NEW SOUTH WALES STATE CORONER

Name of Deceased:	**Michael Magro**
File Number:	**2523/08**
Hearing Dates:	**14 – 17 June 2011**
Location of Inquest:	**NSW State Coroner's Court, Glebe**
Date of Finding:	**1 July 2011**
Coroner:	**Magistrate Scott Mitchell, Deputy State Coroner**

Representations:

- **Mr Brett Thomson appeared to assist the Coroner, instructed by Ms Lisa Molloy, Solicitor, of the Crown Solicitor's Office**
- **Mr N. E. Chen of Counsel appeared for Justice Health**
- **Mr Walters, Solicitor, appeared for Corrective Services NSW**
- **Ms L. Alexander appeared for Registered Nurses, Little and Aldridge**
- **Mr Davis of Counsel appeared for Dr Vincent Lee**

1. Michael Peter Magro, who was born on 17 October, 1968, died at Royal North Shore Hospital at about 6am on 27 December, 2008. Dr. Istvan Szentmariay, whose report on the autopsy which he conducted here at Glebe on 30 December, 2008 is before me, described the cause of death as Hypoxic Brain Injury and commented that *"the injury is most likely a consequence of cardiac arrest and based on histology is most likely due to a recent/acute ischaemic event (small myocardial infarct)."* As a *footnote,* Dr. Szentmariay drew attention to *"the relatively minor degree of coronary narrowing and the relatively severe cardiac enlargement along with dilation of the cardiac chambers"* and expressed the thought that *"these changes may point towards dilated cardiomyopathy (aetiology)"*

2. Professor Gordian W.O.Fulde, Professor of Emergency Medicine and the Director of the Emergency Department at St. Vincent's Hospital, Darlinghurst who was called by the Coroner as an expert witness has nothing to say about the finding of *Hypoxic Brain Injury* but has some reservations regarding Dr. Szentmariay's *footnote,* noting Mr. Magro's history of suboptimal health and suggesting that pre-existing heart damage and lung disease is *"quite likely"* as a contributing factor in his ultimate illness. Regarding lung disease, Professor Fulde observed that *"the ability of the lung to absorb oxygen and the heart to pump blood to the lungs and the body are closely interrelated. In this case, I believe both were increasingly to severely impaired. A severe viral infection of both the lungs and the heart muscle is a definite possibility."*

3. Looking at the history of suboptimal health, I note that Mr. Magro's *Health Notification Form* completed in prison on 16 September, 2008, indicates that, when he entered prison, he was on methadone 2.5mls daily, had been a user of *IV* drugs about five years earlier, was Hepatitis *C* positive and, in 2003, had been treated for depression as well as agoraphobia. Mr. Magro may have believed that he had a gum disease and suffered from mouth cancer. Although it was not recorded on 16 September, he had a history of asthma, high blood pressure and, perhaps, heart disease. He had smoked and drank to excess and had recently been a regular user of cannabis. Taking the whole of the scientific evidence into

account, I think the best I can do with any real confidence is to find that Mr. Magro's fatal Hypoxic Brain Injury was consequent upon cardiac disease, possible viral infection of the lungs and generally suboptimal health.

4. Mr. Magro was previously married to Linda Magro and there are three children of that marriage. In addition, there is a young daughter, now about four years of age, of his *de facto* relationship with Adele Sirman. Judging from the tender and affectionate terms of their telephone conversation of 18 December, 2008, a recording of which is **EXHIBIT 4**, that relationship was a strong and ongoing one.

5. From the 16 September, 2008 until the time of his death, Mr. Magro was an inmate at *Mid North Coast Correctional Centre* at West Kempsey. Initially bail refused on charges of *Contravene Prohibition/Restriction in Apprehended Violence Order x 3* and *Common Assault,* on 15 December, 2008, Mr. Magro was convicted of those offences and sentenced. This is a *mandatory* inquest into his death. Mr. Brett Thomson appeared to assist the Coroner, instructed by Ms. Lisa Molloy, solicitor, of the Crown Solicitor's Office. Mr. N. E. Chen of Counsel appeared for *JusticeHealth*, Mr. Walters, solicitor, appeared for *Corrective Services NSW*, Ms. L. Alexander appeared for Registered Nurses Little and Aldridge and Mr. Davis of Counsel appeared for Dr. Vincent Lee. The *formal documents* including the autopsy report are **EXHIBIT 1** and the Coronial Brief, including the statement of Leading Senior Constable Fraser George Mackay, the officer-in-charge whose dedication and hard work in this investigation I commend, is **EXHIBIT 2.** Those who appeared at the inquest to give evidence included:-

- The Officer-in Charge, Leading Senior Constable Fraser George Mackay;
- David Cooper;
- Kenneth Hawkins;
- Endorsed Enrolled Nurse Anthony Joseph McMahon;
- Registered Nurse Kay Aldridge;
- Registered Nurse Deborah Little;
- Dr. William Patrick Strain;
- Dr. Muhammad Hussein;

- Dr Vincent Lee;
- Paramedic Richard Berry;
- Sandra Steel;
- Maureen Hanly; and
- Professor Gordian Fulde.

7. Michael Magro's mother and step-father attended the inquest throughout. His *de facto* partner Adele Sirman felt unable to be present but asked for a copy of the brief and to be kept informed.

8. On his arrival at the prison, Michael Magro was screened and seen by a *Justice Health* nurse. The intake documents note that, prior to incarceration, he was drinking 10 to 20 *longnecks* and smoking 20 to 30 cigarettes per day, taking daily methadone and smoking cannabis three times per week. He presented with a normal temperature but with low blood pressure, noticeable tremor and an irregular heartbeat. According to his cellmate, David Cooper, he seemed to be in reasonable health when he arrived at the prison but his health rapidly declined.

9. Evidently, one of the arrangement in place to allow inmates to access health care at the section of the prison occupied by Mr. Magro involved the inmate filling out a *Patient Request Form,* known as a *green form,* which is available on request from prison staff. *Justice Health* witnesses told the inquest that the *green form* was intended for use only in non-urgent cases but it is not clear that inmates including Mr. Magro were aware of or always appreciated this limitation. According to *Justice Health*, an inmate seeking medical attention in an urgent case might either use the *knock up* button on the wall of his cell or else *go sick in cell* which means attending the morning muster and reporting an illness or simply staying in bed and failing to report at muster in which case prison officers would go looking for him. The shortcomings of the *sick in cell* procedure in really urgent cases are obvious – an inmate might be left awaiting a muster for up to twelve hours or so before his illness was notified to the authorities. As to the *knock up* button, despite what photographs tendered in evidence suggest was its prominent position on the cell wall and the accompanying explanatory signage,

one of Mr. Magro's cellmates told the inquest that he had not been aware of its existence. It may say something about the other systems, namely the *knock up* button and the *sick in cell* procedure that, on 17 December, 2008, Michael Magro who obviously regarded his need for medical attention as urgent, seems to have preferred the *green form* as the means of obtaining medical attention even for what he clearly regarded as an urgent matter.

10. As at December, 2008, where the *green form* was used, the inmate was expected to ask for a form at the prison officers' station, fill it by outlining the medical issues involved and then place it in a locked box on the prison officer's desk. That box was to be emptied by a nurse, probably an Enrolled Nurse, each evening and the forms were then endorsed with the date of receipt and placed in a manila folder for examination and triage by a Registered Nurse next morning. The patient would then be seen by a medical practitioner as appropriate and the *green form* would be further endorsed with the *"date seen"* which, according to *RN* Aldridge referred to the date on which the inmate's name was placed on a list awaiting a consultation or, according to her superior, *RN* Little, the date on which the patient was actually seen by the doctor or nurse.

11. The statement of Senior Constable MacKay shows no less than 28 *green forms* submitted by Michael Magro between 16 September and 17 December, 2008 (incl.) including one *hand made* form prepared by Mr. Magro when it appears no other form was available to him. Mr. Magro's *green forms* related to a wide variety of issues including new prescription spectacles, the onset of depression, insomnia, elbow-finger pain, aching liver and back, *HIV* therapy, chronic tendinitis, a request for an extra mattress, further supply of methadone, anxiety attacks, agoraphobia, head ache, ear ache and bad tooth ache caused by the recurrence of a dental abscess, infection after a dental procedure, anxiety, analgesia and, subsequently, emergency dental surgery for a broken tooth, swollen hands, sciatic nerve pain and intense and almost immobilising pain in right leg from hip to knee and knee to ankle, further dental abscesses and the perceived need for antibiotic medication to prevent secondary infection and septicaemia. Some of these reports were duly answered by assessments and consultations, the provision of medication and, on at least one instance, by dental

surgery and some may have been of greater concern than others but when Dr. Clare Skinner, the acting Deputy Director of Medical Services at *Royal North Shore Hospital* came to write in her statement for the Coroner that Mr. Magro was admitted to that hospital *"with a three day history of feeling unwell,"* she was reflecting something which, perhaps, she had been told but which was far from accurate. When one takes into account not only what Mr. Magro wrote in his various *green forms* and what he told health workers while in custody and, also, what he told his *de facto* partner in their phone conversation, a recording of which is **EXHIBIT 4,** and how he appeared to his cell mates, it is clear that he had been very unwell for a great deal longer than three days prior to his admission to hospital.

12. In light of subsequent tragic events, four *green forms* submitted by Michael Magro seem particularly significant. On 4 November, 2008, Mr. Magro wrote of *"severe chest pain over top left breast...and milder pain under left arm."* Then, on 19 November, 2008, he outlined a complaint of unfair and discriminatory treatment in being denied adequate psychiatric assistance which, he alleged, had previously caused severe symptoms including sweating and tightness in the stomach and unbearable stress. In his *green form* he pointed out that such unfair treatment had already prompted a mild heart attack some weeks previously.

13. On 17 December, 2008, Michael Magro's *green form* reported *"I am having great difficulty breathing, I don't know whether it is related to panic attacks I have been having or a respiratory ailment but I can't breath. I am very concerned and feel very light headed. I don't think I am getting oxygen. I have never suffered asthma before as such but have been prescribed ventolin for a similar condition..."*

14. And, finally, on the same day, 17 December, 2008, in his hand- made green form, Mr. Magro complained "I can hardly breath, pain when breathing, fever, high heart rate, possible pleurisy or pneumonia. Have had viral pneumonia before, need to see doctor ASAP, URGENT."

15. Kenneth Hawkins who shared a cell with Michael Magro for "a couple of days and nights" in December, 2008, reports that "the whole time I was with Michael in the cell, his breathing was terrible. He sounded like a fifty year old with emphysema. Anyone who was near Michael could hear him wheezing. His breathing was so loud it would keep us awake at night." Mr. Hawkins' recollection is that, during the time they shared a cell, Michael Magro "was struggling to breath whether he was sitting down or stranding up." David Cooper, another cellmate of Michael Magro, recalls him complaining of chest pains about a fortnight before his death. During the day, according to Mr. Cooper, Mr. Magro "would generally stay in the cell because he couldn't get around much because he was short of breath" and "he couldn't even play (his guitar) much without becoming short of breath and tired. Over the last couple of days before Michael left, he kept us awake with his breathing. It was like a loud snoring sound then he would stop and wouldn't be breathing (and) I would get out of bed and push him to wake up and breath again."

16. **EXHIBIT 3** is the criminal histories of Mr. Hawkins and Mr.Cooper.

The witness Kenneth Hawkins recalls that prisoners were required to go to the *"screws' counter"* in order to get a *green form.* Although it was not his personal experience, he says his understanding is that *"sometimes they would give you a form straight away and other times they would tell you they were too busy and to come back in an hour or so."* He recalls Michael Magro handing prison officers a form on the 16 or 17 December but he is not sure whether it was a *green form* or what kind of form it may have been. David Cooper, on the other hand, is clearer in his recollection of Mr. Magro filling in a number of *green forms* citing a number of complaints and handing them to prison officers on a number of occasions. His evidence is that Michael Magro varied the terms of these forms *"because if you keep filling out the green forms with the same complaint, they wouldn't see you."* According to Mr. Cooper, he was present a few days before Michael Magro was taken to hospital and heard Mr. Magro at the prison officers' station asking a prison officer for a *green form* only to be told *"the clinic told us not to give you any green forms because you are a serial pest."*

17. On 17 December, 2008, Mr. Cooper watched Michael Magro walk back to his cell and, later, Mr. Cooper obtained a *green form* for him and put it in the box after the latter had filled it out. Mr. Cooper says that, later on the same day, he watched Michael Magro preparing a handmade form and explaining that *"They aren't giving me any green forms so I'll make my own fucking forms."* He was present, too, when, on the evening of 17 December, 2008, Mr. Magro handed the handmade form to a male nurse, described as *"middle aged with grey hair, about 6 foot tall, thin build"* who turns out to have been Endorsed Enrolled Nurse Anthony McMahon. Mr. McMahon, accompanied by three prison officers, had come to the door of the cell to administer medication to Mr. Cooper and was told that *"Michael is really sick and needs to see someone."* Mr. Cooper says he watched as *EEN* McMahon read the form, laughed and walked away. There is no doubt that it was Mr. McMahon who received Mr. Magro's handmade form because he admits that and, for some reason, he signed the document but, as to Mr. Cooper's allegation of reading the form and laughing or chortling as he walked away, Mr. McMahon told the inquest that he has no recollection of that. *EEN* McMahon says that he was *"shocked"* at having been handed the form and, in court, despite the evidence of Mr. Cooper and Mr. Hawkins as to Michael Magro's dire appearance and affect, he questioned *"whether Mr. Magro's appearance was consistent with what was on the form."* Nevertheless, Mr. McMahon told the inquest that he was not aware of anybody having characterised Mr. Magro as a *serial pest.* He told the inquest that he *would have* read the handmade *green form* only when he got back to his desk and that he *would have* referred it to the nurse in charge, Kay Aldridge but Mr. Cooper was clear that Mr. McMahon *"looked at the form quickly, said something and then laughed"* and *RN* Aldridge denies speaking to Mr. McMahon when he returned from his rounds bearing the handmade *green form* and denies that the *green form* was ever brought to her attention. In the circumstances I have recited, I think it is more likely than not that *EEN* McMahon was aware, at least in general terms, of the contents of the form and, rather than bringing it to *RN* Aldridge's attention, merely filed it away for attention by a registered nurse on the following morning.

18. Mr Cooper says, inaccurately I think, that later that evening, he pressed the *knock up* alarm and that *"about an hour later, a nurse and screws came and looked at him (Michael Magro) before they took him away"* to the prison *Heath Centre.* I don't know whether on some other occasion Mr. Cooper pressed the *knock up* button on Michael Magro's behalf but there is excellent evidence in the shape of the recording of his phone conversation with Ms. Sirman that it was not until shortly after 9am on 18 December that Michael Magro was summoned to the clinic to see Dr. Strain. He spent the night of the 17 December, 2008 in his cell without medical attention.

19. *At about 10am on 18 December, 2008, when Mr. Magro was seen by Dr. Strain, the visiting medical officer at* Mid North Coast Correctional Centre, *the patient* "looked anxious and was breathing at a faster rate than normal. He appeared sweaty and was restless." *Dr. Strain was made aware that there was a history of anxiety. Dr. Strain examined Mr. Magro, found blood pressure at 107/70,* "at the lower end of the normal range," *and noted that the patient* "was breathing at a faster rate than normal." *He found no palpable thyroid abnormality but Mr. Magro was tender to palpation of the right upper quadrant of his abdomen. It was then that an* ECG *was undertaken.*

20. The ECG revealed a pulse rate of 185 bpm, very much faster than Dr. Strain had been able to feel, together with "a dissociation between the P waves and the QRS complexes" Dr. Strain says that, in light of the ECG readings, "a warning bell" sounded and he "suspected that Mr. Magro may have had a rhythm abnormality such as atrial fibrillation with a very fast ventricular response rate and that he may have been thyrotoxic." In those circumstances, sensing 'the possibility of a serious cardiac problem requiring management at a tertiary level", he asked that Mr. Magro be transferred to the Accident and Emergency Department of Kempsey District Hospital.

21. Michael Magro arrived by ambulance at the Emergency Department of Kempsey District Hospital shortly after 11.47am on 18 December, 2008. Registered Nurse Katie Marie Croad was on duty there and recalls that Mr. Magro became agitated and restless while being treated. Registered Nurse Kerryn Bullivant

describes him as looking "critically unstable," struggling and "very frightened." She recalls that he was medicated with adenosine, amiodarone and digoxin, "all designed to regulate and slow the heart rate." Ms. Bullivant tried to pacify Mr. Magro, holding his hand, talking to him and trying to calm him down. When this was not successful, she recommended at 1.20pm that he was given valium. Finally, when that was not successful, Nurses Croad and Bullivant decided to move Mr. Magro out of ED and into Intensive Care.

22. RN Sarah George who was in the ICU that afternoon states that Michael Magro was admitted there at 2.45pm. He was "anxious, clammy and complaining of pain in the left arm and shortness of breath."

23. Dr. Muhammad Hussein was the physician involved in Michael Magro's care in the ICU at Kempsey District Hospital. He reports that, once the heart rate was slowed by medication, atrial fibrillation became apparent. Describing the patient's condition, Dr. Hussein wrote "Initial Troponin and D-dimers were negative. TCO2 was 21 indicating acidosis. Chest x-ray showed pulmonary oedema. He was given a subcutaneous enoxaparin 80mg and IV Furosemide 100mg. Morphine and Diazepam were given for pulmonary oedema and anxiety." Dr, Hussein explained that enoxaerin was administered in order to thin the blood and furosemide as a diuretic in the hope of expelling fluid from the lungs. Dr. Hussein went on to report that Mr. Magro "was transferred to ICU for further management. There he still had dyspnea (breathlessness) and he complained of cough. Bilateral crepitation and vesicular breathing were noticed. Amiodarone was stopped and IV Digoxin was given. Patient was still hypoxic. X-ray showed left lower lobe infiltrate in addition to bilateral hilar prominence and smaller diffuse infiltrates." The notes record that, at 2.45pm, Mr. Magro's saturated oxygen level stood at 75% in room air (via NRM 85%) which, Dr. Hussein says, constituted a medical emergency indicative of significantly impared lungs, the norm being about 97%. Because of his hypoxia and respiratory distress, it was decided to transfer Mr. Magro to Port Macquarie Base Hospital.

24. Mr. Magro was intubated, stabilized and accompanied in the ambulance by Dr. Vincent Lee, the anaesthetist at Kempsey District Hospital but, about 15 minutes out, the patient was seen to suffer a bradycardiac arrest with no palpable cardiac output and the transfer was aborted, Dr. Lee judging that continuing on to Port Macquarie was too perilous. In their statements, both Dr. Lee and Paramedic Richard Berry describe the treatment administered in the ambulance while they worked on Michael Magro for about 15 minutes. Mr. Magro responded favourably to the 3rd. dose of adrenaline and other treatment administered by Dr. Lee while in the ambulance, then rearrested and was revived by a 4th. dose and Dr. Lee reports that, on arrival back at Kempsey District Hospital, he had a pulse 100/minute and good peripheral cardiac output and BP 130/80. But he was gravely ill and Dr. Hussein told the inquest that a chest x-ray disclosed that Mr. Magro's heart was enlarged and misshapen. It was unclear whether it was the heart which was dilated or whether the picture was the result of increased fluid in the sack surrounding the heart but Dr. Hussein thought that it was more likely than not that the heart itself was swelling.

25. The decision was taken to airlift Mr. Magro to Royal North Shore Hospital once he had been stabilised, because the proper management of his condition – severe pneumonia (probably viral), cardiomyopathy (probably stress related but, perhaps, viral in origin), acute pulmonary oedema, atrial fibrillation and consequential respiratory failure – required resources beyond those available at Kempsey District Hospital or even at Port Macquarie Base Hospital.

26. Dr. Hussein told the inquest that he had believed Mr. Magro to have been suffering from Stress (Takotsubo) Cardiomyopathy but, evidently, it was later suggested at Royal North Shore Hospital that the cardiomyopathy may have been of viral origin. The Cardiac Catheterisation Report prepared by Professor Helge Rasmussen at Royal North Shore Hospital on 21 December, 2008 shows that the dominant right coronary artery and its branches, the left main coronary artery and the left anterior descending coronary artery and its branches as normal. Further, the report notes "Cardiogenic shock of unknown cause. No infarct pattern on ECG."

27. It may be that the aetiology of Mr. Magro's heart condition will remain uncertain, no tests for the presence of a virus having been undertaken, but Dr. Hussein is confident that, in the selection of appropriate therapy for Mr. Magro, whether the condition was stress related or viral was not the issue.

28. The statement of Dr. Clare Skinner records that Michael Magro arrived at the Intensive Care Unit of RNSH at 6.46am on 19 December, 2008. Dr. Skinner notes his presenting problems as follows:-

- septic shock (cause unknown);
- respiratory failure due to pulmonary oedema;
- paroxysmal atrial fibrillation;
- poor dentition and recent tooth abscess;
- ischaemic hepatitis; and
- hepatitis C positive secondary to previous IV drug use.

29. According to Dr. Skinner, subsequent examinations demonstrated that while Michael Magro's coronary arteries were normal, he had grossly deranged liver function, renal failure, myocarditis, cardiogenic shock (with ejection fraction 15%) and sepsis. Additionally, a brain scan demonstrated generalised low density within the supratentorial brain parenchyma with loss of normal grey/while matter differentiation and Dr. Skinner notes that "*these features were (in) keeping with diffuse hypoxic brain injury.*"

30. Management at RNSH consisted of broad spectrum antibiotics, inotropes (noradrenaline and milirinone), insulin and amiodarone. According to Dr. Skinner, there was initial improvement but poor neurological recovery and Mr. Magro remained febrile. His condition deteriorated and, with the concurrence of the family, the decision was taken on 26 December to cease active treatment. Comfort measures and supportive treatment were continued until 6pm on 27 December, 2008 when Michael Magro died.

31. Professor Fulde, as an expert in emergency medicine, was asked to comment on the quality of care and treatment afforded Mr. Magro. His view of the treatment afforded to Mr. Magro at Kempsey District Hospital is that it was "appropriate and of a peer practiced standard" and he points to that hospital's very prompt attention, diagnoses and treatment. He is similarly content with the performance of staff at Royal North Shore Hospital and says that it was "*appropriate and consistent with the care of a tertiary teaching hospital.*"

32. As to the care of Michael Magro during the attempted transfer to Port Macquarie Base Hospital, Professor Fulde believes that it was adequate and appropriate and, indeed, he goes further to say that "*the patient was handed over by a consultant physician to an experienced G.P. anaesthetist whose care in a difficult clinical and physical situation (on the road in an ambulance) was good.*" In his evidence to the inquest, Dr. Lee graphically described something of the severe difficulties involved in managing and resuscitating a patient after a cardiac arrest in an ambulance. Nor does Professor Fulde have any criticism of Mr. Magro's management and care during his transfer to Royal North Shore.

33. The chief areas of concern in this inquest relate not so much to the care and treatment of Mr. Magro while in hospital or while being transferred to hospital or between hospitals but, rather, to his care and treatment while in prison and the processes and procedures in place at Mid North Coast Correctional Centre regarding inmates like Mr. Magro requiring medical attention and, further, to the processes and procedures relevant the internal investigations conducted by JusticeHealth and Corrective Services NSW into Michael Magro's care and treatment.

34. Turning firstly to Mr. Magro's care and treatment in prison, there was a gap of about 12 hours between his request to EEN McMahon for assistance and his assessment by Dr. Strain and, of course, even longer if one takes into account his first green form of 17 December. I take into account that the green form system was designed for non- urgent cases and that there was a knock up button available in Mr. Magro's cell. RN Aldridge alluded to the efforts which are made to acquaint inmates with the availability of the knock up button (which

include the provision of a DVD) and with the proper means of seeking medical help in emergencies. Nevertheless, Mr. Hawkins' evidence is that he was not aware of the existence of the knock up button and had never been instructed in its use. Mr Magro, of course, was a far more experienced inmate than Mr. Hawkins and it is clear that, on 17 December, 2008, he was not merely malingering but perceived that he was in real need of help as later events demonstrated was the case but even he seems to have regarded the green form system as the appropriate means to call for help even in urgent situations. I am not sure why that should have been the case. Perhaps the prevailing culture pointed to the use of green forms.

35. Professor Gordian Fulde's evidence is that a complaint of breathlessness is to be taken seriously particularly where the person to whom such a complaint is directed, and this includes EEN McMahon, "*did not have the luxury of knowing the patient.*" Referring to the terms of the second green form, Professor Fulde went on to say that "*at face value, I would be worried... ...It would cause me some concern...He should have been seen." Dr. Hussain had a similar view.* In my opinion, nobody can say – and Professor Fulde does not say, that early attention to Mr. Magro's condition would necessarily have changed the ultimate outcome but nobody, including EEN McMahon, can say that it would not have and it seems to me that where society deprives a person of much of his ability to take care of himself, as in the case of most prisoners, it owes a duty to ensure more watchful and timely care than was afforded Mr. Magro who, despite his appeal, had to wait up to twelve hours for medical attention. Such a delay was dangerous and unsatisfactory.

36. As to the processes and procedures relevant to the internal investigations conducted by Justice Health and Corrective Services NSW into Mr. Magro's care and treatment, it was Sandra Steel of the Investigations Department of Corrective Services NSW who produced the Assessment Report of 5 February, 2009 which is a report for the Commissioner for Corrective Services on whether there had been any breaches of policy and proper procedure by corrections officers. Two irregularities were found, one relating to the failure of the officer present at Mr. Magro's death to file a timely report and the other to do with a mix

up regarding Mr. Magro's next of kin. As I understand it, both those matters have been or are being dealt with and they do not concern me here. Other than that, the Commissioner was to be informed that "*nothing untoward has been disclosed by investigations into the death in custody.*"

37. In that context, it is important to note, however, firstly that Ms. Steel's investigation is, essentially, a review of the papers and that only very limited, if any, interviews were conducted and that nobody at *Justice Health* and, particularly, neither *RN* Little and *RN* Aldridge nor *EEN* McMahon was questioned or interviewed and, secondly, that the report is not intended to be a report as to the circumstances of Michael Magro's death. I was told by Mr. Walters that the Commissioner had no authority to question any of the *Justice Health* nurses so that, as far as *Justice Health's* care of Mr. Magro is concerned, Ms. Steel's *Assessment Report* and therefore the Commissioner were entirely dependent on what *Justice Health* told them.

38. What *Justice Health* told them about what had happened to Michael Magro is contained in the 20 paragraph report to the Commissioner from *Justice Health* which is annexed to Ms. Steel's report. The report, signed by Julie Babineau, the Chief Executive of *Justice Health* and dated 20 January, 2009 is quite uninformative and, in one critical area, misleading where it purports to detail *Justice Health's* care of Michael Magro at the critical time of his final illness.

39. Paragraph 17 of that report reads as follows:-

"*Mr. Magro was reviewed in the health centre on 17 December, 2008 reporting shortness of breath and generally feeling very unwell. An ECG was attended which showed a supra ventricular tachycardia (very fast heart beat). Mr. Magro was transferred to Kempsey Hospital for further investigation.*"

40. The reference to a review on 17 December, 2008 is mistaken and explained as a typo although Ms. Hanly, who gave that evidence on behalf of *Justice Health*, had done nothing to satisfy herself that such was really the case. The last minute statement of Denise Monkley dated 16 June, 2011 and filed in court on

that day, **EXHIBIT 9,** establishes that the mistake was a typo, albeit a quite misleading one. Until corrected at the hearing, the Babineau report provided no explanation as to when and how Mr. Magro had been brought from his cell to the prison health centre to see Dr. Strain or what may have been his then medical condition. Instead, the reader was invited to assume that Mr. Magro's transfer to *Kempsey District Hospital* followed hard on the heels of his appeal for urgent medical attention without any suggestion of the approximately twelve hour delay between Mr. Magro handing his note to *EEN* McMahon and seeing Dr. Strain.

41. There is no mention in the Babineau report of any event which took place between 12 and 18 December and, in particular, there is no mention of Mr. Magro's two green forms of 17 December and no mention of his having handed the hand made green form to EEN McMahon. Considering the terms of his green forms and subsequent events, the passage in paragraph 17 that Mr. Magro was "reporting shortness of breath and generally feeling very unwell" is surely a significant understatement of his condition.

42. Neither RN Deborah Little, the Nurse Manager for Justice Health's northern cluster and RN Aldridge, the senior nurse on duty on the evening of 17 December, 2008 nor even EEN McMahon, as the nurse to whom Michael Magro's ultimate green form was handed, was ever interviewed or invited to take part in any internal investigative process touching on the care, treatment and death of Michael Magro. To the extent that Ms. Babineau's report was intended to adequately inform the Commissioner of Corrective Services of what had happened to a prisoner who had been in his care, it cannot possibly have done so. Further, Ms. Hanly reminded the inquest that the Root Cause Analysis conducted by Justice Health may not be made available to the Commissioner so that it is not clear how he could be assure a clear and complete picture of what had happened to Mr. Magro. But then, it is not easy to see how, in Mr. Magro's case, a useful Root Cause Analysis could have been undertaken without Ms. Aldridge's and Mr. McMahon's participation.

43. It seems to me, therefore, that there were real shortcomings in the processes and procedures which governed the internal investigations of Justice Health and of the Commissioner of Corrective Services into Mr. Magro's care, treatment and ultimate death. In the case of the Commissioner, those shortcomings originated in the narrow scope of inquiry allowed him, that is, to investigate whether there were any breaches of policy and proper procedure rather than to investigate the circumstances leading to Mr. Magro's death. A second shortcoming was the absence of authority in the Commissioner to direct relevant questions to Justice Health staff and, ultimately, his inability to access the Root Cause Analysis. In the case of Justice Health, the shortcoming was its failure to make proper enquiries, in particular by directing questions to the relevant nursing staff, and the failure to produce a comprehensive and relevant report for the Commissioner. The inquest was informed that there was ample opportunity for the Commissioner to be fully appraised by Justice Health, on an informal level, as the circumstances of the death of Michael Magro. Even if there was – and there is no evidence of such opportunity or of such opportunity having been taken up,

FINDING

I FIND that Michael Peter Magro, who was born on 17 October, 1968, died at Royal North Shore Hospital, St. Leonards, NSW on 27 December, 2008 of Hypoxic Brain Injury consequent upon cardiac disease, possible viral infection of the lungs and generally suboptimal health.

RECOMMENDATIONS

Pursuant to section 82, I RECOMMEND to the Minister for Health being the Minister responsible for Justice Health and to the Attorney-General and Minister for Justice as the Minister responsible for Corrective Services NSW as follows:-

(a) That in any internal review of a death in custody whether conducted by Justice Health or Corrective Services NSW, the author(s) of such reviews take all appropriate steps to interview and/or obtain information from relevant staff on duty or involved with the deceased person in the forty eight hours prior to that person's death or transfer to an external medical facility and the cellmate(s) of the deceased;

(b) That if it is not already the case, the Patient Request Forms, known as Green Forms, form part of an inmate's Justice Health medical file;

(c) That any written communication to Justice Health clinically relevant to an inmate's medical condition should form part of the inmate's Justice Health medical file;

(d) That in correctional facilities where Patient Request Forms (Green Forms) are in use, these should be reviewed by a Registered Nurse on the day they are submitted by an inmate;

(e) That Justice Health promptly investigate and seek to devise a policy and procedure or supplement any existing policy and procedure to ensure that any complaint of an inmate regarding breathing difficulty,

chest pain and/or respiratory distress to be immediately assessed by a medical professional; and

(f) That Death in Custody Reports prepared for Justice Health following the death in custody of an inmate include an endorsement by the person responsible to the Chief Executive for the report confirming that that person has had access to the relevant medical records of the deceased inmate prior to submitting that report to the Chief Executive and enumerating all and any source documents relied upon in the preparation of the report.

Magistrate Scott Mitchell,
NSW Deputy State Coroner
1 July, 2011.