



**CORONERS COURT  
OF NEW SOUTH WALES**

<b>Inquest:</b>	Inquest into the death of Neville Gilbert Betteridge
<b>Hearing dates:</b>	18 July 2018
<b>Date of findings:</b>	18 July 2018
<b>Place of findings:</b>	State Coroner's Court, Glebe
<b>Findings of:</b>	<b>State Coroner Les Mabbutt</b>
<b>File number:</b>	2017/63039
<b>Catchwords</b>	CORONIAL – Death in lawful custody, natural causes
<b>Representation:</b>	Coronial Advocate assisting the Coroner Mr Peter Bain  Mr Jobe for Corrective Services NSW Ms Li for Justice Health NSW

**Non publication order s 74(1) of the Coroners Act 2009**

1. *That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the Coroners Act 2009 (NSW):*
  - a. *The names, addresses, phone numbers and other personal information that might identify:*
    - i. *Any member of Mr Betteridge's family; and*
    - ii. *Any person who visited Mr Betteridge while in custody (other than legal representatives or visitors acting in a professional capacity).*
  - b. *The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW'), other than Mr Betteridge.*
  - c. *Direct contact details of CSNSW Officers not otherwise publicly available.*

- d. *Information relating to inmates, other than Mr Betteridge, contained in the Justice Health document entitled 'Long Bay Hospital Aged Care Bed Demand Meeting Minutes' which is located within CSNSW records.*
  - e. *The Metropolitan Special Programs Centre ('MSPC') Area 1 employee daily schedules for 25, 26 and 27 February 2017.*
  - f. *Floor plans of MSPC Area 1.*
2. *Pursuant to section 65(4) of the Coroners Act 2009 (NSW), a notation be placed on the Court file that if an application is made under s.65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.*

## **Introduction**

Mr Neville Betteridge died on 27 February 2017 at Prince of Wales Hospital at 72 years of age. At the time of his death Mr Betteridge was undergoing treatment at the Prince of Wales Hospital, Randwick whilst in corrective service custody.

### **Why was an inquest held?**

Mr Betteridge was in lawful custody at the time of his death. An inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009*.

The role of the Coroner pursuant to s 81 of the *Coroners Act 2009* is to make findings regarding:

- The identity of the deceased
- The date and place of that person's death
- The cause and manner of that person's death

A Coroner may also make recommendations in accordance with s 82 of the Act concerning any public health or safety issues arising out of the death.

### **Mr Betteridge's background**

Mr Betteridge was born in Beecroft, Sydney and grew up in Epping. Mr Betteridge's parents separated when he was five. He and his brother were raised by their mother and grandmother. Mr Betteridge attended high school at Trinity Grammar, Summer Hill and Epping Boys High.

Upon finishing high school, he gained employment as a teacher at Blue Mountains Grammar school, before teaching at St Patricks, Sutherland and later Trinity Grammar.

Mr Betteridge eventually left teaching and became a bus tour operator, moving to Queensland. He returned to teaching in 1989 and took a position as housemaster at Ipswich Grammar before moving on to teaching positions in Alice Springs and then Charters Towers, Queensland.

Mr Betteridge never married and had no children. He was a heavy smoker and drinker for most of his life.

### **Mr Betteridge's criminal and custodial history**

In 2004, Mr Betteridge was charged with 2 counts of indecent assault dating back to his time at Blue Mountains Grammar. He was convicted of these offences in late 2004 and received a 3 year good behaviour bond.

In May 2016, Mr Betteridge was arrested in Queensland and extradited to NSW to face child sexual assault charges, related to his time at Blue Mountains Grammar. He appeared at Central Local Court on 12 May 2016 and was remanded into the custody of Corrective Services. At the time of his death Mr Betteridge was due to appear before Penrith Local Court on 17 March 2017 on 128 historical sexual offences.

Mr Betteridge was in custody at MRRC Silverwater before being moved to the Metropolitan Special Programs Centre in June 2016. He was transferred to the Prince of Wales Hospital on 25 January 2017, after a minor fall and deterioration in his health.

### **Mr Betteridge's medical history**

Mr Betteridge suffered mobility problems relating to spinal disability. He relied on the use of a walker for mobility and suffered from chronic foot ulcers. Mr Betteridge had smoked and suffered from vascular disease, severe cardio obstructive pulmonary disease amongst other medical ailments.

Whilst in custody, Justice Health staff noted Mr Betteridge:

- had a history of heart problems
- had poor circulation
- was easily short of breath and required a walker
- had a history of depression, for which he was treated with medication

Mr Betteridge was provided with appropriate mobility aids and medication whilst in custody. Mr Betteridge was seen by vascular and respiratory specialists and was prescribed a nasal spray and inhaler. Mr Betteridge attended the health clinic at least weekly, for regular dressings to both feet and for regular observations.

### **Events leading up to Mr Betteridge's death**

Mr Betteridge's cell mate informed Police that Mr Betteridge had been feeling unwell in the weeks leading up to his hospitalisation.

About 10.30pm 24 February 2017, Mr Betteridge used the toilet in his cell but had trouble getting up from a seated position. Mr Betteridge lost balance and fell, though the impact was lessened by his cellmate who had grabbed him as he was falling.

Mr Betteridge suffered a cut to his elbow, and remained sitting on the floor until Correctives Officers attended a short time later. He was taken to the correctional centre clinic and seen by nursing staff. Mr Betteridge complained of light headedness and tunnel vision. A decision was made at 2.00am on 25 February to transfer Mr Betteridge to the Prince of Wales Hospital.

Mr Betteridge was admitted at the Emergency Department at Prince of Wales Hospital and later transferred to the geriatrics ward. Tests revealed Mr Betteridge was suffering from a urinary tract infection along with a chest infection, suspected of being either influenza or pneumonia. Mr Betteridge was treated with antibiotics and given oxygen. Further tests revealed concerns with the electrical impulses from Mr Betteridge's heart. It was thought he was also suffering from an artery blockage near his lungs.

About 9.00am, on the morning of the 27<sup>th</sup> February, Mr Betteridge's oxygen levels dropped. Mr Betteridge was given more oxygen and monitored. Mr Betteridge became agitated and delirious. Treating physician, Dr Perreira discussed Mr Betteridge's condition with Professor Billeri. The decision was made to transfer Mr Betteridge to the Intensive Care Unit.

Upon arriving at the ICU, Mr Betteridge was in respiratory distress and his blood pressure had decreased. Invasive exploratory surgery in a catheterization laboratory was considered, however cardiac experts, including Professor Allen advised that Mr Betteridge was not a suitable candidate for this procedure.

Mr Betteridge's condition deteriorated and urgent medical intervention was initiated, including intubation and the administration of adrenaline. Mr Betteridge failed to respond to treatment and clinician Dr Collins and Professor Billeri were consulted. Mr Betteridge's condition was such that he was considered not likely to recover. The decision was made to provide palliative care only. Mr Betteridge's died at 1.30pm.

### **Police Investigation**

Police were notified of the death and attended shortly after. Specialist investigators from the NSW Police Corrective Service Investigative Unit conducted the investigation. Specialist forensic police attended the hospital and examined Mr Betteridge.

Detective Sergeant TESORIERO the officer in charge of the investigation gave evidence at the inquest. Mr Betteridge's cellmate, correctional and health staff were interviewed. Medical, health and prison records were obtained and reviewed regarding Mr Betteridge's care and medical treatment whilst in custody.

### **What caused Mr Betteridge's death?**

Forensic Pathologist Dr Du Toit-Prinsloo conducted an external post mortem examination at the Department of Forensic Medicine at Glebe on 1 March 2017.

Dr Du Toit-Prinsloo determined Mr Betteridge's cause of death was a ruptured abdominal aortic aneurysm.

### **Conclusion**

When the death of a person in custody occurs, even of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility to provide adequately care and treatment to the person detained.

There is no evidence to suggest Mr Betteridge was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to Mr Betteridge's death. I am satisfied Mr Betteridge's death was not suspicious.

Records from Justice Health and Corrective Services have been reviewed. Mr Betteridge's care and treatment in custody was appropriate taking into account Mr Betteridge's existing health issues upon his reception into custody in New South Wales following his extradition from Queensland. Mr Betteridge was transferred to Prince of Wales Hospital when treatment was required beyond the capacity Corrective Services medical services.

Mr Betteridge's family has not raised any care and treatment issues. I find that Mr Betteridge received health care and treatment of an appropriate standard whilst in custody.

Having considered all of the evidence both oral and documentary tendered at the inquest I find that that Mr Betteridge died of natural causes whilst in lawful custody.

### **Findings Pursuant to s 81 of the *Coroners Act 2009***

#### **Identity**

The person who died was Neville Betteridge.

#### **Date of death**

27 February 2017.

#### **Place of death**

Prince of Wales Hospital, Randwick, New South Wales.

#### **Cause of death**

Ruptured aortic aneurysm.

#### **Manner of death**

Mr Betteridge died of natural causes whilst in lawful custody.

Les Mabbutt  
**State Coroner**  
**18 July 2018**