CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Vivian David Anderson
Hearing dates:	4 August 2022
Date of findings:	4 August 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Erin Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody - cause and manner of death
File number:	2020/10127
Representation:	Mr Mullen, Coronial Advocate assisting the Coroner Ms Pickard for Commissioner for Corrective Services New South Wales Ms Szulgit for Justice Health and Forensic Mental Health Network
Findings:	I make the following findings pursuant to Section 81 of the Coroners Act 2009 NSW: Mr Vivian Anderson died between 10 and 11 January 2020 at Long Bay Correctional Centre Malabar NSW 2036. Mr Anderson died of natural causes while in lawful custody on remand.
Recommendations	Nil
Non-publication orders:	See annexure A

FINDINGS

1. Mr Anderson was born in Liverpool on April 20 1967, and was 52 years of age. He had been married three times and had four children as a result of his first marriage. He was arrested and charged with serious criminal offences in February 2019 for which he pleaded guilty and was awaiting sentence. He had a history of heart conditions.

2. The records from Long Bay prison indicated that along with myocardial infarctions in 2000 and 2006 and a dilation of one blood vessel attempted in 2006, he also had high cholesterol levels and high blood pressure. He had complained of left sided chest pain while in custody. A stress echocardiography on 13 December 2019 was negative for exercise induced myocardial ischemia.

3. Mr Anderson had been incarcerated since February 2019. On 10 January 2020 he ate dinner with his cellmate and went to bed. He was found the next morning at approximately 4.00 am by his cellmate who raised the alarm. Corrective Officers attended to him; however, resuscitation attempts were unsuccessful.

Why was an inquest held?

4. A Coroner is required to investigate reportable deaths. Mr Anderson's death is reportable and pursuant to sections 23 and 27 of the Coroners Act 2009 an inquest must be held in this case.

5. As part of the Coroners Court functions, the Coroner must attempt to answer questions in accordance with the Act. This involves an investigation taking place to determine the identity of the person, when and where they died, and what was the cause and manner of their death.

6. A person who is detained at law in lawful custody on remand or sentenced to a term of imprisonment for any reason falls into the category of persons for whom an inquest must be held. This is an important process to ensure the protection of such people while they are in the care of the State. It generally will be the case that the conduct of staff from Corrective Services New South Wales (Corrective Services) and Justice Health and Forensic Mental Health Network (Justice Health) will be examined carefully to ensure the State properly played its part in the care of the individual.

7. The focus of this inquest is to ensure that Mr Anderson received adequate medical care while being detained.

Reflection on the life of Mr Vivian Anderson

1.1. Mr Anderson was born in Liverpool, NSW, on 20 April 1967, to parents William and Dawn Anderson, he was the youngest of 5 Children. Mr Anderson's first marriage was to a long-term partner to whom he had 4 children.

1.2. Around 2000 – 2001, Mr Anderson and Ms Anderson divorced. In 2003, Mr Anderson met his second wife, Lisa. Unfortunately, in late 2006, Lisa passed away due to cancer.

1.3. In 2007, Mr Anderson met a new partner, and they commenced a relationship. Initially they lived in Tahmoor, NSW, before relocating to Tara, QLD. In 2019, the relationship ended, and Mr Anderson returned to NSW.

2. Custodial History

2.1. On 5 February 2019, Mr Anderson was arrested and conveyed to Liverpool Police Station where he was charged with serious indictable offences. Whilst in custody at Liverpool Police Station Leading Senior Constable Bradley Gordon, who was the custody manager, found Mr Anderson standing holding his left arm and complaining of previous heart problems. As a result of this an ambulance was called and Mr Anderson was conveyed to Liverpool Hospital. However, he refused treatment and was returned to custody.

2.2. On 6 February 2019, during the completion of the New Inmate Lodgement and Special Instruction sheet, Mr Anderson stated that he took aspirin as he had previously had two heart attacks, suffered high cholesterol and high blood pressure. There was immediate disclosure by him in relation to his health issues.

2.3. There was only one problematic incident while Mr Anderson was in custody after a search of his cell discovered an excessive amount of medication in his possession, this medication was in fact prescribed to Mr Anderson he just had a large collection of it. Ultimately, Mr Anderson was cautioned with no further action.

2.4. On 18 September 2019, Mr Anderson pleaded guilty to two serious indictable offences. He was due to be sentenced on 13 February 2020. At the time of his death, he was remanded at the Metropolitan Special Program (Area 1) and was awaiting sentence.

3. Medical History

3.1. Mr Anderson was a moderate smoker. Upon review of the medical records, it is apparent that he had suffered from two previous episodes of myocardial infarction, one in 2000 and one in 2006 the second event resulting in the insertion of stents.

3.2. On 14 September 2018, Mr Anderson was admitted to Tara Hospital, in QLD suffering from side arm and chest tightness radiating to left arm and jaw. Mr Anderson was transferred to Toowoomba Hospital due to the concerns of cardiac issues, however after a number of tests, he was discharged with a diagnosis of probable musculoskeletal chest pain and possible left lower lobe pneumonia, for which he commenced antibiotics.

3.3. During his time in custody, he was seen regularly by Justice Health. In relation to relevant health concerns, Mr Anderson was seen on the following occasions:

- On 11 March 2019 he presented with a sudden onset of left chest pain, he was alert, orientated and did not appear in distress. He was given paracetamol and ibuprofen.

- On 30 March 2019, he was seen in relation to chest pain and numbness in his left hand, again he was given paracetamol and ibuprofen.

- On 17 June 2019, Mr Anderson was seen by Professor Arun Krishnaan at the Prince of Wales Hospital, patient neurology clinic in relation to review the left arm numbness and weakness.

- On 5 September 2019, Mr Anderson collapsed while in the yard. As a result of this, he was transferred to the Prince of Wales Hospital where he underwent a series of tests, he was ultimately discharged as an outpatient, with an exercise stress test to be organised by the cardiology team.

- On 7 September 2019, a medical response was called, on this occasion Mr Anderson was experiencing light headedness and pain on his left hand side.

- On 13 December 2019, Mr Anderson underwent a stress echocardiograph. His heart rate and blood pressure were at normal rates. The medical conclusion as a result of that testing was that he did not suffer from exercise induced myocardial ischemia.

4. Events leading to his death

4.1. Objective evidence in the form of CCTV assists in determining Mr Anderson's last movements. On 10 January 2020, Mr Anderson can be seen on CCTV footage entering cell 7. The inmates were locked into the cell at approximately 2:36pm. Mr Andersons cellmate told police that after lock in, the two men had a coffee and dinner together. After dinner, Mr Andersons cellmate went to bed, he said that Mr Anderson was still awake and watching the football. Mr Anderson requested to move into the cell with this cellmate. It seems they enjoyed a pleasant friendly relationship. The usual routine was that his cellmate would retire early in the evening as he had an early sweeping shift, and Mr Anderson would stay up watching TV.

4.2. Footage reflects that, at about 7:57pm, two correctional officers undertook rounds checking and locking each cell door. This is the last time correctives staff entered the wing until returning to assist.

4.3. Mr Anderson's cellmate told investigating police that he woke up at around 4.00 am to get ready for work and have a coffee as he usually did, when he noticed Mr Anderson laying on the ground. He immediately knew something was wrong. He then pressed the knock up button to alert correctional staff.

4.4. At approximately 4:00am on 11 January 2020, a Senior Correctional Officer was notified of the incident. The staff attended and acted swiftly. Medical attention was provided, CPR was administered, and a defibrillator was activated. Emergency services were called and paramedics attended.

4.5. At about 4:35am when NSW Ambulance officers arrived they took over the treatment for Mr Anderson. At 5:02am, there was no sign of life and NSW Ambulance officers ceased CPR and Mr Anderson was declared deceased.

5. Cause of death

5.1. On 21 January 2020, a post-mortem was undertaken by Dr Elsie Burger, with the direct cause of death being determined to be ischaemic heart disease.

6. Family Concerns

6.1. Mr Andersons family raised concerns surrounding an impending surgery for Mr Anderson. There was correspondence sent by Mr Anderson to his family, within this correspondence Mr Anderson refers to a "check up" and that they need to conduct more tests and particularly states "but looks like surgery anyway but will see". However, there is no confirmation as to dates, times nor type of surgery mentioned in this letter.

6.2. Justice Health records have been reviewed and there was no impeding surgery arranged. The Prince of Wales Hospital were contacted, and their records reviewed, and that investigation disclosed that there was no surgery booked for Mr Anderson, nor were there any missed appointments by him.

6.3. **Conclusion**

6.4. After carefully reviewing the evidence, it is the case that Mr Anderson was treated appropriately. Justice Health responded appropriately to his health needs, outsourcing to Prince of Wales when necessary to better manage his care. In relation to the response to finding Mr Anderson unresponsive in his cell, the Officers appeared to do all they could in accordance with appropriate policy to try and revive him. He was

treated for his various medical presentations appropriately while in custody, tests were undertaken but were not able to identify Mr Anderson's underlying heart condition.

6.5. The process could not proceed without the investigating officer Detective Senior Constable Victoria Stein and in this case Coronial Advocate Mr Howard Mullen who both have contributed a great deal of work in assisting this inquiry for which the Court is grateful.

Findings

Pursuant to section 81(1) of the Coroners Act (2009)

a. Identity: Mr Vivian Anderson

b. Date: 10 and 11 January 2020

c. Place: Long Bay Correctional Centre, Malabar NSW 2036

d. Cause: Ischaemic Heart Disease

e. Manner: Natural Causes

To the family and friends of Mr Anderson, I offer my sincere and respectful condolences for their loss.

Magistrate E Kennedy
Deputy State Coroner
4 August 2022

ANNEXURE A

Short Minutes of order

4 August 2022