CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Howlett
Hearing dates:	22 April 2020
Date of findings:	22 April 2020
Place of findings:	State Coroner's Court, Lidcombe
Findings of:	**State Coroner, Magistrate Teresa O'Sullivan**
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody – Long Bay Correctional Centre Ischaemic heart disease and coronary atherosclerosis
File number:	2015/323840
Representation:	Sergeant Tina Xanthos, Advocate Assisting

Findings:	**Identity of deceased**: The deceased person was Robert Howlett **Date of death**: Mr Howlett died on the 3 November 2015 **Place of death**: He died at Long Bay Correctional Centre **Manner of death:** Mr Howlett died of natural causes whilst serving a custodial sentence. **Cause of death:** The medical cause of the death was ischaemic heart disease and coronary atherosclerosis.

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 That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW): a. The names, addresses, phone numbers and other personal information that may tend to identify Robert Howlett's next of kin; b. Portions of the Inmate Accommodation Journal dated 15 October 2015 - 3 November 2015, which reveal details of security checks performed; c. The names, personal information and Master Index Numbers of any person in the custody of Corrective Services NSW ('CSNSW'), other than Mr Howlett; d. The direct contact details of CSNSW staff not otherwise publicly available; e. The Employee Daily Schedule dated 3 November 2015; and f. The following CSNSW policies: i. Section 13.2 '*Death in Custody'* of the Operations Procedures Manual ('OPM') (July 2015); and ii. Section 13.7 '*Crime Scene Management*' of the OPM (June 2011), that are not publically available. 2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, 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.

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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 Robert Howlett.

Introduction:

Mr Robert Howlett was born on the 30 December 1940. At the time of his death on the 3 November 2015, he was serving a custodial sentence at Long Bay Correctional Centre. On the advice of pathologist Dr Ansford, a coronial certificate was issued for the cause of death, which was determined to be ischaemic heart disease with an antecedent cause of coronary atherosclerosis. An identification statement was completed by Sandra Williams, a Correctives Officer who had known Mr Howlett for four years.

Mr Howlett had a long custodial history and was on parole for a life sentence for serious charges. Mr Howlett's initial sentence commenced on 23 March 1984 and he was released on parole on 20 November 2011, whereupon he resided in Community Offender Support Programs residence (COSP) until his parole was breached and he was returned to custody on 15 September 2015. At the time of his death he was housed in cell 7, Wing 15, Area 3 at Long Bay Correctional Centre.

Mr Howlett's sister expressed concerns in her statement to the police that Mr Howlett was not receiving his full medications whilst in custody.

The discharge summary from Campbelltown Hospital following an admission on 23 May 2015 indicates that Mr Howlett had been prescribed nifedipine 20 mg daily, and although this was withheld during admission, it could be restarted. General Practitioner records also list nifedipine as one of Mr Howlett's medications. Mr Howlett was not prescribed nifedipine during his last custodial sentence from 15 September 2015.

The Inquest:

The *Coroner's Act 2009 (***the Act***)* provides that where a person dies in lawful custody, an inquest into their death is mandatory and must be presided over by a senior Coroner (ss. 23 and 27).

Section 81 of the Act requires me to make a finding as to the identity of the individual who died, the date and place of death, and the cause and manner of death. "Cause of death" refers to the physical cause and "manner" refers to the circumstances leading up to and surrounding the death.

A secondary but equally important function of the Coroner is governed by s. 82 of the Act, which empowers me to make any recommendations that are considered "necessary or desirable" in relation to Mr Howlett's death.

Having a public inquest is particularly important when a person dies while in custody because prisoners are a vulnerable group within our community. Their vulnerability is three-fold. Firstly, it is well accepted that many prisoners suffer from some form of physical or mental illness, including those relating to illicit drug use. Secondly, the loneliness and distress of custody may well exacerbate any mental distress. Thirdly, prisoners do not have the agency to make their own decisions about the type of medical care that they can access and are away from family and friends who might otherwise care for them. They are completely dependant on the authorities who detain them; in this case the employees of a State correctional centre.

A hearing for the inquest into Mr Howlett's death was held before me at the State Coroner's Court in Lidcombe on the 22 April 2020. The inquest did not hear oral evidence from any witnesses.

The Evidence:

Background:

In 2015, Mr Howlett was a seventy-four-year-old man with an extensive medical history. He was an ex-smoker with previous heavy tobacco use. He had severe lung

disease, with smoking related emphysema as well as previous bronchiectasis. He had had multiple exacerbations of this lung disease with lower respiratory tract infections requiring anti-biotic treatment. Baseline therapy for his respiratory issues included Seretide and Spiriva.

From an early age Mr Howlett suffered from a profound hearing disability that was unresponsive to hearing aids. He was on a waiting list for a cochlear implant. Communication with Mr Howlett was difficult, although he could lip read to a degree. Written notes were often used as an aid to communication.

He had a history of gastro-oesophageal reflux treated with omeprazole. He had long term back problems including lumbar compression fractures and spinal stenosis. These caused an unsteady gait and necessitated him using a walking frame for mobilization and a chair for showering.

Long standing problems due to benign prostatic hypertrophy with repeated urinary tract infections were noted. He had a recent fracture of the wrist and iron deficiency of unknown cause.

He had a history of hypertension and had been taking the anti-hypertensive nifedipine. Apart from two brief episodes of atrial fibrillation in the context of lower respiratory infections, he was not known to have any heart disease.

During 2015 Mr Howlett had a number of exacerbations of his lung disease. In January 2015 he was seen at Campbelltown Hospital where he was found to have an infective exacerbation of his emphysema. Mr Howlett was treated with antibiotics as an outpatient.

In May 2015 he had a further infective exacerbation of his emphysema, complicated by sepsis and atrial fibrillation. The sepsis led to low blood pressure. The sepsis was treated with antibiotics and Mr Howlett was admitted to Campbelltown Hospital for 3 days for intravenous antibiotics. His anti-hypertensive nifedipine was ceased so as not to exacerbate his low blood pressure.

According to medical opinion within the brief of evidence, in the setting of rapid atrial fibrillation nifedipine may not only lower blood pressure but potentially cause further reflex tachycardia making the atrial fibrillation harder to control. On discharge from this admission it is mentioned within the discharge summary that "nifedipine 20 mg daily withheld during admission, however, can be restarted."

On 25 October 2015, Mr Howlett attended the Long Bay clinic with shortness of breath. An irregular pulse was detected and he was transferred to Prince of Wales Hospital for further investigation and management. He was diagnosed with atrial fibrillation and a lower respiratory infection. The respiratory infection settled with antibiotics and the atrial fibrillation resolved spontaneously.

On the 27 October 2015 Mr Howlett returned to a normal wing at Long Bay Correctional Centre with a course of Augmentin duo forte (a broad spectrum antibiotic).

The Fatal Incident:

Witness accounts of the death

Mr Howlett's cell mate, [redacted], states that on the night of the 1 November 2015, Mr Howlett was coughing and struggling to get his breath.

On 2 November 2015, Mr Howlett was seen in the clinic for a dressing of a boil. His vital signs were attended; all were satisfactory with no abnormalities detected. [redacted] states that Mr Howlett had improved on the 2 November 2015, but he was still coughing during the night. As a result of the coughing, [redacted] asked Mr Howlett if he wanted him to hit the buzzer to alert Correctives staff, but Mr Howlett indicated he was okay.

About 6:30 a.m. on 3 November 2015, [redacted] was released from cell 7 to go to work for the day. About 7:10 a.m. Senior Correctional Officer Manjeet Rana observed Mr Howlett sitting on the edge of the bed. He appeared fine. About 9:30 a.m. Senior Correctional Officer Rana opened Mr Howlett's cell door and saw him

sitting on a chair inside his cell. Again, Mr Howlett appeared fine. Senior Correctional Officer Rana left the cell door unlocked.

About 10:30 a.m., inmate [redacted] walked past Mr Howlett's cell. As he walked past, he saw Mr Howlett lying on his bed, face up, with his arm lying off the bed. [redacted] went to the neighbouring cell and then accompanied another inmate, [redacted], back to Howlett's cell. They then went to the wing office and informed Senior Correctional Officer Rana that Mr Howlett did not look well. Senior Correctional Officer Rana attended Mr Howlett's cell and could not get a response from him.

Inmates [redacted] and [redacted] then carried Mr Howlett from his cell and onto the ground outside the cell. They commenced CPR with the assistance of a third inmate, [redacted] and continued CPR until Justice Health nurses arrived at 10:35 a.m. The nurses took over CPR and administered oxygen therapy.

About 11:00 a.m. NSW Ambulance officers arrived. NSW Ambulance Officer Quigg pronounced Mr Howlett deceased at 11:02 a.m.

At 12:13 p.m. Mr Howlett was examined by Dr Stephen Hampton, who issued a life extinct certificate.

Nifedipine Medication

To better assess how Mr Howlett's medications were administered while he was in Corrective Services custody, a statement was sought from Bernadette Hollis, Regional Nurse Manager Women's and Metropolitan North within Justice Health and Forensic Mental Health Network. She was asked to detail how details of an inmate's prescribed medications are obtained upon arrival to custody and why nifedipine did not appear on Mr Howlett's list of prescribed medications during his most recent period of custody.

She responded that upon arrival into custody a nurse conducts a Reception Screening Assessment (RSA) with the incoming patient. The patient is asked to

provide details of their medications and medical history. If they are taking medications, the patient is asked to sign a release of information form and then this form is forwarded via fax to the community health provider.

In Mr Howlett's case he did not disclose nifedipine as a regular medication during the initial RSA or when subsequently interviewed on the 17 September 2015 by the General Practitioner. When the release of information form signed by Mr Howlett was sent on the 19 September 2015 to his nominated community health provider, Campbelltown Medical Centre, they did not return any information, stating that they had last seen Mr Howlett on the 24 August 2012.

However, Mr Howlett's community health provider appears to have been Campbelltown Mall Medical Centre, which is a different entity to Campbelltown Medical Centre. Records subsequently obtained under a section 53 order for production from Campbelltown Mall Medical Centre disclose records for Mr Howlett up to September 2015, which is shortly before Mr Howlett entered custody. Nifedipine is listed in their records as a long term medication under the name Adalat Oros. Given Mr Howlett's communication and hearing difficulties it may be that a miscommunication occurred concerning the details of his community health provider.

On the 29 October 2015 a Network physiotherapist made a request for information from Campbelltown Hospital regarding a wrist fracture. This request for information noted that Mr Howlett had been prescribed nifedipine, but as the request was requested by the physiotherapist there was no appointment made for GP review.

The Expert Report of Professor Adams

Given the concerns expressed by Mr Howlett's sister and the information from Campbelltown Hospital and Campbelltown Mall Medical Centre about Mr Howlett's current medications, an expert report was sought from A/Professor Mark Adams, the head of the Department of Cardiology at Royal Prince Alfred Hospital, as to whether the non-administration of nifedipine during Mr Howlett's custodial sentence commencing 15 September 2015 would have impacted on his death.

Professor Adams details the effects of nifedipine in his report, describing it as a calcium channel blocker that relaxes blood vessels and thereby lowers vascular resistance and blood pressure. Adams says that unlike certain other hypertensive medications, nifedipine does not confer other survival benefits apart from the lowering of blood pressure. The exception is in relatively rare cases of a syndrome of coronary artery spasm that does not apply in Mr Howlett's case. The sole apparent reason that nifedipine was prescribed to Mr Howlett was to control his blood pressure.

During the period from 15 September and 3 November, Mr Howlett had his blood pressure measured on numerous occasions. On 17 September 2015 his blood pressure was 116/68, on 25 October it was 101/64, and on 2 November 2015 it was 109/59. Professor Adams notes that these measurements are quite low and prescribing an anti-hypertensive might lower the blood pressure to unsafe levels.

Professor Adam's opinion is that it was appropriate not to prescribe nifedipine. Professor Adam's says that if it had been known that nifedipine was a usual medication for Mr Howlett, it most likely would have been withheld for safety reasons. Professor Adams states: "I do not think that the failure to prescribe nifedipine when the deceased began his last custodial sentence in 15 September 2015 made any contribution to the deceased's death on 3 November 2015."

Autopsy Report

On the advice of pathologist Dr Ansford, a coronial certificate was issued for the cause of death, which was determined to be ischaemic heart disease with an antecedent cause of coronary atherosclerosis.

Findings required by s81(1)

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

The identity of the deceased

The deceased person was Robert Howlett

Date of death

Mr Howlett died on the 3 November 2015

Place of death

Mr Howlett died at Long Bay Correctional Centre

Cause of death

The medical cause of death was ischaemic heart disease and coronary atherosclerosis

Manner of death

Mr Howlett died of natural causes whilst serving a custodial sentence

Closing remarks

I wish to acknowledge that Mr Howlett's sister was unable to attend this inquest due to her personal circumstances and the Covid-19 situation. As is evident from her concerns about Mr Howlett's wellbeing while he was in custody, she cared deeply for him. I convey to her my deepest sympathies.

I close this inquest.

Magistrate Teresa O'Sullivan
State Coroner

22 April 2020