CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Into the death of Ivan Metcalfe
Hearing dates:	27 August 2019
Date of findings:	4 September 2019
Place of findings:	State Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E.Truscott
Catchwords:	Coronial Law-Cause and manner of death-
File number:	2018/109798
Representation:	Coronial Advocate: Ms B. Notley Office General Counsel: Ms J De Castro Lopo Justice Health & Forensic Mental Health Network: Mr M Sterry
Findings:	That Ivan Metcalfe died on 8 April 2018 at Prince of Wales Hospital, Randwick NSW 2031. He died of Complications associated with advanced chronic lung disease. He had other significant conditions contributing to his death but not relating to the disease or condition causing it, namely: Diabetes Mellitus (Type 2), Ischaemic Cardiovascular Disease, Atrial Fibrillation. When he died Ivan Metcalfe was in the lawful custody of Department of Corrective Services NSW.
Recommendations:	To the Minister of Corrections That the Department of Corrective Services NSW amend 13.2.2.2 Custodial Operations Policy and Procedures (COPP) to ensure that when a prisoner in the care of an external heath care provider enters palliative care or end of life care, the prisoner's "Emergency Contact Person" (next of kin) is notified so that final visits with the prisoner can be undertaken. To that end, I recommend that the CSNSW enter into discussions with NSW Health to amend their

	Memorandum of Understanding so that NSW Health staff will be responsible for advising on the custodial patient's clinical status and CSNSW staff will contact the custodial patient's ECP if their medical condition becomes life threatening, subject to receiving advice from NSW Health staff.

IN THE STATE CORONER'S COURT
LIDCOMBE
NSW

SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of Ivan Metcalfe who died, aged 82, on 8 April 2018 whilst in the custody of the New South Wales Department of Corrective Services.

2. This is a required inquest to be conducted by a senior coroner pursuant to sections 27 and 23 of the Coroners Act 2009. ("the Act").

3. At inquest the coroner is required if possible to make written findings as to whether the person died and if so, to determine if possible
   - The person's identity,
   - The date and place of the person's death, and
   - The manner and cause of the person's death.

4. Under section 82 of the Act, a coroner may make recommendations considered necessary or desirable in relation to any matter connected with the person's death.

5. Mr Metcalfe was born on 14 January 1936 in Auckland, New Zealand. He later immigrated to Australia. Mr Metcalfe was married to Elaine Metcalfe. The Officer in Charge of this matter, Detective Sergeant Palmer has spoken with Mrs Metcalfe. She did not wish to raise any issues about Mr Metcalfe's

custodial or health care but was upset at not being informed that he was dying and was upset by the manner in which she was told that he had died.

Background

6. In December 2014 and January 2015 Mr Metcalfe was charged with several historical sexual offences. At special hearing, on 31 January 2018, following a qualified finding of guilt he was sentenced to a limiting term of 2 years and 6 months under section 23 of the Mental Health (Forensic Provisions) Act 1990. He entered NSW Corrective Services custody on that day.

7. Mr Metcalfe was received at the Metropolitan Remand and Reception Centre. A comprehensive reception Screening Assessment was conducted. It was Mr Metcalfe's first time in custody. He reported multiple health concerns including, Angina, Chronic Obstructive Pulmonary disease, Diabetes Type 1, Gastroesophageal Reflux Disease, Hypertension, Non-Rheumatic Valvular Heart Disease and Sleep Apnoea. He was receiving a continuous flow of oxygen (as required) for his Chronic Obstructive Disease and from 7 February 2018 he was provided with a CPAP machine which he used whilst sleeping.

8. On 1 February 2018 he was transferred to Long Bay Hospital Sub Acute Unit then the Long Bay Hospital Aged Care Rehabilitation Unit. He was reviewed by a medical officer and his community general practitioner consulted. No changes were made to his current medication.

9. On 5 February 2018 Mr Metcalfe underwent a psychiatric review. There was no evidence of psychotic symptoms and no psychiatric history reported. The psychiatrist's impression was that Mr Metcalfe had a major neurocognitive disorder most likely secondary to vascular disease. Mr Metcalfe remained under the care and treatment of a medical officer throughout his time in custody.

10. On 28 February 2018, Mr Metcalfe was again reviewed by the psychiatrist who formed the opinion that he remained unfit to plea. The psychiatrist was to prepare a report for the Mental Health Review Tribunal scheduled for April 2018. Mr Metcalfe remained under the care of a medical officer.

11. On 21 March 2018 Mr Metcalfe was transferred to the Prince of Wales Hospital for further assessment and management in relation to complaints over the previous 2 days that he was experiencing shortness of breath, dizzy spells and chest pain. He was admitted to the respiratory ward and commenced on intravenous antibiotics to treat community acquired pneumonia. On 30 March 2018 Mr Metcalfe was being discharged from Prince of Wales Hospital back to Long Bay Hospital Aged Care Rehabilitation Unit.

12. The hospital discharge summary reported that Mr Metcalfe was diagnosed as having drug induced pulmonary fibrosis; non-ST segment elevation myocardial infarct, angina chest pain at rest, shortness of breath; chronic type 1 respiratory failure and myoclonus.

13. On 1 April 2018 Mr Metcalfe was reviewed by a medical officer and following that review he returned to Prince of Wales Hospital for management of exacerbation of Congestive Cardiac Failure, unresolved chest infection and bilateral leg oedema.

14. On 4 April 2018 Mr Metcalfe suffered a minor heart attack and on 5 April 2018 he informed medical staff that he did not wish to have any further medical interventions. A low dose of opiates was administered to relieve the sensation of severe breathlessness. He died at 12.08pm on 8 April 2018.

15. Though Mr Metcalfe died of natural causes, because he was in custody at the time of his death the NSW Police are required to conduct an investigation into his death and provide a brief to the coroner.

16. A limited autopsy was conducted on 10 April 2018. The direct cause of death is listed as complications associated with advanced chronic lung disease. Other significant conditions contributing to his death but not relating to the disease or causing it include Diabetes Mellitus (Type 2), ischaemic cardiovascular disease and atrial fibrillation.

17. There is a limited issue in relation to the circumstances of Mr Metcalfe's death. Though his family do not have any issues in relation to his care and treatment by the Department of Corrective Services, Justice Health & Forensic Mental Health Network (JHFMHN) or the Prince of Wales Hospital, complaint is made by Mrs Metcalfe that the Department of Corrective Services failed to notify her, as Mr Metcalfe's emergency contact, that has treatment had become "end of life" care.

18. The Department of Corrective Service New South Wales have policies which govern the notification of a next of kin when inmates are transferred from a prison to a non-prison hospital for medical care.

19. The Custodial Operations Policy and Procedure, 6.2.1.3 'Hospitalisation of inmates,' states that the inmates *'emergency contact person (who may be the next of kin) is to be contacted when an inmate is admitted to a hospital as an inpatient with no advanced warning or their medical condition becomes life threatening and death is imminent.'*

20. Section 13.2.2 'Medical Emergencies' prescribes that *'an inmate's Emergency Contact person must be informed if an inmate is taken to hospital with life threatening injuries and it is obvious he or she will be admitted. For non-life-threatening injuries, the inmate's emergency contact person must be notified on the day the admission is confirmed. An inmate's consent to contact the emergency contact person should be obtained unless the inmate is incapable of giving consent. The emergency contact person must be further notified if an inmate inpatient medical condition deteriorates or the hospital stay is extended.'*

21. Mrs Metcalfe is listed as Mr Metcalfe's emergency contact person on the New Inmate Lodgement Form. She was advised by a CSNSW welfare officer that Mr Metcalfe had been transferred to the Prince of Wales Hospital on 1 April 2018. She visited him the following day. However, she received no further advice except for 8 April 2018 when she was notified of his death. She had not been aware that his health had deteriorated or that an end of life care plan had been put in place.

22. Graham Kemp, a Senior Investigation Officer of the Corrective Services Investigations Branch provided a Serious Incident Report dated 27 April 2018, a statement dated 5 July 2019 and a statement dated 13 August 2019.

23. In his July 2019 statement Mr Kemp advises that Mr Metcalfe *"has no NOK or emergency contact on his file due to the nature of his crime*". He further explains this in the August statement, that it may have been due to Mr Metcalfe advising a Corrective Services intake officer that his family "didn't want to know him". In evidence he has said that it would appear that though the emergency contact details were provided by Mr Metcalfe to the intake officer and written by hand on his file, they were not entered into the database.

24. Whatever the explanation, when Mr Metcalfe was transferred to POW Hospital on 1 April 2018 his file did not contain the name of his next of kin or any family contact details so his hospital file did not have those details either.

25. In his evidence Mr Kemp said that a welfare officer of DCNSW did contact Mrs Metcalfe to advise her that Mr Metcalfe had been transferred to the hospital. I accept the DCSNSW complied with its policy in relation to notifying a prisoner's emergency contact that he was transferred from a prison to a hospital.

26. However, though there is liaison between DCSNSW and the Hospital/Local Health District in relation to the arrangements for a prisoner's custody or

security there is no communication in relation to the management of the prisoner's health and wellbeing which would include notifying family members when a prisoner enters "end of life" care and remains in the hospital. Ultimately, it is the responsibility of the DCSNSW as the custodian of a prisoner to ensure that proper notification is provided to the prisoner's family.

27. Mrs Metcalfe visited Mr Metcalfe the day after she was advised that he had returned to hospital. She was able to do this because she had previously become an approved visitor having visited him in the prison. Apparently there is no procedure whereby the hospital would then obtain her details to then contact her directly or through the prison system to advise her of Mr Metcalfe's deteriorating health.

28. She had not been aware that Mr Metcalfe's death was imminent and when she was advised by DCSNSW that he had died she was shocked and disappointed that she had not been told that he was dying.

29. Mr Kemp set out in his statement that after becoming aware of this situation the matter was referred to the CSNSW Organisational Review Committee. Mr Kemp's statement of 13 August 2019 sets out that the committee discussed the need to review the Memorandum of Understanding between CSNSW and NSW Health and section 13.2.2.2 of the Custodial Operations Policy and Procedures ("COPP") to reflect that it is the responsibility of NSW Health to notify next of kin of the implementation of an end of life care plan and/or deteriorating health of an inmate.

30. Mr Kemp writes "If NSW Health notified JH&FMHN of an inmate's deteriorating health and/or implementation of an end of life care plan, and JH&FMHN informed CSNSW of this information it would be of great assistance to CSNSW personnel and would enable them to comply with section 13.2.2.2 of the COPP".

31. I note that there are some NSW Prisons operated by non CSNSW organisations which are contracted to comply with CSNSW policies. At least one of the prisons has a health provider other than JH&MHFN (MTC's Parklea Corrections health provider is St Vincent's Health). Accordingly, the recommendation will be directed solely at CSNSW so that any Memorandum of Understanding with various health providers is consistent across the State.

32. I recommend as follows:

To The Minister of Corrections:

That the Department of Corrective Services NSW amend 13.2.2.2 Custodial Operations Policy and Procedures (COPP) to ensure that when a prisoner in the care of an external heath care provider enters palliative care or end of life care, the prisoner's "Emergency Contact Person" (next of kin) is notified so that final visits with the prisoner can be undertaken. To that end, I recommend that the CSNSW enter into discussions with NSW Health to amend their Memorandum of Understanding so that NSW Health staff will be responsible for advising on the custodial patient's clinical status and CSNSW staff will contact the custodial patient's ECP if their medical condition becomes life threatening, subject to receiving advice from NSW Health staff.

E Truscott
Deputy State Coroner
4 September 2019