**CORONERS COURT**
**NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of **Farin William Daley** |
| **Hearing dates:** | 27 July 2015 |
| **Date of findings:** | 27 July 2015 |
| **Place of findings:** | NSW Coroners Court - Glebe |
| **Findings of:** | Magistrate E. Truscott, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – Cause and manner of death - Death in custody - heart condition |
| **File number:** | 2013/389043 |
| **Representation:** | Ms D Williamson –Coronial Advocate Assisting**.**<br>Mr S Griffiths – NSW Corrective Services<br>Mr G Singh - NSW Justice Health & Forensic Mental Health Network |
| **Findings:** | **Identity of deceased**:<br>The deceased person was Farin William Daley<br><br>**Date of death**:<br>He died on 28 December 2013<br><br>**Place of death**:<br>He died at Prince of Wales Hospital Randwick<br><br>**Cause of death:**<br>Ischaemic heart disease<br><br>**Manner of death:**<br>Natural Causes |

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

**REASONS FOR DECISION**

1. This inquest concerns the death of Farin William Daley. He was a 43 year old man who was an inmate at Long Bay Correctional Facility.

2. The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

   (a) the identity of the deceased;

   (b) the date and place of the person's death;

   (c) the physical or medical cause of death; and

   (d) the manner of death, in other words, the circumstances surrounding the death.

3. The Act also requires a Coroner to conduct an inquest where the death appears to have occurred while a person is in lawful custody. (s.23, s.27).

> *"The purpose of a s.23 Inquest is to fully examine the circumstances…, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a*

*particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."*[1]

4. Mr Daley was born on 19 May 1970. His father died when he was young and he was raised by his mother and step father. In September 2000 his mother passed away and a few years later his stepfather also passed away.

5. Mr Daley was a fit teenager who played rugby league for the local football team. He never had any health issues growing up except for when he was about 28 years of age playing a game of football when he just dropped to the ground. His family later found out he had suffered a heart attack and was conveyed to Brisbane Hospital. He remained in Hospital for several weeks and eventually recovered and was not sick again.

6. Mr Daley resided in the Casino district and was in an on and off relationship for about ten years. The relationship was volatile and had many domestic violence issues. Eventually Mr Daley went to prison as a result of those issues. He first came into contact with the criminal justice system in 1990. From 1998 to 2005 he was charged with numerous offences and he served about 8 periods of imprisonment, usually short sentences.

7. In 2005 while he was serving a term of imprisonment, he was charged and later convicted of serious offence committed in prison and he was sentenced to a term of imprisonment of seven and a half years with a non-parole period of 4 years and 8 months. His release date was 17 October 2011. Whilst serving this sentence he committed a further similar offence in custody. He was sentenced at Bathurst District Court in 2009 to five years imprisonment and his earliest release date on parole was 28 November 2014.

8. Mr Daley's sister, Karen Daley, visited her brother in Junee Correctional Centre in 2010 and visited him occasionally until about 2012. In her statement Karen said her brother was always happy and looking forward to his release in 2014. He told her he was going to Church and getting into his music. He appeared to have changed dramatically since being in custody. He did not mention that he had any medical issues or had been sick. He wrote numerous letters in which he sounded happy and never mentioned any issues.

[1] Waller's Coronial Law & Practice in New South Wales 4th Edition, page 106

9. Every time a prisoner is received on sentence, Corrective Services creates a case management file and warrant. These files contain documents including inmate requests, alerts, program or further education plans and behavioural type offences committed within Corrective Services custody. Mr Daley's case management file contains nothing of great note. He had made numerous requests to be placed into protective custody due to the nature of his charges. It appears these have been received and acted upon appropriately in each instance, with Mr Daley being classified to varying degrees of protection during his time in custody.

10. Justice Health provides medical care to inmates within the Correctional System. They maintained five volumes of medical records relating to Mr Daley. The records indicate that Mr Daley rarely required medical assistance or attended the medical clinic. The records show two visits in 2013, one for back pain and the other was to request a day off work as he had not been sleeping. Additionally, he only had two visits in 2012 which were for back pain and a rash. On 11 August 2011 Mr Daley reported to a nurse that he was lethargic, dizzy and suffering from headaches. He was treated with paracetamol. He was monitored and assessed by the clinic. The following day he reported that he was feeling a lot better.

11. A 'Clinical Reception Assessment' was completed by Mr Daley on his arrival each time into prison. At no time did he inform Justice Health that he suffered a previous heart attack or had a medical condition. In the questionnaire there are specific questions relating to heart disease. Mr Daley answered these questions in the negative and stated he had never suffered chest pains or tightness of the chest. In relation to the question *"do you have a history of heart disease"* he marked the question with a *"No".*

12. About 2:30pm on Saturday 28 December 2013 Mr Daley was secured in cell 32 with another inmate. Mr Daley cooked up some food in the early evening. About 8:45pm he had a smoke whilst sitting at the table before retiring to the lower bunk. His cellmate heard Mr Daley sneeze once and then a funny sound like he was trying to sneeze. Mr Daley asked his cellmate to hit the knock up button as he was not feeling well. The cellmate hit the knock up button and was waiting at the door for Corrective Officers when he turned and saw Mr Daley holding his head. All of a sudden he fell forward off the bed onto the floor. He feel face first and hit the floor hard. His glasses were under his head and there was blood coming from his nose or mouth. The cellmate pushed the knock up button several more times. He heard Mr Daley take a big breath through his nose and heard gurgling sounds. Mr Daley attempted big breaths in an effort to get oxygen into his lungs.

13. Corrective Services staff entered the cell and found Mr Daley lying face down struggling to breathe. CPR was commenced and ambulance and the night nurse were summoned. Ambulance arrived about 9:19pm and worked on Mr Daley before transporting him to Prince of Wales Hospital. Life was pronounced extinct by Dr David D'SILVA at 10:34pm.

14. A forensic crime scene examination was conducted of cell 32. There were no signs of a struggle. The cell appeared neat and tidy. There was a fresh blood drop on a desk and a small pool of blood on the floor adjacent to the bed. There were no suspicious circumstances surrounding the death.

15. A post mortem examination was conducted by Dr Kendall BAILEY. I accept her opinion that the cause of death was Ischemic Heart Disease.

16. All protocols were followed by Corrective Services with regard to deaths in custody. The Crime Scene was managed by Corrective Services staff in an efficient and competent manner. Justice Health it appears he received satisfactory treatment.

17. Karen DALEY is aware that Farin William DALEY never disclosed a previous heart condition to Corrective Services or Justice Health. She writes that she would like to see all incarcerated inmates have compulsory yearly check-ups. She would further like to see medical background checks being conducted on new inmates when they are first entered into custody. Karen believes this would help identify previous medical conditions which inmates do not like to disclose and believes if this procedure were in place her brother's medical condition may have been able to be treated. Comment was sought from Justice Health in relation to these issues.

18. Justice Health report that as part of the Reception Screening Process the Patient Administration System (PAS) is now checked for relevant alerts, both inactive and active, from previous periods of imprisonment. Additionally as part of staged health care, all patients are requested to complete a 'Consent to Obtain Health Information' form in order for Justice Health and Forensic Mental Health Network to be able to contact their regular health provider. All information is scanned and made available on the Justice Health electronic Health System. Justice Health has developed a centralised model of coordinating access to patient's health information through this process. Further there are additional health care and health screening requirements being implemented for Aboriginal patients.

19. Justice Health and Forensic Mental Health Network continue to work to identify and treat patients who require health interventions within the correctional environment, however also respect the rights of patients to refuse treatment in

line with existing community standards. During the assessment process it is not always possible to identify existing health concerns without the cooperation of the patient. Any health concerns that are identified are referred for appropriate treatment with patient's encouraged to engage in such treatment. This proactive approach to transitioning health care facilitates a more integrated and comprehensive assessment of patients within the corrections system.

20. On my review of the evidence contained within the file, there does not appear to be any relevant matters in relation to Mr Daley's care and treatment during his sentence, which would cause me to consider recommending any changes to policy or procedure in either the Correctional or Justice Health.

**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 Farin William Daley

***Date of death***

He died on 28 December 2013

***Place of death***

He died at Prince of Wales Hospital

***Cause of death***

The death was caused by Ischaemic heart disease

***Manner of death***

Natural causes

**E. Truscott**
NSW Deputy State Coroner
Glebe

**Date**
**27 July 2015**