CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kerry Curtis
Hearing dates:	25 February 2020
Date of findings:	25 February 2020
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Teresa O'Sullivan, State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes.
File number:	2018/334938
Representation:	Ms K Mackay, Coronial Advocate assisting the Coroner Ms B Holliday-O'Brien, Department of Communities and Justice Legal, for the Commissioner of Corrective Services NSW (CSNSW) Mr H Norris, for the Justice Health & Forensic Mental Health Network

Non-publication order:	I direct that, pursuant to section 74(1)(b) of the Coroners Act 2009, the following material is not to be published: a. The names, addresses, phone numbers and other personal information that may tend to identify Mr Kerry Curtis' family and friends; b. Portions of the Hospital Daily Escort Log Sheets which reveal details of escorts, firearms and other security equipment; c. The names, personal information and Master Index Numbers of any person in Corrective Services NSW custody, other than Mr Curtis; d. The direct and personal contact details of Corrective Services NSW staff that are not publicly available; e. The Manger of Security Journal dated 25 October 2018, which reveals schedules and security checks performed by staff;
	I also make the order that pursuant to section 65(4) of the *Coroners Act 2009* (NSW), a notation is placed on the court file that if an application is made under section 65(2) of that Act for access to Corrective Services New South Wales documents in the court file, that material shall not be provided until Corrective Services New South Wales 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**: The person who died was Kerry Curtis **Date of death**: He died on 31 October 2018 **Place of death**: He died at Prince of Wales Hospital, 320-345 Barker Street, Randwick NSW **Cause of death**: He died as a result of multi-lobar pneumonia and pleural effusions on a background of urothelial carcinoma and its treatment, chronic obstructive pulmonary disease and ischaemic cardio-vascular disease **Manner of death**: Mr Curtis died of natural causes while he was serving a term of imprisonment

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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 Kerry Curtis.

Introduction

1. Mr Curtis died at Prince of Wales Hospital, Randwick at the age of 78 years. At that time, he was a sentenced prisoner and had been housed in the Long Bay Hospital Aged Care Rehabilitation Unit.

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 matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what was the cause and manner of their death and the events leading up to it. 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. In such cases, the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death to ensure that the State discharges its responsibility appropriately and adequately. 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 25 February 2020. The officer in charge of the investigation, Detective Senior Constable Luke McNaughton gave evidence and the court considered numerous statements, medical records, photographs and reports.

The Evidence

Background:

5. Kerry Curtis was born on the 26 February 1940 in Hamilton, New South Wales. He was the second eldest of four siblings. Mr Curtis was married between 1963 and 1975, together they shared two daughters.

6. In 1992 Mr Curtis commenced a de-facto relationship, which continued until his death. Mr Curtis's daughters and partner were advised of todays inquest, however did not attend.

7. There is no dispute that Mr Curtis was in custody lawfully. He was convicted on 25 August 2017 for three commonwealth offences of obtain financial advantage by deception. He was sentenced at the Newcastle District Court to three years and nine months imprisonment, commencing on the 25 August 2017 and to conclude on 24 May 2021. His earliest release date was 25 August 2019.

8. Mr Curtis was born with the medical condition pyloric stenosis, he was also diagnosed with asthma, eczema and insufficient adrenaline production requiring prescribed medication.

9. Mr Curtis suffered many chronic and complex medical conditions including:

    a. Asthma
    b. Eczema
    c. Bipolar effective disorder
    d. Hyper-cholesterol
    e. Corticosteroid induced osteoporosis
    f. Osteoarthritis in the hips, spine and knees
    g. Hypertension un-stability
    h. Sinus arrhythmia
    i. Atrial flutter
    j. Congestive pulmonary disease
    k. Fibrosis of the lung
    l. Postural hypotension
    m. Bladder cancer
    n. Chronic obstructive pulmonary disease

10. In 2013 Mr Curtis was diagnosed with low grade transitional cell carcinoma in the bladder, following this diagnosis he had three monthly cystoscopies until November 2016, with no reported recurrence of the cancer.

11. During his incarceration Mr Curtis had multiple falls with no significant injuries, these were secondary to regular complaints of dizziness. Mr Curtis had multiple hospital transfers to external hospitals for cardiac related episodes. He was subsequently transferred to the Long Bay Hospital Aged Care Rehabilitation Unit to manage his chronic and complex health issues. Mr Curtis attended regular consultations with the

clinical director of Aged Care, physiotherapist, nursing staff and psychiatrists. His medication needs were strictly adhered to by Justice health.

12. In June 2018 Mr Curtis had a cystoscopy identifying an invasive carcinoma on the left bladder wall. Between this diagnosis and October 2018, he was scheduled for chemotherapy for stage two bladder cancer with a scheduled surgery date of the 8 November 2018, he attended regular consultations with the oncology consultant and aged care clinical director.

The Fatal Incident:

13. On the 2 October 2018 Mr Curtis attended Prince of Wales Hospital Cancer Care centre to receive chemotherapy, he was described as frail, fatigued, neutropenic and considered unsuitable for chemotherapy. Mr Curtis was admitted and received a transfusion of packed red blood cells. Mr Curtis received ongoing intravenous antibiotics, pain relief and oxygen assistance. His admission became complicated due to a right internal capsule ischaemic infarct.

14. On 30 October 2018 Mr Curtis' family advised the treating team of their wish to stop active treatment.

15. At 10pm on 30 October 2018 Mr Curtis became symptomatically distressed and very short of breath, although he was given hourly intervention, there was minimal effect and at 4:50am on the 31 October 2018 Mr Curtis died.

Autopsy:

16. A post mortem examination was performed on 2 November 2018 by Dr Sairita Maistry at the Department of Forensic Medicine, Lidcombe. Dr Maistry found evidence of bilateral pleural effusions, pulmonary opacification suggestive of lower respiratory tract infection, cardiomegaly, coronary calcification and peripheral vascular disease. Therefore the cause of death was due to multi-lobar pneumonia and pleural effusions on a background of urothelial carcinoma and its treatment, chronic obstructive pulmonary disease and ischaemic cardiovascular disease.

CSNSW Investigation:

17. Mr Curtis's death resulted in an investigation conducted by Senior investigation Officer, John P Gleeson of NSW Corrective Services. This investigation concluded that Mr Curtis was managed appropriately whilst in Corrective Services custody at each centre he was housed.

Findings required by s81(1)

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.

Identity:

The person who died was Kerry Curtis

Date of death:

He died on 31 October 2018

Place of death:

He died at Prince of Wales Hospital, 320-345 Barker Street, Randwick NSW

Cause of death:

He died as a result of multi-lobar pneumonia and pleural effusions on a background of urothelial carcinoma and its treatment, chronic obstructive pulmonary disease and ischaemic cardio-vascular disease

Manner of death:

Mr Curtis died of natural causes while he was serving a term of imprisonment

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

19. I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner
25 February 2020
NSW State Coroner's Court, Lidcombe.