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CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Donald McKinnon
Hearing date:	21 August 2017
Date of findings:	21 August 2017
Place of findings:	NSW Coroner Court - Glebe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – Cause and manner of death - death in custody – natural causes – adequacy of care and treatment received from Corrective Services and Justice Health.
File number:	2015/00024641
Representation:	Coronial Advocate Assisting Sergeant Alex Creagh. Commissioner, Corrective Services NSW: Ms De Castro Lopo. Justice Health: Ms Li.
Findings:	I I find that Donald McKinnon died on 26 January 2015 at Prince of Wales Hospital, Randwick NSW. The cause of death was end stage liver failure due to pancreatic cancer with hepatic metastases. Other significant conditions contributing to his death but not related to the disease causing it were hip fracture, pulmonary emboli; ischaemic heart disease, ischaemic stroke, dementia and hypertension. Mr McKinnon died of natural causes while serving a custodial sentence.

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This inquest concerns the death of Donald McKinnon.

Introduction

1. Donald McKinnon died on 26 January 2015, aged 82 years. As he was serving a custodial sentence 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).

2. Section 81 of the Act requires that when an inquest is held a coroner must record his or her findings as to aspects of the death. These are the findings of an inquest into Mr McKinnon's death.

The role of the coroner

3. The coroner must make findings as to the date and place of a person's death, and the cause and manner of death: Section 81 of the Act.

4. In addition a coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question: Section 82 of the Act.

Mr McKinnon's life

5. Mr McKinnon was born in the Singleton area of NSW on 21 October 1932. He was one of a large family of brothers and sisters. As an adult he spent three years in the Australian Army, then lived in the United States for a period of time. He returned to Australia and lived in Victoria between 1957 and 1964. After that he moved to Sydney and lived in Redfern, Bondi and Surry Hills.

6. On 17 December 2012 Mr McKinnon was convicted and sentenced for historic offences of indecent assault upon a male and sexual intercourse with a male aged between 10 and 18 years. He received a custodial sentence of six years and six months imprisonment, with a non-parole period of three years and two months to expire on 21 January 2016.

Mr McKinnon's medical history

7. When Mr McKinnon went into prison on 23 November 2012 he was aged 79. He was medically assessed and was found to have a number of serious health conditions. These included diabetes mellitus, arthritis, ischaemic heart disease, sleep apnoea and hypertension. For this reason he was housed mainly in the Aged Care and Rehabilitation Unit at Long Bay Hospital. This Unit provides specialised care, assessment and rehabilitation services for older inmates. In this Unit Mr McKinnon had regular health reviews by specialist teams, as well as occupational therapy, physiotherapy and falls risk assessments.

8. In December 2014 Mr McKinnon was transferred to the Prince of Wales Hospital Secure Annex because he was suffering abdominal pain and swollen legs. He had also had some falls. Tests revealed he had developed pancreatic cancer with multiple hepatic metastases and liver failure.

9. Mr McKinnon's treating specialist Professor David Goldstein considered that surgery or chemoradiotherapy were not suitable management options for Mr McKinnon's cancer, because of its advanced stage and also Mr McKinnon's medical comorbidities. In his report dated 6 January 2015 Professor Goldstein noted that Mr McKinnon was also suffering longstanding cardiovascular disease and dementia. He estimated a life expectancy of three months taking into account Mr McKinnon's other medical conditions.

10. Mr McKinnon was transferred back to Long Bay Hospital's Medical Subacute Unit with a direction for full palliative care. After the medical treatment team consulted with Mr McKinnon's brother Lee, on 5 January 2015 he was classified as '*not for resuscitation',* including CPR, intubation or ventilation.

11. On 8 January 2015 Mr McKinnon suffered another fall and returned to Prince of Wales Hospital's Secure Annex. Medical staff noted his condition had further deteriorated and he was given a life expectancy of *'days or weeks, rather than months'*. He was treated for a fractured left neck of femur and made as comfortable as possible. His palliative care was maintained and he received additional visits from Lee.

12. During the evening of 26 January Mr McKinnon's condition deteriorated. At 9.30pm he was noted to be settled but unresponsive, and his death was recorded at 10.06pm.

What caused Mr McKinnon's death?

13. Prince of Wales Hospital recorded the cause of Mr McKinnon's death as *'end stage liver failure secondary to pancreatic cancer with hepatic metastases'*. Other significant conditions contributing to his death but not related to the disease or conditions causing it were noted as '*hip fracture, pulmonary emboli; ischaemic heart disease, ischaemic stroke, dementia and hypertension*.'

14. On 3 February 2015 Deputy State Coroner MacMahon issued a Coronial Certificate giving the cause of death as '*complications of metastatic pancreatic cancer'.*

Are there any other issues to investigate?

15. As Mr McKinnon was in custody, the responsibility for ensuring that he received adequate care and treatment lay with the State. For this reason an inquest is required when a person dies in custody, to assess whether the State has discharged its responsibilities. This is the case even when as here, it appears likely the person died of natural causes.

16. Having considered the evidence I am able to conclude that Mr McKinnon died as a result of natural causes. There are no suspicious circumstances, and no evidence that the care and treatment he received while he was in custody was inadequate or that it contributed to his death.

17. On 16 February 2015 Corrective Services Investigator Mark Farrell provided a report to the Management of Deaths in Custody Committee. Mr Farrell found there to be no issues arising out of the management and care of Mr McKinnon prior to his death, or in the response to his death. In Mr Farrell's assessment, these were appropriate and in accordance with Corrective Services policies and procedures.

18. I have examined Mr McKinnon's Justice Health records. They support the assessment that he received proper medical care and treatment throughout his time in custody and in the weeks leading up to his death.

19. Mr McKinnon's Justice Health records show that when he first entered custody in 2012 his health needs were comprehensively assessed. As a result he was housed in a Unit which could better manage his ongoing health problems and his impaired mobility.

20. It is evident from the records that his mobility and hearing problems and his declining cognitive abilities were regularly assessed. He was provided with hearing aids, a walking frame and physiotherapy to assist him and to reduce his risk of injury. In October 2013 he received screening for dementia and was found to be in the early stages of this disease. He was frail and at various times during 2013 and 2014 he had visits and admissions to Prince of Wales Hospital for treatment and assessment.

21. When Mr McKinnon was diagnosed with terminal cancer in December 2014, appropriate decisions were made and were implemented about his treatment and palliative care. This was also the case when he suffered his fracture and throughout his final days at the Prince of Wales Secure Annex.

22. I note that Mr McKinnon had made no complaints as to his care and treatment; nor have any members of his family raised any such issues.

23. I conclude that Mr McKinnon received health care of an appropriate standard throughout his time in custody. There is no evidence that any action or inaction by Corrective Services or Justice Health contributed to his death. From the outset of his time in custody he had many serious health problems

which were properly managed, and nothing further could reasonably have been done to prevent his death.

24. On behalf of the coronial team I offer my sincere and respectful condolences to Mr McKinnon's family.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to make the following findings in relation to it.

The identity of the deceased

The deceased person was Donald McKinnon.

Date of death

Donald McKinnon died on 26 January 2015.

Place of death

Donald McKinnon died at Prince of Wales Hospital Randwick, NSW

Cause of death

Donald McKinnon's death was caused by complications of metastatic pancreatic cancer'. Other significant conditions contributing to his death but not related to the disease or conditions causing it were hip fracture, pulmonary emboli; ischaemic heart disease, ischaemic stroke, dementia and hypertension.

Manner of death

Donald McKinnon died from natural causes.

I close this inquest.

E Ryan

Deputy State Coroner
Glebe

Date 21 August 2017