STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Richard John O'Connor
Hearing dates:	27 April 2018
Date of findings:	27 April 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes
File numbers:	2016/94829
Representation:	Ms T. Xanthos (Sergeant) - Advocate assisting the coroner Mr A Jobe - Solicitor, Office of General Counsel for Corrective Services NSW.

Findings:

The findings I make under section 81(1) of the Act are,

Identity
The person who died was Richard John O'Connor
Date of death
He died on 28 March 2016
Place of death
He died at the Prince of Wales Hospital, Randwick, NSW.
Cause of death
He died as a result of congestive cardiac failure.
Manner of death
Mr O'Connor died of natural causes. No issues were raised in relation to the quality of his medical care.

Non Publication orders Attached

Table of Contents

Introduction

1. Mr O'Connor died at Prince of Wales Hospital on 27 March 2016, at the age of 76. At that time he was a sentenced prisoner and had been brought to hospital from the Metropolitan Special Programs Centre (MSPC) at Long Bay Correctional Complex for medical treatment and observation. He had a lengthy medical history and was known to have significant and chronic health problems. No issues have been raised in relation to his care or medical treatment.

The role of the coroner

2. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] In addition, the coroner may make recommendations in relation to matters that have the capacity to improve public health and safety in the future.[2]This occurs when opportunities for improvement arise in the evidence.

3. In this case there is no dispute in relation to the identity of Mr O'Connor, or to the date and place of his death. No outstanding questions have been raised in relation to the medical cause of death or in relation to the circumstances surrounding Mr O'Connor's death. However, where a person dies in custody, it is mandatory that an inquest is held.[3] The inquest must be conducted by a senior coroner.[4]

4. There are sound reasons for holding an inquest in relation to the death of each prisoner who dies in custody in NSW. When a person is detained in custody the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice, it is especially important that the care they receive is of an appropriate standard. Even where the death appears to have been naturally caused, it is essential that any medical treatment provided is reviewed independently and that its quality is carefully assessed. This is particularly true in circumstances such as this where it appears that Mr O'Connor had little or no family support after his entry into custody. At the time of his death Mr O'Connor's level of care should have resembled the care any citizen would expect within the public system in the community.

5. Section 81 (1) of the *Coroner's Act* (2009) NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Richard O'Connor.

[1] Section 81 *Coroners Act* 2009(NSW)
[2] Section 82 *Coroners Act* 2009(NSW)
[3] Section 27 *Coroners Act* 2009(NSW)
[4] Section 23 *Coroners Act* 2009(NSW)

The inquest

6. A short inquest was held on 27 April 2018. The officer in charge of the investigation, Detective Senior Constable Joseph Coorey gave evidence and the court considered numerous statements, medical records, photographs and reports.

Background

7. Mr O'Connor was born on 12 October 1939. He was a high school teacher for about 35 years, working within the Catholic system. He joined the Patrician Brothers for a few years, later marrying and having a family. His marriage broke down and at the time of his arrest in 2014 he was single and living in the Lismore area. It appears that since his arrest he had no contact with his children or grandchildren. His sister was noted as his official next of kin on records held by Corrective Services NSW. However, she did not visit him or know of any family member who did.

8. In 2014, Mr O'Connor was charged with 55 offences relating to child sexual and indecent assault. He was convicted of a number of offences at Lismore District Court on 9 October 2015 and sentenced to ten years imprisonment, backdated to his entry into custody on 5 August 2014. There was a non parole period of six years and six months.

Medical history

9. Mr O'Connor had a long histroy of cardiac issues. In the 1980s he had suffered infective endocarditis and had required a valve replacement. He had ongoing atrial fibrillation and was managed in the community with medication.

10. Mr O'Connor had attempted suicide after being charged with the sexual offences and had been briefly admitted to the Lismore Base Hospital. He was later diagnosed with having an adjustment disorder with mixed anxiety and depression.

11. On his entry into custody, Mr O'Connor's health needs were fully assessed. I have had the opportunity to review his contact with Justice Health and have had access to their records. Mr O'Connor's pre-existing conditions were well documented and medications he had commenced in the community were continued. During his time in custody Mr O'Connor was seen regularly by medical staff for minor injuries, medication review and monitoring. He required and received a variety of mobility aids and age related equipment. He received attention in relation to his mental health issues.

12. It is clear that Mr O'Connor's health deteriorated over time and that his mobility was further impaired. Mr O'Connor's respiratory function decreased towards the end of 2015. He had significant weight loss and decreased tolerance for exercise. In 2015 he was seen by both a respiratory specialist and a cardiologist for review.

Admission to Prince of Wales

13. On 17 March 2016, Mr O'Connor suffered an unwitnessed fall in his cell resulting in a grazed elbow. He presented himself the following day to the Aged Care Clinic with shortness of breath and an increased heart rate. He declined to go to hospital.

14. On 20 March 2016, he was found was found to be suffering from significant respiratory difficulties and he was conveyed to the Prince of Wales Hospital.

15. On 26 March 2016, Mr O'Connor entered a palliative pathway and his next of kin was notified. A non-resuscitation direction was discussed and signed. Just before midnight on 27 March 2016, Mr O'Connor was observed to have stopped breathing. A doctor attended and he was certified as deceased in the early hours of 28 March 2016. His death was not unexpected by medical staff who had already diagnosed severe heart failure.

The autopsy

16. A limited autopsy was conducted on 30 March 2016 by Dr Bernard l'Ons at the Department of Forensic Medicine, Sydney. Records obtained from the Prince of Wales Hospital indicated that Mr O'Connor had a history of congestive cardiac failure, aortic valve replacement, atrial fibrillation, asthma, chronic venous insufficiency, hypercholesterolaemia, hypertension, depression and lymphoedema. A whole body CT scan revealed significant coronary artery calcification and an aortic valve replacement, which was consistent with the medical notes provided. The forensic pathologist found that the cause of death was consistent with congestive cardiac failure. The forensic pathologist noted a background of previous aortic valve replacement, atrial fibrillation, and hypercholesterolaemia.

Findings

17. The findings I make under section 81(1) of the Act are,

Identity
The person who died was Richard John O'Connor
Date of death
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He died at the Prince of Wales Hospital, Randwick, NSW.
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Manner of death
Mr O'Connor died of natural causes. No issues were raised in relation to the quality of his medical care.

Conclusion

18. No issues in relation to the quality of the care Mr O'Connor received in custody were raised by family or medical staff at Prince of Wales Hospital. No issues in relation to recommendations emerged from the evidence.

19. I offer my sincere condolences to those close to Mr O’Connor.

20. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
27 April 2018
NSW State Coroner’s Court, Glebe

Form 16
Coroners Act 2009, Section 74

NON-PUBLICATION ORDER

COURT DETAILS

Court	State Coroner's Court of NSW
Registry	Glebe
Case number	2016/94829

PROCEEDINGS

Inquest into the death of	**Richard John O'Connor**

DATE OF ORDER

Date made or given	27 April 2018

TERMS OF 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:
        i. Any member of Mr O'Connor's family; and
        ii. Any person who visited Mr O'Connor while in custody (other than legal representatives or visitors acting in a professional capacity).
    b. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW'), other than Mr O'Connor.
    c. The CSNSW Employee Daily Schedules dated 27 and 28 March 2016.
    d. Images of CCTV footage.
    e. Direct contact details of CSNSW Officers not otherwise publicly available.
2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, a notation be placed on the Court file that if an application is made under s.65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

SIGNATURE

Signature	
Name	Magistrate H. Grahame
Capacity	Deputy State Coroner
Date	27 April 2018