STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Stanley Allan Lord**
Hearing dates:	**9 September 2014**
Date of findings:	**11 September 2014**
Place of findings:	**State Coroner's Court, Glebe**
Findings of:	**State Coroner Barnes**
Catchwords:	**Coronial Law- Death in custody; natural causes; care and treatment**
File number:	**2013/18658**

Representation:	Sgt Samantha Ferguson assisting the NSW State Coroner , Magistrate Barnes Ms Felicity Graham of Aboriginal Legal Service representing the Lord family Mr Gurdev Singh representing Justice Health Ms Jane Blackwell representing Correctives Services
Findings:	**The identity of the deceased** The person who died was Stanley Allan Lord **Date of death** Mr Lord died on 19 January 2013 **Place of death** He died at Prince of Wales Hospital, Randwick, NSW. **Cause of death** Mr Lord's death was caused by dilated cardiomyopathy. **Manner of death** Mr Lord died from natural causes while serving a custodial sentence.
Recommendations:	

The Coroners Act in s81(1) requires the findings as to various aspects of the death to be recorded in writing. These are the findings of an inquest into the death of Stanley Allan Lord.

Introduction

Mr Lord was referred to by his family as Bud. They request that he be called by that name in these proceedings.

On 19 January 2013, Bud suffered a cardiac arrest while in the Prince of Wales Hospital where he was being treated for a heart condition and cholecystitis. He was unable to be revived. He was 39 years old.

As Bud was in custody when he died, an inquest was held into his death. It received evidence sufficient to make the findings required by s81 of the Coroners Act and to consider the adequacy of the health care provided to him while in custody.

The evidence

Social history

Bud was born on 1 February 1973, the middle child of three children. He lived most of his life in Nyngan, NSW.

Bud had strong connections to his family and his community. He played football in the area and was well regarded.

He maintained contact with his nieces and nephews and his older relatives.

He had a number of medical problems throughout his life. From around 2005, he began experiencing chest pains. He sought treatment for this but did not advise his family of the details of his condition. His father understands that he had previously suffered a heart attack.

In 2006, Bud was imprisoned after being convicted of assault occasioning bodily harm, resisting police and driving while disqualified. As a result of that the last charge he received a lengthy disqualification from holding a licence which eventually led to him being imprisoned at the time of his death.

In particular, on 14 June 2012, he was intercepted and charged with driving while disqualified. Three weeks later, he was again seen driving and again charged with the same offence. On that occasion he was denied bail. A few weeks later he was sentenced to a term of imprisonment. Although the length of that sentence was reduced on appeal Bud remained in custody until his death.

Events leading to the death

On 6 July 2012, Bud was received into custody at the Wellington Correctional Centre on remand. At reception he reported some cardiac history involving an irregular heartbeat. An ECG was performed and blood was taken for analysis.

On 9 July blood tests revealed an irregularity suggesting a cardiac condition. Accordingly, Bud was transferred to the Wellington District Hospital. Following examination he was transferred to Dubbo Base Hospital where he was treated for a mild myocardial infarction. He was prescribed medication and further tests were undertaken.

He was discharged back to the Wellington Correctional Centre on 12 July. He did not complain of further symptoms. He attended a follow up appointment with a consultant cardiologist at Dubbo Base Hospital on 10 August 2012. That doctor recommended no change to his treatment.

On the 14 December 2012 Bud was transferred to Long Bay Correctional Centre to facilitate better access to health care.

On 1 January he complained of vomiting and associated gastro intestinal symptoms. The clinical notes record he did not complain of chest pain, however this changed on 2 January and he was at that stage transferred to the Prince of Wales Hospital. There he was diagnosed with cholecystitis- an inflammation of the gall bladder. This was initially treated with antibiotics. A CT scan on 4 January showed an infarct in the lower pole of the left kidney. He developed acute kidney impairment and was treated with haemodialysis. Scans showed a severely dilated left ventricle with severely impaired systolic function and a dilated and impaired right ventricle – serious heart disease probably requiring a heart transplant.

His renal function continued to deteriorate as did his liver function. This was thought to be due to ischaemic hepatitis.

While awaiting surgery to attend to the gall bladder condition, Bud suffered a cardiac arrest. He was intubated and placed in the intensive care unit. His condition initially improved and he was extubated on 13 January. During this period he was visited by various family members.

In view of his condition the surgery planned to address his gallbladder complaint had to be postponed until his general health improved.

Bud's heart rhythm remained unstable and the medical records note consideration was given to inserting a pace maker when his sepsis resolved. On 19 January he developed increasing abdominal pain and sweating. An abdominal CT scan showed a mild increase in free fluid in the abdomen but no abdominal collection. He was returned to the Intensive Care Unit where a central venous catheter was inserted under ultrasound guidance. After the line was inserted Mr Lord again became bradycardic and suffered an asystolic cardiac arrest. He was unable to be revived.

The investigation

Scene examination

Officers from the Corrective Services Investigation Unit attended the hospital on the evening of Bud's death. They found his room secured and guarded by correctional officers. Bud's body and the room were photographed. Hospital staff confirmed that he had died as a result of a cardiac arrest and that no third party had been involved in the death, in their view.

Mr Stanley Lord senior identified Bud's body to police.

Autopsy results

On 21 January 2013, an autopsy was undertaken at the Glebe Department of Forensic Medicine by an experienced forensic pathologist. Bud's heart was found to be severely enlarged and dilated and there was thinning and patchy fibrosis and mottling of the left ventricle wall in keeping with the history of an earlier myocardial infarction. The pathologist considered the enlarged and scarred heart was in keeping with Mr Lord's history of dilated cardiomyopathy. The liver showed congestion and necrosis in keeping with severe ischaemic hepatitis. This was most likely due to chronic alcohol abuse and ischaemic heart disease as there were multiple areas of up to 80% narrowing in the right coronary artery. No injuries or signs of trauma were found.

Conclusions

There is no evidence that any third party played any part in Bud's death. On the contrary, all of the evidence overwhelmingly points to his death being due to natural causes. It is apparent that he had been very unwell for a lengthy period. The autopsy report describes a combination of chronic and acute serious diseases to vital organs that precipitated a steady decline before a sudden death.

All deaths in custody, even from natural causes, are required to undergo an inquest to enable an independent assessment of whether the State has discharged its responsibility to provide the deceased prisoner with adequate health care and treatment. The standard required is the equivalent of that which the deceased would have received had he/she not been in custody.

In this case I am satisfied Bud received health care of an appropriate standard. Soon after his incarceration he was taken to Wellington Hospital and then to Dubbo where he was seen by a cardiologist on a number of occasions. When his condition deteriorated he was moved to Long Bay Correctional Centre to be closer to more high level health care. This was provided by the clinicians at the Prince of Wales Hospital who are some of the most eminent in Australia.

Despite the high level of care provided to him, Bud died as a result of the combined effects of long existing cardiac illness and more acute multi organ failure. There was nothing that could reasonably have been done to avert his demise. It is almost certain the outcome would have been the same had he not been in custody.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given 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 person who died was Stanley Allan Lord.

Date of death

Mr Lord died on 19 January 2013

Place of death

He died at Prince of Wales Hospital in Randwick, NSW.

Cause of death

Mr Lord's death was caused by dilated cardiomyopathy.

Manner of death

He died from natural causes while serving a custodial sentence.

Recommendations

Pursuant to s 82 of the Act, coroners may make recommendations about matters connected with a death.

In this case the lawyer for Bud's family submitted I should make recommendations or comments about the habitual offender provisions of Road Transport (General) Act 2005 that resulted in his being subjected to ever lengthening periods of driving disqualification which in turn led to his being incarcerated.

It is apparent those provisions impacted upon Bud in a way that made it very difficult for him to foresee a time when he would be able to drive lawfully. In those circumstances, it is perhaps understandable, that on occasions he chose to ignore his disqualification and to drive – public transport in rural areas is very limited.

Conversely, the road toll demands that governments respond robustly to drink driving and dangerous driving. Disqualifying offenders from driving is the most direct and obvious response, even though it will also have unintended consequences in some cases.

These competing policy imperatives pose a challenging balancing exercise. However, for a number of reasons, this inquest is not an appropriate forum to attempt to resolve that dilemma. First, I do not consider Bud's death was sufficiently connected with the habitual offender provisions to bring a critique of that regime within the jurisdiction of this inquest – he didn't die because he was disqualified from driving; indeed, he didn't die because he was in custody.

Further, I have insufficient evidence on which to base meaningful comment – a single undesirable outcome would need to be balanced against the benefits that presumably flow from the current arrangements. No relevant material was put before the Court, no relevant witnesses called or questions about the issue asked of those who were. Accordingly, I decline to make comment about the issue.

I close this inquest.

Magistrate Michael Barnes
State Coroner
Glebe, NSW
11 September 2014