FINDINGS of Coroner Simon Cooper following the holding of an inquest under the *Coroners Act* 1995 (Tas) into the deaths in custody of:

Ronald Douglas Grundy, Aaron Leigh Jeffrey and Ian Robert Smith

Record of Investigation into Death (With Inquest)

Coroners Act 1995

Coroners Rules 2006

Rule 11

I, Simon Cooper, Coroner, having investigated the deaths of Ronald Douglas Grundy, Aaron Leigh Jeffrey and Ian Robert Smith

Hearing Dates

With an Inquest held at Hobart on 23 August 2018

Appearances

E Avery – Counsel Assisting the Coroner

Introduction

1. On 5 March 2016 Ronald Douglas Grundy died in the Royal Hobart Hospital of heart disease. On 11 May 2017 Aaron Leigh Jeffrey died in the Wilfred Lopes Centre at the Risdon Prison of lung cancer. Finally, on 17 September 2017 Ian Robert Smith died of heart disease in the Hospital at Risdon Prison. Each man was serving a sentence of imprisonment at the time of his death.

2. Each death is subject to the *Coroners Act* 1995 (the "*Act"*). The *Act* provides that an inquest must be held where a death occurs in Tasmania and the deceased person was, immediately before their death, a person held in custody.

3. Section 3 of the *Act* provides a person is in custody if that person was in the custody or control of a police officer, or a correctional or mental health officer, or a person who has custody under the order of a court for the purpose of taking a person to or from court, or a person detained in a

prison as defined in the *Corrections Act* 1997. As a consequence, an inquest in each case under examination here was mandatory. In most other jurisdictions in Australia an inquest is also mandatory in such circumstances.

4. On 31 July 2018 Coroner McTaggart, holding a delegation from the Chief Magistrate to carry out a number of the Chief Magistrate's functions under the *Act*, directed, pursuant to section 50 of the *Act,* that the deaths of the three men were to be investigated at one inquest. "Inquest" is defined in section 3 of the *Act* as a public hearing.

5. The ambit of any investigation under the *Act* is defined by the *Act*. Relevantly section 28 of the *Act* provides:

> "**(1)** A coroner investigating a death must find, if possible –
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> **(a)** the identity of the deceased; and
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> **(b)** how death occurred; and
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> **(c)** the cause of death; and
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> **(d)** when and where death occurred; and
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> **(e)** the particulars needed to register the death under the *Births, Deaths and Marriages Registration Act 1999*.
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> **(f)** . . . . . .
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> **(2)** A coroner must, whenever appropriate, make recommendations with respect to ways of preventing further deaths and on any other matter that the coroner considers appropriate.
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> **(3)** A coroner may comment on any matter connected with the death including public health or safety or the administration of justice.
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> **(4)** A coroner must not include in a finding or comment any statement that a person is or may be guilty of an offence.

> **(5)** If a coroner holds an inquest into the death of a person who died whilst that person was a person held in custody or a person held in care or whilst that person was escaping or attempting to escape from prison, a secure mental health unit, a detention centre or police custody, the coroner must report on the care, supervision or treatment of that person while that person was a person held in custody or a person held in care."

6. I observed in findings published in 2016 and 2017 (*Mansell*[1], and, *Monson, Michael and Mitchell*[2]) that the particulars referred to in section 28(1)(e) are not to be found in either the *Births, Deaths and Marriages Registration Act* 1999 or the regulations made under that *Act* (which deals only with fees). Although it is over 2 years since the matter was first highlighted, a gap continues to remain in the legislative scheme, which in my respectful view still needs to be addressed by legislation.

7. Section 28(5) of the *Act* imposes an obligation to report on the care, supervision or treatment of each deceased man in this case. The rationale for such a requirement is the public policy reason to ensure that the death of every person who is detained against their will in any state-run institution by reason of an order of a court, tribunal, or the executive is carefully, independently and transparently examined. In Waller's *Coronial Law and Practice in New South Wales* (third edition) at page 28 it is said that:

> "*society, having effected the arrest and incarcerations of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty and is not exacerbated by ill treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the*

[1] [2016] TASCD 01
[2] [2017] TASCD 253

government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that deaths in such places are properly investigated."

Ronald Douglas Grundy

8. Ronald Douglas Grundy, aged 80 at the time of his death, was sentenced on 25 August 2011 to a total of 9 years imprisonment in relation to a number of child sex offences. He was serving that sentence at the time of his death. Mr Grundy's general health was poor when he went into custody and steadily deteriorated thereafter. He suffered from severe lung disease (asbestosis), dyslipidaemia (a blood disorder) and age-related mental deterioration.

9. In late January 2016 Mr Grundy was diagnosed as suffering from pneumonia. He was treated for that condition at the Royal Hobart Hospital (RHH) and made something of a recovery. However, by the end of the following month he needed treatment for both pneumonia and gastroenteritis and was admitted to the prison hospital at 11.30am on 29 February 2016. His condition was such that it was deemed necessary for him to be transferred to the RHH. He was taken there by ambulance at around 4.00am the next day.

10. After his arrival at the RHH Emergency Department, Mr Grundy was assessed and then transferred to a secure, isolated room for security reasons and also to guard against the risk of infection spreading from his gastroenteritis. At all times for the duration of his stay in the RHH until his death on 5 March 2016, Mr Grundy remained in prison custody and had a prison guard supervising him.

11. Whilst in the hospital Mr Grundy was treated with intravenous antibiotics, oral antibiotics and intravenous fluids. Despite appropriate treatment his condition continued to decline. On 3 March 2016 his haemoglobin levels were noted to be dropping. The next day he complained of abdominal

pain and was administered the pain-killing drug endone. A CT scan was also performed.

12. On 5 March 2016 at approximately 8.50am Mr Grundy called for a nurse to assist him to the ensuite bathroom situated in his room. A registered nurse assisted him to the bathroom and sat him on the toilet. Having ensured Mr Grundy could reach the emergency call bell she left him.

13. A few minutes later the supervising corrections officer checked on Mr Grundy. He knocked on the bathroom door and received no reply. A nurse was called who entered the bathroom and found Mr Grundy sitting on the toilet. She noted he was slumped over in the seated position, had a purple face and was unresponsive. Vomit, sputum and blood were noted to be on the floor. A 'code blue' was called and a team of doctors and nurses attempted to resuscitate Mr Grundy. However all attempts at resuscitation were unsuccessful.

14. After Mr Grundy was declared deceased and formally identified his body was transferred to the mortuary at the RHH. At the mortuary an autopsy was carried out by experienced forensic pathologist Dr Donald McGillivray Ritchey. Dr Ritchey expressed the opinion, which I accept, that the cause of Mr Grundy's death was advanced atherosclerotic coronary vascular disease. He noted a significant contributing factor was pulmonary fibrosis.

15. The comprehensive investigation carried out by Tasmania Police on behalf of the Office of the Coroner revealed no circumstances giving rise to suspicion in relation to Mr Grundy's death.

16. Mr Grundy's treatment was reviewed by medical advisor and consultant to the Office of the Coroner, Dr Anthony J Bell MD, FRACP, FCICM. Dr Bell provided a report which was tendered at the inquest.[3] He said that Mr Grundy's medical conditions were insoluble, that he died of natural

[3] Exhibit G17

causes and that his treatment was adequate. I am satisfied that this is so.

17. A review of his Prison Record tendered at the inquest,[4] reveals that Mr Grundy was treated appropriately whilst in custody and his treatment certainly gives no rise to any concerns.

Aaron Leigh Jeffrey

18. Aaron Leigh Jeffrey, aged 55 at the time of his death, was sentenced in 1991 to life imprisonment for the murder of his father. He was serving that sentence at the time of his death at the Risdon Prison Wilfred Lopes Centre. Mr Jeffrey had been moved from the general prison population to the Wilfred Lopes Centre in 2006 to better manage his schizophrenia, a condition which had been first diagnosed in the mid-1980s.

19. Reportedly, Mr Jeffrey was a heavy lifelong smoker. In late 2015 or early 2016 Mr Jeffrey lost a considerable amount of weight quickly and started coughing up blood. He attended a respiratory clinic where he was diagnosed as suffering from lung cancer. The cancer was initially treated at the RHH with both chemotherapy and radiation therapy. Mr Jeffrey's health did not improve and by late 2016 he was diagnosed as being in the terminal stages of his cancer, it being found to be both malignant and untreatable. At about this time, he commenced receiving palliative care. A decision was made by prison management that Mr Jeffrey would remain in the Wilfred Lopes Centre and receive his treatment there. That decision was made in consultation with Mr Jeffrey and reflected his wishes.

20. By Wednesday, 10 May 2017 Mr Jeffrey was very ill indeed. It was several days since he had eaten or drunk anything substantial and he was being palliatively cared for utilising drug therapy. Early in the

[4] Exhibit G20

morning of Thursday, 11 May 2017 Mr Jeffrey received a 10 mg injection of morphine. Nursing staff said he was pale and grey and his breathing was extremely laboured. The staff attempted to make Mr Jeffrey more comfortable realising that his death was imminent. He was moved into a lying position on a couch. Shortly after this, in the presence of staff, Mr Jeffrey died.

21. Because he was serving a sentence of imprisonment at the time of his death the matter was reported under the provisions of the *Act*. An investigation was carried out. Mr Jeffrey's body was formally identified and then transported by mortuary ambulance to the mortuary at the RHH. At the mortuary an autopsy was carried out by the State Forensic Pathologist, Dr Christopher Hamilton Lawrence. Dr Lawrence expressed the opinion in a report tendered at the inquest[5] that the cause of Mr Jeffrey's death was bronchopneumonia due to infiltrating squamous cell carcinoma of the left lung caused in turn by smoking. I accept Dr Lawrence's opinion. In plain English Mr Jeffrey died of inoperable lung cancer caused by smoking.

22. A review of his medical treatment and care whilst in custody shows that both were of an acceptable standard. I take note of the fact that smoking has been prohibited in all Tasmanian correctional facilities since early 2015.

23. Finally, the investigation carried out by Tasmania Police on behalf of the Office of the Coroner in relation to Mr Jeffrey's death did not reveal any suspicious circumstances relating to it or any want of care on the part of the authorities responsible for Mr Jeffrey's care.

Ian Robert Smith

24. Ian Robert Smith, aged 46 at the time of his death, was sentenced in September 1995 to 6 years imprisonment in relation to a number of sex

[5] Exhibit J6

offences. At the same time he was declared a dangerous criminal, the effect of which declaration (made by the sentencing judge under section 392 of the *Criminal Code*, upon the application of the Tasmanian prosecuting authority at the time) was that Mr Smith was detained in prison indefinitely. He applied unsuccessfully in 2012 for an order setting aside that declaration. Accordingly, he was serving an indefinite period of imprisonment at the time of his death on 17 September 2017.

25. Mr Smith had a number of health issues both before and after his incarceration in 1995. He was an epileptic and suffered type II diabetes. Throughout his adult life whilst in custody his health was problematic. He underwent numerous operations and spent extended periods in the Correctional Primary Health inpatient area of the prison. Amongst other things, he was diagnosed and treated for atherosclerotic and hypertensive cardiovascular disease with congestive heart failure, hypertension, chronic kidney failure, peripheral vascular disease and ischaemic cardiomyopathy.

26. He was treated by a number of doctors including, where appropriate, specialists in a variety of disciplines. Mr Smith's heart remained his principal problem. He was treated at the RHH on a number of occasions in relation to heart issues. A summary of Mr Smith's medical records tendered at the inquest[6] indicate that he underwent, at least, the following treatment.

27. On 6 April 2010 he was treated at the RHH in relation to chest pains and tachycardia. An urgent angiogram was performed upon him and he remained in hospital under observation until his return to the prison on 13 April 2010.

28. On 25 June 2010 he suffered congestive heart failure and spent five days in hospital. Another angiogram was conducted. Further treatment

[6] Exhibit S15

was undertaken at the RHH in August and October of the same year in relation to his heart issues.

29. On 16 March 2011 Mr Smith suffered an acute cardiac event for which he was hospitalised. In June he was hospitalised again in relation to unstable angina.

30. On 15 July 2013 Mr Smith suffered a complete heart block and as a consequence an Automatic Implanted Cardioverter Defibrillator (AICD) was fitted to him. As a result, he had a number of regular checks with cardiology experts. After complaining of chest pain on 8 September 2013 the leads associated with the AICD were repositioned.

31. On 1 October 2015 Mr Smith suffered from a decompensated congestive cardiac failure which led to him spending two weeks in hospital. Later the same month, shortly after discharge, he suffered unstable angina and was hospitalised overnight. Mr Smith attended hospital twice in two weeks in January 2016, both in relation to heart related issues.

32. On 16 May 2016 Mr Smith attended the RHH to undergo elective surgery in relation to his AICD. This procedure was completed without complication and involved the revision of the device's leads.

33. On 30 May 2017 he was hospitalised again and his AICD was tested and reviewed.

34. Apart from heart related issues, he attended hospital on several other occasions in relation to rectal bleeding.

35. In the six months leading up to his death his health declined significantly. A goals of care plan was discussed with him on 13 September 2017 when palliative care commenced. The goals of care form, signed by him, makes clear that he did not wish for CPR to be performed upon him. On 14 September, in accordance with his wishes, his AICD was switched off and palliative care commenced in earnest.

36. On the night of 16 September 2017 two nurses were working in the Correctional Primary Health Inpatient area of the Risdon Prison complex. Mr Smith, who was in the inpatient area was checked every half an hour. He was rolled and provided oral care every two hours. At about 4.05am on 17 September 2017, Mr Smith was found by a nurse to be dead. Consistent with his signed goals of care plan no attempts were made to resuscitate him.

37. The fact of Mr Smith's death was reported in accordance with the requirements of the *Act*. An investigation was commenced. After formal identification his body was transported by mortuary ambulance to the RHH. At the mortuary an autopsy was carried out by Dr Ritchey. Dr Ritchey provided a report after autopsy[7] in which he expressed the opinion that the cause of Mr Smith's death was congestive cardiac failure, atherosclerotic and hypertensive cardiovascular disease. Dr Ritchey was of the opinion that type II diabetes and hypertension were significant contributing factors to Mr Smith's death. I accept Dr Ritchey's opinion.

38. The investigation by officers of Tasmania Police carried out pursuant to the *Act* into Mr Smith's death did not reveal any circumstances giving rise to suspicion. The investigation did not reveal any circumstances suggesting any want of care or treatment on the part of the authorities responsible for Mr Smith's custody and treatment.

Comments, recommendations and report on care, supervision or treatment

39. It should be clear from the foregoing that I am affirmatively satisfied on the basis of the evidence at the inquest that the care and supervision of Mr Grundy, Mr Jeffrey and Mr Smith was of an acceptable standard and in no way caused or contributed to their deaths.

[7] Exhibit S5

40. The circumstances of each man's death are not such as to require me to make any comments or recommendations pursuant to section 28 of the *Coroners Act* 1995.

41. I wish to particularly thank Ms Julianne Greenwood, a recent graduate of the Tasmanian Legal Practice Course, for her valuable assistance in the preparation of the inquest.

Dated 14 September 2018

Simon Cooper
Coroner