CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Into the death of Danny Keith Whitton
File number:	2015/ 329568
Hearing dates:	22-26 February 2021, 24-26 May 2021
Date of findings:	19 November 2021
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E. Truscott
Catchwords:	Coronial Law - Cause and manner of death - death in custody - First Nations Prisoner- paracetamol toxicity- care and treatment- delay-CCTV
Representation:	Counsel Assisting Mr T Hammond instructed by Ms T Howe of Crown Solicitors Office Ms Kylie Knight – mother of Danny: Mr S Rees of Aboriginal Legal Services Mr Darren Whitton – father of Danny: Ms H Cooper of Legal Aid Commission NSW The Geo Group Australia Pty Ltd : Ms T Berberian instructed by Ms M Shanahan of Sparke Helmore Commissioner of Corrective Services NSW Mr T Pickering instructed by Ms J de Castro Lopo of Department of Communities and Justice NSW Justice Health and Mental Health Forensic Network

	Mr M Lynch instructed by Mr B Ferguson of Hicksons Lawyers Mr G Bryon, Ms McGloin, Ms Duddy and Mr Marsters Ms B Haider of New South Wales Nurses and Midwives Association Mr A Wall Mr N Dawson of New Law Pty Ltd Dr. D Corbett Mr R Sergi instructed by Ms L Kearney of Avant Law
Findings:	**Identity** Danny Keith Whitton **Date of Death** 9 November 2015 **Place of Death** Royal Prince Alfred Hospital, Camperdown, Sydney, NSW **Cause of death** Multiple Organ Failure due to acute paracetamol poisoning **Manner of death** Danny died after ingesting an overdose of paracetamol at Junee Correctional Centre operated by the GEO Group Australia Pty Ltd. Danny's condition was not appropriately investigated as blood tests were not actioned and Danny's condition was not appropriately monitored. His deterioration was not appropriately actioned in a timely manner due to overall suboptimal care and a significant misunderstanding of the transfer procedure of a patient from the health clinic at Junee Correctional Centre to the Wagga Wagga Base Hospital. Danny's condition was irrecoverable despite appropriate intervention at that hospital and then his transfer to the Royal Prince Alfred Hospital. Danny died whilst he was in the custody of Corrective Services NSW.
Non Publication and Non Access Orders regarding material from Corrective Services	1. That the documents and information identified in the appended Schedule to an Order made on 22 February 2021 with respect to material relating to Corrective Services NSW and contained in the brief of evidence tendered in the proceedings, not be published under section 74(1)(b) of the Coroners Act 2009 (NSW). 2. Pursuant to section 65(4) of the Coroners Act 2009 (NSW), a notation be placed on

NSW and the GEO Group Australia Pty Ltd		the Court file that if an application is made under section 65(2) of that Act for access to the documents referred to above at [1] on the Court file, that the material shall not be provided until Corrective Services NSW has had an opportunity to make submissions in respect of that application. These documents disclose confidential information regarding the security and management of prisoners at the Junee Correctional Centre. Disclosure of the information may result in security breaches at the prison impacting the safety of both staff and inmates.
	3.	That the documents and information identified in the appended Schedule to Orders made on 26 February 2021 and 26 May 2021 with respect to material relating to the GEO Group Australia Pty Ltd and contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the Coroners Act 2009 (NSW).
	4.	Pursuant to section 65(4) of the Coroners Act 2009 (NSW), a notation be placed on the Court file that if an application is made under section 65(2) of that Act for access to the documents referred to above at [3]below on the Court file, that the material shall not be provided until GEO Group Australia Pty Ltd has had an opportunity to make submissions in respect of that application. These documents disclose confidential information regarding the security and management of prisoners at the Junee Correctional Centre. Disclosure of the information may result in security breaches at the prison impacting the safety of both staff and inmates.

IN THE CORONERS COURT

LIDCOMBE
NSW

Section 81 Coroners Act 2009

REASONS FOR DECISION

Introduction

1. Danny Whitton, a First Nations man of the Wanaruah People died aged 25. Danny was the son of Darren Whitton and Kylie Knight. When Danny was a baby Kylie and Darren separated and each re-partnered. Danny was the loved brother of 4 sisters and 3 step brothers. Danny was a young father. When Danny and Emma Price were teenagers they had a daughter who was 8 years old when he died. He had a 2 year old son as well. The Wanaruah Country is around the Hunter Valley area and Danny grew up around Maitland and Newcastle. His family have attended this inquest both in person and by remote technology.

2. Danny lived with each of his parents and siblings at different times during his childhood. His parents have always been supportive of Danny who unfortunately had to deal with numerous difficulties arising from serious and repeated traumatic incidents, causing him significant and ongoing mental health problems. He had significant disruption to his schooling and as a very young teenager he became involved with illicit substances, offending and the criminal justice system.

3. When Danny was 13 years old he first appeared in the Children's Court and despite numerous Juvenile Justice Interventions, he was later sentenced to control orders and then once he turned 18 to sentences of imprisonment.

4. Danny was a talented sportsman, especially playing rugby league and was hoping to be a teenage player with the Newcastle Knights. Darren described how Danny loved his family and though a problem child was a good child and he would do anything for anybody. Danny lived with his girlfriend Emma and they had their daughter when Danny was 17 years old. Danny took much pleasure and pride being a father but his personal problems continued and his drug use escalated as did his offending. At

times he experienced drug induced psychosis and was prescribed Seroquel to manage his mental health.

5. When Danny was 19 he commenced the methadone programme and remained on it until he last collected his prescribed dose on 17 March 2015. He then travelled to Queensland and inevitably started using illicit drugs. He returned to NSW and was involved in a motor vehicle pursuit resulting in his arrest on 3 June 2015. Danny was charged with a number of offences and he was refused bail by the police and then by the Local Court. He later pleaded guilty to charges and was sentenced to imprisonment with an earliest release date of 2 June 2016.

6. In the week leading up to his death Danny became unwell after consuming diverted methadone and a mixture of pills. He presented to the medical unit on Thursday 5 November 2015 and on Saturday 7 November 2015 he was transferred to Wagga Wagga Base Hospital. On Sunday 8 November 2015 he was airlifted to Royal Prince Alfred Hospital in Sydney where he was placed on life-support. He had irrecoverable multi-organ failure. Danny died on 9 November 2015.

7. A post mortem examination included an analysis of a blood sample taken at 5 pm on Saturday 7 November 2015 at Wagga Wagga Base Hospital. That sample indicated Paracetamol at <5mg/L, methadone <0.05 mg/L. A urine sample taken by GEO at 3.45 pm on Friday 6 November 2015 indicated the presence of Buprenorphine and Benzodiazepines.[1] The post mortem report prepared by Dr Bailey sets out that the cause of Danny's death was multi-organ failure. A discussion in the report sets out that the results of toxicology do not exclude Paracetamol toxicity.

8. In this regard an expert opinion was sought from clinical and forensic toxicologist Professor Naren Gunja. He provided a report dated 15 September 2018 and a supplementary report dated 14 March 2020. Professor Gunja also gave evidence in the inquest that in his opinion the cause of Danny's organ failure was Paracetamol toxicity. Associate Professor Anna Holdgate an emergency physician who also provided a report dated 14 November 2019 concurred with Professor Gunja as to the likely cause of Danny's death.

9. The inquest into Danny's death is required under ss23 and 27 *Coroners Act 2009* as he was in custody. The inquest was overdue for quite some time and in 2019 it was set down for hearing in March 2020 but the hearing did not proceed as it was vacated due to Covid-19 restrictions. The inquest heard evidence in February 2021 and also

[1] Tab 4 Certificate of Analysis dated 11 November 2015

in May 2021. That findings are delivered 6 years after Danny's death is highly regrettable.

10. The findings required under s81 in relation to identity, place and date and cause of Danny's death were uncontroversial. It was the manner or circumstance of Danny's death and the issues and any recommendations arising out it which were the focus of the inquest.

11. The issues in the inquest related to the care and treatment provided to Danny whilst accommodated in the medical clinic between 5-8 November 2015 with particular regard to policy compliance, whether the symptoms with which Danny presented were appropriately recognised and investigated, the adequacy of observations and medical testing and whether Danny's deteriorating condition was appropriately responded to. Other issues included whether Danny's placement on the Opiate Substitution Treatment program ("OST") was appropriate. There was also evidence about the diversion by prisoners of their prescribed methadone at Junee Correctional Centre and the availability and stockpiling of Paracetamol by prisoners.

12. An issue arose in the inquest where evidence demonstrated that as a result of Danny presenting to the clinic for medical care a nurse sent an email to GEO Intelligence (Intel) that Danny should be subjected to an Intel urine test. Another issue arose in relation to the selection of material provided to the investigating police officer called the Death in Custody Briefing Package. Though the medical ward cell Danny was house in had CCTV footage for the duration of his time in the clinic only the footage showing his initial attendance at the clinic on 5 November 2015 and the paramedics transferring him from the ward on 7 November 2015 was provided. Given the poor nursing record keeping and observations made of Danny during his time in the clinic, the footage of the entirety of Danny's time in the clinic would have been useful and time saving in the inquest. For the same reasons it would have also been better to have made available the CCTV footage relevant to the time and location of Danny's prison accommodation relating to his movement and appearance. The need for this material was realised after the CCTV footage was deleted which was about 6 weeks later.

13. Evidence was comprised of statements, documents and CCTV footage contained in over six volumes and the testimony over eight days of numerous witnesses including the expert witnesses as well as prisoners (Messrs A, B, C, D) who attested to seeing Danny unwell before he went to the medical clinic on 5 November 2015, a Corrections Officer ("CO") Raewyn Withers who observed Danny over the day he presented to

the clinic, Registered Nurses RN Marsters who admitted Danny onto the ward, RN Duddy who attended Danny once on 5 November 2015, RN Wall who was on duty overnight on 5 and 6 November 2015, RN McGloin a drug and alcohol nurse who saw Danny on the afternoon of 6 November 2015 and RN Bryon who was on duty on the morning of 7 November and who made arrangements for Danny's transfer to hospital, Dr D Corbett who is the General Practitioner who reviewed Danny on 6 and 7 November 2015 and spoke on the telephone with RN Bryon over the morning of 7 November 2015 and finally a prisoner Mr E who was housed with Danny in the medical ward from 6-7 November 2015.

14. Other witnesses called included managerial staff at Junee including Ms J Te Maru, manager of the Medical Unit, Mr W Doherty who was at the time head of Junee CC Intel, and Ms A Wood the past GEO Contract Compliance Manager who gave evidence that the medical unit has undergone a major refurbishment and that prisoners are no longer housed in the ward for medical care. There are now 8 single bed observation cells for the purpose of management of prisoners "at risk". Ms E Halliburton, GEO Human Resources Co-ordinator spoke to the implementation by GEO of a staff training package regarding identifying prisoners intoxicated or withdrawing from drugs arising out of a recommendation in the inquest into the death of Anthony Van Rysewyk. Mr S Ward, the Acting Service Director of Drug and Alcohol Services for Justice and Forensic Mental Health Network ("Justice Health") gave evidence about the availability of places on the OST program and the programme that is now available and has been rolled out in NSW prisons involving depot buprenorphine called Buvidal. He also gave evidence responding to an issue which arose in the inquest relating to GEO health staff's access to NSW Health Education Training Institute. CO Denyer and CO Moisan of Corrective Services NSW ("CSNSW") gave evidence in relation to their guard duties at the Royal Prince Alfred

Hospital and their understanding of providing access to Danny by his family when they visited.

15. After the hearing further evidence was received in chambers and submissions were received which addressed the evidence including the supplementary material.

Danny's custody 4 June 2015 to 16 August 2015

16. Danny was received into custody at Cessnock Correctional Centre on 4 June 2015 as a remand inmate.[2] The "reception screening" of an inmate involves a number of CSNSW forms being completed one of which is often commenced at the Local Court cells which is called an Inmate Identification and Observation Form ("IIO"). The IIO was commenced by CSNSW Officer Andrew Tulan at Maitland Court Cells. Mr Tulan recorded that Danny:

    - was Aboriginal;
    - was on medications Lyrica and Seroquel, [which is Pregabalin and Quetiapine respectively];
    - had last used methamphetamine [recorded as "ice"] on "Sunday" [which was 31 May 2015];
    - was on the methadone program at a dosage of 150mls; and
    - had not previously attempted suicide or self-harm.[3]

17. As a result of the reception screening at Cessnock Correctional Centre it was recommended that Danny be accommodated in a special management area due to "fear".[4]

18. The reception screening also includes a separate interview with Justice Health where a number of health documents are completed. A Reception Screening Assessment

[2] Tab 11.16aaaa Reception Checklist, Cessnock Correctional Centre, dated 4 June 2015; zzz) Intake Screening Questionnaire dated 12 June 2015.
[3] Tab 11.16hhhh Inmate Identification and Observation Form dated 4 June 2015.
[4] Tab 17 Special Management Area placement Form dated 4 June 2015.

("RSA") was completed by Ms Amy Gibbs on 5 June 2015. The RSA recorded that Danny:

- had used benzodiazepines in the last 4 weeks,;
- tended to use ice daily; however he had last used ice one week previously;
- last used cannabis one week previously;
- was experiencing symptoms of withdrawal;
- was on an opioid substitution treatment, namely methadone, that his prescribing doctor was Dr Khan and that the date of his last dose of methadone was 17 March 2015; and
- current medications were listed as quetiapine, methadone and pregabalin.

19. Ms Gibbs recorded that Danny had previously been treated for a mental health problem and that he had tried to hurt himself by "slashing up" nine years ago. It is also recorded that Danny had stopped attending Cessnock Plaza for his methadone because he had moved to Queensland for a period, where he had used street methadone instead.[5]

20. The inquest heard evidence about the difficulties of accessing the NSW Health OST program in NSW prisons. A prisoner was able to continue receiving methadone in prison provided that they had been regularly picking up their dose within the last three days prior to entering custody. Danny, having been two months outside of that time was accordingly unable to access the program and was required to reapply which involved him being placed on a waitlist to see the Drug and Alcohol nurse for an assessment.[6] At that time throughout the NSW prisons there were limited places available on the program and even once a prisoner had applied there were wait times on average of about 18 months. On that basis Danny was never going to be received onto the program as he would be released 6 months prior to the expiration of 18 months.[7]

21. Danny signed a document called "Consent to Obtain Health Information from External Agencies Form" ("Consent Form") which was faxed on 6 June 2015 and responded to that day with a "Full Summary" document to Justice Health, which listed "methadone 75mg/15mls under the heading "Current Medications" and noted the last

[5] Tab 97ss Reception Screening Assessment dated 5 June 2015; p) Progress Note dated 5 June 2015, Justice Health Records.
[6] Transcript 25/2/21 T65.12-18
[7] His earliest release date was 2 June 2016.

script was given on 26/2/15.[8] On 13 June 2015 Danny signed another Consent Form addressed to the Hunter Valley Medical Centre.[9]

22. An Intake Screening Questionnaire completed by welfare officer Neville Bowen on 12 June 2015 recorded that Danny took daily medication for drug-induced psychosis. It further recorded that, in response to the question, "are you withdrawing/expecting to withdraw from drugs" Danny answered "no". Danny was also asked "Have you tried to take your own life or harm yourself in the past", Danny replied that he had harmed himself by cutting his arm 9 years ago; however had had no thoughts or plans of harming himself since that time.[10]

23. On 16 June 2015, Danny was escorted to Maitland Hospital. A Justice Health nurse stated in a referral letter:

> "Thank you for seeing this patient who sustained a king hit to R side of face approx. 6 weeks ago. Since then, has had severe headaches, has been vomiting intermittently, has an unsteady gait, has had clear fluid dripping from nose, has had blood clots in ear (infrequent). Numbness and tingly over site of injury R/eye, confusion, aggression…blurred vision in R/eye and sometimes complete black out of vision…short/long term memory loss, is photophobic and loud noises are distressing…"[11]

24. Danny was reviewed by a Resident Medical Officer on 17 June 2015 at Maitland Hospital, who noted:

> "Investigations: CT Brain – no obvious bleed or midline shift report pending, Diagnoses: …?Methadone Withdrawal…Discharge and Follow up: GP – to look into his methadone program and see if he requires continuation. Follow up the formal CT Brain report."[12]

25. Danny was not admitted into hospital and returned to Cessnock Correctional Centre in the early hours of 17 June 2015[13]. On 26 June 2015, Danny was subjected to a targeted strip search and a half Seroquel tablet secreted in the waistband of his track pants and an uncapped gaol made syringe was located between his buttocks.[14] He was placed on a 14 day segregation order, the reason cited as being "for the good order" of Cessnock Correction centre. Such an order is accordingly not deemed by

[8] Full Summary as at 6/6/15.
[9] Tab 97o Consent to Obtain Health Information from External Agencies Form dated 13 June 2015.
[10] Intake Screening Questionnaire dated 12 June 2015.
[11] Tab 97kkLetter of referral from Kate Quarello RN dated 16 June 2015.
[12] Tab 97qq Maitland Hospital, Discharge Referral dated 17 June 2015, Justice Health Records.
[13] Tab 97qq Maitland Hospital, Discharge Referral dated 17 June 2015, Justice Health Records time recorded 2.00am
[14] Tab 11.16kReport of Senior Assistant Superintendent Adrian Clarke to the General Manager dated 27 June 2015.

CSNSW to be a punishment. Danny receive a penalty for the possession of those items which was 2 months without "buy-up" however by the time he arrived at Parklea he was able to participate in buy-ups.[15] The inquest heard evidence that Danny would trade his buy up items to acquire drugs from other prisoners. Accordingly, withdrawal from the buy-up program would have affected his capacity to pay for drugs in the prison system.

26. Though the find on the strip search would indicate that Danny was using illicit drugs whilst in prison it did not trigger a priority enrolment onto the OST program and Danny continued to apply for the programme whilst apparently being engaged in illicit and unsafe drug use whilst in prison[16].

27. On 7 July 2015 the segregation order was revoked.[17] On 9 July 2015, Danny requested that he be accommodated in another unit as he was "receiving threats from other inmates in relation to drug activity and debts".[18] It was recommended that he be managed as a Protection Requiring Limited Association ("PRLA") inmate until he could be moved to another correctional centre.[19]

28. Shortly after being placed on protection, on 10 July 2015, Danny activated the intercom in his cell ("knock up") threatening to "slash up" with razor blades if correctional officers did not move him. Danny was escorted to an observation or "camera" cell and placed on a Risk Intervention Team ("RIT").[20] The relevant form stated that Danny had presented as:

> "hearing voices, very angry threatening violence" and noted that the trigger for the incident was "not getting psych medication".[21]

29. On 11 July 2015 Danny was transferred from the camera observation cell to a "2-out" cell so he was housed with another prisoner. On 14 July 2015, Danny apparently lit a fire in his cell (although he later denied this)[22] and was taken to John Hunter Hospital

[15] Tab 34 Inmate Discipline Check list, see also Tab 147.
[16] On 22 September 2015 he reported that he had been to RN McGloin.
[17] Tab 38 Memorandum from Adrian Clarke, Assistant Superintendent, Cessnock CC, to the General Manager, Cessnock CC, re Revocation of Segregation Order dated 7 July 2015 and Tab 43, Segregated Custody Directiondated 9 July 2015
[18]Tab 81 CSNSW, Inmate Request Forms
[19] Tab 40 Letter from Assistant Superintendent Scott Sanderman to the General Manager of Cessnock Correctional Centre dated 9 July 2015 and Tab 40 Placement/Threat Assessment at Cessnock Correctional Centre 9 July 2015
[20] Tab 41 Corrective Services NSW Incident Details Report dated 10 July 2015.
[21] Tab 46 Mandatory Notification for Offenders At Risk of Suicide or Self-Harm dated 10 July 2015.
[22] Tab 51 Mandatory Notification for Offenders "At Risk" of Suicide or Self-Harm dated 16 July 2015.

after being removed from his cell unresponsive.[23] The Incident Details Report in relation to the fire states:

> "claims his perceived needs were not met over the last 5 days and this was the result."[24]

30. On 14 July 2015 Danny's placement in the Special Management Area Placement was revoked.[25] On 15 July 2015, at about 12:40 am Danny returned to Cessnock Correctional Centre and he was again placed on a RIT and accommodated in a camera observation cell.[26]

31. On 17 July 2015 a Justice Health nurse, RN Sharpe conducted a mental health assessment and the notes referred to Danny having auditory hallucinations and stated that he "would like to be on methadone".[27] She recorded that Danny reported sexual abuse from the age of 8. Danny reported being a heavy user of "ice" and as having started smoking cannabis at the age of 11, "ice" at 13 and heroin at age 16. He reported that at the age of 15 he spent a few days in the child and adolescent psychiatric ward at John Hunter Hospital (Nexus) until he was discharged into the care of his father. He reported that there was no follow up commitment. He suffered physical chronic pain after he had been deliberately run down by someone driving a car. He was on Seroquel 50 mg each night for depression anxiety and panic attacks. He denied self-harm though had previous thoughts of self-harm.

32. He scored 47/50 on the Kessler scale but RN Sharpe noted that the score might not be consistent with Danny's presentation and queried whether Danny was over reporting to improve his chances of having an increase in his medication and to be enrolled on the OST program. Similarly, it is unclear whether Danny's report of his symptoms which led to the brain CT scan at Maitland hospital in June 2015 was genuinely from an injury, or the result of prison drug use or was an act of drug seeking behaviour. [28]

33. Danny's accommodation was subject to review from 18 July 2015. Danny requested to remain on PRLA until his transfer to another centre but on 25 July 2015, he informed CSNSW Officer Joy Gallen that he would sign off the PRLA in order to be transferred to another centre. He also informed Ms Gallen that his uncle was the then-current

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[23] Tab 97w Emergency Response Form dated 14 July 2015, Justice Health records.
[24] Tab 97oo Incident Details Report dated 15 July 2015.
[25] Tab 29 SMAP cancellation notice
[26] Tab 50 Incident Details report
[27] Tab 97s Mental Health Assessment of Rhonda Sharpe RN dated 17 July 2015, Justice Health Records.
[28] Tab 97s Mental Health Assessment of Rhonda Sharpe RN dated 17 July 2015, Justice Health Records.

active president of the Bandidos, Hunter Valley.[29] A Placement/Threat Assessment conducted on the same date found the likelihood of a threat occurring against Danny as "high".[30]

34. On 27 July 2015 Danny appeared at Maitland Local Court and was sentenced and his earliest release date was 2 June 2016.[31] On 30 July 2015 the protective custody order was extended to 8 October 2015.[32] On 8 August 2015 Danny was transferred from Cessnock Correctional Centre to Parklea Correctional Centre.[33] A Reception Committee Screen form indicates that Danny was offered and accepted a place in the Equips Addiction Program.[34] A box was also checked to indicate that Danny would be referred to psychology services, with a handwritten note stating, "AOD Methadone".[35]

35. On 13 August 2015, Danny was transferred to Junee Correctional Centre via three days at Bathurst Correctional Centre. On 16 August 2015, Danny was received at Junee Correctional Centre as a PRLA inmate,[36] and was placed in Unit B1, B Pod.[37]

Junee Correctional Centre 16 August 2015 – November 2015

36. Junee Correctional Centre is operated by GEO Group Australia Pty Ltd ("GEO"). The medical services provided at Junee are provided by GEO rather than Justice Health.[38]

37. On 18 August 2015, Danny submitted an "Inmate Medical Request" stating "I have been using needls [sic] in Parklea I wish to get back on my methadone".[39]

38. On 19 August 2015 Danny attended an induction interview with an Offender Development Officer. On 25 August 2015 he was assessed as suitable for the EQUIPS program and on 12 October 2015 after attending an information session he was accepted onto the program but he only attended the morning session on 26 October 2015 because he identified that it wasn't the right program for him as he was not a violent person. On 24 August 2014 Danny was referred to another program,

[29] Tab 11.16kk Report of Joy Gallen to Mr Simon Raper, A/General Manager of Cessnock Correctional Complex.
[30] Placement/Threat Assessment dated 25 July 2015, p. 6.
[31] Tab 11.15 Email from B Neville to H Robertson dated 9 November 2015.
[32] Tab 59 Review of protective custody dated 30 July 2015.
[33] Tab 64 Parklea Correctional Centre Reception Committee Screen dated 8 August 2015.
[34] Tab 64 Parklea Correctional Centre Reception Committee Screen dated 8 August 2015.
[35] Tab 64 Parklea Correctional Centre Reception Committee Screen dated 8 August 2015.
[36] Tab 11.16f Inmate Profile Document dated 7 November 2015.
[37] Tab 11.11a Report of P McDermott, Correctional Manager, dated 9 November 2015.
[38] Justice Health provides medical services to government operated Correctional Centres in NSW
[39] Tab 97ii Inmate Medical Request dated 18 August 2015.

IDATP but was unable to attend the commencement session on 4 November 2015 due to being unwell. [40]

39. On 24 August 2015, Danny filled out an Inmate Request Form requesting to sign off PRLA to go to B2 A Pod as a Special Management Area Placement ("SMAP") inmate, as he wished to engage in work and programs.[41] This request was approved and on 26 August 2015 Danny was relocated to Unit B2, A Pod.[42]

40. On 22 September 2015, Danny was assessed by RN McGloin the Junee Drug and Alcohol Nurse, as he had requested to enrol in the OST program.[43] Ms McGloin wrote a progress note:

> "Requesting methadone. Has previously been (on) methadone from aged 19 yrs to 25 yrs. Prior to methadone always in trouble. On methadone stayed out of trouble for 3 years. Came off it on the run. 17 March 2015. Was dosing in Cessnock…While on the run…mainly ? heroin occasionally. Currently using bup whenever he can…could be look at for methadone for pain relief but would need further investigations to prove need…referral for OST."[44]

41. RN McGloin completed an "Initial Risk Assessment for Patients Requesting OST" form and she recorded that there was no evidence of opioid withdrawal, that Danny was previously on opioid substitution treatment and he was opioid dependent prior to custody and was currently using "bup" (buprenorphine prescribed to other prisoners). A box was checked indicating Mr Whitton's matter was "routine". Ms McGloin gave evidence at the inquest and she described the triage system used to assess and prioritise candidates for the OST program.[45] She said that Danny did not meet the criteria for high priority or fast track according to the assessment method used by Justice Health (which was mandated by NSW Health). This meant Danny's application was considered "routine". [46] The fact that Danny had previously been on the program in the community could not be used as a factor for high priority in the triage assessment, [47] nor could Danny having a history of self-harm and suicide attempts. [48]

42. The inquest heard that the delay of 4-5 weeks between Danny's request on 18 August 2015 and his first assessment on 22 September 2015 was not atypical and in fact

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[40] Tab 11.14, see report of Education and Training Managing Peter Guy, 9.11.2015
[41] Tab 70 Junee Correctional Centre Inmate Request Form dated 24 August 2015.
[42] Tab 11.11a Report of P McDermott, Correctional Manager, dated 9 November 2015.
[43] Tab 11.8 Report of Jan Te Maru, Health Services Manager, to Mr Brideoake, General Manager dated 9 November 2015; Tab 97p Justice Health Progress Note dated 22 September 2015.
[44] Tab 97p Justice Health Progress Note dated 22 September 2015.
[45] Tab 103 Second Statement of RN McGloin at [19] and Annexure "B"; see also\Tab 122, Justice Health Policy *OST Program,* p47
[46] Tab 103 Second Statement of RN McGloin at [22] and Annexure "B"
[47] Transcript 25/2/21 T67.13
[48] Transcript 25/2/21 T67.35

continues currently[49]. In effect however, Danny had requested to go onto the program in his reception screening at Cessnock Corrections Centre on 5 June 2015 so the period of 5 June – 22 September 2022 was a period of nearly 4 months. In 2015, at Junee CC, the waiting time to get onto the program for patients assessed as "routine" was between 12 and 18 months but usually around 13 months.[50] Ms McGloin, said that this was "very frustrating". The OST program is now readily available and Ms McGloin said that had the new program been available in 2015 Danny would have been readily able to participate.

43. RN McGloin estimated that at the time in September 2015 there were about 60 prisoners on the same waiting list as Danny. She said she was aware that most of those prisoners would have been engaged in the dangerous activity of procuring methadone or buprenorphine from other prisoners who were on the OST programme. She said that such behaviour could not be taken into consideration when assessing eligibility for the OST program.[51]

44. That prisoners who were unable to access the OST program would engage in the procurement of methadone or buprenorphine from other prisoners who were on the OST program was well known at GEO. The Junee Correctional Centre operated a system to minimise the opportunity for prisoners to divert their doses to other prisoners but despite such measures the practice continued.

45. Given Danny's 10 year history of drug use, his traumatic childhood and his ongoing mental health issues it would seem not only unrealistic to expect that he would not participate in methadone diversion and indeed it would seem inevitable that he would engage in this and other extremely unsafe drug use. In any event, that Danny was due for release prior to the earliest date he might expect to be accepted onto the program raises questions as to the utility of any application process and waitlist.

46. Throughout August and September 2015, Danny was charted to take Naprosyn SR 1000mg nocte ("NSAID") and Seroquel XR SR Tablet 50mg, 2 nocte.[52] Throughout October and early November 2015, Danny was charted to take Naprosyn SR 1000mg nocte p.r.n and Seroquel XR SR 400mg nocte daily.[53]

47. Danny using illicit drugs continued to cause him to be in strife with other prisoners and continued to affect his mental health and wellbeing. On 13 October 2015, Danny

[49] Ms Te Maru Transcript 26/5/21 T192.28
[50] Tab 135, Statement of Sandy Ozols at (2).
[51] Transcript 25/2/21 T68.1-18
[52] Tab 97ff Medication Chart dated 17 August 2015, Justice Health Records.
[53] Tab 97hh Medication Chart dated 16 October 2015, Justice Health Records.

presented to the medical clinic and threatened to cut his throat with a razor, he reported he had been sexually assaulted when he was 7-8 years old, and stated that the trigger for his self-harm threat was "problems with another prisoners [sic] feeling 'down'".[54] He threatened to harm himself or others if he returned to B2.[55] Danny was moved to a safe cell and placed on a RIT. The RIT plan required CSNSW officers to observe Danny every 30 minutes.[56]

48. In an undated Inmate Request Form, Danny wrote that he feared certain inmates in B2A and that he feared if he was placed in B2A he would get hurt. An Offender Information and Management System ("OIMS") Association Alert Registration Details Form dated 16 October 2015 noted that Danny feared (named) inmates due to "prior conflict within the community".[57]

49. On 16 October 2015, following an assessment by a psychologist the RIT plan was amended so that Danny was moved out of the safe cell into Unit B3 A pod Cell 8 and CSNSW officers were to conduct observations every 60 minutes.[58] On 17 October Danny was moved from Cell 8 to Cell 16. On 20 October 2015 Danny was again reviewed by a psychologist and Danny reported to have no thoughts of self-harm. He was removed from the RIT.[59] On 26 October 2015 Danny was transferred from cell 16 to cell 11.[60]

Danny becomes Unwell

50. On Sunday 1 November 2015 Mr C arrived in B3 A Pod and when Danny saw him they arranged that he would move into Danny's cell as they had known each other since 2009. On Monday 2 November 2015 Mr C moved into Danny's cell. On Tuesday 3 November 2015 Danny had a short telephone call to his mother at about 10.45 am. A recording of the telephone call was tendered in the inquest. In the call he did not complain that he was unwell[61] nor does he sound ill or under the influence of any

[54] Tab 11.16ooo Mandatory Notification for Offenders "At Risk" of Suicide or Self-Harm, undated; Tab 11.16lll Incident Details Report dated 13 October 2015.
[55] Tab 11.9 Memorandum from Ainslie Wood, Contract Compliance manager, to General Manager Scott Brideoake, 9 November 2015.
[56] Tab 11.16mmm At Risk Treatment Plan dated 13 October 2015.
[57] Tab 11.16rrr OIMS Association Alert Registration Details form dated 16 October 2015.
[58] Modifications of Risk Treatment Plan or Interim Plan form dated 16 October 2015; Tab 11.9 Memorandum from Ainslie Wood, Contract Compliance manager, to General Manager Scott Brideoake, 9 November 2015. Tab 11.11g Report of P McDermott, Correctional Manager, 9 November 2015.
[59] Tab 11.16iii Release from At-Risk Watch Form dated 20 October 2015. Also see Tab 11.13 Report from Psychologist Samantha Ainsworth 9 Nov 2015; Tab 97, Progress Notes 16/10/15, p.40
[60] Also see Tab 11.13 Report from Psychologist Samantha Ainsworth 9 Nov 2015; Tab 97, Progress Notes 16/10/15, p.40 , also Memorandum from Scott Brideoake dated 9 November Vol 1 Tab 11.9
[61] This was at variance Ms Knights recollection contained in her statement.

substance. On Tuesday inmates have buy-up and the records indicate that Danny obtained items at buy-up.

51. On Wednesday 4 November 2015 Danny was reported as vomiting and his attendance at the IDATP program was cancelled.[62] In the morning of Thursday 5 November 2015 Danny reported to correctional officers that he was vomiting and had pains in his stomach and was urinating blood[63] and he attended the medical clinic reporting that he had kidney pain and was vomiting. He spent the day in the clinic and in the afternoon was admitted as a patient onto the medical ward. The ward was a two observation cell unit. At about 10.00 am on Friday 6 November 2015 Danny was reviewed by Dr Corbett. Mr E, another prisoner was admitted into the ward and shared the cell with Danny. Later that day at about 3 pm GEO Intelligence (Intel) correctional officers obtained a urine sample from Danny to test for drugs use. About 1.40 pm on Saturday 7 November 2015 an ambulance was called for Danny to be taken to hospital and about 3.45 Danny was transferred *in extremis* to the Wagga Wagga Base Hospital.

52. The time at which Danny became ill is difficult to pinpoint. Mr C gave evidence in the inquest. In November 2015, following Danny's death Mr C was interviewed by Mr

[62] Tab 11.14, report of offender development officer Ms G. Turner.
[63] Tab. 11.11 pg 13. report of correctional Officer Mr D. Merrigan

Doherty, who was then GEO's Manager of Intelligence and at the time of the inquest was GEO's Operations Manager at Junee Correctional Centre.

53. According to Mr Doherty's briefing note of November 2015 Mr C told Mr Doherty the following:

- 4 November 2015 Danny injected "pills" known as "Gabbas" having purchased them off "one of the boys" diverted from pill parade.
- Wednesday 5 November 2015 Danny drank regurgitated methadone, having gone halves and was "probably 180 mls".[64]
- Wednesday night Danny woke up and was pissing blood and Mr C told him to go to medical as he believed that Danny's "kidneys were failing", however Danny refused to go.
- Inmates were spewing methadone into plastic bags and passing them under the doors in the unit.

54. The reference to Wednesday being 5 November is incorrect as Wednesday was 4 November 2015. On 9 November 20915 Mr C was also interviewed by Detective Inspector James, the Officer in Charge of the investigation. Mr C made a statement. Relevantly the information he gave was:

- On Tuesday 3 November 2015 Danny was absolutely bombed. He had taken regurgitated methadone and a mixture of pills which

[64] Tab 162 annexure WD1 to Statement of Wayne Doherty

included Pregabalin, Tramadol, Seroquel and Naprosyn – he was mixing it altogether on the day he had the drink of methadone.

- Danny had a shower and returned to the cell, had a little bit to eat for dinner and then crashed on his bed.

- About midnight Danny was vomiting hard in the toilet, he had a drink of water and returned to bed.

- Wednesday he woke up and was still bombed out and feeling really crook. It was buy-up day.

- Danny bought some food and munchies, sat at the table with his head on his arms and sat there, he had a shower and went back to bed.

- Danny spent Wednesday in bed and slept alright without waking Mr C.

- Thursday morning Danny was vomiting hard, he showered and returned to the cell and told Mr C he was pissing blood and had a real bad pain in his stomach. He was worried and sick. He went to the medical unit.

55. In his evidence to the inquest Mr C said Danny received his buy-up but that Danny was still sick and he didn't want to get up to go get it[65]. Though he described that Danny had a tin lid of crushed up white powder in his cell, Mr C said in his evidence that he didn't actually see Danny take the drugs and that he had told Detective James what drugs Danny took because "it was obvious".[66] He said that the lid with white powder was still in his cell when he left it before being placed on segregation on 9 November 2015 but when he returned it was gone. There is no evidence in the inquest that any such item was located from the cell in Mr C's absence.

56. Mr C said in his evidence that he had seen Danny inject "bup" in another prisoner's cell[67] and that he had been in the unit a week before Danny became ill. Though the length of time Mr C says he had been in the unit is incorrect and he had not mentioned this incident to Mr Doherty or Detective James in his interviews in November 2015, it

[65] Transcript 22/2/21 T49.33
[66] Transcript 22/2/21 T57.47
[67] Transcript 22/2/21 T56.20-27

is at least consistent with the toxicology report that buprenorphine was found in the urinalysis sample taken by GEO Intel on Friday 6 November. Mr C likely did see Danny inject "bup" and given that there is a report that Danny was leaving a day between "bup" and methadone use, he likely used the "bup" on Sunday 1 November 2015 when Danny first saw Mr C.[68]

57. Mr C's evidence was fairly unreliable given he denied actually seeing what Danny took and though he may have witnessed on numerous occasions prisoners using diverted methadone or stockpiling and taking pills, given the short period of time he was with Danny in Junee, much of his evidence in that regard unlikely related specifically to Danny. However, Danny's illness and his report of having had "recurrent" pain in his kidneys before taking regurgitated methadone is consistent with Danny having ingested crushed up pills with methadone and or taking crushed up pills generally.

58. On Friday 6 November 2015 Danny told RN McGloin that he had consumed a lot of regurgitated methadone the day before he presented to the medical clinic. CO Withers reports that on Thursday 5 November 2015 she was on duty all day at the medical clinic. She said that after Danny attended the clinic she saw him sitting in the clinic shower for long periods over the day. One prisoner, Mr B gave evidence that he had seen Danny on Wednesday 4 November 2015 spending the day sitting in one of the unit showers. Mr B said that Danny was sick and his skin was yellow. No one in the clinic called in the inquest said that they thought Danny's skin was yellow which indicates jaundice and arouses suspicion of liver injury.

59. It is likely that Danny consumed the regurgitated methadone and the mixture of pills on Tuesday 3 November 2015 after he had spoken with his mother on the telephone. That the mixture contained Paracetamol is consistent with the traces identified in a blood test on 8 November 2015 as well as the trajectory of his illness and ultimate death.

Paracetamol toxicity

60. Professor Naren Gunja identified that "the combination of liver failure, jaundice and hepatic encephalopathy point to a hepatotoxic cause" for Danny's illness and he opined that the trajectory of Danny's illness was consistent with paracetamol use rather than an overdose of methadone and/or buprenorphine. Associate Professor

Holdgate agreed that the likely cause of Danny's death was paracetamol toxicity and there is no issue in the inquest about this.

61. As to when Danny had ingested the toxic dose, Professor Gunja referred to the trajectory of Danny's illness and the analysis of an ante-mortem blood sample taken at Wagga Wagga Base Hospital at 5pm on Saturday 7 November 201. Professor Gunja noted that Danny had metabolised away the paracetamol by the time Danny arrived in hospital. He said that was entirely consistent with the way people metabolise paracetamol from the time they ingest it several days before and succumb to it a week later[69]. He said that the paracetamol could have been ingested as a single large dose or by a repeated ingestion over a period of many hours or days. He opined that a single dose of at least 10 gm (20 tablets of 500mg) would be sufficient.

62. There was evidence in the inquest that prisoners at Junee Correctional Centre were able to obtain up to 6 paracetamol tablets without a script and that these would often be stockpiled and then later made into a drink or a concoction. It would be likely that Danny engaged in such practice given his complaint of pain, his drug addiction and use of diverted methadone and his report that he had experienced kidney pain previously. If it was a single dose of a large quantity of crushed up paracetamol, it may have been on a background of previous and recent such doses.

63. Professor Gunja described the phases of paracetamol toxicity. The first stage is called the "gastrointestinal phase" which is marked by nausea, vomiting and abdominal pain. This occurs over the first or second days. Then there is the "quiescent phase" which lasts a couple of days. The third phase which starts at about day four marks the start of having liver injury. Dr Gunja said that a person can either improve from that point or could progress to full blown liver failure. Such failure is associated with kidney

[69] Transcript 25/2/21 T49.10-15

failure, failure of coagulation, hepatic encephalopathy (seen as a delirium) which then leads to death.

64. Professor Gunja opined that Danny was in multi-organ failure or third phase on 7 and possibly 6 November 2015. He surmised that ingestion occurred 4-7 days prior. He estimated that Danny could have ingested a single dose around 1-3 November 2015.[70]

65. Professor Gunja referred to the elevated results of the blood test on 7 November 2015 and said that had the blood test occurred on 6 November 2015, it would have shown elevated results sufficient to have prompted Danny's hospital admission.

66. Professor Gunja told the inquest that an antidote to paracetamol poisoning is acetylcysteine which is optimally administered within 8 hours of poisoning. He noted that it was administered at Wagga Wagga Base Hospital. He was asked by Mr Rees whether it would have been beneficial to Danny had it been administered on 6 November to which Professor Gunja said it would be more beneficial than the 7th but it was difficult to say whether it would have changed the outcome. He said that had it been administered three days after ingestion of paracetamol it could have possibly altered the trajectory of the overdose.

67. Neither the buprenorphine nor the methadone contributed to the cause of Danny's death. Whether the diverted methadone contained the paracetamol, or whether Danny placed powdered paracetamol into the methadone is unclear. If Danny placed the powder into the methadone it is unclear if he did so knowing it was paracetamol because he had been told that it was or because he had made the powder himself.

Danny's attendance and admission into the Junee Correctional Centre Medical Clinic Thursday 5 November 2015

68. At about 7 am Thursday 5 November 2015 Danny told Corrections Officers that he needed medical help. CO Carr called the clinic reporting that Danny had complained of possible kidney pain and vomiting. Registered Nurse Alfred Marsters was on duty and he relayed a message to tell Danny to drink plenty of water and come up to sick parade.[71] This meant Danny would not be seen until 1.30 pm. Danny notified another

[70] Transcript 25/2/21 T 56.10-Danny
[71] Tab 162 Report of Corrections Officer Withers

officer that he was worse, and he went to the clinic.[72] He arrived at the clinic at 7.15am.[73]

69. The corrections officer on duty at the clinic was CO Withers. She had made a report on 11 November 2019 but it was not included in the briefing package provided by the General Manager Brideoak to Detective James. The report was not provided to those assisting the coroner until it was attached to Mr Doherty's statement of 12 May 2021. There is no explanation as to why CO Wither's report was not included in the briefing package. It should have been as she provided valuable information as to how Danny was presenting throughout the day of 5 November 2015.

70. According to CO Withers, at the time Danny arrived at the clinic, RN Masters was busy "with inmates having blood tests, insulin and medications were still being processed". CO Withers spoke with Danny and she relayed to him what RN Masters had previously said and Danny replied that he wasn't going anywhere and if he vomited on the floor it wasn't his fault. Danny lay on his stomach over some chairs and CO Withers informed RN Marsters that he was there.

71. CO Withers said that during this time RN Marsters was given directions to urgently facilitate a urinalysis report for GEO Intel Officers and RN Marsters told her that all other tasks had to wait until the report for Intel was completed. CO Withers then told all inmates present that all the nurses were very busy and that they could choose to wait or to come back later.

72. CO Withers said RN Marsters spoke with Danny sometime between 8.30 am and - 9.00 am. RN Marsters asked Danny whether he had taken any medication or drugs other than what he was on and Danny said he had not and that he had had the pain before - it was his kidneys. According to CO Withers, Danny was given some medication for pain and she was instructed to place him on the ward. She said she secured him and continued to monitor him throughout the day. She said that Danny spent much of the day sitting for long periods under the shower, or vomiting in the toilet and lying in bed. He refused all food offered. He remained quiet and only responded when questioned. He told her he had vomited the medication provided to him. CO Withers informed RN Marsters of this. Danny was consequently he administered an injection to help settle Danny's stomach. RN Masters advised Danny to drink water. RN Masters kept asking Danny if he had taken anything he shouldn't

[72] Tab. 11.11 pg 13. report of correctional Officer Mr D. Merrigan

[73] Tab 162 Report of Corrections Officer Withers

have and Danny said he hadn't. Danny was formally admitted to the clinic at 3.35 pm.[74]

73. That Danny did not seek medical assistance prior to Thursday and that he did not disclose to RN Marsters the appropriate history of his complaint may have been due to being fearful that the information would not remain private between himself and the medical services provider. Danny may well have apprehended that the consequences of the information being passed onto Corrections would place him in significant trouble. Such consequences include being placed on a segregation order and receiving a punishment as he had experienced after the strip search in Cessnock Correctional Centre. Danny had already experienced difficulties within the prison community due to his drug use which caused him to go onto a RIT and asking to be housed in a separate unit so he may also have been concerned about those consequences as well.

74. That Danny did not tell RN Masters that he had ingested crushed up pills of some kind may have been because he was unaware of the contents of the bag of diverted methadone. On the other hand, that he told RN Masters he had pain in his kidneys before could indicate that he had experienced such when using crushed up pills as described by Mr C. Whatever the reason behind his denials that Danny maintained this position in the face of repeated questioning had the dire consequence of not receiving a more useful medical investigation and treatment.

75. That an inmate believes that his health condition would not be kept private from the custodial services so that he could secure appropriate health care is extremely concerning, particularly where a consequence of death could, or as in this case, did ensue.

76. In any event, RN Marsters apparently did not believe Danny's denials of having ingested something he shouldn't have. After Danny was admitted into the clinic RN Marsters sent an email to Mr Doherty, the Correctional Manager, Intelligence at Junee Correctional Centre at the time, to place Danny on a urinalysis list. The email was copied and sent to Ms Jan Te Maru, the Health Services Manager. It is unfortunate that RN Marsters took this course as opposed to turning his mind as to what communication and assurances he should undertake so that Danny would disclose to

[74] Report of Ms R Withers dated 9 November 2015 attached to statement of Mr W Doherty Tab 162

him what had occurred which may have resulted in earlier treatment of Danny's symptoms.

77. However, that is not to say that RN Marsters should have considered whether Danny's symptoms were as a result of having ingested paracetamol. As Professor Gunja said, paracetamol poisoning would not have been at the top of the list of suspected causes. RN Masters did conduct a dipstick urine sample. He said that he thinks he did this due to Danny's presentation of lethargy, headache, nausea and vomiting that prompted a concern for dehydration - the taking of a urinalysis test would provide a baseline of how his body was functioning.[75]

78. The result of the test was recorded by RN Marsters in a Progress Note (PN)[76]. He recorded "*protein* ++" and"*blood* +++", that is, two plus signs and three plus signs respectively, each indicating levels in the moderate range.[77] There was some confusion about the number of plus signs in RN Marsters' progress note. Dr Corbett understood it to be four[78], and the handwritten note does clearly show a vertical post and another mark, consistent with a fourth plus sign. However, RN Marsters said that four plus signs would indicate a "large amount of blood" in theurine,[79] maintaining he wrote only three plus signs.[80]

79. RN Marsters' PN does not identify the time at which Danny presented to the clinic, writing "seen this morning presented lethargic, headache, nausea and vomiting. Denies any illicit drug use". RN Masters' PN does not refer to being advised at 7 am that Danny had complained of severe abdominal pain and had been urinating blood or that Danny complained about his kidneys. He did record Danny's vital signs but does not record the time at which he made those observations. He recorded that he had a discussion about Danny with Dr Corbett and that the doctor directed that Danny be given Maxalon (by injection) and to push oral fluids. There is no record of the time of this discussion.

80. A "Standard Adult General Observation" ("SAGO") Chart does not appear to have been established at 9.00 am when Danny was given a bed in the clinic nor at 3.30 pm on 5 November 2015 when he was formally admitted into the medical unit. RN Marsters made a second progress note at 3.30 pm indicating he had administered the

[75] Transcript 24/5/21 T62.27
[76] Tab 97p, p42 Progress Notes
[77] Tab 108 Statement of RN Marsters 8/11/20, pp.1-2; Transcript 24/5/21 T63, T79.22
[78] Transcript 24/2/21 T110.50
[79] Transcript 24/5/21 T64.01
[80] Transcript 24/5/21 T63.35-40

Maxalon and again that he had taken Danny's observations and that Danny was given ice and water and he was housed in medical.

81. In his evidence RN Marsters said that he would keep notes on a piece of paper and glance in at Danny throughout the day. CO Withers said she saw that RN Marsters made notes when he periodically interacted with Danny. She said she heard Danny tell RN Marsters him that he had been vomiting blood. There is no reference to such in RN Masters' progress notes, nor is there any reference to Danny complaining of pain in his kidneys or having vomited throughout the day or being under the shower for lengthy periods.

82. A nursing note made by RN Duddy at 4.50 pm records that Danny complained of chest pain, pain in both clavicles and his left wrist, that he had lower abdomen pain but on examination there was no guarding or tenderness. The PN indicates that Danny said he had pain in his kidneys and that it had been there for several days. The PN says "doesn't appear to be in severe pain". RN Duddy did not record Danny's vital signs and she said that she was not sure if there was a chart in use.[81] There does not appear to be any care plan other than push oral fluids and administer Maxolon. According to the overnight shift nurse Anthony Wall, RN Duddy was responsible for Danny until she handed his care over to him at 9.00 pm.

83. The overnight nursing shift was from 6.30 pm to 6.30 am. Mr Wall was the overnight nurse on duty on both overnights 5 and 6 November 2015. His PN for each shift was recorded at 3.00 am. The PN for the first night set out that Danny had nil issues, he was given his medication which he tolerated well and was given three glucose tablets, had a Glasgow Coma Score ("GCS") of 15 and had nil complaints. RN Wall said that he attended Danny between 8.00 pm and 9.00 pm and his progress note was a summary up until the time he made it. He did not make any direct observations of Danny before or after his attendance. He said in his evidence that he would check on Danny on the CCTV screen but that might be only every couple of hours and if the lights were off he would only see a silhouette. He conceded that it was possible that Danny had been vomiting during the night and that RN Wall had not noticed this due to carrying out other duties. He said that such tasks could involve reception screening of new inmates, administrative tasks, impending releases and parole reports. He said that there were big chunks of the night that he could not observe Danny on the CCTV

[81] Transcript 26/2/21 T8.03

monitor. At that time there was no log kept of any "knock up" or stenophone calls an inmate makes whilst a patient on the ward in the medical centre.

Danny's medical review and treatment in the Junee Correctional Centre Medical Clinic Friday 6 November 2015

84. Dr Corbett reviewed Danny at about 10.00 am on 6 November 2015, though the time is not recorded in his notes which are written in the PN form. Dr Corbett recorded that Danny complained of *recurrent upper abdominal pain Nausea. On examination: Tender all over abdomen. Worse epigastrium + RIF. No GRR. PHx Appendectomy. IMP –Gastro 2nd Naprosyn. Stop Naprosyn. Add Pariet. Bloods.*[82]

85. Dr Corbett said that he had had two previous dealings with Danny prior to 6 November 2015. The first was on 17 August 2015 when he had reviewed Danny for a complaint of back pain for which he prescribed Danny Naprosyn. [83] Dr Corbett had also spoken with Danny on 20 October 2015 in his capacity as a member of the High Risk Assessment team when Danny was removed from the RIT [see paragraph 43 above]. Dr Corbett said that he recalled having a discussion with Danny about the use of pain medications such as Naprosyn and Lyrica. [84] On 5 November 2015 RN Marsters telephoned Dr Corbett around 3.30 pm and spoke to him about Danny. Dr Corbett directed that Danny be admitted to the ward, given an anti-emetic and that nurses push oral fluids. He asked for Danny to be placed on the list to see Dr Corbett the following day.

86. Dr Corbett made a statement for the coronial investigation on 2 September 2019. He set out in his statement that he was told that Danny had tea coloured urine, and that Danny complained of pain in the abdomen, nausea and vomiting. He had normal blood pressure, blood sugars and respiration but that he had tachycardia with a heart rate of 120 BPM. He sets out that RN Marsters told him that he suspected that Danny had been using unknown illicit substances. Dr Corbett said that he considered drugs, dehydration and infection including Hepatitis C as causes for the presentation. He said that Danny was admitted for observation due to the tachycardia.[85] There is no

[82] Tab 97p, p42 Progress Notes
[83] Transcript 24/2/21 T108.34-109.14
[84] Tab 101, Statement of Dr Corbett
[85] Tab 101, Statement of Dr Corbett

indication in RN Marsters' PN the reason for admission and there was no indication as to what observations and at what frequency those observations should be made.

87. I note that in a referral letter written by Dr Corbett to the Wagga Wagga Base Hospital on 7 November 2015 Dr Corbett wrote, inter alia, *"On examination yesterday he was lucid co-operative and was vomiting (bile). Motor function was ok. He had some epigastric tenderness. GCS 15, 126/83, pulse 120, sats 96% 36.5, BSL 6.9. Naprosyn was ceased and he was started on pariet and his pain seemed to settle. He had a settled night and was up to pee a couple of times".*

88. There is no record of any vitals taken by Dr Corbett or any nurse on Friday 6 November 2015 ("yesterday") at all. The observations referred to by Dr Corbett in his referral letter match the observations of RN Marsters taken in the morning of 5 November 2015 and recorded in RN Masters' PN. According to RN Marsters he conveyed those observations to Dr Corbett by telephone on 5 November 2015[86]. RN Marsters said he also conveyed the urinalysis results to Dr Corbett. I note that Dr Corbett's referral letter does not contain any reference to such.

89. After RN Marsters spoke to Dr Corbett on 5 November 2015 Danny was admitted onto the ward at about 3.30 pm at which time RN Marsters administered Maxolon and performed another set of observations which recorded that Danny's blood pressure was 106/69 and pulse 102, oxygen saturation was 97% or room air, GCS of 15.[87]

90. In his statement Dr Corbett explained his examination of Danny on 6 November 2015:

> "On 6 November 2015 Mr Whitton denied taking any other substances when I asked him. On examination, Mr Whitton seemed to be getting better from the night before. He was lucid, alert and co-operative. His pulse had decreased to 100 beats per minute and the rest of his observations were normal. He still had nausea and was vomiting bile and had some generalised abdominal tenderness worse in the epigastrium and right iliac fossa. There was no guarding rebound or rigidity and normal bowel sounds were present. I made a provisional diagnosis of gastritis possibly due to the Naprosyn. I ceased the Naprosyn and prescribed Rabeprazole which is a proton pump inhibitor that reduces gastric acid production. I did consider the generalised abdominal pain was a little unusual for gastritis so I ordered blood tests – full blood count,

[86] Tab 108; RN Marsters statement para 5, and PN 5/11/15
[87] Tab 108; RN Marsters statement para 5, and PN 5/11/15

> erythrocyte sedimentation rate, C reactive protein (CRP), electrolytes, urea, creatinine, liver function tests, calcium, magnesium and phosphate. Although Mr Whitton did not appear "yellow" it was not uncommon for patients in the jail suffering from hepatitis C to present with his complaints. Thus Hepatitis C was considered a differential diagnosis".

91. In his notes made at review on 6 November 2015 Dr Corbett did not refer to the abnormal urinalysis results identified in RN Marsters' PN though the PN indicates that RN Marsters had discussed them with Dr Corbett in his telephone call the previous afternoon. Dr Corbett did not note that he had considered whether to conduct another urinalysis. Dr Corbett did not include in his notes any reference to Danny's kidney pain and number of days he had it as set out in RN Duddy's PN of 4.50 pm the previous day. He made no note relating to Danny's tachycardia or vomiting or that it was suspected he had taken drugs. There was no note referring to concerns of dehydration and infection including Hepatitis C. There was no note of any vital sign observations at all. There was no note of what bloods were being ordered and whether they were urgent or when they were required. There was no note or record of what observations, if any, nursing staff should make in relation to Danny's admission in the ward. There was no note on when Danny would be next reviewed. There was no note about continuing Maxolon.

92. After Danny was reviewed by Dr Corbett he was returned to his bed in the ward. The next contact he had with a nurse performing clinical duties appears to be after Dr Corbett left the clinic which was about 12 noon. There is recorded on the telephone order 10 mg Maxolon tablets TDS and according to that record a tablet was administered to Danny.[88] This indicates that a nurse had to telephone Dr Corbett to script the Maxolon as he had apparently failed to note it in his review.

93. The next contact Danny had with a clinical nurse was sometime at about 8.30pm when RN Wall administered Danny's nightly Seroquel.[89] He also administered the Maxolon tablet.[90] I note that it would appear that though Dr Corbett's direction to stop Naprosyn was actioned, Danny was not administered "pariet" on 6 November 2015 that was apparently given for the first time in the morning of 7 November 2015.[91] There is no evidence to explain this. It would appear from Dr Corbett's reference in his referral

[88] Tab 104 Statement of RN A Wall Annexure C
[89] Tab 104 Statement of RN A Wall Annexure A
[90] Tab 104 Statement of RN A Wall Annexure C
[91] Tab 104 Statement of RN A Wall Annexure A

letter that “he was started on pariet and his pain settled” he was not aware that Danny in fact had not been administered the pariet on 6 November 2015.

94. There is no record of Danny having any observations taken of his vital signs from 3.30 pm 5 November 2015 to 9.00 am 7 November 2015. There is no PN made by any clinical nurse on 6 November 2015.

95. The blood test ordered by Dr Corbett was not carried out and Dr Corbett was not advised of this until 7 November 2015. The inquest heard evidence that Dr Corbett had reviewed Danny at about 10 am on 6 November 2015 and ordered bloods which are collected daily by courier at 11.30 am and 4.30 pm Monday - Friday. He said that he conveyed to nursing staff the need to collect the bloods that day and after completing the pathology order would have placed it in a tray on the nurses’ station. He was unable to recall whether he requested that the bloods be taken in sufficient time for the 11.30 am pick up which would require him to hand the pathology report to a nurse rather than leaving it in the tray. He said that he considered that the blood analysis was urgently required. He left the medical centre at about 12 noon.

96. Dr Corbett gave evidence that where a blood test result was concerning (abnormal) the pathology laboratory had a practice of directly contacting him by telephone. He did not receive such a phone call. He had not been advised by any nursing staff on 6 November 2015 that bloods were attempted but were unable to be taken that day.

97. What had occurred with Danny after his review by Dr Corbett at 10 am Friday until he was seen by RN Byron on Saturday morning is unclear because there is no SAGO chart and no clinical PNs during the day and a scant PN written at 3.00 am. It is unclear who had the nursing responsibility for Danny on the day of Friday 6 November 2015.

98. Danny was visited by RN McGloin who was not carrying out any clinical duties. RN McGloin was the drug and alcohol nurse and she had assessed Danny for the OSP on 22 September 2015. RN McGloin made a statement and gave evidence. She thought it was late morning or early afternoon when she saw him. [92] In her evidence she said that the purpose of seeing him was to see if he had taken anything that was considered illicit and whether that might be affecting his current state of health. [93] This was a little different to her statement when she said that the purpose of seeing Danny was to undertake a review as he was on the methadone waiting list. She said in her evidence that she thought she might learn something to advance his position on the

[92] Tab 102, Statement of RN McGloin 12 June 2019 at [6]-[7] and Progress Note 6/11/15 at Annexure A
[93] Transcript 25/2/21 T69.28

waitlist. However, later in her evidence she said that she would not cause a review of an applicant until being notified that they were off the waitlist which was at least 12 months. On balance, it would appear that the reason RN McGloin spoke to Danny was for the purpose to see what he had taken. She made a PN in his clinical records to that effect:

> Drug & Alcohol: Pt seen after ?overdose. He stated he had a lot of recycled methadone the day before he presented to medical. Took the dose in the morning and woke up the next morning unwell. Stated he had been using Bup every now and then and methadone approx.. 2 x month. Always has a day between Bup use and methadone. Stated he had kidney pain prior to presenting to medical and using methadone. He is on the waiting list to go on to methadone.

99. In her evidence RN McGloin said that Danny wasn't really wanting to talk too much but he answered her questions[94], and that she had spent longer than 5 minutes with him but it was difficult to say whether it was as long as 20 minutes. She said that he did not appear to be jaundiced, nor did he appear to be intoxicated or suffering from an overdose.[95] She said that she did not record in the PN that Danny presented as unwell rather than withdrawing or intoxicated because she was not performing clinical duties.

100. She said the drug and alcohol nurse worked Monday to Friday and that her shift ended at 2.30 pm. She said that if Danny was still in the unit on Monday she would have visited him. In relation to the issue of jaundice, she was asked how she was able to observe Danny's colour she said had sat on a beside chair close to Danny's head. She was unable to say whether there was a corrections officer in the room or at the door or whether the door had been left open.[96]

101. That Danny did not tell RN McGloin he had mixed crushed pills into the recycled methadone is somewhat curious. Mr C identified that Danny mixed the pills into the methadone but in his evidence he resiled from actually seeing him do so though he seemed aware that Danny engaged in such a practice. That the recycled methadone

[94] Transcript 25/2/21 T73.30
[95] Transcript 25/2/21 T81.15-81.40
[96] Transcript 25/2/21 T79.30-80.16

had an intoxicating effect on Danny seems likely given that Mr C reports that Danny said he was “smashed” or “bombed” to indicate his level of intoxication.

102. On the afternoon of 6 November 2015 GEO Intel had attended the clinic to take a urine sample from Danny following RN Marsters’ email the previous day. Mr E said that he helped Danny to the toilet to do this and he noticed that the urine sample was “dark as coke”.

103. RN Wall wrote a PN at 3.00 am “nil issues overnight patient stable GCS 15”. In his evidence he said that he made this assessment when he gave Danny his medication at about 8.30 – 9 pm. He said Danny was standing up in front of him in the room at this time. It is not possible to ascertain when it was after about 9 pm that Danny began to deteriorate. Certainly by the following morning he was observed to be in need of medical help

Danny’s deterioration, nursing and medical care and transfer to hospital

104. RN Bryon started his shift at 6.30 am on Saturday 7 November 2015. In his statement of 17 September 2019 RN Bryon wrote that at handover RN Wall told him that Danny was stable overnight. He said he read Danny’s medical file and saw that a drug overdose was suspected and that Danny had been in pain for about 4 days and that a Drug and Alcohol nurse had seen him the day before. RN Bryon wrote in his statement: *“I knew she would assess him again that day”* though RN McGloin was not engaged in a clinical role and the drug and alcohol nurse does not work outside a Monday-Friday shift.

105. RN Bryon said he attended Danny at about 9.00 am. His evidence is that at that time he took Danny’s vital signs observations and entered them on a SAGO chart.[97] He said that he wrote observations in both the SAGO chart and also in the Progress Notes[98]. He said that he wrote the observations that he recorded on the SAGO chart onto the Emergency Response Form.[99] He said that there was no advice or guidance about the frequency with which the vital signs should be recorded – rather that he said that he took it upon himself, when he had a spare moment, to go in and check on Danny, and do his observations, though ideally it would be hourly.[100] He said he photocopied the SAGO chart, the Emergency Form and the Medication chart and sent

[97] Transcript 22/2/21 T70.41, T71.26, T71.21-29, T72.22, 23/2/21 T56.15
[98] Transcript 22/2/21 T76.10, 23/2/21 T26.39-41, T30.36
[99] Transcript 23/3/21 T56.26
[100] Transcript 22/2/21 T71.31-41

them with Danny when he was uplifted by ambulance.[101] RN Bryon could give no explanation as to what happened to the SAGO chart. RN Marsters, Dr Corbett and RN Wall attest that they did not at any time see a SAGO chart for Danny. There was no such chart in either hospital files.

106. The Emergency Response Form has three sets of observations at 9.00 am, 11.30 am and 1.25 pm. The PN note has two sets of observations, at 10.30 and 12.15. According to RN Bryon the 12.15 pm observation is a recording of what was observed at 11.30 am. Over a 6 hour period from 9 am until the ambulance arrived at 3.00 pm, RN made a record of four sets of observations. The observations at 9.00 am were:

> P100, BP 126/83., BSL 6.9. Resp 14, SpO2 98 GCS 11

107. Despite RN Bryon saying quite adamantly that he recorded the observations also in the progress note, there is no PN of his attendance and observations for 9.00 am. RN Bryon said in his statement that Danny "was ambulant around the room". He recalled asking Danny if he was going to have a shower and Danny told him that he had already showered and had been to the toilet. He said that Danny returned to sleep. In his evidence RN Bryon said that it was the cellmate rather than Danny that had said he had showered and been to the toilet.

108. RN Bryon did not say in his statement or evidence that he returned to Danny at around 10.30 am but he must have done as there is a set of observations that he wrote in his PN:

> " pt. [patient] very hard to wake, is moving around has been up and showered, according to cell mate, also has passed urine, nil vomiting today. Rolling around bed naked unable to control his fine motor skills MO (Medical Officer) made aware; to observe him and then ring MO again if concerned. Obs 97% [referring to oxygen sats] BP 114/57, P100, RR 14 T 36.5 Commence on Narcotic programme if necessary. Patient reluctant to eat or drink".

109. RN Bryon said in his statement that he had no recollection of the conversation with Danny's cellmate. RN Bryon said that he was writing the 10.30 am PN when he was talking to Dr Corbett and told him of the vital signs observations. He said Dr Corbett asked him to take bloods and hang fluids (administer IV saline) as Danny might be in withdrawals. Dr Corbett's recollection is quite different in that he gave evidence that

[101] Transcript 22/2/21 T71.16, 23/2/21 T26.25-27

he did not suggest fluids or that bloods should be taken as there was no collection until Monday.

110. RN Bryon says that he unsuccessfully attempted to cannulate Danny and he telephoned the doctor back to say he was unable to cannulate him. Dr Corbett told him he was on his way and would be there shortly. There is no time as to when this happened. In his evidence RN Bryon said that he spoke to Dr Corbett twice – the first was after Dr Corbett returned his call at 10.30 am in response to the 9 am voice message at and the second time was at about 12.15 pm. There may have been other calls as suggested by RN Bryon at times during his evidence.

111. At 11.30 am RN Bryon took another set of observations which are set out in The Emergency Response Form:

> P100, BP 112/55., BSL 5.1. Resp 14, SpO2 100 GCS 11

112. At 12.15 pm RN Bryon made a second PN:

> "pt. [patient] responds to verbal commands then goes back to sleep. Obs 112/55. P98, RR 14 T36.4, 100% [referring to oxygen sats]. staggering around the room short distances when awake unable to hold conversation goes back to sleep MO called will come see patient"

113. In his statement RN Bryon says the observations set out in his PN at 12.15 pm are those taken at 11.30 am but that he had recorded Danny's "pulse as 98 in the progress note but transcribed it as 100 erroneously in the Emergency Response Form" whereas in his evidence he said that he had transcribed the observations from the SAGO chart onto the Emergency Response Form.

114. RN Bryon said in his statement that he called Dr Corbett at 12.15 pm and told him what Danny's vital signs were and that Danny was ataxic. Dr Corbett said he would be there soon.

115. Dr Corbett's referral letter to the hospital set out the observations recorded in the 12.15 pm PN as he did not take any observations when he examined Danny. At the time he examined Danny he assessed Danny as having a GCS of 12 which he included in his letter. Dr Corbett said he immediately identified that Danny required hospitalisation and directed RN Bryon to organise an ambulance and he wrote the referral letter and

then left the prison. RN Bryon took one further set of observations but did not record them in any PN but they are recorded on the Emergency Response Form at 1.25 pm:

P102, BP 101/42., BSL 3.8. Resp 14, SpO2 99 GCS 11

116. The observations recorded on the ambulance Patient Care Record at 2.55 pm set out that that Danny's RR was 96, Pulse was 108, his BP 98/60 his GCS 11 and at 3.30 pm those observations were RR 96, Pulse 104, BP 100/PAL. GCS 11

117. RN Bryon says in his statement that Danny "moved to the ambulance stretcher by himself with some assistance". The CCTV provided by GEO shows that Danny was unable to move on his own accord and was entirely lifted by several people from the bed onto the ambulance stretcher.

118. In his evidence RN Bryon said Danny *"…couldn't hold a conversation, he would wonder off and say different things and which weren't to the answers to what you were saying. Sometimes later on, it became more evident that it was inappropriate words that he was using to describe how he was feeling. And the pupils of his eyes. He would shy away from the light".*[102]

119. In relation to the GCS Mr Hammond asked RN Bryon *"Did you consider that to be a significant drop or change?"* to which he replied *"Yes. I did. The other person said he'd been up vomiting all night. No sleep will certainly drop your GCS down when different people check them"*.[103] He then said that Danny had told him. *"When he said he'd been up vomiting all night and hadn't had much sleep, that sort of covered that area for the moment, for that particular period of time I can understand how tired he'd be if he was in there for drug withdrawal…so everything just sort of makes it a lot harder to assess"*.[104] RN Bryon agreed that what he had been told impacted on how he had assessed Danny under the GSC.[105] It is difficult to accept RN Bryon's evidence that Danny himself told him he was up all night vomiting. His notes do not indicate that he was told this by either Danny or his cellmate Mr E. Indeed there is no note that Danny was vomiting all night. There is a note "nil vomiting" but RN Bryon said that related to just on his shift.

120. I do not accept that Danny had been vomiting overnight nor that Mr E had told RN Bryon that he had been. Having heard from RN Bryon, Mr E and Dr Corbett I am of the view that RN Bryon developed this evidence to explain his inaction upon correctly

[102] Transcript 22/2/21 T 74.5-9
[103] Transcript 22/2/21 T 73.12-15
[104] Transcript 22/2/21 T 73.35-50
[105] Transcript 22/2/21 T 73.45-50

identifying a GCS 11. RN Bryon knew that Danny was deteriorating and that is why he telephoned Dr Corbett at 9.00 am. He was concerned for Danny and though he should have made more frequent vital sign observations he made as many as he could, given the workload with other tasks at the clinic. Dr Corbett was not available to take RN Bryon's call and it was not until 10.30 am that they had their first conversation about Danny. It would be another 2 ½ hours before Dr Corbett could come to the correctional centre but he did not tell RN Bryon that. He told RN Bryon to "wait and see" and to call him back if RN Bryon became concerned. RN Bryon took another set of observations at that time and then an hour later and as a result he was concerned. He rang Dr Corbett again at 12.15 pm and Dr Corbett said he was on his way and would be at the correctional centre soon. He arrived 45 minutes later.

121. RN Bryon did not make any note that Danny had been vomiting or that he had been told that he had been. There is no reference to it in either RN Bryon's statement or Dr Corbett's statement. RN Bryon did not tell Dr Corbett that Danny had been vomiting all night. In his referral letter to the hospital Dr Corbett wrote that Danny "had a settled night and was up to pee a couple of times". Dr Corbett said that he obtained that information from RN Bryon.[106]

122. Mr E was first spoken to by those assisting me on 12 May 2021[107] - over five years since the event- and he was unable to recollect if Danny was vomiting.[108] In his evidence he was asked "Do you recall whether he was vomiting at all?" to which he replied "No. Actually, I do recall one thing. I – he did - I do recall him – he - he started weeing blood at one stage….because I helped him going to the toilet".[109] Later he was asked "Do you recall if Danny was vomiting overnight" to which he replied "Yeah, he was, yeah".[110] He explained his improved memory had been triggered and that he could remember because little snippets were coming to him since being spoken to a couple of weeks earlier.[111] He was later asked "When you say he was vomiting how many times now do you say he made it across the cell on his own to vomit, seemingly neatly in the toilet bowl?" and he replied "The poor bugger could barely move okay. I probably seen him vomit once…Once or twice max. You know what I mean. He was lucky to get up off the bed".[112] Mr E was unable to say when it was that this occurred,

[106] Transcript 24/2/21 T83.40-44
[107] He was not identified until during the inquest.
[108] Transcript 24/5/21 T17.35
[109] Transcript 24/5/21 T7.4-12
[110] Transcript 24/5/21 T12.5
[111] Transcript 24/5/21 T17.44
[112] Transcript 24/5/21 T19.46-T20.4

indeed it could have been earlier rather than later meaning it could have been on 6 November 2015.

123. In his submissions Mr Sergi, on behalf of Dr Corbett, misstated the evidence relating to whether Danny vomited overnight and whether that was known to Dr Corbett. Mr Sergi wrote *"Dr Corbett gave evidence that upon his arrival at the Clinic he was informed (by Danny's cellmate Mr E) that Danny had been up in the night vomiting and going to the toilet".*[113]

124. The evidence of Danny getting up was in relation to him urinating not vomiting. Dr Corbett was asked by Counsel Assisting "Were you advised that Danny had been up all night vomiting?" and he answered "Not that I recall". Counsel Assisting said "Because your referral letter to the hospital says that you were advised that he had a settled night and had been up a couple of times to pee" to which Dr Corbett replied "Yep" and Mr Hammond asked "Do you know where you got that information from?" and Dr Corbett replied "Yeah from his roommate. He was the one that told me that he'd been to the toilet twice".[114]

125. Mr Sergi again misstated evidence in his submissions when he suggested that RN Wall said that he had seen Danny vomiting (despite his PN note recording "nil issues"). Mr Sergi submissions read: *"On day 7 of the Inquest, RN Wall confirmed that he in fact observed Danny vomiting and going to the toilet overnight but had not recorded*

[113] Para 102 Mr Sergi's written submissions
[114] Transcript 24/2/21 T92.41-93.1

those matters". The evidence to which he refers are questions of RN Wall by Counsel Assisting:

> Q. Dr Corbett who saw Danny on the 7th gave evidence that he was told by the cellmate on the morning of the 7th that Danny was up several times in the night
>
> A. Yes
>
> Q. …going to the toilet…
>
> A. yes
>
> Q -and vomiting?
>
> A. Yes I saw that
>
> Q. Now would you agree that that appears inconsistent with the note that you've made?
>
> A Yes
>
> Do you know - well, the observations as reported to Dr Corbett, Danny being up, going to the toilet and vomiting, could that have happened?
>
> A Yes
>
> Q Do you know when the last observations you made of Danny were on that shift?
>
> A It would have been – after that, I would imagine, I would have gone through the clinic. I walk - I walked through the clinic and had a look at the CCTV footage. It could have been – you know, yeah, an hour or so after that: 5.00, 4.00
>
> Q Did you see Danny moving around?
>
> A Not from my observations. My observation was he was in bed at all times. I never saw him wandering around, and asleep from - you know, from the – the footage that I could see, he was in bed. He wasn't out of bed.[115]

126. RN Wall has never said he saw Danny vomiting and Dr Corbett – despite Counsel Assisting's question - has never said that he was told by anyone that Danny had been

[115] Transcript 25/5/21 T101.31-102.10

vomiting. The evidence came from RN Bryon when he was in the witness box to explain away Danny's condition.

127. The evidence from Dr Gunja is that the trajectory of a paracetamol poisoning is that there is a period of time after vomiting stops and before liver failure commences.

128. RN Bryon said that at about 10.30 am Mr E told him that the day before Intel had taken a urine sample from Danny and it was "dark as coke".[116] He said that he didn't take another sample from Danny but rang Dr Corbett back again and the doctor said that he was on his way.

129. RN Bryon was asked questions about why he did not escalate Danny's care or the observations when he saw at 9.00 am a GCS of 11 – a significant deterioration from RN Wall's record of a GCS of 15. He said that did not escalate Danny's care at 9.00 am because Danny *"was tired and he just wanted to rest. So, I just thought I would come and check on him again shortly".*[117] The truth is he mistakenly thought he could not do anything without the doctor's approval and he couldn't get hold of the doctor.

130. RN Bryon said at 10.30 am: *"Yes. I rang him and told him what was happening with him, that he was still vomiting. He was, because he's on call. I don't know where he was he was actually driving from…And I if I didn't contact him, I'd leave a message on his voice, his answering machine and he would ring me back as soon as he got service".*[118]

131. The evidence that "he was still vomiting" was inconsistent with the 10.30 am PN "nil vomiting" and it is uncontroversial that Danny was in fact not vomiting during RN Bryon's shift. He was later asked what he said in the message to the doctor and he replied: "*That could he give me a ring at the, at the Junee Correctional Centre please as soon as he got the message".*[119]

132. RN Bryon was asked about his note regarding a narcotic program and he said that he presumed Dr Corbett and the drug and alcohol nurse had had a conversation about

[116] Transcript 22/2/21 T 76.50-77.16
[117] Transcript 22/2/21 T 74.11-41
[118] Transcript 22/2/21 T 74.23-27
[119] Transcript 22/2/21 T 75.33-35

that and he thought they had to get Danny's pain under control first.[120] He said in his evidence that he didn't know why he had included that in the PN.[121]

133. Dr Corbett gave evidence that he was concerned that Danny may have taken drugs which caused his deterioration. He said that Danny's cell mate told him that Danny had been to the toilet during the night and Dr Corbett explained : *"If they're in the toilet and the curtain is pulled and it just, just the comment from the inmate just raised that, that issue for me when I saw him – just confirmed the suspicion, that you know, maybe he has taken something".*[122] Dr Corbett said he did not record his concern that Danny may have taken something overnight to explain his deterioration.[123] He didn't raise it in his referral letter.

134. That Dr Corbett considered that Danny's deterioration could have been due to Danny having consumed drugs overnight or sometime between RN Walls 3.00 am PN is not on a consideration that is well-founded on the evidence. The symptoms conveyed to him or at least recorded by RN Bryon are not consistent with an opiate intoxication and contrary to Dr Corbett's evidence of the likelihood of a prisoner in the medical ward using illicit drugs. Other witnesses testified that this was not understood to have been an issue at the medical unit ward.

135. RN Bryon said in his evidence that he had no recollection of Dr Corbett asking him about the blood results when they spoke at about 10.30 am.[124] He said he was aware that no bloods had been taken as there was no cannula in Danny's arm. He said he thought there would be a cannula because Dr Corbett had written "fluids" above where he had written "bloods" in his notes. This was a misreading of the notes Dr Corbett wrote on one line "stop Nap" and the next line under that he wrote a version of "Rabe[prazole]". Dr Corbett said that he asked for the blood test results and it was then that he learned that the bloods had not been taken the previous day. Dr Corbett said he didn't direct RN Bryon to take bloods as there would be no point as they would not be collected for testing until the Monday. He said he did not suggest to RN Bryon to administer IV fluids.

136. Dr Corbett attended at about 12.30 pm and wrote a PN "*sig. Deterioration for t/f WWBH ; see (referral letter)*". He said in his statement that he reviewed Danny as set out in the referral letter and "I ordered his urgent transfer to Wagga Wagga Base Hospital for further assessment and wrote the referral letter. In his evidence he said

[120] Transcript 23/2/21.48
[121] Transcript 22/2/21 T76.23-25
[122] Transcript 24/2/21 T94.5
[123] Transcript 24/2/21 T102.30
[124] Transcript 23/2/21 T49.35

that the picture he was presented by RN Bryon over the telephone was very different to what he saw when he attended. He also said in evidence that Danny was a totally different person than the person he saw the previous day. Dr Corbett left the clinic at about 1.30 pm after completing the referral letter and instructing that Danny be conveyed to hospital.

137. RN Bryon said in his statement that between 1.00 pm and 1.50 pm he called the shift manager to call an ambulance. The Justice Health document "Emergency Response Form" completed by RN Bryon indicates that it was 1.50 pm when an ambulance was notified. There is no explanation as to why an ambulance was not called prior to this time given that Dr Corbett had "ordered his urgent transfer". There were significant ambulance service delays and Danny was ultimately transferred to Wagga Wagga Base Hospital at 3.30 pm.[125] By the time the ambulance had arrived Danny was unable to follow directions or move himself from the ward bed onto the stretcher and had to be lifted by several people onto the ambulance stretcher.

Review of the Medical and Nursing Care and Treatment Provided in the Medical Unit up until the morning of 7 November 2015.

138. Associate Professor Anna Holdgate, an emergency physician, provided an expert report and gave evidence in the inquest. She had a number of criticisms about the medical care provided to Danny whilst in the care of the medical unit in the Junee Correctional Centre.

139. Associate Professor Holdgate concurred with Professor Gunja's opinion that Danny died of paracetamol toxicity. She noted that given the lack of history of paracetamol ingestion given by Danny, and his history of polysubstance abuse, mental health issues and chronic pain, his vague presentation did not necessarily immediately point to liver failure. [126] However, she thought that the urinary findings from the dipstick test of 5 November 2015 were significant and warranted further investigation.[127] She noted that Dr Corbett had not recorded in his notes that Danny had haematuria and she thought this was a significant condition to make note of as it is a concerning sign for kidney injury.[128]

140. Associate Professor Holdgate noted that RN Marsters' dipstick urine test did not record leukocytes, nitrites and bilirubin levels. She said that Danny's bilirubin levels would have almost certainly been elevated. She said that every component of the

[125] Tab 99 Wagga Wagga Base Hospital records p.1
[126] Transcript 25/2/21 T12.31; Exh.1 Vol.4 Tab 115 Report of Associate Professor Holdgate at 4.1
[127] Transcript 24/2/21 T70.01-T71.25
[128] Tab 115, Report of Associate Professor Holdgate at 2.3.1 – 2.3.2

test should have been recorded. She noted the protein and blood and commented that "…in the clinical context of someone presenting with reported blood-coloured urine and abdominal pain and vomiting you'd be concerned it could be reflective of an acute injury to the kidney." [129] RN Marsters said in his evidence he only recorded significant readings which suggests that he did not understand either that the bilirubin levels were significant or that they were elevated.

141. Associate Professor Holdgate considered that a further dipstick urinalysis test would have identified a more complex issue than Dr Corbett's working diagnosis of gastritis and that it would have been at least a useful test to monitor Danny's progress.[130]

142. Associate Professor Holdgate noted the lack of monitoring of Danny's condition and that without a standing order Dr Corbett would be expected to set the frequency of such monitoring when he reviewed Danny on 6 November 2015.[131]

143. I note Dr Corbett's evidence that he advised RN Marsters on 5 November 2015 to admit Danny as he had tachycardia. There are no admission documents or patient charts (SAGO) which set out why Danny was admitted, the frequency of observations, the plan for his care other than RN Marsters' comment in the PN "push oral fluids".

144. In November 2015 the applicable process for patient care in the clinic was contained in GEO's Observation Unit Care Manual ("OUCM"). It had been released in 2008, revised in 2010 and was available on the intranet for all staff to access at any time. Nurses were made aware of the manual upon their orientation into the clinic.[132] The OUCM requires observations to be taken every 2 hours. A SAGO Chart requires observations to be taken every 8 hours. Ms Te Maru considered the OUCM as a standard and that observations might be more frequent depending on the clinical indicators. She considered the requirements of the OUCM mandated observations to be consistent with general practice and common knowledge, and a minimum. The disparity between the OUCM and SAGO may be explained by the fact that the cells in the Junee Medical Centre were essentially for observations. RN Wall said in his

[129] Transcript 25/2/21 T6.17 – T6.37;T7.12; T.8.24-31, T10.09
[130] Transcript 25/2/21 T10.44,T11.02, T21.48
[131] Transcript 25/2/21 T11.17 – T11.38

[132] Exhibit 6, Observation Unit Care Manual p.3; Transcript 26/5/21 T170.37; Tab 161 Fourth Statement of Ms Te Maru 21 May 2021 at [29], Transcript 26/5/21 T194.22

evidence that if a patient requires observations every 2 hours then they should be in hospital.

145. It is extremely concerning that it would seem that nurses who had the care of Danny were not aware either of the requirements of the OUCM or if they were so aware, had no regard to it. Further, for the most part, the means of observation seemed to range from none at all to a glance on a CCTV screen while carrying out other duties. If observations were made, such as those by RN Marsters in the morning and afternoon of 5 November 2015 they were written on a piece of paper and the information transferred to a PN.

146. That there was a complete absence of clinical observations of any kind conducted by any clinical nurse on 6 November 2015 demonstrates a gross lack of care. There seemed to be an acceptance of a medical unit with poor systemic compliance.

147. Dr Corbett, when reviewing Danny on 6 November 2015, did not consider a lack of chart as a problem. In evidence he described the practice of nursing staff using a SAGO chart as "hit and miss"[133], which indicates that there was a lack of compliance with "standing orders". However, Dr Corbett did not apparently consider it necessary to set out his own directions. He did say that there was an expectation that observations would be taken three times a day – once on each shift. Dr Corbett should have read the nursing PN when he reviewed Danny. Doing so he would have been aware from that there was no chart and no PN regarding observations since RN Duddy's PN of 4.50 pm 5 November 2015 and no observations in the morning of 6 November 2015. Dr Corbett should have made it clear what observations he expected. He gave evidence that at the time of Danny's deterioration reported to him by RN Bryon on 7 November 2015, he expected that RN Bryon would take observations hourly. If this was so it appears he failed to communicate that expectation to RN Bryon[134] though RN Bryon understood that such observations should be taken in any event.

148. Counsel Assisting submits that inadequate nursing care was provided to Danny and that deficient record keeping not only failed to comply with policy but was a reflection of the inadequate care provided to Danny during his admission in the medical unit. The inadequacy of the care was due to systemic failures of complying with policy,

[133] Transcript 24/2/21 T68.01 – T69.04

[134] Transcript 24/2/21 T96.36-T97.1

understanding the purpose of Danny's admission and actually carrying out the tasks required.

149. Counsel for GEO submit that it was reasonable for GEO to expect that the registered nurses employed by them would carry out their duties appropriately. That should be so, but it is incumbent upon GEO to ensure that best practice, policies and standards are adhered to by a sound management and audit process. If that had been the case GEO may have learned of the apparent lack of understanding and application of the OUCM before that evidence came to light in the inquest. The GEO submissions submit that the primary health services provided at the centre were akin to a GP practice and not a public hospital (as set out in Ms Te Maru's statement). It seems that such an analogy is of little relevance where a prisoner is accommodated in the unit for medical observation and treatment. As that is outside a GP practice situation, whatever hybrid the medical centre was, it performed its function to fulfil the purpose for which the patient was there. I note that the functions of the medical unit are now changed so that prisoners are no longer accommodated for patient care.

150. Mr Sergi, counsel for Dr Corbett submitted that though he made no response on behalf of Dr Corbett in regard to Counsel Assisting's submission, that the context of a custodial setting must be taken into account when determining the adequacy of care. He emphasises that the OUCM identifies that the "care provided to patients in the Observation Unit is under the supervision of a Registered Nurse". He says that whereas a registered nurse is always at the correctional centre, a medical officer is not though is on call and available 24 hours a day.

151. In relation to the morning of 7 November 2015 Mr Sergi's submissions spoke to how busy the ward was, with reference to CO Withers' evidence about being on duty that day. That was yet another misstatement by Mr Sergi of the evidence as CO Withers was not on duty on 7 November 2015. The evidence she gave related to 5 November 2015. The only witness who gave evidence about how busy the nurse on duty on 7 November 2015 was RN Bryon.

152. Mr Sergi's submission that the adequacy of care provided to prison patients should be viewed in the context of the fact that they are in custody is not particularly helpful. Danny was in a medical unit, he was not in a prison accommodation unit. There is no evidence that observations could not have properly been made and charted because a nurse could not access Danny or did not have the time to do so. In relation to 7 November 2015 RN Bryon said he could have made arrangements with a corrections officer to open the cell every hour to make observations but did not do so and was

unable to explain why he did not do so. Dr Corbett did not direct hourly observations before or after he attended Danny. In relation to after he said that he expected that the ambulance transfer would be 15 minutes and I note that he had left the centre well before the ambulance had been called by RN Bryon.

153. In relation to the blood test request, Associate Professor Holdgate held the view that it was the responsibility of the ordering doctor to ensure that the tests were actually done and that there needed to be a system in place that if the blood could not be taken or the blood was not collected that the doctor would be notified. She also noted that Danny had a long history of intravenous drug use and a month prior a nurse had made a record that he deferred a blood test in relation to another matter, commenting that taking blood was difficult. There is no evidence that Dr Corbett considered that taking blood from Danny would present with any problems. In any event, Associate Professor Holdgate considered that it was reasonable that Dr Corbett presumed that the bloods would be taken and that he would be notified of an abnormal result on the basis of there being a system for that communication at the clinic.[135] However, the evidence clearly shows that there was no such system in place.

154. There was no PN that the bloods had been attempted. There is no evidence of the nature of any pathology request on Danny's file other than Dr Corbett's handwritten word "bloods". There is no record of an urgent request or when the bloods should be taken.

155. The Manager of the Medical Unit Ms Te Maru expected that for an urgent pathology request, the doctor would hand the nurse the pathology form. For routine pathology, the doctor would put it into a pathology tray in the clinic.[136] She said that as at this time in 2015, patients from whom blood was not possible to draw would be expected to have been sent to the hospital for this purpose on the same business day.[137] She said that any difficulties in drawing blood should be recorded in the progress notes[138] and the factthat there was no such progress note for Mr Whitton on 6 November 2015 after the doctor had seen him in the morning, meant that nobody sought to draw his blood on 6 November 2015.[139]

156. Dr Corbett said that on Saturday 7 November 2015 he did not suggest to RN Bryon to take bloods because there was no collection service until the Monday. Ms Te Maru

[135] Transcript 25/2/21 T22.22 – T24.
[136] Transcript 26/5/21 T174.41
[137] Transcript 26/5/21 T175.04 – 175.21
[138] Transcript 26/5/21 T176.09
[139] Transcript 26/5/21 T176.14

said urgent blood collection could have been organised at the time, including on the weekend.[140]

157. Counsel Assisting submits that there was no system in place to ensure that requests for blood tests were actioned during the shift the request was made, or that outstanding requests for blood tests were actioned by the next shift. Consequently, the request for bloods made by Dr Corbett was never actioned.

158. Mr Sergi submits that "there could be no reasonable issue that Dr Corbett did order blood tests on an urgent basis". He further submits that though there was a system in place for the collection of bloods it was susceptible to failure and since 6 November 2015 GEO has implemented a more robust electronic system.

159. GEO submits that "the evidence of Dr Corbett as set out in the submissions served on his behalf are also consistent with the system that was in place (as identified in Ms Te Maru's evidence referred to below)[141]. I do not accept that submission because Ms Te Maru's evidence distinguished the system applicable for an urgent blood test as compared to a routine blood test and it would appear that Danny's test request fell into the latter category when it should have been directed on an urgent basis.

160. Any urgency as to the blood test Dr Corbett conveyed to nursing staff is not as Mr Sergi submits. Dr Corbett gave evidence that he reviewed Danny at 10.00 am, he handwrote the pathology blood request, he put the form in the "nurses' job list for the day".[142] At that time that was a tray in the nurses' station and in his evidence he said he assumes that he told a nurse that bloods were to be taken[143]. Though there was an 11.30 am courier collection he understood that the nurses would traditionally action those forms in the afternoon, though someone might flick through the tray in the morning but take the bloods in the early afternoon.[144] The form must have been put in the tray by noon because that is when Dr Corbett left the centre.

161. According to Ms Te Maru, if the bloods were considered to be urgent the doctor would hand the pathology form to the nurse rather than put it in the tray or take the blood themselves[145]. Danny's bloods could have been taken and collected by 11.30 am on 6 November 2015 as there was ample time to do so. Dr Corbett did not recall making such a request,[146] however, it is clear that he did not make any such request because

[140] Tab 161 Fourth Statement of Ms Te Maru 21 May 2021 at [36]
[141] Transcript 26/5/21 T174.31-T176.13
[142] Transcript 24/2/21 T69.15
[143] Transcript 24/2/21 T69.27-44
[144] Transcript 24/2/21 T69.45-70.10
[145] Transcript 26/5/21 T174.40-42
[146] Transcript 24/2/21 T71.46

Dr Corbett's evidence was that he did not consider that Danny was in such a serious state as to get the blood test quicker – he was content to have the results that day.[147]

162. Given that he was content with the form being left in the tray for the nurses to action after lunch it is unlikely that he informed any nurse that the bloods were urgent. There was no reference in his PN or his statement of 2 September 2019 in that regard. Ms Te Maru said that unless the pathology form had a day as to when the bloods were to be taken written on it the nurses would treat the request as "routine" and know to action the forms in the tray "during that week".[148] Dr Corbett did not give evidence about having written a day by which the bloods were to be taken on the form and again there is no such direction in his PN.

163. Associate Professor Holdgate placed significance on the urine test of 5 November 2015 and the fact that it was not repeated the following day. She considered that it would have been useful as a monitoring test for Danny and that it could have assisted in identifying a more complex working diagnosis of gastritis.

164. Dr Corbett's response to this was fairly dismissive and as he did not think it would have added much to his review. He said that he would have ordered blood tests regardless of what the results of another urinalysis test were and that Danny's presentation was not such at that time that he required hospitalisation. That approach accordingly places more weight on the need for Dr Corbett to have ensured that a blood test was carried out so that he could be informed as to what was going on for Danny.

165. Associate Professor Holdgate opined that Danny's colour was likely yellow from 5 November 2015 indicating jaundice. Dr Corbett said that Danny did not have jaundice. That he didn't perform a urine test on 6 November 2015 suggests that he had not included in his differential diagnosis kidney or liver issues. In any event he did not record that he considered anything other than gastritis in his notes. I agree with Associate Professor Holdgate that given Danny's urinalysis dipstick results of 5 November 2015, his complaint and description of pain, a suggestion that Danny may have gastritis was inadequate.

166. Ms Te Maru gave evidence that the fact that there was no PN on 6 November 2015 about drawing blood meant that it was not attempted.[149] Dr Corbett said that on the Monday or Tuesday the following week he "chased up everyone and spoke to the

[147] Transcript 24/2/21 T72.
[148] Transcript 26/5/21 T174.35-50
[149] Transcript 26/5/21 T176.15

boss about" why the bloods weren't taken. He wasn't able to identify who told him the answer. He said "the story I got was that it got very, very busy Friday afternoon there was a lot of code whites that took nurses off, they started taking the blood at 4, couldn't find a vein and by the time the courier had gone the blood didn't-wasn't taken". Ms Te Maru as manager of the unit did not give any evidence in that regard.

167. Ms Te Maru gave evidence that if an urgent blood test was unable to be actioned, the patient would be transferred to hospital for pathology. That Dr Corbett was not advised on 6 November 2015 that bloods could not be taken and that Danny was not conveyed to hospital to take the bloods if the nurses were unable to draw it. That there is no PN tends to indicate that the bloods were not taken as there was no understanding that they were urgently required and/or of the system in place.

168. There is no evidence that as at November 2015 there was an adequate "urgent blood test system" in place at the medical centre let alone a system requiring the nursing staff to clear the pathology tray the same day as the request was placed in it. There was no system in place to notify the Medical Officer in the event that the request could not be carried out other than an expectation that this would be done for an urgent blood request. If the nursing staff understood that the blood test was routine and was unable to draw blood the doctor would not be notified as the doctor would be on site during the week.[150]

169. There was no system in which a copy of the pathology request was kept and since Danny's death no such form has been located. Such a flawed system was perpetuated by both medical and clinical practitioners. In this case, it resulted in Danny's medical condition not being properly investigated so that an accurate diagnosis could be made and an appropriate treatment plan implemented.

170. GEO's response to Counsel Assisting's submissions in relation to any blood testing system in the medical centre submits that that it was "more informal, which was not surprising given the nature and size of the Clinic." It wasn't just the blood testing system which was "more informal" as the poor observations, record keeping absence of nursing attention could be described in such a way. The fact that the clinic was small in terms of admitted patients but large in terms of prisoner population is no excuse for poor practice, informal or otherwise.

171. As a result of the circumstances surrounding Danny's death, soon after the GEO medical centre acquired an i-Stat blood testing machine so tests can be conducted on

[150] Transcript 26/5/21 T175.15-34

site and the results known within 15 minutes. The pathology requests are now electronic.

Review of the care and treatment provided to Danny on 7 November 2015.

172. RN Bryon had been on the same shift (6.30 am to6.30 pm) the day prior but though he was the only RN performing clinical work with 2 or 4 enrolled nurses he had no dealings with Danny.[151] There is a nursing standard called ISBAR (Introduction, Situation, Background, Assessment, Recommendation) system that due to the applicable Justice Health policy was required to be followed at the GEO Junee medical centre. RN Bryon said it was common to receive a fairly cursory handover such as "nil issues" rather than the ISBAR check. This deficiency was identified after Danny's death and GEO updated its clinical handover format to comply with the policy and in service training was implemented to ensure staff used the ISBAR.[152] There were only two patients in the ward: Danny and Mr E. According to RN Bryon he had been informed by RN Wall that they were both stable with nil issues.

173. Nursing staff within Junee Correctional Centre's medical clinic are required to comply with the Justice Health policies *Recognition and Management of Patients who are Clinically Deteriorating* and *Clinical Observation Beds in Health Centres (Adults*). SAGO charts were not consistently used in Junee Correctional Centre health clinic in November 2015 No SAGO chart was being used to indicate that Danny was under appropriate clinical observation and that his vital signs were monitored and recorded. RN Bryon repeatedly said that he used a chart on 7 November 2015 and that the entry of Danny's 09.00 am vital signs followed on from the entry made on the previous shift. As there was no SAGO chart on either 5 or 6 November 2015 I would have expected RN Bryon's evidence to have been that he discovered that there was no SAGO chart in Danny's file and that he had to establish one. He did not give that evidence and I am not satisfied, despite his repeated assertions, that there was one used on 7 November 2015. The effect of not having the chart compromised a longitudinal understanding of Danny's condition making it more difficult to not only identify when he was not "between the flags" but what his deterioration progression was. RN Bryon explained that at one point Danny's 10.30 am blood pressure was lower than it was at 9.00 am because he had moved from a sitting position to a lying position on the bed.

[151] Transcript 23/2/21 T 29.20-30.19
[152] Tab 117, Action Plan, attachment to second statement of Ms Te Maru 16 Sep 2019

I took that evidence as gratuitous as RN Bryon's memory was clearly not being exercised when he said it.

174. RN Bryon's understanding as to why Danny was in the clinic was that it was due to drug withdrawal and associated abdominal pain[153]. He said he had come to that understanding from reading RN McGloin's PN note (which though had not been a clinical note was in the nursing PN) and seeing that Danny had been prescribed Maxalon.

175. The evidence in the inquest clearly demonstrates that Danny should have been hospitalised in the morning of Saturday 7 November 2015 or as indicated by Professor Gunja. Had the blood tests been conducted and reported on by 7.00 pm Friday 6 November 2015, the test results would or should have prompted Danny's hospitalisation.

176. Associate Professor Holdgate referred to evidence that Danny was noticeably jaundiced and that there seemed to be a failure by clinical staff to recognise this as being indicative of liver issues. RN Marsters, RN Wall, RN McGloin, RN Bryon and Dr Corbett all say that Danny did not appear to be jaundiced. Dr Corbett said he looked for it on 6 November 2015 as he was aware of the urine test conducted by RN Masters. His experience was that jaundice can be "very very hard to spot sometimes" and may not be evident even when the bilirubin levels rise above 40-50 umol/L.[154] The medical unit witnesses said that the lighting is not very good in the cell suggesting that may have contributed not being able to recognise Danny's jaundice. Mr E said that Danny was turning yellow. I note that ambulance records do not indicate that Danny's skin was jaundiced but note that his eyes were. Dr Corbett pointed out that the registrar of Wagga Wagga Base Hospital wrote three pages of notes without a mention of jaundice until after the blood test results were in.

177. It is possible that Mr E said that Danny was turning yellow in front of him because he was the only person who spent a significant period of time with Danny and was able to measure that change in him. I accept in regard to the nurses that Danny's skin to them was not appreciably jaundiced, they were not looking for it and they spent minimal time with him. Observations via a CCTV monitor would not afford an adequate opportunity to identify jaundice, let alone recognise it and perhaps the same could be said for the lighting in the cell and the clinic generally. Dr Corbett did not see it on 7 November 2015 and that may have been due to the lighting and the fact that Dr

[153] Transcript 22/2/21 T5-12
[154] Transcript 24/2/21 T85.04 – 87.10

Corbett spent very little time with Danny as he saw immediately that he required transfer to hospital. Dr Corbett then set out directing that that occur and wrote the referral letter. Dr Corbett left the medical unit expecting that the ambulance would arrive within 15 minutes.

178. Associate Professor Holdgate thought that a patient with GCS 11 warranted observations every 30 minutes[155]. Ms Te Maru was familiar with the SAGO chart which stipulates that if a patient has areduced consciousness, and the deterioration was not reversed within one hour of a clinical review, an urgent response would be called for.[156] If the patient was asleep, thiswould mean rousing the patient to conduct the relevant tests. Ms Te Maru said that her practice would have been to rouse him every 10 minutes. It has not been her experience that anyone with a GCS of 11 would improve after sleeping an hour or two.[157]

179. Counsel Assisting submits that Danny was not provided with an adequate level of observation by nursing staff during the morning shift of 7 November 2015. Appropriately detailed progress notes were not made by nursing staff, in particular RN Bryon, during the morning on 7 November 2015, and Dr Corbett was not provided with a satisfactory description of Danny's critical condition.

180. In her second written statement, Ms Te Maru concluded that staff had complied with policies in relation to the management of a deteriorating patient.[158] She resiled from this position in the inquest. It would appear that rather than reviewing Danny's file and requiring written reports Ms Te Maru had relied on her expectation that staff would have complied with policies and guidelines, verbal feedback from the nursing staff and the doctor, and the fact that Danny was transferred to Wagga Wagga Base Hospital. Ms Te Maru said she was not aware of a difference between her expectations and the actual practice within the clinic before Danny's death and only became so aware following a review and creation of an action plan in 2016.[159]

181. I agree that nursing staff did not make detailed progress notes on 6 November 2015 – there were none but for a nonclinical record by the drug and alcohol nurse. Whilst I agree that RN Bryon failed to make appropriate detailed Progress Notes and failed to conduct an adequate level of observations it is difficult to accept that he failed to recognise and provide a satisfactory description of Danny's critical condition to Dr Corbett. I do accept that whatever communication there was between nurse and

[155] Transcript 25/2/21 T44.15
[156] Transcript 26/5/21 T190.01 – 190.26
[157] Transcript 26/5/21 T191.5-12
[158] Tab 117, Second Statement of Ms Te Maru 16 Dep 2019 at [12], Transcript 26/5/21 T171.35
[159] Transcript 26/5/21 T198.04 – 198.20

doctor, RN Bryon did not counter Dr Corbett's direction at 10.30 am to "wait and see" how Danny was until he could attend the correctional centre. That positioning no doubt caused Dr Corbett not to be alerted that Danny required immediate hospitalisation and that there was no time to wait.

182. Mr Sergi submits that Dr Corbett's advice to RN Bryon at 10.30 am to observe Danny and call back if concerned is "evidence consistent with the proposition that RN Bryon understood that Dr Corbett wished there to be a significantly increased level of observation of Danny". I do not accept that submission. In his evidence Dr Corbett did not say that he communicated an increased level of observation, the evidence he gave was that he assumed the observations would be hourly. According to Associate Professor Holdgate, ideally the observations would have been at least every 30 minutes and according to Ms Te Maru they could have been every 10 minutes until Danny's condition improved. Dr Corbett did not communicate any level of observations to RN Bryon. According to Dr Corbett he did not even suggest that RN Bryon cannulate Danny.

183. I do not accept that RN Bryon is so incompetent that he honestly believed that "No sleep will certainly drop your Glasgow Coma Scale down when different people check them".[160] Nor do I accept his evidence and his explanation that he failed to convey urgency to Dr Corbett because *"it wasn't clinically indicated that it was an urgent call apart from the fact that he was a little bit, his Glasgow coma scale was a bit down but only because he hadn't had any sleep and he was still vomiting, he vomited all night sorry".*[161] I do not accept RN Bryon was told that Danny had been vomiting all night so I cannot accept that he believed at the time that Danny's GCS was explained by this nor that he believed he would "sleep it off". He didn't suspect Danny had taken an intoxicant, he said he thought Danny was in the clinic for withdrawal from substances.

184. I have come to the conclusion that RN Bryon sought in the coronial investigation and inquest to suggest that Danny's illness was not as apparently grave as it was – probably to justify the late decision to transfer Danny as well as to demonstrate a lack of discord of opinion and action between himself and Dr Corbett as to that decision. In his written statement RN Bryon said that Danny was sufficiently well and able to move himself from the bed onto the ambulance stretcher. The CCTV footage totally contradicts this evidence and shows Danny was unable to move or follow a command at all and numerous personnel were required to move him. Likewise the CCTV footage does not support RN Bryon's evidence in regard to learning the colour of Danny's

[160] Transcript 22/2/21 T 72.50-T73.14
[161] Transcript 22/2/21 T 75.44-47

urine as being when the ambulance personnel were wheeling Danny out (this version given in his statement).

185. If the CCTV footage of the entire morning had been provided to the police, the events of the day would have been far easier to have ascertained. In this inquest, identifying what is truthful, reliable or otherwise has been difficult as RN Bryon's versions of events were so various. Whether the 9.00 am call to Dr Corbett was a narrative description of Danny's presentation or a simple telephone message to call him back, whether it was urgent or not, whether the doctor returned the call 1 ½ hours later at 10.30 am, whether there was another telephone call before or after 10.30 am or advising the doctor that Danny couldn't be cannulated or about the colour of Danny's urine has all been difficult to ascertain.

186. There is no evidence of how many calls there really were that day nor are there notes about what was said in the telephone calls. Accordingly, it is difficult to ascertain the content of the telephone calls. Dr Corbett says he could not recall being told that Danny had vomited all night, that he had a GCS of 11, that Danny had dark urine, that he had asked Danny to be cannulated or that he was later told on another call that this couldn't be achieved.

187. Mr Sergi submits that "RN Bryon informed Dr Corbett that Danny's urine was normal and that he was no longer vomiting". That is an incorrect statement of the evidence and is a submission that follows from Mr Sergi saying "RN Bryon stated that he did not recall discussing the colour of Danny's urine with Dr Corbett" with a footnote to the transcript.

188. Associate Professor Holdgate thought it was not reasonable for Dr Corbett to have advised at 10.30 am on 7 November to "wait and see" if Danny got better, "in the context of the reason he was there in the first place which was the abdominal pain, the vomiting and the other physiological abnormalities that haven't been noted".[162]

189. Dr Corbett sought to explain his reasoning that he thought Danny might have been intoxicated because the cellmate told him that Danny had been to the toilet. Despite Dr Corbett's evidence that this "happened all the time"[163] this was not supported by

[162] Transcript 25/2/21 T14.24
[163] Transcript 24/2/21 T83.24 – T83.37; T94.11

other witnesses. In any event, RN Bryon didn't share that concern and indeed it wasn't until he was at the prison that Dr Corbett spoke to Danny's cellmate.

190. Associate Professor Holdgate opined that "the clinical staff at Junee did not adequately assess Danny and did not recognize that he was seriously unwell. They failed to recognize his jaundice or the significance of his urinary findings, they responded slowly when he became drowsy and confused."[164]

191. I have come to the conclusion that whilst RN Bryon did not conduct observations as frequently as he should have he did recognise that Danny was seriously unwell. His slow response was due to him thinking that he had to wait for the doctor who unbeknown to him was at 9.00 am some hours away. RN Bryon identified at 9.00 am that Dany's GCS score measured a 2 point drop in fine motor skills and verbal commands respectively.[165] Danny was unable to hold a cup[166] - he was shaking when he was trying to hold a cup of water.[167] RN Bryon said that Dr Corbett advised him to take bloods but he couldn't find a vein to do so.[168] Dr Corbett denied giving such a direction saying that there would be no utility in doing so given that the blood would not be collected until the Monday. RN Bryon said that Dr Corbett did not indicate how often to take observations but that because he was on CCTV and "we could monitor him through that and also just go and do regular obs".[169] CCTV screen monitoring is certainly an inadequate means of observation of a critically unwell patient but RN Bryon had a multitude of other duties that day as well as his concern for Danny must have been very stressful for him. Being told to "wait and see" and "I'm on my way" would have provided little support for the nursing task that befell him.

192. Ms Haider asked RN Bryon "Did you suggest to Dr Corbett that Mr Whitton should go to hospital as soon as possible?" and he replied "No. He said he was on his way, I said I could look after him until he gets there".[170]

193. RN Bryon says that he did not call an ambulance because he understood that a doctor had to authorise a medical transfer of a prisoner. This is a misunderstanding of the policy. However, there is no evidence that RN Bryon at any stage suggested to Dr Corbett that in his opinion that Danny should go to hospital. Dr Corbett said that the

[164] Tab 115, Report of Associate Professor Holdgate at 4.2
[165] Transcript 23/2/21 T 4.14
[166] Transcript 23/2/21 T 4.42
[167] Transcript 23/2/21 T 5.3
[168] Transcript 23/2/21 T 5.10-16.
[169] Transcript 23/2/21 T 6.3
[170] Transcript 24 February 2021 T6.25-30

information RN Bryon gave him over the telephone about Danny's condition was different to how he assessed Danny's condition when he attended.

194. I have considered whether RN Bryon did not really understand that Danny required hospitalisation or that he mistakenly understood he had to wait for Dr Corbett to be transferred to the hospital. On balance I have come to the conclusion that RN Bryon did think Danny required immediate hospitalisation; he did not tell the doctor this because of a misperceived reliance and loyalty to the doctor's opinion and participation. He said "We always looked after people with withdrawal, we've always looked after people with – abdominal pain until they are reviewed by the doctor".[171]

195. I do not accept that RN Bryon did not appreciate that Danny's illness warranted evacuation. Though Danny's vital signs observations were "between the flags" despite a drop in blood pressure, Danny's GCS and inability to hold a conversation, falling back to sleep together with ataxia and delirium, were identified by RN Bryon. Danny's condition warranted immediate hospitalisation especially since he could not be cannulated for bloods to be taken and fluids to be given. Indeed RN Bryon was asked whether he considered that Danny should go to the hospital rather than wait for the doctor he said, "I did make that assumption, yes".[172]

196. The joint decision to wait until Dr Corbett was able to attend was a poor choice to make when Danny could have been easily transferred to the hospital without Dr Corbett's attendance. I note that Dr Corbett still works in the medical unit at Junee Correctional Centre and that there has been significant systemic changes, clarified policy and protocol and training to achieve a culture of best practice. Since giving evidence in February 2021, RN Bryon has ceased working at Junee Correctional Centre.

197. The inquest heard evidence that on 6 November 2015 Dr Corbett had to travel to Sydney for an urgent family matter and he left Sydney in the early morning on 7 November 2015 to return to Wagga Wagga. Dr Corbett was unable to attend the prison prior to 1 pm and that should have been conveyed to RN Bryon. The four hours lost may not have altered the course of Danny's illness but it would at least give his family confidence that on that day Danny received the best health care that could have

[171] Transcript 24/2/21 T 6.35-36
[172] Transcript 23/2/21 T 7.11

been afforded him in the circumstances of being cared for by a Registered Nurse in the absence of a visiting GP.

198. RN Bryon gave numerous versions as to when he learned from Mr E that Danny's urine sample taken by GEO Intel on 6 November 2015 was "dark as coke". He did not make a PN note of it but it is included in the Emergency Response Form. He was asked by Counsel Assisting why he included in his statement (para 18) "Although I have referred to a conversation with…cellmate...in my progress note I have no recollection of this conversation. If the cellmate had described the urine to me at this stage as "dark as coke" I would have sought a sample and escalated his care immediately". He said in his evidence "...the cellmate, that was with him and he said "Geez, that was as dark as coke" and then alarm bells went off of my head to say that usually that is a sign of kidney failure".[173] His evidence was that occurred at 10.30 am on 7 November 2015. [174] At another point in his statement (para 36) RN Bryon said that Mr E told him this information as the ambulance were wheeling Danny out[175]. He said in answer to a question from Ms Haider that he rang the hospital to tell them this information because it was pivotal information.[176]

199. Later in his evidence as to when he was told, he said that it probably would have happened from 10.30 am to 12 noon when the cellmate spoke to me again".[177] RN Bryon said that he didn't take another sample from Danny but rang Dr Corbett back again and the doctor said that he was on his way. Later RN Bryon said that he did not know if he ever told Dr Corbett this information but he did record it on the Emergency Response Form after Dr Corbett told him to call an ambulance so that Danny could go to hospital for "a head and abdo CT". Another time advanced by RN Bryon was "just before the ambulance turned up"[178]. He said he wasn't 100% sure when it was that Mr E told him whether it was the first time, the second time or when he called the ambulance.[179] RN Bryon said he learned the information sometime between after his first attendance on Danny at 9.00 am and before the ambulance but he had no recollection of having told the doctor.[180]

200. Mr E was asked by counsel assisting "And do you recall whether you told the nurse that morning that Danny's urine was "dark as coke" to which he replied "Yep. Yeah…I remember that now that you say that, yeah". As to when that was he said "pretty sure

[173] Transcript 22/2/21 T 75.35- 76.4
[174] Transcript 22/2/21 T77.7
[175] Tab 105 RN Bryon Statement para 36
[176] Transcript 24/2/21 T 28.10-12
[177] Transcript 22/2/21 T 76.50-77.16, 77.35
[178] Transcript 22/2/21 T 79.2
[179] Transcript 22/2/21 T 78.4-11
[180] Transcript 22/2/21 T 76.50-79.4

it was when they done the urine on him". He was asked whether he meant medical or Intel and he said he couldn't remember. He said he remembered about the coke because "that's when I was blowing up, saying that youse need to help him you know". He said that was probably the Saturday.[181] On balance taking into account Mr E's poor memory due to lapse of time, he was unable to assist me in identifying the time at which he told RN Bryon about the colour of Danny's urine. However, given that RN Bryon had read Danny's progress notes, when being told he had urinated that morning it would have been a good information to have inquired into as to whether the colour was normal or not. That is something that Dr Corbett might have inquired over the telephone too when told that Danny had passed urine.

201. RN Bryon's evidence in regard to when he learned that Danny's urine was "as dark as coke" is entirely unsatisfactory. His evidence in his statement that he was only told this by Danny's cellmate when the ambulance was wheeling Danny out is not born out by the CCTV footage.

202. The last observation recorded by RN Bryon is at 13.25 around the time that Dr Corbett left. The ambulance did not arrive until 3 pm and despite RN Bryon being concerned that Danny was deteriorating he did not take any further observations. He said that he looked on the CCTV and "I watched him just lay there on the bed and, and try to get some sleep".[182]

203. That RN Bryon continued this narrative throughout his evidence to the inquest did not convince me that on 7 November 2015 he did not think that Danny was in *dire straits*. His evidence when questioned by his solicitor indicated he is a knowledgeable and experienced registered nurse. RN Bryon was left to complete the paper work, organise Danny's evacuation, deal with an ambulance cancellation and watch and wait until the paramedics arrived.

204. Mr Rees on behalf of Kylie Knight, Danny's mother, submits that the treatment afforded to Danny was "incompetent", displayed a "lack of care" and "attention to detail". Mr Rees submits that in accordance with regulation 151A of the *Health Practitioner Regulation National Law* (NSW), Dr Corbett should be referred to the Medical Council. Ms Cooper on behalf of Darren Whitton likewise makes this submission.

205. I do not think that the evidence supports such a course, though at times Dr Corbett was somewhat flippant in the witness box, it should not be taken as an indication of

[181] Transcript 24/5/21 T 26.1-27.3
[182] Transcript 23/2/21 T 28.44

medical care. For example, such as when he attended Danny on 7 November 2015 he was asked "When you got there, did you physically examine Danny?" he said "I certainly looked at him. I poked his belly, yeah",[183] and that he didn't form a view about a possible diagnosis or speak with any clinicians because "I wanted him out".[184]

206. There is no evidence to suggest that had Danny been conveyed to hospital at 9.00 am that morning, his death would not have occurred. Sadly, the evidence suggests that even at that stage Danny's condition was irreversible. It should be noted that though Danny had arrived at Wagga Wagga Base Hospital it was not until blood test results were known that Danny was treated for paracetamol overdose.

207. Ms Cooper submits that had Danny been hospitalised on 5 November 2015 his death "would certainly have been prevented" and relies on Professor Gunja's evidence in that regard though Dr Gunja did say that acetylcysteine should commence within eight hours of ingestion. Danny presented to the clinic well outside that time period. The evidence does not support a finding that RN Marsters or Dr Corbett should have at that stage transferred Danny to hospital. Associate Professor Holdgate does not provide that opinion nor does Professor Gunja.

208. Ms Cooper lists in her submissions the failings at the medical centre at Junee Correctional Centre. Those issues are identified throughout these findings. Ms Cooper submits this list as indicative of the suboptimal care provided to Danny when he was a patient in the medical unit at Junee Correctional Centre and that it acted as a barrier to Danny being referred to hospital. She acknowledges the changes that have been made to the unit since that time and notes that a patient now presenting as Danny had would be transferred to hospital rather than being admitted.

209. Mr Rees also includes a list in his submissions and for the most part they too are contained throughout the findings. Mr Rees' list includes a failure by Dr Corbett to hospitalise Danny on 6 November 2015 in light of the elevated results in the urine dipstick test of 5 November 2015. The evidence does not support a finding that Dr Corbett should have referred Danny to hospital at that time or in answer to another item on the list that Danny should have had IV fluids that day.

210. In relation to 7 November 2015, Mr Rees' list is contained throughout the findings but he identifies that RN Bryon failed to call an ambulance at 9.00 am and failed to identify that Danny's GCS 11 required a rapid response. The rapid response was to conduct closer observations and record them and if there was no improvement to escalate

[183] Transcript 24/2/21 T 79.50
[184] Transcript 24/2/21 T 80.24

Danny's care. Due to RN Bryon's misunderstanding of the transfer protocols and his misplaced understanding that he should wait for the doctor, his escalation of care was to call the doctor back. It is unclear due to the lack of good record keeping whether RN Bryon told Dr Corbett about the GCS 11 but one would expect that he did. There is an inference available from the evidence of RN Bryon that the GCS was the reason for the call to Dr Corbett, and that information was provided to the doctor. Mr Rees is critical that Dr Corbett did not advise the medical unit on the whiteboard that he was going to be in Sydney. I don't think Dr Corbett knew that he was going to be in Sydney and there is no evidence that he did not convey to RN Bryon his whereabouts. It would have been ideal Dr Corbett had indicated to RN Bryon that he was unable to attend Danny until some hours after RN Bryon called shortly after 9 am.

211. In addition to referring Dr Corbett to the Medical Council, Mr Rees submits that RNs Marsters, Wall and Bryon should be reviewed. I do not intend to do so but that does not prevent either of Danny's parents to pursue such a course.

212. Mr Rees submits that there be a recommendation that Justice Health undertake a review of the staffing levels, training and competency of health staff at Junee Correctional Centre. I decline to do so given the passage of 6 years and the changes made at the Centre since Danny's death.

Changes made at Junee Correctional Centre

213. Following Danny's death GEO Health addressed the issue of recognition and management of clinically deteriorating patients by introducing in-service training around the use of SAGO charts and "between the flags" principles. Ms Te Maru thought medical and existing staff could benefit from refresher courses. The OUCM is now redundant, and in any event if it ever had been in use, it was not by the nurses who gave evidence in the inquest.

214. RN Bryon's evidence was that in 2015 a nurse was unable to call an ambulance without the doctor's approval.[185] RN Duddy said that such authorisation can be given over the telephone if the doctor is not in the clinic.[186] As to the policy in 2015 for calling an ambulance, Ms Te Maru's attention was drawn to a policy that existed in 2015 called the *Transfer Protocol for Wagga Wagga Base Hospital* (the 2015 protocol) relating to the circumstances in which a patient might be transferred to the base hospital. Ms Te Maru, said that she disagreed with RN Bryon's evidence that there was a general policy that a nurse in his position was unable to call for an ambulance

[185] Transcript 23/2/21 T63.30 and 24/2/21 T5.46 – 6.11
[186] Transcript 26/2/21 T14.16 – 14.35

without permission from a doctor, and thought RN Bryon misunderstood the policy.[187] Ms Te Maru said the relevant policy allowed for a nurse to call an ambulance and then inform the correctional group without contacting first the health services manager or a person of higher rank than the registered nurse on duty. [188]

215. Given the time that Danny ingested the paracetamol and his noted deterioration on the morning of 7 November 2015, had RN Bryon called an ambulance at 9.00 am, it is unlikely that there would have been a better outcome for Danny as the damage had been done and he was in multi-organ failure. However, the evidence warrants a finding that an ambulance should have been called at least by 10.30 am.

216. The 2015 protocol was part of the *Junee CC Primary Health Care Manual – Emergency Clinical Guidelines* and was applicable in November 2015. The policy was referred to in oral evidence and later provided to those assisting the Coroner on 2 August 2021 and entered into evidence.[189]

217. The protocol indicates the procedure following the nurse's completion of several urgent information-gathering and resuscitation steps (underlining added):

> *[6] If the condition of the inmate warrants transfer to the base hospital,* ***phone ambulance control on 000 or 131233*** *to arrange a transfer.*
>
> *[7] Only the Doctor or General Manager can authorise the removal of a patient from the Centre and must be notified as soon as possible of all Patients transported out.*
>
> *[8]* ***Inform Central Control****. Central Control is able to inform shift manager (Correctional Manager Operations), Front Gate Officer*

[187] Transcript 26/5/21 T164.20 – 164.27
[188] Transcript 26/5/21 T164.31 – 164.44
[189] Ex 9 *Transfer Protocol to Wagga Wagga Base Hospital*, Junee Correctional Centre Operating Manual, GEO Group.

and the General Manager. Delegate this task if necessary. CMO to arrange Escort Officer to accompany inmate.

[9] Complete Section 24 (Removal of Prisoner from Centre). Delegate this task if necessary.

[10] Complete ***Consultation Emergency Room Referral*** *if time permits. Hand enveloped original to ambulance officers.*

[11] ***Notify Wagga Base Hospital A&E Department*** *of impending arrival of inmate through switchboard.*

[12] Inform Doctor of action taken.

[13] Inform Health Services Manager of action taken

[14] Complete Incident/Assault Report

[15] Update Medical Record

218. The Nurse is then required to inform the Nurse Manager and Justice Health of the action taken. The protocol was apparently approved by the Centre Medical Officer, although there is no signature on the foot of the document confirming such approval.

219. The current policy dealing with the transfer of patients from Junee Correctional Centre to hospital was published on 21 January 2021 and is called the *Emergency Hospital Transfer and Daily Status Update* (the 2021 policy).[190] Relevantly the policy provides:

> *"The decision to transfer a Custodial Patient to hospital is made by either medical and/or nursing staff based on clinical assessment and the determination that the acuity of the Custodial Patient warrants further assessment and/or treatment at an external hospital."* [191]

220. The 2021 policy provides that nursing staff are to make every effort to advise the Shift Manager or Code Co-Ordinator to what kind of escort is required, and are required to complete forms to be kept on JHeHS system.[192] In the case of the transfer of prisoners for serious incidents involving life and death situations, the Health Services Manager (HSM) must be immediately advised of the transfer or if after hours within four hours of its occurrence.[193]

221. Health Related Emergency Response and Emergency Clinical Guidelines (the Guidelines) accompany the 2021 policy and provide that custodial patients are

[190]Ex 10 *Emergency Hospital Transfer and Daily Status Update*, Junee Correctional Centre Operating Manual, GEO Group.
[191] Exhibit 10. *Health Related Emergency Response and Emergency Clinical Guidelines,* Junee Correctional Centre Operating Manual, GEO Group at [3.1]
[192] Ex.10 *Health Related Emergency Response and Emergency Clinical Guidelines* at [3.12],[3.16]
[193] Ex.10 *Health Related Emergency Response and Emergency Clinical Guidelines* at [3.1.9]

required to be given 24-hour access to emergency health care at Junee Correctional Centre, including access to nursing staff and telephone advice or personal attendance by a medical officer 7 days a week. Nursing staff are responsible for leading the coordination and management of a health-related emergency.[194]

222. According to the Guidelines, one registered nurse will assume the role of Health Coordinator and act as liaison with the Shift Manager or Code Coordinator regarding the attendance of an ambulance, the medical officer and advising of the patient's transfer. The guidelines reiterate that the decision to move the patient from the incident location to an external hospital will be made by the nurse or GP.[195]

223. The guidelines expect that all Junee Correctional Centre correctional and health staff are trained and orientated in relation to their respective responsibilities in a health-related emergency, with the HSM responsible for ensuring health staff are adequately trained and adhere to reporting requirements.[196]

224. Counsel Assisting submits that the 2015 protocol was ambiguous as to whether a nurse could transfer a prisoner without the doctor's authorisation which may have given rise to different understandings and approaches by nursing staff. The 2021 policy now makes it clear that a nurse does not require a doctor's authorisation to transfer a patient. However, counsel assisting noted that at the time the nurses gave evidence in February 2021 they were likely not trained about the then recent policy and guidelines and suggests a recommendation that the GEO ensure that training occurs so that all health staff are aware that nurses can call an ambulance to transfer a prisoner without a doctor's authorisation.

225. Counsel Assisting also referred to a change in the use of the cells in the medical unit. The evidence is that the medical unit has undergone significant renovation so that rather than two accommodation cells there are now eight. However, unwell prisoners are no longer accommodated in the medical unit except those who require observation in CCTV monitored observation cells "for the sole purpose of monitoring patients with deteriorating mental health.[197] Counsel Assisting noted that the 2021 policy indicates that a prisoner who is returned the correctional centre from the hospital may be placed in an observation cell or a treatment room. That policy seems to require clarification

[194] Exhibit 10 *Health Related Emergency Response and Emergency Clinical Guidelines* at [2.1] – [2.3]
[195] Exhibit 10 *Health Related Emergency Response and Emergency Clinical Guidelines* at [3.1.11]
[196] Exhibit 10 *Health Related Emergency Response and Emergency Clinical Guidelines* at [2.6], [2.8]
[197] Tab 161 Annexure JTM-4 to Fourth Te Maru Statement, *Observation Cells within the Health Centre*, the Junee CC Operating Manual at [1.1]

that it applies to only mental health patients as the observation cells are, according to the Junee Corrections Centre Operating Manual not for any other use.

226. Counsel Assisting pointed out that GEO Health were in August 2021 reviewing the local policy regarding the observation cells within the health centre and suggests a recommendation that the policy accurately reflects the importance of regular monitoring and notation, recognition of signs of deterioration in patients and clear procedures for escalation for the particular facilities and circumstances that exist at the Junee Correctional Centre health clinic. I have not seen the policy and would presume though that considering the purpose of the policy it would address those matters.

227. Junee Correctional Centre health staff need to be aware of the relevant Justice Health and NSW Health policies. Whilst Justice Health staff have the benefit of training and education on the Health Education and Training Institute ("HETI") platform, GEO health staff do not. GEO Group suggest a recommendation that "Justice Health advocate on its behalf to the Ministry of Health for GEO health staff at Junee CC to have access to training on the HETI system".

228. However, I decline to make such a recommendation due to Mr Lynch's submission on behalf of Justice Health that provides compelling reasons why such a recommendation would not be made:

i. The Health Education and Training Institute (HETI) provides training andeducation to clinical and non-clinical staff, trainers, managers across the NSW Health system.

ii. HETI is a statutory health corporation established pursuant to the *Health Services Act* 1997 (NSW). It is therefore a distinct legal entity to Justice Health and has its own Chief Executive and Board who report to the NSW Health Secretary and NSW Health Minister.

iii. Justice Health has no involvement or authority in respect of the day-to-day business of HETI, including the determination of which agencies or parties haveaccess to HETI training systems.

iv. Justice Health is not in a position to advocate on behalf of any private company, including GEO with respect to access to HETI.

v. Although Justice Health does not oppose GEO having access to the HETI system, this is a commercial decision which must be made by HETI, the NSW Ministry of Health and the GEO Group.

<u>Paracetamol</u>

229. The evidence in the inquest demonstrated that prisoners have ready access to paracetamol and that some, probably a lot, stockpile it. The ready access is due to

the policy that a prisoner can attend the pill dispensing counter and receive up to six tablets for a 24 hour period on a nurse initiated administration. After three days if the prisoner continued to request same, he would be assessed by the nurse. The protocol required the prisoner to ingest two of the tablets at the counter and take four away. Dr Corbett was shown Danny's medication chart and confirmed that from 2-9 October 2015 Danny obtained paracetamol tablets every day over the course of the 8 days. According to the records this amounted to 46 tablets.[198] This was in the addition of Danny's daily Naprosyn which he had been prescribed on 17 August 2015. On the basis that Danny had to ingest 2 tablets each of the 9 days before leaving with the remainder he could have stockpiled up to 28 tablets.

230. The hoarding of medications was well known at Junee Correctional Centre and Dr Corbett tried to initiate the reduction of the dispensing of paracetamol as an attempt to combat this. However, he said this proved unsuccessful due to the ongoing need for pain relief inprisoners with dental and other pain-inducing issues. Dr Corbett also knew that correctional officers would sometimes find a bag of medication and dispensing staffwere asked to identify which inmate the medication corresponded to. Mr E said that prisoners would stockpile paracetamol and exchange it for "buy-ups" or other items.[199] Mr E described paracetamol as the "*wonder drug of the Corrective Services*" because it is given out so frequently – this made stockpiling easier. In Mr E's experience, there was no education whatsoever given to prisoners about the risk of liver failure from excessive paracetamol. He agreed that many prisoners believed that taking paracetamol in large doses would get them 'stoned' because they did not understand it was the codeine ingredient that had the 'stoning' effect.

231. Since 2015 there had been a policy change to reduce the amount of daily paracetamol.[200] Since 2014, training in "*Identifying Inmates under the Influence*" has been deliveredto correctional staff at Junee CC. The training notes that "[p]aracetamol is the most common cause of intentional self-harm and acute liver failure." The training does not, however, provide guidance on recognising the signs of paracetamol toxicity andhow it should be treated. Counsel Assisting suggests that there are opportunities for better education to both prisoners and those working in correctional centres about the dangers of paracetamol toxicity and the recognition and treatment of it.

232. Professor Gunja gave evidence that acetylcysteine, ideally administered within eight hours of a paracetamol overdose, is an effective antidote. Though he agreed that it

[198] Transcript 24/2/21 T104.37; Tab 97gg, Telephone Order p82
[199] Transcript 24/5/21 T11.12.25
[200] Tab 161 Fourth Statement of Ms Te Maru 21 May 2021 at [19]; Transcript 26/5/21 T160

may have had benefit for Danny on 6 November 2015, given that Danny had not presented to the medical clinic until over 36 hours after he had ingested it, even if the acetylcysteine had been administered then, its effectiveness is seriously diminished.

233. Counsel Assisting put forward recommendations dealing with paracetamol toxicity as follows:

> "That Justice Health, in partnership with CSNSW (including privately operated correctional centres):
>
> (i) promote better education amongst the inmate population throughout NSW of the dangers of paracetamol overdose.
>
> (ii) Provide training to correctional staff and health staff at correctional centres throughout NSW on recognising and treating paracetamol overdose; and,
>
> (iii) Ensure that correctional centres are stocked with antidote acetylcysteine and medical staff are trained in the correct administration of the antidote
>
> That the GEO Group Health Services make available in the health clinic at Junee CC the paracetamol toxicity antidote acetylcysteine"

234. Mr Pickering on behalf of CSNSW opposes the recommendations and nominates that Justice Health is the appropriate organisation to address those recommendations. Ms Berberian on behalf of GEO also opposes the recommendations and adopts adopts Mr Lynch's submissions on behalf of Justice Health.

235. Mr Lynch on behalf of Justice Health says that paracetamol overdose is uncommon within the prison cohort despite its ready availability. Justice Health supports the education of prisoners in terms of the general advice readily available in the community which is "do not take more paracetamol you are prescribed". Mr Lynch says that the Justice Health Consumer Medicines Information (CMI) for paracetamol attached to the Adult Nurse Initiated Medication Protocol advises *"Prolonged use of paracetamol without medical supervision may be harmful. Contact the medical officer immediately if you have taken too much paracetamol".*

236. Justice Health would support a recommendation that it review the wording of the paracetamol CMI. The CMI should be reviewed to include in its warning the issue of misuse or overdose and set out the risk of harm and the range of possible symptoms at which a person should seek medical attention.

237. Justice Health does not support the suggested recommendation relating to training correctional and health staff to recognise and treat paracetamol overdose. Mr Lynch

points out that it is extremely difficult to diagnose paracetamol overdose based on physical signs or symptoms and that a patients reported clinical history and pathology, including testing for serum paracetamol concentration in blood is required.

238. Mr Lynch says that there is more benefit in providing education to corrective services and medical staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol. An information sheet prompting staff to inquire with an inmate as to the quantify of paracetamol ingested when they present would be useful. Such information would assist in determining the appropriate clinical management of a patient, particularly in circumstances where paramedics, clinical staff and/or after-hours doctors (ROAMS) become involved.

239. Counsel Assisting's recommendation regarding acetylcysteine is also opposed by Justice Health. Aside from pointing out that there was no evidence led in the inquest about this, Mr Lynch explained in his submissions the complexities of acetylcysteine and why a paracetamol overdose requires review by an Emergency Department team to determine the appropriate treatment, and patients who are suspected of suffering from paracetamol overdoses ought be transferred directly to a hospital for immediate management.

240. For those reasons I decline to make recommendations as advanced by Counsel Assisting. It is necessary however to make the recommendations suggested by Mr Lynch which helpfully meet those put forward by counsel assisting.

GEO Intelligence Urinalysis

241. An issue that was not identified during the coronial investigation but came to light in the inquest was the apparent relationship between GEO Intelligence and GEO Health staff in two particular respects. The first was the provision of lists of prisoners and their medication to GEO corrections so that when a prisoner was required by GEO Intelligence officers to undergo a random urinalysis sample, the tester would know what drugs should or should not be in the sample.

242. Without inquiring into the policy arrangements of that relationship the inquest heard evidence that Danny's medical attention was delayed on 5 November 2015 because RN Marsters was under instruction that the list was required on a prioritised basis that morning. Though RN Marsters said that he did not understand that it was urgently required[201], CO Withers was under the impression it was as she had to clear the area

[201] Transcript 24/5/21 T76.03

to allow RN Marsters to undertake the task[202] and she thought that the direction to RN Marsters "hindered him having to complete his own tasks and also seeing the other inmates that were there for sick parade as well[203]. Mr Doherty gave evidence that his understanding that such lists were prepared by the nurse over the night shift and were generally not urgent but there may have been some imperative attached to it that day[204]. Ms Te Maru expectation is that it was not a priority for a nurse to provide a list upon request to Intel for urinalysis when a patient requires care.[205]

243. It would appear that RN Marsters prioritised the provision of the list to GEO corrections over his duties to provide medical care to prisoners. That he was able to rely on CO Withers to observe Danny and report to him those observations is not an adequate practice. One remark in regards to the practice generally, GEO should ensure that in adopting such a practice it is not imposing upon its medical and clinical staff a risk of breaching patient confidentiality and placing at risk prisoner patient health.

244. The second aspect relates to RN Marsters sending to Mr Doherty an email at 3.09 pm on 5 November 2015 which said:

> *Hi Wayne*
>
> *Danny Whitton presented to the clinic this morning c/o nausea and vomiting. He denies any drug use but his observations seem to indicate otherwise.*
>
> *Requesting a drug urine screen please.*
> *Regards*
>
> *Alf Marsters RN*

245. The email[206] was copied to Ms Te Maru. Mr Doherty sent a response email at 3.10 pm requesting an officer to add Danny to the list for 6 November 2015. Ms Te Maru was again copied into that email chain.

246. The *Privacy and Personal Information Protection Act 1998* (PPIP Act) and the *Health Records and Information Privacy Act* 2002 (HRIP Act) requires 'agencies' such as

[202] Transcript 24/5/21 T36.02
[203] Transcript 24/5/21 T40.25
[204] Transcript 25/5/21 T149.45
[205] Transcript 26/5/21 T197.20

[206] Tab 162, Attachment WD-6 to First Statement of Mr Doherty, Email from A Marsters to WDoherty at 3.09pm on 5 Nov 2015

Justice Health CSNSW and GEO Group collecting 'personal information' or 'health information' from an individual, to ensure that the information is safeguarded from unauthorised disclosure and that **any** dissemination of the information is in accordance with legislation and policy which governs such disclosure.

247. Additionally, cl.288(2) of the *Crimes (Administration of Sentences) Regulation 2014* (CAS Regs) requires that correctional centre prisoner medical records are not to be divulged to any person outside Justice Health except in accordance with guidelines established by the Chief executive of Justice Health. There were applicable "Guidelines on the Use and Disclosure of Inmate/Patient Medical Records and Other Health Information".[207] Though Danny signed a consent for Justice Health to disclose health information "that was reasonably necessary for the functions of CSNSW…under Justice Health's duty of care" to Corrective Services NSW he did not provide such consent in relation to GEO.

248. Mr Doherty also said the email request made by RN Marsters was not common practice, although he could not recall whether this was the first time it had happened.[208] He said that a report from any staff member in the health centre that would warrant that the inmate be targeted for a urinalysis test may arise because "that's the action they're trained to make sure happens".[209] However, despite the policy requiring a written report from a medical officer[210] that was not the practice in 2015 or currently.[211] He said expectation of making a report was more relevant to custodial staff and there was no expectation that nursing staff report such observationsto the Intelligence Group,[212] although he understands the policy to mean requests for urinalysis tests could come from medical or correctional staff.[213] Mr Doherty states that there is no specific policy setting out when medical staff might request Intel to conduct urinalysis on an inmate.[214]

249. RN Marsters was unable to say why he sent this email other than that he may have been confused as to the task he had engaged in earlier that day providing to Intel the list of other prisoners' medications.[215] He accepted that neither task was for a therapeutic purpose. Despite this evidence he and Mr Doherty said it was not

[207] The Guidelines were stablished pursuant to cl.297 of the *Crimes (Administration of Sentences) Reg 2008* - the predecessor to cl.288 of the *Crimes (administration of Sentences) Reg 2014*
[208] Transcript 25/5/21 T150.39 – T150.45
[209] Transcript 25/5/21 T151.27 – T151.30
[210] Tab 162, Attachment WD-9 to First Statement of Mr Doherty, Urinalysis Sampling policy at3.4.1.1
[211] Transcript 25/5/21 T152.50 – 153.04
[212] Transcript 25/5/21 T151.27 – T151.50
[213] Transcript 25/5/21 T152.41
[214] Tab 162, First Statement of Mr Doherty 12 May 2021 at [37]
[215] Transcript 24/5/21 T74.15 – 74.30

common practice and Ms Te Maru said that despite being copied into the email was unfamiliar with such.

250. Counsel Assisting suggested that I might consider a censure in these findings rather than a referral of RN Marsters under s151A(2) of the Health Practitioner Regulation National Law (NSW). Alternatively Counsel Assisting suggested that I could find that "…Given that RN Marsters mistakenly thought that his duties as an employee of GEO Group required such notification to the Intel group, it may be that rather than a referral that the Coroner recommend to GEO that such a practice not be repeated and to ensure that their health service providers are not requested to engage in correctional matters". Ms Haider supports such a course and points out that if RN Marsters breached the Regulations so did Mr Doherty and probably Ms Te Maru. However, I do not accept her submission that RN Marsters thought that his email was "a misguided but honest attempt to assist the patient".

251. Counsel assisting also suggest a recommendation that GEO provide clear guidance and training to health service and correctional staff about the permissible collection, use and disclosure of health information. Ms Haider correctly submits that all nurses including the health service manager were aware of the practice of GEO Intel asking nursing staff to assist in the detection of offences by providing names of inmates and their medication. Ms Haider says that the information is provided without the consent of each patient and it appears to have no therapeutic purpose but that there was a possible overlap between security, patient safety and therapeutic care functions.

252. On behalf of GEO Ms Berberian says in her submissions "GEO considers the email request by RN Marsters to Mr Doherty on 5 November 2015 was an anomaly and one which was entirely inconsistent with the confidential nature of the therapeutic relationship. GEO accepts that such a disclosure is likely to perpetuate a general reluctance in inmates being forthcoming about theirpresenting histories and hence prohibitive to provision of appropriate health services. Whilst GEO considers that it is not necessary to educate the health staff about such fundamental matters as preservation of health information confidentiality, GEO would be more than willing to provide training to health staff about the permissible collection, use and disclosure of health information." GEO considers that the extension of that training to correctional staff as recommended by Counsel Assisting is not appropriate given this is an issue which relates specifically to health staff".

253. There is no evidence from GEO that they have carried out an audit and confirm that RN Marsters' email was an anomaly. Though one would hope it was, the language of

the email and the unquestioning response from Mr Doherty would suggest otherwise. I do not accept that the training should be restricted to health staff as the evidence in this inquest demonstrates that GEO correctional staff are engaged in health matters more than what one would expect and given that GEO employs both sectors it is important that the separation of their functions is implicitly and explicitly understood. Further, Mr Doherty did not question the email nor did the officers who he directed to carry out the task – even though Danny was in the medical unit. The evidence in this inquest demonstrates that a prisoner might not seek medical care for fear of a punitive rather than a therapeutic response and it needs to be addressed at Junee Correctional Centre.

254. Ms Berberian takes issue with the term "punitive" but in her submissions she overlooks the fact that a prisoner's refusal to provide a sample and the outcome of a "dirty urine" can be met by charge and penalty and placing a prisoner in segregation for the good order of the prison.

255. I am of the view that the recommendation put forward by counsel assisting is necessary as the evidence demonstrates that both corrections and medical staff have, even unwittingly, involved in inappropriate disclosure and use of health information and tasking.

Sufficiency of information provided to police investigating Danny's death

Incident Package

256. An issue that arose during the inquest included the information contained in the Briefing Package provided by GEO to the police officer Detective James who was tasked with preparing a brief for the coroner. Counsel assisting submits that GEO Group should have ensured that all incident reports, log books, briefing notes and other relevant material were provided to investigating policeand/or those assisting the Coroner in a timely way and not 5 ½ years after they were written.

257. Mr Scott Brideoake, General Manager of Junee Correctional Centre at the time of Danny's death, said that the "*practice was to collate the incident reports of staff who had relevant interactions with an inmate and for a briefing note to be prepared*" and provide this to the Corrective Services Investigation Unit (**CSIU**) of NSW Police Force

as part of the'Incident Package'.[216] He said Mr Doherty was tasked with preparing the Incident Package and briefing note. [217]

258. Mr Doherty gave evidence that he, at that time, had not previously engaged in such a task and sought advice from other managers about what to include in the package. Later, it was apparent that it was Mr Brideoake who settled and provided the package to the Detective James.

259. As part of the original internal investigation by GEO Group, Mr Doherty interviewed Mr C on 9 November 2015 and made a briefing note containing that conversation. However, the briefing note that was included in the Incident Package to Detective James[218] had been amended from the original version thereby removing any reference to the interview with Mr C. The longer, fuller briefing note was produced for the first time to the inquest as WD-1, attached Mr Doherty's statement dated 12 May 2021. In oral evidence, Mr Doherty had no explanation for why the briefing note he wrote on 9 November 2015 had been edited and that there were two versions.[219] He said a number of senior staff had access to the electronic document.[220] After giving his evidence Mr Doherty provided an explanation in a further statement that he had excised reference to Mr C's interview as he was advised to do so by other officers. I note that Detective James also interviewed Mr C on 9 November 2015 and it may be due to that fact that the version provided to Mr Doherty was considered unnecessary. If that was the case, that is unfortunate as the contents of the interviews taken together would have assisted the investigation and the inquest.

260. More important was the list of witnesses and their incident reports. On 11 November 2015 CO Withers made an incident report relevant to 5 November 2015. Her name and copy of her report was not included in the Package. The identity of Mr E as being a cellmate when Danny deteriorated was not known until the inquest was well on foot. In his second statement Mr Brideoake conceded that a number of correctional officers' incident reports obtained by GEO should have been included in the report but were not. He did not offer an explanation as to why they were not.[221]

261. The investigation also experienced the all too common problem of not having access to the names of the clinical and medical providers who dealt with Danny. Statements

[216] Exhibit 8, Second Statement of Mr Brideoake 9 July 2021 at [5]
[217] Exhibit 8, Second Statement of Mr Brideoake 9 July 2021 at [38]
[218] Tab 11.7 Briefing Note – Death in custody dated 9 November 2015
[219] Transcript 25/5/21 T133.29, T148.29 – T149.04
[220] Transcript 25/5/21 T156.40
[221] Exhibit 8, Second Statement of Mr Brideoake 9 July 2021 at [29-33]

were not taken until over 3 years later. Given the paucity of note making in the clinic, reliance on memories effected the reliability of evidence.

262. Ms Berberian submits that Detective James' investigation was on a very different trajectory than that which was the focus of the inquest. Detective James determined that Danny's continued use of illicit drugs, specifically (an overdose of methadone and buprenorphine) coupled with the fact his liver was in poor condition contributed to his multi-organ failure. He found that "no policy or procedures were breached" in relation to his death in custody. He determined that there should be no recommendations as there were no issues with any care and treatment at the clinic and that Danny was sent to hospital as soon as it became apparent his condition was deteriorating. Further he commended Junee Correctional Centre's attempts to stop prisoners from diverting methadone and buprenorphine and stated that it should be best practice used in all prisons.

263. Ms Berberian correctly identifies that the police investigation did not focus on the medical treatment at the unit and it was not until the reports of Associate Professor Holdgate and Professor Gunja in 2019 that it became an issue.

264. The problem of determining what issues should be investigated and what evidence should be obtained in this case highlights the need for better supervision from the outset which may now be improved given the commencement on 24 September 2021 of Coronial Practice Note 3 of 2021 relating to Deaths in Custody which will also be accompanied by the First Nations People Draft Protocol.

265. However, the determination of what "incident" is relevant to be included in the package could have been identified by Mr Doherty as being the incident referred to by Mr C when he said that bags of regurgitated methadone are passed under the doorway to a prisoner and for Danny this occurred on buy up day. Mr C and other prisoners also told Detective James about Danny's movements until he went to the clinic. CCTV in relation to Danny from buy-up day until he left the prison on 7 November 2015 could have been kept – he was in a video recorded observation cell for about 48 hours. Its utility is particularly relevant for this case given the poor record keeping and observations and work practices inside the medical unit.

266. This could have been identified by GEO as operators of both the correctional and health services. Detective James did not seek it nor did GEO provide it. Danny's death was not understood to be anything other than a self-inflicted accidental drug overdose and this inquest shows that such a bias is a disservice to not only the

coronial investigation but more importantly to Danny and his family who need answers as to what happened to him.

Keeping the CCTV Footage for Coronial Investigation

267. Mr Doherty gave evidence that CCTV footage is available for six weeks. CCTV footage was available for the entire time Danny was at the clinic but the only footage secured and provided to the investigation was the "incident" of Danny being admitted into the clinic the afternoon of 5 November 2015 and the "incident" when he exited the clinic in the afternoon of 7 November 2015.

268. Mr Doherty's determination of what footage to copy and keep was guided by advice from either the Deputy Operations Manager or the Operations Manager that only these parts were "recordable incidents"and relevant to the investigation.[222] This was despite not knowing the cause of Danny's death, there being reports of Danny vomiting, showering for long periods in the day or other movements made by Danny during this time in the clinic. Mr Doherty said he was new to the role and had not dealt with a similar matter previously so relied on advice.[223] Though the policy relating to CCTV footage states that "all recordings of evidentiary value must be downloaded from the CCTV system",[224] there is no guidance as to what is considered of evidentiary value. As Ms Berberian submissions addressed it may well be dependent on what the focus of the investigation is.

269. Though the responsibility for managing the CCTV footage fell to the Correctional Manager, Intelligence, which at the time was, ironically Mr Doherty himself ,[225]he did not hand it to the investigating police. Mr Doherty said that he understood that the process was that the police would arrive at the centre and would view it to see if it was relevant. Mr Brideoake said that Junee CC was guided by any further requests for information and assistance from the CSIU. [226] Though the provision of information appears to be as good as the request made for it, these issues could not be progressed at the inquest as Detective James was not available.

270. Ms Ainslie Wood, former Contracts Compliance Manager GEO Group, could not explain why CCTV might be available from 5 and 7 November 2015 and missing from 6 November 2015, as it has been "*standard practice for a long time that CCTV footage*

[222] Transcript 25/5/21 T136.22
[223] Transcript 25/5/21 T370.6-137.45
[224] Transcript 25/5/21 T144.10, T145.45
[225] Transcript 25/5/21 T142.16 – 142.18
[226] Exhibit 8, Second Statement of Scott Brideoake 9 July 2021 at [13].

is captured in relation to the death in custody". [227] Ms Wood said that since Danny's death, efforts are made to capture relevant CCTV from at least 24 hours before a person's death in custody. [228] The evidence in the inquest demonstrates that 24 hours would be the bare minimum and each case should be carefully assessed, any error should fall on the side of caution. Counsel Assisting suggests a recommendation that all CCTV footage for up to 7 days be kept until the coroner investigating the death orders otherwise.

271. Mr Pickering on behalf of CSNSW submits that selecting and keeping 7 days of footage would involve the need for correctional officers to look at multiple CCTV cameras throughout the correctional centre and taken Statewide that would amount to thousands of hours of time. He submits that the recommendation therefore is impracticable. Ms Berberian for GEO adopts this submission.

272. It is unclear how "thousands of hours of time" is calculated. Most prisoners are locked in their cells or their pods for up to 16 hours a day, their movements such as going to the clinic, the yard, being in the common area, going to education or welfare or the phones are or should be generally known. In Danny's case, his whereabouts were known from the moment he left the pod and went to the clinic. He spent two days in an observation cell which unlike most cells has CCTV recording 24/7. Further, there are thankfully, not the large number of deaths in custody in NSW which would make such a task impracticable. The hours spent in copying and keeping the footage would likely save the more hours which are involved in a coronial investigation and inquest to determine what had happened.

273. The identification and securing of relevant evidence in a correctional centre should be better achieved by the commencement of the Coronial Services PN 3 of 2021.

<u>Buvidal Depot Program</u>

274. The UNLOC-T Clinical Trial of the Depot Buprenorphine (Depot) in the correctional system began in November 2018. NSW Health sponsored the program and by January 2020 the Buvidal Depot program was rolled out across the correctional centres of NSW.[229] The Depot is used in place of the methadone and involves a

[227] Transcript 26/2/21 T27.40
[228] Transcript 26/2/21 T28.25

[229] Tab 158 Statement of Stephen Ward at [5] – [7]

weekly or monthly intramuscular injection of a slow-dissolving gel. It is therefore incapable of being diverted.

275. All inmates requiring OST are now started on the Depot as opposed to methadone. Less resources are required and the old triage system is not necessary. [230]

276. The Depot program is apparently very successful in preventing diversion of prescribed opioid medication. As at 18 May 2021, in Junee CC, of the 161 inmates on the OTP (formerly OST) Program, 120 were on the Depot.

277. In Mr E's opinion, as an inmate with many years' experience in custodial settings, the introduction of the *Buvidal* injection program was "*the best thing they could have done in the gaol system*", as it prevents diversion and 'stand- overs'.[231] RN Bryon said that prisoners will trade anything and it still goes on.

278. Mr A was in custody when he gave evidence and was asked about the difference between the OST program in 2015 and the recently released depot program. In his experience the depot program is much easier to access compared to the methadone and buprenorphine programs saying: "Methadone they just straight out refuse you and back then there was Bupe but they would straight out refuse you for that too. There's no way. Now, with the injection, it's only been around for maybe a year, year and a half, it's pretty easy to get onto."[232]

279. I agree with Mr Rees' submission that had Danny been able to access the OST program he wouldn't have used illicit and dangerous drugs whilst in prison. Mr Rees submits that there is still a delay in prisoners accessing the program and that as at May 2021 there were at least 41 prisoners receiving liquid methadone at Junee Correctional Centre. He puts forward a recommendation that all Opiate Agonist Treatment (OAT) should be intra muscular injection, and staffing levels at Junee Correctional Centre be reviewed to ensure a reduction in the waiting time for eligible custodial patients to commence OAT. I decline to make this recommendation. It was an issue completely outside the scope of this inquest. There is no evidence to suggest that the wait time has anything to do with staffing levels. Rather, applications for OST

[230] Tab 158 Statement of Stephen Ward at [11] – [12]
[231] Transcript 24/5/21 T10.34
[232] Transcript 22/2/21 T28.18

are submitted to Justice Health and then determined by the Pharmaceutical Regulatory Unit of NSW Health.

280. When Danny was transferred to the Royal Prince Alfred Hospital in Sydney, CSNSW communicated with Danny's parents so they could attend hospital. Danny was on life-support and his parents were understandably extremely stressed and upset. Despite being on life support Danny was under guard as he was in lawful custody. Ms Knight found the experience traumatising and was upset with how she was treated by the officer in charge and corrective services custodial officers. The inquest heard evidence from two of those officers.

281. The officers were required to comply with policy but Ms Cooper points out in her submissions that CSNSW policy that applied in November 2015, *13.2 Deaths in Custody, Corrective Services NSW Operations Manual* does not address any procedure around hospital admission under guard and how staff should communicate with family members in the event an inmate is in a serious condition in hospital. One of the incidents involved when Danny's life support was turned off and his mother wanted to physically touch him to be with him but was told that she was unable to as it was a crime scene. CO Moisan denied using that terminology but rather said "Please ma'am, you cannot touch the body", and "I'm sorry, it's the procedure". The police officer in charge then told Ms Knight that she could be with Danny.

282. The Corrective Officers had received no training about dealing with family in such situations and were open to the opportunity should it be provided. Ms Cooper suggests that a recommendation be made to CSNSW that they develop best practice guidelines for communications with families, in particular for First Nations deaths in custody cases.

283. Mr Pickering on behalf of CSNSW submits that "the Corrective Services Officers in attendance at the hospital acted in compliance with their operational guidelines, and in a professional and appropriate manner in what were difficult and emotional circumstances". He does not address the suggestion of a recommendation. I accept

that submission and I think the evidence was insufficient for me to conclude that specific training in relation to this is required.

284. It is hoped that the Coronial Direction PN 3 of 2021 together with the First Nations Protocol will go some way in improving relationships between families and their loved one.

Conclusion

285. I now enter formal findings pursuant to section 81 of the Act:

Identity:

Danny Keith Whitton

Date of Death

9 November 2015

Place of Death

Royal Prince Alfred Hospital, Camperdown, Sydney NSW

Manner of Death

Danny died after ingesting an overdose of paracetamol at Junee Correctional Centre operated by GEO Group Australia Pty Ltd. Danny's condition was not appropriately investigated as blood tests were not actioned and Danny's condition was not appropriately monitored, his deterioration was not appropriately actioned in a timely manner due to overall suboptimal care and a significant misunderstanding of the transfer procedure of a patient from the health clinic at Junee Correctional Centre to the Wagga Wagga Base Hospital. Danny's condition was irrecoverable despite appropriate intervention at that hospital and then his transfer to the Royal Prince Alfred Hospital. Danny died whilst he was in the custody of Corrective Services NSW.

286. The Recommendations I deem necessary are as follows:

To GEO Group Australia Pty Ltd

i. Ensure that training occurs so that all health staff are aware that nurses can call an ambulance to transfer a prisoner without a doctor's authorisation.

ii. Ensure that GEO Health Service policy accurately reflects the importance of regular monitoring and notation, recognition of signs of deterioration inpatients

and clear procedures for escalation for the particular facilities that exist at the Junee Correctional Centre health clinic.

iii. Provide training to health staff and corrections staff about the permissible collection, use and disclosure of health information.

To Justice Health and Mental Health Forensic Network

i. Provide training to staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

ii. Develop an information sheet for health and correctional staff which will prompt staff to inquire with an inmate as to the quantity of paracetamol ingested when they present and provide pathways for staff to take regarding any paracetamol overdose.

iii. Conduct a review of the Paracetamol Consumer Medicines Information to ensure it includes a warning about the misuse or overdose of paracetamol, the risk of harm and the range of possible symptoms and an indication as to when a person should seek medical attention.

Corrective Services NSW (and on behalf of privately operated correctional centres in NSW including GEO Group Australia Pty Ltd)

i. Provide training to staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

ii. Provide information to inmates which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

iii. Implement policy and practice to retain a copy of CCTV footage capturing the last 7 days of movements of a person who has died in custody and only release such footage upon an indication by a senior coroner that such footage is no longer required for the coronial investigation and inquest.

287. I wish to acknowledge that this inquest was held far too distant from when Danny died. That the investigation encompassed a narrow and incorrect perspective and hasty conclusion of the events prior to Danny's transfer to hospital is understandably distressing to Danny's family. It is hoped that these findings go some way to correct

that situation. I again pass on my condolences to Danny's parents, children, family and friends.

288. The inquest is now closed.

E Truscott

Deputy State Coroner

19 November 2021