

CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert George SPRING
Hearing date:	15 October 2026
Date of findings:	18 November 2026
Place of findings:	Coroner's Court of New South Wales
Findings of:	Judge David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, multiple medical issues, care and treatment, experienced GP opinion provided, adequate care provided, response to fall adequate, natural death
File number:	2025/0212012
Representation:	Coronial Advocate Assisting: Mr D Winter-Mirenzi Commissioner of Corrective Services NSW: Ms Jessica Holmes Justice Health And the Forensic Mental Health Network: (Ms Gladys Amal)

Findings:

I make the following findings in relation to the death of Mr Robert George Spring pursuant to s81 of the Coroners Act 2009 NSW:

Identity:	Robert George Spring
Date:	31 May 2025
Place:	John Hunter Hospital, Newcastle, NSW
Cause:	Spontaneous Intracerebral Haemorrhage
Manner:	Natural Causes

Non-publication orders: A Non-publication order was made pursuant to section 74(1)(b) of the Coroners Act 2009 (NSW) on application Corrective Services NSW. A copy of the order is available from the Court Registry

JUDGMENT

Introduction

1 Mr Robert George Spring passed away at 12:40am on the 31st of May 2025 at the John Hunter Hospital, New Lambton Heights NSW, aged 79.

2 Mr Spring was in lawful custody at the time of his death.

3 Mr Spring had suffered an intracerebral haemorrhage on 29 May whilst in Hunter Correctional Centre.

4 An inquest was held into Mr Spring's death on 15 October 2026.

5 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The Coroner's role

6 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

7 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely

- the person's identity;

- the date and place of the person's death; and

- the manner and cause of the persons death.

8 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

9 Prior to holding the inquest a detailed coronial investigation was led by Detective Senior Constable Gemma Trudgett. DSC Trudgett compiled a brief of evidence including a report by a forensic pathologist as to the cause of death, police statements, civilian statements and Body Worn Video [BWV] footage.

10 All the material gathered during the investigation formed part of the brief of evidence tendered in the inquest. All of that material, and the evidence at the inquest, has been considered in making the findings detailed below

Background

11 Mr Spring was born on the 23 May 1946 in Big Bell, Western Australia.

12 Prior to his incarceration Mr Spring was a resident of Coffs Harbour.

13 Mr Spring had been married twice prior to commencing a relationship with Ms Leslie Williams who had remained his partner for 32 years as at the time of his death.

14 Mr Spring had been in the Navy for 25 years and had served in Vietnam and other theatres.

15 On the 23rd of September 2020 Mr Spring was found guilty of historic sexual assault matters and taken into the custody of Corrective Services NSW.

16 On 20 November 2020 he was sentenced to an aggregate term of 14 years and 6 months imprisonment commencing 23 September 2020 and concluding 22 March 2035, with a non-parole period of 9 years, 6 months. His earliest possible release date was 22 March 2030.

17 Mr Spring suffered from multiple health issues that included:

(1) High blood pressure;

(2) Atrial fibrillation;

(3) High cholesterol;

(4) Diabetes (type 2);

(5) Chronic kidney disease;

(6) Cerebrovascular disease;

(7) Recurrent falls.

18 Mr Spring's regular medications included:

(a) Rivaroxaban (anti-coagulant)

(b) Metformin (anti diabetic)

(c) Simvastatin (cholesterol-lowering agent)

(d) Allopurinol (gout prophylaxis)

19 Mr Spring's intermittent medications included

(a) Imodium (constipation),

(b) Panadeine Forte and

(c) Sumatriptan (migraines).

20 At the time of his death Mr Spring was incarcerated at Hunter Correctional Centre in D1 Unit with 24 other inmates.

21 About 7:00am on 29 May 2025 Mr Spring had a hot cup of water prior to heading off to the Corrective Services Industries "A" Building to work in the upholstery area.

22 About 9:00am he attended the medical clinic for re-dressing of leg ulcers. At this location he was placed in Holding Cell 1 with other inmates whilst waiting to see the Justice Health Nurses.

23 Mr Spring remained in the Clinic holding cell until 1pm when he was taken to the clinic and attended upon by a nurse.

24 After he was treated in the clinic he went to the Centre's library at his request, where he remained until about 3:30pm before returning to D1 Unit.

25 At around 3:56pm that afternoon, Mr Spring entered ensuite 5 for his afternoon shower. At around 4:56pm he was found by other inmates collapsed on the floor of the cubicle, with one of the inmates reporting the situation via the intercom system. Corrective Service Officers responded and found Mr Spring laying on the floor of cubicle 5 and being supported by an inmate. Justice Health Nurses arrived and triaged Mr Spring, who was semi-conscious and breathing. NSW Ambulance was notified and arrived on scene at 5:29pm.

26 Mr Spring was ultimately transferred to John Hunter Hospital by ambulance.

27 That evening it was confirmed that Mr Spring had a significant right sided intercranial haemorrhage and was ultimately palliated. His Resuscitation Plan, being signed on the 29 May 2025, was for no CPR in the event of cardiopulmonary arrest. Mr Spring's body was examined by Dr Thilina Arachchige at 12:40am on the 31 May 2025 who pronounced him life extinct.

Issues--care in custody

28 The main issue considered throughout the coronial investigation was the care and treatment of Mr Spring whilst in custody.

29 The officer in charge, Ms Williams and fellow inmates of Mr Spring all raised issues in relation to Mr Springs health. All of them however acknowledged that Mr Spring was reluctant to engage with the health service providers and was not always forthcoming in relation to the details or extent of his medical issues. In part this was due to him not wanting to be sent to the Long Bay custodial hospital. One inmate pointed out that he and other inmates were at times hounding Mr Spring to see staff about his medical issues.

30 Due to the concerns that had been raised Dr Hester Wilson, a clinician with over 35 years of clinical experience in general practice, sexual health, women's health, mental health, and addiction medicine, working in both primary and specialist settings was engaged during the coronial investigation to review all the medical notes and provide her opinion on the custodial care of Mr Spring.

31 Returning to the specific concerns or at least some of them, firstly, I note concern was raised in relation to Mr Spring's prescribed blood thinners. Ms Williams thought these may have been involved in the cause of Mr Spring's death.

32 Dr Wilson explained, whilst it's the case that thinners increase the risk of a bleed and mean a bleed may become more extensive it was nevertheless the preferred method of treatment. Dr Wilson expressed it this way:

> *While anticoagulants increase the risk of intracerebral haemorrhage and can lead to worse outcomes if there is a bleed, bleeding risk is low. Current evidence suggests it is better to be on anticoagulants to manage*

the high risk of stroke due to clots. It is to be noted in this regard that Mr Spring had previously suffered a stroke

33 Another concern was that Mr Spring's failure to eat his lunch on the day he suffered the fatal haemorrhage may have impacted what occured due to his diabetes. It was thought he had missed lunch because of the amount of time he was waiting to be seen in the clinic. However, it was clear on the material available to the OIC on CCTV that Mr Spring in fact had eaten a sandwich whilst waiting to be seen in the clinic and had eaten his lunch later in the afternoon. That lunch had been delivered to his room during his absence from it.

34 A further issue related to the self-referral forms and a question as to whether all had been considered by Justice Health. These are forms Mr Spring filled in to bring a particular matter to the attention of Justice Health staff.

35 Review of all the clinical notes revealed, as confirmed by Justice Health representatives, that all forms were received and attended to. The two particular requests to which my attention was drawn were, one self-referral form relating to blood in Mr Spring's urine and another relating to his leg ulceration.

36 In relation to the blood in his urine, the likely cause of that related to his kidney issue. Dr Wilson indicated that, in a general sense, the kidney issue was monitored appropriately. Specifically, clinical notes confirm that the relevant form was received and Mr Spring was referred to the clinic in relation to that very issue.

37 Whilst Dr Wilson also notes it is unclear what further follow-up there was, I note that the clinical notes reveal a further GP consultation listed for early June which tragically was after Mr Spring's death.

38 Similarly, in relation to the ulceration self-referral, that matter came to the attention of Justice Health staff and Mr Spring was in fact seen for that very issue on the day of his death, as well as having been seen earlier that week in relation to the same issue. I shall refer again to those consultations shortly.

39 The next issue was a question as to whether Mr Spring had bladder cancer. Some records refer to bladder polyps and raise the question of bladder cancer. Dr Wilson addressed this issue as follows:

> "*The issue was followed up with GP and specialist reviews and investigations. There was some confusion over whether bladder cancer was an issue, however this appears to have been excluded.*"

40 Finally, one of the inmates raised concern in relation to the response following Mr Spring's collapse in the shower cubicle on 29 May.

41 Based on the serious incident review and my own consideration of the response, I do not consider there to be any issue in this regard. I note the bleed was so serious that Dr Wilson referred to it as catastrophic.

42 By way of general observation in relation to the care provided to Mr Spring, I note these occasions of attention during the week prior to Mr Spring suffering his fatal bleed:

(1) An optometrist saw Mr Spring on 23 May, made observations and set out those observations in the clinical notes and indicated there would be a further review in twelve months time.

(2) On that same day Mr Spring attended the clinic for attention for what was referred to as *bilateral lower leg wounds*. This is one of the issues raised in the self-referral form. He was seen in the clinic and he indicated that a GP recently froze off the skin on the lower legs. I take that to mean froze of imperfections of the skin on Mr Spring's lower legs. During the same attendance by a primary care nurse a wound on Mr Spring's head was attended to. Mr Spring had suffered a fall on 23 May. The notes reveal that the wound was dressed, that is the head wound, together with the lower leg, and then there is a query "ulcers". In relation to the head wound, it was washed, magnoplasm was applied to help draw out

purulent and waterproof dressing was applied on top. In relation to the lower leg wound/ulcer, it was washed, imidine was applied and waterproof dressing placed on top. A plan was referred to in that cream was given to Mr Spring to help encourage hydration to the legs, he was rebooked for further dressing on 26 May.

(3) On 26 May further dressing took place as a further note from an enrolled nurse confirms. There were two broken areas/ulcers. They were cleansed, Sorbact was applied and sealed, and there was a further booking for review in two days.

(4) It seems likely that either that entry should have read *three days* or there was a change, as Mr Spring was next seen on 29 May. Again on 29 May Mr Spring was seen for bilaterial ulcers, the old dressing was removed, the area was cleansed with saline, dressed with Sorbact and Mr Spring was given spare dressings. He was rebooked for review and dressing change. This entry also refers to two days and then the GP appointment to which I have referred for 5 June 2025 was noted. Mr Spring was advised to let staff know if he had any concerns prior to that date.

43 In my view these attendances are instructive for a number of reasons. It is not easy to render adequate medical care in the custodial setting. Dr Wilson referred to some of the limitations, and I shall shortly refer to them.

44 I do not suggest the care delivered to Mr Spring, with all his known issues, and, given his age, was perfect. However, this short period of time reveals the following. Firstly, he was attended upon by a GP. [As I understand the system at the time in the Hunter Correctional Centre some consultations were "remote" through what is known as the ROAMS system where doctors can be spoken to online. However, as a GP recently froze affected skin area, then that was a consultation in person. Similarly, I read the consultation with the optometrist to be in-person].

45 Next, it is clear to me the involved nurses provided appropriate care for the leg ulcerations. It was applied consistently, the notes are detailed, and Mr Spring returned to the clinic for that treatment when required.

46 Another important part of those records is that after his fall on 23 May, Mr Spring was seen consistently by nursing staff. During those consultations, on the basis of the records, nothing was raised by him in relation to any additional concern following his fall and the injury to his head. I also note no concern is mentioned in the notes in relation to any ongoing issue with blood in his urine.

47 Based on what I accept to be a limited snapshot, the delivery of care during that period was certainly adequate. That is consistent with the ultimate opinion of Dr Wilson, expressed this way:

> "*I opine that the level of care provided was generally adequate. I did not identify deficiencies in care that may have been causative in Mr Spring's death. Mr Spring had a history of a number of significant chronic health conditions. These interact and complicate each other, just as the multiple medications used to manage them can lead to additional side effects and complexities.*"

48 In coming to that conclusion Dr Wilson made clear there are limitations in what can be provided in custody. She referred to them as barriers. Some of the matters she referred to were:

(a) frequent transfers between custodial settings with risk of disconnected care.

(b) limits to transfers for specialist medical appointments and investigations outside the custodial setting.

(c) limits to access to daily medications. [*Doctor did note however Mr Spring managed most of his own medications and this helped to alleviate potential limited access to daily medication dosing].*

(d) lack of therapeutic alliance. [*Dr Wilson explained care was provided by the team and by ROAMS, a remote team rather than an individual doctor or case worker, which may have limited the capacity to develop a therapeutic alliance with Mr Spring*].

(e) complexity of medication regimes.

49 Given that context, as expressed by Dr Wilson, I accept these two things. Mr Spring clearly expressed some frustrations with the medical care he received, both to Ms Williams and his fellow inmates. However, overall, the delivery of care was to an acceptable standard. I accept the opinion of Dr Wilson in this regard.

50 In accepting her opinion I have carefully considered the medical records and as I have indicated, the care Mr Spring was provided with in what turned out to be the last week of his life, was suggestive of dedicated and caring staff.

51 Based on the foregoing there is no need for me to make any recommendation as there is no systemic health or safety issue connected to Mr Spring's death.

52 In relation to the general issues of limitations or barriers as referred to by Dr Wilson, I note that as Doctor was of the view that none of these, nor any other factor, was causative, these issues were ultimately considered by me to be outside the scope of this inquest.

Manner and Cause of Death

53 In relation to Mr Spring's manner and cause of death, I firstly refer to events on the day leading up to what turned out to be the fatal bleed.

54 In the morning Mr Spring attended the industry's A building with fellow inmates as per a usual day. At 9am he went to the clinic as arranged by appointment. He did sit in the clinic cell from 9am to 1pm. He was observed to sit there patiently and, as previously referred to, during that time ate a sandwich.

55 Between 1 and 1.30 he was attended to by medical staff, as I've already set out. From between about 1.30 up until about 3.30 he was in the library, seen first chatting with fellow inmates and then sitting quietly reading. Thereafter, he went back to his cell, consumed his lunch which had been delivered to his cell and then headed off to the shower. He approached the shower at about 3.56 and was found by fellow inmates at 4.56. Up until the time he entered the shower there was no sign that day to suggest he was about to suffer an intracerebral haemorrhage. Mr Spring sat in the clinic cell for a long period of time and nothing untoward was observed. When he was with the nurse there was no report that he was feeling unwell or that he had any headaches. He interacted appropriately, albeit briefly, with fellow inmates in the library and then sat down reading for approximately two hours.

56 All this was, on the observation of those who were with him that day and as revealed through CCTV consideration, in particular, by the officer-in-charge, perfectly normal activity up until the point where he suffered what Dr Wilson described as *a catastrophic bleed in his brain, a haemorrhagic stroke or cerebrovascular accident*.

57 Dr Wilson explained the risk factors Mr Spring had for such an event. Firstly, he had hypertension. He also had dyslipidaemia and diabetes. The hypertension was treated, however, as Dr Wilson noted it increased the risk of cerebral haemorrhage. In relation to dyslipidaemia and diabetes the evidence is unclear as to whether they would have added to the risk of Mr Spring's terminal event. The next risk factor for Mr Spring was the fact that he had the previous thromboembolic cerebrovascular accident (CVA) (stroke) and longstanding atrial fibrillation. Reference has already been made to the risk factor of Mr Spring being on an anticlotting agent and it's been noted that medical evidence suggests that was, nevertheless, the best approach to managing his risk of stroke due to clots.

58 Other risk factors for bleeding according to Dr Wilson included chronic kidney disease which can impact clotting, damage blood vessels and affect medication levels and prior smoking.

59 Whilst Mr Spring appeared relatively well throughout 29 May he was, nevertheless, at risk of the event which ultimately occurred for the reasons set out by Dr Wilson.

Postmortem report

60 Following Mr Spring suffering the bleed and transfer to John Hunter Hospital and, ultimately, his death a postmortem was conducted upon Mr Spring on 4 June 2025. The postmortem found the direct cause of death to be intracerebral haemorrhage.

61 In the examination the forensic pathologist did not identify any skull fractures and in the report the forensic pathologist set out that there was a spontaneous intracerebral haemorrhage in the deep brain regions including the basal ganglia which was said to be most often due to hypertension in the elderly.

62 It was noted that the bleeding in this case may have been exacerbated by the use of rivaroxaban, an anticoagulant medication. The forensic pathologist further set out the features were suggestive of collapse secondary to a spontaneous intracerebral haemorrhage. He noted that there was no evidence of significant trauma.

Formal Findings

63 Based on the foregoing my formal findings are as follows:

Identity: The person who died is Robert George Spring.

Date: 31 May 2025

Place: John Hunter Hospital, New Lambton Heights, New South Wales.

Cause: Spontaneous Intracerebral Haemorrhage

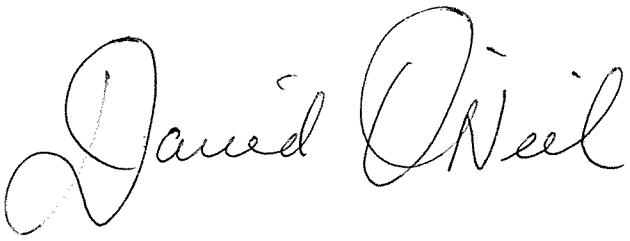
Manner: Natural Causes.

64 I extend the sincere and respectful condolences of all at the Coroners Court to Ms Williams, her family, extended family and friends of Mr Spring.

65 I thank the officer-in-charge who conducted a very detailed, thorough and caring investigation.

66 I also thank Mr Winter-Mirenzi for his assistance in the preparation and running of the inquest.

67 I close this inquest.



David O'Neil

Deputy State Coroner

Coroners Court of New South Wales

18 November 2026