CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Richard Navarro
Hearing dates:	21 July 2022
Date of findings:	21 July 2022
Place of findings:	Coroner's Court of New South Wales
Findings of:	Magistrate Carolyn Huntsman, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody; availability of CPAP machine; natural causes death
File number:	2019/00289826
Representation:	Mr Howard Mullen, Solicitor/Coronial Advocate assisting the Coronial Ms Sian Pickard, Commissioner of Corrective Services Ms Szulgit, Justice Health and Forensic Mental Health Network
Findings:	I make the following formal findings pursuant to s81 of the Coroners Act: (1) Identity: the person who died was Mr Richard Navarro (2) Date: Mr Navarro died on 14 September 2019 (3) Place: the place of death was Westmead Hospital (4) Cause of death: the cause of death was Hypoxic Ischaemic Encephalopathy; antecedent causes being out of hospital cardiac arrest and acute bacterial pneumonia on a background of obstructive sleep apnoea and morbid obesity. Other significant condition contributing to the death but not relating to the disease or condition causing it was hypertension. (5) Manner of death: That the manner of death was natural causes.
Recommendations	Nil
Non-publication orders:	A non publication order was made – refer Annexure A

JUDGMENT

Introduction

1 These written reasons for decision are provided for an inquest into the death of Mr Richard Navarro, who at the time of his death, was in the custody of Corrective Services NSW

2 Under the Coroners Act 2009 (the Act), a Coroner has the responsibility to investigate all reportable deaths. The investigation is conducted primarily to make formal findings as to (1) the identity of the person who died; (2) the date and (3) place they died, and what was the (4) cause and (5) manner of that person's death.

3 An inquest investigates the facts and circumstances of a death, places them on the public record, and in certain cases will examine changes that could be made to prevent similar deaths in the future.

4 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 thoroughly and independently investigated.

5 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 and treatment of that person.

6 The coronial investigation and inquest examines the circumstances surrounding that person's death in order to ensure that the State discharges its responsibility appropriately and adequately.

7 Pursuant to s82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question and to find ways, where possible to stop preventable

deaths. There was no evidence identified to suggested Mr Navarro was not appropriately cared for or treated whilst in custody, however the investigation and inquest examined this issue carefully and these written reasons for decision provide detail.

8 Mr Navarro's family raised some concerns, these have been considered as discussed below.

The evidence

9 The evidence at the hearing was provided by the Officer in Charge of the investigation, Detective Senior Constable Robert Duggan who also provided a witness statement. A detailed coronial investigation was conducted prior to the inquest during which witness statements, medical records, and records of the Department of Corrective Services and Justice Health were obtained. All of that material forms part of the brief of evidence which was tendered to the inquest. Questions were also asked of Corrective Services and Justice Health in relation to access to CPAP machines, this will be detailed below.

10 Witness statements included statements and incident reports by various correctional officers and investigating police. Ambulance records for the ambulance attendance and care of Richard at the custodial facility were obtained and form part of the brief. The brief of evidence also contained the autopsy report, the Justice Health reception screening assessment for the health screening undertaken when Richard entered custody; the Corrective Services cell call reports and statements by cellmates or inmates who shared the cell with Richard. Video and CCTV footage from Corrective Services was also obtained as were crime scene photographs.

Background

11 Mr Navarro was born in the Philippines on 17 March 1976, to parents Virgilio and Ester, and he was the brother to Lyn and Lizza. Richard was married to Charisse and has three children: Tyrone, Jeremy and Caitlin. Although

separated, Richard and Charisse remained married, and he saw his Children regularly.

12 In 1984. Richard and his family moved to Australia. He attended JJ Cahill Memorial High School, in Mascot, before moving to Holroyd High School, where he remained until the completion of year 11. After leaving School, Richard attended TAFE, where he studied spray painting.

13 Prior to his incarceration, Richard was working casually as a process worker. However, Richard was a qualified spray painted, a trade which he had been doing since he was 18, and he would occasionally work for his uncle's, Joe and Danilo who owned a smash repair shop in St Marys' and another location near the city.

Custodial History

14 On 11 September 2019, Richard was arrested by police in relation to two outstanding warrants. He was conveyed to Blacktown Police Station and refused bail, to appear before Blacktown Local Court on the same day.

15 Richard appeared before Blacktown Local Court where bail was refused, and the matter was adjourned to Blacktown Local Court on 25 October 2019. Richard was transferred from the Blacktown Police Station to the Metropolitan Remand and Reception Centre (MRRC) at Silverwater. He underwent the inmate lodgement process which included a reception screening assessment.

16 During the screening assessment Richard was assessed as not being a risk to himself or others, and he told the nurse that he had been diagnosed with Sleep Apnoea in 2005 and was currently prescribed a continuous positive airway pressure machine (CPAP), being a machine that provides air at a pressure to prevent the collapse of a person's airways.

17 As a result of the information obtained at the screening, a Health Problem Notification Form was completed and provided to Corrective Services NSW,

which indicated that Richard had this condition and requested that he been given access to a CPAP machine in his property.

18 Richard contacted Charisse and asked her to bring his CPAP machine. He told her to bring it in the next morning. Charisse then rang Richard's sister, Lizza, and asked her to take the machine to Silverwater. Lizza told police that she had planned to take it in the morning.

19 Richard was housed in MRR (Metropolitan Remand and Reception Centre) - Goldsmith Unit 14, Cell 255, bed 2 at Silverwater Correctional facility. He was transferred from Silverwater to Westmead Hospital for treatment.

Medical History

20 Richard was about 170cm tall and weighed 155kgs. In 2007, he was diagnosed with obstructive sleep apnoea (OSA) by his General Practitioner, Dr Mona Bishay, and a sleep study and review by a specialist was undertaken in 2010. As mentioned above, he was prescribed a CPAP machine.

21 Richard's sister, Lizza told police that in 2017, Richard went to the Philippines for a holiday. Whilst he was there, he contracted swine flu. Upon his return to Australia, he was diagnosed with swine flu, and he spent some time in Blacktown Hospital. During his admission, he was diagnosed with severe pneumonia. She told police that the pneumonia became a recurring illness, and in her view, he was always chasing his breath. She told police that Richard's CPAP machine is custom-made for him with an extra-large mask which is fitted to his face. She stated a belief that if his CPAP machine was unavailable, perhaps another machine could have worked to support his breathing.

22 Hospital records obtained as part of the coronial investigation, include the records of an admission for drug and alcohol detoxification in 2003 and an admission in 2017 for respiratory issues. In December 2017, Richard attended Westmead Hospital where he complained of Chest discomfort, together with dizziness and slight shortness of breath. The 2017 records indicate that after admission he was reviewed by the Cardiology Rapid Assessment Team, at the

Rapid Access Clinic at Westmead Hospital on 21 December 2017. In their report it was noted that he was referred by the Emergency Department to the clinic and it was noted that Richard had a history of smoking 10 to 15 cigarettes a day, with a 20 pack year history, no regular alcohol and that two aunts had died from AMI (acute myocardial infarction) in their 50s. The initial admission to hospital for atypical chest pain was noted by the Clinic. Mr Navarro's exercise tolerance, of walking for about five minutes, was observed, as was the fact that he did not take regular exercise.

23 The risk factors identified by the Cardiology Rapid Assessment Team included the increased body mass index (BMI), hypertension, borderline diabetes, and cholesterol level, in addition to the history of smoking and the positive family history of ischaemic heart disease with two maternal aunts passing from this cause in their 50s. Significant cardio-risks were therefore identified in 2017.

24 The Cardiology Rapid Assessment Team, at the Rapid Access Clinic, arranged as follow up, a stress test as well as follow-up to review of pathology results. The management from a cardiovascular perspective was planned to include risk reduction by lifestyle modifications including changing his diet, regular exercise, cessation of smoking and ongoing review and management of his hypertension and prediabetes. The GP records did not indicate that the lifestyle changes recommended in 2017 assessment had been made by 2019.

25 The 2017 cardiac clinic assessment noted the ECG results were sinus tachycardia and follow-up with GP for risk factor modification and motivating lifestyle changes was recommended. Additionally the follow up plan was put in place whereby Richard was to organise an Exercise Stress Test, a follow up with the clinic and his GP. It appears that Richard did not undertake the Exercise Stress Test and there was no follow up with the clinic in relation to these tests.

26 Records obtained from his general practitioner, Dr Bishay, indicate that investigations for sleep apnoea began in 2007 when a referral to a sleep disorders clinic was made by his GP. A letter from Sleep Services Australia by

the Respiratory and Sleep Physician, dated 25 October 2010, indicated that Mr Navarro had severe obstructive sleep apnoea present throughout the night. The sleep study was conducted on 13 October 2010 and treatment with a CPAP was recommended, as was weight loss, cessation of cigarette smoking, and annual sleep studies to assess adequate adequacy of treatment. There is no evidence that Richard did attend for annual sleep studies. Richard did have some admissions to hospital for respiratory issues over the years, including the emergency admissions in 2017 and 2019.

27 Richard was referred by his GP for dietary intervention and counselling in 2012 due to obesity. The assessment of the dietician was that Richard was more than morbidly obese. The report to the GP of 13 August 2012 states that the facts of obesity and ways to manage it including through diet and exercise as well as other measures, were explained to Richard.

28 The records of the GP indicate that while cigarette smoking may have been reduced it had not been ceased. In a visit of August 30, 2019, Mr Navarro reported feeling unwell and was advised by the general practitioner to attend accident and emergency. The reason for contact was stated to be “Richard still uses ICE, stopped heroin, induced coma during last hospital admission…. Still smokes, uses opiates, returned from Philippines with swine flu and bronchopneumonia”

29 Discharge summaries for hospital admissions contained in the General Practitioner’s medical records indicate that Richard was admitted to Blacktown Hospital as an inpatient in May 2019. He presented at Blacktown Hospital on 17 May 2019 and was admitted to intensive care unit (ICU) for management of community-acquired streptococcus pneumonia. He was discharged home on 20 May 2019. During the admission to ICU he was intubated, but was well after being stepped down from ICU. The chest CT scan showed collapse/consolidation involving multiple bilateral lower pulmonary lobe segments with further ground glass changes in upper lung lobes. The past medical history of swine flu in January 2019 at RPA Hospital and history of

polysubstance drug abuse was noted in the records. It was also noted that the heart was enlarged although no oedema was observed.

30 The discharge summary from Royal Prince Alfred Hospital for the admission of January 2019 notes that Richard was admitted to RPA Hospital from 23/1/2019 until 29/1/2019 under the care of a respiratory physician, he was diagnosed with H1N1 influenza. He was brought into hospital by police after concerns he was driving erratically and involved in a minor motor vehicle collision. On presentation to the Emergency Department he was febrile, tachypnoeic, hypoxic and found to be in acute hypercapnic respiratory failure on a background of OSA with a home CPAP. He was commenced in hospital on a BiPAP machine and started on antibiotics. His admission was complicated by development of a new fever on 26 January 2019; and chest x-ray at that time demonstrated new bilateral patchy consolidation and his antibiotics were broadened to include new antibiotics to cover for possible MRSA pneumonia. A chest CT scan done on 28 January demonstrated consolidation consistent with bronchopneumonia. Antibiotics were continued but on 29 January 2019 Richard expressed a desire to discharge home against medical advice. He was advised of the risk of clinical deterioration possibly leading to sepsis, recurrent respiratory failure and even death. He remained firm in his decision to discharge and subsequently signed a form advising that he was aware that this was against medical advice. He has provided a prescription for further medications after discharge and told to follow-up with his GP for review; and if breathing worsened he was advised to return to the emergency department.

31 From the evidence obtained, it is apparent that Richard had sleep apnoea from at least 2007, that is for a period in excess of 10 years, and obesity for which help was sought in 2012, and some symptoms observed during hospital admissions of pneumonia requiring treatment in ICU (2017, 2019). The evidence indicates that Richard had serious health challenges for several years and was not, medically speaking, a well man.

32 It also appeared that while he used his CPAP machine regularly he did not always follow medical advice for treatment as well as for follow-up with

assessments or reviews – this conclusion follows from the discharge against medical advice in January 2019, and the evidence that Richard did not return for the follow up tests recommended by the Cardiology Rapid Assessment Team, at the Rapid Access Clinic at Westmead Hospital on 21 December 2017 (for pathology tests and stress tests). The conclusion is further supported by the medical notes which indicate that advice such as ceasing smoking, change of diet, losing weight, were not followed. Whether this was due to his drug and alcohol addiction and the challenges this posed to engagement with treatment cannot be known. Richard was a participant in the Drug Court Program in 2012, and the medical and custodial records indicate ongoing challenges with substance abuse including heroin and methamphetamine (ICE). That this was an ongoing issue is supported by the medical records of the general practitioner referred to above.

33 What is clear is that Richard regularly used his CPAP machine and would have used it in custody on the first night he was there if it had been available to him. The circumstances of his access to the CPAP machine have therefore been a focus of the coronial investigation which will be addressed below.

Events leading to his death

34 On reception into custody Justice Health completed health screening assessments which noted the sleep apnoea and CPAP machine and that he had had this condition for 30 years. Richard's sister, Lizza, told police that when Richard was arrested and taken into custody she was aware that he called his wife, Charisse, and asked her to bring in his CPAP machine and that she told him she would bring it in the next morning. Charisse telephoned Lizza and asked Lizza to take it to him in the morning, and Lizza was planning to do so the next morning, but on that night Richard passed away, so she was unable to give him his CPAP machine. What this meant is that on his first night in custody Richard was without the CPAP machine, this issue is further examined below.

35 On 12 September, Richard was placed in pod 14, cell 225, with two other inmates. From the evidence obtained, Mr Navarro was the first person in the

cell. By about 7:35pm the two other inmates had been placed in the cell with Richard.

36 The two inmates tell police that the three men conversed until about 8.30/ 9.00pm, when the cell lights were turned off. The two inmates then continued to converse with Richard falling asleep almost instantly once the lights had been turned off. The two inmates describe Richard as snoring loudly.

37 The inmates stated that Richard was snoring for about an hour before they decided to ask him to stop. Both inmates told him to stop, however they were unsuccessful in their attempts. As a result, one of the inmates got down off the top bunk and shook Richard's leg, again this was unsuccessful in waking Richard or stopping the snoring.

38 Due to his snoring, the inmates continued to attempt to wake Richard, they state that this was over a 5–10-minute period. Initially, Richard did not stop snoring, however the inmates tell police that the snoring stopped suddenly, and Richard slumped on his side.

39 Richard was described as, at that point, being loose like jelly and that it was obvious that he had stopped breathing. Although the light, inside the cell, was not on, the inmates were able to see Richard due to the light coming from outside the cell. Because the inmates were unable to tell whether or not Richard was breathing, they pressed the knock up button for assistance.

40 Shortly after the knock up call, corrective service staff and Justice Health staff attended the cell. Triple zero was called and CPR was commenced until Ambulance crew arrived and took over.

41 While Richard initially responded to medical intervention, it was determined that he would be required to be transferred to Hospital as his condition was critical. Mr Navarro was transferred to Westmead Hospital, where he was placed in Resus Bay 1 and treatment commenced by Hospital staff.

42 After a short period, Richard was transferred to the Intensive Care Unit, where he was intubated and diagnosed with hypoxic brain injury.

43 Richard was declared brain dead on 14 September 2019 at 1:49pm. His family made the difficult, yet generous, decision to consent to organ donation.

44 Richard remained on artificial maintenance (blood/respiration) until 16 September 2019, when his organs were removed for donation.

Cause of death

45 On 19 September 2019, a post-mortem examination was performed by Dr Melissa Thompson, forensic pathologist. Due to Dr Thompson's subsequent departure from Forensic Medicine, a staff specialist forensic pathologist from Forensic Medicine, Dr Maistry, completed the written autopsy report.

46 The pathologist noted that Richard was an inmate at Silverwater correctional facility with a significant elevated body mass index (BMI) and obstructive sleep apnoea requiring a bilevel positive airways pressure therapy. The pathologist noted there had been several hospital admissions for community-acquired pneumonia due to hypercapnic respiratory failure, the most recent being 30 August 2019, however the on that occasion Richard discharged himself, on 1 September 2019. The pathologist also noted that Richard was known to have hypertension and polysubstance abuse. The pathologist noted that on 12 September 2019 he had been in his cell at around 9:30pm, snoring loudly before breathing erratically and becoming silent, and staff were summoned to the cell and CPR was initiated and ambulance contacted.

47 The pathologist reviewed the Westmead Hospital medical records and noted the CT brain examination demonstrated hypoxic ischaemic encephalopathy and a chest x-ray showed extensive lung consolidation. A CT pulmonary angiogram identified no pulmonary embolism and a urine drug screen detected the presence of opiates but these were likely administered during resuscitation efforts. Richard remained in a critical condition in the intensive care unit - a urine screen was positive for Streptococcus pneumonia antigen. Given advice

that testing indicated brain death a family meeting consented for organ donation by Richard.

48 The pathologist noted the post-mortem CT imaging showed extensive bibasal pneumonias, and internal examination revealed an enlarged heart with hypertrophied left ventricle, and extensive bilateral pneumonias. There was severe acute pneumonia revealed on histological examination. There were no significant results on toxicological examination (no toxicological results indicating any substances which contributed to his death).

49 In the discussion section of the autopsy report, the pathologist noted that Streptococcus pneumonia is a bacterium responsible for the majority of community-acquired pneumonia. Obstructive sleep apnoea can predispose individuals to lower airway infections and community-acquired pneumonia.

50 The pathologist, after considering the post-mortem examination results and upon review of the medical records, found that the cause of death was hypoxic ischaemic encephalopathy, due to out of hospital cardiac arrest, secondary to acute bacterial pneumonia on a background of obstructive sleep apnoea and morbid obesity, and that hypertension was a significant contributing condition.

51 An expert report, in relation to CPAP machines, was obtained from Dr Nicholas Murray, a Consultant Physician in Respiratory and Sleep Disorders. This was obtained by the coronial investigation to consider the issue of availability of the CPAP machine for Mr Navarro, and also to better understand the conditions suffered by Mr Navarro. In relation to cause of death Dr Murray considered several matters and observed that he would not call into question the fact that Mr Navarro had a hypoxic ischaemic encephalopathy as a cause of death. Dr Murray did state a belief that, potentially, this may be linked to a prolonged cardio ventilatory arrest. It is noted that this opinion does not conflict with the pathologist's opinion that the hypoxic ischaemic encephalopathy was due to out of hospital cardiac arrest, observing the presence of the pneumonia on the background of obstructive sleep apnoea and morbid obesity and hypertension. It is important to note this opinion of Dr Murray was part of a large discussion

in his report of many factors, including his observation that sudden death is also a documented rare complication of sleep disordered breathing, and that medical literature sheds only partial light on the topic. Dr Murray explains that a small series of 25 patients with the condition who died suddenly showed that only two of them had normal hearts. Similarly, Dr Murray observed that there is not a strong body of evidence regarding causes of death in those with obesity hyperventilation syndrome (OHS), a condition he suspected Mr Navarro to have, although he could not say that Richard did have OHS (this is discussed further below).

52 Dr Murray observed that it was clear that there is an elevated risk of sudden death in those with obesity, and the limited evidence available tends to identify cardiac abnormalities, if any, as likely causes of such death. He noted Mr Navarro had an enlarged heart.

53 Significantly, Dr Murray was unable to find literature that demonstrates an improvement in the risk of sudden death, in those with sleep disordered breathing treated with any kind of PAP. Dr Murray's expert opinion in relation to the availability of the CPAP machine is detailed further below.

Family Concerns

54 Richard's family have raised concerns about him not being asked about his medical conditions. I observe that the evidence shows that Richard's condition was raised in the reception screening assessment, and arrangements had been made to have Richard's CPAP machine brough to him from his property, however it was not in his property, and was to be brought to him the following morning.

55 Family also had questions in relation to the response time. The evidence shows that the knock up call was made by his cell mates at 9:43pm (calling for assistance) and this was soon after Richard appeared to his cell mates to have stopped breathing; and the correctives staff attended at 9:47pm, and at the same time a radio call was made for the ambulance to be called. CPR was commenced at 9:48pm, with Ambulance officers arriving at 9:49pm. The

statement of the officer in charge of the police investigation indicates that ambulance paramedics were already at the gaol attending to an unrelated inmate when they were asked by correctional officers to assess Richard. They took over CPR from correctional officers and continued that until the intensive care ambulance arrived at the scene and took over care. This supports a finding that the call for assistance and provision of CPR and other aid to Richard was not delayed.

Findings on the evidence

56 As mentioned earlier, when a person is lawfully detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person dies of apparent natural causes, their death is required to be properly and independently investigated to assess whether the State has discharged its responsibility.

57 The Corrective Services records reveal that Mr Navarro's care and treatment was appropriate. There was ability for Richard's cell mates to call for assistance and the corrections officers on duty promptly responded. The ambulance was called without delay and all actions which could be taken to try to assist Richard and maintain his life were taken both at the correctional facility and Westmead Hospital.

58 Mr Navarro had been asleep at the correctional facility from about 8.30/9.00pm to when he was observed to stop breathing at 9.40/9.43pm – a period of approximately one hour. During this one hour period of sleep he did not have access to his CPAP machine.

59 There is no evidence to suggest that there was any third-party involvement in Mr Navarro's death and no suspicious circumstances. There is also no evidence to suggest that any action or omission by either Corrective Services or the Justice Health and Forensic Mental Health Network contributed to Mr Navarro's death in any way.

The availability of the CPAP machine

60 As part of the coronial investigation enquiries were made with both Corrective Services and Justice Health Network in relation to access to CPAP machines for inmates.

61 Dr Murray, expert in respiratory and sleep disorders, in his written report voiced the opinion that Mr Navarro had very severe obstructive sleep apnoea (OSA). Dr Murray explains that OSA is a condition characterised by recurrent partial or complete obstruction of the upper airway that leads to repetitive, frequent interruption of sleep. Mr Navarro was diagnosed with OSA in 2010, and managed with CPAP therapy. Dr Murray observed that his sleep study in 2010 did not show any features of the sustained hypoxaemia that is typical of more severe sleep hyperventilation.

62 Dr Murray voiced the suspicion that Mr Navarro, in addition to OSA, may have had undiagnosed obesity hyperventilation syndrome (OHS), a much more dangerous condition. OHS is a much rarer and more dangerous abnormality of breathing during sleep and, when present, usually coexists with OSA. Dr Murray also observed that Mr Navarro had gained 40 kg in weight since the 2010 study which may have worsened his situation. Given his morbid obesity Dr Murray was of the view that Mr Navarro's sleep disordered breathing had evolved into an OHS - although he notes this was not diagnosed and was never proven directly. Dr Murray indicates this is his belief, but concedes OHS was undiagnosed and unproven in Mr Navarro's case.

63 In relation to the role of the CPAP machine, Dr Murray noted that, anecdotally, few sleep physicians would be perturbed by the possibility of allowing a patient with very severe but uncomplicated sleep apnoea to spend a night without CPAP therapy. At the other end of the spectrum, any reasonable sleep physician will be unwilling to allow a patient with advanced hypercapnic respiratory failure - in the setting of OHS - to delay more than an hour or two before being placed on appropriate non-invasive ventilation. However as

previously noted, Dr Murray was unable to state that Mr Navarro had OHS. Dr Murray further observed,

> "no suspicion of OHS was raised by any aspect of Mr Navarro's history or his assessment; nevertheless, I have a strong belief that this is what he had and this is what led to his death. Without quite specific training in sleep medicine, I would not expect that the jail staff should have been able to identify his risk of progression to fatal respiratory failure, not least because I see the medical and nursing staff of a major teaching hospital fail to do so on a regular basis".

64 In relation to whether the emergency responses were appropriate, Dr Murray noted that he was not an emergency physician or intensive care physician and therefore his expertise in this area was limited, but within the limits of his expertise he was unable to identify any significant deficits in the quality of care provided in the emergency phase of treatment.

65 Dr Murray was asked, as part of the coronial investigation, to consider whether there should be CPAP machines available for prisoners who have come into custody and any other preventative measures. He did state that a screening tool should be developed which was specific for sleep disorders and apnoea, and some CPAP machines/equipment should be kept in the gaol if an inmate arrives without their own equipment. Given this recommendation, information was sought from the Department of Corrections as well as the Justice Health Network.

66 A solicitor for Corrective Services advised the coronial investigation, in response to inquiries made during the coronial investigation, that Corrective Services offices were unable to implement a screening instrument to be used by correctional officers to screen for high-risk sleep disordered breathing, at the clinical assessment stage of new inmates, because the Forensic Mental Health Network staff are responsible for conducting the clinical assessment of new inmates. Corrections officers are not clinically trained to determine whether an inmate is at risk of sleep disordered breathing. Correctional officers' medical functions are limited to administering first aid in medical emergencies and calling for the assistance of Justice Health Network staff and call the ambulance. However, Corrections Officers will follow, during operations,

Justice Health Network staff advice and directions. Corrective Services also advised that Corrections staff are not responsible for stocking medical equipment or for allocating medical apparatus to inmates. Clinical health matters fall under the responsibility of the Justice Health Network. Corrections will scan CPAP equipment when it arrives at a Correctional Centre and will then provide the equipment to Justice Health Network staff.

67 Justice Health Network were asked about the ability for Justice Health Network to implement a screening instrument for high-risk sleep disordered breathing at the clinical assessment stage of new inmates, to identify a need for clinical review or sleep clinic review. Justice Health responded that this was not something that the Network has the expertise or resources to do. Treatment for sleep apnoea is driven by specialist units in the community, who assess specifically for sleep apnoea and whether a CPAP machine is used. If patients arrive to custody with their CPAP machine then Justice Health aim to continue their use, and referral to an external respiratory specialist for ongoing management would be necessary for any ongoing management requirements. Justice Health Network works with the public hospital system to obtain specialist assessment and treatment for patients and referrals take time. Justice Health submitted that it is accepted that even in the community, referrals being actioned in a timely manner, is a challenge for the public health system.

68 In response to an enquiry as to whether Justice Health Network keep on hand a supply of CPAP equipment, including a reasonable repertoire of mask interfaces, to allow replication of usual therapy for inmates at risk, the Network responded as follows. CPAP machines are very expensive and equipping facilities, on a Statewide basis, with appropriate equipment would have resource implications. Network clinics presently fund repairs of existing machines and purchase units when patients are prescribed CPAP by respiratory specialists, and all Network treatment is guided by relevant specialists.

69 The findings I make, in relation to the advice provided by Corrective Services and Justice Health Network, and after consideration also of Dr Murray’s report,

in relation to screening for respiratory issues and the provision of CPAP machines or a similar equipment, is as follows. Corrective Services officers and staff are not trained or equipped to make such diagnostic decisions or to decide what is an appropriate CPAP machine for an inmate. The need for, and use of CPAP machines, is diagnosed by qualified medical specialists. Justice Health Network are guided by relevant specialists, such as respiratory and sleep specialists, and will promote the obtaining of a CPAP machine when recommended by such specialists, and repair existing machines to support inmates who are diagnosed as needing such items.

70 As Coroner, on the evidence in this matter, I cannot make any criticism of the need to rely on specialists for the diagnosis of sleep apnoea and prescription/direction of support/treatment required for such apnoea. I note that in Mr Navarro's case his CPAP machine and mask was customed designed which indicates the complexities of treatment of this condition.

71 What I do observe is that action was taken by Corrections staff and Justice Health, as detailed above, to ensure that Richard had access to a CPAP machine in his property. The CPAP machine was not in his property and family were going to bring it to him the following day. There was no failure by Corrective Services or Justice Health, on the evidence before the inquest, to facilitate access to the CPAP machine.

72 I also note the opinion of Dr Murray that Mr Navarro may have had a more serious disorder (OHS) which was undiagnosed and more dangerous, and that Corrections staff could not have diagnosed this condition and associated risks. I observe that despite the recommendation in 2010 for annual sleep studies/assessment this did not occur. The evidence indicates that Mr Navarro self discharged from hospital against medical advice on more than one occasion in 2019, and did not follow the recommendations made by the Cardiology Rapid Assessment Team, at the Rapid Access Clinic at Westmead Hospital, on 21 December 2017. He also appears to have not followed medical advice to minimise risks associated with his medical conditions (cigarette smoking, obesity).

73 That Mr Navarro did not engage with recommended screening tests and other medical advice (including regular sleep studies after 2010) would have meant that even his family members, who clearly loved and cared for him, had no way of knowing how serious his condition might be.

Manner of death

74 The medical evidence, of the forensic pathologist and Dr Murray, supports a conclusion that Mr Navarro had substantial health conditions which were long standing – the sleep disorder since 2007 with confirmation that it was serious by the sleep study of 2010, and the obesity was reviewed, with risk reduction strategies advised, in 2012. As at 2019, it appeared his health had deteriorated partly due to weight gain, increasing the risk of sudden death, as detailed above. He had an enlarged heart and various risk factors. The increasing number of hospital admissions for community acquired pneumonia in 2019, including that Mr Navarro would discharge himself against medical advice, provides further evidence of deteriorating health leading to a greater risk of sudden deterioration. Whilst the CPAP machine was important in reducing risk by maintaining airways pressure, on the evidence I cannot be satisfied that the absence of the CPAP machine during the approximately one hour of sleep before he died, contributed to his death, especially in the context of the medical evidence in this matter, and the evidence of his ongoing serious medical conditions. The manner of death is therefore natural cause.

Formal findings

75 I make the following formal findings in this inquest pursuant to section 81 of the Coroners Act.

(1) Identity: the person who died was Mr Richard Navarro

(2) Date: Mr Navarro died on 14 September 2019

(3) Place: the place of death was Westmead Hospital

(4) Cause of death: the cause of death was Hypoxic Ischaemic Encephalopathy, with antecedent causes being out of hospital cardiac arrest and acute bacterial pneumonia on a background of obstructive sleep apnoea and morbid obesity. Other significant condition contributing to the death but not relating to the disease or condition causing it was hypertension.

(5) Manner of death: That the manner of death was natural causes.

Closing

76 I acknowledge and express my gratitude to Solicitor and Coronial Advocate Assisting the Coroner, Senior Constable Howard Mullen, for his assistance both before and during the inquest. I also thank the investigating Police Officer in Charge of the investigation, Detective Senior Constable Robert Duggan, for his work in the Police investigation and compiling the evidence for the inquest.

77 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Mr Richard Navarro

78 I close this inquest.

Magistrate Carolyn Huntsman

Deputy State Coroner

Coroners Court of New South Wales

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Annexure A

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published:

    a) Within materials originally owned or produced on behalf of the Commissioner of Corrective Services New South Wales (**CSNSW**), the names, addresses, phone numbers, Visitor Index Numbers and other personal information that identifies or might identify any family member, friend or person, other than Mr Navarro (other than legal representatives or visitors acting in a professional capacity).

    b) The names, Master Index Numbers and other personal information of any persons in the custody of CSNSW, other than Mr Navarro.

    c) The personal details of correctional staff, including private numbers and staff identification numbers.

    d) CCTV, body worn camera and handheld video footage, including any stills of that footage and crime scene photographs.

    e) References to the location and serial numbers of CCTV cameras, use of restraints and procedural escort decisions that are not publicly available.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on 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.