**STATE CORONER'S COURT**
**OF NEW SOUTH WALES**

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| **Inquest:** | Inquest into the death of Idris Griffiths |
| **Hearing dates:** | 29 April 2016 |
| **Date of findings:** | 29 April 2016 |
| **Place of findings:** | State Coroners Court, Glebe |
| **Findings of:** | Magistrate Derek Lee, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – death in custody, natural causes, care and treatment |
| **File number:** | 2014/214164 |
| **Representation:** | Sgt S Ferguson, Advocate Assisting the Coroner<br><br>Ms De Castro Lopo for Corrective Services NSW |
| **Findings:** | I find that Idris Kevin Griffiths died on 19 July 2014 at Prince of Wales Hospital, Randwick, New South Wales. February 2015 at Goulburn Correctional Centre at Goulburn, NSW. The cause of death was pneumonia, with multi-organ failure in the form of liver failure (due to chronic Hepatitis C infection) and congestive cardiac failure (due to ischaemic heart disease) as an antecedent cause. Mr Griffiths died of natural causes whilst serving a custodial sentence. |

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## Introduction

1. Mr Idris Kevin Griffiths was born in 1934. At the time of his death he was serving a custodial sentence at Long Bay Correctional Centre.

2. As Mr Griffith was in lawful custody at the time of his death an inquest is required to be held pursuant to sections 23 and 27 of the Act. Section 81(1) of the *Coroners Act 2009* requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into Mr Griffiths' death.

## The role of a Coroner and purpose of this inquest

3. The role of a Coroner, as set out in s 81 of the *Coroners 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.

4. Pursuant to s 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

## Mr Griffith's personal history

5. Unfortunately, very little is known about Mr Griffiths' personal history other than he was born in 1934 and that he had six children. His wife passed away about 5 years before he was last sentenced. The brief of evidence did not contain any statements from any member of Mr Griffith's family. However in an email to the police officer-in-charge, Detective Senior Constable Melissa Martens, one of Mr Griffiths' daughters, Linda Friedland, expressed her thanks that family members were permitted to visit Mr Griffiths at Prince of Wales Hospital.

6. No member of Mr Griffiths' family was present at the inquest.

## Mr Griffith's custodial history

7. On 3 September 2010 Mr Griffiths was sentenced at the Sydney District Court in relation to two offences of supplying a large commercial quantity of a prohibited drug. For one of the offences Mr Griffiths received a 9 year sentence of imprisonment backdated to commence on 25 September 2008 and expire on 24 September 2017, with a five year non-parole period expiring on 24 September 2014.

8. For the other offence, Mr Griffiths received a partially cumulative 8 year sentence of imprisonment from 25 September 2010 to 24 September 2018 with a 4 year non-parole period expiring on 24 September 2014. This last date was Mr Griffiths' earliest possible release date to parole.

9. At the time of entering custody in 2008 Mr Griffiths was 74 years old. He was initially kept at the Dawn de Loas Correctional Centre at the Silverwater Correctional Complex and later permanently transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital.

**Mr Griffiths' medical history**

10. When Mr Griffiths entered custody in 2008 he had a number of serious health conditions. He had previously undergone coronary bypass surgery, he had a history of hypertension and stomach ulcers, and was positive for Hepatitis C with associated liver conditions such as jaundice.

11. In 2010 it was found that Mr Griffiths had an enlarged spleen and his liver function test results were poor. By 2012, Mr Griffiths was under the care of a hepatologist although on many occasions he declined treatment for his Hepatitis C. By 2013 he had developed cirrhosis of the liver and end stage liver disease.

12. In mid to late 2014 it was recognised that Mr Griffiths' poor liver health made him prone to encephalopathy which in turn caused confusion and increased his risk of falls. By this time Mr Griffiths had also developed an unsteady gait and was prone to Parkinson's disease-like symptoms, such as involuntary shaking.

**The events of July 2014**

13. At about 9:35am on 14 July 2014 a correctional officer went to Mr Griffiths' cell to rouse him for breakfast. Mr Griffiths was found lying on the floor with a small amount of blood around his head. Justice Health nurses attended a short time later and Mr Griffiths was taken to the emergency department at Prince of Wales Hospital at about 10:55am.

14. Mr Griffiths was found to have a laceration to the back of his head from the fall. But further examination did not reveal any intracranial pathology. Mr Griffiths was later transferred to a secure bed within the hospital.

15. Over the course of the next few days, Mr Griffiths' condition deteriorated. He developed pneumonia and a viral infection, became hypothermic, and was found to have an abnormally low heart rate.

16. On 17 July 2014 it appears that, following consultation with his treating physicians, Mr Griffiths signed a no cardiopulmonary resuscitation (CPR) order.

17. Mr Griffiths' family were notified of his condition and arrangements were made for them to visit him on 18 and 19 July 2014 as his condition was dire and not improving. Following a discussion between the physicians and Mr Griffiths' daughters it was decided that only palliative care would be provided to Mr Griffiths. Late on the evening of 18 July 2014 a chaplain at the hospital, at the request of Mr Griffiths' family, attended his room to perform the last rites.

18. At about 7:10am on 19 July 2014 Mr Griffiths was noted to be deeply unconscious. By the early afternoon Mr Griffiths was unresponsive to verbal or tactile stimuli and had no heart sounds or pulse. He was declared deceased at 2:10pm.

**What caused Mr Griffith's death?**

19. On 21 July 2014 his Honour Deputy State Coroner MacMahon issued a coronial certificate recording Mr Griffith's cause of death to be pneumonia. Multi-organ failure in the form of liver failure (due to chronic Hepatitis C infection) and congestive cardiac failure (due to ischaemic heart disease) were listed as antecedent causes.

**Are there any other issues to investigate?**

20. When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

21. I have examined Mr Griffiths' Justice Health records. They reveal that in 2013 it was recognised that Mr Griffiths' poor health made his incarceration at Dawn de Loas correctional centre inappropriate due to the environmental risks associated with the fast-paced routine of that particular centre. It had already been identified that Mr Griffiths required assistance from other inmates with his daily living activities. Accordingly, Mr Griffiths' was reclassified and transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital.

22. Justice Health also identified that, due to his end stage liver disease and unsteady gait, Mr Griffiths was prone to falls. It was noticed that most of his falls occurred whilst Mr Griffiths was attempting to get out of bed and so pressure alarms were placed in his bed. He was also given training on how to safely transfer in and out of his bed. Unfortunately, Mr Griffiths had a tendency to remove the alarms which increased his risk of falls.

23. In an attempt to improve the conditioning in his arm and leg muscles, so as to reduce the risk of falls, Mr Griffiths was provided with regular physiotherapy sessions. He was also given appropriate a walking frame to help with his mobility and stability.

## Conclusion

24. Having considered all of the available evidence I reach the conclusion that Mr Griffiths' death is not suspicious and that he died as a consequence of a natural cause process.

25. I also conclude that Mr Griffiths received health care of an appropriate standard whilst in custody. The physical complications associated with his poor health were identified by both Justice Health and Corrective Services, and appropriate measures were put in place to assist Mr Griffiths and to reduce the risk of injury.

26. I also conclude that the circumstances in which Mr Griffith was found on the morning of 14 July 2014 was a result of his poor health making him susceptible to falls, particularly when leaving his bed. There is no evidence to suggest any third party involvement in this incident. There is also no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Griffiths' death in any way. Given Mr Griffiths' long-standing health issues, which were appropriately managed whilst he was in custody, and his rapid deterioration whilst in hospital it does not appear that anything could have reasonably been done to prevent Mr Griffiths' death.

27. On behalf of the coronial team I would like to offer my sincere and respectful condolences to Mr Griffiths' family.

## Findings

28. I now turn to the formal findings that I am required to make under section 8(1) of the Act:

***Identity***
The person who died was Idris Kevin Griffiths.

***Date of death***
Mr Griffiths died on 19 July 2014.

***Place of death***
Mr Griffiths died at Prince of Wales Hospital, Randwick, New South Wales.

***Cause of death***
The cause of death was pneumonia, with multi-organ failure in the form of liver failure (due to chronic Hepatitis C infection) and congestive cardiac failure (due to ischaemic heart disease) as an antecedent cause.

***Manner of death***
Mr Griffiths died of natural causes whilst serving a custodial sentence.

29. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
NSW State Coroner's Court, Glebe
29 April 2016