CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Conway Perrie
Hearing dates:	18 November 2021
Date of findings:	18 November 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:	2019/308628
Representation:	Ms B Notley, Coronial Advocate Assisting the Coroner Ms N Szulgit for Justice Health & Forensic Mental Health Network Ms S Pickard for the Commissioner of Corrective Services New South Wales
Findings:	Conway Perrie died on 1 or 2 October 2019 at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036. The cause of Mr Perrie's death was complications of chronic renal disease on a background of hypertension and type 2 diabetes mellitus, with cerebrovascular accident, bilateral carotid artery stenosis and atherosclerotic cardiovascular disease being significant conditions contributing to the death, but not relating to the disease or condition causing it. Mr Perrie 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, Conway Perrie was 75 years old and in lawful custody at Long Bay Correctional Complex, serving a sentence of imprisonment. Mr Perrie had a history of chronic kidney disease, which had progressed to an advanced age at the time of his death, together with a number of other significant medical conditions.

1.2 After attending a routine medical appointment at hospital on 1 October 2019 Mr Perrie was returned to his usual accommodation at Long Bay, and later went to sleep that night. The following morning, Mr Perrie was found to be unresponsive in bed, with no signs of life. Despite emergency services being contacted and resuscitation efforts being initiated, Mr Perrie sadly could not be revived and was subsequently 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 Perrie was not appropriately cared for and treated whilst in custody.

3. Mr Perrie'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. Regrettably, only limited information is available regarding Mr Perrie's personal history prior to his incarceration.

3.2 Mr Perrie was born in January 1944 to his parents, James and Eileen, who had previously emigrated from Ireland to Australia. Mr Perrie had three brothers and three sisters and was raised in the Liverpool area in Sydney.

3.3 Mr Perrie married in 1961 and had two children. For a time Mr Perrie worked as a truck driver and on the railways. After approximately 12 years Mr Perrie's marriage ended, and he later formed a long-term defacto relationship with Lynette Towers. Mr Perrie and Ms Towers had a child together, and Ms Towers remained in regular contact with Mr Perrie during his time in custody.

3.4 There is no doubt that Mr Perrie was, and still is, loved by Ms Towers, who has been greatly affected by Mr Perrie's passing and feels his loss most deeply. There is equally no doubt that Mr Perrie is greatly missed by his loved ones and those who knew him best.

4. Mr Perrie's custodial history

4.1 On 31 May 2018 Mr Perrie entered the custody of Corrective Services New South Wales (**CSNSW**) after being charged with a number of sexual assault offences alleged to have occurred between 2003 and 2014. After being remanded in custody, Mr Perrie was later convicted of a number of these offences.

4.2 On 16 July 2018, Mr Perrie was sentenced to an aggregate sentence of 11 years imprisonment commencing on 29 May 2018 with an overall non-parole period of 7 years and 6months, meaning that the earliest possible date that Mr Perrie could be released from custody was 28 November 2025.

4.3 Whilst in CSNSW custody, Mr Perrie was housed at Grafton Correctional Centre, Mid North Coast Correctional Centre and the Metropolitan Remand & Reception Centre. On 11 February 2019 Mr Perrie was transferred to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex, where he remained until his death.

5. Mr Perrie's medical history

5.1 Mr Perrie had a history of chronic renal disease (stage 4 at the time of death) with congestive cardiac failure, hypertension, bilateral carotid artery stenosis, type 2 diabetes mellitus, previous cerebrovascular accident (in 1986), gout and squamous cell carcinoma of the skin (multiple lesions).

5.2 According to Justice Health & Forensic Mental Health Network (**Justice Health**) records, Mr Perrie attended a number of consultations with nursing and medical staff between June 2018 and February 2019 where his multiple chronic health conditions were discussed, and treatment provided.

5.3 Between February 2019 and October 2019, following Mr Perrie's transfer to the MSPC, he also attended a number of scheduled appointments at Prince of Wales Hospital (**POWH**). Relevantly, Mr Perrie attended the POWH Renal Outpatient Clinic on 12 March 2019 for review of his chronic kidney disease.

5.4 In August 2019 a recommendation was made for Mr Perrie to be placed within the Kevin Waller Unit, an aged care unit at Long Bay Correctional Complex, due to his age and frailty. However, because of a shortage in available accommodation, Mr Perrie was unable to be placed at this time.

5.5 On 28 August 2019 Mr Perrie was transferred to the POWH emergency department following a possible syncopal episode. On review, Mr Perrie was found to be tired, but reported no preceding chest pain, shortness of breath or palpitations. An examination was conducted, which was found to be unremarkable, and Mr Perrie was noted to be haemodynamically stable and afebrile. Mr Perrie was subsequently given medication for his blood pressure and discharged, to be followed up by a general practitioner.

6. What happened on 1 October 2019?

6.1 On the morning of 1 October 2019, Mr Perrie was transferred by a CSNSW medical escort unit to the renal department at POWH for management of his chronic kidney disease, arriving at approximately 11:00am. Upon review, no medical concerns were identified. It was noted that recent blood tests indicated stable kidney function, and that potassium bicarbonate, calcium, magnesium and phosphate levels were all within their respective normal reference ranges. Available blood pressure readings also showed optimal blood pressure control. The assessment provided no indication for any urgent repeat blood or urine investigations as no immediate concerns were identified. A number of further tests were arranged with a view to maintaining optimal blood pressure and diabetes control to ensure that the trajectory of Mr Perrie's renal function decline in the coming years was not above greater than what is expected with normal aging. Overall, Mr Perrie's medical health was noted to be stable from a renal perspective, and a subsequent review was to be scheduled in four months' time.

6.2 Following his review, Mr Perrie was transferred back to the MSPC. Upon return, at around 12:30pm, the transporting CSNSW medical escort officers discovered that Mr Perrie had vomited in the rear of the escort vehicle. Mr Perrie was offered nursing assistance from available Justice Health staff but declined, indicating that he had vomited due to motion sickness.

6.3 The CSNSW medical escort officers placed Mr Perrie in a holding yard and (according to the escort officers) a verbal handover was completed with the reception CSNSW officer, advising that Mr Perrie had vomited in the medical escort vehicle. According to the escort officers, the reception officer made arrangements for two reception sweeper inmates to clean the escort vehicle.

6.4 CSNSW inmate telephone service records indicate that Mr Perrie called Ms Towers twice on the afternoon of 1 October 2019, once at 1:00pm and again at 1:54pm. During these phone calls, Mr Perrie advised that he had returned from his scheduled appointment at POWH, and reported that he had been told his renal issues and diabetes were "good" and that the cancer behind his ear had "cleared up". Mr Perrie also mentioned that he had vomited during the return journey from POWH, indicating his belief that this had been caused by motion sickness and/or "diesel fumes" from the escort vehicle. Mr Perrie also advised that the escort officers had offered to seek assistance from a Justice Health nurse, but that Mr Perrie had declined this offer. Overall, it is reported that Mr Perrie sounded positive during these phone calls and mentioned his hope of being transferred "up north" (to a different correctional centre) in the near future.

6.5 Mr Perrie was later returned to his cell and was accounted for (together with his cellmate) during a muster and head check at around 2:20pm. According to Mr Perrie's cellmate, Mr Perrie recounted his escort to POWH and advised that he had "spewed" in the back of the escort vehicle. Mr Perrie's cellmate also recalls that Mr Perrie had his evening meal and routine medication before going to sleep that evening.

7. What happened on 2 October 2019?

7.1 Mr Perrie's cellmate woke up at around 6:00am on 2 October 2019 and turned on a television in the cell. He noticed that a piece of paper had been removed from the cell door observation hole. Mr Perrie was known to have a practice of placing a piece of paper in the observation hole following lock in, and would later remove it at around 4:00am the following morning. Mr Perrie's cellmate observed Mr Perrie to be lying on the bottom bunk of his bunk bed, and asked him to get up. However Mr Perrie did not respond. Mr Perrie's cellmate shook Mr Perrie in an attempt to wake him, without success, and then checked for a pulse. Concerned, Mr Perrie's cellmate informed a "sweeper" who was delivering food to the cell at that time of Mr Perrie's unresponsiveness, and was advised to activate the cell call alarm.

7.2 At around 6:21am on 2 October 2019 Mr Perrie's cellmate activated the alarm and informed the answering CSNSW officer that Mr Perrie was unresponsive and could not be woken. CSNSW officers attended Mr Perrie's cell at around 6:23am and found Mr Perrie lying on his back on the bottom of his bunk bed, unresponsive. Mr Perrie was carefully removed from the bunk bed and placed on the ground. Cardiopulmonary resuscitation was initiated by the attending CSNSW officers, assistance was sought from Justice Health staff and emergency services were contacted.

7.3 Resuscitation efforts continued and NSW Ambulance paramedics later arrived at the scene at around 6:44am. However, despite continued resuscitation efforts, Mr Perrie could not be revived and was pronounced deceased at 6:49am.

8. What was the cause of Mr Perrie's death?

8.1 Mr Perrie was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 8 October 2019. Postmortem CT imaging showed three vessel coronary calcification, heavy calcification of the bifurcation of both carotid arteries, old cerebral infarction in the right inferior cerebellar artery territory, with no acute skeletal trauma (other than resuscitation associated rib fractures). Biochemical analysis of serum and vitreous fluid showed a mildly elevated ketone level, elevated urea and creatinine in keeping with chronic renal disease and an elevated C-reactive protein (a protein marker of systemic inflammation, often elevated in individuals with chronic renal disease).

8.2 Dr Maistry ultimately concluded that the postmortem examination, available medical records and ancillary investigations indicated the cause of death to be in keeping with the complications of chronic renal disease on a background of hypertension and type 2 diabetes mellitus. It was noted that Mr Perrie's history of cerebrovascular accident, bilateral carotid artery stenosis and

atherosclerotic cardiovascular disease were all significant conditions contributing to the death but not relating to the disease or condition causing it.

9. Conclusions

9.1 Having regard to the relevant records from CSNSW and Justice Health regarding Mr Perrie's period in custody, and the findings from the postmortem examination, it is evident that Mr Perrie had a significant medical history which directly contributed to his death on 1 or 2 October 2019.

9.2 As to the time of death, it is evident that Mr Perrie went to sleep sometime on the evening of 1 October 2019 and was found unresponsive in the early morning on 2 October 2019. According to Mr Perrie's cellmate, Mr Perrie had a practice of removing the piece of paper which he placed over the cell door observation hole at around 4:00am. Although the piece of paper was found to be removed when Mr Perry's cellmate woke up, there is no direct evidence as to how this occurred. Given that Mr Perry was last confirmed to be alive on the evening of 1 October 2019, and was found unresponsive the following morning, the time of death is best left as being either on 1 or 2 October 2019.

9.3 The evidence also indicates some degree of inconsistency between what is reported by the escort officers upon returning to the MSPC on 1 October 2019, and the CSNSW officer who was rostered on reception duties at the MSPC from 6:00am to 6:00pm. In essence, the reception officer has no recollection of receiving a verbal handover from the escort officers, being informed that Mr Perrie had vomited in the escort vehicle, or of arrangements being made for an inmate sweeper, or sweepers, to clean the escort vehicle.

9.4 Whilst independent records of the reported verbal handover do not exist, it is most likely that Mr Perry did vomit in the escort vehicle. Further, the evidence also establishes that it is most likely that the escort officers offered Mr Perry nursing assistance from Justice Health staff, but that Mr Perry declined this offer. The accounts provided by the escort officers in this regard are entirely consistent with the account of Mr Perry's cellmate, and the telephone calls that Mr Perry later made to Ms Towers, during which Mr Perry confirmed the vomiting episode and declining the offer of assistance.

9.5 Notwithstanding the above, there is no evidence to indicate that the vomiting episode was connected with the cause of Mr Perry's death. Mr Perry himself provided a reasonable explanation of his own of the vomiting being due to motion sickness and/or the diesel fumes from the escort vehicle. As noted above, Mr Perry had chronic renal disease which had progressed to an advanced stage, together with other comorbidities. Relevantly, no correlation was drawn between the vomiting episode and the cause of death by Dr Maistry in the autopsy report. Further, there is also no evidence that even if Mr Perry had accepted the offer of assistance from Justice Health staff that this potential assistance could have materially altered the eventual outcome.

9.6 Overall, the available evidence indicates that Mr Perrie was provided with appropriate nursing and medical care, to address and treat his various chronic medical conditions, whilst in custody. Mr Perrie was regularly reviewed by renal specialists at hospital, and appropriate investigations were conducted based upon his clinical presentation. Relevantly, the review conducted on 1 October

2019 identified no issues of medical concern, noting that Mr Perrie's health from a renal perspective was stable, or any issue which could have predicted the subsequent events. There is no evidence to suggest that any aspect of Mr Perrie's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

10. 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 Brooke Notley, Coronial Advocate, for her excellent assistance both before, and during, the inquest. I also thank Detective Senior Constable Justin Bell for his 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 Conway Perrie.

Date of death

Mr Perrie died on 1 or 2 October 2019.

Place of death

Mr Perrie died at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036.

Cause of death

The cause of Mr Perrie's death was complications of chronic renal disease on a background of hypertension and type II diabetes mellitus, with cerebrovascular accident, bilateral carotid artery stenosis and atherosclerotic cardiovascular disease being significant conditions contributing to the death, but not relating to the disease or condition causing it.

Manner of death

Mr Perrie 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 Perrie's family and loved ones for their loss.

10.4 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
18 November 2021
Coroners Court of New South Wale

Inquest into the death of Conway Perrie

File Number: 2019/308628

Annexure A

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (the Act), the following material contained within Exhibit 1 is not to be published:

Tab	Document
1	Report of Death to the Coroner (P79A) • names of inmates other than the deceased (Part 1 pp.1-3) • addresses and direct/private numbers of CSNSW staff (Part 1 pp.4, 6) • names and MINs of inmates other than the deceased (Part 1 pp.30, 32-33)
4	Statement of Plain Clothes SC Justin Bell • direct number of CSNSW staff (Part 1 p.29)
8	Inmate Profile Document • names and MINs of inmates other than the deceased (Part 1 p.41) • private contact details of family and friends of deceased (Part 1 p.42)
9	Serious Incident Report • names and MINs of inmates other than the deceased (Part 1 p.48, 52) • private contact details of family and friends of deceased (Part 1 pp.51-52)
13	Report of CO Karina Salazar • names and MINs of inmates other than the deceased (Part 1 p.59)
14	Hospital escorts daily running sheets 1 October 19 • names and MINs of inmates other than the deceased (Part 1 pp.60-61)
16	Statement of Paul Coyne, MoS MSCP • names and MINs of inmates other than the deceased (Part 3 pp.45, 47)
17	Statements of Lauren Alston, FCCO • direct numbers and email addresses of CSNSW staff (Part 1 p.75)
18	Crime Scene Timeline • names and MINs of inmates other than the deceased (Part 1 pp.76-82)
20	Bed Placement extracts • direct numbers of CSNSW staff (Part 1 pp.86-88)
30	CSNSW records • private contact details of family and friends of deceased (investigation report, attachments 1, 17, 24-25 and 27) • direct contact details of CSNSW staff (attachment 25) • names and MINs of inmates other than the deceased (investigation report, attachments 1, 3-8, 10-11, 16-17, 21-22, 25 and 27) • details of the assessment process in arranging a transfer to a hospital and medical escort (attachment 17 and 25) • the names and other information which may tend to identify a child or other person involved in a criminal and/or apprehended violence order (attachment 25)

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 CSNSW documents 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.

Magistrate Derek Lee
Deputy State Coroner
18 November 2021
Coroners Court of New South Wales