STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Lawrence Hausia
Hearing dates:	3 November 2020
Date of findings:	3 November 2020
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody, natural causes
File numbers:	2018/372498
Representation:	Ms B Notley (Sergeant) coronial advocate assisting Ms A Smith, solicitor, Department of Communities and Justice(DCJ) Legal, for the Commissioner of Corrective Services NSW (CSNSW) Ms N Slulgt, solicitor for the Justice Health &Forensic Mental Health Network

Findings	Identity
	The person who died was Lawrence Hausia
	Date of death
	He died on 3 December 2018.
	Place of death
	He died at Metropolitan Reception and Remand Centre (MRRC), Silverwater Correctional Complex, Silverwater NSW.
	Cause of death
	He died of atherosclerotic coronary artery disease
	Manner of death
	He died of natural causes.

Non-Publication orders

I make the following non-publication orders

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 That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):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, phone numbers and other personal information that might identify any family and/or person who visited Mr Hausia while in custody (other than legal representatives or visitors acting in a professional capacity).

    b. The names, Inmate Profile Documents and Master Index Numbers relating to inmates other than Mr Hausia.

    c. The direct contact details of Corrective Services NSW (‘CSNSW’) staff.

    d. CCTV footage and CCTV still images of F Block, Pod 10 in the Metropolitan Remand Reception Centre (‘MRRC’), recorded on 3 December 2018.

    e. Crime Scene Photographs including images of F Block, Pod 10 and Mr Hausia’s cell, in the MRRC.

2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, 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.

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Introduction

1. Lawrence Hausia was 30 years of age at the time of his death on 3 December 2018. He was serving a custodial sentence and living at the Metropolitan Reception and Remand Centre (MRRC) at Silverwater, NSW.

2. Lawrence was discovered unresponsive in his cell by another inmate. CPR was commenced and an ambulance was called. Unfortunately, Lawrence could not be revived.

3. A post mortem examination was conducted on 7 December 2018. The forensic pathologist conducting the examination recorded the cause of death as "atherosclerotic coronary artery disease."[1]

The role of the coroner

4. The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death.[2] In addition, the coroner may make recommendations, arising from the evidence, in relation to matters that may have the capacity to improve public health and safety in the future.[3]

5. In this case there is no dispute in relation to Lawrence's identity, or to the date, place or medical cause of his death.

6. Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner[4]. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to be have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care.

7. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Lawrence Hausia.

Scope of the inquest

8. The inquest took place on 3 November 2020. A comprehensive police brief was tendered including police statements, photographs and CCTV footage, as well as prison and medical records. The officer in charge of the investigation, Plain Clothes Senior Constable Joel Swales was called to give brief oral evidence.

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[1] Autopsy Report, Exhibit 1, Tab 3
[2] Section 81 *Coroners Act* 2009 (NSW)
[3] Section 82 *Coroners Act* 2009 (NSW)
[4] See sections 23 and 27 Coroner's Act 2009 (NSW)

Background

9. Lawrence Hausia was born on 11 October 1988. He is the son of Julie and Fakataha Hausia. His father, Fakataha died as a consequence of heart disease some years ago. Lawrence was the third youngest of seven siblings. His sister told the court that Lawrence was greatly loved. He was close to his family and enjoyed spending time with his siblings and nieces and nephews. His family members remembered his humour and kindness and were greatly affected by his sudden and tragic death.

10. Lawrence had been incarcerated on a number of occasions. In 2011 Lawrence had been diagnosed, with type II diabetes while in custody. He commenced monitoring and treatment for the condition. In August 2016 he was also diagnosed, monitored and treated for hypertension while in custody. It appears that when Lawrence was in the community he did not always comply with the prescribed treatment for these medical conditions.

Lawrence's entry into custody in October 2018

11. On the 23 October 2018, Lawrence was arrested by police. Two warrants were executed for supply prohibited drug and reckless wounding in company. He appeared before Campbelltown Local Court and was bail refused. On the 15 November 2018 he was sentenced for drug supply matters to a period of 18 months, commencing on 15 February 2018 and concluding 14 August 2019, with a non-parole period of 9 months and 2 weeks, concluding 28 November 2018. He remained bail refused in relation to the reckless wounding in company matter. His next court appearance was for Penrith local Court, on the 21 December 2018.

12. Lawrence entered the custody of Corrective Services New South Wales on the 23 October 2018, spending time at Amber Laurel Correctional Centre before being transferred to the Metropolitan Remand and Reception Centre. During the reception screening process Lawrence was found to be suffering from high blood pressure and non-insulin dependent diabetes. He was prescribed Metformin and Irbesartan. The health problem notification form (HPNF) indicated that he was to remain in a Darcy group placement until cleared by the primary health care nurse. On the 17 November 2018, an updated HPNF indicated that his diabetes continued to be unstable.[5] Lawrence was to remain in group cell placement while at the MRRC however he was cleared from Darcy. Justice health records show Mr Hausia was given his prescribed medication and had his blood sugar levels taken daily.

13. Mr Hausia was housed in cell 127, pod 10, F block. He shared the cell with another inmate. The cell has two single beds, a toilet, shower and storage area.

Events leading up to Lawrence's death

14. On the morning of 3 December 2018, Lawrence played table tennis in the main area of the pod. After breakfast his blood sugar levels were taken by a nurse from Justice Health and Forensic Mental Health Network (JH) with a reading of 7.6 recorded. Lawrence returned to his cell for lunch before entering the exercise yard about 12.53pm. In the yard he participated in various physical activities, including boxing with makeshift pads. These activities varied in intensity and Lawrence was seen leaning on the wall and lying on the ground in between

[5] Exhibit 1, Tab 15

activities. About 1.50pm Lawrence made a request to a correctional officer to leave the exercise yard and return to his cell. He advised the correctional officer that he had low blood sugar and needed to eat. He declined an offer to attend the clinic. Lawrence was allowed to enter the pod. He was perspiring from his arms and facial area, but appeared otherwise well. He walked up the stairs in his pod unaided, entered his cell and pulled the cell door closed.

15. Lawrence's cell mate entered and exited the cell briefly after Lawrence returned. About 1.56pm another inmate entered Lawrence's cell for linen exchange duties. He observed Mr Lawrence lying on his bed facing the wall with a fan positioned towards him. They had a brief conversation. Lawrence said, "I feel really hot and my chest is sore." The inmate asked if Lawrence needed anything to which he replied, "No, I'm fine." The inmate left.[6]

16. About 3.14pm another inmate entered the cell and saw Lawrence on the floor. He believed that he was sleeping.

17. Muster was delayed due to an unrelated incident in the pod. About 3.20pm Lawrence's cellmate returned to the cell and saw him lying down on the floor on his stomach. The cellmate moved Lawrence onto his side and called for correctional officers to assist. Lawrence's feet were facing the door, the fan was knocked over, his eyes and mouth were open, his face was blue, and his skin was cold to touch.

18. Correctional officers entered the cell and resuscitation attempts began. Lawrence was moved from his cell into the walkway in front of his cell to allow better access for medical staff. Other correctional officers and JH staff continued their resuscitation attempts until the arrival of NSW ambulance personnel. NSW ambulance personnel found Lawrence had no signs compatible with life and resuscitation attempts ceased. He died at 3.55pm.

19. The resuscitation process appears to have been according to policy. No inadequacies were identified.

Police investigation

20. NSW Police conducted a full investigation which involved interviewing inmates and correctional staff and reviewing available CCTV footage. There were no indications that Lawrence's death was suspicious. However family members heard from other inmates about Lawrence's physical activities prior to his death and expressed some concern. The family were worried that Lawrence may have been injured prior to returning to his cell. Plain Clothes Senior Constable Swales conducted an extensive review of the closed circuit television (CCTV) within the MRRC. The CCTV corroborates the accounts given by staff and inmates. Lawrence does not appear injured nor is he engaged in heavy conflict on that day. The family were advised of the outcome of the CCTV review and did not raise further concerns in relation to the care and treatment that Lawrence received.

The Autopsy Report

21. Lawrence's identity was confirmed by fingerprints.

[6] Statement of Sinan Sen, page 27-28, paragraph 8-9.

22. A post mortem examination was conducted by Doctor Kendall Bailey at the Department of Forensic Medicine, Glebe on the 7 December 2018. Doctor Bailey found Lawrence to be overweight with a mildly enlarged heart; significant three vessel coronary artery disease and the myocardium (heart muscle) showed widespread microscopic fibrosis (scarring), indicative of previous ischaemic damage (due to lack of blood supply). Toxicological analysis detected the presence of Metformin (diabetic medication) and Irbesartan (antihypertensive) as expected. No other medications or illicit substances were detected. Doctor Bailey recorded the cause of death as atherosclerotic coronary artery disease. She noted that the degree of disease found in a relatively young man may suggest a genetic predisposition, which could also affect surviving first degree relatives. Lawrence's relatives were advised to seek testing.

23. I note that toxicological testing found no drugs of addiction or illicit substances.

What was the cause and manner of Lawrence's death?

24. I am satisfied that Lawrence's death was due to natural causes and that he was provided with appropriate care for his pre-existing conditions whilst in custody. I did not identify any issues with the attempts made at resuscitation by correctional or medical staff.

Conclusion

25. I thank members of Lawrence's family who attended this inquest. I offer my sincere condolences and acknowledge their significant loss. Lawrence's sudden death was both premature and tragic.

26. I thank those assisting me in the investigation and in preparation of this inquest.

27. I close this inquest.

Formal findings

28. The findings I make under section 81(1) of the Act are:

    Identity

    The person who died was Lawrence Hausia.

    Date of death

    He died on 3 December 2018.

    Place of death

    He died at Metropolitan Reception and Remand Centre (MRRC), Silverwater Correctional Centre, Silverwater, NSW.

Cause of death

He died of atherosclerotic coronary artery disease.

Manner of death

He died of natural causes.

Magistrate Harriet Grahame
Deputy State Coroner
3 November 2020
NSW State Coroner's Court, Lidcombe