CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jamie Walker
Hearing dates:	20 July 2018
Date of findings:	20 July 2018
Place of findings:	State Coroner's Court, Glebe
Findings of:	**State Coroner Les Mabbutt**
File number:	2017/350282
Catchwords	CORONIAL – Death in custody, natural causes
Representation:	Coronial Advocate assisting the Coroner Mr Peter Bain Ms Llewelyn for Corrective Services NSW

Non Publication Order s 74(1) of the *Coroners Act* 2009

That the following information contained in the brief of evidence tendered in the proceedings not be published:

1. *The names, addresses, phone numbers, motor vehicle registration details and any other personal information that might identify:*
    (a) any member of Jamie Walker's family and
    (b) any person who visited Jamie Walker while he was in custody (other than legal representatives or visitors acting in a professional capacity)

2. *The direct contact details of staff of Justice Health and Corrective Services NSW*

3. *The names, Master Index numbers and any other information that might identify any persons in the custody of Corrective Services NSW, other than Jamie Walker (MIN 167279)*

4. *The Employee Daily Schedule dated 19 November 2017*

Introduction

Mr Jamie Walker died on the 19 November 2017 at Prince of Wales Hospital, Randwick. At the time of his death Mr Walker was in lawful custody and under guard of Corrective Services. Mr Walker was 49 years of age.

Why was an inquest held?

The role of the Coroner pursuant to s 81 of the *Coroners Act* 2009 is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death. In accordance with s 23 and s 27 of the Coroners Act 2009, an inquest is mandatory where a person's death occurs whilst in lawful custody

Background

Mr Walker was born in 1968. His family moved to Lethbridge Park when Mr Walker was young. They lived there until 1993. Mr Walker attended Shalvey High School. He left school prior to completing his High School Certificate, eventually taking up employment with State Rail.

Mr Walker worked with State Rail for about 11 years, before leaving due to a workplace injury. He then worked odd jobs, often with his father who was a cabinet maker. When he was 28 Mr Walker suffered a fall and as a result developed epilepsy. He was eventually placed on a pension due to the epilepsy.

Mr Walker had one child. The mother of the child left Mr Walker taking the child with her. Mr Walker only saw his son twice, the last time when the baby was 6 weeks old. They never reconnected. Mr Walker then commenced a 25 year relationship with Ms Linda Lock. Ms Lock also suffered from epilepsy and they resided in Quakers Hill.

Mr Walker's custodial history

Mr Walker taken into custody on 27 April 2015 and subsequently charged with the murder of Ms Lock. Mr Walker was found guilty of murder at trial on 18 August 2017 and was due to be sentenced on 23 November 2017.

Upon admission into Corrective Services custody a health review of Mr Walker disclosed cannabis and benzodiazepines use and he was on the methadone program. Mr Walker was placed in a monitored cell due to his epilepsy and concerns regarding drug withdrawal. He was continued on the methadone program. His medications were continued in custody.

A health management plan involving access to specialists and medical services outside the custodial health system was implemented to ensure Mr Walker's health treatment was

continued at an appropriate level whilst in custody. Mr Walker was transferred to Long Bay Prison hospital in December 2016 where he remained until 27 October 2017 when he was transferred to Prince of Wales Hospital where he remained under guard until his death.

Mr Walker's medical history

Records reveal Mr Walker's past medical history included epilepsy and cirrhosis and that he suffered from Hepatitis C. Mr Walker had a history of drug and alcohol abuse.

Mr Walker was receiving treatment for his epilepsy, with his last seizure about 2 years prior to his death. He was also receiving treatment from a liver specialist for his cirrhosis, as well as receiving regular medication for his hepatitis. Mr Walker was provided with appropriate medication for the duration of his time in custody.

The events leading to Mr Walker's death

On 19 October 2017, Mr Walker was taken to the Prince of Wales Hospital complaining of pain to his abdomen and swelling to his leg. He was seen in the emergency department by the consulting physician Dr Davis and also the emergency department medical officer Dr Perry.

Consultation took place with the gastroenterology registrar and the surgical registrar regarding the possibility of gallbladder disease. Mr Walker's pain had subsided and he was not showing specific symptoms of gallbladder disease. Mr Walker was discharged back to Long Bay Gaol Hospital. Liver function tests were ordered.

At Long Bay hospital, Mr Walker was seen by Professor Lloyd. Mr Walker's liver function tests produced abnormal results and it was noted that Mr Walker was extremely jaundiced. Mr Walker had lost weight in the preceding four months and was suffering from increased fatigue and nausea. On 27 October 2017, Professor Lloyd referred Mr Walker to Prince of Wales Hospital advising Mr Walker was suffering obstructive jaundice on a background of liver cirrhosis.

Upon admission to Prince of Wales Hospital, Mr Walker was assessed then transferred to the Gastrointestinal and Liver Unit for ongoing care. Mr Walker came under the care and management of a team of doctors headed by Professor Stephen O'Riordan and including Dr Brennan and Dr Matthew Kim.

Hospital tests showed Mr Walker was suffering gallstones and inflammation of his gallbladder. Chronic liver disease and hypertension in his veins was also found.

On 3 November 2017, Mr Walker underwent exploratory surgery which revealed an obstructed bile duct, kidney damage and severe liver disfunction. On 8 November 2017, a liver biopsy and other scans revealed cancerous nodules in his liver as well as his upper abdomen and right lung. This suggested that cancer was spreading through his body.

Dr Kim reviewed these results in consultation with Professor O'Riordan. Given the extent of the disease and Mr Walker's background of poor health, specialist surgical and oncological opinions deemed the cancer was not suitable for surgical or chemotherapy treatment.

Over the ensuing days, Dr Kim discussed the results with Mr Walker and his mother, informing them that the clinical focus would be on symptom control rather than curative intent. On 10 November, Mr Walker and his mother agreed that he would be given a 'not for resuscitation status'.

On 13 November, consideration was given to returning Mr Walker to Long Bay Gaol Hospital, however this did not occur as a palliative consultant could only see Mr Walker on a weekly basis at Long Bay. On 13 November, Dr Kim had phone discussions with Mr Walker's mother and informed her that Mr Walker was to be transferred into palliative care at Prince of Wales Hospital.

By 17 November, Mr Walker's condition had continued to deteriorate. Dr Kim consulted with Dr Hertz in palliative care and the decision was made to place Mr Walker onto a terminal pathway treatment, where he was issued pain medication to make him comfortable and ease sporadic convulsions. By this stage, Mr Walker was mostly unconscious, could not communicate and could only be roused by touch.

Mr Walker's condition continued to deteriorate and on 19 November 2017 he died. He was declared deceased by Dr Dominic Vickers at 1.55pm that day.

During his hospital admission, Mr Walker was managed in close collaboration with specialists in Interventional Hepatobiliary Endoscopy, Intensive Care Medicine, Surgery, Oncology, Radiology and Anatomical Pathology.

Police were notified of the death and attended the Hospital. Staff from Corrective Services, Justice Health and Prince of Wales Hospital were spoken to. Medical and health records were reviewed.

At the inquest Detective Senior Constable Cambridge the officer in charge of the investigation gave evidence and the brief of evidence was tendered which contained statements, medical records, photographs, the post mortem report and other material.

The cause of Mr Walker's death

Forensic Pathologist Dr Irvine conducted an external post mortem examination of Mr Walker at the Department of Forensic Medicine Glebe on 21 November 2017.

The direct cause of death was found to be metastatic cholangiocarcinoma.

Conclusion

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.

Records from Justice Health, Corrective Services and Prince of Wales Hospital have been reviewed. There is no evidence to suggest Mr Walker was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to Mr Walker's death. I am satisfied Mr Walker's death was not suspicious.

Mr Walker's family have not raised any issues regarding the care and treatment received by Mr Walker in custody. Having considered all of the evidence both oral and documentary tendered at the inquest I find Mr Walker received care and treatment to an appropriate standard whilst in custody.

I find that that Mr Walker died of natural causes whilst in lawful custody.

Findings pursuant to s 81 of the *Coroners Act* 2009

Identity

The person who died was Jamie Walker.

Date of death

19 November 2017.

Place of death

Prince of Wales Hospital, Randwick.

Cause of death

Metastatic cholangiocarcinoma.

Manner of death

Mr Walker died of natural causes whilst in lawful custody.

Les Mabbutt
State Coroner
20 July 2018