medical science establishes that lungs can't heal from emphysema. Whilst Jay's asthma medication and the fact that he could not smoke in custody would have helped reduce the symptoms of his emphysema as the post-mortem confirmed, the marked damage to Jay's lungs remained.

23 In custody Jay did not shy away from his significant battles with substance abuse over the years. Jay openly revealed his introduction to cannabis, alcohol and heroin at a very young age. He disclosed that ice and heroin were his drugs

of choice and importantly revealed an extensive history of buprenorphine abuse. Jay had used buprenorphine on and off over many years without any reported difficulties. The importance of this is in relation to the fact that Jay had started on the NSW Opioid Treatment Programme just two days before his death. Following a full and thorough assessment as to his suitability, Jay received wafers on 28 April 2022 and his first buprenorphine injection on 29 April. Whilst Jay was observed to be excessively sweaty following his injection this is an expected side effect of buprenorphine. Buprenorphine is only dangerous if a very large overdose is taken. Post-mortem toxicology makes it clear that there was an acceptable, completely non-toxic quantity of buprenorphine in Jay's blood at the time of his death.

24 During his adult life Jay had made many attempts to stop using drugs. He had undertaken rehabilitation on several occasions but had only completed one rehabilitation program. Inevitably after each failed attempt he returned to substance abuse. Nevertheless, he kept trying to stop using drugs including participating in the EQUIPS addiction program whilst at Clarence.

Events leading up to death

25 Throughout the 29 of April 2022 Jay was first seen to enter the kitchen area at 6:10 AM. There was nothing unusual about Jay's activities during the day. He was seen eating lunch, vacuuming the unit and having dinner while mingling with other inmates in unit 4A. Jay appeared to be in good spirits. In the evening Jay was seen walking in and out of his cell to the communal area of the unit. He was last seen to return a bottle of water to the kitchen before retiring to his cell after midnight.

26 At 6:11 AM on 30 April 2022, Jay presented himself for the morning muster. CCTV footage confirms him then returning to his cell. Subsequently no persons were seen to enter or leave the cell.

27 At about 12:04 PM, correctional officer Bathgate approached and knocked on Jay's cell door for the midday muster. When Jay failed to respond, CO Bathgate entered the cell and saw Jay lying on his bed wearing shorts and no shirt. His vital signs were checked and was found to be not breathing and had no pulse. Assistance was immediately sought by calling a "code blue".

28 A number of correctional officers helped move Jay off the bed and commenced CPR. At 12:07 PM, six SERCO nurses arrived with a defibrillator and took over CPR. A doctor then arrived to oversee resuscitation efforts which continued until NSW ambulance arrived at 12:36 PM. After consultation with the doctor, Jay was pronounced life extinct at 12:38 PM.

29 A post-mortem examination by Doctor Allan Cala of Forensic Medicine at Newcastle, revealed a considerably enlarged heart with mild coronary artery narrowing. Jay's lungs showed changes of emphysema due to smoking. Toxicology analysis revealed substances consistent with medications and recent buprenorphine injection. Dr Cala determined the cause of death to be from cardiomegaly [enlarged heart] and coronary artery disease with emphysema and obesity being significant conditions that contributed to Jay's death. The Doctor observed that sudden death may occur in the setting of considerable cardiac enlargement as was the case with Jay.

Whether any recommendations required pursuant to s82 of the Coroners Act

30 The investigation revealed that appropriate processes were in place. Jay was quickly attended to when he was discovered in his room. The investigation also revealed that SERCO, who had responsibility for running Clarence, had in place appropriate relevant "Local Operating Procedures".

31 I am satisfied that there was no system or procedural failure that in any way contributed to Jay's death and as such there is no need for any recommendations.

Findings under s81 of the Coroner's Act:

32 For all the above detailed reasons I make the following findings:

Identity: Jay lee Crich

Date: 30 April 2022

Place: Clarence Correctional Centre, Lavidia, NSW

Cause: Cardiomegaly and Coronary Artery Disease with significant contributing conditions being emphysema and obesity.

Manner: Natural causes.

Closing

33 I acknowledge and express my gratitude to the Coronial Advocate assisting, Inspector Tina Xanthos, for her assistance both before and during the inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Scott and Detective Senior Constable Waddell, for their work in the Police investigation and for providing evidence at the Inquest.

34 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family and friends of Mr Crich.

35 I close this inquest

Magistrate David O'Neil

Deputy State Coroner

Coroners Court of New South Wales