CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of John O'Donnell
Hearing dates:	27 March 2023, 18 September 2023 and 20 September 2023
Date of findings:	27 September 2023
Place of findings:	NSW State Coroner's Court, Lidcombe
Findings of:	Magistrate E Kennedy, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – mandatory inquest – cell placement – whether medical condition adequately managed
File number:	2019/280398
Representation:	Ms S Danne, Counsel Assisting instructed by Ms A Boatman and Ms A Petch of the Crown Solicitor's Office Mr B Fogarty, instructed by Mr V Musico of the Department of Communities and Justice Legal, representing the Commissioner of Corrective Services Mr P Rooney, instructed by Mr B Ferguson of Hickson's Lawyers, representing Justice Health and Forensic Mental Health Network

Findings:	**The identity of the deceased** The deceased person was Mr John O'Donnell **Date of death** 8 September 2019 **Place of death** Westmead Hospital, New South Wales **Cause of death** Complications of metastatic neuroendocrine lung carcinoma **Manner of death** Natural Causes
Recommendations	***1. That the Justice Health and Forensic Mental Health Network give consideration to amending the template the Health Problem Notification Form to include a field expressly prompting assessment and advice relating to cell placement including as to any recommendations for group cell placement, lower or upper bunk placement and top or lower landing placement***
Non-Publication Orders	Non-publication orders prohibiting publication of certain evidence pursuant to the *Coroners Act 2009* have been made in this Inquest. A copy of these orders, and corresponding orders pursuant to section 65 of the Act, can be found on the Registry file.

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INTRODUCTION

1. This is an inquest into the death of John O'Donnell who was 73 years and serving a sentence of imprisonment when he died on 8 September 2019 at Westmead Hospital. Mr O'Donnell died of complications arising from metastatic neuro-endocrine lung carcinoma, commonly known as lung cancer.

The purpose of the inquest

2. The coroner's primary function is set out in s. 81 of the *Coroners Act 2009*. It is to make findings as to the identity of the person who has died, the date and place of their death and the manner and cause of death. The inquest is not adversarial, but inquisitorial. The focus is to determine what happened without attributing blame, guilt or making findings of liability.

3. In this case, there is no controversy as to identity, date or place of death. The manner and cause of death were the subject of the inquest.

4. This is a mandatory inquest pursuant to section 23 of the *Coroners Act 2009* ("The Act"). When any inmate dies in custody, the Act requires that a Senior Coroner undertakes an inquest. This is important given those inmates are reliant upon the care of the State, and have no ability to access any necessary care or treatment themselves. It is incumbent on the State to ensure that necessary and appropriate medical and psychological treatment is provided, to maintain basic human rights and dignity, particularly when an inmate is terminally ill and requiring end of life palliative care.

Reflection on the life of Mr O'Donnell

5. It is important to reflect on the life of Mr O'Donnell. He was convicted at an older age of serious crimes, however his wife and daughter remained in regular contact with him throughout his time in custody. His daughter provided a family statement about her recollections of her father.

6. Mr O'Donnell had spent most of his early life living on the Central Coast of New South Wales. He married and had two children. He was also then a step-father to three of his first wife's children from a prior relationship. Mr O'Donnell separated from his first

wife in around 1985. He then remarried in 1987. He had a further two children with her, and two step-children from his wife's previous relationship.

7. Mr O'Donnell had been diagnosed with end stage lung cancer earlier in 2019, the year of his death. His medical team at the time determined that he was unlikely to respond to chemotherapy and was not suitable for surgery, given the advanced stage of the cancer.

8. On 31 May 2019, shortly after his diagnosis, Mr O'Donnell was sentenced to a term of imprisonment for very serious offences and entered custody at Silverwater Metropolitan Remand and Reception Centre ("MRRC" or "Silverwater"), where he was to serve a 20 year sentence for those crimes. His earliest release to parole would have been on 30 May 2029.

9. At MRRC, Mr O'Donnell was initially assessed by both Corrective Services NSW ("Corrective Services") and Justice Health & Forensic Mental Health Network ("JHFMHN" or "Justice Health") staff. A brief medical history of his lung cancer and other physical difficulties was provided to Corrective Services and was acknowledged in his intake documents. It appears that similar information, including certain details of his lung cancer diagnosis, was provided to Justice Health.

10. As part of the intake interview and documentation process undertaken by Corrective Services, notes taken included:

    (a) That Mr O'Donnell *"can't walk well, won't be able to climb stairs, lives with lung cancer…"*;

    (b) That he *was "not steady when walking, will need to be on lower floor and lower bunk";* and

    (c) That he was "*old and frail*".

11. Justice Health arranged for various medical appointments in relation to Mr O'Donnell's health issues. This included an appointment with both a General Practitioner and a primary health nurse on 3 June 2019.

12. Mr O'Donnell was then scheduled to have a number of further appointments, including those detailed by Mr Shaun Connolly in his statement:

a) Dr Chin, Medical Oncologist, Prince of Wales Hospital, urgent triage level 1, with the following notes attached to the PAS entry: *Lung cancer - appt with Dr Chin. PT MUST BE SEEN - DO NOT CANCEL*

b) Primary Health Nurse, semi-urgent triage level 2, with the following notes attached to the PAS entry: *for BACAT, ECG.BGL. MMSE and penumovax please*

c) Population Health Nurse, non-urgent triage level 4, with the following notes attached to the PAS entry: *EDP 03/06/19 NAO, Hep B non-immune. Waitlisted for vac*

d) Primary Health Nurse. Urgent triage level 1, with the following notes attached to the PAS entry: *hx of Lung Ca, poor progress, for palliative care, please do BACA T as per NUM*

13. One of those included an appointment at Prince of Wales Hospital with a Medical Oncologist, Dr Melvin Chin, for specific care in relation to Mr O'Donnell's lung cancer. Mr O'Donnell was escorted to that appointment on 7 June 2019, and saw Dr Chin along with Dr George Wells.

14. In total, Mr O'Donnell remained at Silverwater for just under a month after his arrival. On 28 June 2019, Mr O'Donnell presented at a Justice Health nursing consultation with cold and flu like symptoms, including difficulty breathing and a temperature.

15. As a result of that presentation, an appropriate and immediate Section 24(1) Order for medical escort to Westmead Hospital was signed that day. It required Mr O'Donnell to be, among other things:

a) under the guard of an armed Corrective Services officer at all times; and

b) handcuffed, ankle cuffed and treated as high risk at all times.

16. Mr O'Donnell was transferred by NSW Ambulance to Westmead Hospital that same day.

17. Over the next few weeks, Mr O'Donnell remained at Westmead Hospital under regular supervision and care. He was declared palliative on 5 September 2019, after having been at Westmead Hospital for just over two months. Thereafter, he was managed at

Westmead Hospital under an end of life care plan. He remained under Corrective Services guard during that time, until he died a few days later on 8 September 2019.

Issues dealt with prior to the hearing

18. Mr O'Donnell's wife and daughter each raised a number of issues in their respective statements. Those issues can broadly be categorised as addressing the general care and attitude towards Mr O'Donnell, including the treatment of and communication with his family.

19. Prior to the hearing, through the facilitation by the team assisting, Corrective Services made available one of its three Deputy Commissioners, Dr Anne Marie Martin, who was able to meet with Mr O'Donnell's family to discuss a number of those issues. As a result, an issue was removed from the final issues list following the successful discussion. Corrective Services should be congratulated for participating in such a productive and helpful discussion, and equally Mr O'Donnell's family, for generously agreeing to participate in what would have been a very difficult discussion. It should be noted that this type of process is all part of the coronial role, and contributes to the coronial process in a meaningful way.

Cause of death

20. In relation to cause of death, the evidence was that Mr O'Donnell was suffering from terminal lung cancer. When diagnosed, his cancer had progressed to a stage where it could not be treated by chemotherapy or surgery.

21. The Medical Certificate relating to Mr O'Donnell which was signed at Westmead Hospital records the Cause of Death as *"Sepsis"* along with antecedent causes, which included *"Metstatic* (sic) *lung cancer*", with "*pulmonary embolism"*, "*pneumonia"* and "*stroke"*.

22. However, the evidence to be preferred is that of the autopsy report by Dr Jennifer Pokorny who was able to confirm the direct cause of death as *"complications of metastatic neuroendocrine lung carcinoma",* without mention of sepsis. No specific antecedent causes were noted, nor were there any other significant conditions contributing to Mr O'Donnell's death.

23. Follow up enquiries were made with Dr Pokorny. She provided a supplementary report which explained the difference in the cause of death listed in the original death certificate as against her finding in the autopsy report.

24. Dr Pokorny provided an opinion that the individual conditions listed on the death certificate were accurate based on the medical records, but that the order of causation in which they were listed was not possible.

25. That is, the carcinoma could not have arisen due to the pulmonary embolisms, the pneumonia or the stroke, all of which were listed on the death certificate as antecedent causes of death. Rather, both the pulmonary embolisms and pneumonia were unrelated complications of the cancer, and the sepsis was a complication of the pneumonia.

Security allocation

26. Mr O'Donnell was classified with a security allocation of "A2" on and from 14 June 2019.

27. An allocation of "A2" is defined in clause 12(1) of the *Crimes (Administration of Sentences) Regulation* 2014 as: "*the category of inmates who, in the opinion of the Commissioner, represent a special risk to good order and security and should at all times be confined in special facilities within a secure physical barrier that includes towers or electronic surveillance equipment."*

28. That "A2" classification carried over into the Section 24 Order relating to his transfer to Westmead Hospital. That allocation has been the subject of evidence from Corrective Services. As noted earlier, that security allocation required, among other things, that Mr O'Donnell be under Correctives Services guard at all times, and that he be handcuffed, ankle cuffed and treated as high risk at all times.

29. The evidence demonstrates that the security allocation was available to be made at the time it was given, pursuant to policies then in place, and also that it was not an inappropriate allocation, acknowledging the difficult balance of factors both for and against.

30. Those factors were set out in the statement of Governor Wilkinson. Governor Wilkinson notes the factors against allocating the "A2"

rating included the "Aged/Frail" alert that was recorded in the Corrective Services System, and the fact that Mr O'Donnell was experiencing a life-threatening condition, breathlessness, and was requiring immediate hospitalisation.

31. In favour of the "A2" classification for the purpose of transfer to Westmead he noted the following:

    a) the nature of the serious offences;

    b) sentenced to imprisonment of 20 years with non-parole period of 10 years;

    c) the Justice Health medical certificate triggering Mr O'Donnell's hospital transfer did not identify medical grounds making restrains inappropriate;

    d) the most recent Health Problem Notification Form ("HPNF") at the time, dated 11 June 2019, did not specify a palliative status sufficiently advanced as to render Mr O'Donnell immobile and incapable of escape. Indeed, it is clear that Mr O'Donnell was not "immobile"; and

    e) was already classified as A2 since 14 June 2019.

32. An important aspect of the security allocation was that Mr O'Donnell was, as a consequence, required to be restrained once he left Silverwater and even while hospitalised at Westmead.

33. Governor Wilkinson gave his opinion that, in those circumstances, it was not inappropriate for the officer signing the Section 24 Order to assess Mr O'Donnell as "A2" and "high risk".

34. Acknowledging the factors against restraint noted by Governor Wilkinson, it does appear that, based on the policy then in place, the decision was not inappropriate at the time and for the then current purpose of transfer to hospital.

35. A separate question arises as to whether the risk assessments were then re-assessed at any point in time.

36. There appears to have been an administrative issue in that Corrective Services has conceded the relevant documentation relating to Mr O'Donnell cannot be located, which presents difficulty in ascertaining whether or not any re-assessment did take

place. On the evidence available, I accept that, in any event, no re-assessment occurred that resulted in any downgrade of the security assessment.

37. Mr Wilkinson has conceded that the classification should have been re-assessed if not prior then, at the very least, at the time that Mr O'Donnell was declared palliative.

38. Governor Wilkinson's statement notes that Corrective Services has since revised the relevant policy. The current version of COPP 19.6 (V1.11) commenced on 26 May 2021. Section 2.2 of that policy makes it explicit that restrains should not be applied if the inmate patient's general medical condition renders handcuffing inappropriate. The example provided within the policy for that category related to "*aged and frail who relies on walking aids*".

39. Mr Wilkinson gave evidence that, if Mr O'Donnell were to be assessed today, it would not be appropriate to assess him as requiring restraint by hand and ankle cuffs.

40. This is a significant improvement to the policy, and it appears to reflect a more humane approach to someone in Mr O'Donnell's circumstances without posing any security risk or exposing Corrective Services staff, medical staff or the community to any other apparent risk as a result. The option for an inmate to remain under guard can still be utilised even where restraints are no longer necessary.

41. A number of steps have been taken, as detailed in the statement of Mr Wilkinson, to improve the training and administrative compliance of staff in connection with medical escorts generally since the death of Mr O'Donnell.

Timing of transfer to Westmead Hospital

42. The timing of Mr O'Donnell's transfer to Westmead Hospital has been the subject of documentary evidence in this inquest.

43. Corrective Services had completed a Serious Incident Report ("the Report") dated 26 June 2020, investigating Mr O'Donnell's death. One finding in the Report that raised an issue was the finding at paragraph 4, that Mr O'Donnell was transferred to Westmead Hospital by reason of two Justice Health nurse diagnoses relating to Mr O'Donnell being palliative, on or around 11 June 2019. Given that Mr O'Donnell was not transferred to Westmead Hospital at that time, this raised a question around whether there was an inappropriate delay.

44. A statement has been provided by Mr Joseph Kemperle, the Investigations Manager at Corrective Services. Mr Kemperle was also one of the reviewers of the Report. He confirmed in his statement that the finding in paragraph 4 of the Serious Incident Report was incorrect.

45. Mr Shaun Connolly confirmed that immediate transfer to an inpatient healthcare facility was not clinically indicated at the time of Mr O'Donnell's arrival at Silverwater, or otherwise prior to his transfer to Westmead Hospital. Mr Connolly confirmed that the transfer occurred as a result of the clinical deterioration with which Mr O'Donnell presented to Justice Health staff on 28 June 2019, the day of the resulting transfer.

ISSUES REMAINING AT INQUEST HEARING

First issue – cell placement

46. Both Mr O'Donnell's wife and daughter, in their respective statements, made reference to their knowledge of Mr O'Donnell being located on the top floor at Silverwater. In evidence it was established that he was on the top floor for almost the entire time that he was at Silverwater. This meant that he was required to traverse a set of stairs several times a day, to comply with correctional centre requirements, and to access exercise facilities and meals.

47. There is evidence that Mr O'Donnell was noted by Corrective Services staff on a number of occasions as, among other things, being old and frail, suffering from breathlessness and not being suitable for either top bunk or "top landing" placement, meaning placement on the first floor as opposed to the ground floor.

48. No specific recommendation regarding cell placement was included in the HPNF forms which were provided to Correctives Services by Justice Health. Based on the written evidence, it appears that had such a recommendation been included by Justice Health, Correctives Services would have been likely to comply with that recommendation.

49. Even absent such a recommendation, it was not clear why Mr O'Donnell was not given a lower floor placement in any event, given the information available to Corrective Services.

50. At least two opportunities were missed to enable Mr O'Donnell to be more comfortably and sensibly located on the ground floor given his serious health issues, age and frailty.

51. The first related to the evidence from Ms Kathy Saul, Manager of the Statewide Disability Service ("SDS"). She was able to explain that the purpose of the SDS team was to make an assessment from the Corrective Services position as to recognising an inmate with a disability and including any recommendations related to that disability in the OIMS system. In this case, an assessment of Mr O'Donnell found him to be aged and frail, and bottom bunk, ground floor location was recommended as a result. This was entered into the OIMS system. This placement was not followed by Corrective Services. Mr Wilkinson explained that usually this would be followed, and so accepted that either it was missed, or alternatively the assessment was completed after the bed allocation had already been made. However, he was then allocated to several different cells and as such it would seem that no regard was had to the recommendation.

52. Mr Wilkinson helpfully conceded that Mr O'Donnell should have been placed on the ground floor and was not. Mr Wilkinson said that if that recommendation had been noted on the HPNF, that would have been followed in this case, given there were no other competing interests in relation to Mr O'Donnell. Mr Wilkinson was a very impressive witness, he noted the error, and explained that there are opportunities for Corrective Services officers generally to raise concerns about physical limitations of an inmate. He explained that it is not an uncommon experience for a Corrective Services officer to request Justice Health to assess an inmate for this reason.

53. Mr Shaun Connolly, Nurse Manager Operations, Access and Demand Management with Justice Health and Forensic Mental Health Network, also gave evidence. He also very helpfully reviewed the case notes and files that related to Mr O'Donnell. He accepted that Justice Health also has an important role to play in cell placement, but significantly raised the issue that both Corrective Services and Justice Health share this role and each should be performing assessments. This was a very important piece of evidence in the proceedings and generally. The system should work in a way, particularly in the case of a visible physical disability, where either service can raise the matter and require the issue of cell placement to be revisited. He also agreed that it

was missed in this case, and that it was appropriate for there to be a notation for lower bunk and ground floor in order to facilitate better care of Mr O'Donnell.

54. Mr Connolly also noted, however, that at this particular facility ground floor rooms are harder to come by, and it might be as a result that practice has developed not to make the request for ground floor placement in the specific location (Darcy) in MRRC. However, his view was that the notation and request should still be made in accordance with policy.

55. One way to address this would be to have a specific location on the HPNF, to address cell placement and specifically include residential level and bunk suitability. This is a very simple thing to do, and could result in a more humane result for some inmates. Mr O'Donnell's physical challenges were obvious and yet this was missed. There are circumstances where a disability may not be so obvious, and this prompted consideration would allow the clear extraction of an important detail that might not be obvious for a new and inexperienced inmate to think to raise.

56. Although both Corrective Services and Justice Health have a role in this space, it seems that Corrective Services will be heavily guided by the HPNF, and as such it is a sensible question from their perspective also.

Second issue – Lanreotide injection

57. Mr O'Donnell had been prescribed a drug called Lanreotide prior to his incarceration at Silverwater. This prescription had been determined by Dr Rajat Rai, the treating medical oncologist in charge of Mr O'Donnell's care at Dubbo Base Hospital. Dr Rai was assisted by Dr Elizabeth Connolly. Both of them had seen Mr O'Donnell for the first time on 7 May 2019.

58. Dr Rai, in his undated statement at Tab 113 of the Brief, confirmed that Lanreotide is a "somatostatin analogue" used primarily for symptom control. He noted a study which presented possible evidence of an anti-proliferative antitumor effect in a different type of cancer, specifically in relation to gastro entero pancreatic tumours, but in any event confirmed that "somatostatin analogues" are not known to improve survival. That evidence is consistent with that of a later oncologist who saw Mr O'Donnell.

59. Dr Rai described two choices of somatostatin analogues for use in patients such as Mr O'Donnell, being Lanreotide and Octreotide.

60. Dr Rai selected Lanreotide for Mr O'Donnell's treatment. The prescription noted that Lanreotide was to be administered via monthly injection, and the first dose was administered at Dubbo Hospital on 21 May 2019, just one week before he went into custody at Silverwater.

61. On the evidence, it appears that Mr O'Donnell was not administered with his monthly injection after having been detained at Silverwater. The medication records of Justice Health do not show that Lanreotide was administered, and Mr Hugh Norris of Justice Heath confirmed that the medication record is the most reliable record of what medications were administered.

62. Separately, Justice Health had, appropriately, made certain requests for information for earlier medical records of Mr O'Donnell. Those enquiries made by Justice Health included a request for information to Narromine Shire Family Health Centre (Mr O'Donnell's GP) on 3 June 2019, and to Dr Connolly at Dubbo Base Hospital on 4 June 2019.

63. Each of those organisations responded to the request for information. However, neither of the responses included information relating to the Lanreotide prescription.

64. Furthermore, a Justice Health General Practitioner had referred Mr O'Donnell to Prince of Wales Hospital for the appointment with Dr Chin on 7 June 2019, referencing that Mr O'Donnell was being treated with monthly injections, but flagging that the specific type was *"(?unknown)"*, further confirming that the type of injection remained unknown to Justice Health.

65. In his statement, Dr Chin provided that the monthly injection would be a long-acting somatostatin analogue, either Octreotide or Lanreotide. This aligns with Dr Rai's considerations. It appears that Dr Chin elected to prescribe Octreotide rather than Lanreotide.

66. The referral noted the next date for administration of the injection was on "18/3/19", which appears to be an error in the reference to March, given that the referral was written in June, and the handwritten progress notes referred accurately to "18/6/19".

67. Dr Chin did not administer either injection during the appointment on 7 June 2019, and noted that Mr O'Donnell was not yet due for the injection. Dr Chin appears to have assessed in any event that the next dose was in fact intended for 18 or 19 June, based on the information in the referral letter from Justice Health recording that the injection was to be administered on 18 March 2019 and 4 weekly thereafter. He scheduled a follow up appointment for 19 July 2019, which he states that Mr O'Donnell did not attend.

68. The evidence suggests that Prince of Wales Hospital did not provide paperwork to Justice Health after that appointment, nor any instruction or recommendation to the referring doctor about the medication dose and frequency, as set out by Dr Melvin Chin.

69. Despite the lack of information flow to Justice Health from other health service providers, Justice Health had been notified of a requirement for a monthly injection and knew the likely timing of that injection, possibly due to information from Mr O'Donnell himself. The progress notes recorded by the Justice Health GP on 3 June 2019 make this apparent, noting *"monthly injection ?immunotherapy?? next due 18/6/19"*.

70. That is also consistent with information Mr O'Donnell had provided to Corrective Services during his intake, for example in the Intake Screening Questionnaire on 31 May 2019, which noted that he required a "injection one month". In both instances, it appears that Mr O'Donnell may not have known or conveyed the name of the prescribed drug. It was also the case that his daughter recalled having a conversation about this issue with a Justice Health nurse, although Justice Health does not have any record of that conversation.

71. Accordingly, the fact that there is no evidence of Justice Health ever receiving specific information confirming the name of the drug to be administered monthly, seems to support the likelihood that the medication records are accurate.

72. After hearing from Mr Connolly on behalf of Justice Health in relation to this matter, it seems that Justice Health worked initially very quickly to obtain his records, and that the records obtained failed to provide detail of this drug. Mr O'Donnell was seen very promptly by an outside facility who took over his care. This drug would not have

improved his outcome, and would not have necessarily assisted him in palliative care. Nonetheless it was an important issue to consider, given Mr O'Donnell had no capacity to source the drug himself, and was reliant on Justice Health and treating doctors to ensure he received his prescribed treatment.

73. In this case the only observation that can be made is that Justice Health should have, on the evidence, followed up the discharge documentation from Prince of Wales Hospital which would have disclosed the prescribed injection. It was acknowledged in evidence that this was an error, and there is a procedure in place that should have been followed to obtain that information. It is however also important to recognise that he was in MRRC for a very short period of time before his care was transferred externally to Westmead Hospital. From the time of his transfer Justice Health had no further reason to pursue the details of his records.

CONSIDERATION OF SUBMISSIONS

74. In relation to Corrective Services, submissions were made that there had been compliance with policy in some respects, but it was accepted that the OIMS reference to cell placement had been missed in this case. Support was given to further and better communication between Justice Health and Corrective Services. I agree there is to be no criticism of any individual in relation to the care and treatment of Mr O'Donnell.

75. In relation to the proposed recommendation, Corrective Services noted that it is not directed to it. However, it does support mechanisms of improving communication between Justice Health and Corrective Services.

76. The submissions on behalf of Justice Health were that there is a policy in place to ensure notification of appropriate cell placement, in particular in relation to bunk allocation and floor allocation. It is submitted that there is no need to make any policy changes as a result, and on the evidence before me and on the facts of this case I agree.

77. It was noted that Mr Connolly conceded that there should have been a reference to Mr O'Donnell requiring a lower bunk bed and a cell on ground floor in the HPNF. I accept that there is no inference to be made in relation to any individual as a result of this concession, the inquest was looking at systems and processes and the concession made was helpful and constructive.

78. Submissions were also made that the HPNF is not singularly determinative of cell placement. Other sources of information remain relevant for placement decisions, and Corrective Services also have a part to play in that assessment. That was agreed to in the evidence.

79. It was submitted on the part of Justice Health that the failure to specify on the HPNF that Mr O'Donnell required a lower bunk and cell on the ground floor was not a systems failure. However, it appears on the evidence that certainly in this location it is not the case that notations of this nature are common. A simple prompt on the HPNF form may assist improving this situation in the future.

CONSIDERATION OF RECOMENDATIONS

80. A single and very simple recommendation was proposed by Counsel Assisting. This is considered by Justice Health to be neither necessary nor desirable. Justice Health provided a supplementary statement of Mr Shaun Connolly dated 22 September 2022, being a third statement. The statement disclosed that Justice Health NSW have taken steps to develop and design an HPNF e-form which will replace the current paper version. It is anticipated that this form will communicate more detailed health information to Corrective Services NSW and will provide a more prescriptive form for Justice Health staff completing the form, including in relation to cell placement. On page 16 of the proposed form is a section in relation to "cell placement" which requires the Justice Health NSW staff member to contemplate the specific type of cell placement.

81. This proposed form includes the option to identify: "assistance required", "ground floor" and "lower bunk". As such, it is suggested that this recommendation is not necessary.

82. It is unfortunate that this material was not able to be provided to the inquest while sitting in hearing, or indeed prior to the inquest, particularly where the issue being discussed was cell placement for an individual with physical challenges as a result of serious illness and age. There is no criticism of Mr Connolly who has sought to now provide the information, however this was a matter known to Justice Health but not made available at a time that permitted it to be explored more fully in evidence.

83. The submission is made that Justice Health has already given the matter "consideration", therefore making the proposed recommendation superfluous.

84. The rationale and strength of any recommendation comes from the findings supporting it, the story behind it and importantly the deceased person's life that is prompting and promoting it.

85. The evidence highlights the lacuna in the form, and at this stage the e-form remains a proposal, and is only anticipated to be in operation at a future date. It is currently not. On that basis I intend to make a recommendation to promote further support for the working group to ensure the changes do become a reality.

CONCLUSION

86. This is a simple recommendation that hopes to support those in the future who are physically infirmed through disability, ill health or mental illness. The purpose is to promote the extension of basic human compassion and dignity to those who remain liberty deprived and depend upon the State to provide practical, appropriate and basic care to cater for individual physical restrictions.

Recommendation

That the Justice Health and Forensic Mental Health Network give consideration to amending the template the Health Problem Notification Form to include a field expressly prompting assessment and advice relating to cell placement including as to any recommendations for group cell placement, lower or upper bunk placement and top or lower landing placement.

Acknowledgments

87. To the representatives to the interested parties to the proceedings for their assistance and helpful submissions, and for facilitating the production of information to ensure relevant matters were the issues in the inquest.

88. To Ms Boatman, Ms Petch and Ms Danne of Counsel for thorough and careful consideration of issues and presentation of the inquest. It was particularly outstanding in this matter that the team assisting facilitated a conference between Corrective Services and Mr O'Donnell's family to address important and pressing issues.

89. I extend my sincere condolences to the family of Mr O'Donnell for their loss.

FINDINGS

90. I make the following findings pursuant to Section 81 of the *Coroners Act 2009* (NSW):

The identity of the deceased

The deceased person was Mr John O'Donnell

Date of death

8 September 2019

Place of death

Westmead Hospital, New South Wales

Cause of death

Complications of metastatic neuroendocrine lung carcinoma

Manner Of Death

Natural Causes

Signed

Deputy State Coroner Magistrate E Kennedy

27 September 2023