CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ian Davidson
Hearing dates:	18 July 2018
Date of findings:	18 July 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Teresa O'Sullivan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes, transport for the frail and aged in custody.
File number:	2016/149781
Representation:	Mr P Bain, Coronial Advocate assisting the Coroner Mena Katawazi, Solicitor, for the Commissioner for Corrective Services Sophie Li, Solicitor, for Justice Health & Forensic Mental Health Network

Non-publication order:	I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), the following material is not to be published: 1. The names, addresses, phone numbers and other personal information that might identify any member of Mr Davidson's family or next of kin; 2. The names and personal information that might identify any victim of the offences for which Mr Davidson was serving a custodial sentence; 3. The direct and personal contact details of Corrective Services New South Wales staff; 4. The names, personal information and Master Index Numbers of any persons in Corrective Services New South Wales custody, other than Mr Davidson; 5. Security checks recorded in the Reception / Intake Journals dated 13 and 14 May 2016, the B Watch OIC's Journals dated 13 and 14 May 2016, the C Watch OIC's Journals dated 13 and 14 May 2016 and the Inmate Accommodation Journals dated 13 and 14 May 2016; 6. The Employee Daily Schedules dated 13, 15, and 16 May 2016; 7. Court Escort Security Unit Senior Correctional Officer MRRC Coordinator C Watch document dated 21 April 2008 and Statement of Duties; 8. Court Escort Security Unit Senior Assistant Superintendent Transport Coordinator document dated 13 September 2002 and Statement of Duties; 9. Court Escort Security Unit Senior Correctional Officer MRRC Coordinator A Watch document dated 21 April 2008 and Statement of Duties; 10. Section 7.25 of the Operations Procedure Manual dated December 2015; 11. Section 6 of the Operations Procedure Manual dated August 2015 reproduced either in part or in full; 12. Corrective Services New South Wales hand held video medical response footage dated 13 May 2016; 13. Corrective Services New South Wales prison truck closed circuit television footage dated 13 May 2016; and 14. The statement of Terry Murrell dated 13 July 2018 and annexures referred to therein including the Standard Operating Procedure dated March 2018 and section 19.1 of the Custodial Operations Policy and Procedures version 1.1. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, I direct that 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.

Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: **The identity of the deceased:** The deceased person was Ian Davidson. **Date of death:** He died on 14 May 2016. **Place of death:** He died at Westmead Hospital, Westmead, NSW. **Cause of death:** He died as a result of complications of hypertensive and atherosclerotic cardiovascular disease. **Manner of death:** Mr Davidson died of natural causes whilst serving a custodial sentence.

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The Coroners Act 2009 (NSW) *in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.*

These are the findings of an inquest into the death of Ian Davidson.

Introduction

Mr Ian Davidson was 84 years old at the time of his death on 14 May 2016. He was an inmate at the Metropolitan Remand and Reception Centre, Silverwater. At the time of his death, Mr Davidson was awaiting transport to the Aged Care Rehabilitation Unit at Long Bay Gaol Hospital.

As Mr Davidson 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* (NSW).

The role of the Coroner

When a person's death is reported to the coroner, there is an obligation on the coroner to investigate the death. The role of a coroner, as set out in s81 of the *Coroner's Act 2009* (NSW), is to make findings as to the identity of the person who died, when they died, where they died, and the cause and manner of their death. If any of these questions cannot be answered then a coroner must hold an inquest.

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 *Coroners Act 2009* (NSW) makes an inquest mandatory in cases where a person dies whilst in lawful custody. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death to ensure that the State adequately discharges its responsibility. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

A short inquest was held on 18 July 2018. The officer in charge of the investigation, Detective Sergeant Andrew Tesoriero, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

There is little information regarding Mr Davidson's life. It is known he was born in 1931, never married and had no children.

A friend advised Police he may have had an estranged sister living in Brisbane, however Police were not able to locate her.

It is known that Mr Davidson worked as a school teacher during the 1950' and 60's. Around 1957 he was employed as a school teacher in Armidale NSW. He then went on to be employed as the Resident Master of the Sydney Grammar Preparatory School at St Ives around 1962.

Mr Davidson's power of attorney advised Mr Davidson had a brief period of employment at Dunlop, though there are no details about this.

Mr Davidson was convicted of serious child sex offences committed against young boys in his care whilst he was a school teacher.

In 1956, he was charged with 6 counts of indecent assault on a male at Armidale. He received a 5-year good behaviour bond.

In 1987, he was charged with stealing and fraud offences. He received a fine.

In 1990 he was charged with numerous further fraud related offences. He was was sentenced to 12 months periodic detention at Malabar Periodic Detention Centre and ordered to pay compensation of just over $20,000.

In January 2015, Mr Davidson was charged with a range of child sex offences dating from 1962-1963 when he was employed at Sydney Grammar Preparatory School. The offences included Buggery and Indecent Assault on young boys under his care.

Mr Davidson was elderly and in poor health at the time of this arrest and charge. He was not remanded in custody whilst he awaited his trial. He was residing in an aged care facility at Surry Hills at the time.

Mr Davidson faced trial in April 2016 at the Downing Centre District Court. He was ultimately convicted on 1 count of buggery and 8 counts of indecent assault. He was sentenced to imprisonment for 7 years commencing 29 April 2016.
He was due for release on parole in April 2019.

After being sentenced on 29 April 2016, Mr Davidson was immediately taken from the court into the custody of Corrective Services NSW to serve his term of imprisonment. He was taken to the Downing Centre Court Cells where an initial assessment was undertaken by Correctives Services staff.

The New Inmate Lodgement & Special Instruction Sheet dated 29 April 2016 notes that Mr Davidson had " Hep[atitis] B, Diabetes, [and] Bowel cancer". The lodgement sheet also states that these issues required review by Justice Health on reception. Other observations recorded were that Mr Davidson "[could] not walk well, needs nappies and constant meds".

Justice Health Registered Nurse Anna Grigore assessed Mr Davidson, and indicated Mr Davidson required attention at the medical clinic prior to review by a general practitioner within the prison network. Mr Davidson's insulin and medications were administered and he was transferred to the Metropolitan Remand and Reception Centre (MRRC). It was noted Mr Davidson's medications included medication for previous heart failure.

Mr Davidson was seen at the MRRC by Justice Health nurses where Mr Davidson's extensive health issues were documented. Given his frailty and health issues, Mr Davidson was housed in a cell within the medical clinic area of the gaol.

Whist housed at the MRRC clinic, Mr Davidson was assessed for admission to the Aged Care Rehabilitation Unit (ACRU), located within Long Bay Gaol Hospital. The assessment also included a Basic Aged Care Assessment.

On 12 May 2016, the Corrective Services Aged Care Bed Demand Committee (ACBDC) met and determined that a bed would be made available for Mr Davidson at the ACRU, Long Bay Hospital. An application for a Medical Certificate Consideration for Special Transport was approved by the Executive Director of Clinical Operations, Custodial Health and faxed to the Nursing Unit Manager at the MRRC clinic.

On 13 May 2016, the Executive Director of Clinical Operations, Custodial Health emailed the medical certificate to officers attached to the Court Escort Security Unit (CESU) who are responsible for the transport of prisoners. The medical certificate recommended Mr Davidson be transported by van, rather than the standard prison truck. There was a breakdown in communication, as staff from the Court Escort Unit provided statements indicated they were not aware of the email from Executive Director of Clinical Operations. In any event, Correctives Officer's made attempts to have Mr Davidson transferred by van, to be told that no vans were available at the time. The decision was made to transfer Mr Davidson to Long Bay Gaol Hospital via the standard prison truck.

The Fatal Incident:

About 12:30pm on 13 May 2016, Mr Davidson was being escorted from the clinic at the MRRC to the intake area where he was placed into a cell to await transport. Correctional officers escorting Mr Davidson stated that he appeared to be having no difficulties with his mobility, only that his movements were slow.

About 8.30pm, Mr Davidson, was removed from the intake cell and escorted to the prison truck which had arrived to transport him and other prisoners to various correctional facilities.

It was apparent Correctional Officers appreciated the fragility of Mr Davidson. He was given access to his wheeled walking frame and given assistance in entering the prison truck. There is no evidence Mr Davidson objected. CCTV footage showed another inmate using a walking stick to enter the truck prior to Mr Davidson.

Mr Davidson attempted to board the truck. However, due to his frailty, Mr Davidson could not step up the 44cm required to enter the truck. Correctives officers and other inmates already on the truck tried to assist Mr Davidson.

Mr Davidson sat on the top step of the truck which led to the holding area on the truck. Correctives Officers instructed Mr Davidson to place his hands by his sides, his feet on the step below then to shuffle backwards using his legs and arms at the same time.

Mr Davidson could do this for a short distance. He tried to repeat the process, however complained of not feeling well. Almost immediately, his face lost colour, his head rolled back and he lost consciousness.

Medical assistance and an ambulance was immediately call for. First aid was rendered by Correctives staff. Justice Health staff arrived, and assisted with first aid.

Mr Davidson was lifted from the rear of the prison truck and placed on the ground. First aid was continued. A pulse could not be detected and a defibrillator was used to restart Mr Davidson's heart. CPR was performed by Correctives and Justice Health staff prior to the arrival of NSW Ambulance.

About 8.55pm an Ambulance arrived and paramedics treated Mr Davidson. He was eventually stabilised and taken to Westmead Hospital. Ambulance officers described Mr Davidson as being blue in colour with ineffective breathing.

Mr Davidson arrived at Westmead Hospital at 9.35pm and had an irregular heart rhythm. Defibrillation and medication was used to rectify this.

Mr Davidson underwent blood tests, a chest X ray and a brain CT scan. All investigations suggested a cardiac arrest. A likely diagnosis of cardiogenic shock due to ischaemic cardiomyopathy was made and he was admitted under the care of the on-call cardiologist, Dr David Tannous.

Dr Tannous and Senior Staff Specialist in Emergency Medicine, Dr Dayamathy Jeganathan determined that a heart operation was unlikely to be beneficial given Mr Davidson's history of cardiac disease, and prolonged CPR.

The decision was made that if Mr Davidson's medical condition was to decline further, medical intervention was not appropriate.

Mr Davidson did not recover and his condition declined. He died around 3.35am on the 14th May. He was formally declared deceased by Dr Prabeen Dulal.

Autopsy:

Forensic Pathologist, Rebecca Irvine conducted the autopsy. She found the direct cause of death to be “complications of hypertensive and atherosclerotic cardiovascular disease”.

Police and CSNSW Investigation

Police were notified of the death and attended shortly after. Specialist investigators from the NSW Police Corrective Service Investigative Unit investigated. Specialist forensic police attended the hospital and examined Mr Davidson.
No evidence was found suggesting foul play. Staff from Corrective Services, Justice Health and NSW Ambulance were spoken to. CCTV footage of Mr Davidson’s collapse was reviewed and tendered as part of the brief of evidence. Medical, health and prison records were reviewed which revealed nothing untoward.

Corrective Services NSW also conducted its own internal investigation and review, which highlighted a number of areas for improvement.

The suitability of Mr Davidson’s planned transport to Long Bay.

Questions arose as to the suitability of Mr Davidson being transported via the regular prison truck, rather than a van, to Long Bay. A critical review of this and other issues was undertaken by Corrective Services NSW. A statement from Terry Murrell, General Manager, State-wide Operations, Custodial Corrections Branch of Corrective Services NSW was tendered as part of the brief.

Mr Murrell outlines new protocols have been put in place for prisoners, such as Mr Davidson, who require special transport needs due to their frailty, ill health or disability.

These protocols outline that where Justice Health assesses an inmate to be transported as having special medical needs and requiring special transport needs, a medical certificate outlining alternate transport needs will be issued.

The medical certificate is then provided to the Coordinator of the CSNSW Court Escort Security Unit (CESU) who is required to update the computerised Offender Integrated Management System with the details of the certificate. A computerised ‘alert’ for the specific inmate is also required to be created. Further, the Coordinator of the Court Escort Unit is also required to complete a ‘Special Transport Package’, consisting of a ‘Special Transport Arrangements Form, a ‘Special Arrangements Checklist’, a copy of the Justice Health issued medical certificate and a copy of the OIMS alert which gives the special transport advice.

The Correctives Officer in Charge of transporting a group of prisoners is required to check the OIMS for any alert or special instructions prior to transporting any inmates. If

a van or car is required to transport an inmate, Justice Health of State-wide Disability Services is then contacted for authorisation and advice.

I am satisfied that the requirement for the Coordinator of CESU to be notified and for the Coordinator to update OIMS with an alert for an inmates' special transport needs will help address the communication breakdown which occurred in Mr Davidson's case.

The removal of medical equipment used to administer medication to Mr Davidson whilst in Westmead Hospital

Two matters became apparent upon post mortem examination of Mr Davidson's body. Pathologists at the Department of Forensic Medicine require all medical equipment on the body of a deceased person to be left in place when that person is transported to the morgue. This is for evidentiary reasons and can assist pathologists in determining a cause of death.

In Mr Davidson's case, medical equipment used at Westmead Hospital had been removed prior to his body being delivered to the morgue. This equipment included containers of medicine which had been attached to intravenous lines inserted into Mr Davidson. The intravenous lines had been left in situ, however the associated containers of medicine had been discarded by nurses at Westmead Hospital.

Kate Hackett, the Director of Nursing and Midwifery at Westmead Hospital provided a statement which forms part of the brief. Ms Hackett indicated that the nurses in question thought that the medication within these containers needed to be disposed of prior to the body leaving the hospital. Certain medications are required to be disposed of after someone dies. The exceptions are deaths reported to the Coroner.

This misunderstanding has since been rectified by Westmead Hospital. The nurses involved have been counselled regarding this issue and an Emergency Department Newsletter distributed in February 2018 included a reminder of the requirements to leave medical equipment in situ where deaths are to be reported to the Coroner.

Further, Ms Hackett indicates that Westmead Hospital Emergency Department and Hospital training resources have been updated to cover this issue. I am satisfied that these actions address the breakdown in procedure which occurred in this case.

The fentanyl syringe

A syringe used to administer fentanyl was attached to Mr Davidson upon his delivery to Glebe morgue. The syringe did not contain the amount of fentanyl expected to be left, given the dosage and frequency prescribed to Mr Davidson. The pathologist expected to find about 8mls of fentanyl left in the syringe attached to his body, however the syringe

was empty. Ms Hackett explained that upon Mr Davidsons death, nurses at Westmead Hospital discarded the fentanyl due to the misunderstanding of protocol described earlier.

Ms Hackett stated that the nurses in question have been counselled. Further, Ms Hackett provided that Westmead Hospital "Care of the Deceased" Resource Folders have been updated to reflect the requirement for medical apparatus to be left in situ upon a deceased persons body, in matters which are to be reported to the coroner. These folders have been distributed to units throughout the hospital. I am satisfied that these actions address the breakdown in procedure which occurred in Mr Davidson's case.

Are there any other issues to investigate?

When a person is detained in custody, the responsibility for ensuring that person receives adequate care and treatment rests with the State. Even when a person in custody dies of apparent natural causes an inquest is required to independently assess whether the State has discharged its responsibility.

CCTV footage, records from Justice Health and Corrective Services have been reviewed. There is no evidence to suggest Mr Davidson was assaulted or deliberately injured prior to his death. There is no evidence to suggest that any person directly contributed to his collapse and cardiac arrest at the MRRC or his subsequent death at Westmead Hospital.

The gaol and health records reveal Mr Davidson's care and treatment was appropriate.

Conclusion

Mr Davidsons' death is not suspicious and he died of a natural cause process. Mr Davidson received health care of an appropriate standard whilst in custody. I do not find that any action or inaction by Corrective Services or Justice Health contributed to Mr Davidson's death. Given Mr Davidson's age and health issues and his deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Davidson's death. I thank the officer in charge, Detective Sergeant Tesoriero and Coronial Advocate, Sergeant Peter Bain for assisting me.

Findings required by s81(1)

After considering all the documentary evidence and the oral evidence heard at the inquest, I make the following findings under s81(1) of the Act:

The identity of the deceased:

The deceased person was Ian Davidson.

Date of death:

He died on 14 May 2016.

Place of death:

He died at Westmead Hospital, Westmead, NSW.

Cause of death:

He died as a result of complications of hypertensive and atherosclerotic cardiovascular disease.

Manner of death:

Mr Davidson died of natural causes whilst serving a custodial sentence.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner
18 July 2018
NSW State Coroner's Court, Glebe.