CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of John Charles Dodd
Hearing dates:	17 April 2023
Date of findings:	17 April 2023
Place of findings:	Lidcombe
Findings of:	Magistrate Kennedy Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody, natural causes
File number:	2021/00259055
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Ms Katharine Guilford for Justice Health & Forensic Mental Health Network Ms Anastasia Poulios for the Commissioner of Corrective Services New South Wales

Findings:	***The identity of the deceased*** The deceased person was John Charles Dodd ***Date of death*** 9 September 2021 ***Place of death*** Geoffrey Pearce Correctional Centre, New South Wales ***Cause of death*** *Ischaemic heart disease* ***Manner of death*** Natural Causes
Recommendations	Nil
Non-Publication Orders	Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

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1. Introduction

1.1. John Charles Dodd died on 9th September 2021 at Geoffrey Pearce Correctional Facility. He was 71 years old at the time.

1.2. 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.

1.3. Pursuant to section 27 of the Act, an inquest in these circumstances is mandatory, and must be heard by a senior coroner (the State Coroner or a Deputy State Coroner).

2. Introductory remarks

2.1. The coroner's primary function is set out in s. 81 of the *Coroners Act 2009*. It is to make findings as to the identity of the person who has died, the date and place of their death and the manner and cause of death. The inquest is not adversarial, but inquisitorial. The focus is to determine what happened without attributing blame, guilt or making findings of liability.

2.2. In this case, there is no controversy as to identity or the date and place of death. The manner and cause of death were the subject of the inquest. This included the circumstances directly leading up to when Trent lost control of his motorcycle and collided with other vehicles. The questions for determination traversed the appropriateness of the care given to John while he was in custody.

3. Reflection on the life of John:

3.1. John Charles Dodd was born on 13th June 1950 in South Africa but moved to Australia in his twenties where he became a permanent resident. He attended school and subsequently worked intermittently as a plasterer. He married Kristen Dodd and they had two daughters; the eldest was present at the inquest and supported her father during his time in custody where they communicated frequently.

3.2. John was known to police having served custodial sentences most of his adult years. Since 1976, he had been charged 19 times with offences mostly relating to drug possession and supply. On 5th November 2015, John was sentenced at the Coffs Harbour District Court to 11 years of imprisonment for drug offences, the most serious being supplying drugs of a large commercial quantity. He was eligible for release on 10th December 2022.

3.3. John had several comorbidities for which he received medical treatment. In 1988, he suffered a cerebral brain aneurysm however, there was nothing to suggest it effected his cognitive function. He had a history of using cocaine and heroin for

which he participated in the methadone program. After his conviction, John was sent to Mid North Coast CC before transferring to Geoffrey Pearce CC on 19th October 2020 to participate in the Intense Drug and Alcohol Treatment Program. He remained at this location until his death.

3.4. During his incarceration, John was described as being remorseful for his offences and proactive in his rehabilitation. This was obvious from the records, he had turned his life around, finally had dealt with drug issues and was looking forward to his release the following year.

3.5. In July 2020, he underwent surgery to repair a large right inguinal hernia without complication. Otherwise, the substance of his Justice Health records describes issues regarding ongoing mobility difficulties. An x-ray performed in January 2020 detailed a '*marked degenerative change in the left hip joint with loss of joint space superiorly, mild flattening of the articular margins and marked subchondral sclerosis*'. As a result, he was housed in normal cell placement with no steps or slopes to accommodate his wheeled walker. By the 5th July 2021, he had received 2 injections for AstraZeneca to protect him from COVID-19.

3.6. When he entered custody, it was recorded John had '*coronary ischaemic syndrome*' as an active health condition diagnosed in March 2014. He also had a history of hypertension that was closely monitored with routine medication including the beta-blocker Metoprolol – a common prescription to treat high blood pressure, angina and irregular heart rhythms. He also visited the Justice Health clinic for weekly blood pressure checks. His last observation checks took place on the 4th and 7th September 2021 respectively.

3.7. John last attended the clinic on 8th September, the day before his passing. He had a 3-day history of discharge in both his eyes. He was given ointment and instructions for review in a week. It is not recorded he made any other complaints however it is acknowledged that his blood pressure was checked the day before.

4. Events leading up to 9 September 2021:

4.1. It is important to carefully analyse the last known movements of John. On 8th September 2021, a head count was performed for the inmates in Block A1. Following the head count, CCTV captures the following chronology of John's movements from 3:18pm:

8th September

15:18	Seen using the telephone whilst seated on his mobility walker/chair.
15:27	Seen wheeling himself towards his cell.
15:28	Seen walking through the threshold of his cell.
18:57	Opens cell door slightly before closing it again.
20:59	Opens cell door and closes it. The light in cell can be seen turned on.

9th September

01:18	Seen leaving his cell door and does a small lap of the common area before returning to his cell at 01:19. No other persons are in the common area.
02:09	Exits his cell and does a lap of the common area and returns to his cell at 02:10am. Again, no other persons are in the common area at the time.

4.2. At 8:18am on 9th September, inmates in Block A1 commenced gathering outside their cells for let-go procedures. John failed to present himself, another inmate went to his cell and opened the door to find John lying on the bed unresponsive. At 8:20am, the inmate used the common area cell call alarm to call corrective service officers for assistance.

4.3. At 8:22am, Corrective Officers' staff entered the unit followed by Justice Health nurses who performed a medical assessment. At 8:47am, ambulance officers arrived and confirmed John's death. The cell was secured for NSW Police to complete their investigation.

5. The Autopsy Report:

5.1. An autopsy was performed at the Department of Forensic Medicine at Lidcombe by Forensic Pathologist Dr du Plessis supervising Dr Garland. The examination identified significant cardiovascular disease was present including an enlarged heart weighing 643g with left circumflex coronary artery atherosclerotic stenosis up to and greater than 90%, left anterior descending coronary artery atherosclerotic stenosis up to 75% and scarring within the heart muscle.

5.2. Atherosclerotic stenosis of even one major heart artery of 75% or greater can predispose to sudden death at any time, such as through a fatal arrhythmia provoked by reduced oxygenated blood supply to the heart muscle. Significant coronary artery stenosis was also noted to cause myocardial infarction and was present in a chronic stage in John's case in the form of scarring of the heart muscle. A potential cause of the significant cardiovascular disease is John's known diagnosis of hypertension.

5.3. The Neuropathologist examination also showed features of inactive multiple sclerosis which would explain Mr. Dodd's mobility issues and unsteady gait. However, this diagnosis is not considered to have contributed to his death.

5.4. The cause of death was determined to be from ischaemic heart disease.

6. Concluding Remarks

6.1. It was important to carefully analyse the care provided to Mr Dodd, to ensure the State had properly ensured that Mr Dodd received the health care that he required.

6.2. As a result, Justice Health were requested to provide further information regarding the treatment John received in custody for his cardiac health. Dr. Gary Nicholls, the Clinical Director Primary Care Medicine provided a statement where he reviewed the medical documents for John confirming that he had never presented with any acute cardiac symptoms which would have then required management by a specialist cardiologist. He further confirmed that John's blood pressure and prescribed medications was regularly checked and reviewed by Justice Health staff. If changes to his health were identified this would have resulted in an appointment being made for him. No acute medical issues were presented prior to John's death.

6.3. It appears that he was provided with proper and adequate health care while in custody.

7. Recommendations

7.1. There are no recommendations that are required to be made as a result of this inquest.

8. Acknowledgments

8.1. To the Officer in Charge for a thorough and careful preparation of the brief, and gathering of relevant evidence.

8.2. To Inspector Xanthos for preparing the matter for inquest, ensuring the relevant inquiries were made, and statements prepared and for presenting the case in a thoughtful manner.

9. Findings required by s81(1)

9.1. 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 John Charles Dodd

Date of death
9 September 2021

Place of death
Geoffrey Pearce Correctional Centre, New South Wales

Cause of death
Ischaemic heart disease

Manner of death
Natural Causes

9.2. I again extend my most sincere condolences to John's family and friends.

9.3. I close this inquest.

Magistrate E Kennedy

Deputy State Coroner

17 April 2023