CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Douglas Anderson
Hearing date:	9 December 2019
Date of findings:	9 December 2019
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody –– what was cause of death – was care and treatment provided by Justice Health and Corrective Services NSW adequate.
File number:	2018/119731
Representation:	Coronial Advocate assisting the inquest: Sgt B Notley. Corrective Services NSW: A Smith, Legal, Dept of Communities and Justice. Justice Health and Forensic Mental Health Network: H Norris, Legal advisor, Justice Health.

Findings:	**Identity** The person who died is Douglas Anderson. **Date of death**: Douglas Anderson died on 14 April 2018 **Place of death**: Douglas Anderson died at Westmead Hospital, Westmead NSW 2145 **Cause of death:** Douglas Anderson died as a result of staphylococcus aureus sepsis complicating metastatic malignancy. **Manner of death:** Douglas Anderson died as a result of natural causes while in custody.

Non-Publication Orders

Pursuant to sections 74(1) and section 65(4) of the *Coroners Act 2009 (NSW),* the Court orders:

1. That the following information contained in the brief of evidence tendered in the proceedings not be published:
    a. The names, addresses, phone numbers and other personal information that may tend to identify Douglas Anderson's next of kin and family members.
    b. Any information which may tend to identify any of Douglas Anderson's victims.
    c. The direct contact details of Corrective Services NSW ('CSNSW') staff and details of external service providers that are not publicly available.
    d. Any part of Section 1.1 of the CSNSW Custodial Operations Policy and Procedure, that is not publically available.
2. That a notation be placed on the Coroner's file that if an application is made under section 65(2) of that Act for access to CSNSW documents on the Coroner's file, that material shall not be provided until CSNSW as had an opportunity to make submissions in respect of that application.

Section 81(1) of the *Coroners Act 2009 (NSW)* [the Act] 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 Douglas Anderson.

Introduction

1. On 14 April 2018 Douglas Anderson aged 84 years died at Westmead Hospital, where his medical conditions were being managed palliatively. On 5 April 2018 he had entered custody on charges of child sexual assault. As Mr Anderson was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. Pursuant to sections 23 and 27 of the Act, an inquest is required when a person dies in custody to assess whether the State has discharged its responsibilities.

2. Pursuant to section 81 of the Act a Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

3. Douglas Anderson was born on 21 November 1933 in Scotland. He emigrated to Australia and had two children who are now adults.

4. Mr Anderson lived alone in the Gorokan area north of Sydney. He had an extensive history of medical conditions and was under the care of Wyong Hospital as well as a geriatric home visit service. In the weeks prior to his arrest he had been losing weight steadily.

Douglas Anderson's health and treatment in custody

5. Mr Anderson's death occurred after he had been only nine days in custody. On 5 April 2018 he was arrested and charged with child sexual assault offences. He was refused bail at Wyong Local Court and was taken to Silverwater Metropolitan Remand Centre. As a result of an initial health assessment he was taken later that day to Westmead Hospital with suspected congestive heart failure. Here he remained under corrective services supervision until his death nine days later.

6. The Justice Health assessment had identified that Mr Anderson had a history of heart disease, hypertension, osteoarthritis, alcohol abuse, mild dementia and basal cell carcinoma. A CT scan was performed which showed a large right pleural effusion with possible pleural lesions. A chest drain tube was inserted and he was moved to a high dependency ward.

7. Over the following days Mr Anderson showed symptoms of dementia and his chest was monitored. Further chest x-rays identified a mass in the gastro oesophageal junction. The gastrointestinal team considered conducting a

biopsy of the mass, but after consultation with medical oncology and radiation oncology teams they determined that further investigations and treatment would not be appropriate given Mr Anderson's dementia, frailty and multiple comorbidities. He was provided with palliative care, and died at 8.42am on 14 April 2018.

The post mortem examination

8. A post mortem examination was performed by forensic pathologist Dr Jennifer Pokorny. The examination revealed a large right sided hydropneumothorax, a collapsed right lung, and a mass in the right adrenal gland. Dr Pokorny concluded that Mr Anderson had a metastatic malignancy, most likely originating as a gastro-oesophageal tumour. His condition was complicated by the development of the staphylococcus infection.

What was the manner of Mr Anderson's death?

9. The coronial investigation establishes that Mr Anderson's death was one of natural causes. It was not brought about through any deficiency in the care and treatment he received while at the Metropolitan Remand Centre or at Westmead Hospital. From the outset of his time in custody his health problems were properly managed, and appropriate decisions were made and implemented about his medical treatment. The care and treatment which he received from Corrective Services NSW and Justice Health and Forensic Mental Health Network was adequate and appropriate.

10. There is no evidence that another person caused Mr Anderson harm, or that his death was caused by an accident or other form of misadventure. The manner of his death was by natural causes.

11. I acknowledge the assistance I have received in this inquest from Coronial Advocate Sergeant Brooke Notley, and the Officer in Charge Detective Sergeant Joseph Correy.

<u>Findings required by s81(1)</u>

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Douglas Anderson.

Date of death:
Douglas Anderson died on 14 April 2018

Place of death:
Douglas Anderson died at Westmead Hospital, Westmead NSW 2145.

Cause of death:
Douglas Anderson died as a result of staphylococcus aureus sepsis complicating metastatic malignancy.

Manner of death:
Douglas Anderson died as a result of natural causes while in custody.

I close this inquest.

E Ryan
Deputy State Coroner
Lidcombe

Date
9 December 2019