CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Laurence Bede O'Connor
Hearing dates:	6 March 2018
Date of findings:	6 March 2018
Place of findings:	NSW Coroner Court - Glebe
Findings of:	Magistrate Paula Russell Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death
File number:	2016/280295
Representation:	Sgt. Christine Xanthos, Coronial Advocate, assisting the Coroner Alexander Jobe, Office of General Counsel for Corrective Services NSW Sophie Li, Justice Health for NSW Dept of Justice Health
Findings:	**Identity** Laurence Bede O'Connor **Date of death**: 17 September 2016 **Place of death**: Long Bay Hospital Correctional Centre, 1300 Anzac Parade, Malabar, New South Wales **Manner of death:** Natural causes **Cause of death:** Combined effects of ischaemic heart disease and chronic obstructive pulmonary disease
Non –Publication Order	**S74 (1)(b)non publication order on attached document**

At the time of his death Laurence O'Connor was in custody serving a sentence of 21 years imprisonment for the murder of his wife. The earliest date on which he would have been eligible for release on parole was 6 September 2023.

He was, then, within the meaning of section 23 of the *Coroners Act 2009,* in lawful custody. An inquest in such circumstances is mandatory pursuant to section 27(1) of that Act.

Background

In 1985 Mr O'Connor travelled to the Philippines where he met a Filipino national. He arranged for her to follow him to Australia where they married and had 2 children.

On 7 July 2007 Mr O'Connor murdered his wife and buried her body in a relatively isolated location on their property, Quandilli near Tooraweenah. He was sentenced for that offence on 5 December 2008.

Mr O'Connor was a heavy drinker. In 1977, after he was involved in a motor accident causing the death of a motorcyclist for which he was convicted of culpable driving causing death, he gave up drinking for some 15 years. He then took up drinking again and drank heavily.

Health while in custody

On 8 September 2007 a Reception Risk Assessment was conducted when Mr O'Connor was received into custody at the Dubbo Court cells. Mr O'Connor reported, *inter alia*, that he experienced respiratory problems, that he drank excessive amounts of alcohol daily and was a heavy cigarette smoker. A chest x-ray conducted on 11 September revealed Chronic Obstructive Pulmonary Disease.

Mr O'Connor also suffered from Asthma and Benign Prostatic Hyperplasia. He had high cholesterol and regularly experienced chest infections. He was prescribed a number of medications including Warfarin. He suffered gum disease which necessitated the removal of his teeth. He had a number of skin lesions removed while in custody.

On 15 March 2013 Mr O'Connor's health deteriorated and he was rushed to Wellington Hospital. He was diagnosed, *inter alia*, with emphysema. His condition was life-threatening and he was transferred to the Prince of Wales Hospital by air for cardiac surgery. A successful repair of the aortic wall was performed. He remained in hospital until September 2013.

On 3 October 2013 Mr O'Connor experienced an exacerbation of chronic obstructive pulmonary disease and was again transferred to the Prince of Wales Hospital. There he was diagnosed with endocarditis.

Mr O'Connor was, subsequently, transported for annual transthoracic echocardiograms at Prince of Wales Hospital.

He continued to have breathing difficulties in 2015 and 2016 and received regular medical reviews and instruction in the use of inhalers. In 2016 he was awaiting cataract surgery and had a basal cell carcinoma removed.

Wing 13 Long Bay Hospital Correctional Centre

Wings 12 and 13 of the Long Bay Hospital Correctional Centre are outpatient wings for inmates who require medical treatment but not hospitalisation. Mr O'Connor had been transferred to Wing 13 on 16 May 2016. In August and September of that year he was sharing cell 9.

Hours leading up to death

At about 5:30pm on 16 September 2016 Mr O'Connor was retching phlegm. He complained to his cell mate of a sore throat and said it was hard for him to talk.

Following the routine visit of the nurse to his cell at about 6pm he was taken to the clinic and assessed. His blood pressure, pulse, temperature and oxygen saturation level were taken. The clinic nurses gave him cough medication and a new Ventolin inhaler and advised him to press the cell call activation button if he felt unwell. He returned to his cell.

When he returned to his cell he told his cell mate that he was feeling better and lay down on his bed at about 8:30pm watching television.

Mr O'Connor did not press the cell call activation button on the night of 16/17 September.

On the morning of 17 September his cell mate could not rouse Mr O'Connor and at 6:23 am pressed the emergency call button to inform the staff. Prison officers immediately responded and called Justice Health staff for assistance.

On arrival at the cell they found Mr O'Connor stiff to touch and could not discern a pulse. Nonetheless Mr O'Connor was moved out of the cell to allow room for cardiopulmonary resuscitation (CPR) which was commenced. Nurses arrived with a defibrillator, the use of which, together with CPR, continued until New South Wales ambulance paramedics arrived at 6:40am. Mr O'Connor could not be revived.

The cause of death

An autopsy was performed by forensic pathologist, Dr Elsie Burger who determined that the cause of his death was the combined effects of ischaemic heart disease and chronic obstructive pulmonary disease.

Mr O'Connor was 73 years old at the time of his death.

Findings required by s81(1)

Laurence Bede O'Connor died at Long Bay Hospital Correctional Centre, 1300 Anzac Parade, Malabar, New South Wales on 17 September 2016.

Mr O'Connor died as a result of the combined effects of ischaemic heart disease and chronic obstructive pulmonary disease.

He died of natural causes.

I close this inquest.

Magistrate P Russell
Deputy State Coroner
Glebe

Date: 6 March 2018

Form 16
Coroners Act 2009, Section 74

NON-PUBLICATION ORDER

COURT DETAILS

Court	State Coroner's Court of NSW
Registry	Glebe
Case number	2016/280295

PROCEEDINGS

Inquest into the death of	**Laurence O'Connor**

DATE OF ORDER

Date made or given	6 March 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, and phone numbers and other personal information that might identify:
        i. Any member of Mr O'Connor's family;
        ii. Any person who visited Mr O'Connor while in custody (other than legal representatives or visitors acting in a professional capacity); and
    b. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales, other than Mr O'Connor
    c. The handheld video recording made by Correctional Officer Johnson; and
    d. The 'Inmate Profile Document' of any persons in the custody of Corrective Services New South Wales, other than Mr O'Connor
2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, a notation be placed on the Court file that any application under s.65(2) of that Act for CSNSW documents that have been placed on the Court file, shall not be provided that material until CSNSW has had an opportunity to make submissions in respect of that application.

SIGNATURE

Signature	
Name	Magistrate P. Russell
Capacity	Deputy State Coroner
Date	6 March 2018