



**CORONERS COURT
OF NEW SOUTH WALES**

Inquest:	Inquest into the death of Ronald Brizzolara
Hearing dates:	7 February 2017
Date of findings:	17 March 2017
Place of findings:	State Coroners Court, Glebe
Findings of:	Deputy State Coroner Teresa O'Sullivan
Catchwords:	CORONIAL LAW – Cause and manner of death Death in custody Cell alarm failure Natural causes
File number:	2014/315543
Representation:	Mr Jake Harris, CSO, Assisting, instructed by Ms Jessica Murty, CSO Mr Griffiths for Corrective Services Ms Szulgit for Justice Health

<p>Findings:</p>	<p>Identity of deceased: The deceased person was Ronald Brizzolara</p> <p>Date of death: Mr Brizzolara died on 25 October 2014</p> <p>Place of death: He died at Long Bay Correctional Centre, Malabar, NSW</p> <p>Manner of death: He died in custody of natural causes</p> <p>Cause of death: Congestive Cardiac Failure Antecedent cause: Chronic Obstructive Pulmonary Disease; Other significant conditions: ischaemic heart disease; obesity</p>
<p>Non-publication order:</p>	<p>No publication of the contents of Tab 37 of exhibit 1</p>

Table of Contents

Introduction:	1
The Inquest:	1
The Evidence:	1
Background:	1
Events of 25 October 2014:	2
Cause of death:	4
Cell call alarm system:.....	4
Mr Brizzolara's cell call alarm:	5
Investigation into the problem:	6

Changes since the death:	6
Findings required by s81(1).....	8
The identity of the deceased.....	8
Date of death	8
Place of death.....	8
Cause of death	8
Manner of death.....	8

The Coroners Act 2009 (NSW) in s81 (1) requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Ronald Brizzolara.

Introduction:

This is an inquest into the death of Ronald Brizzolara, who died on 25 October 2014 in custody at Long Bay Correctional Centre, Malabar NSW. He is survived by his sister, Wendy.

The Inquest:

The function of this inquest, as reflected in s. 81 Coroners Act 2009 (“the Act”), is to identify who has died, the date and place of death, and the manner and cause of death. Section 82 of the Act permits the Coroner to make such recommendations she considers necessary or desirable in relation to any matter connected with the death. As Mr Brizzolara died in lawful custody, this inquest is one that is required to be held.¹

The Evidence:

Background:

Mr Brizzolara was born on 1 April 1954 and he was therefore 60 years old at the time of his death. He identified as Aboriginal. At the time of his death he was serving a 7-year term of imprisonment for sexual offences against children, commencing 12 March 2012, with an earliest parole date of 12 March 2017.² Mr Brizzolara had a substantial criminal history, mainly for offences of dishonesty, commencing in 1964 when he was aged just 10. In about 1990 he moved from western Sydney to far western New South Wales, at Broken Hill, where he later committed the offences for which he was incarcerated.

Mr Brizzolara suffered from very poor health. He was diagnosed with end stage Chronic Obstructive Pulmonary Disease (COPD), congestive cardiac failure, ischaemic heart disease and hypertension, kidney and liver disease, in the context of a 40-year smoking habit and a family history of heart disease and stroke.³ His condition left him short of breath and with very restricted mobility and it resulted in regular admissions to hospital, most recently in April 2014 after suffering respiratory arrest.⁴

¹ Section 27(1)(b) and 23(a) of the Act

² Sentence warrant, tab 22

³ Justice Health progress notes, discharge letter Dr Spasojevic 29 April 2014; report of Dr Ankur Krishna 4 December 2012; report of Dr Ross Francis 6 August 2013.

⁴ Discharge letter, 30 April 2014,

Justice Health staff treated Mr Brizzolara in custody with various medications and reviewed his condition regularly, including by referral to respiratory specialists. He had a nebulizer machine in his cell. In about August 2014 his treating specialist also applied to Enable NSW for funding for a Bi-level breathing machine, which had been recommended, but it does not appear that it was obtained prior to his death.⁵

In view of Mr Brizzolara's poor health, he agreed to a "No CPR" order, accepting that CPR was not likely to be successful and should therefore not be initiated. The records show that he agreed to this course from September 2013 and he confirmed his intentions when he was last discharged from hospital on 30 April 2014.⁶

There is ample evidence in the brief to show that Mr Brizzolara accepted he was likely to succumb to his illnesses, and at some stages he refused treatment, although he was not considered suicidal.⁷

In May 2013, on account of his poor health, Mr Brizzolara had been transferred from Parklea CC to the Metropolitan Special Programs Centre ("MSPC") at Long Bay CC. He was held in cell 11, within the Kevin Waller Unit at MSPC1. That Unit accommodates older inmates and those with health issues. Mr Brizzolara was in a one-out placement, meaning he was the only occupant of the cell.

Events of 25 October 2014:

On Saturday 25 October 2014 at 2.05pm Corrections Officer ("CO") Djoeady performed the daily lock-in. He attended Mr Brizzolara's cell, said "all good?" and in response Mr Brizzolara nodded and said "good night".⁸ Officer Djoeady then locked the cell for the day. This is the last confirmed time that anyone saw Mr Brizzolara alive.

At about 6pm, CO Datta and CO Picker assisted the Justice Health nurse to issue medicines in the Kevin Waller Unit.⁹ The medical records show that Mr Brizzolara was given his evening medication that day, at 4pm and 8pm¹⁰ however, it does not appear that any officer actually entered Mr Brizzolara's cell at those times.¹¹ The notes therefore probably just reflect the fact that Mr Brizzolara already had his medication within his cell.

⁵ Cf. report of Dr Keller 31 July 2014, tab 35; Letter from Enable NSW 28 August 2014; Progress / clinical notes, tab 35 at 12.8.14, 14.8.14

⁶ No CPR orders, Ex 1, tab 34

⁷ See e.g. report of Jeff Schubert, tab 31 at [4]; Progress / clinical notes, tab 35 at 25.7.14, letter of 30.4.14 and General Exam Adult Note 25.4.14

⁸ Report of CO Djoeady, Ex1, tab 7

⁹ Statement CO Datta, Ex 1, tab 9

¹⁰ Regular medication chart, Ex1, tab 35 (Atrovent and Salbutamol at 4pm, Atrovent, Frusemide at 8pm)

¹¹ Statement of Det SC Young, Ex 1, tab 6 at [37]

Cell 12, next door to Mr Brizzolara's cell, was at this time occupied by an inmate called Kevin Smith. Mr Smith was later interviewed by police. He told them that Mr Brizzolara had complained of weakness in his legs during the day.¹² During the evening, Mr Smith could hear the nebulizer machine which Mr Brizzolara used. At around 8.30pm to 9.00pm, Mr Smith heard a banging noise that sounded like something heavy hitting the floor.¹³ Mr Smith knocked on the wall and yelled out to Mr Brizzolara but there was no response. Mr Smith then pressed his cell alarm. For reasons which will become clear, that cell alarm was never answered¹⁴

At 10pm the "B" watch commenced duty. When the new watch commences, the routine includes checking all inmates. At about 10.57pm CO Kark attended the Kevin Waller Unit to perform that check. As he approached cell 12, Mr Smith says he told Officer Kark to check Mr Brizzolara.¹⁵ Officer Kark approached cell 11, turned on the light and observed Mr Brizzolara lying on the floor on his left side, facing the left side wall. A short while later, CO Kark went to get assistance from the Night Senior, Senior Corrections Officer Krishnan.¹⁶

A few minutes later, SCO Krishnan, CO Heyne, CO Anstice and CO Kark attended cell 11. SCO Krishnan brought with her a rapid response kit containing personal safety equipment. The cell door was opened and SCO Krishnan called Mr Brizzolara's name, to which there was no response. Mr Brizzolara was blue and blood was observed coming from his mouth.¹⁷ Shortly afterwards CO Heyne and CO Kark commenced CPR.

CO Anstice called the gatehouse, who asked Nurse Hinde to attend. At that time Nurse Hinde was located in the clinic in 13 Wing and she says it took her approximately 10 minutes to reach cell 11.¹⁸ En route to the cell she discovered that the person she was attending was Mr Brizzolara. Mr Brizzolara was known to her and she knew he was "Not for Resuscitation". Accordingly, she informed Correctional Officers they should cease CPR. She performed an examination when she attended Mr Brizzolara at 11.12pm and confirmed that he was deceased.¹⁹

Ambulance officers attended the gaol at 11.26pm and they too confirmed that Mr Brizzolara was deceased. Police arrived at the scene at shortly after midnight.

¹² Interview Smith, Ex 1, tab 19 at Q63 to Q67

¹³ Ibid at Q97

¹⁴ Ibid at Q130. Mr Smith also states he did not hear any other alarm prior to his own, see Q187. A reason for this may be that he had been in the shower prior to this point, see Q78

¹⁵ Ibid at Q224

¹⁶ Statement Kark, Ex 1, tab 12

¹⁷ Statement Krishnan, Ex 1, tab 13

¹⁸ Statement Hinde, Ex 1, tab 18 at [5]

¹⁹ Life Extinct Form, Ex 1, tab 2

Cause of death:

No autopsy was performed, as the available evidence allowed the cause of death to be established as arising from natural causes. The medical cause of death was certified to be Congestive Cardiac Failure, the antecedent cause being end stage COPD and other significant conditions being Ischaemic Heart Disease and Obesity.²⁰

Cell call alarm system:

As with all cells, Mr Brizzolara's cell was fitted with a distress alarm or cell call alarm system.²¹ This operates in the following way. Pressing the alarm causes an alarm chime or beep at an officer station located at the end of the wing. Pressing the alarm also illuminates a red light in the cell which remains lit until cancelled. When the call is answered, the officers can speak to the inmate and cancel the alarm.²²

The system is also designed so that, after a timed delay, the alarm is relayed through a network and sounds at further locations in sequence.²³ The alarm is relayed first to the Night Senior's office, then to Gatehouse and finally to the Complex monitor room.²⁴ Provided the network is operational, the alarm call and the duration of the call is also recorded on a system log.²⁵

Given the obvious importance of having working cell call alarms located inside cells, Corrective Services NSW has a system of integrity checks in place. This is as follows:²⁶

- Every week, all cell call alarms are manually activated and checked.
- Every day, six cell alarms per unit are randomly selected and checked.
- One of those cell alarms is also checked to ensure it is relayed through the complete pathway (from officer station to monitor room).
- When an inmate is placed in a cell, the cell alarm's complete pathway is checked.
- These checks are recorded in the Inmate Accommodation Journal.²⁷

²⁰ Coronial Certificate as to Cause of Death, Ex 1, tab 5

²¹ The system at Long Bay CC and some other gaols is provided by AustCo Communications System

²² Statement of Det Sgt Young, Ex 1, tab 6 at [28];

²³ Statement of Schultz, Ex 1, tab 36 at [5]

²⁴ Statement of Schultz, Ex 1, tab 36 at [5]

²⁵ System log, report of Matt Damaso, Manager Technical Security, 27 October 2014, Ex 1, tab 29

²⁶ Cell call alarm procedures, Adam Wilkinson and Terry Murell, tab 32 and Operations Procedure Manual 12.1.8.2 (annexure 1)

²⁷ OPM 12.1.8 Cell Call Alarm Systems, Ex 1, tab 32

The system log supports a conclusion that these checks were conducted as required. Mr Brizzolara's cell call alarm was last activated during the weekly check on Sunday 19 October 2014.²⁸ The next weekly check was due to take place on 26 October 2014, the day after Mr Brizzolara died.

SCO Krishnan performed the daily check on 24 Oct 2014, selecting two cells in the Kevin Waller Unit (cells 6 and 7). She recorded that these were operating correctly²⁹ and this is confirmed in the system log.³⁰ However, those cells are in a different part of the Kevin Waller Unit. Mr Brizzolara's cell (cell 11) was in "8 Wing", whereas cells 6 and 7 were in "32 Wing" (identified in the system log as "KWU").

As for the daily checks on 25 October 2014, there is no clear evidence as to which cells were checked, although the relevant Inmate Accommodation Journal records that checks were made as required.³¹

The system log shows that a number of cell alarms were activated by inmates on the day of Mr Brizzolara's death. The several alarms are recorded from 7 Wing, mainly from cell 55, and also from cells 5 and 10, which are located in 32 Wing (the other part of the Kevin Waller Unit.)³² COs Datta, Letby and Picker recall that they attended cell 55 in 7 Wing at various times that day due to problems with the power to that cell.³³

No alarms are recorded at all in the system log for 8 Wing from the time of the weekly check on 19 October 2014 until after Mr Brizzolara's death. This is consistent with the evidence of the staff on duty at the time.

Mr Brizzolara's cell call alarm:

When the Officer in Charge Detective Senior Constable Young attended cell 11 after Mr Brizzolara's death, he observed that the cell call alarm light was lit, indicating that the alarm had been activated prior to the arrival of police. Checks demonstrated that the alarm did not relay through to the Night Seniors office as it was designed to, and also as a consequence did not register on the system log.³⁴ It was therefore apparent that there had been some kind of failure which had affected the network itself.

²⁸ Report of Matt Damaso, Ex 1, tab 29 at point 1 and System log Cell Call events at 19 October 2014 07:15am, cell 13211A

²⁹ Report of Jeff Schubert, Manager of Security, Ex 1, tab 31 at [10]

³⁰ System log, Report of Matt Damaso, Ex 1, tab 29, 24 October 2014 Cell Call events at 12:06 to 12:16

³¹ This document is not within the brief

³² Cell 5 and cell 10, System log, report of Matt Damaso, Ex 1, tab 29, 24 October 2014 at 06:50 and 16:52

³³ "C" Watch OIC's journal, tab 26; statements of COs Datta, Letby and Picker, EX 1, tabs 9, 10 and 11

³⁴ Statement of Det Sgt Young, Ex1, tab 6 at [31]

In the absence of any evidence that another other person activated the alarm, I am satisfied that it was Mr Brizzolara who did so. The alarm must have been activated after Mr Brizzolara was locked in at 2.05pm. Mr Smith told police he heard the Mr Brizzolara activating the nebulizer machine and then at, 8.30pm to 9.00pm, he heard a banging sound. In those circumstances, it is more likely than not that Mr Brizzolara activated the alarm at this point because he was experiencing the difficulties that led to his death.

Investigation into the problem:

Following the discovery of the network failure, Stafford Schultz, a security technician, attended the gaol and examined the network equipment.³⁵ This is housed within an equipment cabinet in the equipment room at one end of 8 Wing.

The network devices and other items are usually connected to an “uninterruptible power supply” or “UPS”, which contains a backup battery that will provide continuous power in the event of a failure of mains power. Mr Schultz observed that the UPS was powered down and that some of the devices attached to it, including signal amplifiers for the inmates’ televisions, had been reconnected directly to the power outlet via a power board. Vitally, the equipment that connected the cell call alarms to the network was not connected to a working power supply.³⁶ The result was that the cell call alarms for 8 Wing were disconnected from the network.

Matt Damaso, who is the Manager Technical Security within Corrective Services NSW, attended the gaol on 27 October 2014 and investigated the problem. He tested the UPS and discovered that it had developed a fault and was not providing power. The records show it had been inspected only four months earlier, on 23 June 2014, when it was found to be in good working order, and it was due to be inspected again after 12 months.³⁷

Mr Damaso checked the system log and concluded that the UPS failed at 10:42am on 24 October 2014.³⁸ From this point forward, cell call alarms activated within 8 Wing would have sounded in the wing inside the equipment room, but would not have been relayed through the network to other locations.

Changes since the death:

At the time of Mr Brizzolara’s death, the system did not alert staff sufficiently to the fact that there was a network problem in 8 Wing. This is for the following reason. A separate part of the network, 10 Wing, was being renovated and power to the

³⁵ Statement Schultz, Ex 1, tab 36

³⁶ Statement of Schultz, Ex 1, tab 36 at [10]; Report of Matt Damaso, tab 29 at p1

³⁷ Report of Matt Damaso, Ex 1, tab 29 letter 23 June 2014 from Antmond Pty Limited

³⁸ Report of Matt Damaso, Ex 1, tab 29 System Messages at 24 October 2014 at 10:42am

network equipment in that wing was disconnected. As a result, the system monitors had been displaying the text “network error” for a period of time. When a further network error occurred due to the power fault in 8 Wing, the system monitors did not reveal a new error had occurred; in other words, the problem in 8 Wing was masked by the existing problem in 10 Wing.³⁹

Mr Damaso took action to fix the immediate problem and he then made a number of recommendations for changes to the cell call alarm system. By and large these have been adopted, although Mr Damaso also made other recommendations that were not pursued.⁴⁰

A summary of the action taken in response to this death is as follows:⁴¹

1. In the event of any new failure on the network, an alarm, described as a high pitched tone, is produced in Night Senior’s office, Gatehouse and Complex monitor room. This alarm continues until it is manually cancelled.
2. Instead of displaying the message “*network error*”, the system monitors now display all network errors in sequence, with a description of the location of the error, so that new errors can be readily identified.
3. The alarm will now be relayed to other locations on the network more quickly. It now sounds in the Night Senior’s office after 10 seconds (previously there was a delay of 30 seconds) and it continues at each subsequent location until answered.
4. Staff at the gaol have been trained to identify and respond to network faults.
5. Equipment room locks have been changed and access to these rooms is restricted.
6. The changes have also been communicated to other gaols which operate the same cell call alarm system.

³⁹ Report of Matt Damaso, Ex 1, tab 29 System Messages at 24 October 2014 at 10:42am

⁴⁰ See statement of Damaso tab 17 at [14] and [17]; report of Wilkinson and Murrell, Ex1, tab 32 paragraph 3

⁴¹ Report of Matt Damaso, tab 29 p3; statement Damaso, Ex 1, tab 17

I would like to thank the officer in charge, Detective Senior Constable Young for his investigation.

I would also like to thank Mr Jake Harris from the Crown Solicitor's office for assisting me and whose excellent submissions I have largely adopted in these findings. I would also like to thank his instructing solicitor, Jessica Murty.

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:

The identity of the deceased

The deceased person was Ronald James Brizzolara.

Date of death

He died on 25 October 2014.

Place of death

He died at Long Bay Correctional Centre, Malabar, NSW.

Cause of death

The death was caused by Congestive Cardiac Failure
Antecedent cause: Chronic Obstructive Pulmonary Disease
Other significant conditions: ischaemic heart disease; obesity.

Manner of death

He died in custody of natural causes.

In light of the changes already made by Corrective Services NSW following Mr Brizzolara's death, no further recommendations are necessary or desirable in this case.

I close this inquest.

Magistrate Teresa O'Sullivan
Deputy State Coroner

Date 17 March 2017