STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of David Fleming
Hearing dates:	8 March 2016
Date of findings:	8 March 2016
Place of findings:	State Coroners Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes, care and treatment
File number:	2015/39150
Representation:	Sgt Ramavat, Advocate Assisting the Coroner Mr Griffiths for Corrective Services NSW Mr Woods for Justice Health & Forensic Mental Health Network
Findings:	I find that David Fleming died on 5 or 6 February 2015 Long Bay Correctional Complex at Malabar, NSW. The cause of death was pulmonary thromboembolus. His above knee amputation, ischaemic heart disease, and emphysema were all significant conditions which contributed to his death. Mr Fleming died of natural causes whilst serving a custodial sentence.

Table of Contents

Introduction

1. Section 81(1) of the *Coroners Act 2009* requires that when an inquest is held the coroner must record his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Mr David Fleming.

The role of a Coroner and purpose of this inquest

2. The role of a Coroner, as set out in section 81 of the *Coroners Act*, is to make findings as to:

   (a) the identity of the deceased;
   (b) the date and place of the person's death;
   (c) the physical or medical cause of death; and
   (d) the manner of death, in other words, the circumstances surrounding the death.

3. As Mr Fleming 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 Act.

4. Pursuant to section 82 of the Act a Coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Mr Fleming's personal history

5. Mr Fleming was born in 1953. Little is known about his early years other than he lost contact with his sister, Narelle Milligan, in the early 1980s. During the same period of time he sustained an injury to his leg which required it to be amputated above the knee.

6. Mr Fleming met his eventual wife, Maureen McConville, in Cairns in 1985. At the time, Mr Fleming was exploring the possibility of receiving an improved prosthesis in the hope of returning to work as a long distance truck driver. After several months he moved to Melbourne where he worked for a company moving containers on the wharves. Ms McConville later joined him in Melbourne where they lived for about 18 months before eventually returning to Queensland. They married in Nambour in 1988.

7. Over the next several years, Mr Fleming moved to a number of different areas – New Zealand, Tasmania, Darwin, and South Australia – before returning to Victoria and settling in the town of Willatook, near Warrnambool.

8. Ms McConville presently resides in New Zealand and was not present at the inquest. She was informed of these proceedings via email communication with the police officer in charge.

Mr Fleming's custodial history

9. Mr Fleming was arrested on 18 January 2005 and extradited to New South Wales on a charge of murder. He entered Corrective Services NSW custody a day later. At the time, Mr Fleming was confined to a wheelchair and suffering from medical difficulties relating to his heart, back and respiratory system for which he was taking medication.

10. Mr Fleming was initially kept on remand until being convicted of murder and then sentenced on 29 June 2007 to a sentence of 21 years (commencing on 18 January 2005) with a non-parole period of 16 years. Mr Fleming's earliest possible release date to parole was 17 January 2021.

11. Whilst on remand Mr Fleming was initially kept at the Metropolitan Remand and Reception Centre (MRRC) in Sydney. Due to his mobility impairment Mr Fleming was later transferred to Junee Correctional Centre in December 2007. However Parklea Correctional Centre was later identified as being more suitable accommodation for Mr Fleming and he was transferred there in November 2011. Due to accommodation changes at Parklea, Mr Fleming was returned to Junee in February 2013 where he remained until he was transferred to Long Bay Hospital in October 2014.

Mr Fleming's medical history

12. Mr Fleming had numerous serious medical issues that required ongoing care and treatment. He suffered from recurring back pain, osteoarthritis, migraines, sleep apnoea and asthma. These ailments were complicated by Mr Fleming's obesity and lack of mobility. In 2012 Mr Fleming underwent an operation for a perforated gastric ulcer. He was referred to a cardiologist for chest pain in 2014. In the same year he was treated for bronchitis and was later found to be coughing up blood. A subsequent CT scan detected laryngeal squamous cell carcinoma (cancer of the larynx). Although several dates were planned for surgical intervention, Mr Fleming did not agree to the surgery proceeding.

13. On 7 October 2014, Mr Fleming was transferred from Junee to the medical subacute ward at Long Bay Hospital. In late 2014 Mr Fleming initially opted for radiation therapy but later decided to have a laryngectomy (surgical removal of the larynx) in December. Several weeks after surgery Mr Fleming refused further treatment causing the wound site to become open. On 12 January 2015 he signed an advanced care directive not to be resuscitated together with a no cardiopulmonary resuscitation (CPR) order.

14. Mr Fleming subsequently developed post-operative complications due to his refusal to eat and resist nasogastric feeding. He also refused to adequately maintain appropriate care in relation to a tracheostomy (surgical insertion of a tube in the windpipe to assist breathing).

15. On 31 January 2015 Mr Fleming was admitted to Prince of Wales Hospital due to difficulty breathing. He later discharged himself against medical advice.

The events of 5 and 6 February 2015

16. On the afternoon of 5 February 2015 Mr Fleming was in the yard area of the subacute ward. He asked a correctional officer if he could return to his cell. At about 3:30pm an officer saw Mr Fleming cleaning his throat with a medical device. At 6:30pm Mr Fleming was given his medication. Approximately two hours later an officer performed a welfare check and did not observe anything adverse. At 10:30pm a final head check was performed and Mr Fleming was seen to be going to the bathroom. At some unknown time later, an officer saw the light in Mr Fleming's cell turn off.

17. At about 6:30am on 6 February 2015, a correctional officer went to Mr Fleming's cell and saw him sitting on the floor facing the wall. It was not unusual for Mr Fleming to be seen sitting in this position. After being unable to rouse Mr Fleming, the officer notified Justice Health staff.

18. Two nurses attended a short time later. They examined Mr Fleming and found that he had nil vital signs and no pulse. In accordance with the advanced care directive and no CPR order signed by Mr Fleming, there was no attempt at resuscitation. Mr Fleming was pronounced deceased at 6:30am.

19. Police subsequently attended at about 7:15am, examined Mr Fleming's cell and found no suspicious circumstances. The police investigation found that the alert system available in Mr Fleming's cell was functional and that no alarm was raised between when Mr Fleming was last observed at about 10:30pm on 5 February 2015 and when he was found the following morning.

What caused Mr Fleming's death?

20. Dr Kendall Bailey, forensic pathologist, performed an autopsy on 9 February 2015. In her report Dr Bailey noted that there were multiple findings in keeping with Mr Fleming's documented medical history, including a large inflamed tracheostomy site.

21. Dr Bailey concluded that the cause of death was pulmonary thromboembolus noting that there was a large saddle thromboembolus obstructing the vasculature to the left lung. Dr Bailey also concluded that Mr Fleming's amputation, ischaemic heart disease and emphysema were all significant conditions that contributed to his death.

Are there any other issues to investigate?

22. 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.

23. Records obtained from Corrective Services NSW indicate that Mr Fleming lodged a number of complaints in his dealings with Statewide Disability Services and the Corrective Services Support Line. Mr Fleming and Ms McConville also lodged complaints with the Anti-Discrimination Board, the Human Rights and Equal Opportunity Commission, the NSW Ombudsman, and the Independent Commission Against Corruption.

24. For the most part, the complaints related to inadequate facilities being available in custody to accommodate Mr Fleming's mobility impairment. It appears that some of Mr Fleming's complaints were initially justified, being a product of his remand classification and corresponding security requirements. However, these issues appear to have been later resolved after Mr Fleming's sentencing, reclassification, and special placement consideration which resulted in his transfer to Junee. Furthermore, Mr Fleming's mobility issues were addressed with appropriate modifications to his cell, wheelchair, and shower facilities.

25. In any event there is no evidence available to me to indicate that any of these factors contributed to Mr Fleming's death in any way. Regrettably the evidence establishes that Mr Fleming often refused alternatives that were offered to him to address his mobility issues and medical conditions, and was highly resistant to medical treatment.

Conclusion

26. I am satisfied that the available evidence reveals that Mr Fleming's death is not suspicious and that he died as a consequence of a natural cause process. Regrettably, it appears that Mr Fleming's reluctance to accept medical treatment and to adequately care for himself following surgery adversely affected the longstanding medical conditions that he had been suffering from.

27. I am also satisfied that despite the difficulties mentioned above, Mr Fleming received health care of an appropriate standard whilst in custody. There is no evidence to suggest that any action or inaction by either Corrective Services or Justice Health contributed to Mr Fleming's death in any way. There was nothing that could have reasonably been done to prevent Mr Fleming's death. Given the combined effects of Mr Fleming's medical conditions, his resistance to treatment, and his reluctance to personally maintain adequate care of himself, it is highly likely that the outcome would have been the same even if Mr Fleming had not been in custody.

Findings

28. I find that David Fleming died on 5 or 6 February 2015 at Long Bay Correctional Complex at Malabar, NSW. The cause of death was pulmonary thromboembolus. His above knee amputation, ischaemic heart disease, and emphysema were all significant conditions which contributed to his death. Mr Fleming died of natural causes whilst serving a custodial sentence.

29. I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
NSW State Coroner's Court, Glebe
8 March 2016