CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Melvin Lynch
Hearing dates:	25 May 2021
Date of findings:	25 May 2021
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death
File number:	2019/388183
Representation:	Ms K Mackay, Coronial Advocate Assisting the Coroner Ms K Pastrovic for the Commissioner of Corrective Services New South Wales Ms N Szulgit for Justice Health & Forensic Mental Health Network
Findings:	I find that Melvin Lynch died on 9 December 2019 at the Annex Unit of Prince of Wales Hospital, Randwick NSW 2031. The cause of Mr Lynch's death was complications of subtotal colectomy for diffuse polyposis and invasive adenocarcinoma, with end-stage renal failure a significant condition contributing to the death, but not relating to the disease or condition causing it. Mr Lynch died from natural causes, whilst in lawful custody serving a sentence of imprisonment.
Non-publication orders:	See Annexure A

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1. Introduction

1.1 At the time of his death, Melvin Lynch was 72 years old and was being held in lawful custody in a correctional centre, having previously been convicted of a number of offences. Mr Lynch was not eligible for release from custody until 4 April 2028. In November 2019 Mr Lynch was admitted to hospital for elective surgery to treat his pre-existing medical condition. This admission was complicated, Mr Lynch's condition subsequently deteriorated and Mr Lynch made a request to be provided with comfort and palliative care, which was instituted.

1.2 On the evening of 9 December 2019, following a routine medication round and regular observations, Mr Lynch was found unresponsive in his hospital bed, with no signs of life. In accordance with standing not for resuscitation orders, no cardiopulmonary resuscitation was initiated and Mr Lynch was later pronounced life extinct.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 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 Act 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.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Lynch was not appropriately cared for and treated whilst in custody.

3. Mr Lynch's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Lynch was born in Casino in November 1947, the youngest of four children. During his childhood Mr Lynch and his family lived in Evans Head and Lismore, before later relocating to Sydney. Mr Lynch attended Kogarah Primary School and Kogarah Boys High School Mr Lynch studied science

at university and worked for a number of large companies. He was described by his sister as being highly intelligent, scientifically minded and with a photographic memory.

3.3 Mr Lynch later married and moved with his wife to the South Coast region. They had two daughters together.

3.4 Following the passing of his wife, Mr Lynch moved to Coffs Harbour. Whilst there, Mr Lynch became active at a local church, and later formed a new relationship.

4. Mr Lynch's custodial history

4.1 In April 2017 Mr Lynch was charged with a number of offences in relation to child sexual assault and child abuse material. He was refused bail and initially remanded at Grafton correctional centre.

4.2 Mr Lynch was later convicted of a number of the above offences. He was subsequently sentenced in May 2018 to a 15 year term of imprisonment, commencing on 4 April 2017, with a non-parole period of 11 years concluding on 4 April 2028.

4.3 Following his conviction, Mr Lynch was classified as a maximum security inmate (due to the nature of the offences for which he had been convicted).

5. Mr Lynch's medical history

5.1 Mr Lynch had a complex medical history, with a background of end stage chronic kidney disease, a previous invasive squamous cell carcinoma of the neck (resected in 2013), ischaemic heart disease, atrial fibrillation, type II diabetes and epilepsy.

5.2 Between April 2017 and October 2019, Mr Lynch was transferred to Prince of Wales Hospital (**POWH**) on a number of occasions for investigations and treatment of his pre-existing conditions. On 21 October 2019 Mr Lynch commenced haemodialysis and was referred to POWH for a hepatic flexure and large bowel lesion.

5.3 On 26 November 2019 Mr Lynch was admitted to the Annex Unit at POWH for elective subtotal colectomy for bowel cancer. Following this, Mr Lynch experienced increased work of breathing and desaturations. A chest x-ray was performed on 28 November 2019 which demonstrated a large right-sided pleural effusion. Subsequent cytological examination showed no evidence of malignancy. However, Mr Lynch showed features of multi-organ dysfunction and had recurring episodes of hypotension. Due to Mr Lynch's ongoing profound hypotension and frailty, he was unable to receive his usual haemodialysis treatment. Concerns were raised for an anastomotic leak, a known complication of colorectal surgery. On 3 December 2019 a CT scan of the brain, chest, abdomen and pelvis revealed intra-abdominal gas compatible with recent surgery. However, perforation or anastomotic leak could not be excluded.

5.4 On 4 December 2019 Mr Lynch made a request for aggressive interventions to cease, and for his medical care to focus on comfort and quality of life. This was discussed with Mr Lynch's family who

were in agreement. Accordingly, on 5 December 2019 Mr Lynch was formally transitioned to palliative care, with daily review by his treating team and a palliative care team. An advanced care directive was put in place noting that Mr Lynch was not for resuscitation. Following this, Mr Lynch's condition continued to deteriorate.

5.5 At around 5:00pm on 9 December 2019 POWH nursing staff administered routine medication to Mr Lynch, and also attended to routine pressure area care and repositioning. Following this, Mr Lynch was observed at half hourly intervals. At around 6:50pm Mr Lynch was found to be unresponsive, with no signs of life. In accordance with the advance care directive no resuscitation was initiated and Mr Lynch was subsequently pronounced life extinct.

6. What was the cause of Mr Lynch's death?

6.1 Mr Lynch was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Jennifer Pokorny, forensic pathologist, on 13 December 2019. Postmortem imaging showed a large right-sided pleural effusion and extensive cystic changes in the kidneys, with intra-abdominal fluid also noted.

6.2 Ultimately, in the autopsy reported dated 6 February 2020, Dr Pokorny opined that the cause of Mr Lynch's death was complications of subtotal colectomy for diffuse polyposis and invasive adenocarcinoma, with end-stage renal failure noted to be a significant condition contributing to the death, but not relating to the disease or condition causing it.

7. Conclusions

7.1 Having regard to the relevant records from Corrective Services NSW (**CSNSW**) and Justice Health & Forensic Mental Health Network regarding Mr Lynch's incarceration, and the findings from the postmortem examination, it is evident that Mr Lynch died as a result of natural disease process. Given Mr Lynch's complex medical history, appropriate investigations were conducted, and treatment provided in the period between April 2017 and December 2019. It is evident that there were a number of complications associated with the surgery performed in November 2019. The evidence indicates that appropriate investigations were conducted in relation to these complications and that, at the request of Mr Lynch (with agreement from his family), it was appropriate to subsequently transition Mr Lynch to a palliative care pathway.

7.2 Overall, the available evidence establishes that Mr Lynch was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Lynch's medical care, or the care provided by CSNSW and POWH staff, contributed in any way to his death. It is noted that Mr Lynch's sister, Marea Andrews, described the care that Mr Lynch received whilst in hospital to be "*wonderful*", and that she was regularly provided with updates as to Mr Lynch's condition.

8. Findings

10.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Karissa Mackay, Coronial Advocate, for her excellent assistance both before,

and during, the inquest. I also thank Senior Constable Elizabeth Toland for her role in the police investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Melvin Lynch.

Date of death

Mr Lynch died on 9 December 2019.

Place of death

Mr Lynch died at the Annex Unit of Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr Lynch's death was complications of subtotal colectomy for diffuse polyposis and invasive adenocarcinoma, with end-stage renal failure a significant condition contributing to the death, but not relating to the disease or condition causing it.

Manner of death

Mr Lynch died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

10.3 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences, to Mr Lynch's family for their loss.

10.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
25 May 2021
Coroners Court of New South Wales

Inquest into the death of Melvin Lynch

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Annexure A

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), I direct that the following material is not to be published:

1. Names, addresses, phone numbers and other personal information that might identify:

   (a) Any member of Melvin Lynch's family;
   (b) Any person who visited Melvin Lynch while in custody (other than legal representatives or visitors acting in a professional capacity);
   (c) Any child victim of an offence committed by Melvin Lynch.

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

3. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of CSNSW other than Melvin Lynch.

4. Portions of section 13.1 of the CSNSW Custodial Operations Policy and Procedures (COPP) concerning Serious Incident Reporting at Tab 18 of Exhibit 1, as identified in the attached schedule.

5. Portions of section 13.3 of the COPP concerning Deaths in Custody at Tab 18 of Exhibit 1, as identified in the attached schedule.

6. Portions of section 13.8 of the COPP concerning Crime Scene Preservation at Tab 18 of Exhibit 1, as identified in the attached schedule.

7. Portions of the document titled Long Bay Hospital Correctional Centre Compliance with Commissioner's Instructions and Governor's Directions for Post Duty Nos. 71 and 72 at Tab 18 of Exhibit 1, that revealed daily operational routine including security checks performed by CSNSW staff.

8. Portions of the Inmate Accommodation Journals at Tab 18 of Exhibit 1 that describe the security checks performed by CSNSW staff.

Pursuant to section 65(4) of the *Coroners Act 2009:*

1. A notation is to be placed on the Court file that if an application is made under s 65(2) of the Act for access to the material referred to above, which is contained in the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

2. A further notation is to be placed on the Court file that access is not to be granted to Tab 9 of Exhibit 1 until such time as a Coroner has determined that it is appropriate to grant access pursuant to s 65(2) of the Act.

Magistrate Derek Lee
Deputy State Coroner
25 May 2021
Coroners Court of New South Wales

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Schedule to Annexure A

Order number	Relevant portion of document
4	COPP Section 13.1: At [2.1] on page 4 of 12: whole sub-section. At [2.2] on page 4 of 12: whole subsection other than the first sentence beginning "A serious incident must…" At [2.3] on page 5 of 12: whole sub-section other than first two paragraphs. At [2.5] on pages 5-6 of 12: whole sub-section other than the first sentence beginning "A serious incident must…" and the box titled "Procedure". At [2.6] on page 6 of 12: whole sub-section. At [2.7] on page 6 of 12: whole sub-section other than the first paragraph including bullet-points. At [3.1] on page 7 of 12: whole sub-section. At [3.2] on page 7 of 12: item #3 in the box titled "procedure". At [3.3] on page 8 of 12: whole sub-section. At [4.2] on page 10 of 12: whole sub-section. At [4.3] on page 10 of 12: whole sub-section.
5	COPP Section 13.3: At [2.4] on page 6 of 17: sentence beginning "Cellmates or suspected…" At [6.1] on page 12 of 17: telephone number.
6	COPP Section 13.8: At [4.1] on pages 10-11 of 14: whole sub-section other than the sentence beginning "For forensic evidence on victims…"