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CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Nathan Reynolds
Hearing dates:	19 - 28 October 2020; 11 December 2020
Date of findings:	11 March 2021
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest - death of a person in custody – cause of death bronchial asthma - was immediate response of custodial officers adequate – was ongoing asthma care adequate – recommendations.
File number:	2018/269824
Representation:	Counsel Assisting the inquest: C McGorey of Counsel i/b NSW Crown Solicitor. The Commissioner for Corrective Services NSW: C Melis of Counsel i/b Department of Communities and Justice The Reynolds family: J Brock of Counsel with C Longman of Counsel i/b Aboriginal Legal Service. K Pochodyla: J Malouf of Counsel i/b Stacks Justice Health and Forensic Mental Health Network: R Mathur of Counsel i/b Hicksons Lawyers Individual registered nurses: Z Alderton of Counsel i/b NSW Nurses and Midwives Association. Individual Corrective Services officers: S Russell of Counsel i/b McNally Jones Staff Lawyers. Dr Landers: T Hackett of Counsel i/b Avant Law.

Findings:	**Identity** The person who died is Nathan Reynolds. **Date of death**: Nathan Reynolds died on 1 September 2018. **Place of death**: Nathan Reynolds died at the Outer Metropolitan Multi Purpose Correctional Centre, Berkshire Park NSW 2765. **Cause of death:** Nathan Reynolds died as a result of bronchial asthma. **Manner of death:** Nathan's death from natural causes was contributed to by deficiencies in the management of his severe asthma by the Justice Health and Forensic Mental Health Network, and deficiencies in the immediate response to his medical emergency by Corrective Services NSW.
Recommendations:	See **Annexure 1** to these findings.

Non-Publication Orders

Orders pursuant to section 74(1)(b) of the *Coroners Act* 2009 prohibiting the publication of certain evidence have been made in this inquest. Orders have also been made pursuant to section 65(4) of the *Coroners Act* 2009.

A copy of the orders can be found on the Registry file.

Section 81(1) of the *Coroners Act* 2009 [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. In addition the Coroner may make recommendations in relation to matters which may improve public health and safety in the future, arising out of the death in question.

These are the findings of an inquest into the death of Nathan Reynolds.

As Nathan Reynolds was in custody when he died, it is mandatory that an inquest is held.

Mr Reynolds' family has requested that he be referred to as 'Nathan', and this is how I name him in these findings.

Introduction

1. Nathan was 36 years old at the time of his death in prison on 1 September 2018.

2. Nathan was a First Nations man of Anaiwan and Dunghutti heritage, and a beloved member of a large family. He had a history of severe asthma and he suffered an acute asthma attack on the night of 31 August 2018. By the time Corrective Services officers attended Nathan, his condition had rapidly deteriorated. Tragically, ambulance paramedics could not save him and he was pronounced deceased.

3. Nathan's medical crisis on the night of 31 August required an emergency response. But the response he received fell well short of this. It was confused, uncoordinated and unreasonably delayed. The delay deprived Nathan of at least some chance of surviving his acute asthma attack. These failures were due both to numerous system deficiencies, and to individual errors of judgement.

4. But the failures in Nathan's care went beyond what happened that night. In critical ways, the health care he had received since entering custody was inadequate. It failed to reduce his risk for a fatal asthma attack. It did not comply with established treatment for the management of severe asthma. It did not even comply with NSW Health's own policies to prevent chronically ill prisoners from deterioration and death. These failings significantly increased Nathan's risk for the fatal attack which took his life on the night of 31 August.

5. Two questions lay at the heart of this inquest. What prevented correctional officers from responding promptly to Nathan's medical emergency that night? And in the months before he died, what went wrong with the management of his chronic illness? These questions go to the central issue of whether Nathan's death could have been prevented.

6. Nathan's death exposed the need for changes to be made in the care given to people with severe asthma in NSW's prisons. This is why I have made a number of recommendations in this inquest. These recommendations are not

focused on attributing blame. Rather, they are made in the hope that people like Nathan who enter custody with conditions of severe asthma will have a better chance of avoiding a life threatening attack, and of surviving one should it happen.

7. A further issue was examined in this inquest. It arose from Nathan's identity as a First Nations man. First Nations people are grossly over represented in custody, a fact officially recognised thirty years ago in the 1991 Royal Commission of Inquiry into Aboriginal Deaths in Custody. As noted by the Commissioners, this over representation '*provides the immediate explanation for the disturbing number of Aboriginal deaths in custody'*. Thirty years later we have no reason to suppose those numbers will fall. In the findings made into the death of First Nations man Tane Chatfield, Deputy State Coroner Grahame said that *'…until we do something about over representation, we will certainly continue to record a disproportionate level of Indigenous deaths in custody'.*

8. The focus of this inquest into Nathan's tragic death was the health care and treatment which he received, both on the fatal night and in the preceding four months he had spent in custody. Thirty years ago the Royal Commission recommended that custodial health and safety practices:

   'demonstrate cultural awareness and be implemented in consultation with Aboriginal Health Services, [Aboriginal Legal Services], and the broader community'.

   The Royal Commission recognised that First Nations people in prison have specific health and emotional needs. Models of care which improve their health outcomes need to be carefully considered. Can anything be learned from prison settings where First Nations health care is delivered by different models? The inquest received some limited evidence about this. Much more however can and must be done to understand and meet the specific health and wellbeing needs of First Nations people in custody.

9. Nathan's family grieve his loss and miss him deeply. They attended each day of the inquest, and participated with dignity and courage. It was profoundly distressing for them to hear that Nathan did not receive the care he needed. I want to express to Nathan's family and friends my deep appreciation for their participation, which they did for Nathan's sake and in the hope of changes which will mean that others do not suffer as they have.

The issues at the inquest

10. Witnesses who gave evidence at the inquest included a number of involved correctional officers and some of Nathan's fellow inmates. In addition, respiratory physician Dr Greg King assisted the court with expert reports and oral evidence. Dr King is well qualified to provide this assistance, as staff specialist and Medical Director at the Royal North Shore Hospital's Respiratory Investigation Unit. He has 27 years' experience in the

management of asthma and as a researcher into asthma and airways disease.

Nathan's life

11. When Nathan died he left behind a grieving mother, sisters and brothers, aunts and grandmother. He also left a partner who is the mother of his 12 year old daughter Summer, and his partner's two children.

12. Nathan was born on 1 December 1981, the eldest child of parents Jodie Reynolds and Steven Hampton. The couple had three other children including Taleah and Shannon, who were both close to Nathan. Jodie Reynolds had other children Makayla, Brodie and Labreh Reynolds and they too had a close connection with him.

13. During Nathan's childhood the family lived mainly in Sydney's Rooty Hill area. When Nathan left school he undertook a gyprocking apprenticeship, and he worked as a gyprocker both for himself and for companies. He was a hard worker and as his sister Taleah described it, most times they saw him he was covered in a layer of plaster dust.

14. Nathan and Karen Pochodyla had known each other since their primary school days, and they commenced living together soon after 2006. Ms Pochodyla had two children from her former marriage, Briley and Brock, who continued to live with herself and Nathan. In 2008 the couple had a daughter Summer who was Nathan's pride and joy. Taleah told the court he usually referred to Summer as '*Darling*', and he told people she was '*his best achievement in life'*.

15. At the close of the evidence the court heard loving and affectionate tributes to Nathan from many family members. Ms Pochodyla, supported by her son Brock, shared with the court a letter Nathan had sent to herself and the three children. At times both reflective and funny, it made clear his genuine love for them all. Briley and Summer made videos in which they spoke of their feelings of loss and sadness. The close and affectionate bonds they shared with Nathan were clear, with Summer describing her father as '*creative and fun and the best Aussie ever'*.

16. On behalf of the Reynolds family Nathan's sister Taleah, supported by her sister Makayla, spoke very movingly about Nathan. She described his central position in their family's life, how dearly loved he was, and the gap he has left behind. Taleah showed great strength and courage in taking on the role of family spokesperson and fulfilling it so well. She gave a generous and loving tribute, highlighting the deep connections Nathan had with his family and their profound sadness that he is no longer with them.

The cause of Nathan's death

17. There was no controversy as to the direct cause of Nathan's death. The autopsy report of pathologist Dr Lorraine Du Toit-Prinsloo recorded this as bronchial asthma.

18. Dr Prinsloo described asthma as *'an inflammatory disease process of the bronchioles with obstruction of airflow and narrowing of the airways.*' The features she observed in Nathan's lungs were in her opinion characteristic of asthma. She found no evidence of injuries to Nathan's body, or of other disease apart from asthma.

19. Dr King concurred. In his expert opinion Dr Prinsloo's post mortem findings, and the evidence about Nathan's deterioration and death that night, were entirely consistent with death from asthma. In the first of his two reports he commented that the descriptions given by those present with Nathan that night were:

    '…consistent with a life-threatening asthma event, then a respiratory arrest … with consequent loss of consciousness, an hypoxic (lack of oxygen) seizure, cessation of breathing and then cardiac arrest….'

General information about asthma

20. Asthma is one of the top five chronic conditions among prison inmates, according to NSW Health's Justice Health's Strategic Plan 2018-2022. At the inquest it was useful to hear some basic information about asthma and its proper management. Dr King provided the following information:

    - asthma is a condition suffered by 5-10% of the general population
    - about 5% of asthma sufferers have *severe* asthma
    - approximately 400 Australians die of asthma each year.

21. Dr King also provided evidence about the types of medications commonly used for treatment of asthma. He explained that the frequency with which a person uses their medication is highly relevant in assessing whether their asthma condition is well managed.

22. Asthmatics are recommended to do as Nathan did, and always carry an asthma reliever puffer for quick relief of their immediate symptoms. These are fast-acting medications which reduce asthma symptoms by relaxing the muscles around the airways. Salbutamol (brand name Ventolin) is a commonly used reliever, delivered from a blue puffer.

23. However reliever puffers do not treat the underlying cause of asthma, namely airway inflammation, and hence do not provide protection from the risk of a severe asthma attack. According to National Asthma Council Australia, use of a reliever puffer more than twice per week is a sign of poorly controlled asthma. As will be seen, there is evidence that while in prison Nathan was using his reliever puffer on a very frequent basis.

24. Asthma preventer medications are regarded as critical to good asthma treatment because they treat the underlying cause of its symptoms. They are taken daily to reduce the risk of asthma attack. Symbicort and Seretide are commonly used examples.

25. Oral corticosteroids such as Prednisone are also sometimes prescribed to regain control during an attack. These are anti-inflammatory medicines which quickly reduce lung inflammation.

26. Key to the effective treatment of asthma is an asthma action plan which has been developed between the patient and an asthma clinician. This reduces the risk of a sudden and severe attack, and guides the response if such an attack occurs.

Nathan's history of asthma

27. Nathan was well aware of his asthma condition, and he understood the need to manage it with medication and seek help when necessary. This he did. However he may also be described as typical of most asthma sufferers, in that he had what Dr King described as a '*high tolerance ..for having frequent attacks'*. This can lead to asthma sufferers '*normalising*' their condition and underestimating their risk for life threatening episodes.

28. Nathan's sister Taleah said that the Reynolds family had a history of asthma. Although Nathan had a Ventolin puffer and preventive medicine, she recalled he often ran out of Ventolin. Taleah reported that when she spoke to him on the phone while he was in custody he often sounded wheezy, as though he was struggling to breathe.

29. According to Ms Pochodyla, Nathan had experienced breathing difficulties since 2015. He regularly attended the Rooty Hill Medical Centre for asthma treatment, where his preferred doctor was Dr Khaled Etri.

30. On 21 February 2016 Nathan spent two days in Mount Druitt Hospital with acute respiratory distress, after being unwell for two days with flu-like symptoms.

31. Nathan commenced a sentence of nine months' imprisonment on 3 February 2017 for domestic violence related offences. While in custody on 3 May 2017 he had an episode of shortness of breath, and he was prescribed a Ventolin inhaler and a Seretide preventor inhaler. The next day he suffered an acute episode of respiratory distress and was admitted to Bathurst Hospital. The hospital records documented the following:

- Nathan had reported two days of worsening wheeze and difficulty breathing, despite hourly use of twelve puffs of Ventolin

- his lung function had fallen to 10% due to his asthma attack, objective evidence which demonstrated very severe asthma.

32. Another asthma attack followed on 7 May 2017, for which he was treated in the prison health centre with oxygen therapy. Thereafter he was reviewed on various occasions until his release to parole on 2 June 2017.

33. In January 2018 Ms Pochodyla took Nathan to Mt Druitt Hospital as he was experiencing a breathing emergency. She reported he was '*blue in the face and couldn't breathe*'. Between February and May 2018, on at least two occasions Nathan was unable to undertake his community service obligations due to asthma attacks. According to a medical certificate, on one of these occasions he was hospitalised.

34. In his report dated 12 March 2020 Dr King stated that Nathan's symptoms as described by his family were *'absolutely typical'* of severe asthma. Furthermore, Nathan's *'frequent ED attendances and ICU admission … are also typical of severe, uncontrolled asthma*'.

35. On 10 May 2018 Nathan commenced a second period of imprisonment. This was to be served at the Outer Metropolitan Multi Purpose Correctional Centre [the OMMPCC], in southwestern Sydney.

Nathan's severe asthma attack and the response to it

36. I will firstly consider the evidence about Nathan's fatal asthma attack on the night of 31 August 2018, the response to it, and whether deficiencies in the response contributed to Nathan's death.

37. Some preliminary information is important to understand the night's events, and how correctional officers responded.

(i) The Outer Metropolitan Multi Purpose Correctional Centre

38. At the time of Nathan's incarceration the Outer Metropolitan Multi Purpose Correctional Centre [the OMMPCC] was part of a complex of three correctional centres. The other two facilities were John Moroney Correctional Centre and Dillwynia Correctional Centre. At that time, inmates for all three centres totalled approximately 1,000.

39. The OMMPCC was a minimum security centre, and Nathan was accommodated in its H wing which housed 25 male inmates. H wing provided what is known as '*open wing'* accommodation. Its inmates were let out at 8.00-8.30am, and returned to the wing at 3.30pm. They were not locked in their individual cells and were able to move around the communal room and in other inmates' cells if they chose. Each cell in H wing had at least one alarm, which connected the inmate to the duty office via a radio communication system. Activating the cell alarm was known as a 'knock up'.

40. At the OMMPCC in common with most NSW correctional centres, the inmates received health services from the integrated Justice Health and Forensic Mental Health Network [the JH Network].

(ii) The night shift on 31 August 2018

41. The correctional officers on B watch night shift on 31 August 2018 were officers Matthew Fawzy, Nirvair Singh and John Fifita. Also on duty was an officer stationed at the OMMPCC's front gate, Mr Sham Dhanju. All four were under the supervision of Mr John Phali, who occupied the role known as the 'night senior' or senior CO, and had overall command for the OMMPCC during the night shift.

42. During the afterhours of 7pm to 7.30am, a sole registered nurse was rostered to provide nursing assistance to the inmates of all three facilities. On the night of 31 August that nurse was Registered Nurse Kasey Wright. She was stationed at the Dillwynnia Health Clinic, meaning that if her help was needed at one of the other two facilities she had to make her way there from Dillwynnia.

43. RN Wright had been registered for two years and employed with Justice Health for twelve months. Her induction training was of a general nature and did not include training specific to performing the role of afterhours nurse. Since Nathan's death RN Wright has left Justice Health and has completed Advanced Life Support training, but at the time she was trained in basic life support only.

(iii) CSNSW policies regarding knock up call responses

44. Two key practices were cited in response to questions about the timeliness of the response made by correctional officers. These were local practices which, the involved officers believed, required the following:

- that a minimum of three officers were to respond to a knock up call after lock down, due to the fact that inmates in open wing accommodation are not secured in their cells.

- that in response to a knock up call, officers were not to consider calling a nurse or ambulance until *after* they had attended the inmate and assessed the situation themselves.

45. As will be seen, these practices created significant delays in the response to Nathan's health crisis. The flow on effect was that it took too long for emergency medical care to reach him.

46. Whether or not CSNSW policies mandated these specific practices is unclear on the evidence. Certainly the involved officers believed that night they were bound to comply with them.

(iv) Jeffrey Preo, Aaron Robinson and Brandon Tan

47. Three other people are important to the events of that night: Jeffrey Preo, Aaron Robinson and Brandon Tan. These three men were Nathan's fellow inmates in H wing. In the weeks leading up to Nathan's death Mr Robinson had become friendly with him, as they were both shortly due for release. Mr Preo knew Nathan as well. For his part, after Nathan's death Mr Tan wrote to

the NSW Ombudsman expressing deep concern at the delayed response to his health crisis.

48. All three men witnessed Nathan's crisis that night, and gave evidence of what they saw and did. Their memories of Nathan's last minutes were visibly painful to them, as was their frustration and distress that he could not be saved. However they knew that Nathan's family had a strong need to know what happened. At the close of the inquest Nathan's family expressed their gratitude for the support and comfort these men had given to Nathan, and for bearing witness at his inquest.

The day and evening of 31 August 2018

49. On the morning of 31 August 2018 Nathan attended chapel devotions. This was a regular practice for him, and he was said to be an active participant in its discussions.

50. For the previous two days Nathan had been complaining of flu-like symptoms. A fellow inmate and a cousin both recalled Nathan taking Panadol or Ibufrofen on 31 August for throat ulcers.

51. During his time in custody Nathan maintained frequent phone contact with his family members. On 31 August he had a number of phone conversations which indicate his respiratory condition was steadily worsening.

52. At about 1.54pm Nathan rang his sister Taleah and they discussed plans for him to live at her place when he was released. Just before this, Nathan had spoken on the phone with Ms Pochodyla and told her he felt '*horrible*' and had the flu. Ms Pochodyla asked if he had gone to see the doctor, but he replied '*you don't see doctors around here, nobody gives a shit about you'*. He told her he'd get some cold and flu tablets.

53. After lock down at 3.30pm Nathan borrowed a blue puffer from another inmate, who described him as wheezing '*quite a bit'*. There is some evidence that on the supervised medication round at about 6.30pm Nathan was issued a new blue puffer, but the evidence is unclear. After that Nathan had dinner and watched football on television.

54. At around 9.30pm Nathan's mother Jodie rang him and asked if he was ok, to which he replied that he was. Jodie believes he said this because he didn't want to worry her.

55. Nathan spoke again with Ms Pochodyla, who said he sounded '*a hundred times worse'* than he had earlier. In fact she couldn't understand a lot of what he was saying. His words were slurring and she had to ask him to repeat them. She urged him to go to the doctors and he replied that he would call them up now. Nathan then spoke to Summer, saying '*I love you baby, I will talk to you tomorrow'*.

56. At 10.30pm and again at 10.45pm Nathan spoke by phone with his brother Shannon. He told Shannon he had ulcers at the back of his throat, that he'd

already '*buzzed up'* but that he was ok. He also said he'd seen the nurse all week because of his breathing issues but they had just kept sending him back. He further said he'd seen the nurse today but she'd sent him back without a puffer.

57. In the opinion of Dr King Nathan's severe asthma condition was worsening that night, and had in fact been deteriorating for many days, based on the above evidence and that of other inmates that he was borrowing their blue reliever puffers. Dr King also noted that Nathan's hospital admissions for severe asthma attack in 2016 and 2017 had been preceded by cold and flu-like symptoms. He thought it probable that Nathan's deterioration had been triggered by a similar infection.

The knock up calls

58. At 11.27pm that night Nathan used his cell alarm to call for medical help. He spoke to Mr Fawzy, who was stationed in the duty room with Mr Singh. The duty room was located across a yard from H wing. Nathan said: '*Chief, I'm finding it hard to breathe and I need you to get a nurse down here'*. Mr Fawzy replied: '*Hold on tight, we'll be down shortly'.*

59. Mr Fawzy then contacted the night senior Mr Phali and told him that an inmate in H Wing had knocked up, was having breathing difficulties, and needed a nurse.

60. Mr Fawzy and Mr Singh did not immediately head to H wing. Nor did they ask for the night nurse or an ambulance. They were insistent that when responding to a knock up call, medical or otherwise, they were first required to attend and verify the gravity of the situation. In addition, as noted they believed that three officers were required when entering an open wing after lockdown. Thus the two officers had to wait until a third officer Mr Fifita could join them.

61. At about 11.29pm a second knock up call came through to the duty office. The caller, who was probably Mr Aaron Robinson, told Mr Fawzy: *'Chief you better get down here quick, he needs a nebuliser'.*

62. Still the officers did not head to H wing. Mr Fifita had not yet arrived at the duty room, as he was using the bathroom in the adjoining reception area. He joined the other two officers at approximately 11.37pm. In the ten minutes that had elapsed since Nathan's knock up call the officers did not take any steps to speed up the arrival of Mr Fifita. Nor did Mr Phali himself monitor their progress, or make enquiry as to why they had not yet notified arrival at H wing.

63. Once Mr Fifita arrived at the duty room the three officers commenced walking to H wing. CCTV footage showed their progress as they made their way across the yard. They were not moving at speed. Mr Fifita can be seen walking about 10 metres behind the other two. He explained that he had injuries to his knees which limited his mobility, and the other two officers were not permitted to get ahead of him. Each was certain they were not permitted

to run to the location. They arrived at H wing at 11.38.25pm, more than eleven minutes after Nathan's first call for help.

The call for the night nurse

64. Meanwhile Mr Phali made a call to RN Wright asking her to attend. Although in his evidence Mr Phali said he rang RN Wright when Mr Fawzy first called him, this is contradicted by his statement, and by RN Wright's evidence that she was not contacted until 11.40pm. For the reasons given at paragraph 69 below, I prefer her evidence on this point.

65. Mr Phali told RN Wright that an inmate had knocked up, was '*breathing funny*', and needed a nebuliser. RN Wright told the court that Mr Phali did not communicate to her any sense of urgency about the inmate's situation.

66. To attend Nathan, RN Wright needed to exit through a number of locked doors to the Dillwynnia car park. She then drove to the OMMPCC front gates, arriving at 11.45pm to be met by Mr Phali. At that moment Mr Phali was receiving an urgent radio report from Mr Singh at H wing. Mr Singh told him that Nathan was now '*unresponsive'*.

67. Realising for the first time that Nathan's situation was urgent, RN Wright told Mr Phali to call an ambulance. It was now 18 minutes after Nathan's call.

68. I note for completeness that in evidence, Mr Phali said he had already directed the front gate to call an ambulance. But this is contradicted by the evidence of RN Wright, of the front gate officer Mr Sham Dhanju, and of NSW Ambulance records showing that they received the call at 11.48pm. At the inquest Mr Phali conceded that the stress of the night's events may have impaired his recollection of their timing and sequence.

69. Mr Phali and RN Wright then set out on foot for H wing, detouring to collect a first aid trolley from the OMMPCC Health Centre. They arrived at H wing at 11.49pm.

70. Twenty two minutes had now elapsed since Nathan's call for help.

Nathan's collapse

71. By this time the three officers Fawzy, Singh and Fifita had been at H wing for eleven minutes. They described approaching the building just after 11.38pm and hearing inmates at the windows, yelling at them to '*hurry up, he can't breathe'.* This did not appear to prompt them to move any more quickly.

72. Inside the communal room they found Nathan lying on the lounge, '*gasping for air'* and repeatedly trying to use a puffer. He was unable to speak. Gathered in the room were most of the wing's inmates. The mood was highly agitated, with some voicing anger and frustration at the officers for the time they had taken to get there.

73. Aaron Robinson and Jeremy Preo were among those gathered there. Both knew Nathan suffered from asthma and that he had been unwell in the previous few days. Mr Robinson said he had realised immediately that Nathan was suffering an asthma attack – he was gasping and appeared unable to exhale, with his chest '*barreling*' with each breath.

74. Mr Robinson sat next to Nathan on the lounge, trying to bring his panic levels down. He told Nathan to look at him and to try to breathe. Hunched over and gasping, Nathan was unable to speak. Mr Robinson was close to tears as he described Nathan's desperate state:
'*He was in a panic, couldn't exhale. He was a man begging for help with his eyes and he couldn't say a word …What little breath he had was just gasping for help'.*

75. Since Nathan was in no condition to walk to the Health Centre Mr Fawzy left to collect a wheelchair, returning with one just before 11.43pm. Mr Fifita, Mr Robinson and Mr Preo then tried to lift Nathan into it.

76. It was at this point that Nathan collapsed. All witnesses described his body as suddenly stiffening. Some said he appeared to suffer a short fit. As one witness described it:
'At that moment the life went out of his body, he had no life'.

77. Mr Robinson and Mr Preo placed Nathan on the floor, on his side in the recovery position, while Mr Fifita put a jumper under his head as a pillow. Mr Singh immediately radioed to Mr Phali: '*We need an ambulance'*.

78. Thereafter Mr Robinson and Mr Preo remained on the floor with Nathan, their attention focused upon him. They talked to him and tried to help him breathe. Mr Fifita stood close by, while the other two officers attempted to manage the increasingly agitated group of inmates.

The attempts to revive Nathan

79. RN Wright told the court that when she arrived at H wing with Mr Phali at 11.49pm, it was immediately clear to her that Nathan's condition was very serious. She moved him onto his back to assess him. She was unable to locate a pulse or any signs of breathing. Nathan's pupils were fixed and did not respond to light. She and Mr Phali commenced first aid, with Mr Phali performing chest compressions and RN Wright providing oxygen via a mask and cylinder.

80. It was then that RN Wright realised the first aid trolley was missing its defibrillator. In accordance with usual practice, it had been taken from the trolley at the commencement of the night shift and placed in the officers' duty room. When the defibrillator was retrieved RN Wright applied its pads, only to find that Nathan had no shockable rhythm. It could provide no assistance in restoring his heartbeat.

81. RN Wright tearfully told the inquest that when she found there was no shockable rhythm she felt sure Nathan was no longer alive. Nevertheless she

and Mr Phali continued to deliver chest compressions and oxygen until the arrival of two ambulance crews.

82. NSW Ambulance had dispatched an ambulance to the OMMCC at 11.56pm, within eight minutes of receiving a call. At the inquest there was no issue concerning the timeliness of this response. Paramedics arrived at the prison main gate at about 12.14am, to find another ambulance crew from Penrith already there. At H wing they found Nathan lying on his back on the ground, with RN Wright performing CPR with a defibrillator attached.

83. The ambulance paramedics confirmed that Nathan was in cardiac arrest. He had no pulse, no spontaneous respirations and there was no rise or fall of his chest. They maintained resuscitation efforts for a further 30 minutes, including CPR and intravenous adrenaline, but to no avail. At 12.44am Nathan was pronounced deceased.

84. During her first aid efforts RN Wright injected a dose of the opioid-blocker Naloxone into Nathan's right thigh muscle. This action was a source of great distress for Nathan's family. It appeared to them that on arrival she had erroneously assumed he had collapsed due to an illicit drug overdose. On his behalf they were deeply hurt by this suggestion. They were also deeply upset at the possibility that administering Naloxone had taken precious time away from the effort to save his life.

85. At the inquest RN Wright explained that although she had asthma '*on her mind'* as the cause of Nathan's collapse, she had hoped there was a reversible cause, such as a drug overdose. She told the court she had not wanted to harm Nathan or insult his family by injecting him with Naloxone.

86. Dr King did not consider RN Wright's administration of Naloxone to have been inappropriate. In addition he thought it had little or no bearing on the outcome, and would have neither enhanced nor impaired Nathan's prospects for survival.

87. The profound distress felt by Nathan's family is very understandable. There is of course no evidence that Nathan had ingested opioid drugs. His tragic death was entirely due to an acute asthma attack. I note Dr King's evidence that at the very least, the administration of Naloxone did not harm Nathan's chances for survival, and I hope that this evidence ameliorates at least to some extent his family's pain.

Expert evidence regarding the emergency response

88. One of the matters upon which Dr King's opinion was sought, was whether a more effective emergency response could have saved Nathan's life that night.

89. In Dr King's opinion, Nathan's asthma attack was impending from the time he began to experience cold and flu-like symptoms, most likely in the preceding two days. His condition clearly worsened throughout the hours of 31 August. By 11.27pm when he called for help, a life-threatening attack was imminent and he was in immediate danger of respiratory arrest.

90. Dr King told the court that thereafter every passing minute reduced Nathan's chances for survival. His airways progressively shut down and he urgently needed treatment to open them.

91. As we know, twenty two minutes passed before the only form of on site medical help arrived, with the arrival of RN Wright at 11.49pm. Dr King commented that by then Nathan was many minutes into respiratory arrest, and his brain was suffering acute lack of oxygen. He had probably ceased breathing from the moment the attempts were made to move him into the wheelchair, about four minutes earlier. To have any chance of survival, he needed aid that only paramedics with advanced life support training and equipment can deliver, namely tracheal intubation and ventilation.

92. In Dr King's opinion, even if RN Wright been able to arrive *before* Nathan became unconscious, the chances were small that she could have averted his death, given the limited equipment she had and her lack of advanced life support training. By this time Nathan's lungs needed mechanical ventilation.

93. Dr King agreed that Nathan's chances of survival would have been greater if an ambulance crew had been able to arrive prior to his respiratory collapse at 11.45pm. This would only have been possible if an ambulance had been called *immediately* when he first sought help at 11.27pm. This evidence must have been very distressing for Nathan's family to hear.

94. I accept Dr King's opinion that from the time of Nathan's first knock up at 11.27pm, there was a very limited window of opportunity to save his life. Thereafter his prospects of surviving without immediate paramedic treatment were poor.

Conclusion regarding the emergency response

95. The above conclusion does not in any way diminish the adverse findings that must be made about the response to Nathan's acute attack that night. Nathan's situation at 11.27pm required an *urgent* response. The response he received fell well short of this. The resulting delays in the request for a nurse and ambulance removed what little chance Nathan had of surviving.

96. When Nathan's severe asthma attack struck, he notified Mr Fawzy that he was having difficulties breathing. CSNSW policy dictates that breathing difficulties constitute '*a medical emergency or serious health problem'*: Custodial Operations Policy and Procedures 5.5: *Cell security and alarm cells*. In such a situation the correctional officer is mandated to *'immediately go to the cell'*. Thus CSNSW policy makes clear that an inmate reporting breathing difficulties is to receive an urgent response.

97. Despite this, and taking Nathan's knock up call at 11.27pm as the starting point for each of the following events, it took:

- over eleven minutes for correctional officers to reach his side
- thirteen minutes for a nurse to be summoned

- twenty two minutes before a nurse arrived at his side
- forty seven minutes before ambulance paramedics attended him.

98. These time frames cannot be accepted as adequate or appropriate to a medical emergency. The lack of urgency which characterised the response of the involved officers, in particular the ten minutes' time which elapsed before they set out for H wing, is in my view inconsistent with the above CSNSW policy.

99. For the most part, the four involved officers did not give the impression of being personally uncaring people. They were emotionally affected by Nathan's traumatic death. Yet the earlier stages of his medical crisis were treated with a lack of urgency which was painful for those in court to witness, let alone the acute distress it must have caused his family.

100. The delayed response was in addition characterised by a lack of coordination and planning. On the walk to H wing the three officers did not discuss a plan and on arrival, no officer took charge or had direct responsibility for Nathan's welfare. Mr Singh said he had assumed that Mr Phali had called for the night nurse some minutes previously. That he was mistaken underlines the absence of communication which also impaired the response.

101. The unreasonable length of time it took for correctional officers to reach Nathan's side had the flow on effect of delaying the nursing and paramedic response to his emergency, to the point where neither RN Wright nor the ambulance paramedics had any real hope of saving his life.

102. Nathan's last minutes of consciousness as he waited for medical help must have been agonising for him and those around him. Mr Robinson's memory of Nathan's desperate attempts to breathe will not be forgotten by those who heard his evidence.

The contribution of CSNSW policy

103. But the delayed response of the officers should not be solely attributed to errors of judgement on their part. It is clear that their adherence to CSNSW practices and instructions played a significant role in retarding their response. This is a systemic issue and in my view those practices now require speedy review.

104. I have outlined at paragraph 45 above certain practices which officers Fawzy, Singh and Fifita believed they were bound to adhere to that night. That is, that a minimum of three officers was required to respond, and that a nurse or ambulance could not be called until they had assessed the situation themselves.

105. The source of the first belief is an Operating Procedure, current at that time and referred to as 'LF4', which appears on its face to require that when there is an emergency at OMMPCC in an open wing environment, three officers must attend. I refer here to Standard Operating Procedure *Posts/Staff Identified for an Emergency Response*.

106. At the inquest Ms Linda Ferrett, Acting Director of CSNSW Northern Region, cited LF4 as the applicable procedure to implement what was referred to as 'COPP 13.2'. This is CSNSW's *Custodial Operations Policy and Procedure for Medical Emergencies*. Ms Ferrett's coronial statement made clear that all officers were required to adhere to this policy.

107. I note that COPP 13.2 is stated to apply to situations where an inmate is discovered hanging or '*is found unconscious or seriously injured'*. There is nothing in the document to suggest application to a situation of serious illness.

108. Secondly, and despite Ms Ferrett's statement that compliance with the Operating Procedure was mandatory, some of her responses at the inquest indicated that this need not always be the case. For example, in the event that one of the required three officers was delayed in joining the others, she considered two officers could proceed to the scene after notifying their night senior.

109. The inquest did not hear any evidence of instruction to correctional officers that LF4 could be modified in certain circumstances. This was certainly not the impression held by any of the four officers involved in Nathan's case. I note all four had been employed for many years as correctional officers.

110. As for the source of the second belief, Standard Operating Procedure *Room Call Systems (Room Alarms)* directs officers to '*proceed directly to the cell/room'*, and '*where appropriate Justice Health staff must be notified of the incident*.' It would appear that the three responding officers interpreted this to mean (or were instructed to this effect) that before they called for nursing or paramedic assistance, they had first to attend the incident.

111. Adherence to these practices significantly delayed the response of the correctional officers to Nathan's medical emergency. Adherence to these practices is incompatible with the urgent response that he required, and which is mandated in COPP 5.5. There is a pressing need for review of these policies.

112. Before moving on to examine Nathan's medical care while he was in custody, I will consider a particular submission made on behalf of the family. This is that on their arrival at H wing, the three officers made their priority the security of the situation rather than Nathan's welfare. The evidence largely supports this submission, although as noted the officers took some steps directed at Nathan's care, such as requesting an ambulance and retrieving a wheelchair.

113. However given the circumstances I do not consider it would be fair to criticise the officers for this aspect of their conduct. The situation in H wing was a challenging one and they were outnumbered. They focused on trying to de-escalate the mood, and this largely remained their focus until the inmates were later transferred to an adjoining wing.

114. I do however strongly endorse the further submission made on behalf of the family, that the response exposed a lack of guidance to correctional officers

on how to manage an emergency medical situation in an open wing. After all, it will not always be the case that fellow inmates are on hand to provide the assistance that Mr Robinson and Mr Preo gave. Recommendations for improvement in this area will be considered later in these findings.

Nathan's ongoing medical care while in custody

115. I will now address the evidence regarding Nathan's medical care for asthma while he was an inmate at the OMMPCC.

116. The JH Network describes its provision of custodial health care as:

> *'.. a staged health assessment process that commences with a reception screening assessment.*
>
> *…Further assessments are undertaken in a planned and coordinated manner with follow up appointments arranged for those patients identified …with a diagnosed acute and/or chronic condition'*.
>
> [NSW Health Policy *Health Assessments in Male and Female Adult Correctional Centres and Police Cells*]

117. As will be seen however, an examination of the actual care provided to Nathan reveals that a structured plan for evaluating and managing his asthma was missing. While Nathan was in custody his severe asthma was not properly managed. The health service provided to him was inadequate, and significantly contributed to his risk for the fatal attack which took his life on the night of 31 August.

118. I have reached this conclusion on the basis of:

- evidence that the asthma treatment provided to Nathan fell short of what is required under JH Network policy; and
- the opinion of specialist Dr Greg King, addressed below, that while in custody Nathan's severe asthma was not diagnosed, properly monitored, or managed.

Nathan's initial screening assessment

119. When Nathan was received into custody on 10 May 2018 he underwent a routine health screening, known as a Reception Screening Assessment. The purpose is to identify and document an inmate's health risks and medications and if need be, to place them on a Wait List for nursing and/or medical appointments.

120. Nathan's Reception Screening Assessment was performed by Registered Nurse Mohini Kumar. Nathan told RN Kumar that he used Salbutamol (Ventolin) for his asthma condition. He also advised her that he had been hospitalised for asthma about two months previously.

121. RN Kumar made an entry on Nathan's Health Problem Notification Form that he suffered asthma and may *'complain of difficulty breathing or chest tightness'*. She then made a written request to Nathan's GP for details of his current medications.

122. As a result of her initial screening RN Kumar placed Nathan on the Wait List for four appointments. These were:

- an asthma review with a Primary Health nurse
- an asthma medication review with a GP, with a '*semi-urgent'* priority
- an appointment with the Aboriginal Health nurse
- an appointment with a Mental Health nurse.

123. RN Kumar explained that she made the first three of these appointments because she recognised Nathan needed a comprehensive assessment of his chronic asthma. She told the court that she expected the appointments would take place promptly. She did not have any further involvement with Nathan.

124. Most unfortunately, and for reasons which remain unknown, RN Kumar's referral of Nathan for an asthma review was electronically discontinued on the Wait List the following day.

The requirement for a Chronic Disease Screen

125. At the time she assessed Nathan, RN Kumar was not aware that according to JH Network policy she was required to refer him for a Chronic Disease Screen. She was one of several JH Network clinicians involved in Nathan's care, who were either unaware of the necessity for a Chronic Disease Screen, or had only limited understanding of its importance.

126. A Chronic Disease Screen [CDS] is mandated for inmates like Nathan who have a confirmed chronic condition. Nathan also met criteria for a CDS on the basis that he was an Aboriginal patient aged 35 years or older.

127. Had Nathan been referred for a CDS, then according to NSW Health Policy this would have been performed within 30 days. It would have involved:

- a review of the frequency with which Nathan used his blue puffer - an important marker for how well or otherwise his asthma was controlled
- a test of his lung function with a Peak Flow meter
- preparation of an Asthma Action Plan
- information to help Nathan identify his asthma attack triggers
- placement on a Wait List for review by a medical officer.

128. The court heard that an Asthma Action Plan is critical to good asthma care. This is, as Dr King described it in his first report, '*a clear and simple plan to implement, to prevent deterioration and death'.*

129. Importantly, as a result of the CDS Nathan would have been placed on the JH Network's Clinical Pathway for Asthma. This is a tool designed to guide an inmate's ongoing asthma treatment while he or she is in prison.

130. As the evidence below describes, while Nathan was in custody he did not receive a Chronic Disease Screen. An Asthma Action Plan was never developed, and his asthma treatment was not coordinated or managed under such a plan.

Nathan's asthma attack on 3 June 2018

131. On 22 May 2018 Nathan attended the OMMPCC Health Centre with symptoms of wheeziing, and was given a replacement Ventolin puffer. Earlier that morning he had a scheduled appointment for a doctor review. An entry was made at 9.00am '*DNA Did not attend'*. It is not known if Nathan knew of this appointment or was prevented for other reasons from attending.

132. Then on 3 June 2018 Nathan had an asthma attack. He came to the Health Centre with shortness of breath, and was attended by Registered Nurse Parveen Samant. She measured his oxygen saturation as at 94%, which indicated he was suffering a severe asthma episode. He was treated with Ventolin via a nebuliser and was given oxygen. In addition he was required to take oral Prednisone for two days.

133. This episode presented an opportunity for staff at the Health Centre to check whether Nathan had received his CDS and importantly, whether there was an Asthma Action Plan in place for him. This did not happen. At the inquest RN Samant acknowledged that she ought to have made this check, but did not.

134. As a result of his asthma attack Nathan was given an appointment with the visiting GP for 5 June. This was the only occasion Nathan saw a doctor while he was in the OMMPCC.

The GP consultation on 5 June

135. Dr Kenneth Landers is a staff specialist and Visiting Medical Officer with the JH Network. In 2018 he was attending five correctional centres on a weekly basis, one of these being the OMMPCC.

136. At the consultation on 5 June Dr Landers concluded that Nathan had not fully recovered from his asthma attack. He left directions for Nathan's lung function to be tested with a Peak Flow Meter. In addition he prescribed a further five days of Prednisone, as well as a Symbicort inhaler which was to be used at least daily. Like RN Samant, he did not check Nathan's records to see if he had undertaken a CDS and had an Asthma Action Plan. Had he done so he would have seen that neither was in place.

137. Dr Landers did not have any further involvement in Nathan's treatment.

138. Dr Landers told the court that his focus on 5 June was to treat Nathan for his recent acute asthma attack. Certainly he did not see his task as extending beyond that, so as to satisfy himself that Nathan's chronic asthma was being effectively managed.

139. It is fair to note that on 5 June there would have been little opportunity for Dr Landers to undertake the comprehensive asthma assessment that Nathan was still waiting to receive. His consultation with Nathan was probably one of the 12-15 consultations that, he said, typically take place on the visiting GP day.

140. Nevertheless it would not have been an arduous task for Dr Landers to confirm whether or not Nathan had received a CDS and had an Asthma Action Plan. At the inquest it was evident that at the time, Dr Landers had a limited understanding of the CDS process and did not see for himself any role in its operation, or indeed in the ongoing management of Nathan's severe asthma.

141. It is striking that in common with Dr Landers, almost every JH Network clinician with whom Nathan had contact lacked an adequate understanding of the CDS, and its key role in ensuring that chronically ill patients did not deteriorate. During his sixteen weeks at the OMMPCC Nathan had many contacts with JH Network staff. These included attendances for replacement Ventolin and for doses of Prednisone. Not one picked up that he had not received a CDS and did not have an Asthma Action Plan. No one was alert to the number of times he had been issued with a fresh Ventolin inhaler, a red flag for uncontrolled asthma. In particular his attendance with an acute asthma attack on 3 June might have been expected to prompt enquiry as to these matters, but it did not.

Dr King's evidence regarding Nathan's ongoing care

142. Dr King was asked for his expert opinion as to whether the management of Nathan's asthma condition while he was custody was adequate. Dr King's opinion regarding the emergency medical response on 31 August has been described above at paragraphs 89 following.

143. There was in fact a high degree of overlap between the two issues. This is because in Dr King's opinion, the prospects for surviving a severe asthma attack are low except in rare cases where medical expertise and equipment are readily available. Consequently for patients like Nathan with severe asthma, the '*death prevention focus'* must be on the ongoing management of their condition.

144. Dr King told the court that ongoing management of severe asthma requires the following elements:

- diagnosis by a specialist respiratory physician

- regular clinical assessment
- formation of a written Asthma Action Plan
- regular monitoring of lung function using a peak flow meter
- regular use of preventor medication
- an action plan for periods when asthma symptoms worsened.

145. Having examined the evidence Dr King had no hesitation in classifying Nathan as a person at high risk of severe asthmatic attack, based on:

- his history of hospital presentations for asthma, in particular in the preceding 12 months
- his frequent use of Ventolin
- his use of Prednisone over the course of a year
- his smoking.

146. Furthermore, at inquest Dr King commented that the number of times Nathan had been issued with a Ventolin puffer from the OMMPCC Health Centre (at least seven times) ought in itself to have been a major red flag. Nathan's asthma was clearly severe and poorly controlled. Proper attention to his condition would have identified other red flags: his likely underuse of preventer medication, and the onset of cold and flu symptoms two days prior to his death.

147. To the question whether the management of Nathan's condition was adequate, Dr King's answer was a qualified 'no'. His primary criticism was the failure of JH clinicians to identify Nathan as a person at risk of severe asthmatic attack. In his view the medical evidence available to the clinicians ought to have compelled this conclusion.

148. Dr King acknowledged that managing asthma well is not easy in the community and was likely more difficult in the physical environment of a prison. Nevertheless he thought it ought to be possible for custodial health services to identify high risk patients such as Nathan when they entered custody.

149. Dr King described the following as the features which had to be included in a plan for Nathan:

- referral to a respiratory diseases specialist
- assessment at four-weekly intervals to monitor how frequently he was using his preventor and reliever medication

- regular lung function monitoring

- a clear plan of action for when his asthma symptoms worsened (increased dosage of preventor medication, commence Prednisone, hospital referral, etc)

- a discussion with him about how to monitor his asthma and recognise when he was at risk of an attack.

150. Regarding the referral of severe asthmatics to a *specialist* clinic, Dr King explained that that many doctors and nurses underestimate the severity of the risks posed by severe asthma. Specialist doctors and nurses on the other hand are expert at identifying it, are more alert to signs of uncontrolled asthma, and have more success in persuading patients to make necessary changes to their behaviour.

Conclusion regarding the adequacy of Nathan's asthma care while in custody

151. Nathan's actual care and treatment fell well short of what Dr King considered adequate for a person suffering severe asthma.

152. The health treatment which Nathan received also stands in strong contrast with the JH Network's statement of its service for chronically ill inmates (paragraph 117 above). Health care was not provided to Nathan in a '*planned and coordinated manner'.* In particular the failure to screen him for chronic disease and to have in place an Asthma Action Plan are serious deficiencies, given their importance in preventing fatal asthma attacks.

153. Based on that evidence, and the expert evidence of Dr King, I have to conclude that while he was in custody Nathan did not receive the health care that he deserved.

154. At the inquest evidence was given by Ms Therese Sheehan, who is the Deputy Director of Nursing within the JH Network. She agreed there were significant gaps in the care Nathan had received while in custody, and readily acknowledged that his case had exposed a disconnect between the JH Network's policies regarding the CDS, and what the actual state of knowledge and practice was on the ground.

155. At the close of evidence a submission was made on behalf of the JH Network, that it was '*unlikely'* that a CDS or an Asthma Action Plan would have averted Nathan's death. The evidence does not support this submission. According to Dr King, a properly implemented Action Plan for a person with severe asthma would have included regular reviews to assess whether asthma was under control. It would also include an intervention plan of action should the patient's condition deteriorate. Both measures would have reduced Nathan's risk for the fatal attack which took his life.

156. At the inquest Ms Sheehan described system changes which have taken place since Nathan's death. These include a prompt at the Reception

Screening Assessment to ensure the clinician places an inmate with asthma on the CDS wait list. The CDS must take place within 30 days. Staff at the OMMPCC have also received refresher training in asthma management and the CDS requirements. These responses are welcome. However the evidence establishes that there is ample scope to build on these improvements with further changes, which will be considered now.

The question of recommendations

157. The evidence at the inquest established that systemic deficiencies contributed to Nathan's inadequate care, both on the night of 31 August and in his preceding months in custody.

158. At the close of the evidence Counsel Assisting proposed recommendations which are future-focused, and designed to build on the lessons learnt from Nathan's tragic death. The recommendations were directed to the Commissioner of CSNSW and to the CEO of the JH Network. Nathan's family supported these recommendations and made further ones.

159. I will now consider whether it is necessary or desirable to make these recommendations.

Recommendations to the Commissioner, CSNSW.

160. I have found that the response made by CSNSW to Nathan's medical crisis on the night of 31 August was unreasonably delayed, uncoordinated and inadequate. It deprived Nathan of the small chance he had of surviving his acute asthma attack.

161. The four recommendations to the Commissioner proposed by Counsel Assisting are supported by the Reynolds family and by the four involved officers.

162. The first two recommendations propose that CSNSW review its practices and procedures in relation to a '*serious health event',* including:

- the way in which COs identify and respond to these events, in particular the importance of assuming that reports of breathing difficulties are a life threatening event

- the role to be undertaken by the senior CO, in particular the circumstances in which he or she ought immediately to request nursing or paramedic assistance.

163. Importantly, Counsel Assisting proposed that the review include instruction to correctional officers about what happened on the night of 31 August, and what can be learnt from it.

164. Regarding the first recommendation, Dr King was in no doubt that where an inmate with asthma had breathing difficulties, this needed to receive the

response of a medical emergency. In his report dated 11 May 2020 Dr King explained this was because:

*'…it is very hard to tell the very few instances [of asthma attacks] that are **immediately** life-threatening. Therefore either all 'breathing attacks' in inmates with asthma have to be treated as potentially immediately life-threatening, or there is a reliable risk stratification at start of incarceration. I would anticipate it would be more feasible to take the former approach, ie that all cases are potentially life-threatening and that the inmates are attended rapidly, with the appropriate equipment and medications, and with the nurse alerted immediately*.'

165. Relatedly, in her evidence Ms Ferrett agreed that in cases of breathing difficulties, and where there would be delay in the gathering of three correctional officers, the policy needed to be that a nurse would be called immediately.

166. I strongly endorse Dr King's statement that reports of breathing difficulties need to be treated as life-threatening events. Nathan's tragic death graphically illustrates this imperative. And this indeed is the intent of COPP 5.5, which effectively mandates that inmates with breathing difficulties receive an urgent response.

167. So why has Counsel Assisting proposed this review? The rationale lies in the practical incompatibility on the one hand of COPP 5.5, and on the other, the obligation of officers to comply with 'LF4' which requires attendance of three officers in open wing environments. To this may be added the belief held by the three responding officers, that before requesting nursing or paramedic assistance they must first attend the scene and assess its gravity.

168. In cases of medical emergency it is simply not acceptable to delay nursing or medical assistance due to a requirement that correctional officers first attend the incident. Nor is it acceptable that in such cases they cannot do so until at least three officers are present. Nathan's tragic death demonstrates the practical difficulty for officers of reconciling the obligations within COPP 5.5, with policies and instructions which carry a real risk of delaying both their response and that of medical assistance.

169. CSNSW opposed these two recommendations. It was stated in submissions that there was 'flexibility' in the policy which required the attendance of three officers (at paragraph 18) and in the instruction that officers are not to run to a medical emergency (at paragraph 20). That there is flexibility in the application of these practices may be a perception within CSNSW management, but this was not apparent to the officers on the ground. This further underscores the need for clarity and clear instruction to officers about how the applicable procedures are to be implemented in cases of serious medical events.

170. Overall the submissions advanced on behalf of CSNSW did not provide a basis to reject these recommendations. The evidence at inquest did not support the submission made that '*Instructions on responding to incidents*

within all correctional facilities … are clear'. Nor can it be accepted that the practices and procedures which the evidence has established as problematical are already '*covered in the COPP 13.2 Medical Eme*rgencies'. As noted, COPP 13.2 is stated to apply to an inmate discovered hanging or found unconscious or seriously injured. Furthermore, COPP 13.2 does not provide guidance as to when a health event might permit departure from the practices which, as this inquest has identified, unreasonably delayed the correctional officers' response.

171. It was proposed by CSNSW that the '*three'* officers could receive retraining. This is not an acceptable response to what happened that night. There is no reason to suppose that the need for retraining is confined to the involved officers in this case. Nor is it clear from the CSNSW submissions what the retraining would cover, as the submissions do not acknowledge that the involved officers departed from any of the policies or practices the subject of the recommendations.

172. The need for review of policies, procedures and instructions in the areas enumerated in recommendations 1 and 2 is strongly indicated.

173. The third recommendation to the Commissioner concerns training of correctional officers about the risks and potential dangers of asthma. CSNSW opposes this recommendation on the basis that 'specific medical training' is outside the scope of correctional officers' expertise and duties.

174. This is acknowledged. However the intent of the recommendation is not to make correctional officers responsible for the medical treatment of inmates. It is to improve their understanding of this potentially fatal condition, and assist them to determine when escalation to nurse and paramedic care is needed. In their evidence officers Fawzy, Singh and Fifita acknowledged they had very limited knowledge or experience of asthma, one of the principal chronic illnesses within the prison population. This point was well illustrated in the evidence of Mr Singh. When asked why on his arrival at H wing he did not immediately request an ambulance, he replied that he had thought Nathan's puffer would fix the problem.

175. The final recommendation to the Commissioner is that the Commissioner review night staffing arrangements for minimum security centres, and ensure correctional officers are sufficiently fit to respond to urgent events.

176. This recommendation is only partially supported by CSNSW. In their submissions it is stated that Mr Fifita '*ought to have made [his knee problems] known to his employer, CSNSW'* (at paragraph 19). Yet as the submissions elsewhere acknowledge, Mr Fifita had no obligation to do so, and officers have no mandated ongoing fitness requirements.

177. The physical fitness of correctional officers to respond to medical emergencies should not be a matter for self-report. The evidence establishes the need for CSNSW to examine its policies in this area to arrive at an acceptable solution.

178. For the above reasons, I am satisfied it is necessary and desirable to make the four recommendations to the Commissioner, CSNSW.

Recommendations to the CEO, JH Network

179. I have found that the ongoing management of Nathan's severe asthma while he was at OMMPCC was inadequate, did not comply with the JH Network's own policies for asthma management, and fell well short of what was recommended by Dr King for proper asthma management.

180. For these reasons Counsel Assisting proposed six recommendations to the CEO of the JH Network. It is encouraging that the recommendations are supported by the JH Network, and also by the Reynolds family and the nurses who were involved in Nathan's care. I acknowledge also the steps the JH Network has taken since Nathan's death to improve staff knowledge of and compliance with CDS requirements.

181. The third and fifth of the proposed recommendations relate to the JH Network's practices for managing inmates who suffer or may suffer *severe* asthma. Dr King's evidence at inquest made a strong case that patients who suffer severe asthma are not easily diagnosed and need the input of a specialist service. Of course specialist diagnosis and management would involve resourcing and logistical challenges, but as submitted by Counsel Assisting, the JH Network should investigate whether telehealth appointments could assist. Telehealth appointments would also reduce problems of continuity that are created with changes to an inmate's placement.

182. Regarding recommendation 4, the response on behalf of the JH Network was that all night first aid trolleys now contain a defibrillator. This is welcome news. The JH Network will however reiterate the need for compliance with this requirement.

183. Underlying recommendation 6, is the evidence at inquest that when she attended Nathan RN Wright did not feel confident about administering an intramuscular injection of adrenaline. The evidence was unclear as to whether doing so was within the capacity of a JH registered nurse. The purpose of the recommendation is to provide clarity on this issue.

<u>Recommendation regarding the Winnunga model of health care</u>

184. Included in the recommendations to the JH Network is one which proposes that it investigate the model of care provided to First Nations prisoners by Winnunga Nimmityjah Aboriginal Health and Community Services ['Winnunga'].

185. Winnunga is a First Nations health organisation which since 2019 has provided health care and support to First Nations people who are incarcerated in the Australian Capital Territory. Winnunga's aim is to more appropriately address the complex social and medical needs of First Nations prisoners. It provides medical and nursing care, as well as social and emotional support for detainees and their families.

186. At the inquest material about Winnunga was provided to the court by Nathan's family. The court also heard evidence from Mr Matthew Trindall, a descendant of the Gomeroi people, and Director of Aboriginal Health for the JH Network. Mr Trindall is aware of the work of Winnunga. On behalf of the JH Network he expressed willingness to explore its model of care, and consider if any of its features could benefit the way in which care is delivered to First Nations prisoners in NSW.

187. Mr Trindall acknowledged that NSW had a much greater prison population than that of the ACT, and further that its First Nation inmates had a more diverse range of needs, due to their diverse environments and backgrounds. Nevertheless he endorsed the advantages to First Nation prisoners when their health care was delivered with the involvement of First Nation clinicians and workers.

188. Dr King agreed that the quality of asthma health care was enhanced when delivered by a clinician who is familiar with the patient's social and cultural background. This was especially important in helping patients to understand the risks of their condition, and persuading them to make necessary changes to their behaviour.

189. The 1991 Royal Commission of Inquiry into Aboriginal Deaths in Custody sent a clear message that the particular health needs of First Nations prisoners need to be recognised and addressed. Models of care which improve health outcomes for First Nations people in custody must be seriously considered. For this reason I make this recommendation.

Joint recommendations to CSNSW and the JH Network

190. Counsel Assisting made two recommendations *jointly* to CSNSW and the JH Network.

191. The first was that the two agencies review the existing communication arrangements between senior COs and JH registered nurses.

192. This recommendation arose from evidence that the officers at H wing did not have a direct line of communication to either RN Wright or the ambulance while they were on route to Nathan's location. As correctional officers are generally prohibited from carrying phones, they had to use their portable radios to relay information to Mr Phali, who as senior CO had the capacity to pass this on via mobile phone.

193. At the inquest Mr Singh expressed frustration that he had been unable to directly relay to RN Wright or to the oncoming ambulance crew any information or updates about Nathan's condition. Nor was he able to directly receive from them any instructions for first aid. For her part, it is clear that until she arrived at Nathan's side RN Wright had not been properly informed by Mr Phali of the gravity of Nathan's situation. She needed real time information about his condition from a correctional officer at the scene. This capacity is of

obvious significance in cases where nursing or paramedic assistance is delayed.

194. This recommendation was supported by Nathan's family, and by the JH Network. It did not appear to be supported by CSNSW.

195. The second joint recommendation was that COs and registered nurses receive training in how to respond to and provide aid, where the medical emergency has occurred in an *open* minimum security environment.

196. The unsecured environment of H wing presented undeniable challenges for the responding officers and for RN Wright. This factor (among others) hampered the ability of the officers to provide aid to Nathan, a fact acknowledged by Mr Singh when he expressed his thanks to Mr Robinson and Mr Preo for their care of Nathan.

197. I was not made aware of any evidence that CSNSW provides specific training for officers to manage an emergency situation in an open wing environment.

198. This recommendation was supported by Nathan's family and the JH Network. Submissions on behalf of CSNSW indicated they would consider scenario training for responding to medical emergencies '*within dormitory style accommodation'*, which I assume equates to open wing accommodation. Consideration would be given to conducting this training alongside JH staff and emergency services. I welcome their support of this recommendation.

199. The evidence strongly supports the need for review and training as outlined in all the recommendations proposed by Counsel Assisting. I am satisfied that they are necessary and desirable.

Additional recommendations made on behalf of Nathan's family

200. Nathan's family supported all the recommendations proposed by Counsel Assisting. In addition they made 16 further recommendations which I will now consider.

201. Nine of the recommendations are directed to the CEO of the JH Network.

202. There is clear merit in Family Recommendation 7, that the JH Network develop prison-specific templates for Asthma Action Plans. The template currently in use is not specific to the custodial environment. The JH Network supports this recommendation, and I will incorporate it within Recommendation 1 directed to the JH Network.

203. The JH Network also supports Family Recommendation 1, that the Adult Emergency Response Guidelines for Acute Asthma be updated, to better guide referral of inmates to the CDS and development of Asthma Action Plans. There is merit in this proposal, which is designed to reinforce JH's existing systems for placing patients onto these pathways. This proposal appears as Recommendation 7 to the CEO of the JH Network.

204. Family Recommendation 3 proposes the development of electronic medication charts, which raise alarms where dispensing signals exacerbation of asthma. The JH Network does not support this, submitting that it would be both costly and unworkable due to the variability of patient use and baselines. I accept this argument, and also the further submission that improved clinician education (contemplated within Recommendation 1 to the JH Network) should help achieve the purpose of the recommendation.

205. Family Recommendation 4 is also opposed by the JH Network. This is that the JH Network develop a protocol for clinicians dispensing asthma medication, to assess correctness of patient use and indications of exacerbation. The education aims of this proposal will be met by Recommendation 1(ii) to the JH Network.

206. The proposal in Family Recommendation 5 is that an audit be conducted to compare numbers of referrals to the CDS, with numbers of likely qualifiers. I accept the submission of JH Network that this proposal would be very costly and of doubtful benefit, noting that there are currently 13,000 NSW inmates who have chronic diseases.

207. Family Recommendation 6 proposes that the Reception Screening handbook be revised to include a specific heading addressing the significance of the CDS. I note however that the current screening handbook has a specific marker drawing attention to the CDS.

208. The content of Family Recommendations 14 and 15 regarding specific training to JH Network staff is already addressed in Joint Recommendation 2.

209. In Family Recommendation 2, the family proposes that evidence relevant to Dr Landers' treatment of Nathan be forwarded to the NSW Medical Council, for consideration of whether his professional conduct on 5 June 2018 should be reviewed. This proposal is not supported by Dr Landers, by the JH Network, or in the submissions of Counsel Assisting in reply.

210. In support of this proposal the family submitted that Dr Landers did not meet his professional obligation to satisfy himself that Nathan's severe asthma was being properly managed. Referral was said to be justified on the following grounds:

(i) his evidence exposed a lack of sufficient awareness of the requirements of the CDS and its clinical pathways
(ii) he did not undertake any enquiry as to Nathan's compliance with medication, frequency of puffer use, or placement on the CDS asthma pathway
(iii) he did not initiate any long term response plan for Nathan's asthma.

211. The evidence establishes that at the time he was treating Nathan, Dr Landers had but a limited understanding of the CDS process and the manner in which a patient entered its treatment pathways. In addition his evidence gave the impression that he had seen little or no role for himself in ensuring that Nathan had received a CDS screen and had an Asthma Action Plan in place

for the ongoing management of his condition. In these respects it must be acknowledged that his treatment of Nathan on 5 June was deficient.

212. Submissions on behalf of Dr Landers acknowledged that '*alternative management should have been considered'* in Nathan's medical treatment. However the acknowledgement was said to be available '*in hindsight'* only [refer paragraph 77]. In addition, Dr Landers' submissions and also those on behalf of the JH Network were that it was necessary to take into account Dr Landers' role as a primary care GP in the custodial setting; and that the standards expected of an asthma specialist like Dr King ought not to be applied to him (paragraph 19 of the JH Network submissions; paragraph 16 of Dr Landers).

213. I do not accept this submission. As a staff specialist and visiting medical officer, Dr Landers was obliged to make himself aware of the JH policies that applied to his patients. These included the policies in place for clinical management of asthma. Accepting that the GP clinic on 5 June provided limited scope for a comprehensive assessment, it would be expected that Dr Landers was sufficiently aware of the centrality of the CDS process and its clinical pathways, to check that these were in place for Nathan and to arrange a follow up appointment to ensure that he was being managed in accordance with them.

214. Nevertheless, and having carefully considered the matter, I am not of the view that it would be appropriate to refer Dr Landers to the Medical Council for consideration of review of his conduct. In reaching this conclusion I have taken into account Dr Landers' evidence that he is now familiar with the CDS procedure and the making of Asthma Action Plans, as this awareness had been reinforced by the JH Network since Nathan's death.

215. A further matter I have taken into account is that Dr Landers' deficiencies in treatment of Nathan were not isolated. The evidence established that there was an overall systemic failure to manage Nathan's asthma in accordance with JH Network policies and the established principles of good asthma management. Given this context, I am not satisfied that it would be appropriate to refer Dr Landers' conduct to the Medical Council for its consideration.

Family Recommendations to the Commissioner, CSNSW.

216. Seven further recommendations were made by the family, directed to CSNSW.

217. CSNSW has indicated support for Family Recommendation 8, that asthma be included as a significant health condition in COPP 6.3 *Inmate Health Needs*. The need for this recommendation is strongly indicated and I will make it as part of Recommendation 3 to the Commissioner, CSNSW.

218. Family Recommendations 9, 11, 12 and 13 have merit, but their content has been substantially addressed in the recommendations which I will be making: respectively Recommendation 1 to the CSNSW/Joint Recommendation 2;

Recommendation 4 to the Commissioner; Recommendation 1 to the Commissioner proposing instruction to officers of the lessons learnt from Nathan's death; and Joint Recommendation 2.

219. Regarding Family Recommendation 16 that defibrillators be made available within each stand alone unit, CSNSW has advised in its submissions that this is now the case.

220. In Family Recommendation 10 it is proposed that CSNSW consider updating its medical emergency policies, to recommend that staff access OIMS for any health alerts. This is not supported by CSNSW. The proposal is said not to be practical, and further that the Health Problem Notification Form is *'used to identify immediate health needs and issues and is the appropriate way for [CSNSW] staff to understand medical conditions of inmates'*.

221. While this recommendation has merit, I am mindful of the need not to overburden staff with additional requirements when they are responding to an emergency. In my view, the purpose of the recommendation would be achieved with proper adherence of officers to the provisions of COPP 5.5.

Conclusion

Nathan's death and the way he died are profoundly sad. His family loved him and they miss him deeply. Like them, I hope that this inquest will lead to real improvements in the care given to inmates with severe asthma, and the response they receive should an emergency occur.

Families like Nathan's also suffer because of long delays leading up to an inquest, and because of the difficulties they experience in getting information and ensuring their concerns will be heard. The NSW State Coroner is seeking ways to reduce the trauma for families of First Nations people throughout the inquest process. On the basis of both justice and compassion there is clearly a strong imperative for families to receive early and continuing attention in such cases.

I will close by expressing to the Reynolds family the sincere sympathy of all of us at the Coroners Court for the loss of Nathan. I thank them for their generous participation in this inquest.

I am very appreciative of the assistance given by Counsel Assisting the inquest, and the Crown Solicitor's Office. I acknowledge also the work of the Officer in Charge Senior Constable Monique Cini, whose compassion and understanding was acknowledged by Nathan's family.

Findings required by section 81(1) of the Act

Identity
The person who died is Nathan Reynolds.

Date of death:
Nathan Reynolds died on 1 September 2018.

Place of death:
Nathan Reynolds died at the Outer Metropolitan Multi Purpose Correctional Centre, Berkshire Park NSW 2765.

Cause of death:
Nathan Reynolds died as a result of bronchial asthma.

Manner of death:
Nathan's death from natural causes was contributed to by deficiencies in the management of his severe asthma by the Justice Health and Forensic Mental Health Network, and deficiencies in the immediate response to his medical emergency by Corrective Services NSW.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
11 March 2021

ANNEXURE 1: RECOMMENDATIONS

Recommendations to the Commissioner, CSNSW

Recommendation 1: Responding to a serious health event

CSNSW review its practice, procedures and the instructions given to Correctional Officers [COs] regarding CO response to reports of an inmate experiencing a *'serious health event'*. The review is to include:

(i) training about how to identify a '*serious health event'* (which includes asthma attacks or serious breathing difficulties)
(ii) how the responding COs are expected to make their way to the inmate (eg walking, jogging or running)
(iii) ensuring COs assume the event may be life threatening until proven to the contrary.
(iv) instruction to COs on the events of 31 August 2018 and the lessons learnt from the death of Nathan Reynolds

Recommendation 2: Role of the senior CO

CSNSW review its practice and procedures concerning the role of the senior CO in responding when an inmate is suspected of suffering a serious health event. This includes the senior CO:

(i) ensuring attending COs are aware of the health emergency involved
(ii) immediately deciding whether to request a nurse or paramedic to attend, before a CO sights the inmate, such as when:
    - COs cannot immediately attend on the inmate
    - a nurse may be delayed in reaching the inmate
    - there is incomplete information as to the inmate's condition
(iii) the senior CO attending on the inmate as soon as practicable to manage the response
(iv) if a nurse or paramedics are called, ensuring accurate information is conveyed to them about the inmate's condition and updates are reasonably provided.

Recommendation 3: Training about asthma

CSNSW provide COs with training or education on asthma including but not limited to:

(i) the risks posed by asthma to an inmate
(ii) the difficulties identifying when a known asthmatic inmate is at elevated risk of a life threatening asthma event
(iii) identifying flags for severe asthma when known asthmatic inmates may be at greater risk of a life threatening asthma event (eg regular or excessive puffer use; cold/flu symptoms)
(iv) bringing this to the attention of the Health Clinic
(v) including asthma as a significant health condition to be included in the Custodial Operations Policy and Procedures 6.3 *Inmate Health Needs*.

Recommendation 4: Adequacy of rostering arrangements

CSNSW review its staffing arrangements including but not limited to:

(i) ensuring there are sufficient COs on duty to enable an immediate response to an inmate who suffers or is suspected of suffering a serious health event

(ii) ensuring rostered COs are sufficiently fit to enable them to respond urgently to a serious health event.

Recommendations to the CEO, JH Network

Recommendation 1: Review of practices for asthma management

The JH Network review, where appropriate in consultation with a respiratory specialist with experience equivalent to that of Dr Gregory King:

(i) its asthma awareness education for patients
(ii) its training for nurses and doctors about severe asthma (including how to identify a possible case, its risks, the need for specialist review, maintaining curiosity about a patient's medication use and when to recommend change in placement or transfer to hospital owing to severity of condition)
(iii) its templates for Asthma Action Plans so that they are specific to the custodial environment
(iv) its training for nursing staff in asthma management or capacity within correctional centres (including developing rapport, learning of inmates' circumstances and enhancing efficacy) and
(v) its arrangements for patients with suspected severe asthma being reviewed in a specialist respiratory clinic, of the kind overseen by Dr Gregory King, including possible use of telehealth.

Recommendation 2: Review of Winnunga Nimmityjah Aboriginal Health and Community Services

The JH Network investigate the Winnunga Nimmityjah Aboriginal Health and Community Service's model of care, and consider if any features of that model are relevant and beneficial to the way in which the JH Network provides medical care to First Nations inmates.

Recommendation 3: Review of rostering arrangements for nurses at night

The JH Network review the adequacy of nursing rostering arrangements at correctional centres in circumstances where a nurse is not based/assigned to a correctional centre overnight (or is required to attend there from offsite).

Recommendation 4: Review of the first aid trolley

The JH Network examine introducing a requirement for all first aid trolleys to be used in responding to a serious health event at night, have a defibrillator om it at all times.

Recommendation 5: Review practices and procedures for management of asthma patients

The JH Network review Chronic Disease screening and asthma management plan protocols/procedures to ensure:

(i) patients suspected of suffering severe asthma have that diagnosis confirmed by a specialist with expertise in asthma management
(ii) for patients diagnosed with severe asthma, their management plans provide for:

- regular lung function monitoring and clinical assessment
- regular reviews of the patient's symptoms and medication usage
- regular reviews of the recorded amounts of reliever and preventer medication being issued to the patient in a given period
- when symptoms worsen, a plan to increase preventer medication and start prednisone treatment.

Recommendation 6: Review of training requirements for nurses on night shift

The JH Network review whether registered nurses are able to administer intramuscular adrenaline when responding to emergency situations.

Recommendation 7: Update of '*Adult Emergency Response Guidelines'*

The JH Network consider updating the '*Adult Emergency Response Guidelines'* for acute asthma to provide more specific guidance on the referral of inmates to the Chronic Disease Screening and for the development of an Asthma Action Plan.

Joint recommendations to CSNSW and the JH Network

Recommendation 1: Review of communication arrangements between senior COs and registered nurses

CSNSW and the JH Network review the arrangements for senior COs and registered nurses having the means of immediate, continuous and real time communication whether through use of portable radios or mobile phones, particularly in circumstances where a registered nurse may be required to attend a medical emergency from offsite.

Recommendation 2: Scenario training for COs and registered nurses in providing emergency first aid to an inmate within an open minimum security environment

CSNSW and the JH Network examine the provision of joint scenario training to COs and registered nurses in managing a situation, and providing emergency first aid treatment to an inmate, within a minimum security wing/environment where inmates may not be secured within cells and in and around the inmate receiving treatment.