CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Craig Daniel James Catley
Hearing dates:	10 October 2018
Date of findings:	10 October 2018
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody –– what was cause of death – was care and treatment provided by Justice Health and Corrective Services NSW adequate.
File number:	2015/6538
Representation:	Coronial Advocate assisting the inquest: Sgt T O'Donnell. Corrective Services NSW: Mr A Jobe, Office of General Counsel, NSW Department of Justice. Justice Health and Forensic Mental Health Network: Ms S Li.

Findings:	**Identity** The person who died is Craig Catley born 2 February 1982. **Date of death**: Craig Catley died on 7 January 2015 **Place of death**: Craig Catley died at Long Bay Hospital, Long Bay Correctional Facility, Malabar NSW 2036 **Cause of death:** Craig Catley died as a result of sudden cardiac arrhythmia. **Manner of death:** Craig Catley died as a result of natural causes while in custody.

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Non Publication Order

1. That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009 (NSW)*:

a. The names, addresses, phone numbers and other personal information that might identify any member of Mr Catley's family.

b. References to and any other information which would tend to identify security contractors retained by CSNSW.

c. CCTV footage taken from Long Bay Hospital.

d. Extracts from section 13.2 of the CSNSW Operation Procedures Manual.

2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, a notation be placed on the court file regarding any application under 65 (2) of that Act for CSNSW documents that have been placed on the court file:

a. access shall not be provided to that material until CSNSW has had an opportunity to make submissions in respect of that application.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Craig Catley.

Introduction

1. On 7 January 2015 Craig Catley aged 32 years died at Long Bay Hospital. The previous day he had been discharged from Prince of Wales Hospital following treatment for a pituitary tumour. Mr Catley was serving a custodial sentence for the manslaughter of his mother and for animal cruelty offences.

2. As Mr Catley was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

The role of the Coroner

3. Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

4. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Mr Catley's life

5. Craig Catley was born on 2 February 1982 to parents Rhonda Catley and Danny Fisher. His father had little or no involvement in his life. His mother developed a dependency on alcohol and heroin, and had a history of domestic violence perpetrated by her intimate partners. When Craig was ten years old she was imprisoned for robbing and wounding a taxi driver. She remained incarcerated for much of the following nine years. During this time Craig was raised by his maternal grandparents.

6. Soon after Rhonda Catley was released from prison she moved to Gateshead near Newcastle. Craig, now an adult, began to spend more time with her and moved in to live with her for periods of time. However their relationship was turbulent, and was made worse by Rhonda Catley's ongoing dependence on alcohol which often made her behave aggressively. While Craig loved his mother he felt resentment against her for not being around to raise him as a child. He also resented her drug and alcohol dependence.

7. Craig too had alcohol and drug dependencies, and became aggressive when intoxicated. During the years 2005 to 2007 there were a number of violent incidents involving Craig, his mother, and Craig's then girlfriend. Craig and his

mother had Apprehended Violence Orders against each other at different times. However despite the anger and physical abuse which characterised their relationship, friends and family reported that Craig loved his mother and at times tried to protect her from the violence of her intimate partners. It was a troubled and complex relationship.

The offences and custodial sentences

8. On the evening of 16 October 2009 Craig came to visit his mother. They began to drink alcohol and to argue. In the early hours of 17 October Craig fatally stabbed his mother in the chest, then killed two of her cats. He then walked to a neighbour's house and asked her to call police as he had *'just killed mum'.*

9. Craig was charged with murder and pleaded 'not guilty' on the grounds of mental illness. He was convicted of manslaughter and of two acts of animal cruelty.

10. On 18 November 2011 he was sentenced to eleven years' imprisonment with a non-parole period of eight years. He also received shorter fixed terms of imprisonment for the animal cruelty offences.

Craig Catley's health and treatment in custody

11. Craig's death occurred after he had been five years in custody.

12. Craig was first received into custody at Cessnock Correctional Centre on 16 October 2009. He reported untreated depression and a suicide attempt in 2007. He was commenced on anti-psychotic medication as he also reported psychotic-type symptoms.

13. In February 2012 Craig was transferred to Junee Correctional Centre where he was gradually weaned off his anti-psychotic medication, with no reported adverse effects.

14. Throughout 2013 and 2014 Craig suffered episodes of dizziness and fainting. In a medical review in August 2013 it was recommended he cease using his clonidine medication, but he was reluctant to do so. It was noted his dizziness occurred mostly when he was standing, and a cardiologist review in May 2014 confirmed he had Postural Orthostatic Tachycardia Syndrome (POTS syndrome). This is a condition in which a change from lying to standing causes an abnormal increase in heart rate. Its symptoms include lightheadedness and blurry vision. Craig was treated with the medication metroprolol and an increase of salt in his diet.

15. However Craig's fainting episodes continued throughout the second half of 2014, and he reported deteriorating vision, gait disturbance, incontinence, confusion and lethargy. In November he received a brain CT which led to an urgent neurosurgery referral on 26 November.

16. At Prince of Wales Hospital Craig was found to have a brain tumour which compressed the optic chiasm and the hydrocephalus. The tumour was surgically removed on 27 November and Craig remained at Prince of Wales Hospital for a further six weeks, under the care of neurosurgeon Dr Jacob Fairhall. Craig also received treatment from intensive care, endocrinology, nephrology, psychiatry and ophthalmology medical teams.

17. Craig was transferred back to Long Bay Hospital on 6 January 2015. He was last seen in person by a Justice Health nurse who had a conversation with him that night at 8.37pm. She assisted him with his prescribed medication and gave him a urine bottle to use during the night. According to her notes, she also reminded him to use his hospital cell call button if he needed assistance.

18. Craig's hospital cell did not contain a CCTV camera, but there was one installed in the main area outside his cell. It is able to capture images of the glass window in Craig's cell door. At about 3.37am on the morning of 7 January, CCTV footage retrieved from this camera shows Craig moving about in his cell. No further movement was shown.

19. Craig was found in his cell unresponsive at 8am that morning by a Corrective Services officer and a nurse who was to conduct a sugar level check. An ambulance was immediately called and CPR commenced, but he could not be revived and he was pronounced deceased at 8.41am. Craig's medical notes do not contain any reference to him seeking medical help during the night. Nor is there any reference to him activating his cell call button. Despite attempts, police were unable to obtain independent verification that Craig's cell call button had not been activated that night. This issue is addressed below.

What caused Craig Catley's death?

20. Pathologist Dr Kendall Bailey performed an autopsy examination of Craig's body. The examination did not reveal any significant abnormalities, and Dr Bailey could not ascertain a cause of death. She noted Craig's background history of tachycardia, and commented that a fatal arrhythmia could not be excluded.

21. At the request of the Coroner, consultant physician and cardiologist Dr John England provided an expert report. After examining the medical records and statements, Dr England confirmed the most likely cause of Craig's death was a sudden cardiac arrhythmia.

22. As to what had caused the arrhythmia, Dr England was unable to determine this with certainty. He did not think Craig's diagnosis of POTS provided the underlying reason, and considered other possibilities more likely. These included that through use of anti-psychotic medication Craig had developed long QT syndrome, a condition which creates an increased risk of irregular heartbeat and sudden death. Dr England also thought it possible Craig's pituitary brain tumour had contributed to his cardiac arrhythmia.

23. Dr England could not find a cause for death in any omission of Craig's medical treatment.

24. On the basis of the above medical evidence, I find on the balance of probabilities that the cause of Craig's death was a sudden cardiac arrhythmia. However it is not possible to ascertain what the underlying cause of this event was.

Was Craig's care and treatment at Prince of Wales Hospital adequate?

25. An independent expert report was obtained from Dr Jeffrey Brennan, a specialist neurosurgeon. Dr Brennan was asked to give his opinion on the adequacy of Craig's care and treatment at Prince of Wales Hospital, and whether this had contributed to his death.

26. In Dr Brennan's view Craig's hospital treatment and care was of a good standard, and fitted within accepted standards of care for Craig's complicated issues. Dr Brennan commented favourably upon the following features:
    - the hospital's rapid diagnosis of and timely surgery for Craig's tumour
    - the multidisciplinary approach taken to his health issues
    - the care he received in the Intensive Care Unit and then on the ward
    - the thorough endocrinological investigation and management of his fluid management issues, described below
    - appropriate plans for follow up at discharge.

Was Craig discharged from hospital too early?

27. Craig's aunt Nicole Catley made regular visits to Craig while he was in gaol and hospital. After he died she wrote to the Coroners Court expressing concern that Craig had been discharged too soon from Prince of Wales Hospital. She wrote of her distress at visiting Craig in hospital and witnessing his loss of sight, his urinary incontinence, and his uninhibited and distressed mental state. She believed these conditions were not improving.

28. In response to Ms Catley's concerns, a report was requested from Dr Fairhall regarding the decision of Craig's treating team that he was suitable for discharge to Long Bay Hospital on 6 January 2015. The inquest was also assisted by relevant comments made by Dr Brennan on this issue.

29. In Dr Fairhall's opinion, the timing of Craig's discharge was appropriate. He noted that Craig had a lengthy postsurgical period in Prince of Wales Hospital, with input from all relevant medical disciplines.

30. Dr Fairhall noted some postsurgical complications. These included Craig's ongoing visual loss, his behavioural concerns, and most significantly, managing his diabetes insipidus.

31. Diabetes insipidus is caused by insufficient production of the hormone which instructs the kidneys to retain water. As a result large quantities of water are

passed as urine and the patient experiences extreme thirst. In Craig's case this condition of hormone disturbance was considered an inevitable consequence of his brain surgery. In Dr Brennan's opinion it was being appropriately managed in hospital with observations, fluid replacement, and the medication desmopressin which aims to reduce nightly urine production. Dr Fairhall noted that on discharge Craig's diabetes insipidus was the subject of a clear management plan prepared by his endocrine team.

32. As regards Craig's visual loss, Dr Brennan explained this had been caused by the brain tumour compressing Craig's optic nerve. He noted that Craig's post surgery visual impairment was not unusual and could take months to resolve. Dr Fairhall considered it had good prospects of improving over time. Like Craig's diabetes insipidus, his visual acuity was to be monitored on discharge with follow up appointments.

33. Craig's confusion and disinhibited behaviour continued throughout his postsurgical period. Dr Brennan considered this to be consistent with derangement as a result of the brain tumour. In his view it was appropriately managed in hospital with supervised care and medical therapy. Craig's discharge plan included ongoing psychiatric input at Long Bay Hospital, and Dr Fairhall was of the view there were prospects for recovery in the following months.

34. Having reviewed the evidence, I conclude there is no basis to find that Craig's death was the result of premature discharge from Prince of Wales Hospital, or of any deficiency in his care and treatment there.

Craig's care and treatment on discharge

35. Dr Brennan was asked about the adequacy of Craig's observations conducted at Long Bay Hospital, in the short period between his discharge from Prince of Wales Hospital and his death. Dr Brennan commented that the observations conducted of Craig were adequate, and that it was normal for these to be reduced to twice daily once the patient has been transferred to a step down facility.

36. Given the suddenness of Craig's death, the question arises whether he might have attempted to get medical help during the night of 6 January.

37. There is no notation in the medical records that Craig sought medical assistance during that period. As noted, his cell contained a call button. This was tested within a short period following his death and found to be in working order.

38. Nevertheless police sought independent evidence about whether Craig had attempted to get help that night. On 9 January 2015 they made a request for a Systems Activity Report for the button in Craig's cell. The purpose was to ascertain whether in the hours before his death Craig had attempted to activate it. The request was made to *[name redacted]* who are the contracted security systems company.

39. However the response from *[name redacted]* was that they were unable to comply, because their system had not been correctly configured to produce such a report.

40. The unsatisfactory result is that it is not possible to ascertain through independent evidence whether Craig had tried to get medical help using the cell call button. I should note that *[name redacted]* has advised they have since carried out modifications to ensure Systems Activity Reports can be generated.

41. Notwithstanding the absence of this evidence, I am able to find on the balance of probabilities that Craig did not seek help by using the cell call button. There is no record in the medical notes of him having done so, and the device was found to be in working order.

What was the manner of Craig Catley's death?

42. The coronial investigation establishes that Craig's death was not brought about through any deficiency in the care and treatment he received at Prince of Wales Hospital or at Long Bay Hospital. This is also the case in relation to his general care and treatment as an inmate. From the outset of his time in custody it would appear that Craig's health problems were properly managed. Appropriate decisions were made and implemented about his medical treatment.

43. Nor is there any evidence that another person caused Craig harm, or that his death was caused by an accident or other form of misadventure. The manner of his death was by natural causes.

44. On behalf of the coronial team I offer my sincere and respectful condolences to Mr Catley's family. I hope that this inquiry and inquest has gone some of the way to reducing their concerns about his death.

45. I also appreciate the assistance I have received from the Coronial Advocate Sergeant Tim O'Donnell, and the Officer in Charge Detective Sergeant Ben Johnson.

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.

Identity
The person who died is Craig Catley born 2 February 1982.

Date of death:
Craig Catley died on 7 January 2015.

Place of death:
Craig Catley died at Long Bay Hospital, Long Bay Correctional Facility, Malabar NSW 2036

Cause of death:
Craig Catley died as a result of sudden cardiac arrhythmia.

Manner of death:
Craig Catley died as a result of natural causes while in custody.

I close this inquest.

E Ryan
Deputy State Coroner
Glebe

Date
10 October 2018