

CORONERS COURT OF SOUTH AUSTRALIA

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INQUEST INTO THE DEATH OF NATHAN JAMES TAYLOR

[2026] SACC 13

Inquest Findings of his Honour State Coroner Whittle

2 June 2026

CORONIAL INQUEST

Examination of the cause and circumstances of the death of a prisoner who was found unresponsive following reporting chest pain. The inquest explored the relevance of earlier abnormal ECG testing that was not actioned.

Held:

1. Nathan James Taylor, aged 40 years, of Port Lincoln Prison, died at Port Lincoln on or about 24 March 2022 as a result of an unascertained cause.
2. Circumstances of death as set out in these findings.

No recommendations made.

Counsel Assisting: MR D EVANS

Hearing Date/s: 01/05/2026

Inquest No: 19/2026

File No/s: 0675/2022

**INQUEST INTO THE DEATH OF
NATHAN JAMES TAYLOR
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Introduction

- 1 The Court conducted a mandatory inquest on the papers in relation to the death of Mr Taylor who died in unclear circumstances while sleeping in his cell overnight.

Nathan Taylor

- 2 Mr Taylor was born on 21 November 1981. He went to school in Port Augusta. He was diagnosed with ADHD while in year 2 and left school in year 10. He used marijuana. In his 20s, Mr Taylor was diagnosed with schizophrenia. He had occasions where he was detained under the *Mental Health Act* due to erratic behaviour and he was eventually put on an order to have depot injections for longer term medication for his illness. Later, his parents purchased a house close to them so he had somewhere to live, and so they could keep an eye on him. He completed hospitality courses through Tafe SA and had work from time to time until he eventually moved onto a disability support pension.¹
- 3 In September 2018, Mr Taylor was taken to the Royal Adelaide Hospital in sepsis with suspected infective endocarditis. Infective endocarditis was confirmed and it was thought that intravenous drug use was the probable cause. He was treated with various antibiotics and spent 23 days in hospital. Examinations of his heart showed that the endocarditis had caused a tricuspid vegetation, resulting in mild to moderate valve regurgitation.²
- 4 Mr Taylor was involved in an incident which resulted in him being charged with domestic violence offences.³ He was alleged to have then spoken to the purported victim of those offences in a manner which resulted in those proceedings being withdrawn. When this was detected, Mr Taylor was charged in fresh proceedings with the offence of preventing a person from attending as a witness. This matter was heard in court in September 2021 and adjourned to 30 March 2022. Mr Taylor was remanded in custody pending determination of the matter.⁴
- 5 Mr Taylor was assessed by a registered nurse during his intake at Port Augusta Prison. His physiological observations were normal. He reported that, up until the day prior, he had smoked 35 cigarettes per day, smoked cannabis 20 times per day and had been injecting illicit substances as recently as two weeks prior.⁵
- 6 On 10 October 2021, Mr Taylor presented to the nurses complaining of chest pain overnight. He said he felt that ‘someone grabs my heart’ and that he had experienced the same thing a number of times over several years.⁶ ECGs were performed in the morning and in the afternoon.⁷ He was told to raise any further experiences of chest pain. These ECGs showed sinus rhythm, but with a left bundle branch block pattern and a QRS duration of 161 milliseconds, which is abnormally prolonged. It appears that a review of

1 Exhibit C6

2 Exhibit C12

3 Exhibit C6 at [17]

4 Exhibit C17 at [36]

5 Exhibit C13

6 Exhibit C21, Nursing notes 10 October 2021 at 9:30 am

7 Exhibit C14 at [8]

the ECG results by a medical practitioner was not conducted, as Mr Taylor only spent one more day in Port Augusta Prison.

- 7 Mr Taylor was transferred to the Port Lincoln Prison where he remained, except when appearing in court, until his death. During his health intake on 13 October 2021, he was specifically asked about any cardiac history and reported nothing.⁸
- 8 He would occasionally tell his cellmate that he missed his pets, but otherwise made no complaints.⁹
- 9 While in custody Mr Taylor had a depot injection of paliperidone for schizophrenia every 28 days¹⁰ and attended psychiatry appointments. He had two dental extractions in November 2021. On 15 March 2022 he had severe tooth pain and was prescribed antibiotics and analgesia.¹¹ On 21 March 2022 he had a further tooth extraction. Notwithstanding engagement with the Health Service, there is no record of Mr Taylor reporting any chest pain after his transfer to Port Lincoln.
- 10 On the morning of Wednesday, 23 March 2022, Mr Taylor got up as required when the guards called cell unlock but then went back to bed, which was not uncommon for him.¹² Throughout the day he watched television and went for walks, stopping to talk to people, including another prisoner who stated that Mr Taylor was off-colour, walking slowly and crouching while he walked.¹³ Mr Taylor told him 'it feels like my insides are shutting down'. During that night, Mr Taylor's cellmate heard him snoring loudly.¹⁴
- 11 The following morning, when cell unlock was called at around 8:10 am, Mr Taylor did not get up. His cellmate tried to rouse him, but he was not reacting.¹⁵ Correctional Officer Andre Froese was performing the unlock procedure for Cell 38 and saw that Mr Taylor was not getting up as required. He entered the cell and said, 'You need to be up for unlock', but Mr Taylor did not respond.¹⁶ He then shook Mr Taylor who still did not respond and felt cold. He pulled back the quilt and saw that Mr Taylor had purple blotches on his stomach and lower torso.¹⁷ Mr Froese's colleague, Mark Panizzolo, came to see what was happening. Mr Froese pressed his portable duress alarm and Mr Panizzolo radioed a medical emergency.¹⁸ A call to triple zero resulted in two crews of paramedics being dispatched at 8:14 am.¹⁹
- 12 Mr Froese and Mr Panizzolo picked up the mattress Mr Taylor was on and took it out of the cell, laying it and Mr Taylor on the ground in the hallway.²⁰ By this time a supervisor, Darren Page, had attended in response to the radio call and CPR was commenced by Messrs Froese and Page, while Mr Panizzolo was returning other prisoners to their cells.²¹

⁸ Exhibit C21, Progress Sheet dated 13 October 2021

⁹ Exhibit C8 at [4]-[5]

¹⁰ Exhibit C17 at [40]

¹¹ Exhibit C13 at [14]-[15]

¹² Exhibit C8 at [7]

¹³ Exhibit C7 at [4]

¹⁴ Exhibit C8 at [18]

¹⁵ Exhibit C8 at [20]

¹⁶ Exhibit C10 at [7]

¹⁷ Exhibit C10 at [8]

¹⁸ Exhibit C9 at [9]

¹⁹ Exhibit C11 at [3]

²⁰ Exhibit C10 at [10]

²¹ Exhibit C10 at [11]; Exhibit C9 at [10]

Other colleagues arrived with oxygen and a bag valve mask. Nursing staff brought a defibrillator device which indicated ‘no shock advised’ once connected.²²

- 13 Paramedics arrived at 8:24 am and took over CPR. Mr Taylor was in asystolic cardiac arrest and resuscitation efforts were not successful. Paramedics declared life extinct at 8:51 am. Mr Taylor was 40 years old.
- 14 Police attended the scene and found no signs of trauma, injury, struggle or violence.²³

Post-mortem examination

- 15 A post-mortem examination was conducted by senior specialist forensic pathologist Dr Stephen Wills.²⁴ Dr Wills found no pathologically significant acute injuries. There were no head or brain injuries, and a specialist brain examination by a neuropathologist found no issues that might have contributed to Mr Taylor’s death.²⁵ Mr Taylor’s heart was also examined by a specialist who found there were no anatomical changes sufficient to account for his sudden, unexpected death.²⁶ His heart was not enlarged and had no significant coronary artery disease. There was a mild interstitial fibrosis of the right atrial appendage and mild scleroatrophy of the left side of the interventricular crest, which were age related, as well as mild coronary artery atheroma. Those issues were not significant enough to have brought about Mr Taylor’s death.
- 16 Toxicological analysis²⁷ showed that Mr Taylor had two drugs in his system at the time of his death; paliperidone – the antipsychotic drug he received via depot, and lignocaine – a local anaesthetic drug, in quantities insufficient to have brought about death.
- 17 Dr Wills concluded that, after those extensive medical investigations, Mr Taylor’s cause of death was unable to be ascertained. He explained in his report that the possibility of cardiac channelopathy remained. This is a group of conditions which act at the molecular level, that is, beyond even the cellular level, and cannot be found at post-mortem examination; not macroscopically and not histologically.

Assessment of the issues

Custody

- 18 Mr Taylor had been remanded into custody by a court pending the determination of charges of interfering with judicial proceedings. He was lawfully held in custody at the time of his death.

Care provided

- 19 The overall quality of care provided to Mr Taylor was reasonable. He received, at the least, the level of services that a person might expect if living in the community.
- 20 There was naturally concern about the failure to have a doctor examine the ECGs which indicated cardiac issues some months before Mr Taylor’s death, and the Court commissioned an independent expert overview of the evidence.

²² Exhibit C10 at [12]

²³ Exhibit C17 at [19] and [26]

²⁴ Exhibit C2

²⁵ Exhibit C5a and Exhibit C5b

²⁶ Exhibit C4

²⁷ Exhibit C3

- 21 Professor William Heddle, an experienced independent cardiologist, reviewed the ECGs. Professor Heddle stated that the results were very abnormal for a patient as young as Mr Taylor, which suggested that there were intrinsic conduction problems in his heart.²⁸ His best explanation for Mr Taylor's death, without strong proof, is that methylamphetamine use brought about disease of the conduction system.
- 22 Professor Heddle has said that, given the results of the post-mortem examination, it is known that a medical review and all expected tests in the scenario would have been normal, and no cause would have been able to be found for the bundle branch block. In particular, Professor Heddle stated that if an echocardiogram, CT coronary angiogram or cardiac MRI scan were conducted, these would all have returned normal results, as conduction issues are not structural and are not detected on scans. He explained that Mr Taylor's clinical course would therefore have been no different had assessment occurred, and there were no treatments which might have prevented Mr Taylor's death. Professor Heddle stated that Mr Taylor's presentation would not have been suitable for a pacemaker installation.
- 23 Based on the evidence, I conclude that the fact that the ECGs were not reviewed had no bearing on Mr Taylor's death.
- 24 The current Director of the South Australian Prison Health Service (SAPHS), Dr Andrew Wiley,²⁹ explained that there is an expectation that doctors will review ECGs by the following day. He said that at the time of Mr Taylor's ECGs, there were significant staff shortages in the SAPHS, with no permanent doctor at the Port Augusta Prison. By the time a fly-in-fly-out doctor arrived on 14 October 2021, Mr Taylor had already been moved. Dr Wiley stated that locum doctors had been booked for 12 and 13 October 2021, but the agencies were unable to fulfil those bookings. Dr Wiley explained that there is now a doctor employed full time at the Port Augusta Prison, and a nurse practitioner two or three days per week. There is a dedicated triage nurse position which operates seven days a week and arranges patient appointments with doctors or nurse practitioners as required. These are significant improvements, with the result that if the same circumstances occurred again, the signs visible on the ECG were unlikely to be missed.

Recommendations

- 25 Considering the lack of preventability and steps which have been taken towards improvement, I do not consider recommendations necessary in this matter.

Cause of death

- 26 Comprehensive post-mortem examinations were undertaken in relation to Mr Taylor's death, including by an expert pathologist, a brain expert and a heart expert, with no specific cause able to be identified. While it is unfortunate to reach the result of not knowing what caused Mr Taylor's death, in line with Dr Wills' opinion, I enter a finding that the cause of death is unascertained.

Keywords: Death in Custody; Prison; Unascertained; Cardiac Issues

²⁸ Exhibit C16 at 2

²⁹ Exhibit C26