STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Carmelo Disano
Hearing dates:	5 October 2018
Date of findings:	5 October 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes
File number:	2015/336444
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Ms S Li for Justice Health & Forensic Mental Health Network Ms S McKinnon for Corrective Services NSW
Findings:	I find that Carmelo Disano died on 13 November 2015 at Long Bay Hospital, Long Bay Correctional Complex, Matraville NSW 2036. The cause of Mr Disano's death was metastatic caecal adenocarcinoma. Mr Disano died from natural causes.

Non-publication orders: Pursuant to section 74(1)(b) of the *Coroners Act 2009*, I direct that the following material is not to be published:

1. The names, addresses, phone numbers and other personal information that might identify:
   (a) Any member of Mr Carmelo Disano's family; and
   (b) Any person who visited Mr Disano while in custody (other than legal representatives or visitors acting in a professional capacity).
2. The names, personal information and Master Index Numbers of any persons in the custody of Corrective Services New South Wales (**CSNSW**), other than Mr Disano.
3. Direct contact details of CSNSW Officers not otherwise publicly available.
4. Legal Correspondence found within Mr Disano's case management file relating to inmate's other than Mr Disano.

Table of Contents

1. Introduction

1.1 At the time of his death Mr Carmelo Disano was being held in lawful custody in a NSW correctional centre. He had been in custody since 2004 and was serving a sentence after being convicted and sentenced in relation to a criminal offence. In September 2014 Mr Disano was diagnosed with a terminal illness and given a prognosis of limited life expectancy. On 13 November 2015 Mr Disano succumbed to the debilitating effects of this illness and died.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This is so even when the death of a person in lawful custody believed to be due to natural causes. It should be noted at the outset that there is no suggestion in this case that the State has not discharged its responsibility in anything other than an appropriate and adequate manner.

3. Mr Disano's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Mr Disano was born in Castiglione in the Sicily region in Italy. He had four sisters and one brother, and was the second youngest child in the family. After leaving high school early, Mr Disano took on an apprenticeship as a tiler. He worked in Italy in the ceramic tiling industry for a number of years, and later spent some time working in Switzerland as well.

3.3 In 1976 Mr Disano migrated to Australia with some of his siblings. They established a home in the suburb of Drummoyne in Sydney. Mr Disano continued his work as a tiler, working for a ceramic company. Mr Disano became self-employed and often worked as a sub-contractor. When not working, Mr Disano often pursued his hobby of fishing.

3.4 In 1978 Mr Disano married and later had two daughters. The family subsequently moved to Concord. In his later years, Mr Disano began to experience difficulties in his marriage, leading to his divorce from his wife in 2004. Following the divorce, Mr Disano became estranged from his children. However, he remained in close contact with his other family members, especially his nieces.

3.5 There is no doubt that Mr Disano is greatly missed by those who were closest to him.

4. Mr Disano's custodial and medical history

4.1 On 2 January 2004 Mr Disano was arrested and charged in relation to an offence arising from a physical altercation with a family member. Mr Disano entered Corrective Services NSW (**CSNSW**) custody on 3 January 2004. On 15 December 2004 Mr Disano pleaded guilty to an offence of manslaughter. He was subsequently sentenced to a term of imprisonment of 17 years with a non-parole period of 12 years, commencing on 2 January 2004 and expiring on 1 January 2016.

4.2 Mr Disano was housed at multiple correctional centres during his subsequent years in custody including at Parramatta, the Metropolitan Remand and Reception Centre, Lithgow, Bathurst, Junee, Goulburn and Oberon.

4.3 On 15 July 2014 Mr Disano reported feeling unwell. He had developed a lump in his abdomen and had experienced several months of decreased appetite and weight loss. Mr Disano was reviewed by a medical officer on 4 August 2014 and subsequently referred for a CT scan of his abdomen on 8 September 2014. The scan revealed that Mr Disano had caecal adenocarcinoma Stage IV B with liver and lung metastases and lymph node involvement.

4.4 On 19 September 2014 Mr Disano was transferred from Oberon Correctional Centre to Long Bay Hospital at Long Bay Correctional Complex. He was initially placed in the Prince of Wales Hospital (**POWH**) Secure Unit before later being transferred to the Medical Sub-Acute Unit (**MSU**) on 22 October 2014.

4.5 On 29 October 2014 Mr Disano commenced palliative chemotherapy treatment. At this time it was noted by Mr Disano's treating clinicians that treatment of his metastatic caecal cancer was not curative, and only for the purpose of hopefully extending his life expectancy. Further, it was noted that "*without treatment, the median overall survival is about 6 months and with treatment, this can potentially double to 12 months in 50% of cases*".[1] Given Mr Disano's poor prognosis, an advanced care directive was discussed with, and signed by, him which confirmed that he was not for resuscitation.

4.6 Between October 2014 and April 2015 Mr Disano was regularly reviewed by the oncology and palliative care teams at POWH. A CT was conducted in April 2016 which showed worsening local and metastatic disease. Mr Disano was also noted to be frail and lethargic, and required regular analgesia

[1] Exhibit 1, Tab 4 at [35].

for pain management. Mr Disano's chemotherapy treatment was changed at that time, and changed again two months later when it was noted that his tumour marker had risen.

4.7 On 1 October 2015 Mr Disano's treating clinicians discussed available treatment options with him. Mr Disano elected to continue with chemotherapy but no further cycles of palliative chemotherapy were administered. On 2 October 2015 Mr Disano was transferred for the final time from the POWH Secure Unit to the MSU. During this period it was noted that Mr Disano was extremely weak and frail, that he began refusing medication, and that he had not been eating and only drinking very little. Mr Disano remained on strong pain relief medication and pressure care was also provided as Mr Disano was spending most of his time in bed.

4.8 Due to Mr Disano's declining condition, arrangements were made for his family members to have increased access to bedside visits from 22 October 2015 onwards. Welfare support services were also provided to Mr Disano and his family members.

5. What happened on 13 November 2015?

5.1 On the morning of 13 November 2015 it was noted that Mr Disano's breathing was shallow and that his condition was declining rapidly. Arrangements were made to notify members of Mr Disano's family who had planned to visit him later in the day. Instead, an earlier visit was arranged and Mr Disano's family spent time with him between about 11:00am and 2:30pm. They were supported by welfare officers and CSNSW chaplain.

5.2 At the end of the visit, CSNSW and Justice Health & Forensic Mental Health (**Justice Health**) staff continued to monitor Mr Disano. During a physical check conducted at around 3:55pm it was noted that Mr Disano was breathing. However, when Mr Disano was checked five minutes later at around 4:00pm he was found to be unresponsive with no signs of life. In accordance with the advanced care directive in place, resuscitation measures were not taken.

6. What was the cause and manner of Mr Disano's death?

6.1 Mr Disano was taken to the Department of Forensic Medicine at Glebe where a post-mortem examination was performed by Dr Rianie Janse Van Vuuren on 18 November 2015. Dr Van Vuuren reviewed Mr Disano's available medical records from POWH and concluded that the cause of his death was metastatic caecal adenocarcinoma.

6.2 There is no evidence to indicate that any external factor contributed to Mr Disano's death. Therefore, his death was due to natural causes.

7. What conclusions can be reached regarding Mr Disano's care and treatment whilst in custody?

7.1 Having considered the available records held by both CSNSW and Justice Health in relation to Mr Disano, I cannot identify any matter associated with Mr Disano's care and treatment whilst in custody that contributed to his death. It is evident that at the time that Mr Disano was diagnosed with his terminal illness, his treatment options were limited as the illness was at an advanced stage. The options were confined to palliative, rather than curative, treatment.

7.2 There is no evidence to suggest that the health care received by Mr Disano whilst in custody was not within an expected standard of care. There is no evidence to suggest that any act or omission by either CSNSW or Justice Health contributed to Mr Disano's death in any way. The evidence indicates that clinical and administrative steps were taken to appropriately manage Mr Disano's declining condition in accordance with his palliative care pathway.

7.3 One matter related to Mr Disano's care whilst in custody requires some further consideration. Due to Mr Disano's declining condition, his family members submitted two applications to the State Parole Authority (**the Authority**) for his early release to parole due to exceptional extenuating circumstances. Both of these applications were declined. In October 2015 additional material in support of a further application was submitted to the Authority. Arrangements were also made to expedite consideration of this material by the Authority. At the time of Mr Disano's death the Authority had not yet made any final determination.

7.4 One of Mr Disano's nieces has queried why the applications for early release to parole were declined.[2] Examination of the previous determinations made by the Authority is beyond the scope and jurisdiction of this inquest. However, on the evidence available there is nothing to suggest that any aspect of the applications made to the Authority was associated with Mr Disano's death.

8. Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Ms Tina Xanthos, Coronial Advocate, for her assistance both before, and during, the inquest. I also thank Detective Sergeant Andrew Tesoriero for his role in the police investigation and for compiling the initial brief of evidence.

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

Identity

The person who died was Carmelo Disano.

Date of death

Mr Disano died on 13 November 2015.

Place of death

Mr Disano died at Long Bay Hospital, Long Bay Correctional Complex, Matraville NSW 2036

Cause of death

The cause of Mr Disano's death was metastatic caecal adenocarcinoma.

Manner of death

Mr Disano died from natural causes whilst in lawful custody.

[2] Exhibit 1, Tab 9 at [12].

19.1 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
5 October 2018
NSW State Coroner's Court, Glebe