CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Kevin Francis Bugmy
Hearing dates:	7-9, 11 February 2022
Date of findings:	6 July 2022
Place of findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; Death of ATSI man; use of inhalants; cardiac death; assessing the suitability of inmates for employment in correctional centres; excessive prisoner transfers between correctional centres; Aboriginal-specific drug and alcohol programs; availability of Aboriginal case managers; partnerships with Aboriginal Community Controlled Health Organisations; access to Medicare for Aboriginal inmates in custody; coordinated management of chronic inhalant use in custody as a health issue
File Number:	2019/120612

Representation:	Counsel assisting: Ms Georgina Wright SC, instructed by Gareth Martin, Crown Solicitor's Office Family (Ms Doreen Webster): Jalal Razi, Aboriginal Legal Service Commissioner for Corrective Services NSW: Patrick Broad, Department of Communities and Justice Legal Justice Health & Forensic Mental Health Network: Ben Bradley, instructed by Makinson d'Apice Lawyers
Non publication orders:	Non-publication orders made 11 February 2022 prohibit the publication of various persons personal information and particular evidence in the brief of evidence. The orders can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was Kevin Francis Bugmy. **Date of death** He died on 13 April 2019. **Place of death** He died at Cessnock Correctional Centre, Cessnock NSW. **Cause of death** Kevin died of severe coronary artery disease. It is likely that Kevin's use of inhalants in custody, including on about 13 April 2019, contributed to an ischaemic event resulting in a sudden cardiac death. **Manner of death** Kevin died in custody. The care he received for chronic substance use over many years was grossly inadequate.

Recommendations:	<u>Corrective Services NSW</u> (a) That Corrective Services NSW (CSNSW) introduce a system or process that allows CSNSW staff who are assessing the suitability of inmates for employment in business units in correctional centres to determine, from a single source of information that is readily accessible and comprehensive in the information it contains, whether there is any health or medical issue that might be an impediment to the inmate being allocated to a particular business unit. The system of 'Alerts' in the Offender Integrated Management System (OIMS) was not effective in the case of Kevin's death to inform the relevant CSNSW staff at Cessnock Correctional Centre that he should not be employed in an area where chemicals and solvents were available due to his history of inhalational drug use. No relevant, current information or warning was contained within 'Alerts', notwithstanding such information was contained in other CSNSW records, including within OIMS. As inmates are transferred between correctional centres, the system adopted should incorporate relevant health or medical alerts from across correctional centres pertaining to a particular inmate and apply statewide. (b) To support implementation of the above recommendation: that CSNSW adopt a policy, procedure or guideline to guide staff whose task is to assess the suitability of inmates for employment in business units in

	correctional centres about the system or process they should follow when doing so. (c) That CSNSW should review its policies, procedures or guidelines applying to inter-correctional centre prisoner movements with an eye to the case of Kevin who was moved over 50 times in 19 years with a view to reducing prisoner movements in the system. CSNSW should consider in this review the impact of prisoner movements on continuity of health and other care and management issues. The rights of long term prisoners should be specifically considered. (d) That CSNSW should introduce a system or process that allows CSNSW to monitor the number of inter-correctional centre prisoner movements an individual inmate has undergone to avoid an individual inmate enduring an excessive number of transfers. Excessive interfacility transfers may be inhumane and, in the case of Aboriginal inmates, it may exacerbate social and family dislocation, health issues and cultural disconnection. (e) That CSNSW should conduct and evaluate a pilot or trial of an Aboriginal-specific drug and alcohol program, being a program that includes culturally appropriate content and integrates Aboriginal perspectives in facilitator training and delivery. (f) That CSNSW should consider options for increasing the availability of Aboriginal case managers to Aboriginal inmates, particularly

	to those who need additional support to participate in drug and alcohol programs, such as Kevin did. CSNSW should seek to increase the cultural competency and cultural safety of its workforce and support this with ongoing training, supervision and leadership. <u>Justice Health and Forensic Mental Health Network</u> (g) That Justice Health and Forensic Mental Health Network (JHFMHN) should continue to explore and promote partnerships with Aboriginal Community Controlled Health Organisations to support the provision of culturally safe primary health care to Aboriginal patients and, in this context, should explore options for developing funding models that enable partnerships of this kind to be developed and sustained in the long term. (h) That JHFMHN should continue its work advocating for a trial for access to Medicare for Aboriginal inmates. In this context, JHFMHN should consider liaising with its equivalent or counterpart bodies in other States to coordinate and advocate for a trial process involving Medicare being made available by the Commonwealth to Aboriginal inmates. <u>Corrective Services NSW and Justice Health and Forensic Mental Health Network</u> (i) That CSNSW and JHFMHN consider convening a high level meeting to discuss

	how to better manage chronic inhalant use in custody, as a *health issue*. Consideration should be given to developing a coordinated therapeutic approach from both services.

Table of Contents

Introduction

1. This inquest concerns the death of Kevin Francis Bugmy. Kevin[1] was born on 2 December 1961 in Mildura, New South Wales. He died on 13 April 2019, at 57 years of age. He was declared deceased at Cessnock District Hospital emergency department, having been brought by ambulance from Cessnock Correctional Centre where he had been serving a lengthy sentence.

2. Kevin was a Barkindji man, a member of the Stolen Generation, separated from his family and raised in foster homes and institutions. His story is one that brings great shame on white Australia. It highlights the role of inter-generational trauma in the over-representation of First Nations people in custody. It demonstrates the need to provide culturally appropriate care to inmates. It calls on us all to listen to Aboriginal voices and acknowledge the terrible damage caused by colonization. It indicates a pressing need for change.

3. Kevin's sister engaged with the inquest process. Doreen Webster was herself a survivor of the Stolen Generation and of the Cootamundra Girls' home.[2] She spoke of the pain of being *"ripped apart from your parents…of being removed from your country and the pain of having stolen from you the right to know and be with your family."* She first met her brother Kevin as an adult when he was serving time in Kempsey Correctional Centre, but the strong spiritual and family connection between them was always evident. She became Kevin's contact and support in the world outside prison. She acknowledged the serious crime he had committed and sought to provide some understanding of the trauma that informed his actions. After Kevin's death, she participated in these proceedings out of love and respect for her brother and in the hope of achieving change within a system that had failed him.

4. I record my utmost respect for Ms Webster. I acknowledge her profound sorrow and send my sincere condolences to her family. Ms Webster showed fortitude, enormous grace and great integrity and I thank her for her participation in these proceedings.

The role of the coroner and the scope of the inquest

5. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[3] A coroner may make

[1] Throughout these findings I will refer to Mr Bugmy as Kevin.
[2] See Ms Webster's family statement at Appendix C.
[3] Section 81 *Coroners Act 2009* (NSW).

recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[4]

6. The forensic pathologist who examined Kevin after death was unable to determine a clear medical cause of death. For this reason, the court conducted further inquiries and obtained expert evidence in relation to Kevin's inhalant use and cardiac health in an effort to understand the reason for his death.

7. It should be noted that in any event, when a person dies in custody it is mandatory that an inquest is held.[5] The inquest must be conducted by a senior coroner.[6] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate. Very significant issues in relation to the quality and appropriateness of the care Kevin received arose during this inquest.

The evidence

8. The court took evidence over four hearing days. The court also received extensive documentary material in nine volumes. This material included witness statements, medical records and expert reports. The court heard oral evidence from those involved in Kevin's imprisonment and in relation to his medical care. Expert oral evidence was received from Associate Professor Mark Adams and Professor Megan Williams.

9. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

10. A list of issues was prepared before the proceedings commenced. These issues guided the investigation:

    (1) The direct cause of Kevin's death and any antecedent causes, including whether severe coronary artery disease and/or the inhalation of volatile substances by Kevin caused or contributed to his death.

    (2) The nature and adequacy of the management of Kevin's health conditions during his incarceration, specifically his known inhalant use and heart condition.

    (3) The adequacy of any measures taken by Corrective Services NSW (**CSNSW**) to prevent Kevin's access to volatile substances, particularly in the period leading up to his death including the adequacy of any alerts or warnings to correctional centres

[4] Section 82 *Coroners Act 2009* (NSW).
[5] Section 27 *Coroners Act* 2009 (NSW).
[6] Section 24 *Coroners Act* 2009 (NSW).

about areas of possible employment.

(4) Whether any recommendations are necessary or desirable in connection with Kevin's death.

Fact finding and chronology

11. Prior to commencing the inquest, a summary of facts taken from the extensive available material was circulated. This document was agreed to by the parties and is annexed at Appendix A. It accurately sets out a chronology of events and for this reason I do not intend to repeat all those details here.

12. Further information was received in oral evidence. Counsel assisting also summarised much of that material in her comprehensive closing submissions. I regard her submissions as accurate and, as will be evident, I rely heavily on that document to set out further chronological details and aspects of the expert evidence in these reasons, where appropriate incorporating her words.

The context to Kevin's incarceration

13. It is necessary to place Kevin's incarceration in its wider social context prior to a close examination of the particular facts of his custodial life and death. In this task the court was assisted by Matthew Trindall, Director of Aboriginal Strategy and Culture for Justice Health and Forensic Mental Health Network (**JHFMHN**) and by the expert evidence of Professor Megan Williams.

14. Mr Trindall told the court that, in NSW, Aboriginal and Torres Strait Islander people make up around 25% of the adult prison population compared to around 3% of the general population.[7] Like Kevin, a disproportionate number of prisoners have experienced Out of Home Care, juvenile detention and the prior incarceration of a parent.

15. The over-representation of Aboriginal and Torres Strait Islander people is hardly a recently discovered phenomenon. As far back as 1991 the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) publicised the fact that Aboriginal people were grossly over-represented in custody. Further, the Commissioners noted that this over-representation in both police and prison custody provides the immediate explanation for the disturbing number of Aboriginal *deaths* in custody. In other words, until we do something about over-representation, we will certainly continue to record a disproportionate rate of Aboriginal deaths in custody. More recently, this ongoing over-representation was accurately described in one submission to the Australian Law Reform Commission's inquiry into the

[7] Exhibit 9, Slides in relation to Aboriginal Patient Overview. I note recent figures released by Bureau of Crime Statistics (BOSCAR) record similar but slightly higher rates of over-representation.

Incarceration rate of Aboriginal and Torres Strait Islander people as a "*national disgrace*."[8]

16. The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration, including:

> "*the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects*".

The RCIADIC identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody.[9] Decades later, these factors remain at the forefront of our failure to reduce incarceration rates.

17. In grappling with the way in which specific legal mechanisms produce over-representation, focus is often drawn to the operation of bail laws. Kevin's case encourages the need for further investigation into the operation of the parole system and sentence length for Aboriginal people. One cannot help but wonder how many long-term prisoners like Kevin are denied parole over decades, without ever having been provided adequate and culturally safe case management. Kevin may have been "institutionalised" by the time of his death, but it must not be forgotten that Kevin was *never* offered a specific program to counter his particular and chronic solvent use issues. He was never offered drug and alcohol programs designed with cultural safety in mind. It is beyond the scope of this inquest to generalise, but I accept Ms Webster's claim that the parole system failed Kevin. Kevin was held in continuous custody for 36 years for an offence he had committed at just 20 years of age.[10] He was continually refused release without ever being offered appropriate case management for issues that had been clearly identified for *decades*.

18. Kevin had been sentenced to life imprisonment for murder. In 1987 he applied to have his minimum term re-determined. Eventually after appeal to the High Court, a minimum term of 16 years was fixed. He was thus eligible for parole for almost 20 years. According to his sister Doreen Webster[11] and a custodial officer's case note that is included in the brief of evidence, by the time of his death Kevin had understandably lost all hope of ever being released. I accept Ms Webster's view that Kevin's inability to get parole and his substance use became intertwined. She stated:

> "*It breaks my heart thinking about the change in him, thinking about him just giving up and sniffing those substances each night – that's a sure way to die.*

[8] ALRC Report 133 (December 2017); Pathways to Justice – An inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples, pp 21-22.
[9] *Ibid*, p 22.
[10] *Bugmy* v *R* [1990] HCA 18 Volume 3, Tab 59.
[11] T7.3-6, 11/2/22.

But when you're locked up like an animal like that without any hope – what's the use of living?"[12]

19. These factors form the relevant background to my specific inquiries. Kevin's inhalant use must be understood in this context. Given the known stigma around inhalant use, the court was keen to better understand the prevalence of inhalant or solvent use in custodial environments. Professor Kate Conigrave assisted in this regard. She is an addiction medicine and public health physician who has worked closely in partnerships with Aboriginal agencies and health professionals for two decades. She is currently the joint director of the Centre for Research Excellence in Indigenous Health and Alcohol.

20. Professor Conigrave advised the court that it is extremely difficult to ascertain the real levels of volatile substance use and results from surveys such as the Australian National Drug Strategy Household Survey must be treated with some caution. It is likely they under-estimate the level of use. Household surveys necessarily exclude individuals who are homeless, in hostels, hospitals or institutions.[13] They are also likely to exclude the very young and the particularly vulnerable. Nevertheless, figures indicate that use among Aboriginal people may be slightly higher than for non-Aboriginal people. She advised that the available figures relating to inhalant use in custody[14] should also be treated with some caution, given that data is obtained during face-to-face interviews with staff members. Nevertheless, it appears likely that the prevalence of petrol or volatile substance use in persons entering prison is somewhat higher than in the general population and is certainly likely to exceed 5%.

Background and custodial history

21. Kevin was the youngest of six siblings. His mother died when he was very young.[15] Kevin and his siblings were separated and placed in various foster homes or institutions, with Kevin being made a ward of the state at a young age. He was placed with various white foster carers[16] but spent most of his time in institutions. In his own words, he explained:

"*I did not emerge from these institutions skilled to enter the workforce or to really control my own life. As a result, my life was controlled by drugs and alcohol*."[17]

22. By the time Kevin was sentenced for the murder which took place in 1982, he had already spent considerable time in custody, commencing with a lengthy period in juvenile detention

[12] T6-7, 11/2/22.
[13] Report of Professor Conigrave Tab 50, p 2.
[14] See her discussion of the NSW Network Patient Health Survey at Tab 50, p 4.
[15] I note a CS case plan (Tab 13, p 19) suggests she died during childbirth, but Ms Webster believes it was when he was very young.
[16] Tab 65, pp 46-47.
[17] Tab 65, pp 46-47.

in 1977. Almost his entire early adult life was also spent in custody. In referring to his prospects of rehabilitation during an application for special leave to the High Court in 1990, their Honours Justices Dawson, Toohey and Gaudron, drew attention to the latest reports from the Victorian Office of Corrections which stated "*[Kevin's] prognosis is entirely dependent on his capacity to refrain from or at least limit his substance use*."[18] In this he clearly needed support.

23. When Kevin requested a transfer from Victoria to NSW custody, his application recorded that he had "*had no contact with anyone from the outside world since he had been imprisoned*." [19] Coming into NSW custody meant he could finally have some meaningful contact with his family of birth, but it did little to assist him with the issues that blocked his prospects for release.

Events leading up to Kevin's death

24. On 13 April 2019, at 12.10pm, a number of inmates saw Kevin collapse at Cessnock Correctional Centre. An inmate promptly used the 'knock up' system in Kevin's cell to call for assistance, saying there was an epileptic fit and asking for an ambulance.

25. Two correctional officers attended the scene immediately. On their arrival, Kevin was already being assisted to his feet by two inmates and saying he was fine. However, once accompanied back to his cell, his arms began to tense and shake and he was observed to have a seizure and to come in and out of consciousness thereafter. Correctional Officer Srur was unable to get a pain response or to obtain a radial pulse. Kevin is reported to have been gasping for air every few seconds.

26. Two JHFMHN nurses attended at 12.19pm and found Kevin to be unresponsive. The nurses immediately commenced Cardiopulmonary Resuscitation (**CPR**), attached a defibrillator and provided oxygen by an oxy viva bag. They administered multiple shocks with a defibrillator before the arrival of paramedics. They recorded that he had "*no palpable pulse*" and his blood pressure was "*unrecordable*". Adrenaline and amiodarone were administered and intravenous fluids were commenced (agreed facts [29]-[40]).

27. At 1.28pm, Kevin was loaded into the ambulance and conveyed to Cessnock District Hospital, arriving at 1.37pm. According to NSW Ambulance records, whilst CPR and treatment continued *en route*, "*multiple shocks [were] dumped due to non-shockable rhythms*" and on arrival at Cessnock District Hospital, Kevin was in "*asystole*" (colloquially known as 'flatline', representing the cession of electrical and mechanical activity of the heart). At 1.39pm Dr Jay Wilma of Cessnock Hospital Emergency Department declared

[18] Bugmy v R [1990] 18, Tab 59.
[19] Tab 65, p 46.

Kevin deceased (agreed facts [41]-[42]).

28. Thus, although he was declared deceased at Cessnock District Hospital, in my view it is almost certain that Kevin died before arriving at the hospital.

29. As set out in the agreed facts at [44]-[52], after his death, NSW Police commenced an investigation.

30. Several inmates who saw Kevin collapse made statements to NSW Police and their evidence is summarised in the agreed facts tendered at the hearing at [28]-[33]. The Officer in Charge, Sergeant Paul Wilks, gave evidence that the fact that inmates were prepared to provide signed statements to NSW Police about Kevin's death was an indicator of both the respect in which he was held as an elder and the absence of any suspicious circumstances surrounding his death.

31. Detective Sergeant Mitzevich of Newcastle Crime Scene section attended Cessnock District Hospital and examined Kevin. She found a film inside a folded piece of paper in Kevin's left short pocket, which was subsequently confirmed by the Forensic & Analytical Science Service (**FASS**) to be a suboxone film containing buprenorphine and naloxone.

32. Detective Mitzevich then attended Cessnock Correctional Centre and, in accordance with protocol, conducted a crime scene examination of the landing where Kevin had collapsed and of his cell. [20]

33. She observed that Kevin's cell was about 10 metres from the identified area on the landing where he collapsed. Two pillows were on the landing and blood was visible on one of the pillows. In Kevin's cell, Detective Mitzevich observed blood staining and vomitus on the bottom sheet near the head of the bed. She located:

    - Two plastic bags tied in a knot in the bottom of a red bucket located below a shelving unit that contained a liquid and white solid substance and smelt like an ignitable liquid.
    - A plastic bag between the sheets of the bed that contained moisture, that looked and smelt similar to the bags located in the red bucket.

34. Analysis by FASS found that the plastic bag from the bed contained a mixture of volatile substances including ethanol, acetone, butanol, toluene, butyl acetate and cyclohexanone. FASS said that these substances are ignitable liquids and can occur in some thinner products. The two plastic bags tied in a knot found in the bin contained the same volatile substances that were found in the plastic bag located in the bed. Also found within one of the two bags found in the bin was approximately 4 ml of a clear, colourless liquid. This liquid was found to contain a mixture of water-miscible substances.

[20] T27, 7/2/2022.

35. No police attended the Furniture Business Unit where Kevin had been employed.[21] Sergeant Wilks gave oral evidence that it is not something that he or the other police considered at the time.

36. Having reviewed all the evidence, I am satisfied that Kevin was using the solvents found in his cell in the hours leading up to his collapse. I note that this opinion is consistent with the available medical evidence, in particular Dr Cala's opinion that sniffing acetone can cause the kind of seizures which were in fact observed.[22] Various inmates described seizures prior to Kevin's death. I also note that one of the bags containing volatile substances was located *in* Kevin's bed. Further, two inmates' statements were to the effect that there were rumours that he had been "*sniffing thinners.*" Some inmates reported the day after Kevin died that he had been "*sniffing paint up at his work and everyone was trying to get it away from him*." [23]

Kevin's inhalant use disorder prior to and upon transfer to Cessnock

37. Kevin spent approximately 18 years in continuous custody in Victoria prior to his transfer to NSW. It is evident from the records that his use of inhalants and other drugs was well known before he entered the NSW system; his substance use disorder is discussed in every sentencing hearing, and there are Victorian custodial reports of Kevin being involved in prison "*home brew*" and found in possession "*a hookah pipe, glue and syringes*."[24]

38. CSNSW was certainly well-aware that Kevin had a chronic inhalant use disorder from the time he entered their custody. The history of the extensive records of his prior solvent use whilst in custody is summarised in the agreed facts, particularly at [60], [62], [64] and [71]. The need to participate in alcohol and other drug programs was also recorded in the vast majority of State Parole Authority notifications as one of the reasons for Kevin's continued failure to get parole.[25]

39. Accordingly, at an institutional level, Kevin's inhalant use was well known. However, it became clear that this knowledge was not properly passed on to relevant operational staff at Cessnock Correctional Centre.

40. On 16 January 2019, Kevin was transferred to Cessnock Correctional Centre from St Heliers Correctional Centre (agreed facts [21]),in response to an incident involving "*a high probability [Kevin] was using thinners and or glue and was unconscious for an amount of*

[21] T26, 7/2/2022, Sergeant Wilks.
[22] Autopsy Report at Tab 4, p 3.
[23] Statements at Tab 35 at [11]; see also Tab 30 at [10].
[24] See, for example, *The Queen* v *Kevin Francis Bugmy*, 2 November 1990, Supreme Court of Victoria No 90 of 1989.
[25] See Tab 63, pp 61, 67, 73, 106, 119, 193, 207. I note that this does not appear to have been referred to on the last two occasions he was refused parole: 13 July 2017 (Tab 63, p 54) and 11 October 2018 (Tab 63 p 2). The last occasion it was mentioned was 25 September 2014 (Tab 63, p 61)

time on the evening of 8/1/2019" (agreed facts [17]). His classification was also regressed from C2 to C1, and he was placed in segregation for 13 days (agreed facts [19]).

41. When interviewed Kevin appeared upset and was adamant that he had done nothing wrong and felt he had been "*targeted*" but was resigned that he would be moved yet again. He said he had plans to do a program at St Heliers and this would no longer occur (agreed facts [20]). He denied "*sniffing stuff*" and said he was now stuck in the yard and unable to work.[26] He reported to prison authorities that he wanted to work, progress to day leave and eventually be released. Kevin informed his new case manager on 13 February 2019 that he was content to do Violent Offenders Therapeutic Program (**VOTP**) Maintenance every two months[27] but he now had no desire to attempt any more programs, education or vocational training.[28]

42. At the time of the incident at St Heliers, CSNSW staff recorded his segregation status between 9 and 22 January 2019 in his Inmate Profile Document and placed a comment in that record on 9 January 2019 which said, "*Offender suspected of using thinners and/or glue to the extent of unconsciousness*". However, no alert was placed on the Inmate Profile Document or other CSNSW record to warn that Kevin must not be employed in any location where solvents may be stored or available.

43. On 18 February 2019, Kevin commenced employment in the Furniture Business Unit at Cessnock Correctional Centre. He worked a total of 210 hours in the Furniture Business Unit before his death.[29]

44. In March 2019, the Serious Offenders Review Council (**SORC**) endorsed the decision to regress Kevin's classification from C2 to C1 and recommended he remain at Cessnock Correctional Centre (agreed facts [26]). That recommendation was approved by an Assistant Commissioner as delegate of the Commissioner of CSNSW (the **Commissioner**) on 5 April 2019. The recommendation said that this would enable "*a higher level of supervision for a period of time*". However, there was clearly no greater oversight brought to bear on Kevin's substance use disorder, which was the stated reason for his transfer.

Access to solvents in Cessnock Correctional Centre

45. A significant part of the investigation entailed inquiries to determine whether Kevin obtained access to the solvents found in his cell from his place of employment within

[26] OIMS case notes, Tab 62, p 147.
[27] Statement of Governor Jeremy Leach at [8] and Annexure I: Tab 13.
[28] OIMS case notes, Tab 62, p 147.
[29] Statement of Mathew Beacher, Operations Manager dated 10 May 2021 at [12]-[13]: Tab 14; OIMS case notes, Tab 62, p 147.

Cessnock Correctional Centre. Given that Kevin was at various times disciplined, transferred, and refused parole for solvent use, one would have expected that CSNSW would, as far as possible, have provided him with an environment with limited access to solvents.

46. There is no doubt that Kevin obtained access to solvents over many years at multiple different correctional centres in NSW, as he was repeatedly suspected to be using, or actually detected using, in possession of, or intoxicated from, items such as paint thinners and glues.

47. It is likely that because these kinds of items are stored in correctional centres for legitimate purposes, they can be accessed more easily than can some other kinds of illegal substances. Professor Alison Jones, Specialist Physician and Clinical Toxicologist, opined that because individuals in prison have limited access to their drug of choice, they could turn to solvent inhalation even if they would otherwise spurn solvent use in the community.

48. I accept that stigma can attach to solvent use and that it is very likely to be under-reported. Prisoners may be reluctant to admit use, particularly when use is treated as a behavioural issue to manage and can trigger segregation and prison transfer.

49. Sergeant Wilks made inquiries of CSNSW about the products stored in both the Furniture Business Unit where Kevin worked and the adjacent Demountable Business Unit. While a number of substances contained acetone, no products contained all six of the solvents (in combination) identified in the three plastic bags found in Kevin's cell.[30]

50. FASS informed Sergeant Wilks that three commercial products on the market (paint thinners) contained all six solvents. None of those three products appeared in the lists provided by CSNSW as being products stored in the two business units. However, after hearing the oral evidence I am not convinced that the lists provided can be regarded as wholly accurate.

51. Counsel Assisting submitted that it would have been impossible for Kevin to obtain access to the substances himself from "*outside*" the prison as he did not have leave to work outside the prison in the months leading up to his death, nor did he have any visits from family (or any person), nor did he have any known contacts in the community apart from his sister. Further, she submitted that a scenario involving someone throwing an item "*over the fence*" to him, as was suggested by one witness, is inherently implausible given his circumstances and contacts outside the prison.

52. Counsel for CSNSW submitted that it was likely that the solvents found in Kevin's cell came from "*outside the gaol*", rather than from his workplace. He drew the court's attention

[30] T28, 7/2/2022.

to Sergeant Wilks's evidence that solvents may have been smuggled into the gaol.[31]

53. I do not accept that Kevin could have sourced solvents or inhalants from outside the prison himself. I accept the submission that it is inherently implausible. In my view, to suggest that Kevin could organise someone to throw inhalants over the fence is particularly far-fetched given his social isolation and recent transfer. I accept counsel assisting's submission that there are only three feasible options; that Kevin obtained the substance or substances himself from *within* the prison (such as directly from within his workplace), from a correctional officer or from another inmate. The evidence does not permit a finding to be made about the exact source of the substances. However, the evidence does show that there were few measures taken to prevent or thwart his access to solvents.

Appropriateness of his employment role and supervision

Alerts

54. At the time of his death, Kevin's Inmate Profile Document contained a table of "Alerts" including one which referred to a "*Recent incident which required hospitalisation after suspected ingestion of a solvent*", however that alert dated from April 2015 and had expired. It related specifically to the Dawn de Loas Correctional Centre. It was not marked on the profile as an "active" alert.

55. The records produced by CSNSW showed that, separate to his Inmate Profile Document, an "OIMS Alerts Query Module" contained two relevant alerts, but they had also expired on 11 and 12 February 2014, namely (agreed facts [58]):

    1. *NOT TO BE EMPLOYED IN INDUSTRIES WHERE SOLVENTS COULD BE OBTAINED[32] DUE TO HISTORY OF SNIFFING SUBSTANCES – AS PER GOVERNOR PROVOST – Expired 12/02/2014*
    2. *Inmate not to be employed in area where chemicals, toxic solvents etc are used inmate is known to 'sniff' these substances – Expired 11/02/2014*

56. On his transfer to Cessnock Correctional Centre, a "reception transfer checklist" noted he was under sanctions "*for possible sniffing spirits/thinners*" (agreed facts [21]).

Kevin's employment in the Furniture Business Unit

57. The court heard evidence from a number of CSNSW staff placed at Cessnock Correctional Centre in relation to Kevin's employment in gaol industries. Matthew Beacher, the Industries Operations Manager[33] at Cessnock Correctional Centre, told the court that all

[31] See submissions of CSNSW dated 19/5/2022 and T31.30, 7/2/2022.
[32] This alert was first registered on 29 November 2001: Tab 65, p 260.
[33] . He was not in that role in January 2019, but he previously held positions in that prison (T35, 7/2/2022)

C minimum security classification inmates were required to be engaged in employment in one of the business units at Cessnock Correctional Centre. Mr Beacher said that vetting an inmate to determine where they should be placed for work involved considering any medical conditions such as epilepsy or mental health issues and medications.[34] This check would be done by reference to the OIMS on the medical screen. If there was no medical condition preventing placement, Mr Beacher said they would be placed "*in the lowest job [to] try them out*".[35]

58. While it was not mandatory that an inmate commence in the Furniture Business Unit, inmates often did commence in that unit because it is one of the biggest units and requires low skill work.[36] The job involved cutting, gluing, stapling and final assembly of bed bases, in addition to painting of wooden treads. There were four staff overseeing up to 60 inmates in that unit, but the number of inmates usually hovered around 40.[37] At the end of the work-day, which was generally six hours, every inmate was pat-searched and at random there was a strip search of three to four inmates per unit. There is also a metal detector that inmates need to go through to leave the unit.[38]

Access to products containing solvents

59. Mr Beacher gave evidence that in his view Kevin did not work with or have access to any solvents when he was employed at the Furniture Business Unit. However, he said that pressure pack paint held in the Furniture Business Unit does contain acetone. He also gave evidence that solvent-based substances were stored in the Demountables Business Unit and the storage was overseen by an inmate. He said that inmates could not freely go between the two units, which were separated by a loading bay for trucks, and in his experience, any inmate who moved between the two units would be sacked.[39]

60. Mr Beacher confirmed that the lists of products provided by CSNSW, as being items with solvents stored in those units, does *not* represent the actual list of what was stored in January 2019 however there has been "*no drastic change*" to any of the business processes since 2019.[40] Mr Beacher said that all the lawn mowers and whipper snippers run on petrol and mowing is one of the lowest paid jobs in the prison, such that there would always be at least access to petrol by inmates in the gaol even though they are always supervised.[41]

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[34] T36, 7/2/2022.
[35] T42, 7/2/2022.
[36] T36, 7/2/2022.
[37] T37, 7/2/2022.
[38] T37, 7/2/2022.
[39] T39, 7/2/2022.
[40] T42, 7/2/2022.
[41] T43, 7/2/2022.

Induction relating to solvents

61. Michael Eden, Industries Overseer at Cessnock Correctional Centre, gave evidence in the inquest. In his role, he supervised inmates in the workshops and delivered induction to them.[42]

62. Mr Eden recalled inducting Kevin in the Furniture Business Unit and asking Kevin how long he had left on his sentence, to which Kevin replied "*I'm not going home*".[43] Mr Eden was surprised to learn that in a minimum security gaol there could be an inmate serving a very, very long sentence.[44]

63. Mr Eden was not given any information that Kevin should be kept away from solvents.[45] He had no role in the allocation of Kevin to his area of employment but as the Industries Overseer providing induction, he should have been made aware that Kevin should not have access to products containing solvents.

64. The induction was delivered in a group of four to six new inmates in the workshop. Mr Eden said that the practice was that the inmates were asked to fill out the form, to read it and understand it, and were asked whether they had the ability to read and write.[46]

65. A document titled 'Inmate Induction: CIC Furniture Business Unit' completed for Kevin, dated 18 February 2019 and signed by Mr Eden was included in the evidence as annexure B to Mr Beacher's statement. It is a 14-page document.

66. The first page of the induction form contains a list of activities, a number of which are marked with a tick or check. Mr Eden said that the person that inducted an inmate should complete that first page of the form indicating which induction activities were provided.[47] However, notwithstanding that Mr Eden said that he provided the induction training to Kevin, he did not recognise the handwriting on the first page of the form.[48] He said it was not his writing. Mr Eden could not offer any explanation why someone else would have filled out the table of induction activities if he was the person that delivered the induction. He said that the forms are filed upstairs in a filing cabinet once they are completed.

67. Mr Eden was taken to the various induction activities on the form that Kevin was said to have received including induction in relation to solvents and he said, "*well if he was inducted in that it wasn't by me*".[49] He said that Kevin was only a sweeper and he was

[42] T46, 7/2/2022.
[43] T48.36, 7/2/2022.
[44] T48, 7/2/2022.
[45] T60.24, 7/2/2022.
[46] T47, 7/2/2022.
[47] T49.11-14, 7/2/2022.
[48] T49, 7/2/2022.
[49] T53, 7/2/2022.

inducted into that role only.[50] Mr Eden was not aware that Kevin was promoted to Leading Hand. He was unaware of any later induction Kevin might have been given (the evidence does not reveal any further induction at a later date), however, he said that the form could have been later revised.

68. Even though the form is headed "Furniture Business Unit" Mr Eden gave evidence that some of the induction activities listed on the form are not relevant to work carried out in that unit[51] such as the use of oxyacetylene. Further, even though page 2 of the form provided a "*safe working practices checklist*" that included a ticked box for "*given instructions about working with flammable liquids and solvents*", Mr Eden said that it was a generic form that was not tailored for the induction of every individual. He said the practice was to tell inmates that if they needed any spray paint or cleaning chemical they had to ask an officer to obtain it for them.[52] Mr Eden said that the spray paint was stored upstairs in an office behind locked doors and that an inmate would access it through a correctional officer.[53] But he also said that "*down the front of the workshop, there's inmates that have access to aerosol, as in spray paint*".[54]

69. Mr Eden's evidence was that it was normal practice for inmates to tick the checklist on page 2.[55] Given his evidence that the officer providing the induction fills out page 1, it is curious that the practice is different with respect to the checklist on page 2.

70. The form states that Kevin received induction relating to solvents. I accept counsel assisting's submission that there is no adequate evidentiary basis to find that Kevin did *not* receive induction relating to the use of solvents in the Furniture Business Unit (such as, for example, the pressure pack paint stored in that unit) in view of the contemporaneous documentary record stating that he did. While Mr Eden stated that he did not complete the section, it may have been completed by another officer. The only other explanation is that some person ticked the form without regard to what actually took place. In all the circumstances, each of the available options is troubling.

71. If CSNSW provided solvent-related training to Kevin, this was inappropriate, given his extensive history of solvent abuse, and particularly as the reason for his very recent transfer to Cessnock Correctional Centre was that he was suspected of abusing solvents. If the form was ticked without regard to what actually occurred, it would demonstrate a very reckless approach to safety practices.

72. Mr Eden was much less certain than Mr Beacher about whether there could have been an

[50] T52, 7/2/2022.
[51] T53, 7/2/2022.
[52] T57, 7/2/2022.
[53] T57, 7/2/2022.
[54] T56.28, 7/2/2022.
[55] T59.37, 7/2/2022.

opportunity for Kevin to access the Demountables Business Unit where pressure pack paint containing acetone was stored. He gave evidence that inmates try "*all the time*" to move between the Furniture Business Unit and the Demountables Business Unit, but he said their employment is terminated if they are caught on the driveway.[56] He said that while there is "*constant*" patrolling by officers, there may be gaps in time when inmates at different business units may be able to make contact with each other.[57] Mr Eden also acknowledged that if an inmate is using a substance like a paint because he has been given access to it, there is nothing to stop that inmate then giving it to another inmate.[58]

Assignment to Furniture Business Unit

73. Steven Jarmain, Manager of Industries at Cessnock Correctional Centre, gave evidence that in January 2019 he held responsibility for assigning inmates to an appropriate business unit for employment. This was done through OIMS. The first step was to complete a check via the booking summary screen to identify any medical issues or concerns that may bear on the decision of where to place the inmate.[59]

74. Mr Jarmain's practice in January 2019 was to check the booking summary and any "active" JHFMHN alerts about the inmate.[60] He did not check "expired" alerts (identified by the status "Pending"). He would also check another section in OIMS under "Intake" for medical issues relating to inmates being placed for employment.[61] He said there was no information about Kevin in that section.

75. Mr Jarmain said that having done those checks, he was not aware of any health issues that Kevin had (on either the health screen or the booking summary screen).[62]

76. Mr Jarmain gave evidence that he did not, nor was he trained to, check that section of the Inmate Profile Document that contained 'Care in Placement' entries,[63] nor was it his practice in 2019 to print off the Inmate Profile Document.[64] He said that it is now his practice to print the Inmate Profile Document.

77. Mr Jarmain said that had he seen the Inmate Profile Document, the Care in Placement entry dated 9 January 2019 about Kevin's segregation (which contained a comment "*Offender suspected of using thinners and/or glue to the extent of unconsciousness*") it would have prompted him to contact the manager of security to raise the issue that the

[56] T65, 7/2/2022.
[57] T66.9, 7/2/2022.
[58] T69.39, 7/2/2022.
[59] T2, 8/2/2022.
[60] T5, 8/2/2022.
[61] T9, 8/2/2022.
[62] T10, 8/2/2022.
[63] T10-11, 8/2/2022.
[64] T10, 8/2/2022.

inmate had a problem with substances.

78. Mr Jarmain said he could not understand why Kevin was placed at Cessnock in minimum security at all when there were solvents in the wing which were readily available from sweepers, such as Windex and surface cleaners.[65] Mr Jarmain said he had "*a real issue with him being in the wing for a start*", and that if he had known of Kevin's solvent use there would have been nowhere to employ him because chemicals are "*everywhere, in all the work locations*".[66] He provided examples of mower fuels in the ground maintenance area, chemicals used by the hygiene crew, paints and chemicals in the Demountable workshop and wood based glue and spray cans for numbering the beds in the Furniture Business Unit.

79. Mr Jarmain said that if there is an alert about a medical issue, it is his practice to contact the Nursing Unit Manager by email about the issue to receive further advice. He said this occurs weekly,[67] and he requires an email response so that it is on record.

80. Mr Jarmain said there is no procedure or policy that guides an officer in how to assess inmates for suitability for work. He said that in preparation for giving evidence in the inquest, he was changing the procedure for assigning inmates to business units. He has created a local operating procedure as of 4 February 2022, however, his new procedure was "*yet to be signed off*" by the Operations Manager.[68] It involves checking information from the Inmate Profile Document as a whole and 12 months' worth of case notes so that information such as that contained in the Care in Placement section is not missed.

81. He agreed that what is needed is a system that allows him to check whether there is any health or medical issue or concern which might be an impediment to an inmate being allocated to a particular business unit for work. It needs to be comprehensive and easily accessible.[69] He added that it needs to operate state-wide, because the issue does not only affect Cessnock and it would need to incorporate health issues that may have come to light from previous correctional centres given that inmates move around quite frequently.

82. Mr Jarmain said that when the incident occurred he was asked by the acting operations manager whether he had checked the Inmate Profile Document and Mr Jarmain's reply was that in nine years he had never done so as he had always operated off the booking summary screen as he was taught.[70]

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[65] T11, 8/2/2022.
[66] T13, 8/2/2022.
[67] T12, 8/2/2022.
[68] T15-16, 8/2/2022.
[69] T15, 8/2/2022.
[70] T17, 8/2/2022.

Transfer to Cessnock Correctional Centre

83. Jeremy Leach, who was the Acting Governor of Cessnock Correctional Centre at the time he gave his statement, gave evidence before me. He is now the Manager of Security and answers to the Governor (and is second in charge at Cessnock Correctional Centre).[71] Although Mr Leach was not involved in making any decisions about Kevin, his views were sought at the hearing about the letter (attached to his statement) from the Senior Assistant Superintendent at St Heliers Correctional Centre to the Governor of that prison dated 9 January 2019 recommending that Kevin be moved from St Heliers Correctional Centre because of suspicions that he had been unconscious for several hours the previous night as a result of sniffing. Mr Leach said that letter was provided to Cessnock Correctional Centre at the time of his transfer.

84. Mr Leach said that in his view Kevin was moved from St Heliers following that incident because they thought his safety was at risk because of other inmates, noting the letter said as much.[72] Mr Leach denied that inmates are moved as a form of punishment for their behaviour, however, he agreed that moving prisoners is, more than likely, used as a deterrent to other inmates. That is to send a message that "*you will not be entitled to the low classification and as a result moved on to a centre that doesn't have the freedoms which were probably given to [Kevin] at St Heliers*".[73]

85. Mr Leach confirmed that the regression from C2 to C1 classification meant that, practically speaking, Kevin would not have access to the same work opportunities and programs as he had at St Heliers.[74] He gave evidence that in placing Kevin into segregation after that incident, he would have been in a single cell by himself and only allowed two hours of exercise per day.[75]

86. However, he maintained that the purpose was not *punishment* of any type. He said that segregation is a management tool to remove people from the wing area and inhibit contact with other inmates. Mr Leach said that the reason for Kevin's segregation was his risk of being assaulted by other inmates.[76]

87. The letter said that the inmates expressed concern that Kevin would die from his continued use of thinners. There was no record made of any expression of disapproval by them. Mr Leach acknowledged this (noting that it was not his letter) but said that he thinks the Acting Superintendent's concern about assault would have been "*fair dinkum*".[77] However, he

[71] T20, 8/2/2022.
[72] T24, 8/2/2022.
[73] T24, 8/2/2022.
[74] T25, 8/2/2022.
[75] T29, 8/2/2022.
[76] T29, 8/2/2022.
[77] T29, 8/2/2022.

acknowledged that he had not known any inmates to be assaulted because they used thinners or solvents or because they used drugs.[78] He agreed it is not a common occurrence for an inmate using drugs to be assaulted by other inmates for that reason. Mr Leach did not agree that segregation was a punitive response, given the Acting Superintendent's concern about a possible assault by other inmates.[79] He said that an Aboriginal inmate in segregation can always have contact with the Regional Aboriginal Support Officer (**RAPO**) and the Aboriginal inmate delegate. If given such access, it should be noted in the OIMS system. It may be true that contact can be provided to an officer or delegate, but I note that in this case there is no record in OIMS that Kevin had any access to a RAPO or Aboriginal inmate delegate when he was in segregation.

88. I do not accept Mr Leach's characterisation of what happened to Kevin after he was detected using solvents of some kind at St Heliers. In my view the regression of his classification, his forced movement away from courses he had been planning to do, and his segregation acted as a clear form of punishment and Kevin would have experienced it as such. Further, it clearly demonstrates that CSNSW saw Kevin's solvent use as a behavioural issue that needed management rather than a health issue which could cause his death.

89. In terms of the information provided to or obtained by Cessnock Correctional Centre at the time of Kevin's transfer in January 2019, Mr Leach furnished a Reception Transfer Checklist together with a Health Patient Notification Form (**HPNF**) dated December 2018 (Annexure F to his statement). He said the Reception Transfer Checklist was likely to have been completed by CSNSW staff at Cessnock. It was signed by Kevin and acknowledged that he did not fear for his safety, did not have any medical requirements, did not have any thoughts of self-harm or require protection or have any placement issues or special dietary requirements. Mr Leach said that Kevin would have been asked the questions and the officer conducting the interview on his reception would have completed the form for him.

90. In relation to the HPNF form, it contained information "*Past history of sniffing solvents*". It was completed by JHFMHN at St Heliers Correctional Centre in December 2018. Mr Leach did not know why there was no updated form completed at the time of Kevin's transfer to Cessnock Correctional Centre on 19 January 2019.[80]

91. The importance of an HPNF in the NSW custodial system cannot be under-estimated. It is the primary method used by JHFMHN to communicate important medical conditions and risks to CSNSW. Given that prisoners have a right to some privacy in relation to their medical records, this form has a crucial role in alerting custodial staff to medical risks which

[78] T29-30, 8/2/2022.
[79] T30, 8/2/2022.
[80] T32, 8/02/2022.

may be present. There are two clear problems with what occurred. Firstly, the move should have generated a new HPNF, particularly as there had been a recent risky use of inhalants. Secondly, the old HPNF supplied stated that Kevin had a *"past history of sniffing solvents".* This characterisation of risk was wholly inadequate when the very reason for the transfer was extremely recent unconsciousness due to sniffing.

92. Mr Leach said that receiving prisons are "*definitely*" looking for advice from JHFMHN on any medical issues affecting inmates and for recommendations about the management and accommodation of inmates.[81] The HPNF is used to provide that advice. He said that the HPNF form would have been reviewed and staff would have been made aware of the issue. He would expect that the issue would have been placed on 'Alerts' in the OIMS system. He said that, if it was not," it would be a problem".[82]

93. The effect of Mr Leach's evidence was that in his view there is no real capacity for a receiving prison such as Cessnock Correction Centre to guarantee a prisoner such as Kevin will not be able to access solvents.[83] He said that, if solvents and like chemicals were secured correctly, it should not be an issue. But he said generally all low classification gaols have industries operating within them and whichever gaol he went to, the same issue regarding access to solvents would arise.[84] He noted that Mary Wade Correctional Centre does not have a lot of industry on site and houses C1 inmates.

94. In my view the evidence reveals a significant failing on the part of CSNSW to properly manage Kevin's known and chronic solvent use. Over the years his solvent use triggered numerous transfers between gaols. However, what is clear from this close examination of the final transfer is that knowledge of the issue did not translate into proper oversight or supervision in relation to his access to solvents. The approach taken was both punitive and careless.

95. When Kevin was transferred from St Heliers Correctional Centre, JHFMHN informed Cessnock Correctional Centre of his past history of sniffing solvents by way of an old HPNF. More should have been done by CSNSW, including at St Heliers Correctional Centre upon the decision to transfer him and at Cessnock Correctional Centre upon his reception, to ensure that his solvent use disorder was properly recorded in OIMS so that all relevant staff at Cessnock Correctional Centre were apprised of that issue and could take steps to minimise future opportunities for access to solvents. A new HPNF could have been sought. Had Kevin's substance use disorder been known to Mr Jarmain, for example, he would not have placed Kevin in the Furniture Business Unit and he would have

[81] T34, 8/2/2022.
[82] T35, 8/2/2022.
[83] T36, 8/2/2022.
[84] T33, 8/2/2022.

escalated the issue. Mr Jarmain's evidence is compelling in this regard. Had Mr Jarmain escalated the issue, this may have resulted in Kevin being placed in a different business unit for employment, being transferred to another facility or being more closely supervised in the workshop.

96. In my view the failure to properly manage the risks involved with Kevin's chronic substance use issues had a direct impact on his health and may even have contributed to his death. It is an issue I will return to when considering recommendations.

Cause of Death

97. An autopsy was conducted by Dr Allan Cala, on 18 April 2019. In his opinion coronary artery disease could "*easily explain*" Kevin's sudden death apart from the complicating factor of long-standing inhalational drug use. Toxicological analysis detected acetone in Kevin's post-mortem blood sample. Dr Cala stated that acetone is known to be associated with seizures and nervous system depression, cardiac arrhythmias and death. He said he assumed the presence of acetone was due to recent "*huffing*" or inhalation, noting that the substance was also found in Kevin's cell after his death. However, as the blood level was unknown, Dr Cala said it was unclear precisely what role this chemical played in Kevin's death.

98. Due to the presence of acetone in Kevin's blood, Dr Cala could not conclusively determine whether the severe coronary artery disease was the cause of his death. Dr Cala stated:

> "*Although this man's death can be explained on the basis of severe natural diseases (heart related), the additional factor of inhalational drug use, with the present of acetone in blood as proof of this, means drug effect cannot be entirely excluded as having played no role in the death of this man. Accordingly, the cause of death is unascertained*."

99. At autopsy, apart from severe coronary artery disease, Kevin was found to have had:

(a) Calcified coronary arteries and aorta, described further as "*severe calcification and narrowing of each coronary artery, particularly the right coronary artery and left anterior descending coronary arteries by atherosclerosis*";

(b) Severe pulmonary emphysema;

(c) Distended urinary bladder

(d) A small scalp laceration at the back of the head on the left side, which Dr Cala said was consistent with a minor fall onto the back of his head as described in the narrative about what occurred at the prison.

Role of heart disease in death

100. The facts about Kevin's medical history are set out in Part G of the agreed facts.

101. The court sought further expertise to understand the nature of Kevin's cardiac risk and the part that could be played by his chronic solvent use. Associate Professor Mark Adams, Department of Cardiology, Royal Prince Alfred Hospital, provided a report dated 10 October 2021 and gave evidence that Kevin had undiagnosed severe and extensive coronary artery disease with previous myocardial infarction. He had a number of risk factors for coronary artery disease including that Kevin was: of Aboriginal background, male gender, over 55 years, incarcerated and a heavy smoker. However, he was not overweight, nor did he have diabetes.

102. In Associate Professor Adams' opinion, Kevin's death was likely a sudden cardiac death due to his underlying severe coronary artery disease and in particular a recent myocardial infarction that would have led to a significant risk of fatal cardiac arrhythmias. He opined that acetone intoxication may have put further stress on the heart and thus increased the risk of fatal arrhythmia developing. He considers there was a risk of sudden cardiac death of around 40-50% in a twelve-month period.

103. Kevin had a number of ECGs. An ECG performed on 30 June 2018 showed an abnormal result, being an old anterior myocardial infarction due to the occlusion of the left anterior descending coronary artery. Associate Professor Adams gave evidence that this type of cardiac damage compromises cardiac function often leading to cardiac failure and predisposes a patient to the development of potential fatal cardiac arrhythmias.

104. Associate Professor Adams gave evidence that the ECG of 30 June 2018 showed significant pathology and was a "*red flag*". He said the ECG provides both a waveform and English words interpreting the result. The machine reading was "*probable anterior infarct age indeterminate*". He said that was "*almost definitely an extensive anterior myocardial infarct*" probably from more than a month in the past.[85]

105. He said that for a person not skilled in ECG interpretation, reading that result "*should be probably a red flag that something is not normal and certainly just that ECG alone normally would trigger some sort of referral*".[86] He said that even though it excludes an acute myocardial infarction (at the time of the ECG), the purpose of the chronic disease screen is to look for chronic care and he would expect it to be escalated.[87] Even if the ECG was not mandated according to the applicable guidelines, once the result is obtained, it is necessary to act upon it (otherwise there is no point doing the ECG "*in the first place*").[88]

[85] T14.20, 9/2/2022.
[86] T14.25-35, 9/2/2022.
[87] T14.35, 9/2/2022.
[88] T14.44, 9/2/2022.

It can't be ignored on the basis it was not a mandatory test.[89] Best practice for a GP or emergency department doctor would be to refer the patient to a cardiologist for further guidance.[90]

106. Associate Professor Adams said in this case, the first referral would probably be to a general practitioner or some other doctor "*who could look at it*" followed by "*some better assessment of his cardiac function*".[91] This would involve an echocardiogram but ultimately probably a coronary angiogram to delineate what coronary artery disease he had. He said "*99% of the time someone with this sort of ECG has got significant coronary artery disease*".[92]

107. On 20 October 2018, Kevin was seen by a general practitioner as a "*follow up*" on his elevated cholesterol (agreed facts at [68]). It was not a follow up of his ECG result as the note made at the 30 June 2018 screen was that ECG and pathology were "*rebooked 2 years*" (agreed facts [67]). Further, no clinical note was made on 20 October 2018 by the GP that the GP looked at the ECG result taken on 30 June 2018. The GP noted only that the clinical examination was "*unremarkable*".

108. Associate Professor Adams gave evidence that the four-month delay in follow up after the 30 June 2018 abnormal ECG was a significant delay[93] and earlier follow up was desirable. Moreover, he said that "*at that follow up, a review of the ECG would've been important*".[94] His evidence was that without looking at the ECG at that consultation, there was in fact no follow up of the ECG result.[95].

109. As set out in the agreed facts at [107], Associate Professor Adams made the following other observations about the ECG records in his report:

    (a) An ECG in 2004 showed normal sinus rhythm and mild ST segment changes.

    (b) An ECG in 2015 when he was admitted to Westmead Hospital due to solvent intoxication was normal and showed no rise in troponin levels.

    (c) The ECGs done on 30 June 2018 and 27 March 2019 showed features consistent with an old anterior myocardial infarction due to the occlusion of the left anterior descending coronary artery. This type of cardiac damage compromises cardiac function often leading to cardiac failure and predisposes to development of potential fatal cardiac arrhythmias.

[89] T15.37, 9/2/2022.
[90] T15, 9/2/2022.
[91] T15, 9/2/2022.
[92] T15.10, 9/2/2022.
[93] T20.45, 9/2/2022.
[94] T21, 9/2/2022.
[95] T21, 9/2/2022.

(d) At some point between 6 February 2004 and 30 June 2018 Kevin had a large myocardial infarction.

(e) It is difficult to pinpoint when the large myocardial infarction occurred and it is possible that Kevin did not seek medical treatment when it happened. However, as he had a normal ECG in 2015, it narrows down the time interval as between 2015 and 2018. There are no clear episodes where his extensive coronary artery disease caused symptoms.

110. Associate Professor Adams considers that it may have been appropriate to perform further cardiac tests in response to the abnormal ECG seen on 30 June 2018. He noted in his report that no medical practitioner records having reviewed the ECG result and that medical review would have made it more likely that abnormalities were picked up.

111. Associate Professor Adams noted in his report that JHFMHN's procedure for managing patients with a chronic condition is appropriate in not performing an ECG routinely. It is commensurate with what should be performed in the community where an ECG is only done in response to symptoms or where a patient may have significant risk factors for coronary artery disease. (He further noted that this is because ECG can yield false positive results and is "*not a great screening test*".) However, I accept his opinion that those factors became largely irrelevant once the abnormal "red flag" result was obtained on 30 June 2018. Best practice would dictate that there should have been some form of follow up of the abnormal ECG result (not merely his cholesterol). JHFMHN failed to do this.

112. Counsel for JHFMHN submitted that as a matter of procedural fairness no criticism ought to be made of the individual nursing or medical staff who were engaged in Kevin's screening or follow up care. The court accepts this and no specific practitioners are the subject of any criticism. The court is only concerned to support reflective thinking about best practise. The issue is an important one and in my view Associate Professor Adams's evidence suggests JHFMHN could properly consider developing a protocol to assist staff who conduct ECGs to properly identify when a results review should be escalated. I do not intend to make a formal recommendation in this regard but consider it appropriate for JHFMHN to review its guidelines so that in similar circumstances a potential red flag is not missed.

113. As to the role of acetone in the heart attack, in Associate Professor Adams' opinion, given Kevin's severe coronary artery disease, solvent use including acetone could have led to an increase in Kevin's heart rate and blood pressure and may have provoked ischaemia thus increasing the likelihood of developing an arrhythmia. Associate Professor Adams notes that toxicological studies of acetone have found little cardiac effect other than tachycardia. However, one 2017 study reported that exposure to solvents can increase

ECG changes and arrhythmias. These studies have generally considered lower doses of solvents than are seen in substance abuse and there are reports of fatal tachyarrhythmias and bradyarrhythmias observed in some cases.

Role of acetone or other solvents in death

114. The opinion of Professor Jones supports the view that Kevin's inhalational drug use may have played a contributing role in the heart attack which caused his death.

115. At the time of post-mortem, the toxicology results showed the detection of acetone with a reading of 0.01% (100 parts per million (**ppm**) in post-mortem blood). Screening tests were not undertaken for the other substances that were found in Kevin's cell, which included ethanol, butanol, toluene, butyl acetate and cyclohexanone.

116. On or about 5 February 2021, the Forensic Science Laboratory within ChemCentre, Western Australia conducted a toxicological analysis of a 6 ml sample of Kevin's blood to determine the level of acetone in the blood and to screen for the presence of the volatile organic compounds known as ethanol, butanol, toluene, butyl acetate and cyclohexanone. Approximately 0.01% acetone was detected. No other volatile organic compounds were detected.

117. Professor Jones reported that Kevin's post-mortem acetone reading of 0.01% is unremarkable. She would not expect clinical features of toxicity; however, in her opinion, the absence of toxic concentrations of toxins in Kevin's post-mortem blood does not exclude the role of volatile organic compound solvents in his death. She said that while the finding of acetone could be due to inhalation or physiological processes or both it does not constitute proof of inhalational or ingestion. Volatile organic compounds such as those found in Kevin's cell evaporate in the air and diminish or degrade over time between sampling and analysis because of their physicochemical nature. Kevin's death occurred on 13 April 2019 and samples were first received by the first toxicology laboratory on 24 April 2019. In her opinion, the lack of detection in 2019 and 2021 does not rule out their presence in his blood at the time of death. Therefore, Professor Jones' expert evidence does not exclude the possibility that Kevin's inhalational drug use played a contributing role in his death.

118. It is also very difficult to judge what role inhalation of various substances may have had on Kevin's cardiac health over many, many years, partly because it is impossible to now know which substances he may have come in contact with and in what quantities. Associate Professor Adams states, "*it is not entirely clear whether inhalational solvent drug use has deleterious effects on the heart, although this may vary depending on the agent used*".[96]

[96] Report of Associate Professor Adams, Tab 49A, p 3.

He goes on to say that some agents have marked adverse cardiac effects, including substances such as toluene, tylene and chlorinated solvents. The situation is further complicated by the fact that most studies have generally looked at much lower levels of exposure such as may be found in occupational settings.

119. Having considered all the evidence, I am of the view that JHFMHN failed to follow up on, or escalate for further cardiac assessment, a clearly abnormal ECG result indicating serious heart disease obtained on 30 June 2018. I also find that in view of Kevin's undiagnosed severe and extensive coronary artery disease with previous myocardial infarction, it is likely, in the sense that there is a real possibility, that Kevin's use of solvents on about 13 April 2019 resulted in an increase in his heart rate and blood pressure that provoked ischaemia, and increased the likelihood of him developing an arrhythmia, resulting in a sudden cardiac death.[97] It is also possible that his use of solvents, over many years had affected his cardiac health in the long term.

120. Given the proximity of Kevin's use of solvents to his collapse, I accept that the two events are likely connected and I find that acetone and/or other solvents are likely to have played some contributing role in his death, in the sense that that there is a real or "not remote" chance or possibility that his inhalation of solvents on 13 April 2019 contributed to the development of a life-threatening arrythmia on 13 April 2019.

Inter-correctional transfers

121. Kevin was subjected to an extraordinary number of interfacility transfers during his nineteen-year incarceration in NSW, particularly for a sentenced prisoner. He moved correctional centres more than 50 times between 2000 and his death. The longest period in one correctional centre was two years and nine months.[98] The most recent transfer before his death occurred on 16 January 2019 when was moved from St Heliers Correctional Centre to Cessnock Correctional Centre.

122. The evidence shows that the reason for some transfers was his solvent abuse. (See, for example, incidents dated 22 November 2001, 12 December 2007, 6 March 2013, 28 January 2016, January 2019 outlined in chronology at [71] of the agreed facts.)

123. Mr Leach gave evidence that, in his experience, 50 plus moves sounded like a "*very excessive amount of times to be moved over that period of time*".[99] He had not seen any

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[97] The word 'likely' appears in many statutes and it is generally interpreted as meaning "a real or not remote chance or possibility" as distinct from a "probability in the sense of a more than 50 percent chance": *Boughey v The Queen* (1986) 161 CLR 10 at 21; *Minister Administering the Crown Lands ACT v Deerubbin Local Aboriginal Land Council* (No 2) [2001] NSWCA 28; (2001) 50 NSWLR 665 at [51]-[52]. While the expert evidence does not permit a finding that there is a *probability* of a causal link, it is open to find that it is likely that Kevin's solvent use contributed to his fatal heart attack.
[98] Inmate Profile Document: Tab 54.
[99] T37.55, 8/2/2022.

other inmate moved with that frequency.[100] While he noted some of the reasons prisoners are transferred for, such as the prisoner has court dates while on remand, changes in classification or completion a particular program, those considerations can only explain a limited number of Kevin's inter-correctional centre moves.

124. However, when questioned further about the implications of the moves, he said if that information was before him as Governor, he would consider it was a high number and think "why?", but he would not take the matter any further as "*that's not up to me*".[101] He said, "*it's not my place to ask anything outside of my correctional centre*".[102] This evidence highlights the need for monitoring of the number of prisoner movements at a higher level than at the level of an individual correctional centre.

125. The court was interested to understand how these constant movements affected Kevin's ability to access health care and relevant programs.

126. Dr Gary Nicholls, Clinical Director, Primary Care Medicine within JHFMHN, gave evidence that frequent movement of inmates can affect continuity of care and the development of effective therapeutic engagement with health services.[103]

127. It is clear from the statement of Danielle Matsuo, Director of State-wide programs, CSNSW, that there were occasions when Kevin's placement had an impact on the availability of programs he could be offered. For instance, staff at Broken Hill Correctional Centre tried to organise one on one counselling with him in March 2013 but this did not occur. In 2014, Smart Recovery and one to one counselling were not available at Bathurst Correctional Centre where he was housed. The intensive drug and alcohol programs IDATP and Ngara Nura were only run in minimum security locations. Kevin was not eligible to access programs when he was in segregation, which occurred in each of the years 2010, 2011, 2013 and 2019 (noting however that periods in segregation are not included in the 50+ transfers). It stands to reason that the greater the frequency of his moves, the greater the impact would have been on his access to programs.

128. In my view, 50 or more transfers in 19 years is excessive and unreasonable, particularly for a sentenced prisoner. These transfers had a deleterious effect on all aspects of Kevin's life including on family contact, ability to engage in educational programs and access to health care.

129. The court was interested to ascertain who was responsible for monitoring these movements as there does not appear to have been any coordinated oversight of the

[100] T38.1, 8/2/2022.
[101] T37, 8/2/2022.
[102] T38, 8/2/2022.
[103] Tab 37 at [7].

number of transfers or application of any guiding principles. The moves appear to proceed on an *ad hoc* and largely reactive basis. I accept counsel for Ms Webster's submission that the constant movements are likely to have caused feelings of powerlessness and despair in Kevin.

130. Legally, the Commissioner was ultimately responsible for Kevin's placement on the advice of the SORC (that body has existed since 1994).

131. As the evidence shows,[104] SORC made a recommendation to the Commissioner[105] for Kevin's placement at Cessnock following the incident at St Heliers in early 2019. That recommendation had its genesis in a recommendation of the Senior Assistant Superintendent at St Heliers Correctional Centre followed by a recommendation by a CSNSW Classification and Placement Officer. SORC's letter to Kevin confirming adoption by the Commissioner's delegate of SORC's recommendation noted that it had regard to reports "*regarding incidents involving the inhalation of solvents*" and that SORC recommended a "*higher level of supervision*" "*for a period of time*".[106] SORC also suggested to him that he consider being assessed for EQUIPS Addiction.

132. That evidence indicates that while inter-correctional centre transfers are ultimately made by the Commissioner (or delegate), decisions are made on the advice or recommendations of staff at multiple levels within CSNSW. There is no evidence that in making those decisions and giving advice about placement, consideration was given to the number of transfers Kevin had already undergone or to the effect it may have had on his well-being.

133. Kevin's case indicates the need for some level of scrutiny within CSNSW of the number of transfers, and the appropriateness of repeated transfers including as a response to ongoing drug use or health matters, for a long-term inmate. It is an issue I will return to when considering recommendations.

Primary health care during lengthy incarceration

134. Dr Nicholls provided four statements and gave oral evidence at the hearing. He was not directly involved in the care of Kevin. He outlined that JHFMHN's role with regard to Kevin's solvent use disorder was to provide care in an acute medical situation.[107] While JHFMHN provides mental health services and drug replacement services such as methadone, JHFMHN does not provide (and is not funded to provide) drug and alcohol programs or psychological services, these being within CSNSW's jurisdiction.[108] He said that to the

[104] Agreed facts at [17]-[18], [26]-[27].
[105] To the Assistant Commissioner as delegate of the Commissioner.
[106] Annexure E to statement of Governor Leach; Tab 13.
[107] T54.31, 8/2/2022.
[108] T55, 8/2/2022.

extent JHFMHN does provide services around drug and alcohol abuse, solvents "*are not really part of the general mix of the work they do*".[109]

135. Further, while JHFMHN staff are trained in brief interventions (involving questioning of a patient about their alcohol or other drug use in order to provide advice in the acute medical situation at hand), brief interventions do not provide "*deeper inquiries around drug and alcohol use*"[110] and are not specific to inhalants in any event.[111]

136. JHFMHN also provided chronic disease screening as part of its primary health care program, although this was not directed to detecting or treating a drug and alcohol or solvent abuse disorder.

137. Dr Nicholls noted that sniffing of spirits and thinners is not a specific health condition in the same way as asthma or heart disease or cellulitis. Rather it is a "*behavioural situation that could lead to health problems*";[112] and that it is primarily "*a behavioural or a housing issue for the Corrective Services staff to be aware of*".[113] It is not recognised by JHFMHN specifically as a health issue nor is it something JHFMHN deals with directly.[114] He said that specific treatments for the abuse of opiates such as Opiate Replacement Therapy are available but the treatment for solvent use is psychological (such as cognitive behaviour therapy). It is "*not a medicalised addiction because there's no specific medical treatment*".[115]

138. In short, Dr Nicholls explained that JHFMHN's role was to provide general medical support and preventative health interventions (such as to detect heart disease), but not to provide any counselling or psychological programs to assist Kevin to overcome the solvent abuse disorder in the short or long term.

139. The court was concerned that the division of services – "medical" to JHFMHN and "psychological" to CSNSW – presents a clear barrier to patient centred care in these circumstances. While the split is the result of a historical division of responsibilities it serves no useful purpose and actually impedes holistic care. Counsel for JHFMHN was critical of what it saw as a tendency of some witnesses not to clearly distinguish between the health services provided to patients such as Kevin and the allied health and programs provided by CSNSW. Mr Trindall suggested, for example, that Professor Williams conflated these services. If this occurred, it likely occurred because the division is arbitrary, unhelpful and difficult for an outsider to comprehend.

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[109] T55, 8/2/2022. See also T57, T59.30-40, 8/2/2022.
[110] T52, 8/2/2022.
[111] Tab 37 at [15].
[112] T58, 8/2/2022.
[113] T55, 8/2/2022.
[114] T58,8/2/2022.
[115] T59, 8/2/2022.

140. Dr Nicholls agreed that the division of responsibilities between JHFMHN and CSNSW regarding the provision of medical services on the one hand and psychological services and drug and alcohol programs on the other hand presents a barrier to the provision of holistic care but said this is a product of the way the services are funded.[116] He suggested that it is not dissimilar to hospital services in the community in which psychological services and programs are provided externally by non-government organisations such as Smart Recovery and in the outpatient setting.[117]

141. However, the correctional setting is not entirely analogous to the public health system. For example, a patient who presents to the emergency department with an acute problem arising from a solvent use disorder could be referred to counselling within the public health system and clinicians would have access to the health records through the electronic medical record, which provides the conditions for providing more holistic care.

142. I accept Dr Nicholls' evidence that there is a potential issue affecting the development of trust and patient confidentiality arising from the fact psychology services are provided by CSNSW, being the agency that is also responsible for imprisonment of the 'patient' (and responsible for recommendations regarding release to parole). He also noted that the psychology services provided by CSNSW follow a "criminology approach" to psychology rather than the type of psychology model which may be provided in the community.[118] He said there are nevertheless opportunities for collaboration between JHFMHN and CSNSW with regard to complex patients (particularly for self-harm) and multidisciplinary meetings can and do occur with CSNSW psychologists, but he acknowledged potential issues can arise concerning patient confidentiality and the sharing of information, arising from the division of responsibilities between the two agencies.[119]

143. Dr Nicholls said that the "*elephant in the room*", so far as the provision of holistic care is concerned, is really access to Medicare as, if prisoners had such access, a lot more services would be available and more collaboration would be possible.[120] Access to Medicare would also assist the continuity of care for people as they move between gaol and living in the community. For example, it would be possible to refer inmates to Aboriginal medical services or their local doctor and there would be reviews on discharge or release from prison and access to the electronic health records. Dr Nicholls said that, currently, there are many problems with linking electronic health records because of the lack of access to Medicare by JHFMHN's patients.[121]

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[116] T54, 8/2/2022.
[117] T54, 8/2/2022.
[118] T59, 8/2/2022.
[119] T59, 8/2/2022.
[120] T60, 8/2/2022.
[121] T60, 8/2/2022.

144. In terms of barriers to holistic care, Dr Nicholls emphasised that Kevin denied solvent inhalant use and declined help when offered it.[122] He gave evidence that this denial could have been partly due to his perception of the risk of being moved or getting into trouble.[123] He appeared generally to agree that Kevin's denials should not have foreclosed other avenues to support being offered or provided, but he did not see this as an issue for JHFMHN, given the division of responsibilities between JHFMHN and CSNSW.

145. In my view when a patient denies or refuses help or treatment, it should be regarded as an opportunity for reflection and potential review of the service being delivered. It was well known that Kevin had a chronic solvent abuse issue; what was needed was much greater curiosity about why the "help offered" was not attractive to him. Was he concerned about being further punished? Was the program or treatment useful and culturally safe? Had he already lost all hope of ever gaining parole?

146. Dr Nicholls gave evidence that there is no specific management strategy for solvent use disorder.

147. In 2011, the National Health and Medical Research Council released "*A Consensus-Based Clinical Practice Guideline for the Management of Volatile Substance Use in Australia*"; a Clinical Practice Guideline for the management of solvent use disorder. It recommended best practice as including the use of brief interventions, culturally appropriate care plans, psychological therapy and managing co-existing health conditions. In other words, a holistic approach to what is required from a health perspective spanning both medical services and psychological services. Dr Nicholls' response was sought as to how CSNSW and JHFMHN could work together and collaborate to coordinate that kind of holistic approach.

148. Dr Nicholls said that such clinical practice guidelines do not reflect the particular complexities of working in the custodial environment or the prevailing funding arrangements. He acknowledged that as far as collaboration around this area for Kevin is concerned, "*it didn't clearly happen at all*".[124] He reiterated that the relevant programs are run by CSNSW and there was no "*specific program for staff to sit down and have a big conference*". To his knowledge, Drug and Alcohol Services in JHFMHN (being a specific division of clinical services within JHFMHN) were not informed about Kevin,[125] but nor does their work generally involve patients with solvent abuse issues.[126] He reiterated that obtaining a holistic view of Kevin would be very difficult as he was moving so much

[122] See, for example, Tab 37 at paragraphs [11], [14], [17], [18], [19], [21], [22], [31].
[123] T51.29, 8/2/2022.
[124] T62, 8/2/2022.
[125] T62, 8/2/2022.
[126] T62, 8/2/2022.

between correctional centres and meeting a different doctor each time.[127] He said, "*it was assumed that Corrective Services were and had managed that, but obviously not as an ongoing situation*".[128]

149. Dr Nicholls provided data regarding the prevalence of inhalation of volatile substances in prisons based on the Network Patient Health Survey which surveys inmates. The latest survey, dated 2015, records that 5.4% of participants reported use of inhalants any time in their life. Of those people, 4.6% reported daily or almost daily use in the 12 months prior to custody, being 1.17% of all prison entrants. 0% reported inhalant use in custody. As stated earlier, I regard these statistics with great caution.

150. JHFMHN nurses also collate information from inmates on their reception into custody about their medical and health history using a Reception Screening Tool. It includes a series of questions about drug and alcohol use including a question about the use of solvents. Dr Nicholls said similar data about the low prevalence of solvent use arises from that screening.

151. The court accepts that Kevin completed the Reception Screening Assessment on his entry into NSW custody in 2000.[129] It records "*nil D&A*." His response demonstrates that one must be extremely wary of self-reported screening statistics of this sort.

Chronic disease screening

152. Dr Nicholls gave evidence about the chronic disease screening provided by JHFMHN, the basic facts about which are set out in the agreed facts (particularly at [67]-[70]). This included a routine ECG.

153. While Kevin did not present with symptoms such as chest pain or high blood pressure at that time, as outlined in the agreed facts, an ECG conducted on 30 June 2018 indicated he had sustained a previous heart attack. This was not picked up or followed up by the nurse who carried out the ECG. The ECG was "*rebooked for 2 years*". Nor is there any evidence that the abnormal ECG result was reviewed by the JHFMHN doctor in a follow up consultation for Kevin's cholesterol that occurred on 20 October 2018.

154. On 27 March 2019, Kevin underwent further chronic disease screening. His ECG result again revealed that he had had a heart attack which was "*age indeterminate*". An on-call doctor was informed but was not concerned as he was "*asymptomatic*" at that time and the results reflected "*previous history of infarct-not current*".

155. Associate Professor Adams' evidence on this issue is outlined above. Dr Nicholls sought

[127] T63, 8/2/2022.
[128] T63, 8/2/2022.
[129] Tab 61, pp 208ff.

to emphasise that the ECG went beyond what JHFMHN was required to perform as this form of screening would not necessarily occur routinely in the community.[130] He also said that a diagnosis cannot be made purely on an ECG and there was not huge diagnostic evidence of any cardiac disease.[131] He emphasised that Kevin did not present with acute symptoms.[132] He said that the heart disease was not known until autopsy.[133] Overall the effect of Dr Nicholls' evidence was that the ECG did not indicate the need for urgent care or follow up.[134]

156. It is clear that Kevin had an abnormal result on 30 June 2018 and that, having received that result, JHFMHN should have reviewed the ECG within a short period of time (by someone qualified to review it). That would likely have resulted in appropriate follow up of Kevin's severe coronary heart disease. His coronary heart disease was so significant that it was very likely to have been detected if the ECG result had been properly reviewed and followed up. In this regard, it is of no relevance whether there was any clinical indication to undertake the ECG in the first place (once the abnormal result was obtained). It is also irrelevant that Kevin did not present with acute symptoms at the time the ECG was undertaken, given that the purpose of an ECG is to detect heart-related conditions.

157. Dr Nicholls said that, in 2019, JHFMHN established the Aboriginal Chronic Care Program and there is no longer any age threshold for screening in that program for Aboriginal patients.[135] Given what is known about the deficiencies in health care for Aboriginal people in the community, this change is to be welcomed and relieves the need for a recommendation in this area.

Health care for Aboriginal people

158. Mr Trindall provided a statement dated 7 February 2022 and gave evidence. He impressed the court as someone committed to working for real change within the system. The difficulties inherent in his role cannot be under-estimated. He joined JHFMHN in early 2018. Mr Trindall outlined the key developments within JHFMHN since 2018 to implement strategic priorities for Aboriginal health. I am unable to refer specifically to all the initiatives he outlined but accept he is attempting to drive significant change from within JHFMHN. I thank him for his contribution to the inquest and accept his evidence of how difficult it can be for Aboriginal staff working within JHFMHN and of the heavy cultural load they carry.

159. Mr Trindall told the court that 3.61% of JHFMHN employees identify as Aboriginal and they

[130] T65, 8/2/2022.
[131] T67, 8/2/2022.
[132] T72, 8/2/2022; T9, 9/2/2022.
[133] T67, 8/2/2022.
[134] See also T6-7 and 9, 9/02/2022.
[135] T2, 9/2/2022.

occupy both clinical and non-clinical roles (but not necessarily roles that are specifically identified as Aboriginal roles).[136]

160. There are seven full-time positions funded for Aboriginal Health Workers across the State, and two positions are currently filled. These are not clinical roles but are specific advocacy and case management positions providing health support for Aboriginal inmates.[137] One element of the role, as described in the job description provided by Mr Trindall, is to provide culturally appropriate health education to Aboriginal patients. They also provide education and assistance to the enrolled nurses who provide clinical services in the Aboriginal Chronic Care Program.[138] The Aboriginal Health Practitioner role is a clinical role (being a registered health worker with the Australian Health Practitioner Regulation Agency) and would combine the clinical role of nurse with the advocacy and educative role of the Aboriginal Health Worker.[139] However, there are currently no funded Aboriginal Health Practitioner positions, and there are currently legal issues relating to their qualification in NSW.[140] Recurrent funding has been provided by the government for the Aboriginal Health Worker roles.[141]

161. Mr Trindall gave evidence about issues concerning recruitment to these roles. These issues include the association which potential Aboriginal staff may have with the prisoner population which presents a barrier to recruitment and the cultural load that Aboriginal patients and staff experience in the organisation.[142]

162. There is no doubt an Aboriginal Health Worker could have been an important support to Kevin, especially if he had the opportunity to develop an ongoing relationship with the worker. There is evidence that Kevin attended the Aboriginal Health Worker clinic on one occasion on 19 April 2017,[143] but there is nothing to suggest an ongoing relationship. Kevin was on the spectrum of intellectual disability (therefore needing more support with health literacy), had been incarcerated for many years and had many interactions with health staff. Further, his chronic solvent use was attended by denial, possibly deriving from shame, such that culturally appropriate support may have been critical to engaging him in ongoing care.

163. Mr Trindall gave evidence that Aboriginal Community Controlled Health Organisations (**ACCHOs**) are an important source of partnership for JHFMHN to deliver culturally appropriate services to Aboriginal patients in custodial settings and indeed, these

[136] T30, 9/2/2002.
[137] T26, 9/2/2022.
[138] T28, 9/2/2022.
[139] T28, 9/2/2022.
[140] T29, 9/2/2022.
[141] T29, 9/2/2022.
[142] T26-27, 9/2/2022.
[143] Exhibit 10, PAS record.

partnerships are high on its agenda.[144] He gave evidence about certain programs already on foot, including a pilot to commence with Durri Aboriginal Corporation Medical Service (**Durri**), an accredited ACCHO on the Mid-North Coast that covers the Macleay and Nambucca Valley local government areas.[145] Durri offers numerous programs including medical, nursing, dental and visiting specialist (medical and allied health) programs. JHFMHN looks to improve coordination and relationships with ACCHOs such as Durri.

164. He gave evidence that to develop these partnerships, JHFMHN uses existing funding. For example, the five vacant Aboriginal Health Worker positions means there is funding available to be used to develop models that JHFMHN then presents to local ACCHOs to gauge interest in working in partnership.

165. Mr Trindall said there has been a lot of stakeholder engagement over the last two years by his unit and this has mostly been well received.[146] For example Durri identified that the model presented by JHFMHN is suitable to address their community needs, improve patient care and assist reintegration of Aboriginal community members back to their community in the area (following release from prison). In November 2021, JHFMHN authorised Mr Trindall's unit to advance discussions for a Memorandum of Understanding and to run a pilot program with Durri this year. This concerns pre-release planning, in-reach services and post release follow-up services to Aboriginal patients returning to the Mid North Coast area. The discussions are ongoing.

166. Mr Trindall gave examples of other stakeholder engagements. He said JHFMHN had an intention "*to engage with the regional alliance groups, so that's all the Aboriginal and community controlled health organisation as part of that region*"[147] and developed a blueprint for this.[148] He said this work meets strategic frameworks which exist, including the Premier of NSW's priorities, concerning the building of partnerships with the Aboriginal community-controlled sector.[149]

167. Since 2014, JHFMHN has also had a partnership with Waminda South Coast Women's Health and Welfare Aboriginal Corporation (**Waminda**). The relevant Aboriginal Health Worker is part of JHFMHN but sits within Waminda for peer support and cultural support, given that they cannot necessarily receive that kind of support in the correctional centre where they work. The idea of this model is that the worker "in-reaches" the custodial setting on designated days, providing support for Aboriginal inmates (in the case of Waminda, female patients) and is also able to follow up with patients who have been released from

[144] T31, 9/2/2022.
[145] T31, 9/2/2022.
[146] T31, 9/2/2022.
[147] T31.40-41, 9/2/2022.
[148] T32, 9/2/2022.
[149] T31, 9/2/2022.

custody. This promotes continuity of care.[150]

168. Mr Trindall highlighted that there have been other partnerships with local ACCHOs and these have involved both formal and informal partnerships over the years, across the State.[151] It seems that some partnerships may be fragile in the sense that they do not endure or are subject to precarious funding arrangements, or do not provide complete coverage in terms of in-reach or post-custody services.

169. These partnerships are to be applauded. If this model had been available in a correctional centre where Kevin was housed, it could have assisted him to access culturally appropriate health services, including drug and alcohol programs.

170. It appears that what may be needed is a model for developing partnerships with more ACCHOs in a sustainable and consistent manner, that is not subject to the contingencies of *ad hoc* funding, so that this sort of engagement is able to be sustained into the future.

171. Counsel assisting submitted that it would be open to the court to make a recommendation for JHFMHN to explore options to develop a long-term model for promoting partnerships with ACCHOs, as well as funding models, to support the provision of culturally safe primary health care to patients in custody and on release from custody. Such a recommendation was supported by Ms Webster. It should be noted however that Mr Trindall gave evidence that "*different fundings from different state and federal funding bodies makes it very difficult to have a one-fit size solution to this*".[152]

172. Developing long term funding to promote ACCHO partnerships is essential. Ms Webster was supportive of this model and clearly stated that she could have been involved in linking Kevin to her local medical service to assist in his release had she been given the opportunity.[153]

173. Mr Trindall also gave evidence that access to Medicare funding would greatly facilitate and increase these initiatives, as it would allow GP consultations and health assessments to occur, using Item 715 of the Medicare Benefits Schedule, being an Aboriginal and Torres Strait Islander Peoples Health Assessment, before patients leave custody. Patients could also be linked in with the National Disability Insurance Scheme for social support services and with local non-government organisations' programs.[154] Pre-release planning could occur, which would include multi-disciplinary case conferencing. Presently, patients leaving custody have to get Medicare reinstated, apply for housing and many other supports, separately.

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[150] T34-35, 9/2/2022.
[151] T35, 9/2/2022.
[152] T43, 9/2/2022.
[153] T7.35-38, 7/2/22.
[154] T35, 9/2/2022.

174. Mr Trindall was asked for his view about the division between CSNSW and JHFMHN in terms of drug and alcohol services and he commented that it can impact on continuity of care for patients.[155] He said that patients being moved between centres also impacts on continuity of care.

175. Professor Williams gave evidence, in her capacity as an expert in public health with a focus on criminal justice contexts and issues for Aboriginal and Torres Strait Islander people. She noted the absence of any clear management plan for Kevin's wide range of health issues and the lack of psycho-social support, the minimal allied health support he received and the clear lack of any additional support for his intellectual disability. Professor Williams considered that questions must be asked about the extent to which Kevin's refusal to engage with staff in the weeks or months before death can be considered a form of social isolation, trauma, post-traumatic stress disorder or other form of health risk-taking behaviour. She suggests that assessments and screening tools validated for use amongst Aboriginal and Torres Strait Islander people are and were available and should have been used to assist him, and her evidence highlights that his reluctance to participate in drug and alcohol programs should not have been taken at face value.

176. Professor Williams drew the court's attention to the fact that neither CSNSW nor JHFMHN have publicly available Aboriginal cultural safety plans. She says this is surprising given there is a long-term gross overrepresentation of Aboriginal people in prisons. She states that since 2004 the Australian Health Ministers Advisory Council (**AHMAC**) has used the terms "cultural safety" and "cultural respect", including in the AHMAC *Cultural Respect Framework* dating from 2004, and that inclusion of cultural safety in workforce plans would shape resource allocation and models of care for Aboriginal people.[156]

177. The AHMAC *Cultural Respect Framework 2016-2026 for Aboriginal and Torres Strait Islander Health* sets out a "*National Approach to building a culturally respectful health syste*m" and is a renewal of the 2004-2009 framework. It committed the Commonwealth Government and all states and territories to embedding cultural respect principles into their health systems; from developing policy and legislation, to how organisations are run, through to the planning and delivery of services. Its stated aim is to guide and underpin the delivery of quality, culturally safe, responsive health care to Aboriginal and Torres Strait Islander people, and contribute to progress made towards achieving the Closing the Gap targets agreed by the Council of Australian Governments (**COAG**). It was developed for AHMAC by the National Aboriginal and Torres Strait Islander Health Standing Committee. Cultural Respect is defined in that framework as: "*Recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait*

[155] T37, 9/2/2022.
[156] T50, 9/2/2022.

Islander people".

178. Professor Williams commented on the fact that CSNSW Drug and Alcohol programs are not designed specifically for Aboriginal offenders or for any specific cultural group. Rather, they are modelled on the need for "*responsivity and engagement on an individual basis within existing group formats*". This model contemplates the provision of a culturally informed approach, but programs have not been tailored for Aboriginal cultures.

179. Professor Williams raised several issues with this approach. One is to ask what the skills and confidence of the facilitators are, and the outcomes they can bring about, when relating to an Aboriginal person. She highlighted that Aboriginal culture is not western culture and it cannot be assumed that treatment, assessment and diagnosing from a western perspective is appropriate. She said culture is a determinant of health and Aboriginal and Torres Strait Islander people generally experience poorer health outcomes than the rest of the Australian population. Professor Williams said that there is not good evidence from mainstream health providers about their successes with Aboriginal people in the criminal justice system.[157] She said that, for ACCHOs, it is a foundational principle that Aboriginal culture increases access to health services and those organisations have enjoyed success in providing health care to Aboriginal people.

180. Professor Williams further highlighted that the Aboriginal and Torres Strait Islander health workforce in CSNSW and JHFMHN is about 3-5% but 26% of the prisoner population is Aboriginal and Torres Strait Islander. In her view, it points to the need for the mainstream workforce to be able to work effectively with Aboriginal and Torres Strait Islander people informed by their cultures, which is a right acknowledged in the government strategic plans that she refers to in her report, including at NSW government level.[158] She argued that there should be alcohol and drug programs in prisons in NSW that are culturally tailored to Aboriginal cultures. I accept her view.

Drug and Alcohol programs for Aboriginal People

181. Ms Matsuo gave evidence about the programs which Kevin was offered or undertook and about CSNSW's policies and procedures concerning cultural safety in drug and alcohol and other programs.

182. In short, CSNSW does not run drug and alcohol programs specifically for Aboriginal inmates. The programs are based on the "*risk, needs and responsivity model of reducing reoffending*". The purpose in the first instance is the reduction of risk and reoffending to

[157] T54, 9/2/2022.
[158] T55, 9/2/2022.

keep the community safe through the programs CSNSW runs.[159] It was deemed that the most appropriate program for Kevin was therefore the VOTP given that he was serving a sentence in respect of a conviction for murder. If drugs and alcohol were factors related to his offending, then it was expected that these would be addressed in that program. Ms Matsuo said that Kevin would not necessarily be ineligible for an intensive drug and alcohol program, but this explains to some extent why it took 17 years for him to be offered the intensive drug and alcohol treatment program known as IDATP (in 2017). By that stage, he was not willing to undertake any further programs.

183. Ms Matsuo made it clear that CSNSW programs are geared towards reducing the risk of re-offending, rather than in providing more holistic psychological care.

184. Ms Matsuo stated that in 2017 the Custodial Case Management Units within CSNSW were implemented and they could potentially have improved the situation for Kevin. Their role is to develop a case plan for each inmate and engage and motivate the inmate to participate in programs, through case management interventions (**CMI**).[160] CSNSW has a CMI that was created or written by Aboriginal staff specifically for the purpose of engaging Aboriginal offenders to seek further treatment or services that are available to them. It should be noted that Kevin had an outdated case plan (dated June 2017) and a case manager at the time he died, whom he first saw on 7 December 2018.

185. Ms Matsuo was asked why CSNSW does not tailor its programs to Aboriginal inmates. Ms Matsuo stated that the evidence is very limited but there is some evidence that Aboriginal offenders perform as well in mainstream programs as non-Aboriginal offenders, from the perspective of reducing offending.[161] She cited a study that showed that Aboriginal offenders did better in a domestic violence program than non-Aboriginal offenders with respect to risk of reoffending.

186. Ms Matsuo also referred to evidence that the rate of reoffending increased rather than decreased following participation in a particular Aboriginal-specific program that was not aligned with CSNSW's risk, needs and responsivity model, being a "healing circles program".[162] She acknowledged that the evidence she relied upon was limited but said the evidence is "*mixed*" as to the merits of tailoring programs to Aboriginal culture, at least from the perspective of reduction of offending.

187. Ms Matsuo said that all CSNSW staff are trained in Aboriginal cultural awareness. This has been mandatory since 2017-2018.[163] The training was designed by and is delivered

[159] T63, 9/2/2022.
[160] T66, 9/2/2022.
[161] T67, 9/2/2022.
[162] T67, 9/2/2022.
[163] T68, 9/2/2022.

by Aboriginal staff.

188. I was extremely unimpressed by Ms Matsuo's explanation for why CSNSW did not offer drug and alcohol programs tailored to Aboriginal inmates and run by Aboriginal staff. For CSNSW to rely on a single study relating to domestic violence to support a decision not to offer drug and alcohol programs tailored to Aboriginal inmates and run by Aboriginal staff is ridiculous. There may well be a lack of comparative research because there are a lack of programs to study. CSNSW should take some initiative, it is well overdue.

189. The court also heard evidence on this issue from Professor Conigrave. She reported that, in NSW correctional settings, the alcohol and drug group programs offered (including EQUIPS Addiction) are generic rather than culturally tailored,[164] and group facilitators are relied upon to ensure 'responsivity' to the cultural needs of Aboriginal participants.

190. Professor Conigrave gave evidence about two qualitative studies from 2021, conducted by Worimi woman and psychologist Dr Elizabeth Dale (Professor Conigrave is a co-author),[165] that offer insights into Aboriginal peoples' experiences of SMART Recovery, a program Kevin completed in prison. Key recommendations included the need for culturally appropriate program materials and integrating Aboriginal perspectives into facilitator training. The 11 Aboriginal SMART participants who took part in one of the studies suggested an Aboriginal-specific SMART program should be developed.[166]

191. When pressed, Ms Matsuo said it was not "*out of scope*" that CSNSW could pilot a targeted Aboriginal drug and alcohol program.[167] She said there are two strategies being developed currently by the Strategy and Policy Unit which are relevant. One is an Aboriginal strategy for CSNSW which concerns cultural safety (which she noted aligns with matters raised by Professor Williams) and the second strategy is an 'AOD' strategy for the entire organisation. She acknowledged that there is a potential aligned with these strategies for a pilot program to be run, for example in a correctional centre where there is a high proportion of Aboriginal people.

192. It is patently clear that trialling a culturally tailored drug and alcohol program for Aboriginal and Torres Strait Islander inmates is well overdue. CSNSW is in a position to conduct a trial or pilot program by drawing on the expertise of ACCHOs. I find it shocking that it has not yet occurred. In my view, CSNSW's explanations of its approach on this issue were extremely weak and totally out of line with almost all current thinking about the need for culturally appropriate programming in this area.

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[164] Tab 50 at [82]. See also Tab 15, p 20.
[165] Tab 50 at [58], [99].
[166] Tab 50 at [58].
[167] T68, 9/2/2022.

193. Ms Matsuo was also asked about access to counselling outside formal programs, given the evidence that Kevin does not appear to have ever seen an Aboriginal drug and alcohol worker or counsellor. She gave evidence that prior to 2013, CSNSW had 'AOD' workers, welfare workers and psychologists. Now CSNSW has Services and Programs Officers and psychologists. Staff undertake 10 weeks of primary training that includes cultural awareness and trauma-informed practice. Policy effectively requires that psychologists prioritise self-harm risk.[168] While Ms Matsuo said it was not within her remit, she is aware that there are initiatives at a departmental level to increase the proportion of Aboriginal staff.

194. In this context it is also relevant to note Mr Trindall's evidence that many Aboriginal patients of JHFMHN have a drug and alcohol dependency at some level and therefore in his view CSNSW likely does need to consider its Aboriginal workforce or specialised programs moving forward. However, from a practical perspective, he also noted that there would be a very small pool of candidates who are trained and qualified in the requisite skill sets.[169]

195. Having considered all the relevant evidence, I intend to recommend that CSNSW conduct a pilot drug and alcohol program tailored to Aboriginal inmates' cultural needs.

The need for recommendations

196. Counsel assisting put forward a number of recommendations arising out of the evidence for the court's consideration. Further recommendations were provided by legal representatives for Ms Webster. Some of the recommendations overlapped and I will deal with them together.

197. Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

Corrective Services NSW

198. There was significant evidence that CSNSW did not have adequate systems in place to mitigate the known risk that Kevin might seek solvents through a work placement. This created danger for Kevin, as placing him in environments where he could access inhalants of various sorts, given his known and chronic disorder, set him up to fail. It increased his health risk and made it likely that he would once again be refused parole. The issue goes beyond the facts of this particular case, as it is not hard to imagine specific risks for other

[168] T71, 9/2/2022.
[169] T41, 9/2/2022.

inmates which would also require a system that ensures officers are well placed to assess the risks of a work placement against the known personal characteristics of an inmate.

199. The Commissioner of Corrective Services accepted that Mr Jarmain did not know of Kevin's recent involvement in the incident at St Heliers because it was not recorded as an Alert on OIMS. However, counsel for CSNSW also suggested that *had* Mr Jarmain examined the Care and Placement screen in OIMS he would have seen the relevant information and assessed Kevin as unsuitable for employment in the Furniture Business Unit.

200. CSNSW submitted that it had "*committed to undertaking a review of the Alerts Custodial Operations Policy and Procedure to ensure that it provides clear guidance to CSNSW staff as to how particular events, incidents and identified risks should be correctly categorised as an Alert and recorded in OIMS*…"[170] In addition, it submitted that Corrective Services Industries (**CSI**) had committed to reviewing and implementing operational procedures to provide clearer guidance when assessing an inmate's suitability. These measures, it was suggested, obviated the need for recommendations.

201. It appears to me that these stated commitments are directed to the very issues set out in counsel assisting's recommendations. Given that I have been provided with no information about when these reviews are likely to take place and some years have now passed since Kevin's death, I have decided the prudent approach is to make the recommendations in the terms suggested. CSNSW should have few difficulties in carrying them out.

202. For this reason I recommend

(a) That CSNSW introduce a system or process that allows CSNSW staff who are assessing the suitability of inmates for employment in business units in correctional centres to determine, from a single source of information that is readily accessible and comprehensive in the information it contains, whether there is any health or medical issue that might be an impediment to the inmate being allocated to a particular business unit. The system of 'Alerts' in the OIMS was not effective in the case of Kevin's death to inform the relevant CSNSW staff at Cessnock Correctional Centre that he should not be employed in an area where chemicals and solvents were available due to his history of inhalational drug use. No relevant, current information or warning was contained within 'Alerts', notwithstanding such information was contained in other CSNSW records, including within OIMS. As inmates are transferred between correctional centres, the system adopted should

[170] CSNSW submissions.

incorporate relevant health or medical alerts from across correctional centres pertaining to a particular inmate and apply statewide.

(b) To support implementation of the above recommendation: that CSNSW adopt a policy, procedure or guideline to guide staff whose task is to assess the suitability of inmates for employment in business units in correctional centres about the system or process they should follow when doing so.

203. Both counsel assisting and counsel for Ms Webster identified issues relating to Kevin's many movements throughout the system. It was a source of considerable pain to Kevin's family and caused him great consternation.

204. CSNSW submitted that there was "*no basis for concluding that [Kevin's] movements were excessive or unreasonable*."[171] It was submitted that "*it is necessary to move inmates for a variety of reasons and the number of movements is an arbitrary figure, dependent on the medical, social and educational needs of the inmate, change to the inmate's classification and the security requirements of CSNSW*."[172] CSNSW submitted that little weight should be given to Mr Leach's evidence that the movements appeared "*excessive*."

205. Further, CSNSW did not support the introduction of a system to monitor the number of inter correctional centre movements as regulation 20 of the *Crimes (Administration of Sentence) Regulation* 2014 already sets out the matters CSNSW are required to consider when considering placement.

206. It may be that regulation 20 *should* provide appropriate guidance, but it clearly does not. In my view, it would be very useful to review the policies, procedures and guidelines applying to inter-correctional movements to see whether CSNSW can make improvements to the current system.

207. Counsel for Ms Webster suggested a recommendation that CSNSW create a Charter of the Long-Term Rights of Long-Term Prisoners, that is given effect in the case management of long-term inmates, so they have greater control and certainty around their lives, including inter-correctional transfers. I note that no other party sought to address the court on this recommendation. Examining the specific issues that relate to long-term prisoners has merit. It was clear from the evidence of Ms Matsuo that the focus of CSNSW programs is on reducing the re-offending risk. For this reason, it is easy to see that the opportunities and case management of long-term prisoners may well be lacking. I intend to ask CSNSW to consider this issue in their review of movement guidelines.

208. For the reasons outlined above I make the following recommendations

[171] CSNSW submissions dated 19/5/2022.
[172] CSNSW submissions dated 19/5/2022.

(c) That CSNSW should review its policies, procedures or guidelines applying to inter-correctional centre prisoner movements with an eye to the case of Kevin who was moved over 50 times in 19 years with a view to reducing prisoner movements in the system. CSNSW should consider in this review the impact of prisoner movements on continuity of health and other care and management issues. The rights of long term prisoners should be specifically considered.

(d) That CSNSW should introduce a system or process that allows CSNSW to monitor the number of inter-correctional centre prisoner movements an individual inmate has undergone to avoid an individual inmate enduring an excessive number of transfers. Excessive interfacility transfers may be inhumane and, in the case of Aboriginal inmates, it may exacerbate social and family dislocation, health issues and cultural disconnection.

209. Both counsel assisting and counsel for Ms Webster recommended the need for consideration of culturally appropriate case management, health care and drug and alcohol support.

210. I note that both CSNSW and JHFMHN supported the draft recommendations in this regard. In my view there is an urgent need to conduct and evaluate Aboriginal-specific drug and alcohol programs in the NSW custodial environment. I remain shocked that CSNSW provide nothing in this regard and have not yet prioritised this essential service.

211. I make the following recommendations

(e) That CSNSW should conduct and evaluate a pilot or trial of an Aboriginal-specific drug and alcohol program, being a program that includes culturally appropriate content and integrates Aboriginal perspectives in facilitator training and delivery.

(f) That CSNSW should consider options for increasing the availability of Aboriginal case managers to Aboriginal inmates, particularly to those who need additional support to participate in drug and alcohol programs, such as Kevin did. CSNSW should seek to increase the cultural competency and cultural safety of its workforce and support this with ongoing training, supervision and leadership.

<u>Justice Health and Forensic Mental Health Network</u>

212. It is noted that JHFMHN do not oppose making recommendations in relation to exploring partnerships with ACCHOs or advocating for reform to Medicare but advise that the recommendations are not strictly necessary as the work is already being undertaken.

213. There is no doubt that JHFMHN has already been working with ACCHOs where possible, and it should be commended for these important partnerships. However, the work is

restricted because there is no access to ongoing funding. This must change. There is a need to draw attention to the work JHFMHN is doing in this regard and to find secure funding. The work has the capacity to save lives and must be prioritised and supported.

214. Similarly, I accept that JHFMHN is committed to advocating for prisoner access to Medicare. However, there is a need for reform at a national level and it will require state and territory cooperation. As Governments struggle to "close the gap" the time must be right for trialling access to Medicare for Aboriginal patients in custody. I intend to make the recommendations suggested by counsel assisting and to send a copy of these findings to both NSW and federal Health Ministers for their information. Further I intend to send a copy to state and federal ministers with responsibility for Aboriginal Affairs/Indigenous Australians.

215. I make the following recommendations

(g) That JHFMHN should continue to explore and promote partnerships with Aboriginal Community Controlled Health Organisations to support the provision of culturally safe primary health care to Aboriginal patients and, in this context, should explore options for developing funding models that enable partnerships of this kind to be developed and sustained in the long term.

(h) That JHFMHN should continue its work advocating for a trial for access to Medicare for Aboriginal inmates. In this context, JHFMHN should consider liaising with its equivalent or counterpart bodies in other States to coordinate and advocate for a trial process involving Medicare being made available by the Commonwealth to Aboriginal inmates.

<u>Corrective Services NSW and Justice Health and Forensic Mental Health Network</u>

216. A further important area for recommendation arising out of the evidence was suggested by counsel for Ms Webster. It goes to the issue of the way in which chronic inhalant use was regarded by both CSNSW and JHFMHN and calls for stronger coordination of a joint therapeutic response. The evidence made clear that CSNSW primarily deals with inhalant use as a behavioural management issue and provides no specific psychological services. JHFMN deals with chronic effects and acute episodes but offers no ongoing psychological care. In my view, the management of this issue falls between the cracks which have developed because of the historic division of health and psychological/allied health services such as Drug and Alcohol programs. It is clear to me that the division is a barrier to holistic treatment and should be reviewed. Clearly that goes beyond the scope of this inquest. However, in the short term, and on the evidence directly arising from this inquest, some effort must be taken to coordinate an approach to this specific health issue.

217. I note that no party sought to comment on the proposal put by counsel for Ms Webster requesting a joint and coordinated approach to chronic inhalant use in custody. I make the following recommendation

(i) That CSNSW and JHFMHN consider convening a high-level meeting to discuss how to better manage chronic inhalant use in custody, as a *health issue*. Consideration should be given to developing a coordinated therapeutic approach from both services.

Findings

218. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Kevin Francis Bugmy.

Date of death

He died on 13 April 2019.

Place of death

He died at Cessnock Correctional Centre, Cessnock NSW.

Cause of death

Kevin died of severe coronary artery disease. It is likely that Kevin's use of inhalants in custody, including on about 13 April 2019, contributed to an ischaemic event resulting in a sudden cardiac death.

Manner of death

Kevin died in custody. The care he received for chronic substance use over many years was grossly inadequate.

Recommendations pursuant to section 82 *Coroners Act 2009*

219. For the reasons stated above, I recommend:

Corrective Services NSW

(a) That CSNSW introduce a system or process that allows CSNSW staff who are assessing the suitability of inmates for employment in business units in correctional centres to determine, from a single source of information that is readily accessible

and comprehensive in the information it contains, whether there is any health or medical issue that might be an impediment to the inmate being allocated to a particular business unit. The system of 'Alerts' in the OIMS was not effective in the case of Kevin's death to inform the relevant CSNSW staff at Cessnock Correctional Centre that he should not be employed in an area where chemicals and solvents were available due to his history of inhalational drug use. No relevant, current information or warning was contained within 'Alerts', notwithstanding such information was contained in other CSNSW records, including within OIMS. As inmates are transferred between correctional centres, the system adopted should incorporate relevant health or medical alerts from across correctional centres pertaining to a particular inmate and apply statewide.

(b) To support implementation of the above recommendation: that CSNSW adopt a policy, procedure or guideline to guide staff whose task is to assess the suitability of inmates for employment in business units in correctional centres about the system or process they should follow when doing so.

(c) That CSNSW should review its policies, procedures or guidelines applying to inter-correctional centre prisoner movements with an eye to the case of Kevin who was moved over 50 times in 19 years with a view to reducing prisoner movements in the system. CSNSW should consider in this review the impact of prisoner movements on continuity of health and other care and management issues. The rights of long term prisoners should be specifically considered.

(d) That CSNSW should introduce a system or process that allows CSNSW to monitor the number of inter-correctional centre prisoner movements an individual inmate has undergone to avoid an individual inmate enduring an excessive number of transfers. Excessive interfacility transfers may be inhumane and, in the case of Aboriginal inmates, it may exacerbate social and family dislocation, health issues and cultural disconnection.

(e) That CSNSW should conduct and evaluate a pilot or trial of an Aboriginal-specific drug and alcohol program, being a program that includes culturally appropriate content and integrates Aboriginal perspectives in facilitator training and delivery.

(f) That CSNSW should consider options for increasing the availability of Aboriginal case managers to Aboriginal inmates, particularly to those who need additional support to participate in drug and alcohol programs, such as Kevin did. CSNSW should seek to increase the cultural competency and cultural safety of its workforce and support this with ongoing training, supervision and leadership.

(g) That JHFMHN should continue to explore and promote partnerships with Aboriginal Community Controlled Health Organisations to support the provision of culturally safe primary health care to Aboriginal patients and, in this context, should explore options for developing funding models that enable partnerships of this kind to be developed and sustained in the long term.

(h) That JHFMHN should continue its work advocating for a trial for access to Medicare for Aboriginal inmates. In this context, JHFMHN should consider liaising with its equivalent or counterpart bodies in other States to coordinate and advocate for a trial process involving Medicare being made available by the Commonwealth to Aboriginal inmates.

Corrective Services NSW and Justice Health and Forensic Mental Health Network

(i) That CSNSW and JHFMHN consider convening a high level meeting to discuss how to better manage chronic inhalant use in custody, as a *health issue*. Consideration should be given to developing a coordinated therapeutic approach from both services.

Conclusion

220. This inquest raises very significant issues and provides modest suggestions for achievable change.

221. I offer my sincere thanks to counsel assisting, Georgina Wright SC and her instructing solicitor Gareth Martin for their hard work and enormous commitment in the preparation of this matter and in drafting these findings.

222. Finally, once again I offer my sincere condolences to Kevin Bugmy's family, especially Ms Doreen Webster.

223. I greatly respect Ms Webster's decision to participate in these difficult proceedings and acknowledge her family's ongoing sorrow and grief. Ms Webster survived the Cootamundra Girls' Home and considerable personal trauma to emerge as a respected elder. Her strength and devotion to family are obvious. Her commitment to continue speaking the truth and agitating for change are remarkable. I am profoundly sorry her brother, Kevin Bugmy died in these circumstances.

224. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner, NSW State Coroner's Court, Lidcombe
6 July 2022

Appendix A

Contents of Exhibit #1: Agreed Statement of Facts

INQUEST INTO THE DEATH OF MR KEVIN BUGMY

SUMMARY OF EVIDENCE

A. BACKGROUND

1. Mr Kevin Bugmy was born on 2 December 1961 in Mildura, New South Wales and died on 13 April 2019 aged 57 years old. He was declared deceased by Dr Jay Wilmer at the Cessnock District Hospital emergency department at 1.39pm that day.

2. At the time of his death Mr Bugmy was an inmate at Cessnock Correctional Centre (**Cessnock CC**) and serving a full time custodial sentence of life imprisonment. His non-parole period had expired on 5 October 2000. Mr Bugmy was in apparent good health at the time of his death. He was of a small, thin build, unmarried and had no dependents. He was an Aboriginal Australian male of the Barkindji Nation.

3. The autopsy report of Dr Allan Cala (Autopsy Report) concludes that the direct cause of Mr Bugmy's death was "unascertained".

4. Mr Bugmy was the youngest of six siblings. His mother died in August 1965 during childbirth and his father left the family home around the same time.[173] As a result all siblings were separated to various foster homes.[174] Mr Bugmy became a ward of the State at the age of 3. He spent approximately four years with foster parents but was otherwise raised in institutions. He met his natural father at the age of 19 years old.[175] His father died as a result of alcohol poisoning.

Custodial sentence

5. At the time of his death, Mr Bugmy was serving a life sentence in respect of a conviction for murder that was imposed by Brooking J of the Supreme Court of Victoria on 5 November 1984. A concurrent sentence of nine years imprisonment was imposed for armed robbery.

[173] Corrective Services Offender case plan dated 9/06/2017: Tab 13 p 19.
[174] Statement of Governor Leach at Annexure G: Vol 1 Tab 13.
[175] Request for interstate transfer: Vol 6 Tab 65 p 46.

6. In 1987, Mr Bugmy applied to the Supreme Court of Victoria for a minimum term to be fixed in respect of his life sentence. On 1 May 1989 Brooking J imposed a minimum term of 18 years and 6 months.[176] That term was reduced to 16 years on appeal to the High Court (an appeal to the Victorian Court of Criminal Appeal was dismissed).[177] As a consequence, Mr Bugmy's minimum term commenced on 5 November 1984 and expired on 5 October 2000.

7. In imposing the minimum term, Brooking J commented that Mr Bugmy's education effectively ceased at grade 6 level and his background was "highly deprived and tragic". He had had three jobs, covering only about 10 months of his adult life. He had been abusing alcohol and drugs for some years prior to the murder. He was living a "hopeless, aimless life" at the time of that offence. The judgment also records that his prison record had been "dominated by his substance abuse", which had been "his major problem".

8. On 26 September 2000, Mr Bugmy was transferred to Corrective Services NSW (**CSNSW**) custody.

9. Most recently prior to his death, on 9 August 2018 the State Parole Authority refused to grant parole on the basis that he needed to participate in external leave programs and the Serious Offenders Review Council (**SORC**) did not consider the release of the offender was appropriate.[178] That decision was confirmed on 11 October 2018. He was able to apply for reconsideration for possible release on 5 October 2020.[179]

10. At the time of death, he was classified as a C1 minimum security inmate.[180] He was housed in cell (22)13, a one out cell by himself on level 2 of Wing 2 of the prison.[181]

B. TRANSFER FROM VICTORIA TO NEW SOUTH WALES CORRECTIONAL SYSTEM

11. Mr Bugmy made three applications for transfer to New South Wales on welfare grounds under the *Prisoners (Interstate Transfer) Act 1983* (Vic). The first application dated 30 January 1985 was declined on 3 August 1987 on the basis that family in New South Wales was unlikely to visit him. The second application dated 19 March 1991 was declined on 22 May 1992, however, no reasons were given for that decision.[182]

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[176] *In the matter of a minimum term application pursuant to section 18A of the Penalties and Sentences Act 1985 by Kevin Francis Bugmy* (unrepeated, Supreme Court of Victoria, Court of Criminal Appeal, Brooking J, 1 May 1989): Vol 2, Tab 57.

[177] *The Queen v Kevin Francis Bugmy* (Unreported, Supreme Court of Victoria, Court of Criminal Appeal, Crockett, Fullagar and Marks JJ, 21 June 1989) (Tab 58); *Bugmy v The Queen* (1990) 169 CLR 525 (Tab 43); *The Queen v Kevin Francis Bugmy* (Unreported, Supreme Court of Victoria, Court of Criminal Appeal, Young CJ, Murphy and McDonald JJ, 2 November 1990) (Tab 44); [1986] VR 671.

[178] State Parole Authority notification: Vol 2, Tab 53.

[179] Decision to Refuse Parole, State Parole Authority, 11 October 2018, Vol. 1, Tab 37, p. 1.

[180] Inmate Profile Document: Tab 38

[181] Statement of Detective Senior Constable Paul Wilks: Tab 7.

[182] Memorandum dated 16 March 2000 regarding third application: Vol 6 Tab 65 pp 55-57.

12. On 29 March 2000, then Victorian Minister for Police and Emergency Services and Minister for Corrections wrote to then Minister for Corrective Services, the Hon Bob Debus, requesting that Mr Bugmy's third transfer application (date unknown) be approved.

13. Minister Debus consented to the transfer on 17 August 2000.[183] A submission by the New South Wales Department of Corrective Services recommending that approval outlined that Mr Bugmy had no family in Victoria and that his sister and nephew had each written a letter of support of his move to New South Wales.[184] The Department's submission also noted that the *Royal Commission into Aboriginal Deaths in Custody* had found that for Aboriginal prisoners, the maintenance of family relationships is of primary importance and should be actively encouraged. (The Royal Commission's final report was published in April 1991.)

14. On 15 September 2000, then Victorian A/Minister for Corrections, the Hon Robert Cameron, ordered the transfer of Mr Bugmy to NSW under s. 8 of the *Prisoners (Interstate Transfer) Act 1983* (Vic).[185] On 26 September 2000 the transfer was effected.[186]

15. In New South Wales, between September 2000 and his death on 13 April 2019, Mr Bugmy moved prison locations over 50 times. The longest period in one correctional centre was two years nine months when he was housed at Mid-North Coast CC.[187] The most recent transfer occurred on 16 January 2019 when was moved from St Heliers CC to Cessnock CC.

C. TRANSFER FROM ST HELIERS CORRECTIONAL CENTRE TO CESSNOCK CORRECTIONAL CENTRE AND EMPLOYMENT AT CESSNOCK CC

16. Mr Bugmy was transferred to St Heliers CC from Mid-North Coast CC on 7 December 2018.

17. By letter dated 9 January 2019 Intelligence Manager at St Heliers CC, Senior Assistant Superintendent S Martin, recommended to the Governor of St Heliers CC that consideration should be given to changing Mr Bugmy's placement on the basis there was "*a high probability Bugmy was using thinners and or glue and was unconscious for an amount of time on the evening of 8/1/2019*".[188]

18. On 10 January 2019 a CSNSW Classification and Placement Officer, Lisa Thorley, reviewed Mr Bugmy's classification and placement and recommended that his classification should be regressed from C2 to C1 and that he should be placed at Cessnock CC.[189]

19. Between 9 and 22 January 2019, Mr Bugmy was placed in segregation for "sniffing thinners".[190]

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[183] Vol 6 Tab 65 p 40.
[184] Vol 6 Tab 65 pp 41-44, p 57; In a report dated 2 December 2004, Professor Greenberg reported that "*Mr Bugmy states that he was transferred interstate in year 2000 as he originates from Broken Hill and Wilcannia in NSW"*.
[185] Vol 4 Tab 63 pp 34, 37.
[186] Vol 4 Tab 63 pp 34-37.
[187] Inmate Profile Document: Vol 2 Tab 54.
[188] Statement of Governor Jeremy Leach at Annexure B: Tab 13.
[189] Statement of Governor Jeremy Leach at Annexure C: Tab 13.
[190] Email dated 10 January 2019 at Annexure D to Statement of Governor Jeremy Leach: Tab 13; Inmate Profile Document: Vol 2 Tab 54; Segregation Custody Direction: Vol 5 Tab 64 p 46.

20. On 11 January 2019 Mr Bugmy was interviewed by a senior case manager at St Heliers CC. He appeared upset and was adamant that he had done nothing wrong and felt he had been "targeted". He appeared resigned when told that he would be moved on to another centre. He said he had plans to do a program at St Heliers and this would no longer occur.[191]

21. On 16 January 2019 Mr Bugmy was moved to Cessnock CC.[192] Upon his transfer, a "Reception transfer checklist" noted he was under sanctions for "possible sniffing spirits/thinners".[193] He was placed in a single bed cell.

22. On 8 February 2019 he participated in an individual maintenance session of the Violent Offenders Therapeutic Program (**VOTP**). He reported that he had been regressed to a C1 classification and transferred. He denied "sniffing stuff" and said he was now stuck in the yard and unable to work.[194] He said he wanted to work, progress to day leave and eventually be released.

23. On 13 February 2019 a new case manager met with him. Mr Bugmy expressed an understanding that he was moved due to "past indiscretions sniffing substances". He said he was content to do VOTP Maintenance every two months[195] but had no desire to attempt any more programs, education or vocational training.[196]

24. On 18 February 2019 he commenced employment in the Furniture Business Unit at Cessnock CC.

25. Between 18 February 2019 and 12 April 2019 Mr Bugmy worked a total of 210 hours in the Furniture Business Unit at Cessnock CC.[197] On 12 March 2019 he was promoted to Leading Hand in the Furniture Business Unit with increased pay and responsibility over eight other inmates to ensure work was completed on schedule.

26. On 12 March 2019 the Serious Offenders Review Council (**SORC**) recommended that Mr Bugmy should be reclassified from C2 to C1 and remain at Cessnock CC.[198] This would enable "a higher level of supervision for a period of time".[199]

27. On 5 April 2019 an Assistant Commissioner as delegate of the Commissioner of Corrective Services approved the SORC's recommendation. By letter dated 11 April 2019 the SORC advised Mr Bugmy of

[191] OIMS case notes Vol 4 Tab 62 p 146.
[192]
[193] Statement of Governor Jeremy Leach at [10] and Annexure F: Tab 13.
[194] OIMS case notes Vol 4 Tab 62 p 147.
[195] Statement of Governor Jeremy Leach at [8] and Annexure I: Tab 13.
[196] OIMS case notes Vol 4 Tab 62 p 147.
[197] Statement of Mathew Beacher, Operations Manager dated 10 May 2021 at [12]-[13]: Tab 14; OIMS case notes Vol 4 Tab 62 p 147.
[198] The Serious Offenders Review Council (**SORC**) was responsible for making recommendations to the Commissioner of Corrective Services with regard to Mr Bugmy's classification and placement. Statement of Governor Jeremy Leach at [8] and Annexure E: Tab 13.
[199] Letter from SORC to deceased dated 11 April 2019: Annexure E, Tab 13.

the regression in his classification.[200] A meeting was scheduled for 15 April 2019 for Programs and Services staff to meet with him.[201]

D. 13 APRIL 2019: COLLAPSE

28. On 13 April 2019 at approximately 12.15pm, Mr Bugmy was seen by at least four inmates standing on the landing of level 2 of Wing 2 of Cessnock CC, holding the bars across the railings near the front of his cell.[202] He was seen to suddenly fall backwards, hit the back of his head on the concrete floor and then begin to have a "fit" or "seizure" on the floor.

29. He was assisted by a number of inmates. Inmate Stojanov went into Mr Bugmy's cell, pressed the buzzer and spoke to a female Correctional Officer, saying "there is an epileptic fit up here can you call an ambulance".[203]

30. Inmate Nathan Lehane asked Mr Bugmy "are you right?" and Mr Bugmy answered "yeah".[204] Inmate Nguyen, who held a Senior First Aid Certificate, put Mr Bugmy in the recovery position after observing him have a seizure for five to ten seconds. Mr Bugmy said he did not want to go to hospital. Mr Nguyen helped him to stand up.[205]

31. Correctional Officer Liron Srur answered the 'knock up' at 12.15pm. She immediately instructed Correctional Officer Lendon to contact "the nurses and the clinic".[206] Around the same time, inmate William Date entered the Wing office and informed officers Srur and Lendon that an older Aboriginal inmate was having a fit or seizure on the middle landing.[207]

32. Officer Srur entered the wing and saw Mr Bugmy being assisted by two inmates either side to stand to his feet. Officer Srur approached Mr Bugmy and asked whether he was ok. He repeatedly said "I'm fine miss, it's all good".

33. Officer Srur accompanied Mr Bugmy back to his cell, supported by inmate Dickson. Mr Bugmy sat on his bed and said "miss I am fine".[208] Officer Srur then observed Mr Bugmy's arms tense and shake. She instructed inmate Dickson to assist her to put Mr Bugmy on his side. They placed Mr Bugmy in the recovery position on his side.[209] He then had what appeared to be a minor seizure. Once he stopped

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[200] Letter from SORC to deceased dated 11 April 2019: Annexure E, Tab 13.
[201] Letter from Nicola Chappell, Manager, Offender Services and Programs to A/Governor, Cessnock CC dated 15 April 2019 in Statement of Governor Jeremy Leach, Annexure J: Tab 13.
[202] Statement of Jason Borchet dated 18 April 2019: Vol 2 Tab 28; Statement of Nathan Lehane dated 18 April 2019: Vol 2. Tab 30; Statement of Goran Stojanov dated 17 April 2019 at [5]: Vol 2 Tab 32; Statement of Hoa Nguyen dated 17 April 2019: Vol 2 Tab 33.
[203] Statement of Goran Stojanov dated 17 April 2019: Vol 2 Tab 32.
[204] Statement of Nathan Lehane dated 18 April 2019 at [7]: Vol 2, Tab 30.
[205] Statement of Hoa Nguyen dated 17 April 2019: Vol 2 Tab 33.
[206] Witness report of Officer Srur dated 13 April 2019: Tab 20; Statement of William Date dated 17 April 2019: Vol 2 Tab 34.
[207] Witness report of Officer Bruce Lenden: Tab 21.
[208] Lehane, Tab 11; Nguyen, Tab 10.
[209] Statement of Benjamin Dungay dated 17 April 2019: Vol 2, Tab 35; Statement of Kevin Dickson dated 17 April 2019: Vol 2, Tab 36.

shaking, Officer Srur noticed him come in and out of consciousness and eventually appear to be still. Inmate Dickson observed him take two big breaths and stop breathing.[210] Officer Srur attempted to get a pain response but this failed. She was not able to obtain a radial pulse. He was now gasping for air every few seconds.

34. At 12.19pm Justice Health and Forensic Mental Health Network (**Justice Health**) nurses Sarah Abbott and Halee Binks were notified that an inmate in 2 Wing was having a possible seizure.[211] Nurse Abbott retrieved the Emergency Response Trolley (ERT) and they both ran from the Justice Health clinic to 2 Wing, attending Mr Bugmy's cell at 12.25pm. Nurse Abbott requested that an ambulance be called[212] and Officer Srur instructed officer Lendon to arrange one. Inmate Dickson was asked to exit the cell.

35. The ambulance was called at 12.28pm (by Officer Bloemers).[213]

36. According to the Justice Health clinical notes, on arrival Mr Bugmy was unresponsive, not breathing but centrally warm. His Glasgow Coma Score was documented at 3. The nurses immediately commenced Cardiopulmonary Resuscitation (**CPR**), attached a defibrillator and provided oxygen by an oxy viva bag. They administered multiple shocks with a defibrillator, before arrival of paramedics. Office Srur assisted with compressions[214].

37. At 12.40pm nurse Matthews and Senior Correctional Officer Mark McGrath attended Mr Bugmy's cell and saw him lying on a bed with Nurse Binks performing CPR on him. Senior Correctional Officer McGrath noticed an acrid smell inside the cell.[215]

38. The ambulance was dispatched at 12.31pm and attended upon Mr Bugmy at 12.52pm.[216]

39. Access was "difficult due to the protocol in entering the correctional facility and that extrication of the patient was also difficult due to the staircase and equipment management". There was "delayed time on scene due to location".[217]

40. Upon arriving, Ambulance officers continued CPR and defibrillator shocks.[218] They recorded that he had "no palpable pulse" and his blood pressure was "unrecordable".[219] Adrenaline and Amiodarone were

[210] Statement of Kevin Dickson: Vol 2 Tab 36.
[211] Statement of Sarah Abbott dated 15 August 2020 at [11]: Vol 2 Tab 39; Statement of Haylee Binks dated 17 August 2020 at [6]: Vol 2 Tab 40.
[212] Statement of Sarah Abbott dated 15 August 2020: Vol 2 Tab 39.
[213] Witness report of Mark McGrath ,Tab 22; Ambulance Electronic Medical Record at Tab 28
[214] JHFMHN clinical notes, Tab 61 page 64; Witness report of Officer Srur, Tab 20; witness report of Shai Parker, Tab 24
[215] Witness report of Senior Correctional Officer Mark McGrath, Tab 22.
[216] Ambulance Electronic Medical Record - Statement of Virasavath Sayasith dated 23 July 2020, Annexure A: Vol 2 Tab 41 (**Ambulance Electronic Medical Record**).
[217] Ambulance Electronic Medical Record.
[218] Witness report of Shai Parker, Tab 24; Incident Detail Report - Statement of Virasavath Sayasith dated 23 July 2020, Annexure C: Vol 2 Tab 41 (**Incident Detail Report**).
[219] Ambulance Electronic Medical Record.

administered and intravenous fluids were commenced.[220] Mr Bugmy was unresponsive. A second ambulance arrived at the prison at 12.57pm.

41. At approximately 1.18pm Mr Bugmy was placed on a stretcher and carried out of his cell and down the stairs to the bottom landing.[221] On the way to the ambulance Ambulance staff continued CPR compressions and gave two further defibrillator shocks (the 8th and 9th administered by paramedics).[222] At 1.28pm he was loaded into the ambulance.[223] The ambulance conveyed Mr Bugmy to Cessnock District Hospital, arriving at 1.37pm. According to NSW Ambulance records, whilst CPR and treatment continued en route, 'multiple shocks dumped due to non-shockable rhythms' (the last shock was recorded at 1:28pm hours) and on arrival at Cessnock District Hospital, Mr Bugmy was in 'asystole'[224].

42. At 1.39pm Dr Jay Wilma of Cessnock Hospital Emergency Department declared Mr Bugmy deceased.[225]

Injury

43. At autopsy, Mr Bugmy was found to have a 3cm length superficial laceration at the back of the head 30mm left to the midline.[226]

E. INVESTIGATION OF DEATH

44. At 1:33 pm on 13 April 2019, following the departure of the ambulance from Cessnock CC, Corrective Services advised Detective Sergeant Hardy of Cessnock Police Station that an inmate was unresponsive and on his way to Cessnock District Hospital.[227]

45. After Mr Bugmy was pronounced deceased, Senior Constable Stoker and Constable Winchester interviewed Correctional Officers Averell and Dewey at the hospital.[228] Following the pronouncement of death, at about 1:47 pm Mr Bugmy was moved to a nearby sealed room at Cessnock District Hospital.

46. At 4.30pm Detective Sergeant Mitzevich of Newcastle Crime Scene section attended Cessnock Hospital and conducted an examination of Mr Bugmy. During the search, Detective Mitzevich found what appeared to be a portion of buprenorphine film inside a folded piece of paper in Mr Bugmy's left short

[220] Statement of Virasavath Sayasith dated 23 July 2020 at [9] and Ambulance Electronic Medical Record.
[221] Witness report of Casual Correctional Officer Shai Parker: Tab 24; Witness report of Correctional Officer Peter Harris: Tab 23.
[222] Witness report of Shai Parker, Tab 24.
[223] Ambulance Electronic Medical Record; Incident Detail Report; witness report of Mark McGrath, Tab 22; witness report of Peter Harris, Tab 23; Witness report of Shai Parker, Tab 24.
[224] Tab 45; Ambulance Electronic Medical Record.
[225] Verification of death signed by Dr Wilmer: Tab 7.
[226] Autopsy Report at p 6: Tab 4.
[227] Covering Report by Christopher MacGregor dated 13 April 2019,: Tab 18; Incident Details by Christopher MacGregor, 13 April 2019: Tab 19.
[228] Witness Report of Christopher Dewey, 13 April 2019: Tab 25; Witness Report of Joshua Averell, 13 April 2019: Tab 26.

pocket.[229] It was secured as an exhibit. A FASS Certificate of analysis later confirmed it to be a suboxone film containing buprenorphine and naloxone.[230]

47. Detective Mitzevich then attended Cessnock CC and conducted a crime scene examination of the landing where the deceased had collapsed and Mr Bugmy's cell (Cell 13 in 2 Wing). She was informed that the deceased had collapsed in an area on a landing where a blue towel was hanging.

48. Detective Mitzevich observed that 2 Wing was a three level building, that the identified area on the landing was on the southern side of the building on the middle or second floor outside Cell 17. The landing had a concrete floor and a black metal railing on the northern side. She observed that Mr Bugmy's cell was about 10 metres from the identified area on the landing where he collapsed. Two pillows were on the landing near the entrance to Cell 13 and blood was visible on one of the pillows. No damage, blood, hair or any other biological material was visible on the landing or metal railing in the area outside Cell 17 or between this area and Cell 13.

49. In Mr Bugmy's cell, Detective Mitzevich seized plastic bags containing a clear liquid believed to be a solvent. She Mitzevich located:

- two plastic bags tied in a knot in the bottom of a red bucket located below a shelving unit on the western wall of the cell. The bags contained a liquid and white solid substance and smelt like an ignitable liquid. Detective Mitzevich states this item smelled like "acetone/paint thinners or similar".
- A plastic bag between the bottom sheet and top sheet on the single bed in the cell. The top sheet and a lightweight blanket were pulled back (to Detective Mitzevich's observation). This bag looked and smelt similar to the bags located in the red bucket. It had moisture inside.

50. Detective Mitzevich collected the items for further analysis. Item XF000125734 was the bag found in the bed. XF000125734 was the two bags tied in a knot found in the red bucket.

51. During the examination of the cell, Detective Mitzevich also observed blood staining and vomitus on the bottom sheet near the head of the bed and that there were no pillows on the bed.[231]

52. Analysis by the Forensic & Analytical Science Service states that:[232]

(a) The first plastic bag labelled "XF000125734 … Bag from bed" contained a mixture of volatile substances including ethanol, acetone, butanol, toluene, butyl acetate and cyclohexanone. These substances are ignitable liquids and can occur in some thinner products;

[229] Statement of Detective Sergeant Sharon Mitzevich dated 27 July 2020 at [13.8]: Tab 9.
[230] Certificate of Analysis, Forensic and Analytical Science Service, 28 June 2019: Tab 11.
[231] Statement of Detective Sergeant Sharon Mitzevich at [15.9]: Tab 9
[232] Certificate of Analysis, Forensic and Analytical Science Service, 28 June 2019: Tab 12.

(b) The second plastic bag labelled "XF000125734… Two white bags tied in knot containing substance" contained the same volatile substances as found in the first plastic bag. Some of these substances are miscible with water and a water-containing mixture of these substances can be non-ignitable. Also found within the second bag was approximately 4 ml of a clear, colourless liquid. This liquid was found to be miscible with water and to contain a mixture of water-miscible substances. This liquid was found to be non-ignitable.[233]

F. ALERTS ON INMATE PROFILE / CSNSW RECORDS

53. On 9 January 2019 a "Care in Placement" comment was placed on Mr Bugmy's Inmate Profile Document as follows:

EFFECTIVE DATE	EXPIRY DATE	INTERNAL STATUS	REASONS	CAUSES	COMMENT
09/01/2019	22/01/2019	SEG	GOOD ORDER & DISCIPLINE WITHIN A C.C.	THREAT TO GOOD ORDER & DISCIPLINE	Offender suspected of using thinners and/or glue to the extent of unconsciousness.

54. Following the incident of 8 January 2019, no alert was placed on the Inmate Profile Document or other CSNSW record to warn staff that Mr Bugmy must not be employed in any location where solvents may be stored or available.

55. At the time of his death, Mr Bugmy's Inmate Profile Document contained the following table under "Alerts":[234]

ALERT TYPE	ALERT CODE	COMMENTS	STATUS
Placement	Not to be placed	Whilst at DDL to remain housed in I Block only. Not to be moved to J Block. Not to have any unsupervised access to the Maintenance area. not to be employed	Pending

[233] Expert Certificate, Forensic and Analytical Science Service, 12 June 2019:, Tab 35, p. 1.
[234] Inmate Profile Document : Tab 54.

		in any location other than as Domestic Sweeper in I Block. Authorised by GM S Fitzergald.	
Security	Behavioural Risk	Recent incident which required hospitalisation after suspected ingestion of a solvent in the Engineering area at DDLCC. Report received that suggests inmate is canvassing other inmates to steel thinners for him and bring back to J Block.	Pending
Management Program	Life Sentence Redetermined/I-state w NPP		Active
Management Program	Serious Offender Review Council	Convicted of murder (interstate transfer from Victoria)	Active
Disability	Intellectual Disability Or Low Cognitive Func	Had a full neuropsych assessment completed in 2006. 23/12/09 Has been assessed by psychologist and meets criteria for placement in an additional support unit. Should placement be required, please contact SDS by email SDS@dcs.nsw.gov.au (P Snoyman)	Active
Self Harm	History of self harm incident	System generated conversion - 09/02/20214. For detail, refer previous bookings.	Active

265.

56. The same alerts appeared on his inmate profile document as at 28 January 2016.[235] An additional alert appeared on that profile, namely that "Inmate found in possession of Spray Can in his cell 113 in I block at DDL CC. SORC inmate with a history of substance abuse. Last offence in custody 06/2013. Was employed in Maintenance".

[235] Vol 6 Tab 65 p 87.

57. "DDL" and "DDLCC" referred to Dawn de Loas Correctional Centre.

58. As at 1 April 2015, the following alerts were contained on the "OIMS Alerts Query Module" in CSNSW records but not on his Inmate Profile Document[236] (Vol 6 Tab 65 p 98 and 105):

> 3. *NOT TO BE EMPLOYED IN INDUSTRIES WHERE SOLVENTS COULD BE OBTAINED[237] DUE TO HISTORY OF SNIFFING SUBSTANCES – AS PER GOVERNOR PROVOST – Expired 12/02/2014*
>
> 4. *Inmate not to be employed in area where chemicals, toxic solvents etc are used inmate is known to 'sniff' these substances – Expired 11/02/2014*
>
> 5. *INMATE HAS MADE THREATS OF SELF HARM WHILST UNDER INFLUENCE OF SOLVENTS OR TOXIC FUMES – EMOTIONALLY UNSTABLE IN THIS CONDITION - Expired 31/07/2010.*

59. At the time of the incident of 1 April 2015 (which resulted in Mr Bugmy being admitted to the Intensive Care Unit at Westmead Hospital for five days, as outlined below), Mr Bugmy was employed in the Engineering Unit at Dawn de Loas CC and obtained access to a solvent which he ingested causing him to collapse in "J Block". A search of his work location revealed an empty container of paint thinners.[238] He was moved from the "J Block" to the "I Block" at Dawn de Loas CC to remove access to Engineering inmates.[239]

G. MEDICAL HISTORY

Mental Health history

60. On 23 November 2001, Mr Bugmy was assessed by a mental health nurse. It was noted at this time that he had a history of solvent abuse whilst in custody. He was thought to be dysthymic (low grade depression) with polysubstance abuse. He was prescribed Zoloft, an anti-depressant medication.[240]

61. On 7 February 2002, he was assessed by a psychiatrist who changed his anti-depressant medication to Cipramil. Mr Bugmy reported feeling depressed at the time due to the death of members of his family.[241] On 8 August 2002, he asked that his anti-depressant medication be withdrawn.[242]

62. On 2 December 2004, Professor David Greenberg, forensic psychiatrist, conducted a full psychiatric review of Mr Bugmy at the request of the SORC for the purpose of their consideration of his inmate classification. Professor Greenberg concluded that he had an antisocial personality disorder with associated polysubstance abuse/dependence.[243] He referred to "significant use of solvents whilst in

[236] Inmate Profile Document as at 1 April 2015 at Vol 6 Tab 65 p 119; but see Tab 65 p 232.
[237] This alert was first registered on 29 November 2001: Vol 6 Tab 65 p 260.
[238] Vol 6 Tab 65 p 98.
[239] Vol 6 Tab 65 p 106.
[240] Justice Health Records, Psychiatric Report of Professor David Greenberg, 2 December 2004: Vol 3 Tab 61 p 291.
[241] Ibid, p 293.
[242] Ibid, p 293.
[243] Justice Health Records: Vol 3 Tab 61 p 291.

prison as well as other illicit substances". Mr Bugmy admitted to sniffing solvents in both Victoria and NSW gaols, including paint, petrol and glue.[244] Professor Greenberg considered that he had a "simplistic view" that because he had not used alcohol in the recent past, this should not be viewed as a problem in the future. Professor Greenberg opined that there are no reasonable grounds for considering that he suffered from a developmental disability.

63. Professor Greenburg noted that Mr Bugmy reported doing some drug and alcohol counselling whilst he was in Victoria, but that he had had no such treatment in New South Wales. He said at page 7 of this report that: "*Serious consideration should be given to developing a management plan for this man in order that he can benefit from therapeutic schemes whilst serving the remainder of his sentence*". Professor Greenburg stated "The benefits of him attending some further therapy such as the Violence Prevention Program and further drug and alcohol counselling cannot be underscored in this man…"

Neuropsychological Functioning

64. On 26 September 2006, at Long Bay MSPC, Mr Bugmy underwent a neuropsychological assessment by two psychologists following a referral by the State Parole Authority due to his long history of substance abuse.[245] During that assessment, Mr Bugmy reported that he started inhaling solvents (glue, paint and other substances) at 23 years of age.[246] Mr Bugmy's overall level of intellectual functioning was estimated to be in the Borderline to Low-Average range. However, there was no evidence that his solvent or other substance use had caused long-term cognitive impairment at that stage.[247]

65. The psychologists recommended, *inter alia*, that Mr Bugmy participate in educational and therapeutic programs to address his polysubstance abuse and that he address his long-standing/ongoing polysubstance abuse to reduce his high risk of permanent substance-related cognitive impairment in the future.[248]

66. On 23 December 2009, Mr Bugmy was assessed as meeting the criteria for placement in an additional support unit following a psychological assessment.[249] He was not placed in an additional support unit at any stage.

Electrocardiogram Results 2018-2019

67. On 30 June 2018, Mr Bugmy undertook a "chronic disease screen" (**CDS**) assessment at the Justice Health Clinic. He had pathology blood tests and an ECG. The pathology indicated an elevated cholesterol (6mmol). The results of his ECG revealed that he had a "probable anterior infarct, age indeterminate" with "lateral leads also involved".[250] A note was made that "ECG and Pathology

[244] Report of Professor David Greenberg: Vol 3 Tab 61 p 291.
[245] Neuropsychological Assessment: Vol 3 Tab 61 p 272.
[246] Neuropsychological Assessment,: Vol 3 Tab 61 p 273.
[247] Ibid, p 275.
[248] Ibid, p 276.
[249] Inmate Profile Document, Tab 54, p. 2; OIMS Case Note, 23 December 2009, Vol 3 Tab 47 p 22.
[250] Justice Health Records, ECG Results, 30 June 2018: Vol 3 Tab 61 pp 132, 134.

attended. Rebooked 2 years".[251] The records do not indicate that the ECG result was reviewed by a medical practitioner on 30 June 2018 or at a subsequent medical review.

68. On 20 October 2018, Mr Bugmy was reviewed by a general practitioner for follow up of his CDS, specifically his elevated cholesterol.[252] Clinical examination was noted to be "unremarkable".[253] The plan was to review again in six months.

69. On 27 March 2019, Mr Bugmy underwent further CDS, which entailed observations, urinalysis, pathology and an ECG.[254] Mr Bugmy's observations were noted to be within "normal range"; however his ECG results revealed that he had an "anteroseptal infarct, age indeterminate", which was noted to be similar to the ECG results obtained on 30 June 2018.[255] The ECG was scanned and uploaded onto Justice Health electronic Medical Health System (**JHeHS**) that day.[256]

70. Dr Landers (an on-call but remote GP) was contacted. The CDS records that Dr Landers 'reviewed ECG, nil further orders'[257]. Nursing staff recorded: "*Spoke with Dr Landers on the phone & he advised it's not a concern as patient is asymptomatic & this represents a previous / history of infarct – not current*."[258] Mr Bugmy was informed of his ECG results. Mr Bugmy stated that he was not aware of any "family history issues". The nurse noted that Mr Bugmy was healthy and that he did not report any concerns about his health.

H. HISTORY OF INHALANT USE

71. Mr Bugmy had a long-standing history of drug or solvent inhalation while in custody. Known events are summarised in the following table:

DATE	***EVENT***	***REFERENCE***
31 July 2001	A correctional officer attended Mr Bugmy's cell following reports that he was "sniffing a substance from a plastic bag and appeared to be intoxicated". The corrections officer obtained 3 plastic bags containing "contact adhesive". Mr Bugmy had to be forcibly taken to Grafton Base Hospital. A	*Vol 4 Tab 63 p 89* *Vol 5 Tab 64 p 110* *Vol 6 Tab 65 pp 8-16*

[251] Justice Health Records: Vol 3 Tab 61 pp 60, 132, 134.
[252] Justice Health Records, 26/10/18 at Tab 61 page 60; Statement of Gary Nicholls at [30].
[253] Statement of Gary Nicholls at [30].
[254] Vol 3 Tab 61 p 137.
[255] Justice Health Records, Progress/Clinical Notes: Vol 3 Tab 61 p 63; ECG Results, 27 March 2019: Vol 3 Tab 61 p 133.
[256] Justice Health Records, Progress/Clinical Notes: Vol 3 Tab 61 p.152.
[257] Justice Health Records, Progress/Clinical Notes: Vol 3 Tab 61 p.139.
[258] Justice Health Records: Vol 3 Tab 61 pp 63.

	mandatory notification form states that "long history of solvent abuse crisis situation associated with SORC and custody requirements".	
22 November 2001	Mr Bugmy was transferred to Cessnock District Hospital after he was suspected to have inhaled "solvent/paint fumes". Mr Bugmy was unconscious and there was spontaneous movement of his arms and legs. He smelt heavily of paint thinners, his pulse became irregular dropping at times to 30/min and resps irregular to 10/min. Shivering at times (Vol 5 Tab 64 p 119). A search of his cell showed a "large quantity of solvents in his cell (Paints/pain thinners/white out/bleach) in numerous containers" (Vol 5 Tab 64 p 89; photo at p 95). He was referred to mental health. On 29 November 2011 an alert with expiry dated 31 December 2015 was registered "Not to be employed in industries where solvents could be obtained due to history of sniffing substances as per Governor Provost" (Vol 5 Tab 64 p 79-80). In December 2001 the Governor of Cessnock CC requested that he be urgently moved from Cessnock CC to another gaol "due to his continuing solvent abuse" and informed the Serious Offenders Review Council that he had been confined to maximum security in order to prevent him	*SORC letter: Vol 5, Tab 64 p 75.* *Mandatory notification form: Vol 5 Tab 64 p 83.* *Case Notes, Letter from Craig Kelly to Governor Cessnock CC, 22 November 2001: Vol 5 Tab 64 p 87.* *Case Notes, Letter from P. Latimer to Governor N. Provost, 22 November 2001: Vol 5 Tab 64 p 89* *Vol 5 Tab 64 p 119* *Justice Health Records: Vol 3 Tab 61 pp 301, 305-306*

	gaining access to solvents. It was decided that he would be transferred to the MSPC urgently, which occurred on 31 December 2001.	
24 June 2002	Mr Bugmy was found lying on his bed in his cell. He reported that he had a headache and chest pain, and that he felt weak. During medical assessment, the nurses noted a "chemical smell" from his breath. Mr Bugmy denied ingesting any substances. He stated that he had a nosebleed earlier that day; however his nose was not bleeding at the time of the assessment. Mr Bugmy was transferred to Prince of Wales Hospital for two days. Nurses noted that there were "several types of paint" found in Mr Bugmy's cell. Mr Bugmy also had "black paint on his hands and bed clothes". After being in hospital, he was admitted to Long Bay Hospital to convalesce for one week and reviewed by a psychiatrist.	*Justice Health Records: Vol 3 Tab 61 pp 326, 345, 353, 357.*
15 August 2002	During a search of his cell, bottled paints were found. An inmate had reported that "maintenance was bringing the paint [to Bugmy] from 7 Wing".	*Vol 5 Tab 64 pp 292, 311*
29 May 2003	Mr Bugmy was taken to the clinic after he was caught by a corrections officer "sniffing a substance of volatile type" in a red cloth.	*Vol 5 Tab 64 p 226*
2 September 2005	Corrections officers reported that Mr Bugmy's eyes looked "funny" and that he was "dribbling" and "waving his arms	*Justice Health Records, Progress Notes, 2 September 2005, Vol 3 Tab 61 pp 169-170.*

	about". He was taken to the Justice Health clinic for medical assessment. During the assessment, medical staff noted that Mr Bugmy had a "strong solvent smell". Mr Bugmy refused to answer when asked whether he was taking solvents. He was then placed on "intoxication watch" until his condition stabilised. A case officer report to the SORC dated 15 July 2005 states that other inmates have "revealed their concern for his continued use of solvents for inhaling" (Vol 6 Tab 65 p 15).	
17 November 2006	Mr Bugmy was detected taking prohibited material from DET Furniture 2 J Block at Mid North Coast CC on return to C Pod at completion of work on Thursday 16/11/2016. The material consisted of contact spray adhesive secreted in a roll-on deodorant container. He received an institutional charge. 266.	*Volume 3 page 10 OIMS case notes* *Vol 4 Tab 62 p 1*
12 December 2007	Moved between parts of Mid North Coast Correctional Centre "due to suspected petrol sniffing in M6 Pod"	*OIMS case notes Vol 4 Tab 62 p 6*
14 March 2010	Mr Bugmy was forcibly taken to the Justice Health Clinic for assessment after he was found "sniffing paint" in his cell whilst corrections officers were conducting security checks. Mr Bugmy denied that he was sniffing any substances and stated that he had possession of the paint in order to	*Justice Health Records, Progress Notes, 14 March 2010: Vol 3 Tab 61 pp 48 and 83.*

	paint his cell. It was noted that Mr Bugmy had a strong smell of "spirit/paint" on him. Mr Bugmy's blood pressure, pulse, respiratory rate, oxygen saturations and temperature (hereafter referred to as the "vital signs") were noted to be within normal range. He was coherent and oriented to time, place and person. Mr Bugmy had "superficial scratch marks" on his right shoulder, which was presumed to have been caused by the force applied by the corrections officers when they took him to the clinic for assessment. He was kept in the clinic overnight for monitoring. In relation to this incident, other notes record that he was aggressive towards correctional officers when he was removed from his cell to be escorted for assessment, and also that he was placed on a "section 10 order for the good order and discipline of the centre". After this event, he was seen by nursing staff on 18, 19, 21, 22 and 24 March 2010. The note on 24/03 states "gone from segro now in Area 1".	*OIMS case notes: Vol 4 Tab 62 p 23*
5 March 2013	Reports received that he is actively petrol/paint sniffing after lock in every night. Searches turn up nil. To be randomly strip searched and pat searched when returning from work.	*OIMS case notes Vol 4 Tab 62 p 59*

6 March 2013	The JHC nurses were asked to assess Mr Bugmy after he was found to have petrol in his possession (in a small plastic bottle) upon returning from a community program. During their assessment, the nurses noted that Mr Bugmy "hasn't sniffed today" and that his neurological observations were normal. He was charged with 'possess prohibited goods'. Broken Hill CC management recommended he be transferred to a larger CC with access to services to address his issues.	*OIMS case notes Vol 4 Tab 62 pp 59, 60* *Justice Health Records, Progress/Clinical Notes, March 2013, Vol 3 Tab 61 p 55.*
1 April 2015	At 6.50am Mr Bugmy approached the wing staff in "J Block" common area at Dawn de Loas CC but was unable to speak. Mr Bugmy clutched his chest and collapsed as he was trying to explain to the corrections officers that something was wrong with him. Mr Bugmy was unresponsive. Mr Bugmy was taken by ambulance to Westmead Hospital where he stayed in the intensive care unit for four days. An empty solvent container was later found at the offender's work station (Vol 6 Tab 65 p 105; p 98), although this may relate to a separate incident on or about 9 or 10 April 2015 (see below). His cellmate had been reporting that he had been "sniffing solvent with [a] rag throughout the night" (Vol 3 Tab 61 p 127). Prison staff noted that Mr Bugmy likely	*OIMS case notes Vol 4 Tab 62 p 94* *Email from Andrew Sneddon, A/Manager of Security, Dawn de Loas CC dated 10 April 2015: Vol 6 Tab 65 p 104.* *Tab 65 pp 110-114* *Justice Health Records, Discharge summary and Progress Notes, Vol 3 Tab 61 pp 57, 127.*

	inhaled "Motorspray Superglow", a paint thinner containing toluene, acetone, ethyl alcohol, xylene, aliphatic esthers and ethyl benzene. Mr Bugmy denied any knowledge of "chemical sniffing" when he returned from Westmead Hospital (Vol 5 Tab 61 p 58). One document said the collapse occurred However, the incident occurred at 6.50am and another document states that he collapsed "on his way to work": Vol 6 Tab 65 p 110. The discharge summary notes that he was sent to hospital after complaining of chest pain, collapsed and became unresponsive. Pathology tests were normal. An Electrocardiogram (ECG) showed no ischaemic cardiac changes.	
9 April 2015	There appears to have been a recurrence shortly after he returned from hospital. This occurred in the Engineering Workshop at Dawn de Loas CC. He asked inmates in the Engineering Unit to bring thinners back to him in J Block (Vol 6 Tab 65 p 106). He also appears to have been questioned about paint thinner found in his cell. He said that he confused it with water but could not account for its presence in his cell (Vol 4 Tab 62 p 95).	*Vol 4 Tab 62 pp 94-95.*

	He was moved to the I Block and removed from employment in the Engineering workshop at Dawn de Loas CC to prevent access to solvents: Vol 6 Tab 65 p 106.	
21 August 2015	He was found in possession of a spray can in his cell at Dawn De Loas Correctional Centre and charged with self-intoxication. He was placed on a "management contract" for three months. As at February 2016 there were no referrals in place for AOD or psychology treatment.	*OIMS case notes Vol 4 Tab 62 p 99 Photo at Vol 5 p. 413, 447*
28 January 2016	At St Heliers CC, he was subject to a routine cell search. Officers discovered a quantity prohibited items consisting of 500ml of paint thinners believed to have been obtained from the maintenance workshop and engineering. It is recorded that he initially denied possession of the items, but then conceded that they were his items after being reminded that he "nearly died" in 2015 as a result of ingesting paint thinners. The case note says that he would be recommended for an alternative placement as he is not suitable to remain at a correctional centre which has access to chemicals or solvents. (He was moved from Dawn de Loas gaol to Bathurst CC on 27 February 2016).	*OIMS case notes Vol 4 Tab 62 p 101* *Inmate Discipline Action form Vol 6 Tab 65 pp 79-85*
15 August 2016	Staff conducted a search of inmates returning from K Block. Mr Bugmy dropped an article near his feet. It was a rolled up	*OIMS case notes Vol 4 Tab 62 p 112.*

	piece of foil in a plastic bag and a shampoo bottle containing black acrylic lacquer paint containing a high percentage of solvent. He was warned but not charged.	
9 January 2019	Mr Bugmy was taken to the clinic after it received reports that he was "sniffing thinners" on a regular basis when locked into his cell in the evenings, and that he collapsed on 8 January 2019 following an "episode of sniffing". He was noted by clinic nurses to be oriented to time, place and person. There was no obvious odour detected or evidence of intoxication. When asked if he had any form of substance, Mr Bugmy strongly denied using thinners stating that he used to participate in "thinners sniffing" but had not done so for many years due to an "overdose a few years ago". His vital signs were noted to be within normal range. He was placed in the observation cell for monitoring. He was then placed in segregation until 22 January 2019. The note placed on his placement record at this time says he was suspected of using thinners and/or glue to the extent of unconsciousness. A record dated 8 February 2019 states that he "adamantly denied" "sniffing stuff" of which he had been "accused".	*Inmate Profile Document, Vol. 2 Tab 54* *Justice Health Records, Progress/Clinical Notes, Vol 3 Tab 61 pp 61-62.*

I. PARTICIPATION IN PROGRAMS AND EMPLOYMENT

72. Mr Bugmy completed some programs during his custody in New South Wales.

73. In relation to alcohol and drug programs, Mr Bugmy completed the Getting Smart Program in 2008 and 7 sessions of SMART Recovery in 2012 in conjunction with his completion of the Violent Offender Treatment Program (**VOTP**). He did not participate in any intensive alcohol and drug (**AOD**) program. In April 2017 he declined an offer to participate in the Intensive Drug and Alcohol Treatment Program. There were other times when he expressed a lack of interest or willingness to undertake programs.[259]

74. Key dates regarding his participation in programs, based on CSNSW case note (OIMS) records, are as follows:

- 16/11/2006 – Mr Bugmy was placed on a waiting list for assessment of suitability for Violent Offender Programs;[260]
- 6/12/2006 – Mr Bugmy expressed a wish to do the high intensity AOD program "*Phoenix*" at Cessnock CC (Tab 62 p 3);
- July 2007 – Mr Bugmy completed an application for *Phoenix*;
- 17/09/2007 – *Phoenix* program communicated that he would need to do another AOD program first such as *Getting Smart* (Tab 62 pp 5-6);
- 14/2/2007 - SORC said he needed to do AOD programs;[261]
- 14/1/2008 – a Services and Programs Officer noted that his application to attend *Phoenix* may be reconsidered in January 2008 to determine if he could attend (Tab 62, p 6);
- 25/1/2008 – Mr Bugmy indicated that he had changed his mind about being assessed for the VOTP and signed a referral form (p 7). He had not heard anything back from VOTP as at 23 July 2008 (Tab 62 p 8);
- 22/09/2008 – Mr Bugmy was assessed as not suitable for the VOTP as his motivation to address his offending behaviour was noted to be "quite low". The assessor recommended that he improve his literacy skills and participate in a program to address his substance abuse such as *SMART* or the *Phoenix* program (p 9). Mr Bugmy is reported in Case notes dated 24/09/2008 to have acknowledged these recommendations and agreed to participate in AOD programs and literacy education;[262]
- 26/11/2008 – Mr Bugmy completed *Getting Smart* program sessions 1 to 7 and 8 to 12 with good participation (Tab 62 p 11; Statement of Danielle Matsuo, Tab 15-3, [19]);

[259] For example Vol 4 Tab 62 p 2; p 3.
[260] Vol 4 Tab 62 p 1.
[261] Vol 4 Tab 62 p 3.
[262] Vol 4 Tab 62 p 10.

- 11/05/2009 – Mr Bugmy was assessed as suitable for entry into the medium/high intensity VOTP and his name was placed on waiting list (Tab 62 p 14);
- 29/06/2009 – Mr Bugmy signed a consent to a place offered in VOTP (Tab 62 p 17);
- 24/09/2009 – Mr Bugmy completed the readiness/assessment phase of the VOTP (Tab 62, p 20);
- 30/09/2009 – Mr Bugmy was attending Aboriginal Studies classes (Tab 62, p 20);
- 26/10/2009 – Mr Bugmy attended the first session of the *Getting Smart* program. He agreed to re-do the program to reinforce and consolidate knowledge (Tab 62, p 20). He did not attend the group on 2 or 9 November saying he changed his mind because he had done the program before (p 21). Later case notes entry (25/05/2010) confirm that he completed the *Getting Smart* program (Tab 62, p 25);
- 5/11/2009 – Mr Bugmy commenced the VOTP treatment, Stage one (Tab 62, p 21);
- 23/12/2009 – Mr Bugmy was assessed by a psychologist as meeting the criteria for placement in an additional support unit, being a unit for inmates with a cognitive disability (p 22);
- 2/03/2010 – Mr Bugmy successfully completed Stage 1 of the VOTP on 4 December 2009 and was participating in Stage 2 (Tab 62 pp 21-22);
- 24/03/2010 – Mr Bugmy was discharged from the VOTP due to an incident in which he was believed to be sniffing solvents and pushing an officer when being removed from his cell (on 14/03/2010) (Tab 62 p 23);
- 16/07/2010 – Mr Bugmy said he was being asked to do the VOTP again but said he would rather do the *Phoenix* program (p 26); *Phoenix* program said they may not run the program again until 2011 (p 27);
- 24/09/2010 – Mr Bugmy said that he was not willing to do the VOTP even if that meant staying in gaol (p 27);
- 27/09/2010 – a CSNSW case plan for Mr Bugmy noted that he "will be referred for possible inclusion in a relapse prevention program" (Tab 65 p 127);
- 13/12/2010 – Mr Bugmy was willing to return to VOTP and signed a consent form (Tab 62 p 29);
- 3 and 14/03/2011 – Mr Bugmy was offered and accepted a place in the VOTP (Tab 62, p 30);
- 3/06/2011 – Mr Bugmy declined to join the *SMART Recovery* program and signed a form to this effect (Tab 62 p 31);

- 5/06/2011 – Mr Bugmy said he hoped to eventually transfer to Broken Hill CC to be closer to family;
- 13/07/2011 – Mr Bugmy commenced the readiness groups of the VOTP and presented positive attitude (Tab 62 p 36). He was also attending a First Aid course (p 37) and Koori art classes to keep himself occupied. He told Community Corrections that he was already doing two programs (VOTP and First Aid) and was not prepared to do any further "as he did not feel he would cope", and said he had already done SMART Recovery at MSP (p 35);
- 8/9/2011 - he progressed in to the treatment phase of VOTP program, completing Stage 1 on 28/09/2011 (Tab 62, pp 39-41);
- 25/11/2011 – Mr Bugmy commenced Stage 2 of the treatment phase of the VOTP. He asked the SORC if he could be transferred to Broken Hill CC after VOTP was completed (p 42). As at 3/2/2012 Mr Bugmy was doing the Victim Empathy stage of VOTP (p 44);
- 13/04/2012 – Mr Bugmy graduated from the VOTP (p 48); thereafter he attended "VOTP maintenance" sessions (pp 46, 58, 61, 96). He identified a number of times boredom as a risk factor for him for when he gets into trouble (p 96);
- March-May 2012 – Mr Bugmy attended 1-hour sessions of *SMART Recovery* Maintenance Groups (Tab 15, p 22);
- 8/03/2013 – Broken Hill CC was "to source some one on one counselling" and he was "to do getting Smart program" (Tab 62, p 59);
- 7/06/2013 – at reception to Parklea CC Mr Bugmy was offered "AOD intervention" (Tab 62, p 65);
- 26/06/2013 – a Psychology assessment yielded an AOD score of 7. The case note records that he had completed *Getting SMART* and *SMART Recovery* and "is encouraged to self-refer should any AOD issues arise" (Tab 62, p 65);
- 15/10/2013 – Mr Bugmy assessed as functioning in the borderline range of cognitive functioning (Tab 62, p 74)
- 29/7/2014 – Mr Bugmy reported that he is no longer interested in sniffing glues and solvents and is "over that" (p 85). He also reported that he committed the offence "to survive" as he was "living on the street";
- 2/09/2014 – currently Bathurst CC did not have *SMART Recovery* available for participation. It was also noted that "There are no current aod interventions available that have not already been completed by Mr Bugmy and specific one to one counselling is not available at BTH CC. No further action required for aod specific programs" (Tab 92, p 90);

- 21/01/2015 – a System Program note records that the status of Mr Bugmy's participation in *SMART Recovery* Maintenance Groups was "New status: Abandoned" because "Program /Service Discontinued" (Tab 62, p 92);
- 22/12/2016 – Mr Bugmy enquired about attending VOTP maintenance. The Services and Programs Officer emailed VOTP and was informed that his VOTP maintenance will continue at Wellington CC (Tab 62 p 116);
- 20/03/2017 – Mr Bugmy declined a referral to the *Intensive Drug and Alcohol Treatment Program* (**IDATP**) saying he had completed all necessary programs on the advice of the SORC (Tab 62, p 119). On 1 May 2017 he was removed from the IDATP waitlist;
- 23/06/2017 – during a Pre-Program suitability interview, he was reported to have "flatly refused" to do any programs (Tab 62, p 123);
- 15/09/2017 – Mr Bugmy was on a waitlist for the *Equips Addiction* program (Statement of Danielle Matsuo, Tab 15-4, [30]);
- July 2017 until February 2019 – Mr Bugmy continued to attend VOTP maintenance sessions. In October 2017 he said he was "currently doing his VOTP via AVL once a month, is working and that's enough for him" (Tab 62 p 130);
- 13/02/2019 – it is recorded that "He spoke highly of the VOTP Maintenance program. He looks forward to hearing from them every 2 months or when possible via video. Kevin has no desire to attempt any more programs, education or vocational training. We agreed to meet again next week to look at other options for his future" (Tab 62, p 147).

75. He was employed in various parts of the correctional centres in which he was held. Examples include:

(a) Metal shop and Construction and Building program – Cessnock CC - as at September 2001;[263]

(b) Technology - Mid North Coast CC - as at 21/12/2006;[264]

(c) As a clipper in Textiles – Mid-North Coast CC - as at 23/2/2009[265] and 4/06/2009;[266]

(d) As a painter in the Girrawaa Centre at Bathurst CC from 14/11/2013 as at 16/09/2014.[267] He was undertaking Aboriginal Studies and had sold two paintings and didgeridoos, described as "high quality work";[268]

(e) Main Warehouse/garbage run - Dawn de Loas CC – as at 12/05/2015;[269]

[263] Vol 5 Tab 64 p 96.
[264] Vol 4 Tab 62 p 3.
[265] Vol 4 Tab 62 p 11.
[266] Vol 4 Tab 62 p 15.
[267] Vol 4 Tab 62 pp 80, 90.
[268] Vol 4 Tab 62 p 93.
[269] Vol 4 Tab 62 p 97.

(f) Maintenance – Dawn de Loas CC - as at 21/08/2015;[270]

(g) In the art centre – Bathurst CC - as at 12/05/2016;[271]

(h) Furniture Business Unit – Cessnock CC – from 18/2/2019 to 12/4/2019.

HISTORY OF PAROLE APPLICATIONS

76. On 5 October 2000 Mr Bugmy became eligible for parole.

77. On 7 December 2000 parole was refused on the basis he would be unable to adapt to normal lawful community life, was at risk of reoffending and needed to do pre-release programs.[272]

78. On 4 May 2001 parole was refused on the basis he was "unable to adapt to normal lawful community life; risk of reoffending; need for further drug and alcohol counselling and need to participate in pre-release program. Involved review hearing".[273]

79. On 15 October 2002 parole was refused.[274]

80. On 28 October 2003 the SORC recommended that he be transferred to Broken Hill CC to allow family visits with the placement being conditional on him undertaking all AOD programs recommended by Broken Hill AOD staff.[275]

81. On 25 October 2005 parole was refused on the basis the Parole Authority "has sufficient reason to believe that if released from custody at this time the offender would not be able to adapt to normal lawful community life; risk of reoffending: no post release plan; Inappropriate in public interest; need to address offending behaviour (AOD/Violence); poor prison performance".[276]

82. On 30 November 2006 parole was refused on the basis he was "unable to adapt to normal lawful community life, Risk of reoffending, No suitable post-release plan or accommodation, inappropriate in the public Interest, Need to address offending behaviour (AOD / violence), Poor prison performance".

83. On 30 August 2007 parole was refused on the basis "Inappropriate in the public interest, need to further address offending behaviour (AOD/ violence), not supported by SORC".[277]

84. On 7 August 2008 parole was refused on the basis of "not in the public interest, need to further address offending behaviour (AOD/Violence), not supported by SORC".

85. In a parole interview on 13 July 2011 he informed staff that he only commenced using drugs and sniffing solvents once he entered gaol and not before and that this was as a result of boredom (Tab 62 p 35). He said that as far as he was concerned sniffing solvents was not a problem as he had done it for over 12

[270] Vol 4 Tab 62 p 99.
[271] Vol 4 Tab 62 p 105.
[272] Tab 63 p 185, 207.
[273] Tab 63 p 193.
[274] Tab 63 p 167.
[275] Tab 63 p 146.
[276] Tab 63 p 119
[277] Tab 63 p 106

months (p 35). His sister informed CSNSW that she was willing to have him reside with her if he was released to parole. She confirmed this a number of times including on 31/07/2014 (p 86).

86. On 6 October 2011 parole was refused on the basis he "needs to further address offending behaviour (Therapeutic) [needs to complete therapeutic program(s) to address violence eg VOTP etc], need for post release accommodation [unconfirmed post release accommodation], needs to participate In the external leave program and SORC advised that it Is not appropriate for the offender to be considered for release on parole."[278]

87. In 2012 he applied not to be considered for parole.[279]

88. In 2013 he applied for parole, indicating he would be happy to be placed in a COSP.[280] On 12 September 2013, parole was refused.[281] The reason given was "Needs to further address offending behaviour (General) [needs to complete program(s) that address alcohol and other drugs problems], need for post release plans [structured post release plans in the community]; need for post release accommodation [no suitable post release accommodation], poor prison performance [poor correctional centre report], needs to participate In the external leave program and SORC advised that it is not appropriate for the offender to be considered for release on parole".

89. On 25 September 2014 parole was refused.[282] The reasons stated were "Needs to further address offending behaviour (General) [needs to complete program(s) that address alcohol and other drugs problems], need for post release plans [structured post release plans In the community], need for post release accommodation [unconfirmed post release accommodation], needs to participate In the external leave program and SORC advised that it is not appropriate for the offender to be considered for release on parole".

90. OIMS case note of 1 August 2014 record that the "thinking" of SORC and Community Corrections Officer in recommending against parole was that he had spent 32 years incarcerated, that between his juvenile and adult detention had had a total of 4 months in the community and that an integrated approach for his return to the community was needed involving progression to a C3 classification so as to be eligible for day leave.[283] He was required to progress to C3 classification to be considered eligible for parole.[284]

91. On 13 July 2017 parole was refused on the basis there was a "need for structured post release plans and/or accommodation to be finalised, needs to participate in the external leave program and Serious Offenders Review Council does not consider the release of the offender is appropriate".[285]

[278] Tab 63 p 73
[279] Tab 62 p 50
[280] OIMS case notes Tab 62 p 62
[281] Tab 63 p 67
[282] Tab 63 p 61
[283] Tab 62 p 87
[284] Tab 62 p 109
[285] Vol 4 Tab 63 p 54

92. On 11 October 2018 parole was refused on the basis he "needs to participate In external leave program and Serious Offenders Review Council does not consider the release of the offender Is appropriate. Next eligibility date: 5 October 2020."

J. POST-MORTEM RESULTS AND EXPERT ANALYSIS

267. Cause of death

93. An autopsy was conducted on 18 April 2019 by Dr Allan Cala, forensic pathologist. Mr Bugmy was identified by fingerprints.[286] Correctional Officer Josh Averell also identified Mr Bugmy at the hospital.[287]

94. The post mortem examination revealed that Mr Bugmy had severe coronary artery disease with extensive old and more recent infarcts (heart attacks) throughout the left ventricle of the heart. [288]

95. Dr Cala opined that "coronary artery disease could easily explain the deceased's sudden death apart from the complicating factor of long standing inhalational drug use".

96. Toxicological analysis detected acetone, amiodarone and lignocaine in Mr Bugmy's post-mortem blood sample.[289] Neither alcohol nor buprenorphine were detected. The amiodarone and lignocaine had been given to Mr Bugmy by the ambulance officers who treated him at the scene.

97. Dr Cala assumed the presence of acetone was due to recent prior "huffing" or inhalation, noting the substance was found in his cell after the death. Dr Cala stated that acetone is known to be associated with seizures and nervous system depression, cardiac arrhythmias and death. However, as the blood level was unknown, it was "unclear precisely what role this chemical has played in this man's death".[290]

98. Due to the presence of acetone in his blood, Dr Cala could not conclusively determine whether the severe coronary artery disease was the cause of his death. Dr Cala stated:

> "Although this man's death can be explained on the basis of severe natural diseases (heart related), the additional factor of inhalational drug use, with the present of acetone in blood as proof of this, means drug effect cannot be entirely excluded as having played no role in the death of this man. Accordingly, the cause of death is unascertained."

99. At autopsy, apart from severe coronary artery disease, Mr Bugmy was found to have had:

(e) Calcified coronary arteries and aorta, described further as "severe calcification and narrowing of each coronary artery, particularly the right coronary artery and left anterior descending coronary arteries by atherosclerosis";[291]

[286] Statement of Detective Senior Constable Ian Bray dated 23 April 2019: Tab 3.
[287] Statement of Josh Averell dated 13 April 2019: Tab 2.
[288] Autopsy Report: Tab 4.
[289] FASS certificate dated 6 May 2019: Tab 5
[290] Autopsy Report p 3 at [4]: Tab 4.
[291] Autopsy Report at p 7: Tab 4.

(f) Severe pulmonary emphysema;

(g) Distended urinary bladder;

(h) A small scalp laceration at the back of the head on the left side, which Dr Cala said was consistent with a minor fall onto the back of his head as described in the narrative about what occurred at the prison.

Further toxicological analysis

100. Post-mortem blood was preserved.

101. At the time of post-mortem, the toxicology results showed the detection of acetone with a reading of 0.01% (100 parts per million (**ppm**) in post-mortem blood). Screening tests were not undertaken for the other kinds of substances that were found in Mr Bugmy's cell, which included (in addition to acetone) ethanol, butanol, toluene, butyl acetate and cyclohexanone.

102. On or about 5 February 2021, the Forensic Science Laboratory within ChemCentre, Western Australia conducted a toxicological analysis of a 6 ml sample of the deceased's blood (that had been stored in ethylenediamine tetra-acetic acid) and frozen at -20 degrees Celsius) to determine the level of acetone in the blood and to screen for the presence of the volatile organic compounds known as ethanol, butanol, toluene, butyl acetate and cyclohexanone. Approximately 0.01% acetone was detected. No other volatile organic compounds were detected.[292]

103. According to Professor Alison Jones, specialist physician and clinical toxicologist, Mr Bugmy's post mortem acetone reading of 0.01% ppm is unremarkable. She would not expect clinical features of toxicity. The finding of acetone could be due to inhalation or physiological processes or both and does not constitute proof of inhalational or ingestion by Mr Bugmy. However, the absence of toxic concentrations of toxins in the post-mortem blood does not exclude the role of volatile organic compound solvents in his death.

104. Volatile organic compounds such as those found in My Bugmy's cell evaporate in the air and diminish or degrade over time between sampling and analysis because of their physicochemical nature. Mr Bugmy's death occurred on 13 April 2019 and samples were first received by the first toxicology laboratory on 24 April 2019. The lack of detection in 2019 and 2021 does not rule out their presence in blood at the time of death.

Cardiologist opinion

105. A/Professor Mark Adams, Department of Cardiology, Royal Prince Alfred Hospital, considers that at the time of his death Mr Bugmy had undiagnosed severe and extensive coronary artery disease with previous myocardial infarction. He had a number of risk factors for coronary artery disease including

[292] Report dated 5 February 2021: Vol 1, Tab 6.

being of Aboriginal background, male gender over 55 years and incarcerated and a heavy smoker.[293] He was not overweight nor did he have diabetes.

106. In A/Professor Adams' opinion, Mr Bugmy's death was likely a sudden cardiac death due to his underlying severe coronary artery disease and in particular a recent myocardial infarction that would have led to a significant risk of fatal cardiac arrhythmias. He opines that acetone intoxication may have put further stress on the heart and thus increased the risk of fatal arrhythmia developing. He considers there was a risk of sudden cardiac death of around 40-50% in a twelve month period.

107. A/Professor Mark Adams makes the following observations about the ECG records:

    (a) At some point between 6 February 2004 and 30 June 2018 Mr Bugmy had a large myocardial infarction;

    (b) An ECG in 2004 showed normal sinus rhythm and mild ST segment changes.

    (c) An ECG in 2015 when he was admitted to Westmead Hospital due to solvent intoxication was normal with no rise in troponin levels;

    (d) The ECGs done on 30 June 2018 and 27 March 2019 showed features consistent with an old anterior myocardial infarction due to the occlusion of the left anterior descending coronary artery. This type of cardiac damage compromises cardiac function often leading to cardiac failure and predisposes to development of potential fatal cardiac arrhythmias.

    (e) It is difficult to pinpoint when the large myocardial infarction occurred and it is possible that Mr Bugmy did not seek medical treatment when it happened. However, as he had a normal ECG in 2015, it narrows down the time interval as between 2015 and 2018. There are no clear episodes where his extensive coronary artery disease caused symptoms.

108. A/Professor Adams notes that toxicological studies of acetone have found little cardiac effect other than tachycardia. However, a study reported in 2017 that exposure to solvents can increase ECG changes and arrhythmias. These studies have generally considered lower doses of solvents than is seen in substance abuse and there are reports of fatal tachyarrhythmias and bradyarrhythmias observed in some cases. Acetone does not seem to have as marked adverse cardiac effects as toluene, tylene and chlorinated solvents.

109. In A/Professor Adams' opinion, given his severe coronary artery disease, solvent use including acetone could have led to an increase in Mr Bugmy's heart rate and blood pressure and may have provoked ischaemia thus increasing the likelihood of developing an arrhythmia.

110. He considers that it may have been appropriate to perform further cardiac tests in response to the abnormal ECG seen on 30 June 2018. He notes that no medical practitioner reviewed the ECG result. Medical review makes it more likely that abnormalities are picked up.

[293] Report dated 10 October 2021: Vol 2 Tab 49A.

111. A/Professor Adams considers that Justice Health's procedures for managing patients with a chronic condition in custody are appropriate with one exception, namely that the Heart Foundation recommends commencing screening Aboriginal and Torres Strait Islander patients at the age of 30 rather than 35 years as specified by Justice Health.[294]

112. He notes that Justice Health's procedure for managing patients with a chronic condition does not mention performing an ECG routinely and that this is commensurate with what should be performed in the community where ECG is only done in response to symptoms or where a patient may have significant risk factors for coronary artery disease. This is because ECG can yield false positive results and is "not a great screening test".

7 February 2022

[294] Attachment 15 to A/Prof Adams' report: Vol 2 Tab 49A p 98 (Heart Foundation, *Time to book a heart health check?*); Justice Health 7 Forensic Mental Health Network *Procedure for Managing Patients with a Chronic Condition in Custody*: Vol 8 Tab 77.

Appendix B

Kevin's statement – extracted from the 'Request by a prisoner for transfer to a participating state for the prisoner's welfare' located at Tab 65, pp 46-47 of the Brief of Evidence, as read onto the record by Professor Megan Williams on 11 February 2022 on behalf of Doreen Webster:

> "I, Kevin Frances Bugmy, currently a prisoner held at HM Prison Melbourne assessment prison in the State of Victoria, hereby request in the interests of my welfare, to be considered for transfer to the State of New South Wales, a participating State for the purposes of the Prisoners (Interstate Transfer) Act 1983, to serve the balance of my sentence.
>
> 2) Outstanding legal matters. Have you any outstanding legal matters pending, appeals, charges or complaints against you in Victoria or interstate? No.
>
> 3) Grounds for welfare request. Please outline your case for transfer interstate on welfare grounds. I have no family whatsoever in the State of Victoria. All of my family live in New South Wales, mostly in and around Kempsey. I suppose I am what is now termed one of the Stolen Generation, my mother having died when I was born. After her death, I was placed in a foster home with non-Aboriginal carers. From there, I was placed in various homes and institutions. My life is in many respects similar to others in my situation. That is, that I spent a long period of time in different institutions, set up to care for children.
>
> These institutions sometimes have children who are placed in them, go on to live happy and productive lives. With other children, this did not happen. I was one of the other children. I was introduced to offending at a young age by other kids I met in the system. At a young age, I was introduced to alcohol and drugs. I did not emerge from these institutions skilled to enter the workforce or to really control my own life. As a result, my life was controlled by drugs and alcohol. Many Aboriginal kids have stories the same as mine.
>
> I did not meet my natural family until I was 19 years old. Jim Bourke, who worked at the Aboriginal Legal Service arranged it. After not seeing my father since I was born, I was driven up by Jim to meet him. He hoped that it might have a positive effect on me. Perhaps by that time, it was too late. It was hard at the age of 19 to start a relationship with a father who had not been part of my life. Now I am older, I feel that I am in a stronger position to make a go of it. I have been making regular contact with my family, particularly my sister Doreen. My family is unable to visit me at all due to the long distance from here to northern New South Wales.
>
> I believe the closest gaol to my family is Grafton Prison. If I were transferred there, I am sure they would visit me. My niece Kathleen tells me she is going to travel down here to meet me. She was only a baby the last time I saw her. That will be the first visit I have had from any of my family in all the years I have been in prison. In fact, I have had no contact with anyone from the outside world since I have been in prison. For an Aboriginal person, this is hard. I believe that family contact is an important factor in

people completing parole and developing socially acceptable ways of interacting with others.

I realise that it will be very hard for me to adjust when I get out of prison, as I have been in here for so long. I am really going to need the support from my family when I get out of here. They are willing to help. The only people that I know in Victoria are those whom I have met in the various prisons I have been held in. I don't want to get mixed up with them when I get out of here, because I know that I will just end up in prison again. The last year that I spend in prison will be important for me. If I am to have a chance of developing a strong supportive relationship with my family, that is important that I be near them.

They are not wealthy people and to ask them to travel to Melbourne to visit me is not fair. If on the other hand I am moved to New South Wales and over time I can build up the sort of relationship which will assist me when I get out. Whilst I do not hang out with the sorts of people I have met in prison, all human beings require some contact. I will need people to talk to and to be with. I would hope that this would be my family. I am worried about myself if I cannot develop the sorts of relationships that will allow me to move into the outside world.

My brother Alfred has been very sick in hospital. I want to spend as much time with him as I can during the time he has left. My father died three or four weeks ago. I was refused permission to attend his funeral. Since his death, I think that our family is feeling the need to spend more time together. I have nearly finished serving my sentence and I'm looking forward to spending the rest of my life keeping out of trouble and getting to know the young kids in my family. I can teach them to keep out of trouble and to not make the mistakes I made.

4) Should the case involve medical reasons? Provide details. They're provided."

Appendix C

The Family Statement prepared by Doreen Webster as read onto the record by Professor Megan Williams on 11 February 2022 on behalf of Ms Webster:

"My name is Doreen Webster. I am a Barkindji woman, I am an Aboriginal person. I am a survivor of the Stolen Generations and I am a survivor of the Cootamundra Girls Home. I am also a great-grandmother to too many children to count, a grandmother to 40 or 50 grandchildren, a mother to six and a sister to five siblings. I am 74 years old and the 74 years of my life have not been easy and especially has not been easy to talk about the struggles that I have lived through, throughout my life.

I have been asked to talk about these struggles too many times by lawyers, by journalists, by the Royal Commission into Institutional Responses to Child Sexual Abuse and I have chosen to speak about these struggles in my role as the secretary for the Cootamundra Girls Corporation, for the Coota girls, the women who like me, were survivors of the Stolen Generations and survivors of the Cootamundra Girls Home. Not many of us are left alive to speak about these struggles and so I have had to, so that our story is told. How can it be easy to talk about these experiences.

To talk about the pain of being ripped apart from your parents, the pain of being removed from your country and the pain of having stolen from you, the right to know and to be with your family. To western law, some of this is not relevant or not connected to the story of Kevin and to what happened to him. But to us, how these things be understood in isolation from one another, is a question. Kevin was a Barkindji man, he was an Aboriginal man, he was a man that belonged to law, a man that belonged to culture and a man who was the son of a mother and father, Maud Bates and Jack Bugmy.

The brother of five siblings Johnny, me, Margaret, Alfred and Malcolm. He was also an uncle and someone who should have had the chance to be an elder to his community and to his family. But how can I speak about my brother's life when in so many ways, we were strangers to one another. We never truly got to know one another in the way that a brother and sister ought to know one another. A way that they have the right to know one another, at least a right recognisable in our law, to grow together as any normal family should.

That was taken away from us through no fault of our own. I never knew his deepest thoughts, I never knew his deepest fears. We never truly knew one another how we ought to have, because we were never given the chance to know one another in that way. When he died, he was alone without his family there, only his prison mates. Imagine how distressed he was. At the same time, I did know Kevin and Kevin knew me. That is because to us, to us as Aboriginal people, knowing is something deeper. It is a spiritual thing. It is more than just a thread of information you gather or even the experiences you share with someone throughout your life.

Knowing comes from the spirit. Kevin and I knew each other in spirit and we knew each other through the many connections we had for our country,

through our bloodline and through our spirit and we knew each other through our efforts to get to know one another, the visits and phone calls over the years. When I first learned that I had a brother by the name of Kevin Bugmy, I was only seven when me, my brother Johnny who has only told me and our little sister Margaret, were taken from our parents in Wilcannia.

Johnny and I spent the first night in the cells at the Wilcannia Police Station and I'm not sure where they kept Margaret that night. I remember feeling terrified and wondering what would happen to us and wondering why we were not with our mother and father. The following day, we were driven to Broken Hill, where we were put on a train that took us to Central Station in Sydney. At Sydney, a welfare man named Johnny came for Johnny and took him away to Kinchela Boys Home. There was a welfare woman who took me and Margaret to Cootamundra Girls Home.

When the man took Johnny away from us at Central Station, I remember crying out and running after him and shouting 'You are going the wrong way.' I actually thought we were going to be together. At Cootamundra we were told that our parents had died and that our family were now the people at the girls home. It wasn't until about nine years later, maybe when I was 16, when I got a visit from my older brother Johnny, who had just turned 18, had left Kinchela and got a job with the welfare board and told me that I had three more brothers, the youngest being Kevin.

He told me that two of them were just like him, had ended up at Kinchela, but the third and youngest born to mum Kevin, was taken away to Victoria and that mum died shortly after he was born and the way that she died was not during childbirth, like some of the records have said, but that she was murdered. It was so wrong about Kevin being taken from country and it is still happening today to our children. In the years after Cootamundra Girls Home, they were really difficult. I had a lot of pain and a lot of anger that I did not know what to do with.

There were many years which I lost to my grief and to alcohol. Those years were hard and I will never forget them. It wasn't until the 80s that I was able to find the strength to move forward, despite still carrying that grief with me even now and that's when I gave up drinking once and for all. I think it was somewhere around that time that Kevin and I first spoke. I cried when I heard his voice for the first time. It was years later that I found out that my mother was a survivor of the Cootamundra Girls Home. That was very traumatic for her and it was traumatic to see the continuation of that into generational trauma and of my experience.

I'm not quite sure whether it was Kevin or whether it was me who first reached out and made contact, it might have been Kevin. All I remember is speaking to him over the phone and just thinking that this was my brother on the other side of the line and feeling like it was a connection I needed to fight for. I remember Kevin really wanted to transfer to New South Wales. I remember him talking about having no one in Victoria and wanting to come over so he could get to know me and the family.

I think my daughter Kathleen might have gone and visited him when he was still in Victoria, but I know that I didn't see Kevin in the flesh until he got to New South Wales. My earliest memory of seeing Kevin was when he was up here in the Kempsey Gaol. I remember we talked the whole way through the visit and the screws had to tell us a couple of times to finish up, because we weren't running out of words to say to one another. He had, he asked a lot about family, about what happened to all of us. He also asked about the family I'd made for myself and wanted to get to know who everyone was.

I was asking him about how he was coping and the life that he had had but it wasn't easy for either of us to talk about our pain. I just remember thinking how skinny he looked, he was very thin and that his teeth were really bad. That made me quite upset. I remember thinking that they mustn't have been looking after him very well if he looked like that and I wondered did he ever get to see a dentist. I used to put money in his bank account so he could go for buy-ups. Over all, we talked a lot more over the phone than in prison.

He'd ask about my family, about his nieces and nephews and about wanting to come home and stay with me and start his life over again. Kevin's loss of hope, I couldn't tell you exactly which time it was, but I remember one time after he was refused parole yet again, noticing something change in him. He'd get really excited each time before parole, say to me that 'maybe I'd get it this time' and 'maybe I'd get to come home to you.' I held on to that hope that maybe this time he'd be paroled, but I remember one time after he was refused, he just lost all hope and it seemed like he just gave up on getting out and had accepted that his life was only ever going to be in prison. He lived and died in prison.

We'd still speak on the phone from time to time, but he was different after that. He wasn't happy and it showed in his voice. It breaks my heart thinking about the change in him, thinking of him just giving up and sniffing those substances each night, that's a sure way to die. When you're locked up like that, like an animal without any hope, what's the use of living. Deaths in the family, over the years there have been too many deaths in the family. Kevin was in fact the last of my brothers to pass on. He was in prison and not free for all those years, but in a way we were all imprisoned by what they have put all of us through. The boys in their own way, but us girls too.

The trauma, it doesn't leave you. You carry it with you your whole life. Anger with the system, it makes me really angry thinking about this whole system, the prisons, corrections, the health system, they're all the same to me. They come up with their excuses and they point the finger at each other to shift the blame away from themselves, but they all knew what was going on. They knew he was taking those substances, they knew it would affect his health, but they just looked the other way and sent him somewhere else so it wasn't their problem.

The support of his health wasn't adequate. They failed him in his care, they failed him in every way. They failed Kevin and they set him up to fail too. 'Oh you do your programs' they'd tell him, 'you go out and you do your parole' and he tried. He really tried, but what was the point, it was never going to get him out. How come they couldn't stop him harming himself

when they knew what he was doing. If he had been out, the Aboriginal people here have their own medical centre, it's called the Durri Aboriginal Medical Service. We've got our own doctors, our own drug and alcohol system and I could've made appointments for him there.

They all know me, they all call me Aunty. If he was out and they let him stay with me, I could've looked after him. I could've made appointments for him and he would've gotten better. I did it for myself with my grief and my problems with alcohol. I did it for the others in my family, I could've done it for him too. They don't understand how our families heal us and Kevin had us, we were his family and we could've helped him heal too. He would've gotten far more support on the outside than he ever did on the inside, but they won't see that.

The whole system in the gaol just passed the buck, not wanting to take the blame for anything. They will find a way to do that where there is no other. Final thoughts, to them Kevin is just another statistic, another black deaths in custody. They don't actually give a shit. It's all about the respect that they have for Aboriginal people. It's been 35 years since we had that Royal Commission into Aboriginal people dying in custody and they keep letting it happen. How come, those and they will do what they can to push the blame away while claiming they care about our people and respect our cultures.

That just like Kevin Rudd's apology, sorry means you won't do it again. He should've been let out, he should've been paroled, they should've looked after his health and given him some hope to live and some hope that he could have a life. If he was with me, I would've looked after him and he would've had hope and he would've been happy, despite his pain. Aboriginal prisoners are human beings too and I think it's time this system understands that, not just in their words but in their actions too. Every day, they still keep taking the kids away and when they get older, some of these kids will become just like Kevin.

Every day they are making a new Kevin Bugmy. All of these kids and my brother Kevin Bugmy deserved better. Please help the kids, they are our next generation. They should be empowering our people, they should be facing the wrongs that they've committed against us and letting our elders guide and heal us. Instead, they break our spirits and rob us of hope, but when you've lost all hope, you've died even before you were dead. Kevin died so many deaths in gaol before he actually died.

We, when I was at Cootamundra Girls Home and all those things were happening to me, when they'd send us out to farms or to work with black families and the old white men would come and approach us young Aboriginal girls, who could we tell it to, who could we go to. There was no one we could ring who could help us with our problems. To me, it's just the same for Kevin.

He couldn't go and get any real help from the prison when they were the ones locking him up and to them, he was their property, he was under their thumb. They could do as they pleased with him. It breaks my heart to say

it, but my brother Kevin Bugmy was never free and he had no place to turn to, because he wasn't given a chance.

The statement of Aunty Doreen Webster on 10 February 22."