CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mr Jake Andrew Carter
Hearing dates:	7 September 2026
Date of findings:	7 September 2026
Place of findings:	Coroners Court of New South Wales, Lidcombe
Findings of:	Judge Carmel Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest – death in custody – was the cause of death asthma or arrythmia – was the medical care and treatment appropriate
File number:	2025/00015721
Representation:	Counsel Assisting the inquest: Mr Alex Brown of Counsel instructed by Ms Bronwyn Lorenc, Crown Solicitors Office Commissioner of Corrective Services NSW: Ms Amy Douglas-Baker of Counsel instructed by Ms Lilyanne Jones of Department of Communities and Justice Legal
Non publication orders	Non publication orders have been made in this matter. A copy of the orders can be obtained on application to the Coroners Court of New South Wales registry.

Findings:

Identity of deceased:
The person who died was Mr Jake Andrew Carter

Date of death:
Mr Carter died on 13 January 2025

Place of death:
Mr Carter died at the John Morony Correctional Centre, NSW.

Manner of death:
Mr Carter died from an arrythmia of unascertained cause

Cause of death:
Mr Carter died as a result of natural causes while he was in lawful custody.

REASONS FOR DECISION

Introduction

1. Mr Jake Carter was only 29 years old when he died of an arrythmia on 13 January 2025.

2. An inquest is required to be held into Mr Carter's death, because he died while he was serving a sentence in custody.[1]

3. The role of a Coroner as set out in s 81 of the *Coroner's Act 2009* (NSW) is to make findings as to:

    i. the identity of the deceased;

    ii. the date and place of the person's death;

    iii. the physical or medical cause of death; and

    iv. the manner of death, in other words, the circumstances surrounding the death.

4. Section 82 of the *Coroner's Act 2009* (NSW) provides that a Coroner may consider whether it is necessary or desirable to make recommendations about any matter connected with the death. This includes matters of public health and safety.

5. The coronial investigation into Mr Carter's death and this inquest have been a close examination of the cause of his death and the medical care and treatment he received while he was in custody. Pursuant to section 37 of the *Coroner's Act 2009* (NSW), a summary of the details of this case will be reported to Parliament.

Jake Carter

6. Mr Carter's youngest sibling and his only sister, Tiarna, gave a moving family statement about him at this inquest. She explained that Mr Carter always took his role as her brother very seriously and that he was a loving uncle to six children. She explained that Mr Carter's death has left a hole in her family that simply cannot be filled.

[1] Sections 23(1)(d) and 27(1)(b) of the *Coroners Act 2009* (NSW)

7. In 2020, Mr Carter's mother passed away, and he stepped up to make sure the family was okay. He was always gentle and kind.

8. Mr Carter's father passed away when he was young and this death affected Mr Carter deeply and he carried that loss.

9. Mr Carter's absence is still felt every single day by his family and he will always be missed by them.

13 January 2025

10. As of 13 January 2025, Mr Carter was in custody as an unsentenced prisoner at the John Morony Correctional Centre (JMCC). He had been in custody since 6 July 2024. He was being housed in the Alternative Sanctions Program (or ASP). The ASP is a rehabilitative initiative offered to inmates to have drug related sanctions suspended subject to their participation in a treatment program. Mr Carter was participating in the Opioid Agonist Treatment Program and receiving depot buprenorphine injections from time to time as part of his drug rehabilitation efforts. He had last received an injection of buprenorphine on 20 December 2024, about 3 weeks prior to his death.

11. On the morning of 13 January 2025, Mr Carter was observed to be normal, polite and respectful towards correctional staff. He carried out his duties as an assistant sweeper cleaning the E Wing without any apparent difficulties.

12. At 2:30 pm that afternoon, he was observed to be in good health during the muster before lockdown.[2] CCTV footage from that early afternoon period shows Mr Carter appearing in good health, including taking every second step when walking up stairs and later jogging down them.[3]

13. Over the course of the day, Mr Carter made numerous calls to his sister Tiarna between around 11:15am and 7:53pm[4]

[2] Exh 1, Tab 25, Serious Incident Report (**SIR**) at [69]-[73].
[3] Ex 1, Vol 1, Tab 6
[4] Ex 1, Vol 3, Tab 114

14. Between about 8:09pm and 9:28pm, Mr Carter made eight calls to his partner Shontaya.[5]

15. Mr Carter and Shontaya had been in a relationship on and off since 2021. They shared a daughter who was born in September 2024 after Mr Carter went into custody.

16. Mr Carter and Shontaya had a telephone conversation at 9:28pm on 13 January 2025. It lasted for 3 minutes and 6 seconds.

17. During the call, Mr Carter can be heard breathing heavily and using what sounds like a Ventolin puffer.

The knock up call

18. At 9:35pm – within minutes of this call, Mr Carter "knocked up". To "knock up" is to use the intercom system within a cell to contact correctional staff. The transcript of the knock up call can be seen at Tab 112A of the brief, in Volume 3. A Correctional Officer received the call in the monitor room.

19. Mr Carter's first words in the call were, "I can't breathe, chief". About 15 seconds into the call, Mr Carter told the Correctional officer that he had asthma.

20. Mr Carter did have a documented history of asthma and was prescribed both a Ventolin inhaler and a preventer. Mr Carter's asthma had most recently been assessed in custody on 18 November 2024, at which time he was stratified as having "mild asthma" and provided with an asthma action plan handout sheet.

21. Twenty seconds into the knock up call, the Correctives Officer who received the call, requested a medical response.

22. The Correctional Officer encouraged Mr Carter to keep breathing and to keep talking to him. He sought confirmation that Mr Carter had asthma, and he replied that he did. The Correctional Officer asked if he had a puffer and Mr Carter said that it wasn't working.

[5] Ex 1, Tab 87.

23. The Correctional Officer continued talking to Mr Carter while following up a medical response from his colleagues. Mr Carter asked him to hurry up and at several points in the call said, "I can't breathe, I'm gonna die".

24. At the time that Mr Carter knocked up and assistance was requested by the Correctional Officer in the monitor room, a shift change was under way. Officers from the outgoing shift and the incoming shift were at the main gate doing a handover. The night senior – or the supervising officer – for the incoming shift was a Senior Correctional Officer. Upon receiving the request for assistance at around 9:37pm, the Senior Correctional Officer and a number of other Correctional Officers on the incoming shift headed immediately for Mr. Carter's cell.

25. Those officers who first proceeded to Mr. Carter's cell were the Senior Correctional Officer and two other Correctional Officers; one from the incoming shift and one from the outgoing shift. The officers who were coming on shift had to collect their radios, keys and duress alarms en route to Mr. Carter's cell.[6] They also had to proceed through several doors to get there.

26. Two further Correctional Officers from the incoming shift arrived at the main gate shortly after and proceeded immediately to Mr. Carter's cell upon being notified of his medical emergency.

27. CCTV footage of the ASP accommodation where Mr Carter was housed shows:[7]

    a. A Correctional Officer first entering the area (following the medical response call) at about **9:43:30pm**;

    b. A Senior Correctional Officer and two further Correctional Officers, can be seen at Mr Carter's cell door by **9:43:45pm**; and

    c. By **9:44:04pm** Mr Carter's cell door had been opened.

28. A Correctional Officer opened the cell door and saw Mr Carter sitting on the cell floor, leaning towards his bed with his left hand on the bed and his right hand on the cell

[6] Exh 1, Vol 2, Tab 71 at [Q3].
[7] Exh 1, Vol 1, Tab 25, SIR at p.18ff.

floor. Mr Carters's mouth was partially open and he appeared to be struggling to breathe. One of the Correctional Officers "immediately informed Control and gate officers of the situation, via his two-way radio, and asked for an ambulance and JH [Justice Health] Night Nurse to attend the cell".[8]

29. The Senior Correctional Officer recalls Mr Carter being "barely responsive" when he first saw him. He could talk but it was barely audible and he could tell he "wasn't in good shape".

30. Another Correctional Officer who was present could not recall Mr Carter responding verbally but said he was moving his head and hand in response to communications from the officers. The Senior Correctional Officer went straight to the wing office to call an ambulance.

31. At **9:45:51**pm a call was made to 000. The operator was told that Mr Carter was "actually on the floor, leaning up against the bed, not looking very well at all" and that "He has got an asthma puffer with him so I'm assuming he's an asthmatic."

32. At **9:50:53pm** by reference to the timing on the CCTV, two Correctional Officers arrived in the vicinity of Mr Carter's cell, and the Senior Correctional Officer also returned to the cell area.

33. At **9:52:40pm**, a Correctional Officer entered Mr Carter's cell and shortly after came out.

34. At **9:53:41pm**, two Correctional Officers entered Mr Carter's cell.

35. At this point, each officer describes attempting to get a response from Mr Carter and one of the Correctional Officers checking for a pulse and failing to find one. The officers then determined to commence CPR and moved Mr Carter to the floor of the cell. CPR had commenced by **9:54:35pm**, by reference to the time stamp on the CCTV.

36. At **10:00:28pm**, the Justice Health Night Nurse who had been contacted arrived at Mr Carter's cell;

37. At **10:00:42pm**, so very shortly after the Justice Health Nurse arrived, paramedics arrived at Mr Carter's cell;

38. From the Commencement of CPR at or about **9:54pm**, continuous efforts were made, firstly by Correctional Officers and then by paramedics, to resuscitate Mr Carter,

[8] Exh 1, Vol 1, Tab 25, SIR at [87].

however efforts were discontinued at 10:30pm (following administration of a fourth dose of adrenalin) and Mr Carter was pronounced deceased.

WHAT WAS THE CAUSE OF MR CARTER'S DEATH?

39. An autopsy was conducted on 16 January 2025 by Dr Elsie Burger, Forensic Pathologist. The cause of Mr Carter's death could not be determined, and no significant contributing factors were identified.

40. Dr Burger reported both an absence of mucous plugging and an absence of microscopic indicators that would typically be expected at autopsy following a severe asthma attack.

41. One of the paramedics who attended on Mr Carter noted "good lung compliance" when attempting to revive him, indicating that "the lungs responded well to ventilation and there was no evidence of gas trapping". These were not observations that would be expected in the context of an asthma attack.

42. At the time of the initial autopsy report, Dr Burger identified a puncture wound in the crook of Mr Carter's left arm with a dried blood trail extending from it as being of potential significance;[9]

43. She also noted that tablets of then unknown nature were found in Mr Carter's cell; and that buprenorphine and its active metabolite, norbuprenorphine were present in toxicological testing.

44. Dr Burger otherwise noted that "sudden, unexpected death without a morphologically identified cause at post-mortem examination can also occur for other reasons, including cardiac rhythm disturbances due to genetic abnormalities".[10] These are otherwise known as cardiac arrythmias.

45. The police Officer in charge identified in the body worn footage taken by one of the Correctional Officers who performed CPR – that Mr Carter's left arm did not have a needle puncture mark in it when CPR was commenced,[11] suggesting that the puncture wound was the product of subsequent medical intervention and not evidence of a

[9] Exh 1, Vol 1, Tab 3, page 2.
[10] Exh 1, Vol 1, Tab 3, Page 3.
[11] Exh 1, Vol 1, Tab 3, Page 14.

drug injection site. This was later confirmed in BWV footage as a site where intravenous access was unsuccessfully attempted by paramedics.

46. As to the unknown pills, these have subsequently been tested and found to be variously paracetamol, ibuprofen and nicotinamide (which is a form of vitamin B3) and not relevant to cause of death.

Independent expert review by Dr G King

47. An expert opinion was sought from Dr Greg King, the Head of the Department of Respiratory Medicine at the Royal North Shore Hospital.

48. Dr King stated

> *The chances of a fatal or even serious asthma attack at the time of death are vanishingly small. The spirometry and peak flow records, as well as the absence of documented previous moderate or severe attacks of asthma, are indicative of well controlled and/or mild asthma. The spirometry recordings show mild airway narrowing, that is consistent throughout recordings and is consistent with longstanding asthma and smoking. The records from the paramedics during CPR indicate that the lungs were functioning normally (good compliance and no gas trapping). The postmortem findings of a lack of any evidence of mucus plugging and inflamed airways, are also consistent with this. Together, these observations exclude asthma either as a cause of death or contributing to the death*.[12]

49. Dr King otherwise expressed the opinion that a serious cardiac arrythmia was the likely cause of death and noted that cardiac events such as arrythmias can present with symptoms of breathlessness. An arrythmia was a possible cause of death that Dr Burger had earlier flagged.

50. Dr King also noted that pre-existing asthma may cause diagnostic confusion and can cause people to wrongly attribute symptoms such as breathlessness to asthma rather than to a cardiac problem.

[12] Vol 1, Tab 25A, Page 3-4.

Independent expert review by Dr Adams

51. Given Dr King's opinion that a cardiac event was the most likely cause of death, an opinion on cause of death was sought from Dr Mark Adams, Cardiologist, attached to Royal Prince Alfred Hospital and Sydney University.

52. Dr Adams formed the opinion that Mr Carter's most likely cause of death was an arrythmia.

53. He described how symptoms of breathlessness can present with an arrythmia as follows:[13]

> *The mechanism whereby rapid arrythmias, such as ventricular tachycardia, cause shortness of breath is through a degree of heart failure. Rapid ventricular tachycardia impairs the ability of the left ventricle to contract effectively, and this leads to lowering blood pressure and increased left atrial pressure, leading to the development of lung congestion and interstitial oedema. Interstitial oedema was one of the findings at autopsy and would be consistent with death due to ventricular tachycardia*.

54. Dr Adams noted also stated that:[14]

> *Primary arrhythmias…in most cases, leave no evidence that can be seen on postmortem analysis as any electrical changes that might have been evident in life on an ECG, are not present after death*.

55. He further stated that in "more than 40% of cases of young adults under the age of 35 years that suffer sudden unexplained death, no clear cause is found at autopsy" and cited literature indicating that the vast majority of these deaths are due to arrhythmias[15], some of which are due to inherited conditions and some of which are due to external factors."

56. In Mr Carter's case, Dr Adams was not clear what the underlying cause of the arrythmia – or its trigger – was likely to have been . Dr Adams did form the opinion Mr Carter's historic drug was a factor. He did not think the buprenorphine that Mr Carter was receiving was a cause. He noted that part of the reason that it is used in place of

[13] Vol 1, Tab 25B, p.3.
[14] Ibid.
[15] Vol 1, Tab 25B, Attachment 5.

methadone is because it is safer and less likely to cause arrythmias. He did note that Mr Carter appeared to have been stressed during his phone final telephone call, and that such stress *can* be a trigger for cardiac arrythmias.

57. Dr Adams concluded:[16]

> *It is possible that mental stress may have triggered it, however this alone would be an unusual cause for VT. It is also possible that buprenorphine may have contributed to the risk of him developing an arrhythmia, however the effect of this medication is mild. I think that it would be worth considering genetic testing looking at a cardiac panel of tests for sudden death.*

Further report of Dr Burger Forensic Pathologist

58. The reports of Drs King and Adams were provided to pathologist, Dr Burger for further opinion.

59. Dr Burger agrees that it is highly unlikely that asthma was the underlying cause of death and that sudden cardiac death may present with symptoms of breathlessness that could be mistaken for asthma.

60. Having regard to the further expert reports, Dr Burger formed the opinion that it highly likely that Mr Carter's cause of death was an arrythmia, but that the underlying cause of that has been unable to be ascertained.

61. It does not appear to have been caused by cardiomyopathy, which is a possibility raised by Dr King but discounted by Dr Adams and Dr Burger.

62. It does not appear to have been related to either recent or historic methamphetamine use based on what was observable at autopsy and the results of toxicological screening.

63. Dr Burger formed the opinion that the most likely cause is an underlying genetic condition. For this reason, members of Mr Carter's family have been referred to the NSW Health Cardiac Genetics Team for assessment and possible testing.

64. Dr Burger concluded:[17]

> *The autopsy examination and toxicological analysis have excluded, to the best of our ability, all unnatural causes of death.*

[16] Vol 1, Tab 25B, p.5.
[17] Vol 1, Tab 3C, p.3

The circumstantial evidence points to an arrythmia as mechanism of death.

In light of the circumstances and autopsy findings, an underlying genetic condition seems to be the most likely cause of the arrythmia.

The effects of previous chronic methamphetamine use cannot be completely excluded but are unlikely in the absence of the typical microscopic changes caused by chronic methamphetamine toxicity.

DID MR CARTER RECEIVE ADEQUATE AND APPROPRIATE MANAGEMENT IN CUSTODY NOTING HIS PERSONAL BACKGROUND?

65. Dr King reviewed Mr Carter's custodial records and formed the opinion there were no issues around the management of Mr Carter's asthma.[18] He had appropriate access to Ventolin and a preventer, and an asthma action plan and the severity of his asthma was being monitored in custody.

66. Dr Adams stated that "*Mr Carter was not at high risk for a cardiac event, other than that related to his illicit drug use. He was also at a young age where it would not be expected to screen for cardiac disease or cardiac risk factors. In addition, he was receiving buprenorphine rather than methadone for his OAPT, with buprenorphine having a much better risk profile in terms of causing arrhythmias.*"[19]

67. Dr Burger stated that neither buprenorphine nor illicit drug use is likely to have played a role in Mr Carter's death. Indeed, Mr Carter appears to have been making a concerted effort to turn around his historic drug use and to have been doing well on the OATP.

[18] Vol 1, Tab 25A, p.2.
[19] Vol 1, Tab 25B, p.7.

WAS THE RESPONSE OF CORRECTIVE SERVICES NSW TO MR CARTER'S CELL ON 13 JANUARY 2025 ADEQUATE AND APPROPRIATE?

68. Dr King stated that, "given the difficult circumstances of being uncertain what the medical problem was, and the reasonable assumption that he was he was having an asthma attack, the response to breathing difficulties was adequate and appropriate."

69. Dr Adams said:

> *I think that the response of Correctional staff and Justice Health staff to Mr Carter's Complaint of breathing difficulties was reasonable. Rapidly after receiving Mr Carter's call that he Couldn't breathe a medical response was broadcast over two-way radio at 21:37 hours. Staff arrived at Mr Carter's cell at around 21:42 hours, that is around 6 minutes after the response was broadcast. I cannot be sure whether this a reasonably long time as I am unaware of the size of [JMCC] and what the staffing levels are at that time of the evening. It would also have been difficult for those responding to the call to know the seriousness of the medical event.*
>
> *Once officers were on site in Mr Carter's cell they clearly recognised that Mr Carter was quite unwell and rapidly called for an ambulance, unfortunately there were no medical staff on site. It seems that Mr Carter was still breathing at the time the staff arrived at around 21:44 to 21:45 hours, it is less clear, however, what time Mr Carter went into cardiac arrest, although it appears that the staff recognised that he was in cardiac arrest at around 21:54, when staff moved Mr Carter to the floor and Commenced CPR.*
>
> *In an ideal situation Mr Carter might have been attached to an automatic defibrillator, however I can see where this might not have been Considered when the obvious assumption would have been that Mr Carter was having a severe asthma attack. Similarly, I would not expect that the Correctional centre staff would have medical expertise in Considering other diagnoses and Considering that a cardiac arrest might be imminent. It is also worth Considering that Mr Carter was extremely ill at the time of his call for assistance, and I don't think that there was sufficient time to*

have trained medical staff on site in time to avoid his cardiac arrest. Out-of-hospital cardiac arrests carry a large mortality rate, with less than 10% surviving to discharge form hospital. Even cardiac arrests occurring in hospital carry close to 80% mortality rate.

70. When Mr Carter knocked up the Correctional Officer in the monitor room promptly recognised that Mr Carter was experiencing a medical emergency and called for assistance. That was consistent with the CSNSW policy.

71. At the time of the emergency, officers were at the main gate due to a shift changeover. Those officers proceeded directly to Mr Carter's cell. Due to the need to travel to his cell; to collect gear on the way; and to pass through several doors; this took around 6 minutes.

72. Once at Mr Carter's cell, officers quickly recognised that Mr Carter was experiencing a medical emergency and called for a nurse and for an ambulance.

73. When officers first arrived at Mr Carter's cell, he was conscious and responsive, although he was clearly struggling to respond.

74. It is not entirely clear when Mr Carter fell into unconsciousness, but it had certainly happened by around 9:53pm when Corrections Officer Kunkel checked for a pulse.

75. Having checked for a pulse and found none, Corrections Officer Kunkel and Corrections Officer Jay promptly commenced CPR.

CONCLUSION

76. I find that the cause of Mr Carter's death was an arrythmia. I note that correctional officers receive scenario-based training as part of their training for responding to medical emergencies.

77. Given the unusual circumstances of Mr Carter's death, it would be desirable that one of the training scenarios include guidance that a cardiac arrythmia can occur in someone of any age and that breathlessness or difficulty breathing can be an indicator of a cardiac event (including an arrythmia), even if the person otherwise suffers from asthma.

78. I am grateful to the Commissioner of CSNSW for indicating their support of such a recommendation and I propose to make such a recommendation under s 82 of the Act.

FINAL REMARKS

79. Mr Carter's family has been concerned to know that all that could have been done for him was done appropriately. I offer my condolences and sympathy to Mr Carter's family.

80. I thank Counsel assisting, Mr Alex Brown and his instructing solicitor Bronwyn Lorenc from the Crown Solicitors Office for the work they put into assisting me in this inquest. I would also like to acknowledge the work of Detective Senior Constable Christopher Page who performed the role of Officer in Charge of the Police investigation.

SECTION 81 CORONERS ACT (2009) NSW FINDINGS:

Identity

The person who died was Jake Andrew Carter

Date of death

Mr Carter died on 13 January 2025.

Place of death

Mr Carter died at the John Morony Correctional Centre, NSW.

Cause of death

The cause of Mr Carter's death was arrythmia of unascertained causes

Manner of death

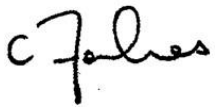
Mr Carter died as a result of natural causes while he was in lawful custody.

SECTION 82 CORONERS ACT (2009) NSW RECOMMENDATION

To the Commissioner of Corrective Services of NSW

1. That the Commissioner consider, in respect of the scenario-based training provided to Correctives Officers, the inclusion of the circumstances of Jake Carter's death so as to provide guidance that:

    a. Cardiac arrythmias can occur in persons of at any age
    b. Breathlessness or difficulty breathing can be an indicator of a cardiac event and;
    c. That can be the case even if the person otherwise suffers from asthma



Judge Carmel Forbes

Deputy State Coroner

Coroners Court of NSW, Lidcombe

7 September 2026