CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Andrew Amos
Hearing dates:	5 October 2018
Date of findings:	5 October 2018
Place of findings:	NSW Coroners Court - Glebe
Findings of:	Magistrate Paula Russell Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in Custody. Cause and manner of death
File number:	2015/23577
Representation:	Assisting the Coroner: Sgt Samantha Ferguson, Coronial Advocate Corrective Services New South Wales: Mr Alexander Jobe Office of General Counsel
Findings:	Andrew Amos died at the Long Bay Correctional Complex at Malabar on 24 January 2015. Mr Amos died of natural causes The cause of his death was ischaemic heart disease.

Non –Publication Order	S74 (1)(b)non publication order on attached document

Contents

Andrew Amos died at the Long Bay Correctional Complex at Malabar on 24 January 2015. He was 30 years old, having been born on 3 October 1984.

On 21 February 2014, an aggregate sentence of 2 years and 3 months with a non-parole period of one year and 6 months had been imposed on Mr Amos by the Parramatta Drug Court for two offences of breaking into houses and stealing and an offence of breaking into a house with intent to steal. That sentence was set to commence on 12 August 2013[1] and to conclude on 11 November 2015. Mr Amos's earliest possible release date was 11 February 2015.

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.

Mr Amos's classification within the prison system was as a minimum security prisoner. At the time of his death, he was housed in cell 17 of wing 16 at the Metropolitan Special Programs Centre at Long Bay Correctional Complex at Malabar, NSW.

Background

Mr Amos was born in Sydney. He had two brothers and an older maternal half-sister. His parents separated when he was a child and he and his brothers moved between his mother's and his father's homes.

When he left school, Mr Amos worked as a removalist and as a labourer at a transport company.

When he was about 18 he became addicted to heroin and later started using amphetamines and methamphetamines. He started committing offences to fuel his addictions.

He first entered adult custody on 16 October 2004 and had a number of periods of incarceration.

Mr Amos had a de facto partner with whom he had been living since about 2003. They had three children together and Mr Amos was a stepfather to two older children belonging to his partner.

Mr Amos's partner spoke of the shock of Mr Amos's death and of the terrible loss that she, her children and Mr Amos's wider family continue to experience.

[1] Although the sentence was set to commence on 12 August 2013, Mr Amos was, in fact, taken into custody on 10 December 2013.

Functions of the Coroner

Section 81 of the *Coroners Act 2009* sets out the principal functions of a coroner conducting an inquest. Those are to record the identity of the person who has died, the date and place of his death and the manner and cause of his death.

Findings as to date, place, cause of death

Andrew Amos died on 24 January 2015 at the Metropolitan Special Programs Centre at Long Bay Correctional Complex, Malabar, New South Wales.

An autopsy was performed by Dr Istvan Szentmariay, forensic pathologist on 27 January 2015. Dr Szentmariay observed no suspicious external or internal injuries. He determined that the cause of Mr Amos's death was ischaemic heart disease.

Health

Mr Amos was an obese 30-year-old man. His body weight at autopsy was 102.5 kg and his body length 1.70 m. He was a heavy smoker and engaged in little exercise.

Mr Amos suffered periodically from depression. At the commencement of his final period of incarceration he reported that he had a history of several mild traumatic brain injuries resulting from assaults and heroin overdoses and had experienced loss of consciousness as the result of a car accident. He was assessed by a psychologist, a M Raymond, within the prison system. Mr Raymond did not find 'any indication of intellectual disability or cognitive impairment'.

Dr John England, cardiologist, reviewed Mr Amos's medical records[2] and the post-mortem report of Dr Szentmariay. With reference to the findings of Dr Szentmariay, he noted that the left anterior descending coronary artery showed narrowing of at least 90% lumen obstruction due to a soft yellow plaque. He said:

> *[T]here was no evidence of a recent preceding scarring or death of heart muscle tissue to suggest a previous heart attack … [T]here was no evidence of any other heart disease such as vegetations due to bacterial endocarditis on the heart valves.*

A copy of Mr Amos's medical notes from the Fairfield Medical Centre, attached to his Justice Health file, include an entry of 7 June 2004 in the following terms:

> *several episodes of sudden LOC [loss of consciousness] over the past few years - has been to hosp[ital] but says has never been investigated.*
> *Nil associated symptoms*
> *Lousy diet - often misses meals and has long h/o [history of] recurrent head injuries due to fights bp [blood pressure] 110/70 …*
> *cvs [cardiovascular system]/cns [central nervous system]/ent [ear, nose, throat] nad [likely, in context, to mean no abnormality detected or no active disease]*

[2] Both from Justice Health and from Mr Amos's doctors in the community.

ECG [electrocardiogram] – NAD – sinus rhythm.

Dr England's review of Mr Amos's medical records from the Fairfield Medical Centre, noted the normal electrocardiogram result and noted, in particular, the

> *normal sinus rhythm with no prolongation of the QT interval and … nothing to suggest underlying coronary artery disease*.

He said there was nothing in that medical history

> *to suggest heart symptoms or any history to suggest angina of effort such as would be referred to underlying coronary artery disease.*

Health records on admission to custody

A document entitled 'New Health Problem Notification Form for Inmates in Correctional Centres' was completed by a Justice Health registered nurse on 12 December 2013. That document noted that Mr Amos '[d]enies any health issues' and that he was suitable for 'normal cell placement'.

Mr Amos had, on eight previous occasions, been received into the custody of New South Wales Corrective Services. On his first reception into custody in October 2004, on a document entitled 'Medical Alert Form', under the heading 'Primary Health', a tick had been placed against 'Heart Disease/High Blood Pressure' with 'Heart Disease' underlined. Mr Amos's doctor was noted to be Dr Fitch at Fairfield. On a document entitled 'Health Risk and Harm Minimisation Checklist Form', the question '[d]o you have heart disease?' was ticked and the comment added, 'irregular heartbeat'.

The 'Reception Risk Assessment Summary'[3], in 2004, noted that Mr Amos had had problems with irregular heartbeat and that Dr Fitch had prescribed heart medication but that Mr Amos could not remember the name of the medication. It is apparent that Mr Amos told the registered nurse on that occasion that he had used the medication for four months and then stopped taking it. He had stopped taking it three months before that assessment. A prescription for 'heart medication' is not apparent on Dr Fitch's records.

On each subsequent occasion on which Mr Amos was received into custody, it would appear that he did not indicate that he had any heart disease. There is no record in the reception documents to indicate that Mr Amos had a heart condition or heart disease. In fact, the contrary is recorded. On a document called Reception Screening Tool, from 2012, for example, the question was asked:

> *Do you have a diagnosed heart disease, stroke hypertension, chronic heart failure, rheumatic heart disease, valvular heart disease or two or more risk factors?*

[3] A document produced on a detainee's entry into custody and produced for the purpose of identifying *inter alia* health risks.

The answer ‘no’ was chosen from available answers ‘yes’, ‘no’, ‘unsure’ or ‘declined to answer’.

Should Mr Amos’s heart disease have been detected while he was in custody from December 2013?

It was Dr England’s opinion that, ‘after a careful consideration’ of the Justice Health and private health records of Mr Amos,

> *there was no prior indication that Andrew Amos was suffering from coronary heart health issues which could/should have been detected by the medical staff prior to his death*.

That opinion, as I understood it, reflected the normal ECG result in 2004 and the absence of medical or Justice Health records since 2004 which would suggest symptoms of any heart disease or condition.

Mr Amos was not investigated, during his final period of custody, for heart disease or a heart condition but there is no reasonable basis on which to conclude that Justice Health staff should have initiated such investigations.

Hours leading up to death

In the period leading up to his death Mr Amos was agitated about his grandfather who was dying and anxious to be free from custody in time to see him before he died.

On the day of his death, at about 4.30pm, Mr Amos told his cellmate that he was ‘crook in the stomach’. As I understand the evidence, the afternoon muster of inmates took place outside the cells at 5pm on 24 January 2015. Mr Amos did not, at that time, complain to staff about any pain or discomfort. His cellmate said that he seemed ‘okay’ at muster. He spoke to another inmate after muster and seemed, to him, to be ‘okay … no complaints at all’.

At about 6pm he complained to his cellmate about pain in his chest and back. Another prisoner went to Mr Amos’s cell on being called. Mr Amos appeared to him to be in distress and complained of pain in his back and left side around the shoulder blade. That other prisoner gave him a massage for about 3 to 4 minutes. Mr Amos then got up and sat on a chair. That other prisoner said ‘you better go to the clinic’. Mr Amos said ‘no, I just need to rest. Thanks mate.’ He lay down on his bed watching television.

His cellmate went to check on him about half an hour later and found him face down on the bed. He did not appear to be breathing and his lips were blue. His cellmate notified Correctional Officer Steven Hokin, who was preparing the wing for ‘lock in’, that Mr Amos was ‘not waking up’. Mr Hokin made an urgent call for assistance to the senior staff member on duty to respond with a medical team. This, Mr Hokin thought, was about 6:45pm.

Mr Amos's cellmate and another prisoner dragged him off the bed and commenced Cardiopulmonary Resuscitation (CPR).

Correctional Officer Dan Xu heard Officer Hokin calling for assistance and ran with him to Mr Amos's cell. He, too, called for urgent medical attention.

In response to the first call (by Officer Hokin) the senior staff member on duty, First Class Correctional Officer Campbell Dixon, went to the clinic and told Nurse Manju George and Nurse Duncan Newsome that they were required urgently in wing 16. Nurses Newsome and George were working in the dispensary at the time. With the help of Officer Dixon, they obtained the two emergency bags and the heart start defibrillator from the central corridor of the clinic. Emergency bag 1 is a resuscitation bag containing oxygen, masks, pulse oximeter and other essential emergency resuscitation equipment. Emergency bag 2 contains pharmaceuticals and other items required for general emergency response.[4] They then went straight to wing 16 and were taken directly to Mr Amos's cell.

They arrived at Mr Amos's cell, Officer Dixon estimated, at about 6:55pm. Correctional Officer Sean Powell places Officer Dixon's arrival in the wing at an earlier time.

Nurse Newsome observed that Mr Amos was unresponsive with cyanosed lips and fixed and dilated pupils. He could detect no respiration or pulse. He commenced CPR while Nurse George attached a pulse oximeter, commenced oxygen therapy, attached the heart start defibrillator and commenced the heart start defibrillator diagnostic/action program. Correctional Officer Powell, who had been an ambulance paramedic, took over from the inmates who were assisting the nurses performing CPR on Mr Amos.

First Class Correctional Officer Dixon directed that a call be placed for urgent ambulance assistance. He estimated that he did that at about 6:57pm but the New South Wales ambulance service records a 000 call at 18:54:38.

Ambulance officers arrived at the cell at about 7:15pm and continued CPR. Mr Amos did not respond and he was declared dead at 7:35pm.

There is no basis to conclude that the prison officers and prison nursing staff responded other than urgently and appropriately from the time that the first prison officer became aware of Mr Amos's situation.

Findings required by s81(1)

Andrew Amos died at Long Bay Hospital Correctional Centre, 1300 Anzac Parade Malabar, New South Wales on 24 January 2015.

The cause of Mr Amos's death was ischaemic heart disease.

[4] The evidence of Registered Nurse Newsome.

He died of natural causes.

I close this inquest.

Magistrate P Russell
Deputy State Coroner
Glebe

Date: 5 October 2018

Form 16
Coroners Act 2009, Section 74

NON-PUBLICATION ORDER

COURT DETAILS

Court	State Coroner's Court of NSW
Registry	Glebe
Case number	2015/23577

PROCEEDINGS

Inquest into the death of	**Andrew Amos**

DATE OF ORDER

Date made or given	5 October 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 Amos' family; and
        ii. Any person who visited Mr Amos' 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, other than Mr Amos.
    c. The Employee Daily Schedules for the Metropolitan Special Programs Centre ('MSPC') dated 24 and 25 January 2015.
    d. Direct contact details of CSNSW Officers not otherwise publicly available.
    e. The hand drawn floor plan of MPSC Wing 16 included in the Initial Report of Sergeant Windass dated 24 January 2015.

f. Documents relating to the care and case management of any persons in the custody of Corrective Services New South Wales, other than Mr Amos.

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	5 October 2018