CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Into the death of Neville Raymond Towner
File number:	**2018/199143**
Hearing dates:	4 February 2020
Date of findings:	4 February 2020
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E.Truscott
Catchwords:	Coronial Law-natural causes death in lawful custody
Representation:	Ms K McKay: Coronial Advocate assisting The Coroner Ms K McKinley: Commissioner of Corrective Services, NSW Mr M Steery: Justice Health & Mental Health Network
Findings:	**Identity: Neville Raymond Towner** **Date of Death: 27 June 2018** **Place of Death: Prince of Wales Hospital, 320-345 Barker St, Randwick NSW** **Cause of death: Respiratory Distress Syndrome** **Manner of death: Mr Towner died of natural causes whilst in the lawful custody of Corrective Services, NSW**
Non-Publication Order	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 That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):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, contact numbers and addresses of any member of Neville Towner's family, members of the family church, external day leave sponsors, medical professionals treating Neville Towner's mother and visitors other than legal or professional visitors; b. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services NSW other than Neville Towner; c. The direct contact details of CSNSW staff and staff from external service providers not otherwise publicly available; d. The names, contact numbers and addresses of the victim and the victim's family, as well as all references to Inmate Towner's offences; e. The following Corrective Services NSW policies, portions of which are not publicly available: i. Corrective Services NSW Operations Procedures and Policies (COPP) Manual Section 13.3 Deaths in Custody (version 1.2 dated December 2017); and ii. Corrective Services NSW Operations Procedures and Policies (COPP) Manual Section 13.8 Crime Scene Preservation (version 1.0 dated December 2017). 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 section 65(2) of that Act for access to Corrective Services NSW documents on the Court file, that material shall not be provided until Corrective Services NSW has had an opportunity to make submissions in respect of that application.

IN THE CORONERS COURT
LIDCOMBE
NSW

Section 81 Coroners Act 2009

REASONS FOR DECISION

1. Neville Towner was a 52 year old man serving a life sentence at Long Bay Correctional Complex at the time of his death, an inquest is mandatory pursuant to Sections 23 and 27 of the *Coroners Act 2009.*

2. Mr Towner's mother, [redacted] suffers advanced dementia, she resides in [redacted]. Mr Towner's only other known relative is [redacted]. They have been advised of this inquest, however did not attend.

3. The officer in charge Senior Constable Stuart Highfield prepared the Brief of evidence and appeared by Audio Visual Link from Ballina Police Station.

4. Mr Towner was born on the 21 December 1965. Prior to his incarceration, In 1989 he had been residing at the Nepean River Caravan Park, 91/95 Mackellar St, Emu Plains NSW 2750. He had never married and apparently did not have any children.

5. On 18 May 1989 On 19 May 1989 Mr Towner was entered into custody at Parramatta Correctional Centre. During his screening assessment it was identified that he suffered Alcohol abuse, and was a smoker of a packet of cigarette daily for over 40 years. Mr Towner was serving a life imprisonment with a non-parole period of 20 years.

6. He was transferred between numerous correctional centres including Goulburn, Cooma, Berrima, Lithgow, Maitland and Long Bay where he spent remainder of his sentence. Mr Towner's final placement was within the Metropolitan Special Programs Centre Area 3, Wing, Cell 35 at Long Bay Correctional Centre. Mr Towner was placed in this area due to the category of his offences.

7. During his period of incarceration Mr Towner received treatment for many medical conditions including ischaemic heart diseases, anxiety disorder and back pain.

8. On 20 January 2012 Mr Towner underwent a quadruple bypass surgery at Prince of Wales Hospital, following this he continued regular appointments with the medical officer, nurse and specialists.

9. On 9 May 2018, Mr Towner reported pain in the left leg, he presented as sweaty and with mild tremors, he was transferred to Prince of Wales Hospital Emergency department. He had an elevated temperature and increased white cell count indicating an infection of unknown origins. Mr Towner discharged himself against medical treatment. The following day, , Mr Towner was reviewed by a registered nurse at Long Bay Correctional Centre, he denied experiencing any pain stating he felt ok.

10. On 18 May 2018, Mr Towner was reviewed by a general practitioner, discussing his blood results and continued on his current treatment**.**

11. On the 15 June 2018 Mr Towner attended a consultation with the nurse at Long Bay Correctional Centre reporting difficulty breathing, standing, walking and a dry cough. During his medical assessment Mr Towner was noted to be experiencing low oxygen saturation. Accordingly, he was placed on supplementary oxygen and transferred to the Prince of Wales Hospital emergency department by ambulance. He was admitted to the respiratory ward, and treatment commenced with high flow nasal prongs which were initially tolerated.

12. However, his condition deteriorated and on 19 June 2018, Mr Towner was intubated, he was treated with regular antibiotics for severe community acquired pneumonia, however there was no improvement in his condition. He was started on a high dose of methylprednisolone 1500mg for 3 days in addition to the high ventilator support.

13. On 27 June 2018, Mr Towner suffered an acute deterioration becoming increasingly tachychardic and tachyponeic. A chest x-ray and ultrasound did not show any acute change to account for his deterioration and it was determined

that he was suffering acute respiratory distress syndrome and that all therapeutic options had been exhausted. Management changed from active treatment to comfort care. At 4.46pm he was pronounced deceased.

14. Mr Towner was provided appropriate medical care, there are no suspiscious circumstances surrounding his death. His progression to death could not be stopped despite multiple antibiotics and high dose of methylprednisolone.

15. The evidence establishes that Neville Towner died of acute respiratory distress syndrome on the 27 June 2018, at Prince of Wales Hospital, 320-346 Barker St, Randwick, New South Wales, Australia, he died of natural causes whilst in the lawful custody of Corrective Services NSW..

Magistrate Truscott
Deputy State Coroner
4 February 2020