8. 2357/07 Peter Leslie Garner

Inquest into the death of Peter Leslie Garner at Junee Correctional Centre on the 28 December 2007. Finding handed down by Deputy State Coroner Dillon on the 14 December 2009.

Mr Peter Garner was a 35 year-old remand prisoner at the Junee Correctional Centre charged with sexual offences when he was he was found dead in his bed on the morning of 28 December 2007.

Mr Garner's father asserted that the circumstances of his death were suspicious but the mandatory inquest conducted by DSC Dillon in Griffith on 14 December 2009 not only found no evidence to support this claim but that the weight of evidence positively refuted it. Mr Garner's father based his assertion on the fact that his son was relatively young and had shared a cell.

No injuries or other suspicious circumstances were found by detectives during their thorough investigation. A post mortem examination revealed that Mr Garner's death was due to severe atherosclerotic narrowing ('furring up') of the coronary arteries supplying his heart muscle, a condition with a well-recognised association with sudden death. Mr Garner was a heavy smoker and had a high blood cholesterol count, significantly increasing his risk.

DSC Dillon found no basis on which to suspect or criticise the prisoner who shared the cell with Mr Garner, nor of his treatment in prison. He made the following findings pursuant to s.22 of the Coroners Act 1980.

Formal Finding:

Peter Leslie Garner died at the Junee Correctional Centre on 28 December 2007 due to severe Coronary Artery Atherosclerosis, to which Hypercholesterolaemia was a significant contributor, while asleep in his cell.

9. 58/08 Wilberforce Cyprien

Inquest into the death of Wilberforce Cyprien on the 11 January 2008 at Liverpool Hospital. Finding handed down by Deputy State Coroner Milovanovich on the 8 December 2009

As previously stated, the death of Wilberforce Cyprien, it was a death that is mandatorily reportable to the coroner by virtue of the fact that he died a sudden unnatural death, and secondly it is a mandatory inquest under s 13A of the Coroners Act on the basis that at the time or during, or shortly before his death, police were involved in an operation, and that is why the matter falls under s 13A. Having read the brief I am satisfied that the police used their best endeavours to persuade Mr Cyprien not to take the action that he did. Police actions cannot be in any way criticised.

He was in his own home at the time and there was no other form of restraint or force that could have been used to try and avoid the tragic circumstances. I think it is simply a matter of making a formal finding. Sergeant, I understand that this is a matter where you had considered some further comments in relation to the brief being sent to the American Consulate.

Formal Finding:

I find that Wilberforce Cyprien died on the 11th January 2008 at Liverpool Hospital from multiple injuries sustained on the 10th January 2008 at unit 764/360-362 The Horsley Drive, Fairfield when he jumped from the balcony with the intention of taking his life.

10. 166/08 David Kentwell

Inquest into the death of David Kentwell on the 27 January 2008 at Junee Correctional Centre. Finding handed down by Deputy State Coroner Milovanovich on the 26 November 2009.

David Kentwell, aged 42 years died at Junee Correctional Centre, Junee on the 27th January 2008.

The deceased was sentenced to a term of imprisonment of 3 years for the offence of grievous bodily harm causing wounding at the Parramatta District Court on the 28th November 2005. His earliest release date on parole would have been the 10th November 2008.

The deceased served the first 18 months of his sentence at the Silverwater Correctional Centre and was transferred to Junee in May 2007. Upon reception at the Junee Correctional Centre the deceased was subjected to the normal medical and risk assessments. The deceased had a history of minor medical problems, however, had no prior history of cardiac or respiratory problems.

On the 27th January 2008 the deceased presented to the Clinic at Junee Correctional Centre complaining of generalised epigastric and chest discomfort. He was assessed by a Nurse and prescribed Mylanta, stood down from work duties and told to rest in his cell and re-present at noon.

The deceased re-presented at about 11.30am still complaining of chest pain. A number of observations were made, including checking his pulse, blood pressure etc.

He was then prescribed Panadol and Ibuprofen and told to rest in the observation room of the Clinic. At about 1.00pm the deceased further complained of chest pain and was then subjected to 3 ECG's over a period of 20 minutes.

The first two ECG's indicated an abnormal result. Nursing staff then made a decision to contact the on call medical practitioner. Those attempts were unsuccessful with calls to both the Doctor's home and mobile either going to an answering service or indicating that the mobile phone was switched off or in a non-service area.

At about 2.00pm the deceased was observed to be fitting and further medical attention was provided including the administration of Anginine and a cannula was inserted. A number of attempts to contact the on call Doctor were unsuccessful and nursing staff then called for an Ambulance. Nursing staff formed the opinion that the deceased was in cardiac arrest and two defibrillations were undertaken. Ambulance were called at 2.27pm and arrived and rendered medical assistance at 2.42pm. The deceased was given CPR and medications and transferred to Junee Hospital were life was pronounced extinct at 3.50pm.

The Inquest determined that the deceased had died from natural causes. The cause of death being an Acute Myocardial Infarction due to Coronary Atherosclerosis. A number of issues were identified in the Inquest, they being the following.

1. The failure of Nursing Staff to contact an Ambulance, a discretion that they had without consultation with the duty Doctor, once the deceased re-presented at about 11.30am still complaining of chest pain. It was apparent that the Junee Correctional Centre did have protocols in place wherein a prisoner presenting with continuing chest pain should be transported to hospital. The Coroner was satisfied that appropriate protocols were in place and that on this occasion the Nursing staff did not exercise that discretion as they firstly wanted to contact the Doctor and secondly did not believe that the deceased presentation was cardiac related.

2. The inability to contact the duty Doctor was identified as an issue. It was established that the on call Doctor ordinarily is contactable and when not messages that are left are responded to in a timely manner. On this occasion it would appear that the Doctor's phone might have been switched off. The Coroner was satisfied that new protocols are now in place so that if the on call Doctor could not be contacted, Nursing Staff have access to a Doctor and Clinical Staff at Justice Health in Sydney who are available 24 hours a day.

Formal Finding.

That David Kentwell died on the 27th January 2008 at the Junee District Hospital, Junee in the State of New South Wales from an Acute Myocardial Infarction due to Coronary Atherosclerosis.

11. 167/08 Adam Shipley

Inquest into the death of Adam Shipley between the 20th May and the 21st May 2007. Finding handed down by Magistrate Jerram, State Coroner.

THE FACTS

Adam Douglas Shipley, aged 36, had been an inmate at Kirk Connell Correctional Centre (Kirk Connell) near Bathurst since his transfer there on 22 March 2007. He was taken back into custody on 24 December 2006 following a breach of parole, and had spent the early weeks of his term at the Metropolitan Remand Reception Centre (MRRC) and at Kirk Connell, then been moved again to the MRRC and thence to John Morony Correctional Centre where he was placed on a RIT (the Risk Intervention Team) protocol following an incident of threatening self harm, (of which he had a lengthy history) on March 3, 2007. His return to Kirk Connell in March was partly because of his threats to self harm again unless he was placed there.

Adam Shipley (Adam) was allocated to 4 Unit, a relatively self sufficient group house for Aboriginal prisoners, and put in to Cell 7 alone, or 'one out' at his request. In accordance with standard procedure, at about 4.50pm on 20 May 2007, all units including 4, were 'locked down'. After lock-down, inmates were free to move around the unit. They prepared their own meals. The cells were not locked. Adam did not eat that night, and was not seen, according to fellow inmates Kirt Field and Robert Allen, after about 8.30 pm.

At approximately 7.00am on Monday 21 May 2007, Kirt Field and others noticed that the door to Adam's cell was still closed, although Adam was usually one of the first to be up and about. Field went to Adam's cell door, and observed that it was somehow held shut. He had to pull the door and break what eventuated as a cord holding it closed. Field then entered the cell, and saw Adam hanging by his neck at the end of the bunk bed by a cord made into a noose. He touched him on the shoulder and he was stiff. Correctional Officers were then called and attended, led by C.O. Fred Kentwell.

Adam was observed dressed in green tracksuit pants, a green t-shirt and a green jacket. He had a deep indentation to the front of his neck and this extended further up and met the lower section of his skull. No vital signs were detected.

Officer Kentwell saw a letter on the bed and a piece of paper under the deceased's shoulder which he picked up, read, and put on a shelf to keep it free of fluids which were seeping on to the floor from Adam's body.

The Forensic Pathologist, Dr J Duflou, after autopsy, gave as his opinion in the Post Mortem Report (dated 20 December 2007) that Adam Shipley died somewhere between 1700 hours on 20 May and 07.10 hours on 21 May 2007 at Kirk Connell and that the direct cause of death was by HANGING.

The inquest into this death was mandatory pursuant to ss.13A and 14B of the *Coroners Act 1980* (the Act). As State Coroner, I held a view at Kirk Connell, and heard evidence in both Bathurst and Glebe courts, over 8 days from 21 witnesses. The Officer in Charge of the investigation, Detective Senior Constable Edmund Belfanti presented a meticulous lengthy statement, which formed part of the Brief of Evidence.

ADAM SHIPLEY'S HISTORY

The Department of Corrective Services (DCS) inmate profile for Adam reveals a long and extensive criminal record going back to February 1984. He spent time in custody for varying periods from 1989 until this final episode when he was taken back into custody for a breach of parole on 24 December 2006. He was a diagnosed paranoid schizophrenic with a history of suicidal ideation and self harm. Adam was also known to be non-compliant with his anti-psychotic medication. Staff described him as 'high maintenance', in that he was very demanding of attention, but likeable. He was constantly worried about the relationship with his partner, Bronwyn Irwin, breaking down, and other personal issues. He discussed these worries with many prison officers and welfare staff throughout his time at Kirk Connell, and constantly spoke of self harm. The DCS psychologist, Kim Hyland, gave evidence as to the procedures set out for inmates applying for consultation. Officers Kentwell and Turner, who had in turn been assigned as Adam's case officer, gave evidence that they had never formally conferred with Adam or each other on hand over. Officer Kentwell agreed that the system had not assisted Adam, but that he had 'fallen through the cracks'.

There is some evidence that Adam had attempted to commit suicide a few days before 21 May 2007. That evidence only came from inmates in 4 Unit, and none suggests that the alleged failed attempt was ever known to any Correctional Officer.

Inmate Field told both the Assistant Superintendent, and this inquest, that, incomprehensibly, he had made a noose for Adam at his request as he was known amongst the prisoners for doing so. Inmate Field gave evidence that he made the nooses, which he usually lacquered, because they "look[ed] good". He claimed that Officers knew of this hobby and took no action. It seems most likely that he had made the ligature by which Adam was found hanging, and also that it was in fact made from a cord identical to that used as drawstrings in the prisoners' laundry bags.

On 20 May 2007, Adam was permitted to make two phone calls to Bronwyn Irwin, the second of which was answered and a transcript made available to the court. Despite Ms Irwin's evidence, the transcript indisputably proves that she made it clear to Adam that their relationship was over, that she was with someone else at the time and had 'moved on'. After lock-down, several of his fellow inmates observed that he appeared down. He was last seen by any of them early that evening. Although one, not necessarily reliable, witness claimed that it was at 8.30pm it seems more likely that he remained in his cell with the door closed after about 5.30 pm.

As previously described, he was found hanging the next morning by Field, who had to break the shoelace which had tied the door closed from inside.

THE INVESTIGATORS' REPORTS

Three reports were ultimately sought by the DCS from its own Investigations Branch. The first was assigned to Dawn Watson, an Investigator with the Unit, who on the day that Adam was found dead, accompanied by Investigator William Beale, made an initial inspection at Kirk Connell of the unit, the cell and the crime scene. She provided an interim report a week later, which she herself in evidence agreed was 'to furnish the very basic of details to the director of the Investigations Branch'.

It appears there is a format required by the Department, which in my view, barely furnishes even 'basic details'. Watson herself merely recommended that Officer Kentwell be reprimanded for moving the note from under the body, on first entering the cell. Soon after, she resigned from the job following a Departmental inquiry into her conduct as an investigator in an unrelated matter. Her evidence was that she signed the interim report, although no signed report of hers was produced to this inquest in answer to either the subpoena or a letter from the Crown Solicitor's Office (dated 6 January 2009).

Because of her resignation, the matter was then transferred to a Mr Nigel Webb, but on his almost immediate transfer, Investigator Beale was asked to review Ms Watson's report. His subsequent report was dated 24 September, 2007 and he then went on sick leave for a month.

On his return, he found that his report had been substituted by a report prepared by another Investigator Paul Coyne, who had been requested by John Crawford, Director of the DCS Investigations Branch, to review the inquiries made to date, and complete a report in to the death of Adam Shipley in the 'approved format' (the Final Report). Mr Beale was very angry, as Mr Coyne had never been to the scene, had not interviewed any personnel involved, and had primarily repeated the words of Ms Watson.

Discussions which followed between Mr Beale on the one hand, and Messrs Coyne, and Crawford on the other, were differently recalled by each, and formed the basis of particular allegations by Mr Beale that there was a 'cover up' by the Department, only a 'benign' report was sought, and therefore his, far more comprehensive and detailed report was 'buried'. As a result of his views, Mr Beale resigned from the DCS on 26 November 2007.

These allegations are now the subject of an investigation by the Independent Commission against Corruption (ICAC). Consequently it would be improper for me to make any finding relating to them, and I neither do so, nor determine whose versions of those conversations is the most reliable. I shall, however, make comment upon the general contents of the three reports.

ISSUES

Having regard to the foregoing, I consider the issues raised on the evidence at the inquest to be as follows:

Did Adam hang himself, deliberately committing suicide?

Was any recent suicide attempt made, and if so, was it known to Correctional Officers?

Should nooses, cords and other potential ligatures have been allowed within the units by DCS?

Should DCS have taken steps to remove potential hanging points from the units?

Was Adam provided by both DCS and Justice Health with care and treatment appropriate for an inmate who was known to be schizophrenic, non-compliant with medication, upset and with a history of self harm, and RIT placements, i.e. a high risk?

Was Adam's classification to Kirk Connell, and allocation to a one-out cell appropriate for such a prisoner?

Were the investigation reports sought by the DCS accurate, detailed and useful particularly in terms of unearthing possible systemic issues or problems?

Should the report of Mr Beale, albeit not in the proper format, have been given closer consideration and/or formed part of the Final Report on the death of Adam Shipley?

THE LAW

Under ss.13A and 14B of the Act, this was a mandatory inquest, because Adam died in custody. I am required to make findings as to the identity, place, date, manner and cause of death of Adam Shipley. S. 22A of the Act provides for recommendations to be made if the Coroner considers it necessary or desirable to do so in relation to any matter connected with the death under investigation. S. 22A (2) states that public health and safety,

and a recommendation that a matter be investigated or reviewed by a specified (person or) body are examples of matters that can be the subject of a recommendation.

I had the benefit of Mr Lonergan as Counsel Assisting, instructed by the Crown Solicitor, while Mr Saidi represented the DCS, Mr Singh Justice Health, and Ms O'Sullivan Adam's mother, Lynette Shipley. All counsel made written final submissions, to some of which I shall refer.

CONCLUSIONS ON THE ISSUES

There is sadly clear evidence that Adam Shipley died as a result of hanging and further, that he hanged himself with the intention of taking his own life. I must be satisfied to the Briginshaw Standard[4] that Adam suicided. It is obvious that he tied himself in to his room, and there is evidence that there was no sign of forced entry other than that by Field witnessed by other inmates after fears for him had arisen.

There is a suicide note written by him, his history of depression and self harm, the relationship difficulties or ending with Ms Irwin, as well as with his daughter and new grand daughter, and recent disappointment over legal advice. He apparently sought out an effective noose. It may be that he had made a previous attempt to hang himself a few days before. On the evening of 20 May 2007, events had overtaken Adam.

It is likely that Adam had, as previously stated, made a prior suicide attempt, by similar means, within the last few days. A few prisoners may have known of this. There is no evidence to suggest that any staff either of DCS or Justice Health had any information or knowledge whatsoever of that attempt.

The question of the availability of hanging points and materials for making ligatures is difficult in this case. Kirk Connell is a minimum security institution, which allows some inmates to work in the afforestation camp or in outside day release programmes preparing prisoners for return to the freer community.

Considerably greater latitude is allowed to its inmates than in prisons with higher inmate classification gradings. Units for about 12 prisoners, although 'locked down' from 4.30 pm till 7.30 am nightly, allow for inmate's independence inside the unit between those hours. Officers do not enter the units unless in an emergency; prisoners prepare their own meals and govern themselves as a group or individually. In such an environment, hanging points and the availability of rope, cords and other tying devices are virtually impossible to restrict, let alone eliminate.

Unit 4 was particularly designated for Aboriginal prisoners so that they could share their culture and understanding. Adam particularly wanted to be in that unit.

4 *Briginshaw v Briginshaw* (1938) 60 CLR 336.

The views of several staff were that it would have been a huge deprivation to him had he been refused, and placed where he would have been better supervised or observed.

Similarly, he had asked to be allocated a one-out cell. One wonders why the authorities allowed this, given his history. It is understandable that many prisoners may prefer privacy, but had Adam had a cellmate to keep any eye on him, he may have been able to talk of his feelings, and discouraged from acting upon them – indeed, this death may not have occurred.

It is difficult not to conclude that the relative freedom allowed prisoners at Kirk Connell did not assist Adam's mental health and may not have been the optimal placement for him.

There is a considerable amount of evidence to indicate that at Kirk Connell, Adam received extensive help and assistance from individual DCS staff to help him cope with his personal and emotional problems, as was amply demonstrated by the evidence relating to his interaction with DCS Welfare Officer Michelle Hadley. I agree that there is no criticism of persons such as Ms Hadley that he was not given attention, advice and assistance to deal with his ongoing difficulties, particularly with his relationship with Ms Irwin.

However, at no stage after he was taken into custody as and from 24 December 2006 does it appear that there was any coordinated review or response with regard to Adam's psychological and emotional welfare, with his long history being well documented. At his inmate screening on admission, it was noted that he had a long custodial history, was schizophrenic and had both threatened and acted upon self harm many times. There is simply no evidence to indicate that the relevant DCS or Justice Health staff turned their minds to the need for a coordinated, ongoing and pro-active management of Adam Shipley. He was placed on a RIT protocol on 3 March 2007, and discharged from it two days later, yet no ongoing plan or follow up was activated, or apparently even considered, by the DCS.

It is appreciated that many prisoners enter the system with mental health problems. However, Adam was at the high end of the spectrum according to his records, and it has to be said that there was a complete deficiency of any plan for his psychological/psychiatric well-being.

The 'case officer system' also failed Adam, in that the significant observations and interaction with Officer Catherine Turner, relating to his self-harm threats , were not passed on to his next 'case officer', Officer Kentwell who in his three weeks in that position, did not have the opportunity to meet or formally conference with Adam because of his workload and shift roster. Further, Officer Turner agreed that she had not documented any of Adam's self harm threats (although conceding this was desirable), a matter of obvious concern given the potential significance of such threats. I acknowledge that both officers were commendably open and frank in their evidence, and agreed that to be the case.

It is the lack of system, which urgently needs improvement. There was clearly also some intervention in the provision of care provided by Justice Health personnel Ms Parker and Mr Muller. Overall responsibility for Adam's welfare, however, rested with the DCS.

The report format required by the Investigations Branch of the DCS, is in my view, inadequate, in that it elicits very little information other than the utterly basic. While I acknowledge that Ms Watson's report was incomplete and interim, the only concern it contained was the fact that Officer Kentwell, in what was actually an attempt to preserve forensic evidence, moved some pills and the note left by Adam Shipley, before the police attended.

I am also concerned that despite her being adamant that her report had been signed, no signed document was ever produced, and that, as with those of both Messrs Beale and Coyne, the reports were not produced to this inquest despite a subpoena, until a further letter of demand was sent by the Crown Solicitor. (The Final Report produced by Investigator Coyne mirrors Watson's exactly, with the addition of a few further paragraphs, but without any useful further information and ostensibly, without any independent analysis).

Investigator Bill Beale was tasked to undertake the review of Ms Watson's investigation after her departure. He was a highly experienced investigator, previously with both ICAC and the Special Investigation Unit for the Attorney General's Department. His evidence was that he was surprised at the brevity of the Watson report and that he delved into Adam's file, analysed what he found, spoke to Detective Belfanti, and made his report on 24 September 2007. Mr Beale's report is detailed, relevant in the main, and compassionate, albeit not in the 'required' format.

In it, he is critical of the fact that there was no evidence of a coordinated, ongoing and proactive management of (Adam) as someone at risk. He makes a number of (apparently unwanted) suggestions and recommendations for an improved plan for such inmates.

Mr Beale then went on sick leave from 15 October 2007 until 26 November 2007. On his return he discovered that his report had been substituted with one prepared by fellow Investigator Coyne. Mr Coyne, while agreeing in evidence that the investigatory role is to identify, inter alia, any systemic issues and failings observed, nevertheless admitted that he was told to put his report in the proper form, and that he did not interview any personnel involved in the matter at all.

As previously said, his report is merely a copy of Ms Watson's other than five paragraphs in which he includes a little information not previously obtained by her. His instructions from Mr Crawford, the Director of the Investigations Branch, appear to have centred on his using the approved format, as opposed to that of Mr Beale. He had not been shown Mr Beale's report, nor had he read the report of the '*Royal Commission into Aboriginal Deaths in Custody*' (1987 – 1991), nor does he make any reference to hanging points and ligatures. Nevertheless, he claimed that his was a 'thorough and comprehensive report' into the death of Adam Shipley.

It is of narrow focus, and silent upon many relevant issues concerning the treatment and lack of care of Adam, as well as upon any systemic issues whatsoever. Like Ms Watson, the only concern he raises is the 'failure' of Officer Kentwell to maintain the crime scene.

Mr Beale, Mr Coyne and Mr Crawford differ on their respective versions of discussions, which followed Mr Beale's return and discovery that his report had been replaced by Mr Coyne's. These are matters, which will no doubt be ventilated fully during the course of the ICAC investigation. What is clear is that as a consequence of events and conversations, Mr Beale tendered his resignation from the Department that day, and wrote a few days later, to another officer of the Department within the Employment Branch setting out his concerns, which in both letters reflect the evidence he gave to this court.

The Beale report, albeit not in the DCS approved standard format, does contain an in-depth analysis of the history of Adam. It identifies some systemic issues with respect to DCS actions that if corrected, may have led to the better management of Adam. Many of Mr Beale's observations and opinions were specifically agreed with by the DCS Clinical Coordinator, Jenny Barton in her evidence, unlike the DCS Acting Principal Advisor, Psychology, Ms Spilsbury. Mr Beale may have stepped outside his realm of experience at some points in the report, for example in his recommending the ANZ Safety Standards, which really were not applicable to the custodial situation.

He may have far exceeded what was asked of him, and what the Investigations Branch required. He was clearly not an employee who blindly accepted 'the rules'. However, it is difficult to understand why his considerable knowledge and analysis was neither given proper consideration nor included in the Final Report. Mr Crawford admitted that Mr Beale, was a 'competent investigator'. But because of the report's lack of correct format, he seems to have ignored it, saying that he found it unbalanced and unsubstantiated. For him to have preferred the cursory and repetitive report of Mr Coyne defies belief that there was any real desire on the part of the DCS to explore the circumstances of Adam's death.

Although I make no finding as to the Beale allegations for the reasons noted above, I otherwise consider Mr Beale ought be commended for his strength of conviction and apparent professionalism in undertaking his investigative duties. Moreover, I found his report to be of assistance for the purposes of the inquest.

Ultimately, however, this inquest is about how an Aboriginal man in the custody of a government department, known to be at high risk, and diagnosed as a schizophrenic, was able to take his own life without being discovered probably for several hours. It is not primarily about reports and investigators. Documents tendered to the court clearly demonstrate that the DCS has in recent years seriously addressed the issue of deaths in custody and reduced the number of suicides. This is hugely to its credit. The question is raised by the tragic death of Adam Shipley however, of the usefulness of its own Investigation Branch and its protocols.

If investigatory reports are not to look at all aspects of a death and to make recommendations, for whose good are they? Of what use? How do they assist in the reduction in future deaths?

Finally, I commend Detective Senior Constable Belfanti for a comprehensive and thorough brief of evidence prepared for my assistance.

FORMAL FINDING

That ADAM DOUGLAS SHIPLEY died on 21 May 2007 at Kirk Connell Correctional Centre sometime between 17.00 hours on 20 May and 7.10 hours on 21 May 2007 as a result of hanging himself with the intention of taking his own life.

RECOMMENDATIONS

Under s. 22 of the Act, I make the following recommendations to the **Minister for Corrective Services:**

That the Department of Corrective Services review the systems and protocols in place for inmates known to be at-risk, to determine whether these presently provide for a coordinated and pro-active management plan for such inmates (including involving Correctional Officers and mental health professionals), particularly following a release or discharge from a RIT protocol.

That the Department of Corrective Services review its Investigative Services Branch and the requirements of reports made by its investigators to ensure that full information is gathered, systemic issues are identified, and, if necessary any recommendations are made, by the Investigators both for the use of the Coroner, and for full consideration by the Department.

That the Department of Corrective Services provide all investigation reports undertaken by or on behalf of the said Department into deaths in custody to the Office of the State Coroner immediately upon finalisation (subject to any legal claims made).

12. 400/08 Xarnde Jane Jacobs

Inquest into the death of Xarnde Jane Jacobs on the 10 March 2008 at Ingleside. Inquest suspended by Deputy State Coroner MacPherson on the 15 September 2009.

The death of Xarnde Jane Jacobs was deemed to be as a result of a death in a police operation. Following advice from investigating police a known person was charged with an indictable offence arising from the death. The NSW Deputy State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

13. 529/08 Steven Charles Whitton

Inquest into the death of Steven Charles Whitton on the 28 March 2008 at Wellington Hospital. Finding handed down by Deputy State Coroner Dillon on the 5 May 2009.

Mr Whitton was a 37 year-old prisoner at the Wellington Correctional Centre. He died in the yard of one of the prison 'pods' after suffering a heart attack while exercising.

Nursing staff of Justice Health and ambulance officers attended him. Resuscitation was attempted in the yard but unsuccessfully. He was transported to Wellington Hospital but was pronounced dead shortly after his arrival there.

Mr Whitton suffered from latent heart conditions that were probably not known to him and not detected by Justice Health staff that interviewed him on arrival at Wellington Correctional Centre.

Three issues of significance were explored during the inquest. First, a question was raised whether the Justice Health nurses were adequately trained in the use of oxygen equipment. Second, the question whether the Justice Health screening interview for inmates was appropriate or could be improved was raised. Third, the police investigation revealed that CCTV coverage of the yard was incomplete.

The evidence showed that, while the Justice Health nurses on duty during the incident were experienced professionals, they were attempting to use oxygen equipment different from that with which they were familiar and which they were therefore unable to operate in an emergency situation. In all probability, this had little or no effect on the outcome in Mr Whitton's case but it showed the need for more systematic training of health staff in the use of new equipment at Wellington Correctional Centre.

The reception-screening interview was conducted in accordance with a checklist developed by Justice Health. Mr Whitton suffered from latent heart conditions that made it dangerous for him to engage in vigorous, sustained exercise. They included an enlarged heart and coronary atheroma (fatty deposits in the arteries). He died of ischaemic heart disease and probably suffered a cardiac arrhythmia. These conditions were not known to Justice Health staff at the time of his death. He was probably unaware himself of the fact that he was afflicted with serious heart disease.

It is a matter of common knowledge that many prisoners use their enforced leisure time to exercise. Many, however, suffer from physical disorders brought on by poor diet and misuse of drugs, alcohol and tobacco. While exercise is, of course, generally beneficial to health, in some cases latent problems may place those undertaking exercise programmes at risk.

At the inquest, evidence was given of a pre-exercise screening test developed by Sports Medicine Australia, a body under the aegis of the Commonwealth

Department of Health and Ageing. Evidence was also given that Justice Health was itself in the course of developing a new screening questionnaire for prisoners being received into or transferred within the NSW corrections system. Much of the ground covered by the Sports Medicine Australia document was covered by the draft Justice Health document. Nevertheless, there appeared to be advantage in incorporating some aspects of the SMA document into the new Justice Health document.

The final issue was that of CCTV coverage of the 'D' pod exercise. After Mr Whitton's death, the police investigators obtained copies of the relevant CCTV tapes. They discovered that the cameras did not provide complete coverage of the exercise yard. As there is no watchtower on the perimeter of the yard, this raised an obvious security and safety issue.

Formal Finding:

That on 28th March 2008, at Wellington Correctional Centre, Steven Charles Whitton died in the 'D' pod yard after suffering Cardiac Arrhythmia caused by Ischaemic Heart Disease and Coronary Atheroma

DSC Dillon made the following recommendations pursuant to s.22A of the Coroners Act:

To the Minister for Health:

1. That Justice Health staff commencing work at a Dept of Corrective Services facility is given a workplace induction including familiarisation with emergency equipment.
2. That Justice Health considers incorporating the Sports Medicine Australia pre-exercise screening assessment criteria in its reception and transfer health assessment questionnaire for prison inmates.

To the Minister for Corrective Services:

1. That CCTV footage of the exercise yards at the Wellington Correctional Facility is reviewed and gaps in the CCTV monitoring coverage be eliminated.

14. 595/08 Roy Robert Puckeridge

Inquest into the death of Roy Robert Puckeridge on the 10 April 2008 at Junee Correctional Centre. Finding handed down by Deputy State Coroner Milovanovich on the 26 November 2009.

Roy Puckeridge died at the Junee Correctional Centre, Junee on the 10th April 2008.

The deceased was sentenced to a term of imprisonment for 20 years for the offence of Murder. The deceased was eligible for release on parole in 2010.

The deceased had an extensive medical history and had been diagnosed with Chronic Obstructive Airway Disease and was seen regularly by the visiting Doctor. The deceased was a heavy smoker. The deceased was prescribed a number of medications, including Celecoxib, Esomeprazole Magnesium Trihydrate, Nifedipine and Panadeine.

On the 10th April 2008 the deceased awoke and was seen by other prisoners to be his normal self. He had presented for his medication and returned to his cell and had not made any complaints to either medical or correctional staff in regard to not feeling well. At about 9.00am the deceased was seen to be lying on the floor of his cell and was unresponsive. A medical emergency was called and nursing staff administered CPR, which continued for 20 minutes until the arrival of the NSW Ambulance. The deceased could not be revived. His treating Doctor was at the Junee Correctional Centre at the time and pronounced life extinct.

The Coroner was satisfied that the deceased had died from natural causes. A post mortem examination confirmed the cause of death as being Coronary Atherosclerosis. No prohibited drugs or alcohol was detected in the deceased blood. There were no suspicious circumstances surrounding the death.

Formal Finding:

That Roy Robert Puckeridge died on the 10th April 2008 at the Junee Correctional Centre, Junee in the State of New South Wales from Coronary Atherosclerosis.

15. 669/08 Thi Pham

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Inquest into the death of Thi Pham on the 19 June 2008 at Nepean Hospital. Finding handed down by Deputy State Coroner Milovanovich on the 30 June 2009.

Thi Pham aged 64 years, died from natural causes while serving a sentence of imprisonment.

Facts.

The deceased was sentenced to a term of imprisonment of 5 years and 10 months in 2007 for drug trafficking offences. Her earliest release date on parole was on the 18th September 2009.

The deceased had a number of medical problems before her incarceration and her medical condition deteriorated while in custody. In June 2007 the deceased suffered a stroke, which resulted in hospitalisation. The deceased recovered from the stroke and was placed on Warfarin therapy of 4-5 mg daily. The deceased was regularly monitored by Justice Health while in custody and her condition appeared to be stable.

On the 18th June 2008 the deceased collapsed at the Dillwynia Women's Correctional Centre, Windsor and was taken by Ambulance to Hospital. Tests revealed that the deceased had suffered a 4 x 4 cm cerebral haemorrhage. The deceased did not recover from this second stroke and was confirmed to be brain dead.

On the 19th June 2008 a decision was made to withdraw further life support, the ventilator was turned off and life was pronounced extinct.

The death was identified as one falling within the provisions of Section 13A of the Coroners Act 1980 and reported to the Office of the State Coroner. A post mortem examination was ordered and the final post mortem report confirmed the cause of death as being Pneumonia and Pulmonary Thromboembolism following Intracerebral haemorrhage following Warfarin therapy.

An investigation by Police and the Department of Corrective Services confirmed that there were no suspicious circumstances surround the death of the deceased and there was no evidence to suggest that she had been assaulted. The Coroner was satisfied that the deceased had died from natural causes.

Formal Finding:

That Thi Pham died on the 19th June 2008 at Nepean Hospital, Penrith in the State of New South Wales from Pneumonia and Pulmonary Thromboembolism following Intracerebral Haemorrhage due to or following Warfarin Therapy.

16. 773/08 John Darad Drage

Inquest into the death of John Darad Drage on the 24 March 2008 at Cessnock Hospital. Finding handed down by Deputy State Coroner MacMahon on the 14 July 2009.

Background:

John Darad Drage was a thirty six year old man who, on 24 March 2008, was serving a sentence of imprisonment at the Cessnock Correctional Centre. He had been at that facility since 5 March 2008. At about 12.15 pm he was seen to stumble from his cell clutching his chest and grasping for breath. He fell to the ground on the concrete outside his cell. Other inmates came to his help, called for assistance from prison authorities and provided CPR until nursing and paramedic assistance arrived. Ambulance officers transferred Mr Drage to Cessnock District Hospital where a doctor found him to be deceased.

Function of the Coroner:

The role and function of a Coroner is found in Section 22, Coroners Act 1980. That section, in summary, provides that at the conclusion of an Inquest the Coroner is required to establish, should sufficient evidence be available, the fact that a person has died, the identity of that person, the date and place of their death and the cause and manner thereof.

Section 22A also provides that a Coroner conducting an inquest may make such recommendations as he or she considers necessary or desirable in relation to any matter connected with the death with which the Inquest is concerned. The making of recommendations is discretionary and relates usually, but not necessarily only, to matters of public health, public safety or the conduct of services provided by public instrumentalities. In this way the coronial proceedings can be forward looking, aiming to prevent future deaths, rather than allocating blame.

Mr Drage was a person who died whilst in custody. He had been sentenced on 29 January 2008 and was due for release on 25 July 2008. Section 13A provides that where that occurs it is mandatory for an inquest to be conducted by either the State Coroner or a Deputy State Coroner. At such an inquest the Coroner is, in addition to the matters set out in Section 22, also required to be satisfied, in general terms, that the circumstances of incarceration did not cause, or materially contribute, to his death.

Matters for Determination:

Dr K Lee, a forensic pathologist, conducted an autopsy and expressed the view that the cause of Mr Drage's death was aortic stenosis. Dr Lee thus concluded that Mr Drage's death was due to a natural cause process.

Aortic stenosis is a valvular disease that can develop in early childhood and progress for a considerable time before symptoms develop. It may cause very little interference in the life of a person who suffers from the condition before symptoms develop. At that time, however, sudden collapse and death is a real possibility. Dr Lee's examination found that in the case of Mr Drage the degree of his aortic valvular disease was such that sudden collapse and death could have occurred at any time.

Mr Drage was aware that he was suffering from aortic stenosis. In 2006 his general practitioner referred him to Professor P. J. Fletcher, Director, Cardiovascular Department, Hunter New England Health, for assessment. Professor Fletcher diagnosed him as suffering from:

> *'a bicuspid aortic valve associated with severe concentric left valve hypertrophy. The valve is both stenosed and incompetent.'*

In November 2006 Professor Fletcher confirmed that Mr Drage would need to have an aortic valve replacement at some time and noted that he was:

> *'extremely frightened, disturbed and anxious about the prospect'.*

Professor Fletcher gave him advice about the management of his condition and recommended he be further assessed in twelve months.

Possible assault:

The investigation into the death of Mr Drage raised the possibility that he had been the subject of an assault by other inmates whilst in custody. The coronial investigation was thus directed towards whether or not such an assault had occurred and if so could it have contributed to his death.

The suggestion that Mr Drage had been assaulted arose from two sources. The first was when an inmate alleged that Mr Drage had been assaulted in his cell immediately before he collapsed. In addition Mr Drage's mother, and a family friend, stated that Mr Drage had informed them prior to his collapse he had been assaulted. These allegations were thoroughly examined as part of the coronial investigation.

As far as the suggestion that Mr Drage was assaulted in his cell immediately before he collapsed is concerned I am satisfied that this did not happen.

The suggestion that this had occurred arose from an allegation made to correctional staff on 2 April 2008 by an inmate Richard Whitten. Whitten alleged to Senior Assistant Superintendent C.P. MacGregor that:

'he had been 3 feet away from the cell and saw three inmates in Drage's cell, an argument occurred because Drage was not helping the wing cleaners and one of the three inmates in the cell punched Drage in the side (Whitten believed) that as a result of this punch Drage went into convulsions which in turn caused his heart to stop'

This allegation was contradicted by all other inmates in the vicinity of Mr Drage's cell at the time and was, in fact, subsequently withdrawn by Whitton. Whitton appears to have made the allegation in order to obtain a personal benefit. The foundation for the suggestion appears to have been rumour.

I am satisfied that there is no credible evidence to suggest that on 24 March 2008 Mr Drage was assaulted in his cell shortly before he collapsed.

In addition Mr Drage's mother, as well as a family friend, informed police that Mr Drage had complained of being assaulted whilst he was in custody.

The Justice Health nursing progress notes for 11 March 2008 record that he complained of an assault that had occurred on 7 March 2008. Following an examination by the registered nurse the record of examination was that he suffered:

'slight bruising to (L) upper eyelid noted. No other obvious injuries noted.'

Mr Drage appears to have first reported this injury to his mother on 7 March 2008. At that time he told her he had fallen out of bed and split his lip and blackened one of his eyes. On 8 March 2008, however, Mr Drage told his mother that he had been assaulted by another inmate and received the injuries because he had been:

'mauling the fruit (handling the fruit too much)'

Mr Drage also reported the alleged assault to correctional staff. They, in turn, reported it to the Police. The police report records Mr Drage as alleging he had been assaulted by an unknown aboriginal male, that he had been treated for bruising to his mouth, that he denied knowing who his alleged attacker was and that he did not want the matter to be investigated any further.

On the evidence available it would seem likely that Mr Drage was assaulted on 7 March 2008. It is not, however, the function of the Coroner to investigate such matters except insofar as they affect a determination of the cause and manner of Mr Drage's death. The question that must therefore be answered is whether or not there is any evidence to suggest that the assault, if it occurred, contributed to Mr Drage's death.

Dr Cala, a forensic pathologist employed at the Department of Forensic Medicine Newcastle, gave evidence at the Inquest.

Dr Cala had available to him the clinical findings made by Dr Lee at autopsy (Dr Lee, the pathologist who undertook the autopsy, was unavailable to give evidence) and was able to give evidence as to the cause of Mr Drage's death and the contribution to his death, if any, of the injuries he suffered on 7 March 2008.

Dr Cala' s evidence was, in summary, that the post mortem examination showed no evidence of any recent assault suffered by Mr Drage, that had he had been assaulted on 7 March 2008 the injuries he received did not contribute to his death and that his death, which Dr Cala agreed was caused by the condition of aortic stenosis, was a result of a natural cause. I found Dr Cala to be an impressive witness and I accept his evidence.

I am satisfied that even if Mr Drage was assaulted on 7 March 2008 there is no evidence to suggest that any injuries he might have suffered contributed to his death on 24 March 2008. I am satisfied that Mr Drage died as a result of the natural progression of his previously existing condition of aortic stenosis and that the manner of his death is natural cause.

Place of death:

The Report of death to the Coroner (P79A) suggested that Mr Drage died at Cessnock District Hospital on 24 March 2008. This was based on the certificate of life extinct issued by Dr Kenneth Dobler who examined him at the hospital and found him to be deceased at 1.12pm that day.

The evidence would, however, suggest that Mr Drage died at the Correctional Centre. When examined by the Justice Health registered nurse at 12.18pm he was found to be:

> *'cyanosed, nil pulse present, ?x1 cheyne-type breath heard, then nil resps. Pupils fixed and unequal.'*

Mr Drage was also assessed as having a Glasgow Coma Scale of '3'(the lowest possible score). On the evidence I am satisfied that Mr Drage died at the Correctional Centre at or about the time the Justice Health nursing staff arrived at his cell.

Other matters:

The unexpected death of a man of 36 years of age is always distressing and difficult for family and loved ones to accept particularly when the deceased is serving a sentence of imprisonment. They naturally ask themselves whether the fact of the imprisonment contributed to the death. Mr Drage's mother expressed the view at the Inquest that it did. She thought that had he not been sentenced to imprisonment he might not have died when he did. It is not within the jurisdiction of a Coroner to review the decision of a sentencing court and, as such, no evidence was called at the Inquest in support, or otherwise, of this suggestion. What might have happened had Mr Drage not been sentenced to imprisonment is thus a matter of speculation and not something that this court is able to determine.

Formal Finding:

John Darard Drage died at the Cessnock Correctional Centre, Cessnock on 24 March 2008. The cause of his death was aortic stenosis and the manner of his death was a natural cause process.

17. 1047/08 Christine Michelle Paterson

Inquest in to the death of Christine Michelle Paterson on the 6 September 2008 at Windsor. Inquest suspended by Deputy State MacMahon on the 4 September 2009.

The death of Christine Michelle Paterson was deemed to be a death resulting from a police operation. Following advice from investigating police a known person was charged with an indictable offence arising from the death. The NSW deputy State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

18. 1048/08 Christine Sarah Paterson

Inquest in to the death of Christine Sarah Paterson on the 6 September 2008 at Windsor. Inquest suspended by Deputy State MacMahon on the 4 September 2009.

The death of Christine Sarah Paterson was deemed to be a death resulting from a police operation. Following advice from investigating police a known person was charged with an indictable offence arising from the death. The NSW deputy State Coroner in accordance with the Coroners Act suspended the inquest. No formal finding other than identity date and place of death was made.

19. 1137/08 Eric Thomas Turner

Inquest into the death of Eric Thomas Turner on the 15 July 2008 at Long Bay Gaol. Finding handed down by Deputy State Coroner MacMahon on the 22 December 2009.

(Note: This is a summary of findings delivered in court. For detailed reasons a transcript of the findings should be applied for.)

Mr Turner was at the time of his death in the custody of the Department of Corrective Services. He has been in custody from 26 August 1973. As such the conduct of an inquest into his death by either the State Coroner or a Deputy State coroner is mandatory (Section 13A(1)(a)).

Mr Turner was diagnosed as suffering from small cell carcinoma of the lung in May 2007. The condition was considered terminal.

Mr Turner underwent palliative chemotherapy and radiotherapy for his treatment.

On 12 June 2008 Mr Turner collapsed in his cell. He was admitted to Prince of Wales Hospital, Randwick for treatment. He was found to be suffering from cerebral metastases secondary to the primary lung tumour. Mr Turner refused further palliative treatment.

On 27 June 2008 he was readmitted to the Long Bay Hospital.

On 14 July 2008 Mr Turner died. An autopsy found that the direct cause of Mr Turner's death was:

1. (a) Acute bronchopneumonia, due to
(b) Metastatic adenocarcinoma of the left lung.
2. Coronary artery and hypertensive heart disease.

An examination of the care and treatment provided to Mr Turner by the Department of Corrective Services and Justice Health during Mr Turner's end stages found that it was appropriate. No recommendations were made pursuant to section 22A.

Formal Finding:

Eric Thomas Turner (born 18 February 1928) died on 14 July 2008 at the Long Bay Hospital, Malabar NSW. The cause of his death was:
1. (a) Acute bronchopneumonia, due to
(b) Metastatic adenocarcinoma of the left lung.
3. Coronary artery and hypertensive heart disease.

The manner of his death was natural.

20. 1247/08 Jason Hapi

Inquest into the death of Jason Harvey on the 30th July 2008 at York Street, Sydney. Finding handed down by Deputy State Coroner MacMahon on the 9 November 2009.

The short facts are that Mr Hapi suffered from chronic paranoid schizophrenia for which he had been receiving treatment for many years. There was evidence of three previous attempts of self-harm two of them in 2008. The latter two occurred after he had decided to cease taking medication because of the weight gain it caused. On 30 July 2008 at about 1pm he was found on the upper floor of 51 York Street and escorted from the building.

He was subsequently observed on a ledge on the top floor of 55 York Street. Police were advised and attended. Negotiators were also called and attended. The police negotiator communicated with Mr Hapi for some time but was unable to get him to leave the ledge.

Police rescue officers attended the building and consideration was given to attempting to overpower Mr Hapi but this was rejected as being likely to be unsuccessful. Unfortunately just before 3.45pm Mr Hapi pushed himself backwards and fell to his death in York Street.

The event was dealt with as a critical incident by the Police and investigated independently of the relevant Local Area Command. The investigation found that the actions of the relevant police involved were appropriate and the Critical Incident Guidelines were complied with one exception that was not possible to be complied with and did not; in any event, interfere with the outcome of the investigation.

I did not make any recommendations under Section 22A.

I made an order in accordance with section 44(4) allowing the publication of the proceedings and findings of the Inquest but made anon-publication order in respect of with the name of the deceased an any material that would identify the deceased. I also made non-publication orders in respect of certain crime scene photographs and the photographs of Mr Hapi on the ledge of the building during the time that the police were negotiating with him.

The parents of Mr Hapi were in attendance at the Inquest and Mr Hapi's father gave evidence.

Formal Finding:

Jason J.Harvey HAPI (born 19 March 1980) died on 30 July 2008 in York Street Sydney. The cause of his death was multiple injuries, which he sustained when he jumped from the roof of 55 York Street Sydney with the intention of taking his own life.

21. 1582/08 Rona Shaw

Inquest into the death of Rona SHAW on the 15 September 2008 at Macquarie Hospital. Finding handed down by Deputy State Coroner Milovanovich on the 16 March 2009.

Rona Shaw, aged 74 years died in a Hospital in which she was as an involuntary patient under the provisions of the Mental Health Act.

The deceased had resided at the Lavender Unit, Macquarie Hospital, North Ryde, NSW for the past 15 years and had been diagnosed with schizoaffective disorder and developmental disabilities. The deceased also had a number of medical problems, which included a history of pulmonary embolus, recurrent transient ischaemic heard disease and oesophageal reflux. At the time of her death, the deceased was an involuntary patient under the Mental Health Act and accordingly her death was identified and reported to the Office of the State Coroner as a death falling within the provisions of Section 13A of the Coroners Act 1980 (a death in custody).

Police conducted an investigation into the death and following the submission of a brief of evidence a mandatory inquest was held. The Coroner was satisfied as to the identity of the deceased and the date and place of her death. The Coroner was satisfied that the deceased had been a long term resident of the Lavender Unit, Macquarie Hospital and that she had died from a combination of natural causes and her disabilities. The deceased family had no concerns regarding the care and treatment that the deceased had received while a patient at Macquarie Hospital.

A death certificate was issued by the deceased treating Doctors, however, that certificate was invalid due to the mandatory reporting requirements of Section 13A of the Coroners Act. The Coroner directed that no post mortem examination was necessary and the Coroner determined the cause of death from the known medical history and the facts presented.

Formal Finding.

That Rona Shaw died on the 15th September 2008 at the Lavender Unit, Macquarie Hospital, North Ryde in the State of New South Wales from Aspiration Pneumonia, Lack of Nutrition, Depression and Schizoaffective disorder.

22. 1012/08 Dana McEwan

Inquest into the death of Dana Andrew McEwen on 7 June 2008 at Kempsey Hospital. Finding handed down by Deputy State Coroner Milovanovich on 3 December 2009.

Dana McEwan, aged 31 years died at the Mid North Coast Correctional Centre, Kempsey from natural causes.

The deceased was a 31 year old Aboriginal male who was sentenced to a fix term of 3 months on the 21st April 2008 for motor traffic offences.

The deceased has been diagnosed with cardiac complications and underwent surgery in 2004 to clear a blockage in his heart following a heart attack. The deceased was prescribed various medications for his high blood pressure and high cholesterol.

When the deceased was admitted into custody his medical history was disclosed and he was prescribed and administered various medications which where routinely dispensed to him through the Clinic at the Correctional Centre. The medical files indicated that the deceased was generally compliant with his medication.

On the 7th June 2008 the deceased was involved in a game of touch football and during the game he was seen to collapse. Inmates immediately went to his assistance and informed correctional staff who immediately instigated a medical alert and requested the assistance of nursing staff and called for an ambulance. Initially the deceased was seen to be breathing, however, when he stopped breathing CPR was commenced by correctional staff, continued by Nursing Staff and the Paramedics when the Ambulance Service arrived. The deceased was transported to hospital, however, he could not be revived and was pronounced deceased at Kempsey District Hospital.

The Coroner was satisfied that the deceased had died from natural causes. A post mortem examination confirmed the cause of death as being Coronary Artery Heart Disease. No illegal drugs or alcohol was found in the deceased blood. The Coroner was satisfied that the deceased had been appropriately assessed when admitted into the Correctional Centre and that his care and treatment for his medical condition was appropriate.

Formal Finding

That Dana McEwen died on the 7th June 2008 at the Kempsey District Hospital, Kempsey in the State of New South Wales from Coronary Artery Heart Disease.

23. 2219/08 Joseph Nguyen

Inquest into the death of Joseph Nguyen between the 21 November 2008 and 22 November 2008 at Mid North Coast Correction Centre. Finding handed down by Magistrate MacMahon on 14 October 2009

The death of Joseph NGUYEN was reported to the Kempsey Coroner on the 24th November 2008 following the death of Mr Nguyen at the Mid North Coast Correctional Centre, Aldavilla, NSW some time between 10pm on the 21st November and 12.18pm on the 22nd November 2008.

The Local Coroner issued an order pursuant to Section 48 of the Coroners Act 1980 for a post mortem examination to be conducted. The deceased was transported to the Institute of Forensic Medicine at Newcastle where Dr Kasinathan Nadesan performed a post mortem examination on the 25th November 2008.

The death of Mr Nguyen was identified as a death falling within the provisions of Section 13A of the Coroners Act 1980, that is, being a death in custody. Pursuant to Section 13A of the Coroners Act an Inquest into the death of a person who dies in custody is mandatory and can only be presided over by the State or one of the Deputy State Coroners.

Accordingly the investigation into the death of Joseph Nguyen was transferred by the Kempsey Coroner to the Office of the State Coroner, Glebe. I in my capacity as the NSW Deputy State Coroner was allocated the responsibility of reviewing the investigation and presiding over the Inquest.

The Role of the Coroner.

In this case, Mr Nguyen's family, being his Sister, Hong Nguyen and his mother Thi Ca Phu expressed a desire to attend and participate in the Inquest. Nr Nguyen's sister attended one of the hearing days at Wauchope and his mother attended and also gave evidence at the resumption of the hearing (with the aid of an Interpreter) at Parramatta on the 9th October 2009.

The Coroners role in an Inquest is to determine the identity of the deceased, the date and place of death and the manner and cause of death. The finding that the Coroner makes under Section 22 of the Coroners Act 1980 becomes the official cause of death recorded on the deceased's certified death certificate.

The Coroner also has the power under Section 22A to make recommendations and recommendations are usually made on issues that touch upon public health and safety. In regard to the death of Joseph Nguyen the evidence that has been presented indicates that the issues of identity, date and place of death and the manner and cause of death are all apparent and unchallenged.

Background and Established Facts.

The deceased was a 27-year-old male who had been sentenced to a term of imprisonment of 14 months, which was imposed at the Local Court Liverpool on the 18th February 2008. The deceased was convicted of offences involving Receiving and Disposing of Stolen Property and Attempted Break Enter and Steal.

The total sentence imposed on the deceased would have expired on the 21st April 2009 however; he was eligible for parole as from the 21st December 2008.

The deceased was initially classified as a CIU inmate with placement at the Metropolitan Remand and Reception Centre on the 21/2/2008. He was subsequently re-classified as C2 and transferred to the Parramatta Correctional Centre. On the 29/2/2008 he was transferred to the Silverwater Correctional Centre and remained there until his transfer on the 16/9/2008 to the Mid North Coast Correctional Centre. It is understood that this last transfer was due to the Silverwater Correctional Centre being in operational during renovation works.

The deceased was subjected to the normal intake procedures when he arrived at the Mid North Coast Correctional Centre. A risk assessment determined that he had no current or prior suicidal ideation and was not at any risk of self-harm. He was checked medically and made a disclosure that he was taking Serequel for Schizophrenia; however, no other ailments or medical problems were disclosed or detected. The deceased did not make any disclosure regarding any possible heart condition or ailments that might be considered as relevant in regard to any cardiac problem, at the time of his reception at the Mid North Coast Correctional Centre. It is highly probable that the deceased was not aware that he had any cardiac or cardio vascular compromise.

After assessment the deceased was housed in Unit W4, Cell number 22, bed 1. Unit W4 is a minimum security section of the gaol and houses 10 inmates the majority of which were all low risk category C2. The 10 inmates in Unit W4 share half the wing, which comprises of 6 rooms. The majority of the inmates at the gaol work at the facility, the individual cells are not locked, however, the unit is locked down at night. The unit allows the prisoner's free access within the unit including the use the common area, kitchen and have access to each other prisoners cells.

On the 21st November 2008 the deceased had gone about his daily duties and as per the normal routine was locked into his unit block at 6.00pm by Correctional officers. Correctional Officers have stated that at the time the deceased was locked into the unit he made no complaint regarding feeling unwell and that he appeared to be physically well.

The evidence presented would suggest that after lockdown the deceased was in his cell and laying down and was in the company of his cell mate Chui Ngo. At around 8.30pm another inmate in the unit by the name of Aaron Ames

came and spoke to the deceased. Inmate Ames invited the deceased to come out and play cards, they then joked for a short time and kicked an exercise ball around in the corridor for around 10 to 15 minutes. Inmate Ames has stated that the exercise was somewhat strenuous and that he was a little "puffed" after the activity. The evidence would suggest that the deceased returned to his room some time between 9.30 and 10pm. Inmate Ames has stated that he fell asleep watching a movie and woke around 11.40pm.

At about this time the evidence suggests that Inmate Ngo was playing cards with other inmates and when he returned to his cell he saw the deceased laying face down on his bunk. Inmate Ngo approached the deceased and nudged his shoulder, however, he did not respond. Inmate Ngo then noticed that it appeared as if the deceased might have wet himself. Inmate Ng then called the other inmates, which resulted in Inmates Ames, Steain and Pham attending the deceased's cell.

They all tried to rouse the deceased and noticed that he appeared blue in the face and then called the Correctional officers who attended shortly thereafter.

Corrections officers Susanne Waters and David Kyle attended the scene with other inmates. They rolled the deceased over and noticed mucous and blood coming from his nose and mouth. They commenced CPR and an ambulance was called. The Ambulance attended at 12.45am and the ambulance officers examined the deceased. The Ambulance Officers confirmed that the deceased had been dead for some time. Police where then called, the area in which the deceased was located was declared a crime scene and was locked down. Police found no drug paraphernalia or any other evidence to suggest that the death of Joseph Nguyen was suspicious.

The post mortem examination conducted on the 25th November 2008 by Dr Nadesan determined that the cause of death was due to Coronary Artery Disease. Dr Nadesan has stated that the deceased had mild to moderate enlargement of the heart with the right coronary artery and left main coronary artery showing more than 90% focal occlusion with atheroma. Toxicology results revealed that the deceased had no drugs or alcohol in his system at the time of his death.

It would appear that the deceased did not know that he had significant heart disease. There was nothing located in the medical records to indicate that the deceased had ever declared having a heart condition, nor did he ever complain about heart related symptoms, such as, chest pain, tingling in fingers, numbness in arms and fingers or dizziness.

The Correctional Officers who gave evidence at the Inquest have stated that the deceased did not make any disclosure to them on the day prior to his death of feeling unwell or expressing a desire to see a Nurse or Doctor. Evidence has been given and the medical records confirm that the deceased presented himself to Nursing Staff on the 18th November 2008. The medical records indicate that the deceased complained that he had coughed up blood in the morning after coughing during the night.

It is understood that the deceased indicated that he noticed streaks of blood in mucous that he had coughed up. The medical records indicate that the deceased was examined, no trauma was detected to the bronchi and vital observations appeared normal. His blood pressure was 120/70 and Oxygen saturation at 97% with a temperature of 36 degrees ©. The above observations would indicate that the deceased was certainly not exhibiting any signs of heart failure when he presented to the Clinic on the 18th November 2008.

It is clear from the evidence that the deceased has died from natural causes. There was no evidence of a struggle or any marks on the deceased body. It would appear that he has died in his sleep from his compromised cardio vascular system. The investigation also confirmed that the deceased had not activated the "knock up" button in his cell which would support that it is unlikely that the deceased was feeling unwell, but rather that his death was either sudden or in his sleep.

The Department of Corrective Services conducted an internal investigation and a copy of that investigation has been provided to the Coroner and has been tendered and marked as Exhibit 9. That investigation also confirmed that the deceased had been appropriately assessed upon admission and appropriately cared for while in custody.

Thi Ca Phu, the deceased's mother has given evidence at this Inquest and has expressed the view that her son's death could possibly been avoided if he had received appropriate medical attention. Mrs Phu also expressed the view (albeit through an interpreter) that "there had to be some justice" in relation to her son's death. The Coroner's Court of course, is not a court of justice, but a court of Inquiry with limited statutory responsibility. The Coroners Court is also not the vehicle through which, a person convicted and or incarcerated, may ventilate the appropriateness of the conviction and or sentence.

I am satisfied on reviewing all the evidence that Joseph Nguyen had died from natural causes and that his death was sudden and unexpected. There was no evidence to suggest that he had made a complaint or had been diagnosed with any life-threatening ailment that would have required Justice Health to provide immediate medical assistance or the transfer of the deceased to a hospital. On the balance of probabilities, I am satisfied that the deceased died on the 21st November as the evidence would suggest that he had been deceased for some time when first examined by ambulance staff at about 12.45am on the 22nd November 2008.

Formal Finding.

That Joseph Nguyen died on or about the 21st November 2008 in Cell 22, Wing 4, Mid North Coast Correctional Centre, Aldavilla, New South Wales from Coronary Artery Disease.

*** W denotes Westmead Matter**

No.	File No.	Date of Death	Place of Death	Age	Circumstances
1	1740/06	09/11/06	Darlinghurst	46	In custody
2	749/07 (w)	31/07/07	Penrith	28	Police Op
3	1020/07	14/6/07	Old Bar	34	Police Op
4	1231/07 (w)	25/12/07	Westmead	44	Police Op
5	63/08	04/01/08	Main Arm	36	Police Op
6	418/08	12/03/08	Eastwood	22	Police Op
7	541/08/2625/09	23/05/08	Malabar	53	In Custody
8	567/08/2977/09	28/05/08	Westmead	23	In Custody
9	816/08	22/07/08	Silverwater	27	In Custody
10	1202/08	23/07/08	Newcastle	49	In Custody
11	1435/08	26/08/08	Goulburn	39	In Custody
12	1793/08	10/10/08	Belmont	43	Police Op
13	1969/08	28/01/08	Junee	50	In Custody
14	1647/08	23/09/09	Quirindi	40	Police Op
15	2474/08	20/12/08	Penrith	25	In Custody
16	2523/08	27/12/08	Sydney	40	In Custody
17	40/09	31/12/08	Brooklyn	40	Police Op
18	168/09	16/01/09	Blacktown	26	Police Op
19	174/09	18/01/09	Deepwater	21	Police Op
20	180/09	19/01/09	Castlereagh	41	Police Op
21	847/09	17/02/09	Yowie Bay	67	In Custody (home det)
22	710/09	16/03/09	Silverwater	34	In Custody
23	725/09	17/03/09	Silverwater	24	In Custody
24	744/09	19/03/09	Erskineville	34	Police Op
25	777/09	22/03/09	Woollamia	18	Police Op
26	832/09	27/03/09	Malabar	26	Police Op
27	948/09	8/04/09	RPA Hospital	74	In Custody
28	1221/09	30/04/09	Gilgandra	33	Police Op
29	1196/09	3/05/09	Nowra	34	Police Op
30	1213/09	4/05/09	Penrith	32	In Custody
31	1330/09	17/05/09	Canberra	48	In Custody
32	1519/09	2/06/09	Armidale	24	Police Op
33	1868/09	4/07/09	Malabar	76	In Custody
34	1949/09	10/07/09	Parklea	57	In Custody
35	1961/09	11/07/09	Malabar	68	In Custody
36	2204/09	31/07/09	Katoomba	25	Police Op
37	2304/09	10/08/09	Willoughby	63	Police Op
38	2539/09	1/09/09	Canley Vale	18	Police Op
39	2648/09	11/09/09	Bathurst	42	In Custody
40	2897/09	2/10/09	Walgett	34	Police Op
41	3043/09	20/10/09	Randwick	62	In Custody
42	3333/09	18/11/09	Campsie	36	Police Op
43	3605/09	14/12/09	Lithgow	56	In Custody
44	3716/09	25/12/09	Lisarow	46	Police Op
45	3744/09	31/12/09	Liverpool	2	Police Op