CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ahmed Rizk
Hearing dates:	4 April 2019
Date of findings:	4 April 2019
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Teresa O'Sullivan, Acting State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes, end of life
File number:	2017/275550
Representation:	Mr D Welsh, Coronial Advocate assisting the Coroner Mr Tumeth for the Commissioner for Corrective Services Mr Sterry for Justice Health & Forensic Mental Health Network

Non-publication order:	I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), the following material is not to be published: 1. a. The names, addresses, phone numbers and other personal information that might identify: i. Any member of Mr Ahmed Rizk's family; and ii. Any person who visited Mr Ahmed Rizk 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 Ahmed Rizk. c. Direct contact details of CSNSW Officers not otherwise publicly available. d. Schedule of Orders for Removal/ Transfer of Inmate from Correctional Centre to Correctional Centre and Escort Assessment forms. e. Portions of the Long Bay Hospital Time Log dated 10 September 2017. f. CSNSW Section 19.6 Medical Escorts, Custodial Operations Policy and Procedure, referred to as 'Annexure A' in the statement of Terry Murrell dated 1 February 2019. g. CSNSW Section 6.4 Operations Manual regarding Medical Escorts (version 1.28) and associated Protocol for Guarding Inmate Patients. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, I direct that 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.

Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: **Identity of the deceased:** The deceased person was Ahmed Rizk. **Date of death:** He died on 10 September 2017. **Place of death:** He died at Prince of Wales Hospital, Randwick, NSW. **Cause of death:** He died as a result of complications of metastatic gastric adenocarcinoma **Manner of death:** He died of natural causes whilst serving a custodial sentence.

Contents

The Coroners Act 2009 (NSW) *in s81 (1) 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 Ahmed Rizk.

Introduction

1. Ahmed Rizk was 49 years old at the time of his death on the 10 September 2017. He was an inmate of Long Bay Hospital, but was being treated at the Prince of Wales Hospital, Randwick. He was pronounced dead at 5:50 a.m. on the aforementioned date. As Mr Rizk was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The role of the Coroner

2. When a person's death is reported to the coroner, there is an obligation on the coroner to investigate the death. The role of a coroner, as set out in s81 of the Coroner's Act, is to make findings as to the identity of the person who died, when they died, where they died, and the cause and manner of their death. If any of these questions cannot be answered then a coroner must hold an inquest.

3. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the *Coroners Act 2009* (NSW) makes an inquest mandatory in cases where a person dies whilst in lawful custody. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death to ensure that the State adequately discharges its responsibility. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

4. A short inquest was held on 4 April 2019. The officer in charge of the investigation, Detective Senior Constable Michael Cambridge, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

5. Ahmed Rizk entered custody on the 21 June 2017. He was sentenced to nine months imprisonment commencing 21 June 2017 and expiring 20 March 2018. The non-parole period was 6 months commencing on the 21 June 2017 and expiring on 20 December

2017. On the 24 June 2017, Justice Health assessed Mr Rizk and did not note any medical, mental health or drug and alcohol issues. On the 25 July 2017, Mr Rizk was transferred to the Glenn Inness Correctional Centre as a C2 – Minimum Security inmate.

6. On the 10 August 2017, Mr Rizk complained to nursing staff at Glen Inness Correctional Centre of abdominal pain and difficulty emptying his bowel. His abdomen was tender to the touch. Laxatives and an analgesic were given. The abdominal pain persisted over several days, during which Mr Rizk returned to the clinic complaining of being scared to eat and increasing pain. On the 19 August 2017, Mr Rizk was taken to Glen Inness District Hospital where blood tests were done.

7. On the 21 August 2017, Mr Rizk was again taken to Glen Inness District Hospital where he remained for three days. On the 23 August 2017, a gastroscopy was conducted, which revealed a malignant tumour in the gastro-oesophageal tract.

8. On the 24 August 2017, Mr Rizk was transferred to Armidale Hospital for specialist treatment. On the 26 August 2017, Mr Rizk suffered a large haematemesis (vomiting of blood). Consequently, on the 27 August 2017, he was transferred to the Armidale Hospital's Intensive Care Unit. On the 30 August 2017, Mr Rizk was transferred from Armidale Hospital to Prince of Wales Hospital. On the morning of the 1 September 2017, Mr Rizk was found to be aphasic, with right sided facial palsy and inhibited limb movement. It was determined that between arriving at Prince of Wales Hospital on the 30 August 2017 and the 1 September 2017, Mr Rizk had suffered a left sided Middle Cerebral Artery infarction (stroke). Due to the stroke, Mr Rizk was transferred to the Prince of Wales Hospital Stroke Ward.

9. Medical notes made on the 2 September 2017 record that Mr Rizk had suspected early in the year that he had cancer and had been suffering haematemesis since then.

10. On the 7 September 2017, treating teams determined that Mr Rizk was not well enough for surgery or chemotherapy and that symptom management and palliative care were Mr Rizk's best options. On the 8 September 2017, Dr Sands of the Department of Palliative Medicine expressed the opinion in writing that Mr Rizk's life expectancy was potentially days or weeks.

11. About 5:50 a.m. on the 10 September 2017, Mr Rizk was pronounced life extinct by Dr Naseer Mohammed Abdul. On Mr Rizk's resuscitation plan, which forms part of the tendered medical records, the "No CPR" option is selected. The form is signed by Dr Karsovitsky and dated the 9 September 2017.

Autopsy:

12. Pathologist Dr Irvine examined Mr Rizk's body and found the direct cause of death to be Complications of Metastatic Gastric Adenocarcinoma. She found no significant injuries or evidence of maltreatment.

Issues raised by Mr Rizk's Family:

13. Family members stated that the presence of Corrective Services staff within Mr Rizk's room caused them distress and impinged on the privacy they had with him in his last days. Treating doctor, Hanka Laue-Gizzi, expressed to investigating police her disappointment that Correctives Officers were not able to wait outside the room as there was no chance of Mr Rizk escaping.

14. Mr Terry Murrell, General Manager Statewide Operators for Corrective Services New South Wales, provided a statement addressing this issue. He states that a Medical Escort Unit has been approved to commence a 12 month pilot and is currently in the set-up phase. The Unit will be based within the Sydney Metropolitan Region and will be responsible for the management of all state-wide scheduled medical appointments co-ordinated through the Justice Health Co-ordination Centre.

15. Mr Murrell states that a new paragraph "5.2 – Risk Assessments, End of life care" has now been included within the section of the Custodial Operation Policy and Procedures that governs medical escorts. The "End of life care" paragraph states that if an inmate is receiving end-of-life care, security arrangements can be reviewed to assess supervision requirements and visiting arrangements by family and friends. This is to be determined on a case-by-case basis, and in consideration of the security of the hospital.

Conclusion

16. There is no evidence that any action or inaction by Corrective Services or Justice Health contributed to Mr Rizk's death. Given Mr Rizk's age and health issues and his rapid deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Rizk's death. While it is regrettable that Mr Rizk's family felt that the actions and presence of Corrective Services officers encroached on their final moments with him, Corrective Services have now amended their policy in a way that addresses those concerns.

Findings required by s81(1)

17. After considering all the documentary evidence and the oral evidence heard at the inquest, I make the following findings under s81(1) of the Act.

The identity of the deceased:

The deceased person was Ahmed Rizk.

Date of death:

He died on 10 September 2017.

Place of death:

He died at Prince of Wales Hospital, Randwick, NSW.

Cause of death:

He died as a result of complications of metastatic gastric adenocarcinoma

Manner of death:

He died of natural causes whilst serving a custodial sentence.

18. I thank the officer in charge, Detective Senior Constable Michael Cambridge, for his thorough investigation and preparation of the brief of evidence. I thank Sergeant Durand Welsh for his excellence assistance.

19. On behalf of the NSW Coroners Court I extend my sincere and respectful condolences to Ahmed's family for their painful loss.

20. I close this inquest.

Magistrate Teresa O'Sullivan
Acting State Coroner
4 April 2019
NSW State Coroner's Court, Glebe.