CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Richard Lewis
Hearing dates:	11 July 2018
Date of findings:	11 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:	2015/116507
Representation:	Mr D Welsh, Coronial Advocate assisting the Coroner Ms Binning for the Commissioner for Corrective Services Ms 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order:	I direct that, pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), the following material is not to be published: 1. The private address of Mr Lewis; 2. The names, addresses, phone numbers and other personal information that might identify any member of Mr Lewis' family; 3. The Visitor Index Numbers (VIN) of any person who visited Mr Lewis while in custody (other than legal representatives or visitors acting in a professional capacity); 4. The names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW'), other than Mr Lewis; 5. The banking account identification details of Mr Lewis; 6. Any data storage (TRIM) references of Corrective Services NSW. 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 Richard Lewis. **Date of death:** He died on 19 April 2015. **Place of death:** He died at Prince of Wales Hospital, Randwick, NSW. **Cause of death:** He died as a result of complications of pneumonia **Manner of death:** Mr Lewis 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 Richard Lewis.

Introduction

1. Richard LEWIS was 91 years old (dob: 29/04/1923) at the time of his death on 19 April 2015. He was an inmate within the Kevin Waller Unit within the Long Bay Correctional Complex. The Kevin Waller Unit houses elderly inmates with mobility issues.

   As Mr Lewis 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

2. 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.

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. 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

4. A short inquest was held on 11 July 2018. The officer in charge of the investigation, Detective Sergeant Garry James, gave evidence and the brief of evidence was tendered.

The Evidence

Background:

5. Mr Lewis resided the majority of his life on a rural property at Belmore River on the mid-north coast. He married in April 1948 and had two children, Narelle and Dianne. In 1975 his wife passed away and he remarried with Christine Lewis on 1 November 1991. They separated in 2013, but remained married.

6. Richard LEWIS entered custody on the 11 December 2014. He was sentenced to a total of 16 years for a number of child sex offences. The non-parole period was 2 years and 6 months that expired on 10 June 2017.

7. The New Inmate Lodgement & Special Instruction Sheet dated 11 December 2014 notes that Richard LEWIS had "several life threatening health issues". The lodgement sheet also states that these issues required review by Justice Health on reception.

8. The deceased suffered from multiple health conditions:

    Ischaemic heart disease including heart failure
    Pulmonary oedema
    Cardiac arrhythmia
    Degenerative osteoarthritis
    Chronic constipation
    Gallstones
    Squamous cell carcinoma of the left foot

9. An acceptance form from LBH (Long Bay Hospital) is within the brief and dated 12 December 2014. The "Transfer In and Out" form is dated 13 December 2014. General reasons for a transfer are recorded on the sheet and include the following:

    Address immediate health needs
    Identify risks and accommodate as necessary

10. The "Assessment Inpatient Form", dated the 14 December 2014, contains the field "Diagnosis (provisional) or reason for admission." It is subsequently recorded that Mr Lewis' transfer to Long Bay Hospital was for assessment due to his age and frailty.

11. On 23 February 2015, Mr Lewis was transferred from Long Bay Hospital to the Kevin Waller Unit. A note on 24 February 2015 records that Mr Lewis was not happy about his transfer to the Kevin Waller Unit and thought that he should be in the aged care ward at the hospital. Mr Lewis complained that it was hard for him to breathe in his room because there was no air-conditioning. Mr Lewis was informed that none of the rooms in the Kevin Waller Unit had air-conditioning. He was further informed that while the Kevin Waller Unit is an extension of the Aged Care and Rehabilitation Unit (ACRU) within Long Bay Hospital, not all facilities are present in the Kevin Waller Unit.

12. Throughout late March the primary concern in the records appears to be a leg lesion. Mention was made in the medical notes on 31 March 2015 that Mr Lewis' daughter made a complaint regarding his treatment.

The Fatal Incident:

13. On 6 April Mr Lewis was seen in the clinic. He complained of shortness of breath, general malaise and a slight cough productive of yellow sputum. He was transferred back to Long Bay Hospital on the same date due to his worsening condition. He was generally stable until 8 April when he developed a low grade fever and appeared unsteady. On 9 April an echocardiogram revealed severe global impairment of left ventricular systolic function. On 9 April 2015 he was transferred to the Corrective Services Annex of Prince of Wales Hospital. Notes relating to 9 April indicate he was in a critical condition following a lung infection and suspected heart attack.

14. Over the next few days he developed increased need for supplementary oxygen, a troponin leak (suggestive of acute myocardial damage) and fleeting chest pain.

15. On 14 April 2015 Mr Lewis underwent treatment following congestive cardiac failure that resulted in pulmonary oedema (fluid on the lungs).

16. On 16 April 2015, palliative care treatment for Mr Lewis commenced. This included light sedation and pain relief. On 19 April 2015 at approximately 07:11 p.m., Nurse Louise Kelly found the deceased not breathing and she informed Correctional Officer Robert Cappelleri. Dr Wickremaarachchi attended shortly thereafter at 07:28 p.m. and pronounced Mr Lewis deceased.

Autopsy:

17. Forensic Pathologist, Rebecca Irvine conducted the autopsy. She found the direct cause of death to be "complications of pneumonia". Other significant conditions contributing to the death, but not relating to the disease or condition causing it, were atherosclerotic cardiovascular disease and chronic lung disease.

Issues raised by Mr Lewis' Family:

18. Narelle PENSON, Mr Lewis' daughter, expressed concerns regarding the decision to move Mr Lewis from the Aged Care and Rehabilitation Unit (ACRU) within Long Bay Hospital to the Metropolitan Special Programs Centre, which contains the Kevin Waller Unit. She recalls Mr Lewis complaining about sanitary conditions at the Kevin Waller Unit.

19. Christine LEWIS stated that during Mr Lewis' stay in the Long Bay Hospital, he never complained about his treatment or conditions. He told her over the phone that the hospital was fine. After he was transferred to the Kevin Waller Unit he complained to

her about the sanitary conditions. However, she also states, "He never complained that he was not getting his medication or being looked after it was just the different environment."

Mr Lewis' transfer from the Aged Care and Rehabilitation Unit to the Kevin Waller Unit

20. The Kevin Waller Unit's eligibility and exclusionary criteria form part of the brief of evidence. A statement from Paul Holden, Manager of Security, states that the Aged Care Bed Demand placement committee vets inmates as to suitability for entry into the unit. The criteria for eligibility includes that they be male and over the age of 65 years. Poor mobility, age-related frailty and the need for additional resources such as shower chairs, bed rails, etc., are other criteria that require assessment.

21. The exclusionary criteria are as follows: Risk to Others (e.g., an inmate with an ongoing or recent history of violence/aggression), Significant Medical Issues (i.e., they require significant medical treatment that cannot be addressed by local clinic staff), High Dependency (e.g., they require ongoing practical/physical assistance with personal care tasks or daily living), Unstable Mental Health (e.g., dementia), and their Independence (e.g., older inmates functioning well in general population).

22. The Justice Health medical records for 23 February 2015 indicate that Mr Lewis was suitable for transfer from the ACRU to the Kevin Waller Unit. Medical notes for 22 February 2015 record that his chest was clear and his observations stable.

Expert Witness Statements of Professor Iven Young, respiratory physician

23. Professor Iven Young, a respiratory physician, prepared two reports commenting on any possible relation between Mr Lewis' environment, being the Kevin Waller Unit, and the pneumonia. He was provided with relevant documents, including the statements of both Narelle Penson and Christine Lewis.

24. Professor Young was satisfied that Mr Lewis died of a lobar pneumonia as described in the post-mortem report. He reviewed Prince of Wales Hospital records and was satisfied that care and treatment provided at Prince of Wales Hospital immediately preceding the death was appropriate.

25. He stated that pneumonia is generally classified as community acquired or hospital acquired (nosocomial) pneumonia. The latter implies exposure to unusual organisms in a hospital setting that may require treatment with unusual and more powerful anti-

biotics. As Mr Lewis acquired his pneumonia in the Kevin Waller Unit, he would be classified as having a community-acquired pneumonia.

26. Professor Young states that by far the most common cause of pneumonia in the elderly is pneumococcal infection and that this infection is either caused by aspiration of resident pneumococci in the patient's nasopharynx from past contact, or a recent transfer of this organism from close contact with a pneumococcus carrier. It is a person to person infection and is not acquired from unsanitary surroundings.

27. Assessment by a speech pathologist indicated that aspiration pneumonia was unlikely. Although no causative organism for his pneumonia was found, Professor Young stated that this was very frequently the case. Professor Young stated that Mr Lewis' urinary antigen for Legionella was negative, making his infection from an environmental cause unlikely. Professor Young's opinion is that Mr Lewis had acquired a pneumococcal pneumonia.

28. Professor Young states: "Although the physical circumstances of the Kevin Waller Unit (KWU) appear to have been less comfortable for Mr Lewis than those of the Long Bay Hospital, I cannot find any evidence that his accommodation in the KWU would have led to abnormally close person-to-person contact or exposure to second-hand cigarette smoke that may have contributed to causing his pneumococcal pneumonia."

29. Further to this, he states: "The cause of his infection was related to his age and chronic medical conditions and was, in my opinion, independent of his accommodation in the Kevin Waller Unit where the infection presumably developed."

30. Professor Young reviewed the Prince of Wales Hospital and the Justice Health medical records. He did not identify any deficiencies in care and treatment.

Conclusion

31. Mr Lewis' death is not suspicious and he died of a natural cause process. Mr Lewis 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 Lewis' death. Given Mr Lewis' age and health issues and his rapid deterioration whilst in hospital, it does not appear that anything could have reasonably been done to prevent Mr Lewis' death.

Findings required by s81(1)

32. 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 Richard Lewis.
Date of death:
He died on 19 April 2015.
Place of death:
He died at Prince of Wales Hospital, Randwick, NSW.
Cause of death:
He died as a result of complications of pneumonia
Manner of death:
Mr Lewis died of natural causes whilst serving a custodial sentence.

33. I thank the officer in charge, Detective Inspector Garry James, for his thorough investigation and preparation of the brief of evidence. I thank Mr Durand Welsh for his excellent assistance in this matter.

34. On behalf of the NSW Coroners Court I extend my sincere and respectful condolences to Richard's family for their painful loss.

35. I close this inquest.

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