



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Anthony Sampieri
Hearing date:	12 September 2023
Date of findings:	12 September 2023
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of inmate at Long Bay Correctional Centre – natural causes death.
File number:	2021/87981
Representation:	Coronial Advocate assisting the inquest: Senior Constable K Jiang. Justice Health and Forensic Mental Health Network: M Sterry. The Commissioner, Corrective Services NSW: M Williams, Department of Communities and Justice.

Findings:	<p>Identity The person who died is Anthony Sampieri.</p> <p>Date of death: Anthony Sampieri died on 28 March 2021</p> <p>Place of death: Anthony Sampieri died at Prince of Wale Hospital, Correctives Annex</p> <p>Cause of death: The cause of Anthony Sampieri's death is hepatocellular carcinoma and its complications.</p> <p>Manner of death: Anthony Sampieri died of natural causes while he was in lawful custody.</p>
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Non publication orders

Orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* [the Act] have been made in this inquest. A copy of these orders, and corresponding ones pursuant to section 65(4) of the Act, can be found on the Registry file.

Section 81(1) of the Act requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Anthony Sampieri.

Introduction

1. On 28 March 2021 Anthony Sampieri aged 57 years died in Prince of Wales Hospital. Mr Sampieri was in lawful custody at the time, having been convicted on 12 February 2020 of serious offences.
2. Mr Sampieri had a diagnosis of end stage hepatocellular carcinoma. On 18 March 2021 he was transferred from Long Bay Correctional Centre to the Prince of Wales Hospital for palliative care. He died there ten days later.
3. Since Mr Sampieri was in lawful custody at the time of his death, an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

4. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

5. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The post mortem report

6. A post mortem examination following Mr Sampieri's death found the cause of his death to be hepatocellular carcinoma and its complications. He had no injuries.

Mr Sampieri's background

7. Mr Sampieri was born on 14 December 1963, to parents of Italian descent. The couple had moved to Australia from Egypt before Mr Sampieri and his younger brother were born.
8. In 1980 Mr Sampieri's parents separated. His mother described him as being afraid of his father who was '*very severe on him*'. He did not complete school, and commenced using drugs and alcohol.
9. In his early twenties Mr Sampieri met his then partner and they had two sons. When the boys were aged seven and nine years, the couple separated and the boys saw little of their father.
10. Mr Sampieri was incarcerated in 2013 and released to parole in 2017. He lived with his mother, who was concerned to see that he had increased his use of alcohol. He had little social contact and she considers that he was depressed.
11. By the year 2018 Mr Sampieri was injecting methamphetamines on a daily basis. On 15 November 2018 he committed very serious offences for which he received life sentences on 12 February 2020.
12. In custody, Mr Sampieri was kept in segregation due to the nature of his offences. He received pastoral support from the prison's chaplaincy service.

Mr Sampieri's medical history

13. Mr Sampieri had a number of serious health conditions. They included cirrhosis of the liver, which was diagnosed in 2012 and was secondary to Hepatitis C viral infection. Mr Sampieri also had liver disease, portal hypertension, mild hepatic encephalopathy and type 2 diabetes mellites for which he used insulin.
14. Mr Sampieri had started drinking alcohol at a young age and used cannabis when he was 13, progressing to amphetamines and heroin. He commenced using intravenous methamphetamines in his late thirties, with increased alcohol consumption to deal with his drug withdrawals. Although he attempted a number of drug rehabilitation programs, he was only able to achieve abstinence for about six months before relapsing.
15. In 2018 Mr Sampieri was diagnosed with hepatocellular carcinoma. While in custody he received treatment of chemoembolism, which was provided to him at

Prince of Wales Hospital. Despite this, his disease progressed and he received further courses of treatment.

16. In October 2019 Mr Sampieri's liver disease was assessed to be at its end-stage, with about a 60% chance of survival over a five year period. Despite medical treatment Mr Sampieri's liver began to fail due to his carcinoma. In March 2021 he was transferred to the Correctional Annex at Prince of Wales Hospital. He was placed in palliative care a few days later.
17. Mr Sampieri's two sons and his mother attended his bedside on 28 March 2021. His condition was monitored by staff of the Justice Health Network, with the final check performed at 8.25pm. When he was checked a few minutes later there were no signs of life, and he was pronounced deceased.
18. In a report from Mr Sampieri's oncologist, Clinical Conjoint Professor David Goldstein stated that Mr Sampieri had received appropriate treatment for his liver cancer, and that he had been well supported in his care through the course of his illness.

Conclusion

19. The time, place, cause and manner of Mr Sampieri's death are able to be established on the evidence. Furthermore, I am satisfied on the basis of the evidence that Mr Sampieri's death was medically expected, and that he received appropriate medical care while he was in custody.
20. The evidence in this case does not disclose any systemic failings or other basis for recommendations.
21. I thank Coronial Advocate Senior Constable Kai Jiang for his assistance in the preparation and conduct of this inquest.
22. I convey to Mr Sampieri's family my condolences for his death.

Findings required by s81(1)

23. As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity:

The person who died is Anthony Sampieri.

Date of death:

Anthony Sampieri died on 28 March 2021

Place of death:

Anthony Sampieri died at Prince of Wales Hospital Correctives Annex

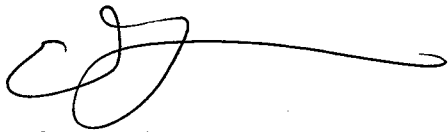
Cause of death:

The cause of Anthony Sampieri's death is hepatocellular carcinoma and its complications.

Manner of death:

Anthony Sampieri died of natural causes while he was in lawful custody.

24. I close this inquest.

A handwritten signature in black ink, consisting of a large, stylized 'E' followed by a long horizontal line that tapers to a point.

Magistrate E Ryan

Deputy State Coroner, Lidcombe

Date

12 September 2023