New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Francis William Athol Cable
Hearing dates:	15 May 2025
Date of Findings:	15 May 2025
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:	2022/273459
Representation:	Ms K Mackay, Coronial Advocate Assisting the Coroner Ms K Guilford for Justice Health & Forensic Mental Health Network Ms L Ovens for the Commissioner of Corrective Services New South Wales
Findings:	Francis William Athol Cable died on 12 September 2022 at the Corrective Services NSW Secure Annex within Prince of Wales Hospital, Randwick NSW 2031. The cause of Mr Cable's death was pneumonia complicating ischaemic heart disease. Mr Cable 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 Francis Cable was in lawful custody serving a sentence of imprisonment at the time of his death on 12 September 2022. He had a history of cardiac and respiratory issues for which he had been provided treatment during his time in custody. On 5 August 2022, Mr Cable was transferred to Prince of Wales Hospital (**POWH**) following a deterioration in his condition.

1.2 Despite an initial period of improvement during the course of his admission, Mr Cable's condition deteriorated significantly on 11 September 2022. In the early hours of the morning on 12 September 2022, Mr Cable was found to be unresponsive and showing no signs of life. A rapid response was called but no resuscitation was initiated in accordance with an existing advanced care plan. Mr Cable was pronounced life extinct a short time later.

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. This type of examination typically involves consideration of, where relevant, the conduct of staff from Corrective Services New South Wales (**CSNSW**) and Justice Health & Forensic Mental Health Network (**Justice Health**). It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Cable was not appropriately cared for and treated whilst in custody.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Mr Cable'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 Cable was born in 1932 to Edward and Jane Cable. He was the youngest of two children. Mr Cable spent his childhood in Townsville. Mr Cable's older brother died in 1984.

3.3 Mr Cable was a Marist Brother between 1952 and 1978. He worked as a teacher at Marist Brothers in Hamilton between around 1969 and 1974. After he left the order, Mr Cable moved to Canberra where he enjoyed woodworking in his retirement. He kept in contact with his niece, Annette Sirianni.

3.4 Unfortunately, little else is known about Mr Cable's personal background. However, there is no doubt that Mr Cable's niece and loved ones still feel his loss most deeply.

4. Mr Cable's custodial history

4.1 In March 2015, Mr cable was convicted of a number of historical child sexual assault offences. On 18 June 2015, he was sentenced to a term of imprisonment of 16 years commencing on 19 March 2015, with a non-parole period of eight years expiring on 18 March 2023.

4.2 Mr Cable was subsequently transferred to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex to serve his sentence.

4.3 On 14 March 2019, Mr Cable was convicted and sentenced in relation to a number of further historical child sexual assault offences. The cumulative effect of Mr Cable's sentences was a non-parole period of 11 years, with his earliest possible release date being 18 March 2026.

4.4 On 17 August 2020, Mr Cable was again charged with a number of further historical child sexual assault offences. These matters had not been finalised at the time of Mr Cable's death. Mr Cable was due to appear in court on 17 November 2022 via audiovisual link in relation to these charges.

4.5 During his time in custody, Mr Cable was primarily housed at the MSPC and Long Bay Hospital due to his age, frailty and health issues.

5. Mr Cable's medical history

5.1 Mr Cable a complex medical history of coronary ischaemic syndrome, pulmonary disease, hypertension, osteoarthritis, non-ST elevation myocardial infarction, total left knee replacement, hypercholesterolaemia respiratory failure (with exacerbation), chronic cardiac failure, risk of falls and pneumonia. Due to his frailty, he required a walking frame for mobility.

5.2 During his incarceration, Mr Cable had been transferred to POWH for treatment for a variety of conditions including light headedness, bilateral leg weakness, and respiratory issues.

6. The events of August and September 2022

6.1 On 5 August 2022, Mr Cable was admitted to POWH on a background of severe multi-lobar pneumonia and exacerbation of congestive cardiac failure. He was transferred to the coronary care unit where he received non-invasive ventilation, intravenous diuresis and antibiotic therapy and cardiac monitoring under the care of both the cardiology and respiratory teams.

6.2 During the course of his admission, Mr Cable reported ongoing dizziness and headaches, shortness of breath on exertion, chest tightness and a dry cough. With treatment, Mr Cable was weaned off a BiPAP (bi-level positive airway pressure) machine to nocturnal CPAP (continuous positive airway pressure) only, and placed on a waitlist for rehabilitation.

6.3 On 31 August 2022, Mr Cable was transferred from the general ward to the secure annex at POWH suffering from respiratory failure and exacerbation of chronic cardiac failure.

6.4 On 9 September 2022, Mr Cable reported poor sleep overnight, headache, dizziness, ongoing sciatic pain and indicated that it was the "*worst day [he] had in months*".

6.5 On 10 September 2022, Mr Cable reported increasing breathlessness and oxygen requirements. On examination, Mr Cable was found to have bilateral widespread fine and coarse crackles in the chest.

6.6 On 11 September 2022, it was noted that a CT scan of the brain showed ischaemic frontal lobe changes. Mr Cable was also noted to have significantly deteriorated in the previous 24 hours. He reported headache, dizziness, a significant increase in dyspnoea and being unable to eat. Mr Cable also told nursing staff that he felt like he was dying.

6.7 Following a discussion with medical staff, it was agreed that Mr Cable's treatment would be aimed at controlling his symptoms rather than prolonging his life. It was also explained that morphine could help with his dyspnoea and anxiety. In addition, attempts were made to obtain contact details for Mr Cable's niece (who resided in Queensland) and his Power of Attorney (who resided in Victoria).

6.8 At around 9:30pm on 12 September 2022, Mr Cable was noted to have deceased oxygen saturations (86-88% via nasal prongs) and increased work of breathing. He was moved to a room where he could be monitored more closely by nursing staff.

6.9 At around 12:15am on 12 September 2022, clinical staff attended Mr Cable's room to perform a blood test. He was observed to be restless but responding to instructions from staff.

6.10 At around 2:00am, a nurse attended Mr Cable's shared room to provide medication to another patient. The nurse observed that Mr Cable was unresponsive and not breathing. An emergency rapid response call was made and emergency staff attended Mr Cable's room short time later. However, due to a standing Do Not Resuscitate order, no resuscitation efforts were initiated. Mr Cable was subsequently pronounced life extinct.

7. What was the cause of Mr Cable's death?

7.1 Mr Cable was later taken to the Department of Forensic Medicine where a postmortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 15 September 2022. This identified the following relevant findings:

(a) age-related atrophy of the brain;

(b) degenerative changes of the cervical spine;

(c) extensive coronary artery calcification and an enlarged heart;

(d) consolidation in both lungs; and

(e) diverticuli in the large bowel

7.2 In the autopsy report dated 23 January 2024, Dr Szentmariay opined that the cause of Mr Cable's death was pneumonia complicating ischaemic heart disease.

8. Care and treatment provided to Mr Cable

8.1 The relevant records from CSNSW and Justice Health regarding Mr Cable's time in custody, and the findings from the postmortem examination, establish that Mr Cable died from progression of a natural disease process. The records also establish that Mr Cable was appropriately transferred to POWH for further management of his condition when this was indicated.

8.2 During his final admission to POWH, the treatment provided to Mr Cable resulted in some initial improvement. However, on 11 September 2022, Mr Cable experienced a sudden and drastic deterioration in his condition and, due to his poor prognosis, it was agreed that only comfort care measures would be instituted.

8.3 Overall, the available evidence indicates that Mr Cable was provided with appropriate medical care, to address and treat his medical conditions, whilst in custody. There is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual outcome. There is also no evidence to suggest that any aspect of Mr Cable' medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

9. Findings

9.1 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 Assisting the Coroner, for the assistance provided throughout the coronial investigation and the sensitivity shown to Mr Cable's relatives.

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

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

Identity

The person who died was Francis William Athol Cable.

Date of death

Mr Cable died on 12 September 2022.

Place of death

Mr Cable died at the Corrective Services NSW Secure Annex within Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr Cable's death was pneumonia complicating ischaemic heart disease.

Manner of death

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

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

9.5 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
15 May 2025
Coroners Court of New South Wales

Inquest into the death of Francis Cable

File Number: 2021/273459

Annexure A

Non-Publication Orders

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) The direct contact details, employee identification and login codes of CSNSW staff and other agencies and organisations that are not publicly available.
    b) The names, Master Index Numbers, and other identifying information of inmates other than Mr Cable.
    c) The names, telephone numbers, residential addresses, and any other identifying information of any member of Mr Cable's family, friends and/or visitors (other than legal representatives or visitors acting in a professional capacity).
    d) The Annex Telephone form identifying the names and phone numbers of visitors who visited other inmates.
    e) The daily schedule of Long Bay Hospital.
    f) Information in the escort assessments and orders made under s 24 of the *Crimes (Administration of Sentences) Act 1999* (NSW) that details the procedures involved in hospital escorts.
    g) CCTV, body worn camera and handheld camera footage, including any stills of that footage and crime scene photographs.
    h) The statement of Governor John Harrison dated 21 October 2024 at paragraph [12].
    i) The following policy documents annexed to the statement of Governor John Harrison dated 21 October 2024, in their entirety:
        i. Long Bay Hospital Correctional Centre – Post Duties of Supervisor B WATCH 1&3 dated 8 October 2024 (marked Annexure JH-2);
        ii. Long Bay Hospital Correctional Centre – Post Duties of Functional Manager – Accommodation 1 (MHU; ARU; MSU) dated 8 October 2024 (marked Annexure JH-3).
    j) Portions of the following CSNSW policy material identified in the appended Schedule to these Short Minutes of Order:
        i. Custodial Operations Policy and Procedures (**COPP**) 13.1 Serious Incident Reporting
        ii. COPP 13.3 Death in Custody
        iii. COPP 13.8 Crime Scene Preservation
    k) Portions of the Local Operating Procedure: Secure Annex Prince of Wales Hospital relating to safety and security identified in the appended Schedule to these Short Minutes of Order.

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.

Magistrate Derek Lee
Deputy State Coroner
15 May 2025
Coroners Court of New South Wales

Inquest into the death of Francis William Athol CABLE
SCHEDULE TO NON-PUBLICATION ORDER

Order 1(h) i. **Custodial Operations Policy and Procedures (COPP) 13.1 Serious incident reporting**	
Page	**Portion of document**
P5	The phone numbers in paragraphs 1 and 3 under the heading '2.5 Telephoning the duty officer'.
P6	The email in paragraph 2 under the heading '2.6 Briefing note'.
P7	The phone number in paragraph 2 under the heading '3.1 Timeframes for IRM reporting'.
P9	The email in paragraph 2 under the heading '4.1 Incident and witness reports'.

Order 1(h) ii. **COPP 13.3 Death in custody**	
Page	**Portion of document**
P6	The text in the second last sentence, under the heading '2.4 Crime scene preservation'.
P12	The phone number under the heading '6.1 Aboriginal Strategy and Policy Unit'.

Order 1(h) iii. **COPP 13.8 Crime Scene Preservation**	
Page	**Portion of document**
P10	The text in the two paragraphs, under the heading '4.1 Holding Inmates for forensic processing'.
	The last paragraph on page 10, under the heading '4.1 Holding Inmates for forensic processing'.
P11	The text in the 'Procedure' column of the table under the heading '4.1 Holding Inmates for forensic processing'.

Order 1(i) Local Operating Procedure: Secure Annex Prince of Wales Hospital	
Page	**Portion of document**
P2 and P3	At [5.1.1]: the text following the words 'must accompany every inmate' to end of page and continued to the top of P3 and finishes at '6.0 Discharge Procedures'.
P3	At '6.0 Discharge Procedures': • At [6.1.1]: all text all text under the heading '6.0 Discharge Procedures'. • At [6.1.2], the second sentence • At [6.1.3] – [6.1.7]: all text
	At '7.0 'Weapons and Accruements': all text from [7.1.1] – [7.1.2]
P4	At '10.0 Armoury Check': all text following heading
	At [11.1.5]: all text
	At [12.0]: all text under the heading 'Reception/Discharge Summary Sheet'.
P4-5	At 13.0: • Heading • [13.1.2] – [13.1.4]: all text • [13.1.6] – [13.1.8]: all text
P5	At '14.0 Forensic/Correctional Patients, inmates on RIT's': the last typed paragraph, comprising of one sentence ([14.1.4])
	At '16.0 Add- On Medical Appointments': all text from [16.1.2] – [16.1.4]
P7	At '19.0 CCTV/Electronic Maintenance': all text in [19.1.1] – [19.1.2]
P8	At [22.1.5]: the text, in the second line
	At [22.1.6]: all text
	At '23.0 Cell Searches': all text from [23.1.1] – [23.1.3]