STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Jack Keith King
Hearing dates:	17 November 2021
Date of findings:	17 November 2021
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:	2020/273670
Representation:	Mr D Welsh (Sergeant) coronial advocate assisting Ms M Smith, solicitor, Department of Communities and Justice(DCJ) Legal, for the Commissioner of Corrective Services NSW (CSNSW) Ms N Szulgit, solicitor for the Justice Health &Forensic Mental Health Network

Findings

Identity

The person who died was Jack Keith King

Date of death

He died on 20 September 2020

Place of death

He died at Long Bay Correctional Centre Hospital, Long Bay NSW - Aged Care Rehabilitation Unit (ACRU)

Cause of death

He died of complications of metastatic squamous cell carcinoma, likely urothelial origin.

Manner of death

He died of natural causes, in custody.

Non-Publication orders

I make the following non-publication orders

1. That the following documents and information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):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, Master Index Numbers (MINs) and any other identifying information of inmates other than Jack King;

    b. The names, Visitor Index Numbers, contact numbers and addresses of any member of Jack King's family, friends and/or visitors, other than legal or professional visitors;

    c. The direct contact details of Corrective Services New South Wales ('CSNSW') staff that are not publicly available;

    d. Any identifying details of victims of Jack King's offending;

    e. The photographs at tab 6, Timeline of CCTV footage, of the brief of evidence.

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 any 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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Introduction

1. Jack King was 77 years of age at the time of his death on 20 September 2020. He was serving a custodial sentence and was placed at Long Bay Prison Hospital within the Aged Care and Rehabilitation Ward.

2. Mr King had been in NSW custody since he was bail refused on 2 July 2015. He had a long history of offending against children.

3. Mr King was discovered unresponsive on 20 September 2020. He could not be revived.

4. A post mortem examination was conducted on 24 September 2020. The forensic pathologist conducting the examination recorded the cause of death as "complications of metastatic squamous cell carcinoma, likely urothelial origin."[1]

The role of the coroner

5. 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]

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

7. 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 have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care. I note that the court was not notified of any potential issues with his care or treatment.

8. 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 Jack King.

Scope of the inquest

9. The inquest took place on 17 November 2021. A comprehensive police brief was tendered including police statements, photographs and CCTV footage, as well as prison and medical records.

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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

10. Mr King was born on the 12 November 1942 in Fulham West in the United Kingdom. On the 24 September 1954, when Mr King was aged 11, he was admitted to care at the request of his father. Mr King was transported to Sydney as a child migrant under the auspices of Barnados and arrived in Sydney on the 29 September 1955 at the age of twelve. He completed his secondary education at the Dr Barnardos Farm School, Mowbray Park, Picton NSW. After school he commenced working at a service station in Ryde.

11. In 1971 Mr King met and married M and fathered two children with her, a son and daughter.

12. In 1986 Mr King was charged with criminal offences in NSW but failed to appear before Redfern Local Court and a warrant was issued for his arrest. Mr King left NSW and made his way to Western Australia without this warrant being executed.

13. In Western Australia Mr King met and married J and fathered three children with her.

14. The court was informed that at the time of his death Mr King was estranged from his family. No family members wished to take part in the inquest process and no care or treatment issues were raised.

15. As a result of further offences previously committed in NSW, he was extradited from Western Australia and on the 2 July 2015, after being bail refused, entered NSW Correctives Services custody. He was sentenced at the Downing Centre District Court on the 3 March 2017 to 15 years imprisonment with a non-parole period of 7 years 6 months, with the sentence commencing on the 2 July 2015.

Medical History

16. On the 17 July 2020, Mr King was taken from Junee Correctional Centre to Wagga Wagga Base Hospital/Rural Referral Hospital following routine blood tests that identified he had hyponatraemia and hyperkalaemia. At the time of admission, Mr King's medical conditions included dementia, osteoarthritis, gastric reflux and hypercholesterolemia. He denied feeling pain or recent urinary symptoms. Medical records indicate he was feeling well during this admission.

17. Following the discovery of a mass during a renal ultrasound, Mr King underwent a CT IVP examination on the 20 July 2020, which identified numerous lesions around the right kidney and the liver.

18. A further CT scan was conducted on the 21 July 2020. The findings were in keeping with bladder transitional cell carcinoma with upstream extension. The liver lesions were thought to be benign.

19. On the 3 August 2020, an ultrasound guided biopsy was conducted. This biopsy resulted in a diagnosis of squamous cell carcinoma.

20. Mr King was discharged from Wagga Wagga Base Hospital on the 3 August 2020, with the intention of him being transferred back to Junee Correctional Centre and potential transfer to

Long Bay Correctional Centre for palliative care. The discharge summary from Wagga Wagga Base Hospital noted that given Mr King's social circumstances and dementia, treatment would likely be of a supportive/palliative nature.

21. On the 13 August 2020, Mr King was transferred from Junee Correctional Centre to Wagga Wagga Base Hospital at the request of medical staff at Long Bay Correctional Centre. This was to ensure adequate medical care prior to his transfer to Long Bay Hospital. During this admission at Wagga Wagga Base Hospital, he was assessed by both the urology and oncology teams and deemed to be appropriate for conservative palliative care management only. On the 17 August 2020, Mr King was transferred to Long Bay Hospital for palliative care management.

22. On the 21 August 2020, Dr Hovey, a Senior Staff Specialist within the Department of Medical Oncology at Prince of Wales Hospital, saw Mr King. Mr King reported no pain and did not appear to be in distress. She advised that he was not suitable for any form of systemic therapy and recommended supportive palliative care for Mr King. Dr Urban saw Mr King on the 26 August 2020 and 9 September 2020 and concurred with Dr Hovey that Mr King was not suitable for systemic treatment due to his frailty and dementia.

Events leading up to his death

23. On the 20 September 2020, Mr King was housed within cell 11 of the Aged Care Rehabilitation Unit. He was cared for by nurses Francine Cullen and Pramila Ranjitkar. First Class Correctional Officer Ross Sparkes was assigned to that area.

24. On the morning of the 20 September 2020, Mr King was incontinent of faeces and Nurse Cullen had to shower and dress him. He was then placed in a recliner chair and moved to the dining area where he refused food but consumed a meal replacement drink. Mr King remained in the dining room until about 11:00 a.m, when he was placed back in his cell and into bed.

25. About 12:30 p.m., Mr King was placed in the recliner chair and moved to the dining area. Mr King again refused to eat but consumed a meal replacement drink. He was placed in front of the television until being returned to his room at 2:30 p.m. He was left in the recliner chair before his television. Nurse Cullen undertook half-hour visual checks and observed movement in Mr King's limbs in these checks.

26. About 4:00 p.m. Nurse Cullen did another round and detected the smell of faeces coming from the hallway where Mr King was housed. She identified the smell as coming from his cell and looking into the cell she saw him fidgeting.

27. Nurse Cullen requested assistance from Nurse Ranjitkar. Nurse Ranjitkar was about to commence a meal, so they agreed she would eat and then the two of them would change him. Nurse Cullen and Nurse Ranjitkar donned personal protective equipment prior to entering the cell, as Mr King has previously attempted to touch staff after defecating. Nurse Cullen looked into the cell and saw Mr King was not moving. She then collected a trolley of observational medical equipment and checked Mr King's heartbeat, pulse and blood pressure. She confirmed he was deceased.

28. Nurse Cullen completed the life extinct form, recording the time of death as 4:30 p.m. Police reviewed CCTV showing the exterior hallway of Mr King's cell and no suspicious circumstances were identified. The "knock up" button located within the deceased's cell was confirmed to be operational.

Police investigation

29. NSW Police conducted a full investigation including reviewing the available CCTV footage. There were no indications that Mr King's death was suspicious.

The Autopsy Report

30. Mr King's identity was confirmed by a nurse who had been caring for him.

31. A post mortem examination was conducted by Doctor Rebecca Irvine at the Department of Forensic Medicine, Sydney on the 24 September 2020. Her findings were consistent with the medical records which were obtained.

What was the cause and manner of Mr King's death?

32. I am satisfied that Mr King's death was due to natural causes and that he was provided with appropriate care for his pre-existing conditions whilst in custody. I have not identified or been made aware of any care or treatment issues.

Conclusion

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

34. I close this inquest.

Formal findings

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

    Identity

    The person who died was Jack King

    Date of death

    He died on 20 September 2020

Place of death

He died at Long Bay Correctional Centre Hospital, Long Bay NSW - Aged Care Rehabilitation Unit (ACRU)

Cause of death

He died of complications of metastatic squamous cell carcinoma, likely urothelial origin.

Manner of death

He died of natural causes, in custody.

Magistrate Harriet Grahame
Deputy State Coroner
17 November 2021
NSW State Coroner's Court, Lidcombe