CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Charles Yan
Hearing dates:	18-20 June 2024
Date of findings:	3 July 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death from drug overdose of a person in correctional centre – was supervision of inmates adequate – was emergency response appropriate – question of recommendations.
File number:	2018/328285
Representation:	Counsel assisting the inquest: K Holcombe of Counsel i/b NSW Crown Solicitor The Commissioner for Corrective Services NSW: V Wei, Solicitor Advocate Department of Communities and Justice, Legal. Members of Mr Yan's family: P McManus of Counsel i/b Legal Aid NSW

Findings:	**Identity** The person who died is Charles Yan. **Date of death**: Charles Yan died on 25 October 2018. **Place of death**: Charles Yan died at the Outer Metropolitan Multi Purpose Centre, Berkshire Park NSW **Cause of death:** The cause of Charles Yan's death is mixed drug toxicity (MDMA, methylamphetamine and methoxyamphetamine). **Manner of death:** Charles Yan died as a result of an accidental drug overdose, while he was in lawful custody.

Non-publication orders prohibiting publication of certain evidence pursuant to section 74(1)(b) of the *Coroners Act 2009* [the Act] have been made in this inquest. A copy of these orders, and corresponding ones pursuant to section 65(4) of the Act, can be found on the Registry file.

1. Section 81(1) of the Act requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

2. In the early morning of 25 October 2018, Charles Yan aged 30 years died in prison. An inquest into the circumstances of his death is mandatory, because he died while he was in custody in a NSW Correctional Centre. Responsibility for his health care was therefore in the hands of the State.

The role of the Coroner

3. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

4. In addition, pursuant to section 82 of the Act, the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Charles' life

5. Charles Yan's family has asked that he be referred to as 'Charles' in this inquest.

6. Attending each day of the inquest were Charles' aunt Thyda Sin, and/or Charles' sister Felisha Rose, who brought her baby daughter with her for some of the time. Charles' mother Hoeun Yan did not feel able to attend the inquest in person, but she was very much there in spirit. Charles' family provided to the courtroom a beautiful photograph of him, and at the close of the evidence Felisha spoke lovingly about her brother on behalf of the family. She told the court that Charles was a kind, funny and loving person who was deeply missed. The sadness of Charles' family due to his passing has not been helped by the long wait for this inquest. We who work in this under-resourced jurisdiction witness every day the additional hardship caused to bereaved families on account of these long delays.

7. Charles was born on 16 January 1988. When he became an adult he worked as a tradesman. He did not marry or have any children. According to Corrective Services records, Charles began using cocaine and MDMA from the age of seventeen years.

8. On 20 March 2015 Charles was sentenced to a term of imprisonment of seven years and seven months, back-dated to commence on 2 January 2015. This followed his conviction for conspiring to import a commercial amount of a border controlled drug. Charles would be eligible for parole on 1 January 2019.

The issues at the inquest

9. There is no question as to the cause of Charles' tragic death. Forensic pathologist Dr Rebecca Irvine performed a post mortem examination. She did not find any external or internal injuries. However, toxicological analysis of Charles' blood detected:

    - a non toxic concentration of MDMA
    - methoxyamphetamine at a concentration which has been reported within the fatal range
    - a toxic to lethal concentration of methylamphetamine
    - a non toxic concentration of buprenorphine.

10. Dr Irvine stated that MDMA is a hallucinogenic stimulant class drug. Methylamphetamine is a stimulant, and methoxyamphetamine has hallucinogenic properties. Dr Irvine explained that any concentration of MDMA and methylamphetamine can cause sudden and unexpected death.

11. Dr Irvine concluded that Charles had died as a result of mixed drug toxicity (MDMA, methylamphetamine and methoxyamphetamine). There is no dispute that this was the cause of Charles' death, and this is how I have recorded it.

12. The inquest focused on the following issues:

    - whether the inmates of the area where Charles was accommodated were adequately supervised on the night of his death; and
    - whether he received appropriate care and assistance that night.

Charles' medical history

13. Chares did not have any significant medical problems. Nor did he have any reported mental health issues. When he entered custody he informed health staff that he had a history of polysubstance dependence including alcohol, benzodiazepines, psychotropic drugs, stimulants, and anabolic steroids.

The Outer Metropolitan Multi Purpose Correctional Centre

14. Soon after entering custody Charles was transferred to the Outer Metropolitan Multi Purpose Correctional Centre [the OMMPCC], which is located about five kilometres south of Windsor NSW. The OMMPCC is now known as the Geoffrey Pearce Correctional Centre. It is part of a complex of three different correctional

centres, now collectively known as the Francis Greenway Correctional Complex. The OMMPCC was a minimum security centre for male inmates.

15. On 23 February 2016 Charles was placed in OMMPCC's B Wing, a residential unit which accommodated 18 inmates. He had been reclassified as a 'C2' inmate, meaning that in the opinion of the Commissioner of Corrective Services NSW [the Commissioner], he did not need to be confined by a physical barrier, and needed only minimal supervision by correctional officers.

16. The inmates of B Wing were able to move freely around their unit, and were not locked in their individual rooms. It is for this reason that B Wing was known as an 'open wing'. At any time, its inmates were able to access a common area which had a kitchen, bathroom and living area. At the inquest Mr Malcolm Brown, who is the General Manager of Statewide Operations for Corrective Services NSW, explained that open wings are designed to replicate as far as possible the housing conditions of life in the community. Thus their inmates enjoy a higher degree of autonomy than other inmates, and a correspondingly lower level of supervision by correctional staff.

17. Each cell in B Wing had a cell call alarm, known as a 'knock up' alarm. This is for use by inmates if they need the assistance of a correctional officer. When an inmate knocks up, the call is transmitted to a control room, which is staffed at night by a correctional officer.

18. In 2018 there were no CCTV cameras within B Wing. The inquest heard however that in open wings throughout the new buildings (equivalent to B Wing which has been knocked down) in the correctional centre, there are now CCTV cameras located in the common areas. Mr Brown told the inquest that the purpose was to enhance safety within the open wings, by increasing deterrence of illegal activities such as drug use.

The night of 24 October 2018

19. For the most part, there is no dispute about what took place on the night of 24 October 2018.

20. Four of the men who had lived with Charles in B Wing gave evidence at the inquest. They had all known Charles for some time before he died. All spoke warmly of him as a good and kind person, and they had been very distressed by his death, a distress which they continued to feel. They had chosen to give

evidence at the inquest, for the sake of Charles' family members and their need to know what happened.

21. These witnesses told the court that what they termed a 'party night' had been planned for 24 October 2018. Notably, one witness WH told the court that 'party nights' were not at all uncommon in B Wing at that time.

22. At around 8.00pm that night, Charles and some fellow inmates consumed a paste which the witnesses understood contained MDMA. Some saw Charles take a second amount at about 11.00pm. One witness, DR, said that Charles had also smoked buprenorphine before and during his taking of the MDMA.

23. DR told the court that at first Charles had seemed '*chilled out'* after taking the paste, but he had then became very affected. He was '*really blank'*, was *'not responding'*, and was unsteady on his feet. According to witness AB, he was mumbling and not making any sense. Witness TP observed that Charles was sweating profusely, grinding his teeth and had very enlarged pupils. According to witness WH, sometime after midnight Charles became very agitated and was twitching and kicking.

24. At about 1.00am a group of inmates walked Charles to the bathroom and showered him with cool water. They then took him back to one of the rooms and laid him on a bed. At least two other inmates remained in the room with him. They felt relieved to see that he appeared to be calming down, and they assumed that the effects of the drugs were starting to wear off. TP commented that Charles seemed to '*come to'*, and was making more sense.

25. None of the witnesses who observed these symptoms had thought that Charles needed medical help. Most had either used drugs themselves or been around others who did. They told the court that they didn't consider Charles' presentation unusual for someone who had taken amphetamines.

26. At some point however AB became concerned. Charles started mumbling the words *'I feel sick'*. DR noticed that his breathing had become shallow, and this was the first time he began to think that Charles was in fact very unwell.

27. WH was in his own room when he heard one of the men shouting '*Charlie's dead' or 'Charlie's stopped breathing'.* WH ran in and saw that Charles' lips were blue. Another inmate, TP, checked Charles' wrist and neck for a pulse, but he could not find one. Nor could he see any rise and fall of Charles' chest.

28. One of the inmates, possibly WH, went to the cell alarm and buzzed it for help. Records show that the time was now 3.35am.

29. Inmates (TP, DR and perhaps WH) commenced cardiopulmonary resuscitation [CPR]. DR and TP said they had been trained in giving CPR while in employment, and both had also undertaken further training while in custody. WH also had been trained in CPR while in custody.

The knock up calls and resuscitation effort

30. According to cell call alarm records, the first 'knock up' call was made from B Wing at 3.35am. It was answered 47 seconds later by Correctional Officer John Fifita, who was at his station in the control room. The ensuing conversation took two minutes and 39 seconds. It appears that other inmates made knock up calls as well, in the seconds and minutes after the first call.

31. According to Mr Fifita's Incident Report, the first knock up call took place '*at about 3.40am'* and the caller told him that an inmate was *'not breathing'.* These details also appear in Mr Fifita's statement, which he provided to the investigation police on 25 October 2018.

32. Mr Fifita told the court that he understood this to be a medical emergency, and in accordance with CSNSW procedure he immediately contacted the Senior Correctional Officer, Kevin Priest.

33. In his statement of the same date, Mr Priest recorded that there had been a knock up call at about 3.40am '*that an inmate in cell 32 B Unit was not breathing'*. These details are reflected in the Incident Report which he prepared at about 7.00am, a few hours later.

34. At the time of Mr Fifita's call, Mr Priest was with two other correctional officers in an area called the lunch room. Mr Priest had an automated external defibrillator [AED] with him. CCTV footage confirms that the three officers walked to the nearby duty office, where they retrieved a first responder kit. They were joined by a fourth officer, and all four made their way on foot across the yard towards B Wing. They arrived there at about 3.42am.

35. Mr Priest told the court that the group of officers had walked quickly towards B Wing. Running was not recommended, he said, because the lighting was poor and the ground was uneven due to rabbit holes.

36. Although Mr Priest's Incident Report suggests that before setting out for B Wing he summoned the duty night nurse, this is at odds with his oral evidence. At the inquest he said that he did not call for the nurse until he had arrived at the scene, and had assessed that this was indeed a medical emergency. I will return to this issue later in these findings.

37. On arrival Mr Priest saw two inmates performing CPR on Charles, who was lying on a mattress which had been placed on the floor. Mr Priest positioned the AED pads onto Charles' chest, but the device recorded there was no shockable rhythm. This generally means that the heart's electrical system has shut down and there is no heartbeat. In such cases the AED cannot provide any help to the patient, and it is recommended that CPR continue.

38. Mr Priest asked the two inmates if they were alright to continue CPR, as he could see they were performing it competently and had achieved a good rhythm. They replied that they were.

39. NSW Ambulance records show that an ambulance was requested at 3.44am, and its paramedic crew were at Charles' side by 4.02am. In the meantime Registered Nurse Annchen Bornman, who was the duty night nurse, arrived at the scene at 3.50am. She provided what medical treatment she could, while noting that Charles was unresponsive and had no heartbeat.

40. The inmates' CPR efforts continued until the paramedic team took over.

41. Despite the efforts to resuscitate him, Charles did not regain consciousness at any time. The ambulance records show that for the entire time the paramedics were present his heart was in asystole, meaning that it was not beating at all. He was pronounced deceased at 4.25am.

42. I turn now to the issues which were examined at the inquest.

Were the supervision arrangements for B Wing inmates adequate?

43. Charles' family was very disturbed to learn that illicit drugs had been so freely available to him while he was in B Wing. This naturally caused them to query

whether security arrangements within B Wing had been sufficient to safeguard his health and security, and that of his fellow inmates.

44. At the inquest the court heard that there are legitimate reasons for housing certain inmates in an open style of accommodation. As General Manager Mr Malcom Brown explained, for inmates who pose a low security risk it is considered good policy to place them in accommodation which replicates the conditions to which they will be returning on their release. Inevitably this approach involves a lower level of supervision by correctional officers. I accept that this is the case.

45. Nevertheless it was welcome news that since Charles' tragic death, open wings in the correctional centre are now subject to an additional layer of supervision. Their common areas are now monitored on a 24 hour basis by CCTV cameras. Mr Brown told the court that this measure is designed to reduce the level of illegal activity within those wings, including drug taking.

46. It would be naïve to suppose that this measure has had a decisive effect on the scourge of illicit drug use within NSW prisons. However according to one of the former inmates who gave evidence at the inquest, it has helped to create what he described as a 'calmer' environment in the open wings. This also was Mr Brown's impression.

47. There is therefore some evidence that the introduction of CCTV monitoring has enhanced the health and safety of inmates, and I commend this measure.

Did Charles receive appropriate care and assistance on the night of 24 October 2018?

48. The witnesses who were housed with Charles at the time of his death gave varying accounts of the speed with which correctional officers responded to the knock up calls.

49. Witness TP told the court that it took the officers *'a long time'* to arrive. His initial evidence was that he and his fellow inmates gave Charles CPR for two hours before any help arrived. On reflection however he agreed that he had not been looking at the time, as he was focused on trying to keep Charles alive, but that it had certainly felt like a long time. This also was the impression of witness AB.

50. However witness WH's recollection was that the officers came '*quite quickly'.*

51. Evidence derived from the cell call alarm records was tendered at the inquest. As I have noted, these establish that the first knock up call was made at 3.35am, and was answered 47 seconds later. Senior Correctional Officer Priest and the accompanying officers can be seen on CCTV footage retrieving the first responder kit and arriving at B Wing at 3.42am. The request for an ambulance was made two minutes later. Registered Nurse Bormann arrived at the scene at 3.50am, and the ambulance crew at 4.02am.

52. I accept that given the practical realities, these response times were reasonable despite the tragic outcome. This was also the opinion of emergency specialist Professor Anthony Brown, whose evidence is now examined.

The evidence of Professor Anthony Brown

53. Professor Anthony Brown is an Emergency Medicine specialist with the Royal Brisbane Women's and Children's Hospital. He has extensive professional experience in emergency and trauma medicine, including the treatment of drug overdose.

54. Dr Brown was asked to provide his expert opinion on the adequacy of the care given to Charles on the night of 24 October 2018.

55. Having reviewed the briefing material, Dr Brown concluded that the care Charles received was *' ..not just adequate and appropriate, it was both exemplary and timely. It gave Mr Yan the very best possible chance of survival.'*

56. In particular Dr Brown commended the efforts of Charles' fellow inmates to save his life, commenting:

> *' … the initial response of Mr Yan's inmate colleagues to rapidly call for help and provide immediate and prolonged CPR, particularly mouth-to-mouth by TP, and external cardiac massage performed by inmate DR was heroic, and particularly commendable … These inmates gave Mr Yan absolutely the best possible chance of survival.'*

57. Furthermore, Dr Brown found no fault with other aspects of the care provided to Charles, including the use of the defibrillator, the efforts of the night nurse, and the resuscitation attempts of the paramedics. He considered that the response times and the actions of the correctional officers were reasonable in the circumstances.

58. At the inquest Dr Brown told the court that in his opinion, no other treatment could realistically have been given to Charles that night which would have saved his life.

59. Dr Brown explained this conclusion. He said that survival of a cardiac arrest in an out-of-hospital setting is possible only if there is a shockable rhythm, and defibrillation is provided within about 6-8 minutes of the arrest. But he thought it most unlikely that Charles' heart had any shockable rhythm when he collapsed. On the report of Charles' fellow inmates, he appeared to have gone quiet very quickly, and he had almost certainly been in asystole when the correctional officers arrived. Dr Brown commented that the chance of surviving a cardiac arrest where there is a non-shockable rhythm *'is essentially negligible'.* Unfortunately Charles' heart had stopped:

> *' …in a rhythm that could not then be started by a defibrillator. This is an almost universally fatal situation'*.

60. At the inquest Dr Brown was questioned about the symptoms which Charles had begun to display after midnight. Charles' inmate colleagues had observed that he was sweating, agitated, unsteady on his feet, and not making sense. Dr Brown confirmed that these symptoms are typical of amphetamine toxicity. Amphetamines can cause a rapid pulse, high blood pressure, very high body temperature and hyperthermia, leading to abnormal heart rhythms and the risk of cardiac arrest. There is thus a strong association between use of stimulants such as amphetamines, and sudden cardiac arrest.

61. Dr Brown explained that because of this strong association, when a person who is known to have taken stimulant drugs is brought into the Emergency Department, the standard treatment will include cardiac monitoring. In addition, symptomatic treatment will be given: IV fluids, oxygen, and sedating medication to reduce the patient's high levels of agitation and consequent physiological stress.

62. At the inquest, witnesses AB and DR expressed deep regret that they had not called for medical help when they first noticed these signs. DR spoke of his sadness at the thought that if they had acted earlier they might have been able to save '*a really decent person'.*

63. But Dr Brown was clear that he would not have expected Charles' fellow inmates to have sought medical help any sooner than they did. In his opinion, there was nothing about Charles' appearance, before his sudden collapse soon after 3.30am, that would have indicated to a layperson that he was about to suffer a cardiac arrest. Prior to that, his signs and symptoms would have appeared to be typical of a person who had taken stimulant drugs. The first abnormal indication was that he stopped breathing, at which point his fellow inmates had immediately sought help and commenced CPR.

64. Furthermore Dr Brown did not consider that Charles' period of calmness after the shower would have alerted the inmates watching over him. A layperson would reasonably suppose, as they did, that the effect of the drugs was wearing off, and they would not have predicted that a cardiac arrest was imminent.

65. I accept Dr Brown's expert evidence on these matters. I note that in submissions on behalf of Charles' family, Mr McManus expressed their appreciation and gratitude for the efforts which Charles' fellow inmates made to try to save his life.

66. Regarding the adequacy of the response to Charles' emergency by the correctional officers, I find that this was reasonable and appropriate. Although Charles' life could not be saved, the steps taken by the correctional officers in response to his emergency were reasonable in light of policies in place at that time. I will return to this topic shortly.

The question of recommendations

67. In her submissions Counsel Assisting proposed three recommendations.

68. The first was that CSNSW policy be amended to expand the descriptors of a medical emergency. This recommendation relates to CSNSW's *Custodial Operations Policy and Procedure 5.5: Cell Security and Alarm Calls* [COPP 5.5].

69. This policy instructs correctional officers on the steps they must take when an inmate activates a cell call alarm. In particular, Part 2 of the policy describes the circumstances in which officers must immediately go to the cell where the alarm has been activated. At the time of Charles' death, these circumstances included '*a medical emergency or serious health problem such as chest pain or difficulty breathing'*.

70. At the inquest, Dr Brown was informed of COPP 5.5 and in particular Part 2. Although he considered that the contents of this policy were appropriate, he thought it would be useful to expand the descriptors of *'a medical emergency or serious health problem',* to include terms such as '*collapsed; not breathing; turning blue'; loss of consciousness; loss of signs of life'*. These, he said, were the most likely signs to a layperson that an incident required an immediate medical response.

71. I accept Dr Brown's evidence on this point. In submissions on behalf of the Commissioner, the court was informed that the Commissioner supports this proposal. Furthermore, I have since received into evidence a revised version of COPP 5.5 which was published internally on 21 June 2024. The revision implements the recommendation proposed by Counsel Assisting. As a consequence, Table 1 has been expanded to include two further descriptors: *'collapse or loss of consciousness'*, and *'loss of signs of life (turning blue, not breathing'.* This prompt response on the part of the Commissioner is very welcome, and removes the need for me to make this particular recommendation.

72. The other two proposed recommendations arise from Charles' family and their expressed desire that more be done to encourage inmates to knock up earlier, in the event of a drug overdose emergency.

73. In making this submission on behalf of the family, Mr McManus was clear that Charles' family accepted that to his fellow inmates, it would not have been apparent that Charles required medical help sooner. They wondered however whether more information about the signs of drug toxicity might lead inmates to seek medical help at an earlier stage.

74. The evidence of Charles' fellow inmates was that in their experience, most inmates did knock up when they or another inmate needed emergency help as a result of a drug overdose. This was despite a reported reluctance among some to do so, for fear of possible disciplinary consequences arising out of the drug use.

75. Nevertheless, witnesses AB and DR expressed regret that they had not known at the time that Charles needed to be in hospital. When Mr McManus asked DR if he thought it would be useful for inmates to be given more information about the signs of drug toxicity and the need to knock up for help, DR strongly agreed. Dr Brown also considered this to be a very useful suggestion.

76. At the inquest it emerged that CSNSW do prepare and disseminate materials which are designed to help inmates identify the signs of serious drug toxicity and the need to seek immediate medical help. The materials include the Health Safety Tips Program. The court heard that similar information is also available to inmates on the tablet devices with which they are issued.

77. The precise content of the information available on tablet devices was not available to the inquest. This is not a criticism of CSNSW or their legal representatives, as the existence of this material emerged at a late stage in the inquest. The consequence however is that it was not possible to hear evidence as to how efficacious this material is, and the degree to which it is absorbed within the inmate community.

78. In light of this, Counsel Assisting proposed two further recommendations:

    - That there be a review of the information provided to inmates regarding drug overdose and toxicity, first aid, and the need to seek medical assistance, and that the review include consultation with inmates
    - That CSNSW consult with appropriate first aid experts as to whether any improvements could be made to the above information.

79. The evidence heard at the inquest suggests that such a review would be useful, and would have the potential to enhance the health and safety of inmates. I endorse the proposal made by Charles' family that the review process include consultation with the target group, namely the inmates themselves.

80. It was again encouraging to hear from Counsel for the Commissioner, that there was support for both recommendations. With regard to the information on drug toxicity provided to inmates on their tablet devices, it was noted that this content belongs to the Justice Health and Forensic Mental Health Network.

81. There is one final matter for comment.

82. I have mentioned that according to his evidence at the inquest, Senior Correctional Officer Priest did not call for the night nurse to attend Charles until he (Mr Priest) had personally attended the scene and assessed that this was a genuine medical emergency. Mr Priest explained that there are occasions when inmates knock up for frivolous or 'prank' purposes, and therefore it was often necessary to verify that the call related to a real emergency.

83. Nevertheless it was surprising that Mr Priest evidently considered that a report of an inmate '*not breathing'* required verification before calling for the nurse. In his evidence he said that he would still consider a report of this nature to require verification. It may be thought that information of this gravity would justify an immediate call. This was Dr Brown's comment also.

84. It is the case that at the time, COPP 5.5 did not require that the Officer in Charge summon the nurse immediately in the case of medical emergency. Mr Priest therefore was not in breach of any policy or protocol in not doing so immediately after he was notified of the knock up call.

85. After Charles' death certain changes were made to COPP 5.5. The evidence at inquest included a statement, which Mr Malcom Brown endorsed, of Mr Wayne Taylor who formerly held Mr Brown's position. In his statement Mr Taylor referred to the 2021 *Inquest into the death of Nathan Reynolds.* In that inquest the court had been critical of deficiencies in the response of correctional officers to Mr Reynolds' medical emergency.

86. Mr Taylor stated that following that inquest, amendments to COPP 5.5 have been made which include the following:

    - that correctional officers are to move urgently (ie quickly) to the location when they are alerted to a serious medical incident; and
    - that the Officer in Charge must immediately alert the night nurse on duty, or NSW Ambulance, if a correctional officer cannot immediately attend or a nurse is not available at that particular correctional centre.

87. These amendments are welcome.

88. However, in light of Mr Priest's evidence at inquest that he would consider a knock up report of an inmate '*not breathing'* to require verification before calling a nurse, Counsel Assisting submitted that there was a basis for the Commissioner to consider issuing a reminder to all correctional staff of the requirement, pursuant to COPP 5.5, to immediately alert the night nurse if the circumstances set out in Part 2 are present.

89. I endorse these comments, and ask that the Commissioner does give consideration to issuing such a reminder to correctional staff.

Conclusion

90. On behalf of all at the Coroners Court, I offer Charles' family my sincere sympathy for the loss of their much loved son and brother.
91. I express my appreciation to the Assisting team for their work in preparing and presenting the evidence at inquest, and to the representatives of the interested parties for their cooperation. My thanks also to the Officer in Charge, Detective Senior Constable Chris Bruzzone.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died is Charles Yan

Date of death:

Charles Yan died on 25 October 2018.

Place of death:

Charles Yan died at the Outer Metropolitan Multi Purpose Correctional Centre, Berkshire Park NSW.

Cause of death:

The cause of Charles Yan's death is mixed drug toxicity (MDMA, methylamphetamine and methoxyamphetamine).

Manner of death:

Charles Yan died as a result of an accidental drug overdose, while he was in lawful custody.

Recommendations

To the Commissioner of Corrective Services NSW [CSNSW]:

1. That CSNSW undertake a review of the information provided to inmates concerning drug toxicity/overdose, including recognising the signs of overdose, first aid management of persons experiencing overdose and seeking assistance for overdose, within the:
    - CSNSW's Health Survival Tips Program; and
    - inmate intranet portal, accessible through inmate tablet devices

including in consultation with representatives of the inmate community and, where necessary, with the Justice Health and Forensic Mental Health Network, and any relevant external providers.

2. That consideration be given to consulting with an expert in first aid management of persons who are suffering from drug toxicity, for the purpose of determining if any improvements could be made to the information provided to inmates in recommendation 2 above.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner, Lidcombe
3 July 2024