CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Victor John Russell
Hearing dates:	9 July 2018
Date of findings:	9 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.
File number:	2015/139332
Representation:	Ms T Xanthos, Coronial Advocate assisting the Coroner Ms M Katawazi for the Commissioner for Corrective Services Ms S Li for Justice Health & Forensic Mental Health Network
Non-publication order:	I direct that, pursuant to section 74(1)(b) of the Coroners Act 2009, the following material is not to be published: 1.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 Russell's family; b. Any person who visited Mr Russell whilst he was in custody (other than legal representatives or visitors acting in a professional capacity); c. Any victim of the offences for which Mr Russell was serving a custodial sentence. 2. The direct and personal contact details of Corrective Services New South Wales staff. 3. The names, personal information and Master Index Numbers of any persons in Corrective Services New South Wales custody, other than Mr Russell.

	4. The 'Summary of Procedures' document derived from section 13.2 of the Operations Procedure Manual dated September 2012. 5. The Employee Daily Schedule dated 10 May 2015. 6. Tab 8 in brief of evidence (sensitive material). I also make the order that pursuant to section 65(4) of the *Coroners Act 2009* (NSW), a notation is placed on the court file that if an application is made under section 65(2) of that Act for access to Corrective Services New South Wales documents in the court file, that material shall not be provided until Corrective Services New South Wales 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: **Identity**: The person who died was Victor John Russell **Date of death**: He died on 10 May 2015 **Place of death**: He died at John Morony Correctional Centre, Berkshire Park NSW 2756 **Cause of death**: He died as a result of Ischaemic Heart Disease **Manner of death**: Mr Russell died of natural causes while he was serving a term of imprisonment

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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 Victor John Russell.

Introduction

1. Mr Russell died at John Morony Correctional Centre on 10 May 2015 at the age of 48. At that time, he was a sentenced prisoner and had been housed in C Unit, cell 53 as the only occupant.

The role of the Coroner

2. When a person's death is reported to the Coroner, there is an obligation on the Coroner to investigate matters surrounding the death. This is done so that evidence may be gathered to allow a Coroner to answer questions about the identity of the person who died, when and where they died, and what was the cause and manner of their death and the events leading up to it. If any of these questions cannot be answered then a Coroner must hold an inquest.

3. 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. In such cases, the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death to ensure that the State discharges its responsibility appropriately and adequately. This is so even in cases where the death of a person in lawful custody was due to suspected natural causes.

The Inquest

4. A short inquest was held on 9 July 2018. The officer in charge of the investigation, Detective Senior Constable Michael Cambridge gave evidence and the court considered numerous statements, medical records, photographs and reports.

The Evidence

Background:

5. Victor John Russell was born on 30 May 1967 in Walgett, New South Wales. He was one of seven siblings. His parents separated when he was young and was adopted by his paternal aunt and uncle, however he still maintained a relationship with his mother. Mr Russell never married, but has one 14-year-old daughter and an adult son.

6. There is no dispute that Mr Russell was in custody lawfully. He was charged on 9 June 2009 with 19 offences including sexual assault, take/detain for advantage and act with intent to pervert the course of justice. He was sentenced in the NSW District Court to a custodial sentence commencing on 15 April 2011 for a term of 8 years; his earliest possible release date being 8 June 2014. His attempts at parole were unsuccessful. The State Parole Authority refused parole because of his continuing drug use and poor behaviour in custody. Mr Russell had a history of poly-substance abuse that included the use of methamphetamine and heroin. His heroin addiction was being treated with methadone. He was transferred from Cessnock Correctional Centre to the Outer Metropolitan Multi-Purpose Correctional Centre (OMMPCC) on 3 July 2014. At this location, he participated in the Intensive Drug and Alcohol Treatment Program, which he successfully completed on 30 March 2015. His next scheduled parole hearing was 26 May 2015.

7. There was some history of heart problems in the family. In early March 2014, Mr Russell's older sister suffered a heart attack. Mr Russell was subjected to 4 ECGs between 16 July and 9 December 2014, the last test reflecting results of '458 millisecond QTc borderline'. He also suffered from asthma that was managed with Ventolin. It was reported he was a heavy drinker and a smoker of cigarettes. He was also prescribed Quetiapine and Serequel for schizophrenia. Throughout his incarceration, it was not uncommon for Mr Russell to refuse treatment and/or miss appointments.

8. Mr Russell's phone call records were obtained and the last phone call he made prior to his death was to his daughter on 7 May 2015. In this call, he made a complaint about an abscess on his tooth, otherwise there were no other complaints relating to his health.

The Fatal Incident:

9. Mr Russell was in an inmate in minimum security of C Unit within the OMMPCC. This unit allowed inmates to move freely from their cells to bathroom and kitchen amenities within the Wing after hours. Mr Russell was housed in cell number 53 as the only occupant.

10. About 5:30am on 10 May 2015, Jason Arthur West, an inmate in cell 49 went to the bathroom. At the same time, Mr Russell also exited his cell and was seen to make his way to the hot water dispenser to make a cup of coffee.
    Mr West said to Mr Russell, "Good morning Unc".
    Mr Russell replied, "Good morning Neph".
    This was the last time; Mr Russell was seen alive.

11. About 8:10am, correctional centre officers were performing the morning muster procedures. Inmate Shane Pittman was standing outside cell 53 calling to Mr Russell,

"Come on brother yo come on muster come on bro". Correctional officer Matthew Fawzy said to Mr Pittman, "You go outside, I'll get him". Officer Fawzy along with Officer McCready entered cell 53 and saw Mr Russell laying on his bed and it appeared to the officers that he was sleeping. Officer McCready put his hand on Mr Russell's left shoulder and said, "Come on Victor. Up. It's muster". With no response, the officer again gave Mr Russell a shake saying, "Victor, get up. Come on. Wakey wakey". Officer McCready squeezed Mr Russell's earlobe and rubbed his face between the eyes not receiving a response. After making checks for signs of life, Officer McCready called for medical assistance to Justice Health on his radio. At the same time, Acting Superintendent Frank Cunningham entered the cell and assisted Officer McCready in checking for a pulse.

12. Officers McCready and Fawzy pulled Mr Russell off the bed and placed him on the floor outside his cell. Acting Superintendent Cunningham commenced CPR and was assisted by Officer Domek who used a resuscitation shield to perform 'mouth-to-mouth'. The shield was ineffective and had to be replaced with a handkerchief.

13. At 8:15am, Justice Health nurses Ram Pant and Margaret Smith arrived with a defibrillator and face mask. The defibrillator was affixed to Mr Russell's chest. At 8:16am, the ambulance was called. Officer McCready used the face mask and exhaled twice when a 'coffee-like substance' came out of Mr Russell's mouth. CPR continued until the first ambulance arrived at 8:27am. Mr Russell was pronounced deceased at 8:44am.

14. Detective Inspector James of NSW Police spoke with Jason Paul Hodgson, who stated that he was a close friend of Mr Russell. He said that Mr Russell had been complaining about waking up at night, "gagging, vomiting and gasping for breath". Despite having an inhaler, Mr Russell was reluctant to complain about his health issues as he did not want to be placed on a nebuliser device.

Autopsy:

15. A post mortem examination was performed on 12 May 2015 by Dr Istvan Szentmariay at the Department of Forensic Medicine, Sydney. Dr Szentmariay found that the left anterior descending coronary artery showed full, nearly complete up to 90-95% narrowing due to the hardening of the vessel. Therefore, the cause of death was consistent with Ischaemic Heart Disease.

CSNSW Investigation:

16. Mr Russell's death resulted in an investigation conducted by Acting Senior Assistant Superintendent Shane Bagley of NSW Corrective Services. Mr Bagley prepared a report on 6 July 2015 where he expressed a concern regarding the accessibility of Laerdal resuscitation masks for correctional officers in the minimum-security section of John Morony Correctional Centre. Currently, officers can only carry resuscitation face shields that did not appear effective in successful breaths when CPR was performed on Mr Russell and was substituted by an ordinary handkerchief.

17. The correctional centre's Work, Health and Safety Committee considered Mr Bagley's report and have responded by making additional kits available in locations more easily accessible by correctional officers and placed near inmate accommodation units. This includes:
    a. 22 fixed first aid kits with Laerdal resuscitation masks in each kit;
    b. Four portable first aid kits with Laerdal resuscitation masks in each kit; and
    c. Five ERKs (Emergency Response Kits) with two Laerdal resuscitation masks in each kit.

18. Despite the ineffectiveness of the face shield used by officers when performing CPR on Mr Russell, I do not find that this contributed to his death. Officers still performed the necessary task under the supervision of Acting Superintendent Cunningham who was a first aid trainer at the complex. There is no evidence to indicate the performance of mouth-to-mouth was performed inadequately. I commend NSW Corrective Services on their response to Mr Bagley's recommendations.

Findings required by s81(1)

19. 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 Victor John Russell.

Date of death:

He died on 10 May 2015.

Place of death:

He died at John Morony Correctional Centre, Berkshire Park, NSW.

Cause of death:

He died as a result of Ischaemic Heart Disease

Manner of death:

Mr Russell died of natural causes while he was serving a term of imprisonment

20. On behalf of the NSW Coroners Court I extend my sincere and respectful condolences to Victor's family for their painful loss. I am grateful to them for travelling such a long distance to attend the inquest.

21. I close this inquest.

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