STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ian Turnbull
Hearing dates:	10 October 2018
Date of findings:	10 October 2018
Place of findings:	NSW State Coroner's Court, Glebe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes
File number:	2017/95138
Representation:	Ms T Xanthos, Coronial Advocate Assisting the Coroner Mr A Jobe for Corrective Services NSW Ms S Li for Justice Health & Forensic Mental Health Network
Findings:	I find that Ian Turnbull died on 27 March 2017 at Prince of Wales Hospital, Randwick NSW 2031. The cause of Mr Turnbull's death was acute kidney failure due to possible sepsis or cardiogenic shock, with congestive cardiac failure being a significant condition contributing to the death. Mr Turnbull died from natural causes.
Non-publication orders:	Pursuant to section 74(1)(b) of the *Coroners Act 2009*, I direct that the following material is not to be published: 1. The CCTV footage taken from the Prince of Wales Hospital Secure Annex contained in the brief of evidence (Exhibit 1) tendered in the proceedings.

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1. Introduction

1.1 Mr Ian Turnbull died on 27 March 2017 in hospital, but whilst in lawful custody. He had been held in custody after being arrested, and then convicted and sentenced, in relation to a criminal office committed on 29 July 2014. In November 2016 Mr Turnbull suffered a serious medical event and made a partial recovery. However, Mr Turnbull was later admitted to hospital on 20 March 2017 in a serious condition, which did not improve and ultimately resulted in his death six days later.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 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 Act 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.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This is so even when the death of a person in lawful custody believed to be due to natural causes. It should be noted at the outset that there is no evidence to suggest that in this case the State has not discharged its responsibility in anything other than an appropriate and adequate manner.

3. Mr Turnbull's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future. Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way.

3.2 Unfortunately, in this case, very little is known about Mr Turnbull's personal life. Mr Turnbull was born in Moree, in northern NSW, in 1934. He was married to his wife, Robeena, and together they had four children. At the time of his death, Mr Turnbull also had 13 grandchildren.

3.3 Mr Turnbull previously worked as a carpenter and joiner. In the early 1960s he and his wife bought their first farm in the Croppa Creek area outside of Moree. Mr Turnbull and his wife originally farmed

stock and grain, but later changed focused on grain farming only. The success of the farm allowed Mr and Mrs Turnbull to expand their farming operations, and over time they acquired a number of other farms with members of their family.

3.4 Prior to the events which resulted in his incarceration Mr Turnbull had been, by all accounts, an industrious farmer of many years. He had also gained a positive reputation as a member of the local community in the Moree region.

3.5 Throughout his life, Mr Turnbull enjoyed the love and support of his wife, children, and grandchildren. There is no doubt that Mr Turnbull's passing has caused them great sadness and grief, and that he is enormously missed by them, and his close friends.

4. Mr Turnbull's custodial and medical history

4.1 On 29 July 2014 Mr Turnbull, then aged 79 years old, was arrested and charged in relation to an offence of murder involving the discharge of a firearm. He was later convicted of this offence and on 23 June 2016 Mr Turnbull was sentenced to a term of imprisonment of 35 years with a non-parole period of 24 years, commencing on 29 July 2014 (the date when Mr Turnbull was taken into police custody) and due to expire on 28 July 2038.

4.2 Following his transfer from police custody to the custody of Corrective Services NSW (**CSNSW**), Mr Turnbull was initially housed at Cessnock Correctional Centre before later being transferred to Mid North Coast Correctional Centre. This was the first time in his life that Mr Turnbull had been incarcerated. Upon entering into custody it was noted that Mr Turnbull had a relevant history of hypertension, ischaemic heart disease, angina, gastroesophageal reflux disease, basal cell carcinoma on his nose, peripheral neuropathy and osteoporosis.

4.3 Between July 2014 and June 2016 Mr Turnbull was referred by Justice Health and Forensic Mental Health Network (**Justice Health**) staff for a number of diagnostic tests and consultations with external specialists. This was done so that his chronic and complex health issues could be adequately managed, and involved Mr Turnbull's transfer to Long Bay Correctional Complex (**Long Bay**) so that he could attend appointments at Prince of Wales Hospital (**POWH**).

4.4 On 6 November 2016 Mr Turnbull was transferred to Port Macquarie Hospital where he was subsequently diagnosed with a right-sided cerebrovascular accident (**CVA**). He was later transferred from Port Macquarie to POWH for continued rehabilitation. On 3 January 2017 Mr Turnbull was transferred from POWH to the Medical Surgical Unit at Long Bay.

4.5 Mr Turnbull was referred back to POWH for review in February 2017. It was noted that Mr Turnbull had been reporting some breathlessness since suffering his CVA. On examination it was found that he had a mild reduction in lung volume since his last examination (in December 2016). It was also noted that it was likely that Mr Turnbull had asbestos-related pleural disease given his past significant asbestos exposure while having previously worked as a carpenter and joiner for many years.

4.6 Later in the same month, upon review in the POWH rehabilitation clinic, it was noted that Mr Turnbull had recovered well from his CVA but had minor residual impairments of left-sided facial

droop, paraesthesia, mild dysphagia, and decreased balance and lower limb strength. Plans were made for Mr Turnbull to continue with physiotherapy to increase strength and balance.

4.7 On 20 March 2017 Mr Turnbull attended a consultation with Justice Health staff where it was noted that he had difficulty swallowing and dyspnoea. He was subsequently transferred to the POWH emergency department for further investigation. Om examination it was found that Mr Turnbull had an abnormal breathing pattern (Cheyne-Strokes respiration), bilateral oedema to his mid-shins, and raised white cell count, lactate and creatinine levels. Mr Turnbull was subsequently admitted to POWH Secure Annex with septic shock and renal failure.

4.8 The following day, 21 March 2017, Mr Turnbull's condition deteriorated and it was noted that he had hypotension and bradycardia, requiring cardiac rhythm resynchronization therapy. Due to his multiple comorbidities and poor prognosis, a clinical decision was made to place Mr Turnbull on a palliative care pathway.

4.9 Mr Turnbull's condition continued to decline over the following days. On 22 March 2017 Mr Turnbull's family were advised of his prognosis and that his life expectancy was limited to the next few days. On 25 March 2017 it was noted that Mr Turnbull was no longer verbally communicating, nor eating and drinking.

4.10 On 27 March 2017 arrangements were made to allow Mr Turnbull's family to visit him. During the visit Mr Turnbull ceased breathing and became unresponsive. In accordance with existing advanced care directives that were in place, no resuscitation measures were taken. Mr Turnbull was later pronounced deceased at 3:42pm.

5. What was the cause and manner of Mr Turnbull's death?

6.1 Following the death, Mr Turnbull was taken to the Department of Forensic Medicine at Glebe where a post-mortem examination was performed by Dr Lorraine Du Toit-Prinsloo on 29 March 2017. Dr Du Toit-Prinsloo reviewed Mr Turnbull's medical records and performed a limited autopsy by way of external examination only. Dr Du Toit-Prinsloo concluded that the cause of Mr Turnbull's death was acute kidney injury due to possible sepsis or cardiogenic shock, with congestive cardiac failure being a significant condition contributing to the death.

6.2 There is no evidence to indicate that any external factor contributed to Mr Turnbull's death. Therefore, his death was due to natural causes.

6. What conclusions can be reached regarding Mr Turnbull's care and treatment whilst in custody?

7.1 Having considered the available records held by both CSNSW and Justice Health in relation to Mr Turnbull, I cannot identify any matter associated with his care and treatment whilst in custody that contributed to his death. Following diagnosis of Mr Turnbull's CVA in November 2016, it is clear that appropriate treatment in the form of clinical management and rehabilitation therapy was provided. It is equally clear that in March 2017 Mr Turnbull's condition rapidly deteriorated over a number of days and that appropriate palliative care was provided.

7.2 There is no evidence to suggest that the health care provided to Mr Turnbull whilst in custody was not within an expected standard of care. There is no evidence to suggest that any act or omission by

either CSNSW or Justice Health contributed to Mr Turnbull's death in any way. Evidence given by the police officer in charge, Detective Sergeant Joseph Coorey, confirms that Mr Turnbull's family have raised no concerns about the care and treatment provided to Mr Turnbull whilst in custody. Mr Turnbull's deterioration due to natural disease process is well documented in the available medical records. The evidence indicates that appropriate clinical and administrative steps were taken to manage Mr Turnbull's declining condition in accordance with his palliative care pathway.

7. Findings

8.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my thanks to Ms Tina Xanthos, Coronial Advocate, for her assistance both before, and during, the inquest. I also thank Detective Sergeant Coorey for his role in the police investigation and for compiling the initial brief of evidence.

8.2 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Ian Turnbull.

Date of death

Mr Turnbull died on 27 March 2017.

Place of death

Mr Turnbull died at Prince of Wales Hospital, Randwick NSW 2031.

Cause of death

The cause of Mr Turnbull's death was acute kidney failure due to possible sepsis or cardiogenic shock, with congestive cardiac failure being a significant condition contributing to the death.

Manner of death

Mr Turnbull died from natural causes whilst in lawful custody.

19.1 On behalf of NSW State Coroner's Court I extend my sincere and respectful condolences to Mr Turnbull's family and friends for their loss.

19.2 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
10 October 2018
NSW State Coroner's Court, Glebe