STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mootijah Douglas Andrew Shillingsworth
Hearing Dates:	4 – 5 April 2022
Date of Findings:	22 July 2022
Place of Findings:	Coroners Court, Lidcombe
Findings of:	Magistrate Joan Baptie Deputy State Coroner
Catchwords:	CORONIAL LAW – Death in custody; Death of ATSI man; prevalence of ear disease in ATSI community and prison population; availability of health screening for ATSI prison population, particularly for ear disease; inclusion of ear disease on Chronic Health Screen; partnerships with Aboriginal Community Controlled Health Organisations; access to Medicare for Aboriginal inmates in custody
File Number:	2018/54603
Representation:	Counsel assisting: Mr Christopher McGorey, instructed by Mr Gareth Martin, Crown Solicitor's Office Family (Ms [redacted] [redacted]): Mr Jeremy Styles, Aboriginal Legal Service Commissioner for Corrective Services NSW: Ms Emma Sullivan, instructed by Ms Elizabeth Trovato, Department of Communities and Justice Legal Justice Health & Forensic Mental Health Network: Ms Ragni Mathur, instructed by Mr Les Sara, Hicksons Lawyers Dr Heather Rogers: Mr Patrick Rooney, instructed by Ms Kate Hinchcliffe, Makinson d'Apice Lawyers

Ms Kylie Cover and Ms Joy Ramsay: Ms Pat Robertson, NSW Nurses and Midwives Association

Non-publication orders:

Non-publication orders made 23 September 2021 prohibit the publication of various persons' names and/or 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 Mootijah Douglas Andrew Shillingsworth.

Date of Death
He died on 15 February 2018.

Place of Death
He died at the Westmead Hospital, Westmead NSW.

Cause of Death
Mootijah died from the Complications of a Left Temporal Lobe Abscess.

Manner of Death
Mootijah died in lawful custody. Whilst his manner of death was from natural causes, this was clearly precipitated by the failure to identify and treat his ear disease whilst in custody.

Recommendations:

<u>To the Chief Executive Officer, Justice Health and Forensic Mental Health Network ("**JHFMHN**"), and the Minister for Health (being the Minister responsible for JHFMHN):</u>

a) The Chief Executive Officer of JHFMHN and Minister for Health review the findings in this inquest and the evidence of Dr Gary Nicholls as to proposed reforms to JHFMHN's practices and procedures regarding ear disease and hearing difficulties as outlined in his written statements dated 25 February and 29 March 2022.

b) Priority be given by JHFMHN to determining and finalising the changes proposed to JHFMHN's practices and procedures and arrangements necessary to fund these initiatives.

To the Chief Executive Officer, JHFMHN

c) 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.

d) 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.

Introduction

1 This inquest concerns the death of Mootijah Douglas Andrew Shillingsworth. In these findings I have referred to Mr Shillingsworth as Mootijah, being his tribal name which means "strong one" and a "warrior", in the Muruwari language.

2 Mootijah was born on 6 August 1973 and died on 15 February 2018, at the age of 44, at Westmead Hospital in Sydney. Mootijah had been transported by ambulance and admitted to Westmead Hospital on 12 January 2018 from the Metropolitan Reception and Remand Centre (**MRRC**).

3 Mootijah died from a neurological injury caused by sepsis, stemming from a left temporal abscess, which had originated from a left middle ear infection. He was lawfully in the custody of Corrective Services NSW, pursuant to a remand warrant and was awaiting sentence for matters arising from his arrest for criminal charges on 3 March 2017, for which he had been bail refused.

4 Mootijah's family have expressed their concern that

> "*Although there will be no justice, we sincerely hope that his death in custody will bring about change. His death has left his family devastated to the core in all forms of incapacity.*"

His cousin, Ms [redacted] expressed the family's ongoing grief, stating

> "*More so from the disbelief and awe-inspiring questions that haunt us when we think of Mootijah. When we see his totem, his moiety, when we listen to, or tell Mootijah's stories, and hear his song on the breeze, we will look at his photo and not get any answers but a great sense of numbness, shock and loss. Mootdjah was a son, he was a brother, he was a father, he was a nephew and a cousin.*"

5 I acknowledge Mootijah's family's profound loss and continuing anguish and heartbreak and would like to express my sincere condolences and respect for

their loss. I would like to also acknowledge and thank his family members for their contribution and participation in this inquest. I hope that Mootijah's memory has been honoured by the careful examination of his medical treatment during this inquest and the lessons that have been learned from the circumstances of his tragic passing.

The role of the coroner and the scope of the inquest

6 A coroner is required to investigate all reportable deaths and to make findings as to the person's identity; as well as when and where they died. A coroner is also required to identify the manner and cause of the person's death. In addition, a coroner may make recommendations, based on the evidence deduced during the inquest, which may improve public health and safety.

7 If a person dies within a custodial setting, it is mandatory that an inquest is held, and that the inquest be conducted by a senior coroner. A person may be detained in lawful custody either as a result of the refusal of bail pending the determination of alleged criminal charges, or as a sentenced prisoner, after conviction.

8 The coronial investigation and inquest provides an independent inquiry into the circumstances surrounding a person's death in custody in an attempt to assess issues of accountability and transparency surrounding the provision of general services to a person who is wholly dependent on the State to provide care in a safe, secure and humane environment.

9 In addition, where an inmate dies from "natural causes" in custody, an inquest is undertaken to ensure that the State has discharged its duty of care to an individual who is totally reliant on the State to provide appropriate and adequate physical and mental health care.

10 During these proceedings, evidence was received in the form of statements and other documentation, which was tendered in court and admitted into evidence. In addition, evidence was received from a number of witnesses involved in Mootijah's medical treatment in custody. Expert evidence was

received from Professor Kelvin Kong, both written and oral. All of the material placed before the court has been thoroughly reviewed and considered. I have been greatly assisted by the summary of facts and the written submissions of counsel assisting, Mr Chris McGorey and the other legal representatives. I have embraced their descriptions at times in these findings.

11 During these proceedings, significant issues and concerns arose as to the adequacy of Mootijah's medical treatment and the likelihood that his death was preventable.

Mootijah's life

12 Mootijah's early years were spent in Enngonia, Bourke, Brewarrina, Weilmoringle and Kinchela. His maternal line is from the people of the Budjedi nation and his paternal line is from the people of the Muruwari nation.

13 By the time that Mootijah turned 18 years of age, both his parents had died. His two siblings also died prematurely. It is reported that his brother died from leprosy.

14 Mootijah had also been treated for leprosy (also known as Hansen's disease). Toes on both of his feet had been amputated, although it does not appear that this was attributed to leprosy. He had a history of acute mental health episodes which were attributed to schizophrenia. He was treated for Hepatitis C and an alcohol brain injury in 2001. At some stage it had been suggested that he had developed diabetes, however, this was subsequently disavowed.

15 On the available evidence, Mootijah experienced recurring otitis media (or middle ear infections) throughout his life. These recurring infections resulted in hearing impairment. The magnitude of his impairment is unclear owing to limited medical records and treatment. Unfortunately, his hearing impairment was not appropriately addressed over many years. It is possible that his hearing difficulties contributed to the impression of him suffering from a cognitive impairment. The extent of any cognitive impairment is unable to be ascertained on the available evidence.

16 Mootijah was in Corrective Services NSW custody on 13 occasions between 9 May 1997 and 15 February 2018. This inquest has focused on his treatment for otitis media, or lack thereof, during his periods in custody.

The list of issues considered during the inquest

17 The following list of issues was prepared before the proceedings commenced and considered during the inquest:

1. From the time Mootijah entered custody on 3 March 2017 until late December 2017:

    (1) What was Mootijah's ear and hearing condition?

    (2) Was Justice Health and Forensic Mental Health Network (**JHFMHN**) aware of Mootijah's ear and hearing condition given:

        (a) JHFMHN's past treatment of him (eg JHFMHN's referral to an Ear, Nose and Throat (**ENT**) specialist for assessment and treatment on 23 January 2014)

        (b) Mootijah's screening upon entry into custody on 3 March 2017, and/or

        (c) Mootijah's presentation at various times between March and December 2017?

    (3) Was ongoing monitoring and treatment of Mootijah's ear and hearing condition, in the period March to December 2017, reasonably required? If so, what sort of monitoring and treatment?

    (4) What monitoring and treatment did Mootijah receive for his ear health and hearing in the period March to December 2017 and was this reasonable in the circumstances?

2. With regards to issues 1(3) and 1(4) above:

   (1) Were there particular vulnerabilities or factors in Mootijah's case that ought to have informed the monitoring and treatment provided to him (eg his mental health, concerns as to his cognitive functioning and/or a history of being resistant to/not seeking out medical treatment?

   (2) If so, were these factors reasonably factored into the treatment and monitoring provided to Mootijah for his ear health and hearing in the period March to December 2017?

3. Regarding JHFMHN's *Chronic Disease Screening* (**CDS**) procedure in March to December 2017:

   (1) Did the CDS procedure identify ear health/hearing as a chronic disease (eg history of recurring otitis media)?

   (2) Should Mootijah have undergone a CDS after he entered custody in March 2017 or at other times thereafter (whether for ear health or other reasons)?

   (3) If so, why did that not occur and what difference might such a screening have made to the monitoring and treatment of Mootijah's ear health and hearing in the period March to December 2017?

4. In the week or weeks preceding Mootijah's admission to Westmead Hospital on 12 January 2018:

   (1) Can it be ascertained when Mootijah's middle ear infection, which ultimately cause his cerebral abscess, likely onset (approximately)?

(2) Did Mootijah exhibit signs or symptoms that pointed to the possibility of middle ear infection? If so, what were they?

(3) What treatment was reasonably required at this time given Mootijah's (a) signs and symptoms and (b) his history (eg, past treatment for recurring otitis media)?

(4) Was the treatment Mootijah received reasonable and timely in the circumstances?

(5) Subject to any finding as regards (4) above, what difference might that have made to Mootijah's prospects of surviving (if any)?

5. Aboriginal community context:

(1) What is the prevalence of ear infections in the First Nations' person's population?

(2) What is the proportion of First Nations' persons in the custody of Corrective Services NSW (at the time of death and currently)?

6. Would particular measures be capable of improving First Nations health outcomes in a correctional setting?

(1) Could access to Medicare for inmates afford improved access to health services ?

(2) Could Health Justice Partnerships with Aboriginal Controlled Health Organisations ACHOs improve medical outcomes for First Nations' people?

7. Are there lessons which can be drawn from Mootijah's death?

Non-contentious facts

18 Prior to this inquest commencing, a summary of non-contentious facts was prepared by counsel assisting the coroner. This factual summary was prepared from the extensive documentation contained in the brief of evidence. The summary was circulated to the parties and was accepted by the parties as a reasonable representation of that material. It was updated following the hearing and further circulated to the parties with counsel assisting's submissions. The document titled "Outline of non-contentious facts" is annexed to these findings and marked Annexure A.

Otitis media and ear health

19 Otitis media is the presence of a build-up of fluid in the space behind the eardrum, known as middle ear effusion, or alternatively an infection within the middle ear cleft.

20 Fluid is naturally secreted within the middle ear, ensuring that the ear cleft is clean. The fluid can become trapped, causing the eardrum to bulge and, if the eustachian tube becomes blocked, it can prevent the fluid from draining effectively. If the fluid becomes infected, acute otitis media can develop. The patient may present with fevers, high temperatures and systemic illness, typical of an acute infectious process.

21 Otitis media frequently begins with a common cold, which leads to infection and/or blockage of the eustachian tube which prevents drainage of fluid from the middle ear. It is often self-resolving but if prolonged, medical treatment may be indicated. Treatment may include antibiotics or surgical interventions to drain the fluid via ventilation tubes (grommets) in the tympanic membrane or repair tears or holes in the ear drum.

22 Pressure in the middle ear can cause the eardrum, known as the tympanic membrane, to perforate. Chronic suppurative otitis media ... is characterised by a persistent discharge from the middle ear through a tympanic perforation. A severe complication may occur when bacteria spreads from the middle ear

to the mastoid bone's air cells (within the bone) where inflammation causes damage to bony structures (Mastoiditis). A known medical complication can be a cerebral infection, which can be fatal.

23 The above facts with respect to otitis media have been drawn from the outline of the non-contentious facts at Annexure A. A more comprehensive description of otitis media is included at pages 5-7 of that outline.

Mootijah's medical treatment between 1997 and March 2017

24 Mootijah was in Corrective Services NSW's custody on 13 occasions between 1997 and 2017. His longest term of imprisonment was 2.5 years and the shortest term was 0.5 months. On each of those 13 occasions, Mootijah participated in a general medical screening questionnaire conducted by a nurse on his reception into custody, known as the Reception Screening Assessment (**RSA**) tool.

25 On Friday, 19 December 1997, he was assessed by a registered nurse at the clinic. The registered nurse recorded that he "*Comes from way out far west…Has not left town 10-11 years. Presents as same, very unworldly very environmentally uncomplicated.*" The notes refer to a history of chronic ear problems since childhood and that he was supposed to have an operation 15 years ago but didn't. On examination, Mootijah's right ear was noted as "*no drum clear canal*". The notes record that the left drum looked compromised and that he should see the medical officer.

26 On Monday, 22 December 1997, it appears that Mootijah was reviewed by a medical officer. The notation made by the medical officer refers to "*bilateral eardrum damage and loss from chronic ear infection. Needs appropriate management and surgery.*"

27 On 25 February 1998, Mootijah signed a form cancelling his specialist ENT appointment scheduled for 27 February 1998, citing his reason as "*Will deal with medical problem when released.*" He was due to be released from custody on 12 March 1998.

28 Mootijah did not follow up with a specialist assessment after his release into the community.

29 On 23 August 2001, Mootijah underwent a psychological assessment where it was noted that he "*[r]eported having a hearing difficulty – lifelong problem – denied seeking medical assistance for it*". During this assessment the medical officer questioned whether Mootijah had cognitive difficulties, had a diagnosis of an alcohol related brain injury and was distressed "*re: chronic alcohol abuse – wanting to seek treatment.*" No hearing assessment or specialist referral resulted from this consultation.

30 On 21 July 2004, Mootijah was referred to the Statewide Disability Services (**SDS**) (which sits within Corrective Services NSW) for an assessment.

31 On 22 July 2004, he was assessed by a psychologist. Mootijah's intellectual functioning was assessed as being in the low average range and not in the range of an intellectual disability. A notation records "*hearing to be checked – not done released 23/8/04*".

32 A referral was received by SDS on 15 May 2013. SDS itself does not conduct hearing assessments and refers patients to JHFMHN for assessment. SDS appears to have emailed the correctional centre within which Mootijah was housed to ascertain whether he wished to be referred to JHFMHN. There is no record to indicate whether Mootijah signed the consent referral form or as to whether a signed consent form was returned to SDS.

33 On 24 December 2013, Mootijah was assessed by JHFMHN. The clinical notes include the following observations: "*L ear ache 2 weeks + states pus + smelly which he cleaned ear out with toilet paper*"; "*states when blows nose?? Pus comes out of both ears" and "black area bottom of R drum + top of R drum.*"

34 On 23 January 2014, he was referred to an ENT specialist who noted "*Chronic recurrent Bilateral Otitis Media with L perf and very DEAF – needs ENT and Hearing tests plus hearing aid.*"

35 On 6 February 2014, he presented with much cleaner ears "*with slight moist discharge evidence on the ear drums.*"

36 On 15 December 2014, Mootijah was reviewed by Dr Lowinger, an ENT specialist at the Prince of Wales Hospital. Dr Lowinger's treatment notes refer to "*Bilateral chronic suppurative otitis media*" as well as "*No visible inner ear bone ossicles*" (being the tiny bones in the middle ear, that form a chain connecting the ear drum, ie the tympanic membrane and the inner ear). It also notes "*purulent discharge*". The future plan includes a prescription for antibiotic eardrops and suggests, "*review for audio after healed*", "*reconstructive work, tympanoplasty*" and "*review in 12 weeks*". There is no record of Mooitjah undergoing a review of his ear health from this date until his release on 11 August 2015.

37 Incomprehensively, a JHFMHN alert pertaining to his hearing impairment was made inactive on 19 July 2015. At that time, Mootijah was still lawfully incarcerated. No explanation for the decision to render that alert inactive has been provided.

Mootijah's medical treatment during 2017

38 On 5 March 2017, Mootijah entered Corrective Services NSW custody (following his arrest on 3 March 2017). At that time, his ear and hearing issues were not identified as a "significant health issue".

39 Indeed, as at March 2017, there does not appear to be any evidence that he had undergone any hearing assessment whilst previously in custody or in the community. It is clear that, at this time, his hearing and ear health were not identified as a significant health issue and he was not referred for any assessments, ongoing monitoring or treatment for his hearing issues.

40 It should be noted, that despite JHFMHN having no active alerts at this time, Corrective Services NSW records confirmed that Mootijah was "*deaf or hearing impaired*" with a recommendation to Corrective Services officers to contact JHFMHN to have his "*ears checked or referral to audiologist*" if there were concerns with his hearing.

41 JHFMHN confirmed that as of March 2017, it did not provide specific screening to nursing staff in relation to the identification and treatment of patients with hearing impairments. JHFMHN, however, had an expectation that any patient identified with a hearing deficit would be referred to a general practitioner for an assessment.

42 JHFMHN further confirmed that as of March 2017, its CDS procedure did not mandate a chronic disease screening for all Aboriginal or Torres Strait Islander (**ATSI**) persons. A CDS was however mandated for ATSI persons aged 45 years and over. By July 2017, the provision of a CDS was varied and mandated to occur for ATSI persons aged 35 years and over.

43 On 13 March 2017, Mootijah participated in a mental health assessment. His medical history notes "*chronic bilateral (?) otitis media*" and "*amputated foot (?)*".

44 On 6 April 2017, he was transferred to Westmead Hospital for the urgent treatment of his septic left foot, which was reported to be severely swollen and hot to touch with reported fevers. Mootijah was admitted to surgery where his right hallux, left hallux and left second digit (toes) were amputated. At that time, he had "*a provisional diagnosis of diabetic foot ulcer (necrotic with pus tracking into the joints)*."

45 On 8 April 2017, Mootijah was discharged from hospital after it was reported that he was abusive to staff and refused any medications prescribed post-surgery. On his return to custody, he was transferred to the Mental Health Screening Unit at the MRRC. His presentation over the following days was

noted as "*agitated, abusive, refusing to engage in interview or have his wound reviewed.*"

46 On 12 April 2017, he was scheduled pursuant to section 19 of the *Mental Health Act 2007* (**MH Act**). His presentation improved somewhat over the ensuing days. He remained compliant with his medication regime but was, at times, unco-operative with wound treatment. On 19 April 2017, he was transferred to Long Bay Hospital.

47 On 21 April 2017, Mootijah was assessed by a psychiatric registrar, Dr Gray, who noted that he had been expressing paranoid delusions with aggressive behaviours and major thought disorder. Dr Gray concluded that he had experienced a relapse of his psychosis owing to his non-compliance with his medication.

48 On 30 May 2017, the Mental Health Review Tribunal (**MHRT**) ordered that Mootijah remain at the mental health facility at Long Bay Hospital to receive ongoing care and treatment.

49 On 6 July 2017, he was again assessed by Dr Gray and another consultant psychiatrist. The two experts concluded that Mootijah was likely suffering a disease of the mind at the time of the commission of his offences on 3 March 2017.

50 On 20 July 2017, the MHRT made a 12-month Community Treatment Order (**CTO**). On the same day, Mootijah entered guilty pleas to affray, and to resisting and assaulting police, and the remaining charges were withdrawn.

51 On 21 July 2017, he was transferred from the Long Bay Hospital to the MRRC's Hamden Unit. At that time, the Hamden Unit consisted of four PODs, (an acronym for "place of detention"). Two of the four PODs housed mental health patients, being PODs 17 and 18. The other two PODs housed 'protection' prisoners, being PODs 15 and 16. Each POD housed approximately 60 – 65 inmates.

52 Mootijah received depot injections, initially on an involuntary basis. His symptoms diminished over time, however, it was noted that he had limited insight into his mental health needs.

53 On 25 October 2017, the MHRT reviewed his CTO and continued the order without variation until 19 January 2018.

Notations in his medical records relevant to his ear health and deficits during 2017

54 On 24 April 2017, JHFMHN staff recorded "*Communication at times difficult (illegible) him slightly hard of hearing and slurred accent. At times does not answer questions directly ? disorganised thought form.*"

55 On 25 April 2017, it was noted that his "*reaction time to questions was slow, seen turning his ear towards speaker ? deterioration of hearing or ? preoccupied from internal stimuli.*" A similar notation is recorded on 28 April 2017.

56 On 1 May 2017, JHFMHN staff noted that "he *has significant hearing impairment, uses special headphones in court but nil other management*". "*When asked about the pain in his toe wound pt did not respond, ? secondary to poor hearing.*"

57 On 4 May 2017, it is noted that "*his reaction time to q/s was slow, ? deterioration in hearing.*" A similar notation is recorded on 16 May 2017.

58 On 9 July 2017, JHFMHN staff noted "*Isolative, minimal engagement with peers. Struggles to communicate (with) staff deafness but he does try.*"

59 On 16 August 2017, a notation reads "*needing questions repeated (deaf).*"

Events from 8 – 12 January 2018

60 On 8 January 2018, Mootijah presented to the Hamden Clinic at the MRRC. The Hamden Clinic has been described during these proceedings as a satellite

clinic to the main clinic. The main clinic is staffed by the Nursing Unit Managers (**NUMs**), medical officers and dentists; as well as nursing staff.

61 The Hamden Clinic is largely run by registered nurses between 7am until 10pm. The nursing staff attend to daily medications, common medical interventions, as well as assisting a medical officer at the Hamden Clinic. The clinic is physically proximate to PODs 15 – 18 described earlier in these reasons.

Evidence of Registered Nurse (RN) Ms Cover

62 Ms Cover gave evidence that she was rostered between 1.30pm until 10pm on 8 January 2018. Ms Cover was not ordinarily rostered at the Hamden Clinic and had not previously dealt with Mootijah. She confirmed that

> *"[The clinic is] staffed mainly by nurses. We did have a psychiatrist five days a week in the Hamden unit who helped with the mental health patients and we would get GPs down sporadically. But most of the care was given by nurses."*

63 Ms Cover confirmed that shortly after she commenced her shift, a Corrections Officer brought Mootijah to the clinic. Mootijah presented with toilet paper in his left ear.

64 Ms Cover recalled that Mootijah was non-verbal, and pointing to his ear. She noticed that "*his left ear was full of toilet paper, which appeared to have turned into a paste-like substance.*".

65 Ms Cover made the following record in her progress notes: "*Left ear, had inserted toilet paper into his left ear earlier today as he had a headache. Reports ear now throbbing.*" She recalled that she had gleaned this information from the Corrective Services Officer. Ms Cover confirmed that at that time she was unaware of Mootijah's medical history, apart from her knowledge that he was medicated daily in relation to his diagnosis of schizophrenia.

66 Ms Cover confirmed that she had used on otoscope in the clinic to look in Mootijah's ears. She had attempted to remove the toilet paper (which she described as being the consistency of paste) from his left ear, without success. She further indicated that the toilet paper was obstructing her view inside his ear.

67 Ms Cover then spoke with Dr Rogers. Dr Rogers was conducting a clinic but agreed to review Mootijah as a "walk-in". Dr Rogers used the otoscope and recommended using Waxsol for two days in an attempt to expel the toilet paper from his ear. Ms Cover then applied the Waxsol and advised Mootijah that he should let the clinic staff know if the pain continued. Ms Cover saw Mootijah later that evening when she was administering his medication. She asked him how he was feeling and "*he gave me a thumbs up.*"

68 Ms Cover confirmed that she had previously seen other inmates apply toilet paper inside their ears. She stated that this had been in a context where the patient presented with psychotic symptoms and used the toilet paper in an attempt to "*block out the voices and things like that.*" She agreed that Mootijah did not appear to be displaying any psychotic symptoms on 8 January 2018.

69 Ms Cover confirmed that she had never received specific training in relation to otitis media or perforated eardrums. She further confirmed that if a patient presented as confused or irritable that she would not have associated that presentation with an ear infection.

70 Ms Cover was asked what percentage of her patients at that time identified as ATSI, and she responded that it was a "*high percentage.*" She stated that she had been unaware of the high incidence of ear infection in ATSI communities prior to her involvement in these proceedings.

71 Ms Cover confirmed that she did not have access to Mootijah's main paper based medical file on 8 January 2018. She confirmed that medical staff would manually record medical information on a loose-leaf form, known as a "progress note" which would be filed on the patient's main file by a clerk at a

later time. She confirmed that there was no access to an electronic patient file at that time.

72 Ms Cover agreed with the proposition that the JHFMHN electronic Health System (**JHeHS**) now contains information relating to *"discharge summaries, progress notes, things of that nature"* and that *"for some [it has] allowed for active health alerts"* for health conditions. She indicated that as at 2018, that information was also recorded on the Patient Administration System (also known as PAS) *"which we use to book the appointments."*

73 In Mootijah's case, he was not on the list of patients to be reviewed and no inquiry would have been made. It would appear that even if Ms Cover had made an inquiry on the JHeHS, no alert was contained on the system flagging Mootijah's prior hearing health.

Evidence of Dr Rogers

74 Dr Rogers confirmed that she had worked with JHFMHN as a GP staff specialist from 2005. During 2014-2018, she worked part-time, being two days per week in the Hamden Unit and/or the main clinic.

75 Dr Rogers gave evidence that her GP waiting list at the Hamden Clinic would include *"urgent, semi-urgent, non-urgent, routine and follow-up"* cases. Dr Rogers confirmed that the Hamden Unit housed 240 inmates. She stated that she would be provided with a waitlist and would be required to triage the patients to determine which patients she would see on any day at the clinic. She also indicated that she had no ward clerk or administrative assistance to determine her schedule or source the client files.

76 Dr Rogers stated that she would typically see eight patients from a waitlist of 77 patients daily. She confirmed that if she did not see a patient on the waitlist, they would remain on the waitlist until *"they're seen. Sometimes I can sort out their issues on paper and I don't have to see them."* She provided an example where she could check a patient's blood results and adjust their medication accordingly.

77 Dr Rogers confirmed that in January 2018 "*we did the progress notes in the paper files. The electronic progress notes only came into being, I believe, the end of 2019, early 2020. We now do all our progress notes on the electronic JHeHS system.*" She confirmed that in January 2018, she would check a patient's JHeHS records in terms of "*what there was, and their progress notes. But I would normally do that for a scheduled patient appointment.*"

78 Dr Rogers stated that in January 2018, she would have expected that the JHeHS would include

> "*Any, any past correspondence. For example, in the case of Mr Shillingsworth, the, the ENT handwritten notes. Assessment by other people. Recent information from the community which I often would chase eg they weren't there to get more information, Also, their blood results are on JHeHS, all their past blood results.*"

Dr Rogers confirmed that what she would be looking for on the JHeHS would be "*their active health conditions, which would include chronic health conditions.*"

79 Dr Rogers confirmed that she had not seen Mootijah prior to 8 January 2018. She confirmed that he was presented to her as a "walk in". She confirmed that in relation to the electronic front sheet summary for Mootijah

> "*It was never there. Never. Hearing impairment was there until the middle of 2015 but then someone, a nurse, made it inactive in the middle of 2015. So, that wasn't on the electronic front sheet of active medical conditions.*"

Dr Rogers further noted that

> "*So, I never saw him about hearing impairment and the electronic front page summary was never updated with hearing impairment in that ten months.*"

80 Dr Rogers does not recall being told that Mootijah had been experiencing headaches or throbbing ear pain at the time of her examination. Dr Rogers believed that the issue was simply one relating to paper being lodged in his ear and unable to be extracted. Dr Rogers agreed that she did not recall seeing any inflammation within Mootijah's ears, because of the presence of the toilet paper. Dr Rogers did not notice any malodorous smell coming from his ears.

81 Dr Rogers agreed that on the information currently available, it was likely that Mootijah was suffering from a middle ear infection. She agreed that she may not have written a progress note, however did state that often progress notes were still left in the filing tray for weeks, without being attached to the patient's file.

82 Dr Rogers confirmed that she had not been provided with an observation chart relating to 5 January 2018, which disclosed that Mootijah had a raised temperature and heart rate, as that information was contained in his paper file at the main clinic. In addition, Dr Rogers noted that Mootijah was not placed on the waitlist on the basis of those clinical observations.

83 Dr Rogers stated that if she had been made aware of Mootijah's history of chronic ear disease she would have most definitely changed her approach on 8 January 2018. Dr Rogers stated that

> *"If I'd known that he had chronic suppurative otitis media and deafness, that would have definitely changed my approach; not only by a referral to the ENT, knowing his history, I would have talked to the ENT registrar, which is always helpful, to expedite an appointment at Prince of Wales because he had a long history of never receiving definitive treatment, and a strong likelihood of not receiving any ENT treatment once he was released back into the community."*

84 Dr Rogers also raised her concerns that

"There were multiple observations in the progress notes that he had a hearing impairment, including three doctors mentioned that he had hearing problems. Multiple nurses and two HPNFs said he was very deaf. However, he never got put on a GP waitlist in that ten months for hearing impairment."

85 Dr Rogers stated that

"The other way to see me would have been because he had multiple medical conditions for a comprehensive GP assessment....if I'd seen him about any one of those things during his five month stay in Hamden, I would have done a comprehensive assessment of his medical history, including reviewing all documentation in his paper and electronic files and this would have revealed the bilateral chronic suppurative otitis media and deafness. It would have resulted in referrals to audiology and to the ENT clinic, and hopefully he would have got definitive treatment before his release back into the community. But even if he hadn't got that specialist treatment by the time I saw him on the eighth of the first, then at least, at least I would have been aware that he had chronic suppurative otitis media when he presented to me for the first time as a walk-in with what appeared to be a simple problem".

86 Dr Rogers also raised her concern that the oppressive heat at that time of the year may have exacerbated Mootijah's condition. Dr Rogers noted that despite the heat, none of the PODs were air-conditioned within the gaol.

Events on 11 January 2018

87 At around 13.50 hours on 11 January 2018, a "medical response" was called by one of the Corrective Services Officers in relation to Mootijah. A "medical response" in a custodial setting can be specific, that is when there is a specific concern for a patient. Alternatively, it can be less specific and the nursing and medical staff will attend on the patient and assess the patient's presentation. On this occasion, little information was available. Three medical staff attended

Mootijah in his cell: Ms Ramsay, a registered nurse, working in primary health at the Hamden Clinic; Ms Breen, NUM, working on mental health; and Dr White.

88 Ms Ramsay confirmed that she had no previous dealings with Mootijah. She confirmed that she did not review his medical records prior to attending on him in his cell. Ms Ramsay confirmed that someone had told her that Mootijah was complaining of a headache.

89 Ms Ramsay stated that he was lying on his bed and when she spoke with him he held up his hand with an open palm. Ms Ramsay recalls Dr White asking Mootijah if he had a headache and there was no response from Mootijah. Ms Ramsay took his pulse and attempted to gauge his pupils. She confirmed that she had not been able to obtain his blood pressure or temperature. Ms Ramsay did not notice any malodorous smell. Ms Ramsay recalls asking the officers why they had been called and being told that Mootijah had been lethargic and had been lying in bed for about one week.

90 Ms Ramsay recalls a discussion with the NUM, Ms Breen, that Mootijah needed a further assessment at the clinic. Ms Ramsay indicated that she had a scheduled appointment with another patient and was unable to review Mootijah immediately. She stated that it was her understanding that Ms Breen agreed that Ms Breen would review Mootijah in the clinic. Ms Ramsay recorded a progress note stating *"NUM Geraldine also present. Pt for review again in clinic as organised by NUM, DCS aware."*

91 Immediately after Ms Ramsay's progress note, the NUM, Ms Breen, records her progress note of the same consultation in Mootijah's cell. Ms Breen noted that he was

> *"Unkempt. Malodorous. Very poor selfcare. No eye contact looking straight ahead. No communication, no interaction from Douglas. Nil overt psychotic symptoms. Appeared distracted and lost in thought. Nil evidence of acute psychotic sx. Negative symptoms +++evidence.*

Nil evidence of physical distress. Due imi (?) depot today. Roll over to tomorrow. Monitor mental state PRN."

92 Ms Breen denied that there had been an agreement between herself and Ms Ramsay that Ms Breen was to assess Mootijah that afternoon. Ms Breen explained that Ms Ramsay was a primary health nurse and Ms Breen was a mental health nurse. She stated that whilst she could attend to minor physical issues with patients, it was the responsibility of the primary health nurses to follow up with "*the physical side of things*." As such, she denied that she would have agreed to assess Mootijah that afternoon in the clinic and had an expectation the Ms Ramsay would attend to the review. Ms Breen did, however, concede that she saw the earlier progress note authored by Ms Ramsay referred to above.

93 Ms Breen stated that she had previously noticed

"nurses putting on some cream onto his feet and then putting socks over them, and I remember thinking, "This is no good. This is – this man probably needs to be somewhere else because he – we cannot attend to his care properly in this environment"

She further stated that

"I think it was on a Thursday, we had a multidisciplinary meeting, so we had nursing staff, psychiatrists, Corrective Services, like ...and psychology where we would discuss the inmates of patients (sic) at that time and would have looked at where was the best placement within the correctional placement for Mr Shillingsworth."

94 Ms Breen's progress note does not indicate that Mootijah was displaying signs of mental health symptoms. It is clear from her note that she was identifying physical symptoms, symptoms that she had, on her account, raised previously as matters requiring attention and intervention.

95 There was a clear conflict between the evidence of Ms Ramsay and Ms Breen in relation to who was to follow up with Mootijah at the clinic. Ms Breen's progress note does not suggest that there had been an understanding or agreement that Ms Ramsay would assess Mootijah that afternoon after the cell visit. Indeed, Ms Breen's subsequent progress note at 15.10 hours states,

> *"Seen out in Pod 17 in cell sitting on the bed. Had been given dinner to eat in the cell. When asked how he was feeling gave an incoherent answer. Lay down on the bed."*

96 It is unclear why Ms Breen did not conduct a mental health assessment at that time given the abovementioned response, particularly when juxtaposed with her earlier progress note entry at 14.00 hours, where she records that there are no signs of mental health issues. Ms Breen's oral evidence was at times, non-responsive and appeared to be evasive. Where there was a conflict between her evidence and that of Ms Ramsay, the court preferred the evidence of Ms Ramsay. In any event, this was clearly another missed opportunity to assess and treat Mootijah's physical symptoms.

Events on 12 January 2018

97 On 12 January 2018, Mootijah's presentation is recorded in the progress notes as "*Appeared vague. Ataxic gait. Agreed to attend clinic.*" A further progess note authored by Ms Breen states "*Pyrexia. Ear infection?*" Mootijah was eventually transported to Westmead Hospital that afternoon.

98 On admission to Westmead Hospital, it is noted

> *"On admission, he was not verbal, did not respond to any visual or verbal cues and withdrew to pain. An urgent CT brain showed a 1 to 1.5cm lesion in the left parietal lobe extending into the temporal lobe and vasogenic oedema. CSF culture – positive for strep constellatus. Anatomical Pathology report 12 January 2018 – left temporal lobe biopsy consistent with acute brain abscess. No fungal or protozoal organisms identified."*

99 The postmortem report prepared by Dr Liliana Schwartz records the following history:

> *"On 12 January 2018, this 44 year old man presented to hospital with behaviour disturbance and a left temporal lobe abscess. On the following day, he underwent an emergency craniotomy to remove the abscess. Following surgery, he was taken to Intensive Care Unit and remained there until 29 January 2018. On 9 February 2018, he was taken back to Intensive Care Unit where he was ventilated via a tracheostomy. Following surgery, he had a poor neurological recovery. On 1 February, it was decided that the patient will receive palliative care and he died the following day."*

100 Dr Schwartz reviewed the electronic medical records from Westmead Hospital and noted the following:

> *"CT brain, 13 January 2018 – Features in keeping with that of long standing bilateral mastoiditis. Evidence of previous, aggressive left middle ear infection that has extended superiorly to destroy the tegmen tympani. Evidence of cerebral oedema causing a loss of definition of the basal cisterns and tightness of the aqueduct of Sylvius and also narrowing of the posterior part of the 3rd ventricle and consequently dilatation of the lateral ventricles, and particularly the tips of both temporal horns."*

101 Dr Schwartz was of the view that the cause of Mootijah's death was "*Complication of Left Temporal Lobe Abscess.*"

Expert Evidence – Professor Kelvin Kong

102 Professor Kelvin Kong is a Paediatric and Adult Otolaryngology, Head and Neck Surgeon, ENT Surgeon. Professor Kong provided three reports relating to Mootijah for these proceedings. Professor Kong indicated that

"I have a special interest in ear disease. A lot of the work I do is around otitis media and a lot of my research work is around otitis media, and the ramifications thereof."

103 Professor Kong noted that

"Otitis media affects all populations and it affects about 80% of our Australian children. The age it normally occurs in is around the age of three when they start preschool and start mingling a lot with other kids. In our Aboriginal and Torres Strait Islander communities, that occurs under the age of 12 months when they start getting infections....The problem with otitis media is that it's often decided to be a silent disease process where people don't actually notice what's happening because it's not actually causing pain. It's not actually causing a discharge in the very early phases. And so, the first primary issue that occurs is hearing and hearing loss, so they present with speech development issues, balance issues or presentation to school where they mixing in preschool and early school where they're behind all the other children."

104 Professor Kong continued, stating that

"most children in Australia who get otitis media don't get these kinds of nasty complications because it's treated, it's looked after and it's addressed very promptly. So, they don't actually fall behind in school but more importantly, they don't get any health effects associated. In our Aboriginal and Torres Strait Islander communities, the access to health care is quite poor and so therefore the presentation becomes a late presentation and devastatingly, it presents as a complication whether that be abscess, brain abscess, balance issues, speech, and language. The lifetime consequences from that building up at an early phase continues then, and the problem with it it's not life-threatening; it's more progressive and just chronic and so for their life, they're falling behind in school, they're often missing school, they're having

time off school. It's not uncommon for me to see these children present in my clinics where they're considered the naughty kids in class when in actual fact they're just not hearing. So rather than actually bringing them up the front of the classroom, they're expelled or put to the back of the classroom, or told they're dumb, or all these other kinds of other biases that occur associated with that. A lot of the problems that we're doing now, trying to readdress that and make sure that those things aren't – as you get to adolescence and as you get further on, those consequences are far reached from there but also have their opportunities taken away. Their education is behind, their opportunity for employment is behind, and that's when it leads to social breakdowns, inter-relationship issues, and also frequent contact with the justice system associated. In our justice systems we see quite a lot of hearing loss associated and the in-and-out pattern of the recidivism really affects how they're actually relating to the society in general being."

105 Professor Kong noted that

"From a medical perspective the natural history of otitis media should resolve on its own accord. If the fluid does not resolve and medical treatment is not sought, then several things can result as a consequence. The most common complication and sign of chronic ear disease in Aboriginal and Torres Strait Islander population is tympanic membrane perforation. This is a scenario where the fluid and infection accumulate for such a long period of time that the ear drum disintegrates and breaks down, leaving a hole. Most children in the Non-Indigenous population do not develop this chronic problem. If it does happen in the general population, it is relatively small perforation and spontaneously closes. The problem that we see in our Aboriginal and Torres Strait Islander population is that this is chronic in nature and therefore the perforation remains and often increases in size. Again, the biggest consequence of this is the

disruption of learning, language, speech and social engagement. With fluid building up into the ear other things may happen."

106 Professor Kong summarised Mootijah's presentation as follows:

"[He] suffered a left otalgia (throbbing ear) and headache, prior to his admission to hospital on 12 January 2018. The tissue spear indicated Chronic Suppurative Otitis Media. I suspect that he would have endured lifelong intermittent infections and sequelae. The nature of otitis media with suppuration is that it intermittently discharges. Some patients have intermittent infection which lasts for several days and then can be a long period between infections, but other people have quite commonly. Often these patient's self-treat with tissue spearing, which he had done. Symptoms from this would have been common to him which would have been discharging ear, offensive smell and may or may not have had a slight headache associated depending on the infection. He can also have some mastoid or postauricular pain associated. Chronically discharging ears are somewhat less urgent and often negated as trivial but in his scenario something which is crucial. These are often early signs of a severe disease illness, which can have catastrophic circumstances particularly if there is any immune dysfunction or decrease in their immune system. His background history (diabetes, amputation, chronic and recurrent abscesses, poor nutrition, mental health and lifelong trauma) suggested his immune dysfunction may have been predisposed to worsening infection. Adding to the clinical presentation of agitation may have represented cerebral irritation and early abscess formation , masked by mental health concerns and lack of awareness of the severity of ear disease."

107 Professor Kong noted that Mootijah had a "*lifetime of ear disease*" and he

"presented with quite a lot of ear disease and self-reported hearing loss. Associated with that was purulent discharge of smelly –

smelliness of the infection was associated, and there was some red flags around his ear disease that was concerning for us in looking at that, going forward. And in hindsight, it's very easy to see but obviously at the time, it must have been very hard to try and decipher some of those. The things that were red flags to me that highlighted the issues were the discharging ear, the headaches associated with the discharging ear, the combative nature in which he presented with, and also his comorbidities which were quite lengthy."

108 Professor Kong noted that

"when someone presents in a combative or a delusional state, it's very easy with a mental health background to assume that this is a mental health cause here. That's the bias that we naturally have, rather than taking a step back and saying "Are there other factors or health conditions that may be affecting this? And in this case the ear disease may have been or probably was affecting this, and not addressing that issue but rather, treating more down the mental health illness which may have then subsequently led to what occurred."

109 Professor Kong stated that

"Where it causes agitation or combativeness…. is at the meninges or the lining that protects the brain is irritated by that, and that's when you get the agitation or delirium or other kinds of neurological disorders associated".

He later commented that

"you can actually have an infection in the mastoid and the ear actually looked normal. So, clinical signs such as agitation would be a kind of a red flag to note that with the ear disease."

110 Professor Kong commented that Mootijah's ear health was

> *"confounded by a lot of the other comorbidities associated. And then when you combine that with the kind of social disadvantage that certainly Mootijah experienced, it's just a recipe for disaster."*

111 Professor Kong indicated that where a patient had both a history of mental health issues and possible ear problems that it was very important to address and stabilise the mental health first, as it is difficult to assess if the agitation relates to the mental health presentation or hearing issues.

112 Professor Kong was asked to comment on Mootijah's presentation with toilet paper suck in his ear. He responded that

> *"he had the tissue being stuck in his ear indicates to me that he's had a long history of ear disease and he actually knew, in some way, how to treat some of that or mop up some of that pus."*

113 Professor Kong confirmed that the short-term treatment of otitis media required ear toileting with tissue spears (from tissues not toilet paper), antibiotic drops, washes and sometimes high-dose intravenous antibiotics. He indicated that you need to keep on top of the therapy until the discharge stops. He stated that in the

> *"medium and long-term plan would be how to actually close these eardrums or what operations do these need to stop that discharge from occurring as an infective source. And the second part of that then would be with his hearing loss or if he did have hearing loss, what do we need to do to address that hearing loss and how we manage that? Whether that be hearing aids or implantable devices."*

114 Professor Kong was asked to express his opinion as to whether or not Mootijah's presentation on 12 January 2018 suggested that he already had an

ear infection on 8 January 2018. Professor Kong stated that he suspected that was the case. He gave evidence that

> *"To erode the – so, the ear is protected from the brain by a thin layer of bone. To erode that bone would take a while to – over a period of time. Whether that occurred in the preceding period or long time before, it's really hard to say. Needless to say, that when it was actually through there and the osteomyelitis or the bone infection was there as well as going up in the brain, it would have been going for quite a while and the rapidity of it toward the end there may have been because of the confounding factors."*

115 Professor Kong was asked to comment on a patient presenting with signs of infection, such as a raised temperature of raised respiratory rate. He stated that

> *"when you get a complication, you're on that rapid decline straight away there. So, a fever and a rapid heart rate will be a late-stage presentation, or it means that the infection has actually gone into one of those complicated areas, such as the meninges, such as the semi-circle canals which is the balance area."*

116 In his report dated 1 June 2021, Professor Kong stated

> *"In reviewing this case, one also realises that much has escaped attention to detail and that many Aboriginal and Torres Strait Islander people are enduring the consequences of otitis media. Similarly, we must be vigilant in awareness and access to healthcare services to ensure appropriate treatment is timely. Confounding all these is his lack of access to primary healthcare and the general community not being aware of the long-term consequences of otitis media. When there are such severe complications of otitis media it is imperative that they seek specialist attention, so that they can be diagnosed and worked up appropriately to prevent long-term sequelae."*

Treating ear disease in a custodial setting in NSW

117 Professor Kong opined that

> *"My personal feeling is that every incarcerated person should have (a) hearing assessment as part of their admittance, which would also improve the understanding and their pathway for hearing loss. It should also be complimented with a measured management plan."*

Professor Kong also noted that hearing loss also impacted on a prisoner's ability to engage with lawyers and the court during trial or sentencing proceedings. He also noted that some regional and remote Aboriginal people have English as a second language.

118 Currently, a hearing impairment or chronic ear health is not caught by the Chronic Disease Screening procedure in NSW correctional institutions. Professor Kong had been provided with copies of the statements prepared by Dr Nicholls from JHFMHN for these proceedings. Professor Kong applauded the proposed changes, particularly by "*Putting those platforms in place really encourages us to make sure that that – doesn't matter who's presenting that they'll be picked up early on.*"

119 Professor Kong indicated that undertaking a screening hearing test or audiogram, together with a photograph of the eardrum and a brief history of the person's ear health/disease would allow health staff to "*see the people we need to see, and screen those who are okay and safe to move on from there.*"

120 Professor Kong confirmed that you need specialist equipment and someone trained to do hearing tests. He indicated that video otoscopes containing a camera are now readily available to purchase. The video otoscopes are fed into the ear and a photograph can capture the state of the inner ear. He confirmed that the cost of a video otoscope can range from $30,000 down to $50. He stated that there are little pen otoscopes which can be purchased online for $50 and which his team have been using "*quite effectively*". He agreed that these photographs can be used as part of a referral or to seek

advice from a specialist. He confirmed that you do not have to have access to a soundproof room to undertake these types of tests. He was also aware of "*some of the technology with apps that you can actually do hearing tests and not be person-dependent at all.*"

121 Professor Kong noted that there is a dearth of ENT surgeons in Australia and the wait time at outpatient clinics is often up to five years. His team have been training Aboriginal health workers, called ear health workers or ear health facilitators, to liaise with the clients in a culturally safe and competent fashion, ensuring the client is comfortable and permitting the health facilitator to take the photograph of the eardrum and conduct the audiogram and obtain the history. These workers become the primary point of contact between a GP/or nurse and an ENT specialist, such as Professor Kong.

122 Professor Kong was aware that there are education courses currently available for nurses as well as doctors to undertake ear and hearing assessments, however these were limited. He was aware of training which was provided by the EarTrain program through TAFE NSW which involves approximately 26 hours of online training for nursing staff. He stated that it is

> *"quite an intensive program. I think the people who are at the forefront dealing with these patients should be, but I think there should be a general awareness of ear disease and its effects across the whole society."*

123 Professor Kong was asked to comment on the effect of hot weather conditions on ear infections. He stated "*Yeah, fascinating question, and absolutely. Particularly moist heat.*" He noted that in the northern parts of Australia and "*when it's the wet season, the ears are constantly pouring with discharge. So, heart and particular moist heat does play a role in that.*" He continued to note that "*if you're wearing earplugs or putting things into your ear, then it probably holds the moisture more, and when it holds the moisture more, you're more predisposed to infection or discharge associated.*"

Evidence of Dr Gary Nicholls

124 Dr Gary Nicholls, Clinical Director Primary Care Medicine within JHFMHN provided an initial statement and three supplementary statements in these proceedings.

125 In his initial statement, he perused Mootijah's JHFMHN files and confirmed that he came into custody on 5 March 2017

> *"against a background of schizophrenia with predominant negative symptoms, alcohol related brain disease, chronic ear infections with associated deafness, leprosy, chronic poly-substance abuse, hepatitis C, poor self-care and an itinerant lifestyle."*

126 In his first supplementary statement, Dr Nicholls noted that

> *"[JHFMHN] does not have any formal procedures to identify inmates who are vulnerable and at risk of not seeking proper medical care owing to their cognitive, intellectual, or other factors. [JHFMHN] are in the process of developing a NDIS Procedure to support patients that are enrolled in the NDIS."*

He also confirmed that

> *"[JHFMHN] does not provide specific training to nursing staff in regard to the identification and treatment of patients with hearing impairment."*

127 Despite this, he continued to opine that a patient identified with a hearing deficit would be referred to a GP and then to an external organisation if required.

128 Dr Nicholls confirmed that the Reception Screening Assessment did not contain questions about sensory disabilities in 2017. He confirmed that in February 2021,

"a question was added to the Reception Screening Assessment tool relating to disabilities, which includes sensory disabilities. If a hearing issue is identified or observed, the patient would be referred by nursing staff to the GP for further assessment and referral to external service if needed. Given the issues highlighted by this case it may be beneficial for the RSA to contain specific questions about hearing and deafness – after questions about eye conditions."

129 In his second supplementary report, Dr Nicholls confirmed that

"As at March 2017 there were 3 criteria that determine whether a patient requires a chronic disease screen:

(i) Patients with a confirmed chronic condition (following release of information to community practitioner confirming the condition)

(ii) All Aboriginal and/or Torres Strait Islander patients who are 45 years and over

(iii) All non-Aboriginal and/or Torres Strait Islander patients who are 55 years and over"

130 Dr Nicholls conceded that Mootijah should have been referred for a chronic disease screening in 2017, based on the fact that he had one or more confirmed chronic conditions. He was not referred. Dr Nicholls stated that Mootijah was placed on "*semi-urgent waitlists*" on at least two occasions. Mootijah was seen by a GP on 8 March 2017. According to Dr Nicholls, Mootijah was "*subsequently seen on at least 80 occasions between 8 March 2017 and 7 January 2018.*" Dr Nicholls acknowledged that

"I am unable to say why Mr Shillingsworth was not referred for chronic disease screening. There were numerous opportunities for this referral to be made based on his documented clinical history. Whilst he

received intensive treatment for complex acute primary health and mental health symptoms, I acknowledge that the failure to identify asymptomatic chronic disease and provide sub-acute care to Mr Shillingsworth was a missed opportunity."

131 In light of Professor Kong's statements, it is less clear what Dr Nicholls was suggesting when he stated

"Noting the complexity of Mr Shillingsworth's clinical presentation at the relevant time and the absence for the most part of obvious symptoms of ear disease, it is very difficult in hindsight to comment on what difference a referral would have made to his ear condition."

Dr Nicholls then juxtaposes the following,

"I am comfortable in saying however that a referral for chronic disease screen would have at least increased the likelihood of Mr Shillingsworth being referred to an ENT Specialist for follow up assessment and treatment if required".

132 In this regard, it should be noted again, that according to Dr Nicholls, Mootijah was seen by a GP on 8 March 2017. Dr Nicholls states that

"Currently hearing services within the adult custodial environment are provided by Precision Hearing, an external private diagnostics and hearing rehabilitation provider. Patients access these services after assessment by the JHFMHN General Practitioners (GP) who then refer the patient for testing, diagnosis and treatment."

133 Again, it is noted that despite Mootijah being seen by a GP on 8 March 2017, and a further 79 times (possibly by other GPs), only two referrals were made on 22 December 1997 and 15 December 2014 for "*testing, diagnosis and treatment.*"

134 Dr Nicholls indicated that

"[JHFMHN's] Primary Care team is currently in the process of determining the scope of an ear health and hearing pathway. To date, the following has occurred:

- *A proposal to develop an ear health and hearing pathway pilot project which will include:*

  i) Provision of training to primary health care staff (enrolled and registered nurses, nurse practitioners, and general practitioners) to undertake study to gain qualifications to complete hearing/ear assessments. Training would be provided by the EarTrain Program, through TAFE NSW (approximately 26 hours of online training for nursing staff)

  ii) Funding for additional nursing positions to adequately resource the project, noting existing staffing restraints.

  iii) Initially a small number of staff will be selected for the purpose of the pilot. A pilot site correctional centre is also to be identified.

  iv) Purchase of specialised equipment to support the introduction of hearing/ear assessments. A supplier has been identified and quotes have been obtained.

  v) Unfortunately, more rapid development of the pilot project has been impacted by COVID-19.

- *A proposal to create a Visiting Medical Officer (VMO) ENT Specialist position to facilitate clinics for patients identified with symptoms or risks that may be associated with ear disease. This would improve the access available to ENT specialist care for Network patients. The ENT Specialist position will also*

provide specialist advice for the development of an ear health and hearing pathway. A brief has been submitted for approval of funding to create this position."

135 By the time Dr Nicholls gave evidence, his view of the proposed training model had changed. In evidence, he stated

"the plan would be to upskill all staff. When you're talking about a specific type of training program, like a 20-hour TAFE course, that's unattainable for the whole group of staff, obviously. But, you know, as Professor Kong says, there's an awful lot of information that can be distributed. There is – there are- we can do in-house education, we can review, sort of, education that's been provided by Hearing Australia. We can develop a shorter education set of sessions that can be just a few hours with some experts in the area. And that can be shared with the whole group of people in grand rounds. We can also share that information with our community providers, as well."

136 As Dr Nicholls' evidence progressed, the court was left with the impression that a pilot program may be developed in some form, subject to finding funding from some other internal funding source, rather than from an additional funding source.

Evidence of Mr Matthew Trindall

137 Mr Matthew Trindall is the Director of Aboriginal Strategy and Culture for JHFMHN. In that role he is responsible for the development and implementation of strategic priorities for Aboriginal Health.

138 On 27 July 2021, JHFMHN released a Statement of Commitment to Aboriginal Health. This statement was intended to form the basis for JHFMHN to develop a Reconciliation Action Plan that had previously been endorsed by the JHFMHN Board in 2021. A copy of that statement was received in evidence in these proceedings.

139 The NSW State Government provides the funding for NSW prison health services, without access to Federal funding through the Medicare Benefits Schedule (**MBS**) and the Pharmaceutical Benefits Scheme (**PBS**). Section 19(2) of the *Health Insurance Act 1973* (Cth) prevents a health service from accessing funding from the Commonwealth if they are in receipt of funding from another level of government or from a statutory body. As the State of NSW is responsible for funding NSW prisons, inmates incarcerated in NSW are excluded from receiving Medicare benefits.

140 Item 715 on the MBS supports an annual Indigenous-specific health check for all Aboriginal persons, regardless of their age. The '715 assessment', also known colloquially as an Aboriginal health assessment, is designed as an annual health screen, separate and distinct from a typical GP consultation provided by JHFMHN. Mr Trindall noted that it was designed especially for Aboriginal people. It was established because Aboriginal people have considerably higher morbidity and mortality levels than non-Aboriginal people, with earlier onset and more severe disease progression for many chronic diseases.

141 Unfortunately, NSW Aboriginal inmates are unable to access this Medicare benefit whilst incarcerated. This benefit was designed to allow appropriate access, screening, identification and treatment plans for Aboriginal persons. No similar scheme operates outside of the Medicare system in NSW.

142 Mr Trindall confirmed that although the 715 assessment was not available for NSW inmates, JHFMHN had recently been granted access to patient Medicare numbers. This access permits JHFMHN clinicians the ability to review patient information held on the Medicare system database. Such access informs a clinician about a patient's prior history, treatment and identifies the patient's community health providers. This can be crucially important in developing networking with the community medical service in preparation for an inmate's release into the community.

143 At present, an Aboriginal Community Controlled Health Organisation, such as the Aboriginal Medical Service at Redfern, cannot enter a NSW Correctional facility and perform a 715 assessment, either during the person's incarceration or in preparation for their release from custody. Mr Trindall gave evidence that JHFMHN has been actively establishing networks with community medical centres in an attempt to streamline medical services for inmates, particularly inmates preparing for release from custody by way of a case conference.

144 Mr Trindall referred to a number of community Aboriginal health services in the NSW and ACT communities. He confirmed that following the recommendations in the Inquest into the death of Mr Nathan Reynolds in March 2021, where recommendations were made that "*[JHFMHN] investigate the Winnunga Niimityjah Aboriginal Health and Community Service's model of care, and consider if any features of that model are relevant and beneficial to the way in which [JHFMHN] provides medical care to First Nations inmates*", that meetings have been held to establish a network. This is still a work in progress. Mr Trindall noted that there are significant differences between the models, not the least being the vastly larger and disparate populations of Aboriginal persons in NSW as compared to the ACT; as well as the fact that the culture and practices of the relevant populations are not homogenous.

145 Mr Trindall confirmed that a formal partnership had been established between JHFMHN and Waminda South Coast Women's Health and Welfare Aboriginal Corporation to deliver the Aboriginal Family Health Worker program which assists women in custody, who are transitioning back to their communities on the South Coast. Similarly, JHMFHN has an ongoing relationship with the Durri Aboriginal Corporation Medical Service, on the Mid North Coast of NSW; as well as a pilot program between the Anangu Ngangkari Tjutaku Aboriginal Corporation and the Wellington Correctional Centre. As a result, the Ngangkari Traditional Healers Pilot was conducted over two days at the Wellington Correctional Centre in 2021.

146 On behalf of Mootijah's family, Mr Trindall was asked if consideration has been given to having an Aboriginal man from deep in country NSW being treated by

female clinicians in custody. Mr Trindall responded that "*Yes, that's definitely on our radar. Men's and women's business and being respectful of those as well, yes.*" He continued by indicating that "*we do have a blueprint for having gender-specific programs that are currently operating in [JHFMHN].*"

Considerations

147 During the investigation and hearing of Mootijah's preventable death, a number of issues emerged.

148 Incontrovertible conclusions to several of those issues are as follows:

a) Otitis media is a condition which is readily identifiable and easily treated in the early onset phase if clinicians have adequate training and access to diagnostic tools, which are now easily sourced and cost effective.

b) Failure to identify and treat the symptoms of otitis media may result in ear infections, hearing loss or potentially worse outcomes. The social impacts are legion, including social alienation, poor educational and employment outcomes, and potentially an increased likelihood of substance abuse and contact with the criminal justice system.

c) The incidence of ongoing episodes of otitis media in the non-indigenous community is low as compared to Aboriginal communities. There is a high and disproportionate infection rate in Aboriginal communities, associated with poor socio-economic conditions and limited healthcare; as well as limited training and identification by clinicians.

d) Given the high, and disproportionate rates of indigenous incarceration in NSW, it is reasonable to conclude that there is a high incidence of otitis media, chronic suppurative otitis and related difficulties among Aboriginal persons in custody in NSW.

149 It is clear that there were missed opportunities over many years of incarceration to specifically treat Mootijah's hearing deficits and ear infections.

No doubt, opportunities were missed owing to the lack of ear health training, and exacerbated by the reliance on paper health records. JHFMHN have confirmed that these paper records are in the process of being transferred onto a fully integrated electronic records system, although this does not appear to have been completed.

150 Although missed opportunities were present during the period from 2017 – 2018, I am not of the view that any particular individual should be found accountable, and therefore no adverse findings will be made in relation to any individual identified in these proceedings.

151 Mootijah's death was the result of the systemic failures prevalent in the public health system, the custodial health system in NSW and the lack of identification and appreciation of this silent killer, otitis media. To embrace counsel assisting's words,

> "*It is hoped Mootijah's story focuses the attention of the community and Federal and State governments on the incidence of otitis media in Aboriginal communities, the magnitude of its impact when it is not properly treated and the need for appropriate early intervention. The intervention required is a multifaceted one involving public health awareness, high risk population screening, early access to tertiary referral pathways, intervention early and a great deal of work into educational outcomes. It is reasonable to assume the costs of medical treatment of this condition in later life, by which time the physical and psychological damage caused has become entrenched, along with the costs associated with persons coming into increasing contact with police, courts, and custodial environments, would outstrip that required to fund appropriate early intervention.*"

The need for recommendations

152 Section 82 of the *Coroners Act 2009* (NSW), permits a Coroner to make recommendations which are necessary or desirable in relation to the death of a person the subject of an inquest.

153 Counsel assisting suggested that the court consider making four recommendations arising from the evidence. To paraphrase, the first two proposed recommendations suggest a need for the CEO of JHFMHN and the Minister for Health responsible for JHFMHN to review these findings and Dr Nicholls' evidence regarding proposed reforms to JHFMHN practice and procedures regarding ear disease and hearing difficulties, and to prioritising those reforms and funding for same.

154 Legal representatives of the other interested parties have made submissions as to the need for those recommendations; as well as suggesting alternative recommendations.

155 It would appear that JHFMHN have received and accepted the expert evidence and guidance of Professor Kong. His clear and concise evidence relating to the identification, treatment and prevention of ongoing sequelae of hearing disease was compelling.

156 No doubt based on Professor Kong's experience and expertise, JHFMHN provided evidence, largely through Dr Nicholls, that JHFMHN was focused on implementing change. Counsel appearing for JHFMHN stated that they are "*committed to implementing changes to readily identify, treat and manage otitis media in the indigenous prison population and (to specifically) tackle its endemic prevalence and reduce the risk of acute presentations*".

157 The changes proposed by JHFMHN include the following:

a) It is intended that the Chronic Disease Screen recognises ear health or hearing issues as chronic conditions. It is their intention that all inmates, whether identifying as indigenous or not, are screened for the risk of ear disease within a specified time of their reception into custody.

b) JHFMHN propose to introduce a Visiting Medical Officer position, with a speciality in ENT health shortly. They have indicated that they are deferring the specifics of the "*successful design, detail and*

implementation of the screening procedure (the details of which) should be informed by the specialist ENT."

158 The legal representatives appearing on behalf of JHFMHN support the first two recommendations as they were proposed by counsel assisting. However, JHFMHN does not support the additional recommendations proposed by the legal representatives for the family, although does agree with those recommendations, in principal.

159 On behalf of Mootijah's family, it is submitted that the recommendations include the words "*hearing problems*" and "*chronic ear disease, to the reception screening assessment.*" This submission has merit, however appears to be encapsulated in counsel assisting's draft recommendation.

160 Further additional recommendations proposed on behalf of Mootijah's family relate to making efforts to "*fill vacant Aboriginal Health Worker positions.*" Such a submission is understandable and important.

161 Mr Trindall provided evidence to the court relating to the ongoing logistical difficulties experienced to date. Mr Trindall identifies as a Gomeroi person, with family links to the Dhungutti, Gundungurra and Kooma people. He cautioned that

> "*care ought to be taken to properly understand [JHFMHN's] care model and health service responsibilities as well as the systems [JHFMHN] has in place to meet the challenges that [JHFMHN], its Aboriginal and non-Aboriginal staff and its Aboriginal patient cohort face on a daily basis. Undermining [JHFMHN's] achievements in this space by not taking time to understand the services [JHFMHN] provides and the strategies it adopts, will only increase the challenges [JHFMHN] already faces in attracting and retaining dedicated health workers from the Aboriginal community to meet the needs of its Aboriginal patients.*"

162 Based on that information, the Court does not propose to specifically adopt the alternative recommendation as sought by the family.

163 On behalf of Mootijah's family, a submission has been received that the recommendations include the words "*work to improve collaboration between clinical and mental health nursing teams where treatment is offered by both teams*." This submission is aligned to a submission received on behalf of Dr Ramsay requiring the mandating of dual qualifications for the NUM. Both submissions have merit, particularly given the evidence this inquest has heard relating to Ms Ramsay and Ms Breen.

164 Counsel appearing for JHFMHN opposed the addition of these words to the proposed recommendation, owing to the fact that the

> "*model in Hamden has been reviewed and changed since Mootijah's death. Many of the Hamden patients have subsequently been transferred to the Long Bay Correctional Centre Complex (either 13 wing or MSPC Area 2 mental health step down beds). [JHFMHN] does cohort patients with mental illness in Hamden 15 however, this POD now comes under the management of Operations and Nursing and as a result Primary Care nurses are allocated to this area and manage all patients in Hamden 15, 16, 17 (currently closed for refurbishment for aged care beds) and 18. Custodial Mental Health provides mental health care only*."

165 But for the changes reflected above, this recommendation would have been adopted. Given these changes, this recommendation would now appear to be somewhat redundant, and for that reason, is declined.

166 On behalf of Mootijah's family, a further suggestion is made for inclusion within the proposed recommendations. This relates to implementing "*cultural awareness training to improve understanding of cultural norms and gender issues for Aboriginal people in custody*." Again, this is a submission which is welcome and needs to be implemented. Mr Trindall has provided information

as to the efforts and support his team has been making to implement such reforms in a meaningful and supportive fashion. I emphatically support and encourage such training and awareness within JHFMHN and Corrective Services NSW.

167 I note that Corrective Services NSW have confirmed, through Ms Aicken, that she has

> *"reviewed the current training packages regarding how hearing impairment may present in a custodial context. A case study loosely based (to maintain his privacy as a deceased person) on the key characteristics of Mr Shillingsworth's presentation has been prepared to aid learning outcomes."*

168 On behalf of Dr Rogers, it is submitted that the recommendations reflect the need for the installation of climate control within the gaols in NSW. Again, I strongly support this suggestion, which appears to have a recurring theme in a number of recent inquests. Clearly, with changing climatic circumstances, it is even more of an imperative.

169 I recommend the following:

To the Chief Executive Officer, Justice Health and Forensic Mental Health Network ("JHFMHN"), and the Minister for Health (being the Minister responsible for JHFMHN):

a) **The Chief Executive Officer of JHFMHN and Minister for Health review the findings in this inquest and the evidence of Dr Gary Nicholls as to proposed reforms to JHFMHN's practices and procedures regarding ear disease and hearing difficulties as outlined in his written statements dated 25 February and 29 March 2022.**

b) **Priority be given by JHFMHN to determining and finalising the changes proposed to JHFMHN's practices and procedures and arrangements necessary to fund these initiatives.**

170 Counsel assisting also proposed that the Court consider and, if appropriate, adopt two recommendations that were being considered in the Inquest into the death of Kevin Bugmy. Those recommendations go to exploring and promoting partnerships between JHFMHN and Aboriginal Community Controlled Health Organisations, and JHFMHN's advocacy for a trial for access to Medicare for Aboriginal inmates.

171 I note the evidence during this inquest which focused on the efficacy of joint partnerships between JHFMHN and Aboriginal Community Controlled Health Organisations. The importance of this collaboration reflected the need to be able to readily access and share health information, both in terms of an inmate's reception into custody; as well as the inmate's release from custody.

172 Professor Kong highlighted the efficacy of Aboriginal community clinics providing culturally sensitive treatment and avoiding unconscious bias during health treatment.

173 Both Mr Trindall and Dr Nicholls confirmed the potential benefits to patients held in custodial settings in NSW being granted access to Medicare benefits, including treatment and access to health records.

174 For those reasons, I adopt the recommendations made in the inquest into the death of Kevin Francis Bugmy as follows:

<u>To the Chief Executive Officer, JHFMHN:</u>

a) **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.

b) **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.**

Findings

175 The findings I make pursuant to section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Mootijah Douglas Andrew Shillingsworth.

Date of Death

He died on 15 February 2018.

Place of Death

He died at the Westmead Hospital, Westmead, NSW.

Cause of Death

Mootijah died from the Complications of a Left Temporal Lobe Abscess.

Manner of Death

Mootijah died in lawful custody. Whilst his manner of death was from natural causes, this was clearly precipitated by the failure to identify and treat his ear disease whilst in custody.

Conclusion

176 During the course of this inquest, it has become clear that Mootijah's death was preventable. It is accepted that Mootijah was at times reluctant and resistant to medical interventions, both in the community and in custody. It is also clear that Mootijah was a vulnerable individual in both settings. His dual presentations of significant health and mental health conditions was challenging, not the least for Mootijah himself.

177 It is hoped that by investigating his death, the insidiousness and perniciousness of ear disease, particularly within the indigenous communities in Australia has been highlighted. In addition, it is noted that Mootijah was sentenced to short periods of incarceration on a number of occasions. It is unclear whether these periods reflected additional periods of incarceration on remand, or whether they simply reflected sentences of less than six months or possibly breaches of parole. In any event, it is hoped that consideration is given to providing additional services in regional and remote areas to permit the consideration of alternatives to the imposition of periods of full-time custody, where appropriate.

178 I would like to record my gratitude to counsel assisting, Mr Chris McGorey and his instructing solicitor, Mr Gareth Martin, for their assistance, their commitment and their untiring efforts to prepare and present this case.

179 Finally, I would like to again record my most sincere condolences to Mootijah's family. I have annexed the family submissions received from both Mootijah's cousin, Ms [redacted] and her husband, Mr [redacted], to ensure that the proper context and sentiment is recorded appropriately.

180 I close this inquest

Magistrate Joan Baptie

Deputy State Coroner,

NSW State Coroner's Court at Lidcombe

22 July 2022

Note: Paragraph 179 of Findings amended 6 October 2022.

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Annexure A: Outline of Non-Contentious Facts as at 22 May 2022 (incorrectly dated 1 April 2022)

Inquest into the death of Douglas Andrew Shillingsworth (Mootidjah)

OUTLINE OF NON-CONTENTIOUS FACTS (1 APR 2022)

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1. Douglas Andrew Shillingsworth (**Mootidjah**), an Aboriginal man born 16 August 1973, died on 15 February 2018 at Westmead Hospital, Sydney, after his ventilator was removed the previous day. He was 44.

2. Mootidjah died owing to a severe intracranial infection (left temporal abscess), which resulted in an intracranial spread of infection, systemic sepsis, and major neurological injury. The left temporal abscess was associated with mastoid osteomyelitis and extensive associated intracerebral venous sinus thrombosis. The origin of the cerebral abscess was a left middle ear infection.[1]

3. Mootidjah was in the custody of Corrective Services NSW (**CSNSW**) at the time of his death. This inquest is mandatory as Mootidjah died while temporarily absent from a correctional centre as defined in the *Crimes (Administration of Sentences) Act 1999*: ss 23(1)(d) and 27, *Coroners Act 2009.*[2]

BACKGROUND

4. Mootidjah grew up in regional NSW.[3]

5. His parents passed away when he was 18, his brother passed away from Leprosy and his sister from 'alcohol and stress'. He was married but divorced in about 2002.

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1 Iredell WS 4.11.2019, tab 11.

2 This outline focuses on Douglas' health and the treatment he received while in custody, but does not represent a comprehensive overview of all aspects of his life.

3 Douglas reported in medical assessments having family in Dubbo and Mt Druitt. A medical record dated 14 August 2015 noted his residential address as 2A Eni St, Dubbo NSW.

6. Mootidjah is survived by two adult children (aged 24 and 25). He completed TAFE training in carpentry and plumbing but in the years preceding 2017 was homeless.[4]

7. At the time of his death Mootidjah was not in receipt of a disability support pension, although applications for the same had been lodged on his behalf on 13 August 2015 and 24 March 2016.[5]

Custodial history

8. Mootidja came into contact with the criminal justice system numerous times during his life. He was imprisoned a number of times from the age of 24 years old (in 1997). At the time of his death on 15 February 2018, he had been in custody from 3 March 2017, approximately 11 months. A table of incarceration dates is annexed to this outline.[6]

Physical health

9. Mootidjah had recorded diagnoses including Hansen's disease (leprosy), Hepatitis C and schizophrenia.

10. With regards to his leprosy:

    (a) *June 2001*: on 22 June 2001, Mootidjah was transferred from Bourke District Hospital to the Royal Prince Alfred Hospital (**RPA**) for treatment of a chronically infected right great toe and management of his borderline lepromatous leprosy. He was noted to have cellulitis of the right great toe with ulceration and osteomyelitis. His right great toe was amputated on 5 July 2001. His history at the time noted 'heavy alcohol abuse' and 'mild cognitive impairment'.[7]

    (b) *August 2004:* a Justice Health and Forensic Mental Health Network (**Justice Health**) notation on 13 August 2004 recorded that Mootidjah

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4 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70.

5 Centrelink notification tab 79.

6 Coorey WS 14.8.2019 [9]-[10], tab 10.

7 Reported to have received reviews in 2017 by a Visiting Infectious Diseases Consultant (Professor Lloyd) and the Public Health CNC (Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70). Dr Roberts noted on 4.7.2013 that Douglas received a diagnosis of Hansen's disease by dermatology at Royal Prince Alfred Hospital (RPAH) in 2001, tab 80.

had '*completed 2 years of leprosy treatment*' and showed no clinical signs of that condition.[8]

(c) *March-April 2017*: Mootidjah had toe amputations (first and second toes) on his left foot while in custody, although this was not on account of leprosy (see below).[9]

Mental health

11. Mootidjah received mental health treatment between 2007 and 2017 including[10]:

(a) *December 2007*: an admission to St Vincent's Hospital's Emergency Department. He had been found at a Youth Hostel running around, dancing, screaming, and banging his head against a wall. He was noted to be hostile and guarded. He reported being homeless and admitted to cannabis use and prior heavy alcohol use but refused blood or physical investigations. He was discharged without clear diagnosis.[11]

(b) *Drug and Alcohol services in Kempsey in 2013*: this service referred Mootidjah to mental health services owing to him having symptoms suggestive of acute mania with grandiose delusions, auditory hallucinations, and psychomotor agitation. He was later admitted to Long Bay Hospital (**LBH**) for involuntary psychiatric treatment and treatment of his Hansen's disease (Leprosy) and diagnosed with psychosis in July 2013 while serving a sentence of imprisonment.[12] He was noted to be guarded and uncooperative with medical interventions. He was prescribed low dose quetiapine for a short period.[13]

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8 JH progress note 14.6.2013, tab 80; Dr Roberts progress note 2.7.2013, tab 80.

9 Iredell WS 4.11.2019, tab 11; JH letter dated 12.1.2018; JH progress notes 5.3.2014 & 14.6.2013, tab 80.

10 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70.

11 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70.

12 MH Assessment 15.7.2013, tab 80; Schedules 4.7.2013, tab 80.

13 Douglas was assessed by Dr Roberts (psychiatrist) on 2 April 2013 who noted he had been transferred from Kempsey in custody for criminal charges, tab 80; Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 80.

(c) *Referral to Justice Health mental health services in March 2014*: this referral was made owing to concerns about his mental state including him describing hearing 'evil voices' of two males and presenting as paranoid. He was suspected to be suffering paranoid schizophrenia and brain injury. Quetiapine was reinstated at a lower dose.

(d) *Mental health assessment at Parklea Correctional Centre in November 2015:* a mental health assessment on 6 November 2015 noted Mootidjah appeared to present with a 'mild intellectual disability' and some persecutory ideas.[14]

EAR HEALTH

Otitis media[15]

12. Fluid is secreted within the middle ear as a thin serous fluid. The fluid ensures the middle ear cleft is clean to ensure good transmission of sound.

13. Otitis media is the presence of middle ear effusion (*build-up of fluid in the space behind the eardrum*) or infection within the middle ear cleft of the ear.[16]

14. The fluid becomes trapped which causes the eardrum to bulge. This occurs when the eustachian tube becomes blocked preventing drainage of the fluid.

15. If the fluid becomes infected (e.g., bacterial) acute otitis media develops. The sufferer may present with fevers, temperatures, and systemic illness indicative of an acute infective process.

16. In some cases, the pressure in the middle ear can cause the eardrum (tympanic membrane) to perforate or burst.

17. Chronic suppurative otitis media (**CSOM**)[17] is characterised by a persistent discharge from the middle ear through a tympanic perforation.[18]

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14 MH Triage 6.11.2015, tab 80.

15 The following information is drawn from Dr Kong's report 1.6.2021 (tab 16) and information contained in the WHO publication: https://www.who.int/pbd/publications/Chronicsuppurativeotitis_media.pdf.

16 Kong report 1.6.2021, tab 16-1-3.

17 Suppurative refers to a process which produces, or causes the production of, pus.

18 https://www.who.int/pbd/publications/Chronicsuppurativeotitis_media.pdf.

18. Otitis media frequently begins with a common cold, which leads to infection and/or blockage of the eustachian tube which prevents drainage of fluid from the middle ear. It is often self-resolving but if prolonged medical treatment maybe indicated. Treatment may include antibiotics or surgical interventions to drain the fluid via ventilation tubes (grommets) in the tympanic membrane or repair tears or holes in the ear drum.

19. A severe complication when bacteria spreads from the middle ear to the mastoid bone's air cells (within the bone) where inflammation causes damage to bony structures (Mastoiditis).[19] A complication can be cerebral infection (e.g., cerebral abscess) which can be fatal.

20. Mortality rates relating to chronic middle ear infection were high before the advent of antibiotics, but this significantly declined in the past 50 years.[20]

21. A middle ear infection with cerebral abscess is, typically, rare owing to the availability of access to care, immunisations, and improvements in medical treatment.

22. Infants have an increased susceptibility to middle ear infections as they are more likely to develop bacterial growth in the nasopharynx (upper part of the throat that lies behind the nose).

23. Aboriginal and Torres Strait Islander children are more likely to develop bacterial growth in the nasopharynx at a very early age, generally under 12 months compared to non-Indigenous children around 2-3 years of age.

24. A complication, and/or indicator of, chronic ear disease is tympanic membrane perforation, where fluid and infection accumulate for a long period resulting in the disintegration of the ear drum disintegrates leaving a hole.

25. Typically, where perforation does occur, it is relatively small and spontaneously closes. Where this condition is chronic and/or recurring, the perforation may remain and may increase in size.

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19 https://en.wikipedia.org/wiki/Mastoiditis.

20 https://www.sciencedaily.com/releases/2018/04/180416142450.htm.

26. A perforation that does not correct can intermittently discharge; these being associated with subsequent infections. Untreated complications of chronic suppurative otitis media may be a recurring health issue in a person's life.

27. A person whose middle ear cleft is filled with fluid may experience hearing difficulties. Recurring chronic otitis media can result in long term or permanent impairment to hearing.

28. Multiple ear infections at a very early age, with its impact on the person's hearing both in the short and long term, can adversely impact on his or her performance in education and educational outcomes. It can also manifest in social alienation and/or behaviour difficulties.

1st ENT specialist referral while in custody (December 1997 to February 1998)

29. On 19 December 1997, Mootidjah underwent assessment by a registered nurse at Bathurst Correctional Centre noted:

> "New reception first time in gaol...Comes from way out far west...Has not left local town 10-11 years. Presents as same, very unworldly very environmentally uncomplicated. Gives hx of chronic ear problem from childhood. O/E (R) ear no drum clear canal. Hx states was suppose to have an operation on same at 15 yrs (ago). DIDN'T. (L) drum looks compromised ?? infection to see M.O on Monday. Given cotton wool and clear instructions nothing in ears plug when showering. Client is a cotton bud user!!!"

30. Mootidjah' report was also noted on or around that same date, that:

> "Hearing (R) ear Hx 14 years of age"

31. On 22 December 1997, a progress notation was made that:

> "Both drums devastated + [?]. Discharge L. ear – [?] ENT Referral."

32. That same day, a referral was noted by a medical officer which included following details:

> "Consultant: ENT

Provisional diagnosis:	Bilateral eardrum damage + loss from chronic ear infection.
Summary:	Needs appropriate management and surgery."

33. On 25 February 1998, Mootidjah signed a form *"Appointment cancellation by inmate"* regarding an ENT appointment scheduled for 27 February 1998. In that form it was noted "(reason for cancellation) *Will deal with medical problem when released"* and *"I will continue to have my hearing deficit without investigation/treatment".*

34. There is no known record of any subsequent referral being made before Mootidjah' release to custody in March 1998 or of him undergoing an ear specialist assessment in the community after his release.

Hearing difficulty noted August 2001

35. On 23 August 2001, Mootidjah underwent psychological assessment at LBH. The assessing doctor noted a diagnosis of "ARBI?" and noted inter alia:

> "Reported having a hearing difficulty – lifelong problem – denied seeking medical assistance for it. Often need to repeat myself or speak louder for pt.
>
> ..
>
> ..
>
> Conclusion
>
> 28 yr old man with cognitive difficulties ? ARBI. Hx of psychotic/pseudo psychotic? Experiences in recent months. Distressed re: chronic alcohol abuse – wanting to seek treatment...
>
> Pt. also reported having difficulty talking to doctors – "I don't like [?] – this may also be impeding rapport + responses"

36. There is no known record of a hearing assessment or referral to an ear specialist following this assessment.

Statewide Disability Services in July to August 2004

37. Mootidjah was in custody between 21 July and 23 August 2004.

38. During reception screening at the Metropolitan Reception and Remand Centre (**MRRC**) on 21 July 2004, Mootidjah was referred to Statewide Disability Services for assessment.[21] Statewide Disability Services falls within Corrective Services NSW (not Justice Health).

39. On 22 July 2004, while at the MRRC, Mootidjah was assessed by a psychologist with the Statewide Disability Services. Testing using the Wechsler Abbreviated Scale of Intelligence (**WASI**) instrument was carried out. The examiner noted:[22]

> "Suspected brain damage due to alcohol?
>
> Responds slowly + at times its is difficult to understand what he is saying; sometimes responses indecipherable."

40. The assessment indicated that Mootidjah did not function in the range of intellectual disability.[23] He was assessed to function in the low average range of cognitive functioning.[24]

41. On 25 July 2004, Mootidjah was transferred to Bathurst Correctional Centre.

42. On 23 August 2004, he was released from custody.

43. A subsequent notation was made by Statewide Disability Services (date not specified):

> "hearing to be checked – Not done released 23/8/04"

44. Statewide Disability Services received no further referrals for Mootidjah beyond that received in July 2004 until 2013 (see below).[25]

45. It is noted that mental health reports subsequently completed in 2017 refer to Mootidjah' medical records and him having a previous diagnosis of alcohol related brain injury. This diagnosis was reportedly made in Long Bay Hospital

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[21] Aicken WS 10.3.2022 [4], tab 15A-1.
[22] Statewide Disability notation, tab 18A-1.
[23] Aicken WS 10.3.2022 [5], tab 15A-1/2.
[24] Aicken WS 10.3.2022 [16], tab 15A-3.
25 Aicken WS 10.3.2022 [12], tab 15A-2.

in 2001.[26] However, as seen above, the assessment completed in 2004 appear to indicate that Mootidjah' intellectual functioning did not fall within the range of intellectual disability.

Period in custody in 2013-2015

46. Mootidjah was imprisoned between 13 March 2013 to 11 August 2015.

47. On 15 May 2013, Statewide Disability Services recorded receiving a referral for Mootidjah for a Functional hearing assessment and Physical/Mobility assessment.[27]

48. About this time, a Statewide Disability Services' Sensory Physical Coordinator reviewed Mootidjah' file and emailed the correctional centre he was placed at to inquire if Mootidjah wished to be referred to Justice Health. Statewide Disability Services itself does not conduct hearing assessments and refers patients to Justice Health for assessment.[28] There is no record to indicate whether a signed consent referral form was returned or not.[29]

49. On 15 August 2014, the Offender Integrated Management System (**OIMS**), an electronic record keeping system operated by Corrective Services NSW, was updated to note that in Mootidjah' case disability assistance was not required for mobility/physical impairment and the Statewide Disability Service was to be advised if assistance was required with respect to his hearing.[30]

50. There is no known record of Statewide Disability Services involvement with Mootidjah beyond August 2014.

Difficulties with engagement (26 June 2013)

51. On 26 June 2013, the following was noted by Justice Health staff:[31]

> "AHW – interviewed patient with manager of Aboriginal health Justice Health, Patient stated he was unwilling to engage or be interviewed by

26 E.g., see Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70.
27 Aicken WS 10.3.2022 [6]-[7], tab 15A-2.
28 Aicken WS 10.3.2022 [17], tab 15A-4.
29 Aicken WS 10.3.2022 [8], tab 15A-2.
30 Aicken WS 10.3.2022 [10], tab 15A-2.
31 Progress note 26.6.2013, tab 82D-17.

any medical staff. Recommend urgent mental health assessment Health, with Aboriginal Health worker present. Recommend liase with Aboriginal medical service Redfern, with Mental Health coordinator Barbara Kennedy..."

....

PSHN: Handover from the Aboriginal Health workers described pt as difficult to engage, tangential and adamant he will not be seen by Doctors. Paranoid about researchers due to hx of their involvement in his Rx for Hansens Disease 2011. Clearly traumatised by his brother's demise (ie same disease). Wait list (urgent) for MH assessment...."

2nd ENT specialist referral (December 2013 to January 2014)

52. On 24 December 2013, during that period in custody, a Justice Health note was made noting Mootidjah' report that *'L ear ache 2 weeks + states pus + smelly'* which he *'cleaned ear out with toilet paper'*.[32] It also noted "*States when blows nose ?? pus comes out of both ears"* and "*black area bottom of R drug + top of R drum*".

53. On 16 January 2014, a plan was noted as follows:

"PLAN

(1) Swab [?] L.Ear

Rx 10/7 ciprofloxacin...

(2) I'll research "how" to get hearing tests/ENT opinion/Hearing ALD "inside" as he has – (1012 left of sentence)

See me 1/5."

54. On 23 January 2014, Mootidjah was referred to an Ear, Nose and Throat (**ENT**) specialist for assessment and treatment of '*Chronic recurrent Bilateral Otitis Media with L perf and* ***very DEAF*** *– needs ENT and Hearing tests plus hearing aid'*.[33] A progress note made that same date noted:

"- He is "OK" about referral to ENT POW [?] – an PAS

32 Clinical Assessment Template 24.12.2013, tab 37.
33 JH Referral 23.1.2014, tab 37.

- Section [?] toilet L EAR. Impossible to see whole drum
  Impression of granulations lower drum + probable perf.
- Section [?] to be repeated (2/52)"

55. On 6 February 2014, Mr Shillingsworth's ears were noted to be much cleaner with slight moist discharge evident on the ear drums.

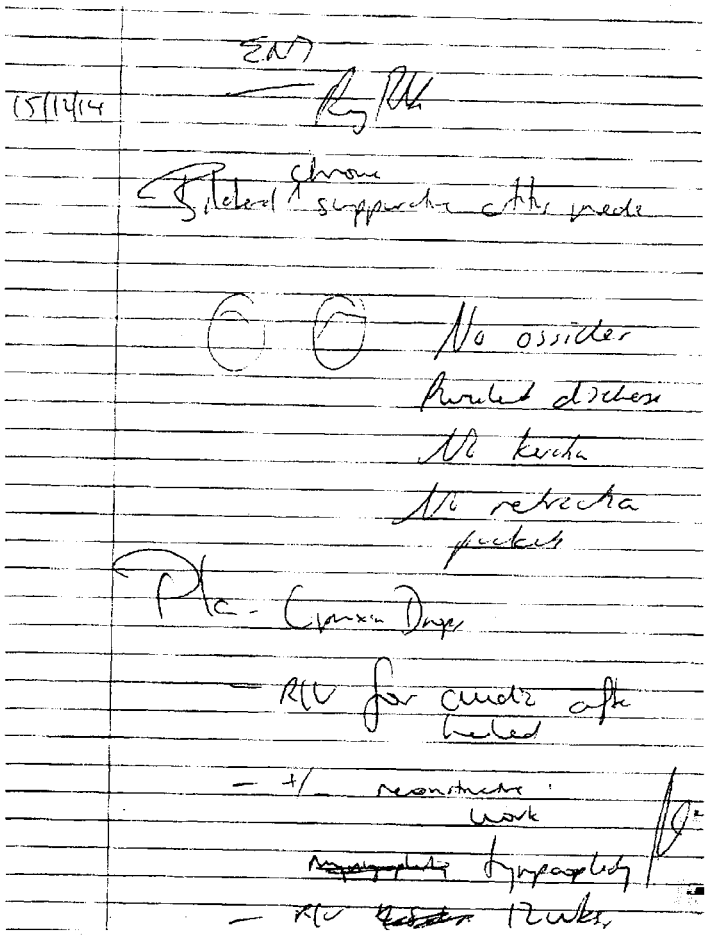
56. Between 18 and 28 February 2014, Mootidjah was noted to be in "segro" at Cessnock Maximum Security wing.

57. On 5 March 2014, a MH practitioner reviewed Mootidjah' health record and noted inter alia: "*2014 + chronic ear infections + deafness to (L) ear 12/2/14…*". The impression noted was:

> "40 yr old Aboriginal man w hx of Hansen's Dx, probably ARBD + psychotic illness consistent w paranoid schizophrenia wanting meds to gain relief from voices w derogatory content.
>
> PLAN (1) Quetiapine XR 100mg PO nocte (2) R/V by MHNP 10/3/14"

58. On 15 December 2014, Dr Lowinger, Ear Nose and Throat Specialist (**ENT**) at Prince of Wales Hospital, reviewed Mootidjah. Mootidjah was assessed as having chronic suppurative Otitis Media with purulent discharge with no visible inner ear bone ossicles. He was prescribed ciproxin ear drops with a plan for a further review in 12 weeks possibly to determine if surgical treatment was necessary.[34] A handwritten notation was made regarding that review:[35]

34 Nichols 1st WS [27] tab 101-5.
35 Progress note 15.12.2014, tab 80-1.



59. There is no record of Mootidjah undergoing an examination or review of his ear condition after 15 December 2014 and before his release on 11 August 2015.[36]

Change in active health alert on 19 July 2015

60. As at 19 July 2015, Mootidjah had an active health alert noting his hearing was impaired. On 19 July 2015 that alert was made inactive. There is no JH record of Mootidjah undergoing a formal hearing test between January 2014 and December 2017.[37]

Release and return to custody in 2015

61. On 23 October 2015, Mootidjah returned to custody.

36 Nichols 1st WS [27] tab 101-5.
37 Nichols 1st WS [32] tab 101-6.

62. On 18 November 2015, he was released again after serving his full sentence (without securing release to parole).

November 2015 and March 2017

63. Between 15 July and 22 August 2016, Mootidjah attended on the Bourke Aboriginal Corporation Health Service in Bourke for treatment of his leg.[38] There are no other known records of Mootidjah attending medical practitioners in the community in the years before his passing.[39]

CHRONIC DISEASE SCREENING

64. Justice Health has a *Chronic Disease Screen* (**CDS**) procedure, which includes an electronic screening component.

65. As at March 2017, when Mootidjah entered custody, Justice Health's *Health Assessments in Male and Female Adult Correctional Centres* (issue date 5 May 2015) (**2015 Assessment Protocol**) stipulated "mandatory requirements" for assessments.

66. On 12 July 2017, after Mootidjah' entry into custody in March 2017, the 2015 Assessment Protocol was superseded by Justice Health's *Health Assessments in Male and Female Adult Correctional Centres* (issue date 12 July 2017) (**2017 Assessment Protocol**).

67. The 2015 and 2017 Assessment Protocols deal with Justice Health requirements for:[40]

    (1) Reception Screening Assessments (**RSA**), which requires a nurse to complete an RSA in Justice Health's electronic Health System (**JHeHS**) for all patients entering correctional centres within 24 hours of admission where possible. This requires checking, reviewing and updating where appropriate active and inactive PAS alerts.

    (2) The *CDS*, which provides for "the assessment and management of Chronic Disease takes place with the use of the following assessment

38 Bourke Aboriginal Corporation Health Service Ltd letter 9.3.2022, tab 17D.
39 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70.
40 *Health Assessments in Male and Female Adult Correctional Centres* (5 May 2015), tab 104-3.

and management processes: chronic disease screen; multidisciplinary care plan; clinical pathways as identified in the chronic conditions toolkit". This must be completed by a Registered or Enrolled Nurse and includes physical assessment, screening and multidisciplinary consultation. If symptoms are identified during assessment indicate further investigation, a referral is to be made to the appropriate health stream for "expert management" with placement on appropriate waiting lists for clinician review; and

(3) The *Chronic Disease Clinical Pathways* ("...designed to aid in the assessment and management of chronic conditions...They provide a pathway of care from reception, while in custody and to release...assists clinicians to manage patients with diagnosed or suspected chronic conditions").

68. The scheduling of a CDS typically occurs via Justice Health's *Patient Administration System* (**PAS**), which is an electronic system that permits the entry of patients onto waitlists for Primary Health Nurse reviews. A CDS would be scheduled by placing a patient on the PAS' "*Initial Chronic Disease Screen"* waiting list.

69. As at March 2017, Justice Health procedure mandated a CDS if:

(1) Patients with a confirmed chronic condition (following release of information to community practitioner confirming the condition).

(2) All Aboriginal and/or Torres Strait Islander patients who are 45 years old and over.

(3) All non-Aboriginal and/or Torres Strait Island patients who are 55 years old and over.

70. In contrast to the 2015 Assessment Protocol, the 2017 Assessment Protocol provides that the CDS is to be completed for "*All Aboriginal and/or Torres Strait Islander patients who are 35 years and over*".[41]

[41] See 2017 Assessment Protocol, tab 104.

71. As at March 2017, Justice Health mandated a CDS (where required) to be completed:

(1) Within 30 days of an RSA,

(2) If the patient was assessed as meeting the CDS criteria at "*another point during their incarceration* (e.g., is diagnosed with a chronic disease or reaches the age of 55 years) within 30 days of the patient's presentation to health staff, or

(3) Any time deemed appropriate by health staff with clinicians encouraged to exercise clinical autonomy as appropriate.

72. The objectives of the CDS are to:

(1) Facilitate the identification of incoming or current inmates with possible or actual chronic diseases,

(2) Refer the inmate using a *Chronic Care Clinical Pathway* procedure for assessment by a medical officer or nurse practitioner,

(3) Aid in the completion of a multidisciplinary care plan (**MCP**), and

(4) To "ensure continuity of care".

73. Identification of an inmate with a diagnosed chronic disease occurs:

(1) At the inmate's reception into custody via an RSA (once the patient's "Release of Information" from the community is returned); or

(2) Anytime a Justice Health Medical Officer or Nurse Practitioner diagnoses a chronic condition.

74. Another related Justice Health protocol is the *Procedure for Managing Patients with a Chronic Condition in Custody* and the *Chronic Conditions Clinical Pathways*, which are "designed to assist clinicians in assessment, timely diagnosis and management of chronic conditions".

75. The MCP is to:[42]

[42] *Health Assessments in Male and Female Adult Correctional Centres* (12 July 2017).

(1) Stipulate a timeframe for the next CDS to be conducted as decided by the clinician and the appropriate pathway ("The patient must be placed on the 'CDS Follow Up' waiting list on PAS including a 'see by' date"),

(2) Outline health conditions, clinical findings and the interventions initiated to manage the condition.

(3) Contain recommendations for treatment, monitoring, and other interventions (including, where appropriate, referral for specialist assessment).

76. All specialties as appropriate are to contribute to it and to timely reviews.[43]

77. Written clinical pathways have been developed by Justice Health to guide the assessment and management of patients diagnosed with the following chronic health conditions: (a) Arthritis and Musculoskeletal Problem, (b) Asthma, (c) Chronic Liver Disease, (d) Chronic Obstructive Pulmonary Disease, (e) Coronary Ischaemic Syndromes, (f) Diabetes, (g) Epilepsy, (h) Kidney Disease, (i) Osteoporosis, (j) Stroke and (k) Valvular Heart Disease.

78. Justice Health has a *Health Problem Notification Form* (**HPNF**) protocol. The purpose of the protocol is to enable Justice Health clinicians to provide advice and recommendations to Corrective Services NSW about an inmate's clinical status. This involves a proforma form in which information is recorded about an inmate's health issue (e.g., mental health, head injury, heart trouble), possible indicators for elevated risk and recommendations as to monitoring.

79. At present, Justice Health's written procedures for CDS, Clinical pathways for assessment and management of patients with chronic disease, and the use of the HPNF, does not identify otitis media as a chronic disease or as a condition requiring the conduct of a CDS (if a patient presents with a history of otitis media) or outline a clinical pathway for that condition.

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43 Ibid.

RETURN TO CUSTODY IN MARCH 2017

Arrest and charging

80. On 3 March 2017, Mootidjah was charged with various offences including assault and resist police.[44] The offences were allegedly concerned alleged physical aggression towards arresting police. Mootidjah was living in the Sydney area and had no fixed abode at this time. Mootidjah later reported he had been using methamphetamine every two weeks before entering custody. Reports of past intravenous amphetamine use were previously documented in Justice Health records.[45]

Entry to MRRC on 4 March 2017

81. On 4 March 2017 Mootidjah was remanded to custody at Silverwater Metropolitan Remand and Reception Centre (**MRRC**). On entry he was noted to have suffered a broken hand (6 weeks ago).[46] He was initially placed on RIT and reportedly aggressive and abusive towards Corrections Officers.[47]

82. At the time of his reception, Mootidjah had active health alerts on JHeHS for *disorder of amputation stump* and *foot injury*.[48]

83. At this time CSNSW's *Offender Alerts* had a "deaf or hearing impaired" disability alert for Mootidjah, which noted " ... *referred due to possible hearing disability. Past history of hearing loss noted. If related to conductive hear loss from colds, sinus etc. hearing may fluctuate. If concerned about hearing contact Justice Health re having ears checked or referral to audiologist...* "[49]

84. During a mental health assessment by a registered nurse on 10 March 2017, it was noted:[50]

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44 Common assault, behave in offensive manner near public place, stalk and intimidate, resist police in execution of duty, affray and assault police: see Indictable brief H63765226, tab 64.

45 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70; also see JH DOA Assessment 16.3.2006 which noted 'uses speed daily (x1) uses heroin x 2 (iv) per week – marijuana – 2 x bons with 3-4 people daily'.

46 Inmate ID form 4.3.2017.

47 See OIMS 15.3.2017, 21.3.17, 4.4.2017, tab 35.

48 Nichols 1st WS [9] tab 101-2.

49 Wilkinson WS 4.5.2021 [19], tab 13-3; Inmate Profile Document 5.3.2017 tab 22-2.

50 MHOAT 10.3.2017, tab 81-58.

"43 year old with probable mild intellectual. Some persecutory ideas "white doctors", "being discriminated against". Denies any psychotic phenomena. Mildly though disordered and tangential. Nil acute risk issues".

85. On 7 March 2017, a solicitor with the Aboriginal Legal Aid Service appeared for Mootidjah in his criminal matters at the Parramatta Local Court's bail court. That solicitor noted that same date:[51]

"Although he seemed ok initially. The conference ended as I could not get instructions. He was very difficult. Possibly coming off drugs/ mental illness (however no history of s33 on record).

Would not allow me to read him the allegations.

Mentioned the matter in court. Advised that I could not get instructions.

[Magistrate] indicated that the court papers had been marked hearing difficulties.

I advised that I did not experience any issues but rather that it was another issue.

HH asked me to attempt to get further instructions with the benefit of microphone at 2pm.

I again spoke with Shane. Again would not give me instructions.

'I wont talk to you', 'don't understand' There did not appear to be hearing issues and he was responsive. However would not give me inxs in his matter.

HH has indicated PNG already entered. He was going to set a hearing date but I suggested a JH assessment on Monday.

We were told that JH Officer on leave this week so uncertain whether anyone could assess this week.

..."

51 Email 7.3.2017, tab 75-1.

86. On 13 March 2017, a solicitor with the Aboriginal Legal Service noted with respect to Mootidjah that:[52]

> " – history of chronic ear infections
>
> - Told JH deaf.
> - perhaps warrant could be endorsed to have his hearing assessed..."

87. Available records do not show if the relevant court paperwork was marked to recommend a hearing assessment or of such request being communicated to Justice Health.

88. On 13 March 2017, during a mental health assessment, it was noted as regards Mootidjah' medical history that *"chronic bilateral [?] otitis media"* and *"amputated foot [?]".*[53] He was placed in a camera cell with 20 minute observations recommended on 15 March 2017.[54]

89. Also on 15 March 2017, Aboriginal Welfare Officer Elayne Bell was asked to speak to Mootidjah to determine whether he would engage in the CSNSW screening process. Ms Bell attempted to speak to Mootidjah that same day. However, Mootidjah refused to engage with Ms Bell. [55]

90. On 21, 23, 27 and 31 March 2017 Mootidjah was noted to be refusing to speak to staff.[56]

91. On 31 March 2017, Dr Matthew Hearps (MRRC psychiatrist) issued a schedule under s 19 of the MH Act, noting Mootidjah presented with a high level of agitation and aggression with no apparent trigger.[57]

92. On 3 April 2017, Dr Tuan Nguy (Consultant Psychiatrist) reported that Mootidjah was refusing antipsychotic medications and presented that day as

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52 File note 13.3.2017, tab 76-1.
53 MHOAT 13.3.2017, tab 80-4.
54 At risk notice 15.3.2017, tab 45.
55 OIMS 15.3.2017, tab 35-1
56 Case notes (e.g., responding *'fuck off'* when spoken to).
57 Schedule 1 31.3.2017, tab 81.

aggressive and refusing to cooperate in any assessment including with Aboriginal Health worker. He was in a RIT safe cell with daily observations.[58]

93. On 4 April 2017 he was 'highly aggressive and verbally abusive to staff' and refused to engage in a RIT review.[59]

94. On 5 April 2017 an order was made under s 55(3) of the *Mental Health (Forensic Provisions) Act 1990* (**MHFP Act**) to transfer Mootidjah to a mental health facility.[60]

Transfer to Westmead Hospital on 6 April 2017

95. On 6 April 2017, Mootidjah was transferred to Westmead Hospital urgently for treatment of his septic left foot (which was severely swollen and hot to touch and reported fevers).[61]

96. Mootidjah underwent surgery to amputate his right hallux, left hallux and left second digit (toes).[62] A provisional diagnosis of diabetic foot ulcer (necrotic with pus tracking into the joints) which likely related to neuropathy secondary to previous leprosy.[63]

97. On 8 April 2017, Mootidjah was discharged after reported conflict with his treating staff, including him becoming abusive and refusing medications. He was transferred to the Mental Health Screening Unit at the MRRC.[64]

98. Thereafter, Mootidjah reportedly isolated in his cell, refused to show his wound to medical and nursing staff and presented as paranoid and agitated stating '*I don't trust you college students*' and refused to engage with the General Practitioner in custody. He also refused all physical observations and

58 Progress note 3.4.2017 (11:10) tab 81-72; Nguy report 3.4.2017, tab 81-178 and tab 81-180.
59 OIMS 4.4.2017, tab 35.
60 MHRT order 30.5.2017, tab 53-39.
61 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70; Electronic progress note 7.4.2017, tab 80.
62 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70; Westmead letter 28.11.2017.
63 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70.
64 Discharge summary for 8.4.2017 (printed 8.5.2017) (noted within discharge summary that psychiatry at Westmead Hospital was contacted to assess Douglas's capacity to consent); JH progress notes 8.4.2017, tab 81.

observations to monitor for infection such as temperature and blood pressure.[65] For instance, it was noted:

(a) *10 April 2017*: Mootidjah was being hostile, abusive, and demanding with the RIT team and an assessment could not be conducted.[66]

(b) *12 April 2017*: a schedule was issued under s 19 of the *Mental Health Act 2007* (**MH Act**), with Mootidjah noted as agitated, abusive, refusing to engage in interview or have his wound reviewed.[67]

(c) *16 April 2017*: while in the Mental Health Screening Unit (**MHSU**), Mootidjah was noted to initially be polite and cooperative but then suddenly changed and refused to continue with the interview.[68]

(d) *18 April 2017*: Mootidjah was noted to be calm and cooperative. He denied negative feelings towards staff but would not let persons look at his foot wound. He was compliant with medication.[69]

99. Staff noted his room was increasingly foul-smelling and they were concerned his wound was infected.

Transfer to LBH on 19 April 2017

100. On 19 April 2017, owing to his refusal to engage in treatment, which was considered secondary to underlying psychosis, he was transferred to LBH.[70] A Justice Health progress note on this date noted his psychotic illness may have been exacerbated recently by his incarceration and foot disease.[71]

101. On 21 April 2017, Dr Meredith Gray (Psychiatric Registrar) issued a notice under s 56 of the MHFP Act certifying her opinion that Mootidjah ought to remain in a mental health facility for treatment. Dr Gray also noted Mootidjah had been transferred to LBH after refusing treatment for his psychosis and his foot and expressing paranoid delusions about staff along with aggressive

65 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017, tab 70.
66 OIMS 10.4.2017, tab 35.
67 Schedule 1 12.4.2017, tab 36.
68 OIMS 16.4.2017, tab 35.
69 OIMS 18.4.2017, tab 35.
70 HPNF 19.4.2017; Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70.
71 JH progress note 19.4.2017 tab 81.

behaviours and major disorder of thought. His behaviour at LBH included him being withdrawn and hostile and shouting without provocation, with his verbal abuse indicative of thought disorder. There was no indication of delirium and it appeared he had experienced a relapse of psychosis owing to medication non-compliance.[72]

102. On 1 May 2017, Mootidjah refused to give a blood sample stating, '*I don't want nothing to do with you, I don't like you all*'.[73] On 3 May 2017 he was dismissive of nursing staff and refusing to allow a change of his foot dressing.[74]

103. On 5 May 2017 he was reported feeling 'fine' and appeared relaxed and cooperative.[75]

104. On 8 May 2017, a psychiatrist at LBH attempted to interview him. Mootidjah stated he did not want to speak to her in an aggressive manner when she persisted.[76] A HPNF issued that same day noted Mootidjah had had two toes recently amputated from his left foot and that he was suitable for a non-camera cell.[77]

105. By 23 May 2017, Mootidjah' treating mental health doctor considered Mootidjah was presenting as far '*warmer and more engaging*'. He reported sleeping and eating well and not experiencing auditory or visual hallucinations.[78]

106. On 30 May 2017, the MHRT ordered Mootidjah remain detained in LBH being a mental health facility to receive care and treatment.[79]

107. Justice Health records in June and July 2017 recorded ongoing improvements or stability in his mental health presentation. That included him presenting as cooperative and pleasant (6.6.2017), presenting without overt psychotic symptoms (5.7.2017) and complying with his wound dressing for his foot

72 Medical Report (Dr Gray) 21.4.2017, tab 66E.
73 JH progress note 1.5.2017 tab 80.
74 JH progress note 3.5.2017 tab 80.
75 JH progress note 5.5.2017 tab 80.
76 OIMS 8.5.2017, tab 35; JH progress note 8.5.2017, tab 80.
77 HPNF 8.5.2017, tab 80.
78 JH progress note 23.5.2017 by Dr Gray, tab 80.
79 MHRT order 30.5.2017, tab 67C.

(9.7.2017). There are several noted references to his self-reports to nursing staff - '*good miss*' and '*yeh alright*' (e.g., frequent notations about him being superficially polite and cooperative). He was also considered to be having minimal interaction with other patients.[80]

108. On 6 July 2017, Mootidjah underwent a mental health assessment by Dr Antonio Simonelli (Consultant Psychiatrist) and Dr Meredith Gray (psychiatric registrar). He was cooperative with parts of the assessment but noted to be guarded about his mental health and to become irritable and verbally aggressive when discussing his foot wound and incarceration. His thought form appeared disordered at times. He was diagnosed with schizophrenia with a relapse secondary to medication non-compliance and multiple stressors including social isolation and homeless with mild cognitive impairment. It was considered Mootidjah was likely suffering a disease of the mind at the time of his March 2017 offending.[81]

109. On 20 July 2017, the MHRT made a 12 month community treatment order (**CTO**).[82] He was being medicated with Clopixol depot 200 mg intramuscular once a fortnight and Olanzapine 10 mg twice a day.[83] That same day he entered pleas of guilty to resist officer in the execution of duty, affray and assault police. The remaining charges were withdrawn. He was committed for sentence to the District Court.[84]

Assessment on 21 July 2017

110. On 21 July 2017, a mental health staff specialist documented on 25 July 2017:[85]

> "[Mootidjah] was assessed at MRRC [25 April 2017] to be demonstrating signs of mental illness. He was behaving in a bizarre & aggressive way. He appeared highly agitated & was [?] irritated. He admitted to having auditory hallucinations. He also had a deteriorating toe but was refusing

80 Medico-Legal Psychiatric report for MHRT hearing 5.7.2017 tab 70; during this period his foot care was managed by Dr Spasojevic and he was prescribed oral antibiotics.
81 Medico-Legal Psychiatric report for MHRT hearing 6.7.2017 tab 70.
82 OIMS 13.7.2017 and 27.7.2017, tab 35; MHRT order 20.7.2017, tab 81-544.
83 JH Treatment Plan 12.7.2017, tab 67E.
84 Court order 20.7.2017, tab 55.
85 HPNF 21.7.2017, tab 37; JH MH Assessment 25.7.2017 tab 80.

any interventions. He was deemed necessary to transfer to LBH for his mental & physical health needs.

...

[Mootidjah] was first admitted to G ward, where he received his first dose of depot involuntarily. He continued to be very changeable & distressed at times. When asked directly, he would admit to auditory hallucinations. Slowly, after multiple doses of depot, this stopped.

[Mootidjah] continued to receive appropriate medical care for his infected toe whilst he was here. This made a complete recovery.

[Mootidjah] has limited insight into his mental health needs."

111. Justice Health progress notes in early August 2017 recorded him as quiet and polite with nursing staff (e.g., report on 3.8.2017 *'I'm good miss'*, mental state stable and observed to be quiet and isolative with minimal interaction with others

Transfer from LBH to MRRC on 10 August 2017

112. On 10 August 2017, Mootidjah was transferred from LBH back to the MRRC after a 3 month 3 week hospital admission.[86] It is understood he remained in general population thereafter.

113. On 25 October 2017 the MHRT reviewed the CTO and confirmed it was to continue without variation with a further review listed on 19 January 2018.[87]

114. On 19 November 2017, it was noted during a mental health review that Mootidjah had not undergone a mental health review in recent times (last review on 5.9.2017). Mootidjah was noted to be 'guarded', 'quiet' with not much interaction with others. He was compliant with medication and presented no management issues.[88]

115. On 28 November 2017, Mootidjah underwent a medical review at the Westmead Hospital Foot Wound Clinic. It was noted at the time that the

86 Inmate Profile, tab 19
87 OIMS 25.10.2017, tab 35.
88 JH MH review by Y. Lin 19.11.2017 tab 81.

'*Hospital previously raised questions over guardianship and pts capacity to consent*' but that prison nursing staff advised he did have capacity to consent. A treatment plan was recommended including special shoes and daily topical antifungal creams to both feet for 6 weeks to ensure he did not develop secondary bacterial infection.[89]

Notations relevant to possible hearing and/or mental health during 2017

116. During 2017, notations were made by Justice Health staff possibly relevant to Mootidjah' hearing and/or mental health (amongst other matters), namely:

(1) 24 April 2017: noted "*Communication at times difficult [ineligible] him slightly hard of hearing and slurred accent. At times does not answer questions directly. ? disorganised thought form*".[90]

(2) 25 April 2017: T Nguyen RN noted that Mootidjah' "*reaction time to questions was slow, seen turning his ear towards speaker. ? deterioration of hearing or ? preoccupied from internal stimuli*".[91]

(3) 28 April 2017: similar notation made as to that on 25 April 2017 by another registered nurse.[92]

(4) 1 May 2017: noted "[D - letter appears in circle] *reports that he has significant hearing impairment, uses special headphones in court but nil other management*".[93] A nurse also noted "*when asked of pain in toe wound pt did not respond, ? secondary to poor hearing*".[94]

(5) 4 May 2017: noted that "*his reaction time to q/s was slow, ? deterioration in hearing*".[95]

(6) 16 May 2017: similar notation made as to that on 4 May 2017.[96]

89 JH letter 28.11.2017 (Honouree Lain, Podiatrist) tab 81
90 JH notation, tab 81–232.
91 Ibid, tab 81-234.
92 Ibid, tab 81-238.
93 Ibid, tab 81-239.
94 Ibid, tab 81-241.
95 Ibid, tab 81-245.
96 Ibid, tab 81-255.

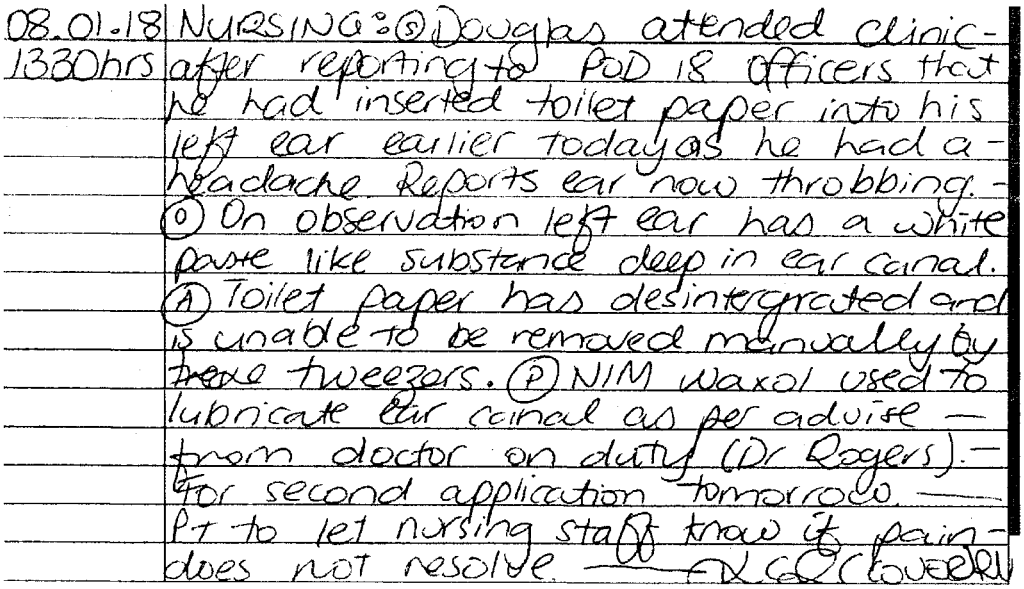
(7) 9 July 2017: noted "*Isolative, minimal engagement with peers. Struggles to communicate [with] staff [shorthand symbol] deadness but he does [possibly reads 'try']*".[97]

(8) 16 August 2017: a MHN notation "*needing questions repeated (deaf)*".[98] Tab 81 – 376.

8 January 2018

117. On 8 January 2018, Mootidjah was seen at the MRRC's Hamden Clinic.

118. The following progress note was made by Registered Nurse Kylie Cover on this date:[99]


08.01.18 1330hrs NURSING: (S) Douglas attended clinic after reporting to POD 18 officers that he had inserted toilet paper into his left ear earlier today as he had a headache. Reports ear now throbbing. (O) On observation left ear has a white paste like substance deep in ear canal. (A) Toilet paper has desintegrated and is unable to be removed manually by these tweezers. (P) NIM Waxol used to lubricate ear canal as per advise from doctor on duty (Dr Rogers). For second application tomorrow. Pt to let nursing staff know if pain does not resolve — KC (Cover RN)

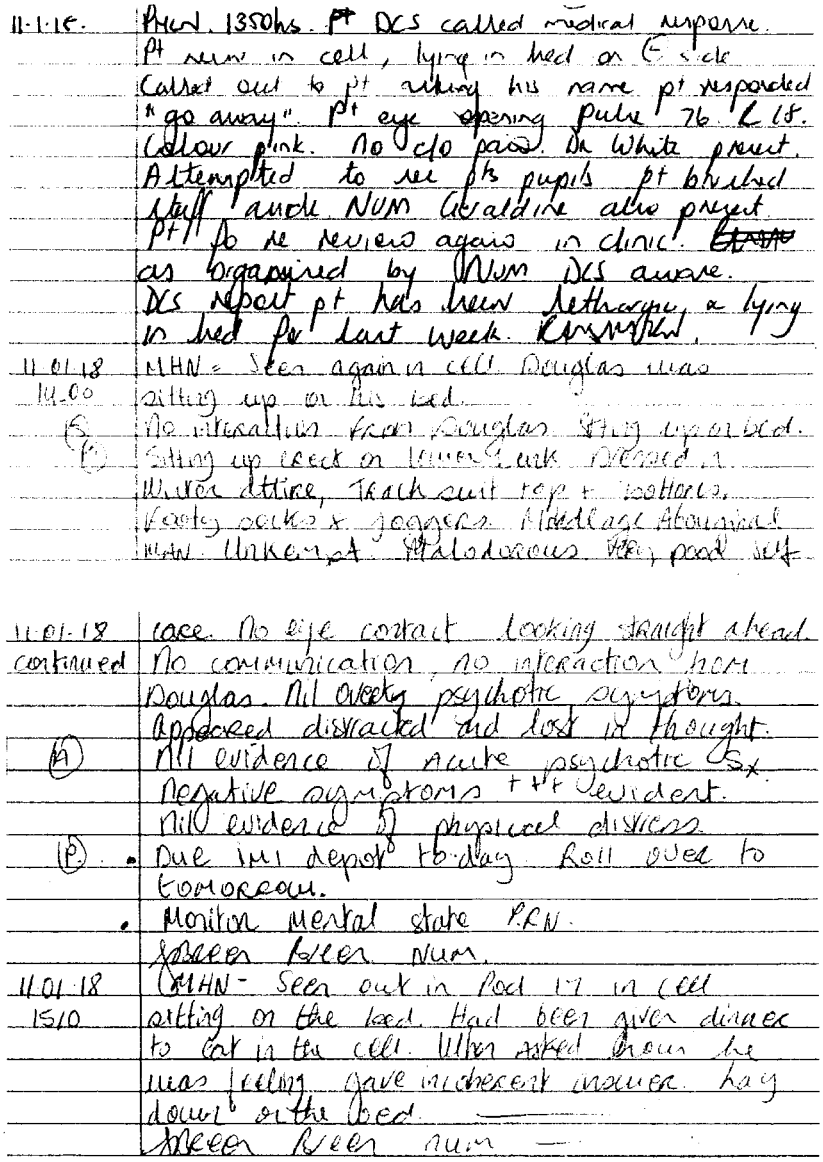
9 January 2018

119. Mootidjah was seen by a mental health nurse for the application of anti-fungal cream to his feet and Waxsol to his ears.[100]

11 January 2018

97 Ibid, tab 81-522.
98 Ibid, tab 81-376.
99 Progress note, tab 81-392.
100 Nichols 1st WS [20] tab 101-4.

120. On 11 January 2018, the following progress notes were made regarding clinician contact with Mootidjah:[101]



11.1.18.	Phone 1350hrs. Pt DCS called medical response. Pt seen in cell, lying in bed on L side. Called out to pt asking his name pt responded "go away". Pt eye opening pupils 7b L 15. Colour pink. No c/o pain. Dr White present. Attempted to see pts pupils pt blocked staff and NUM Geraldine also present. Pt to be reviewed again in clinic. ~~Event~~ as organised by NUM DCS aware. DCS report pt has been lethargic & lying in bed for last week. Confirmed.
11.01.18 14.00	MHN - Seen again in cell. Douglas was sitting up on his bed. No interaction from Douglas. Sitting up erect on lower bunk. Observed in. Wears attire, Track suit top + bottoms. Footy socks + joggers. Moderate Abnormal MSE. Unkempt. Malodorous. Poor self-
11.01.18 continued	care. No eye contact. Looking straight ahead. No communication, no interaction from Douglas. Nil overtly psychotic symptoms. Appeared distracted and lost in thought. Nil evidence of acute psychotic Sx. Negative symptoms + PE evident. Nil evidence of physical distress. (P) • Due IM1 depot tb-day. Roll over to tomorrow. • Monitor mental state RCN. Seen by Nurse.
11.01.18 15.10	MHN - Seen out in Pod 17 in cell sitting on the bed. Had been given dinner to eat in the cell. When asked how he was feeling gave incoherent answer lay down on the bed. Seen by nurse.

12 January 2018

121. On 12 January 2018, Mootidjah was observed walking with ataxic gait and complained of pain. He had a temperature of 38.8 degrees. He was alert and orientated with pale complexion and was clammy to touch. A urine sample

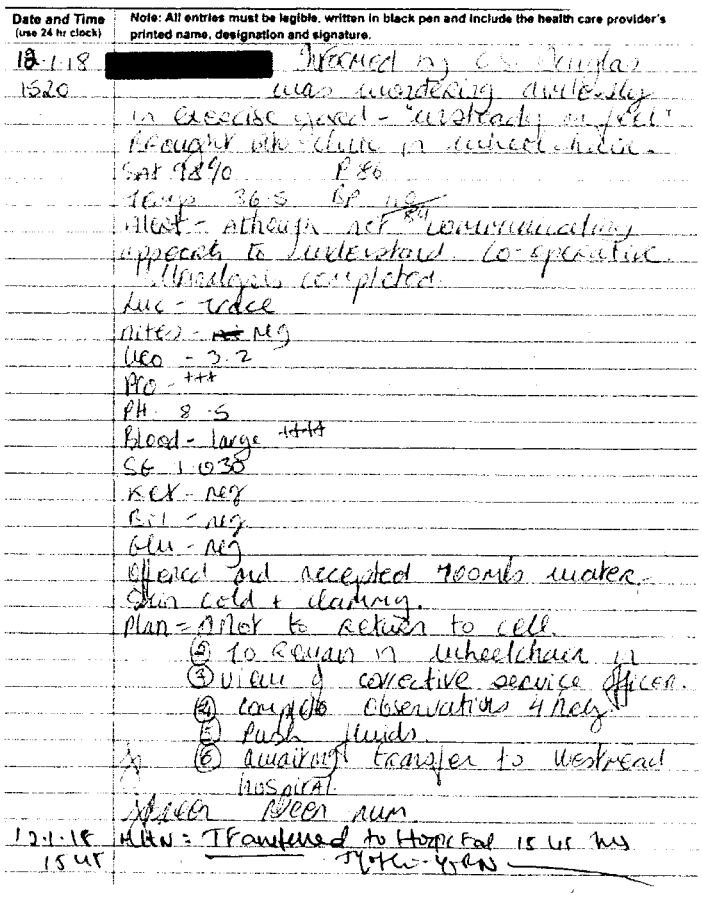
101 Note: Mootidjah was accompanied to the clinic by Corrective Services Officer Aviral Mohan, who has provided a written statement dated 26.2.2021 (tab 14) in which he stated that to the best of his recollection (as at February 2021) when he attended the cell Mootidjah was sitting on his bed but "could not get up" and CSO Mohan got a wheelchair while another inmate helped Mootidjah put his shoes on. The Nursing Unit Manager and doctor attended the cell. CSO Mohan, as at February 2021, did not recall commenting to the nurse or doctor that Douglas had "'been lethargic and lying in bed for a week": Mohan WS [8] tab 14-2.

was sought but none provided as at midday. He was provided paracetamol at about 10 am.

122. The General Practitioner on duty recommended he be sent to hospital for assessment.

123. A notation made at 2:40 pm noted Mootidjah' temperature as 36.5 degrees at 2:40 pm and recorded 'Rhinorrhea evident' (*understood to be condition where the nasal cavity is filled with a significant amount of mucus fluid*).

124. Subsequent notations were made that same day:[102]



Date and Time (use 24 hr clock)	Note: All entries must be legible, written in black pen and include the health care provider's printed name, designation and signature.
12.1.18 1520	[redacted] Treated by CO Douglas was wandering aimlessly in exercise yard - "unsteady on feet" Brought into clinic in wheelchair. Sat 98% P 86 Temp 36.5 BP 119/84 Mood - although not communicating appears to understand co-operative Analysis completed. Leuc - trace Nitrite - NEG Uro - 3.2 Pro - +++ PH - 8.5 Blood - large ++++ SG - 1.030 Ket - neg Bil - neg Glu - NEG Offered and accepted 700mls water. Skin cold + clammy. Plan - Not to return to cell. ② to remain in wheelchair ③ view by corrective service officer. ④ complete observations 4 hrly ⑤ push fluids ⑥ awaiting transfer to Westmead Hospital Officer Peer num.
12.1.18 1545	HMN - Transferred to Hospital 15 us hrs [illegible] MHC-RPN

125. On 12 January 2018 at 5:45 pm, Mootidjah was taken to Westmead Hospital with reported headaches and behavioural disturbance.[103] This occurred after a subsequent two consultations with the mental health nurse at the MRRC.[104]

102 Progress notes, tab 81-395.
103 COPS E 67203476.
104 Coorey WS [36], tab 10.

126. A CT scan revealed a left temporal lobe with vasogenic oedema and some early enhancement of the rim indicating focal cerebritis.

127. On 13 January 2018, he underwent an emergency procedure to evacuate the left temporal abscess. The procedure involved the insertion of an extra-ventricular drain (**EVD**).[105] Subsequent imaging showed an improvement in his hydrocephalus (understood to be an accumulation of cerebrospinal fluid within the brain).[106] It appears from Justice Health records he remained intubated after this procedure.

128. On 25 January 2018, he was tracheostomised (procedure involving the creation of an opening in the neck and insertion of a tube into the windpipe to allow air into the lungs). This was done as he was unlikely to recover his capacity to protect his airway (e.g., by cough, gag, swallow reflex, consciousness).[107]

129. On 29 January 2018, he shifted from the intensive care unit (**ICU**) to a medical ward. At some point his EVD was removed on ward.

130. On 9 February 2018, Mootidjah became deeply unconscious (GCS E1M1VT). Repeat CT showed dilated ventricles with mass effect. An EVD was re-inserted, and he was readmitted to ICU owing to his poor neurological recovery.[108]

131. On 13 February 2018, the EVD was removed. He showed no signs of significant neurological recovery after a month of extensive interventions. In the view of Professor Iredell little more that could be done by way of neurosurgical and critical care intervention.[109]

132. On 14 February 2018, his ventilator was removed but he remained Tracheostomised. His next of kin, [redacted] (cousin), in consultation with his treating doctors, approved his transfer to palliative care.

105 Report of Death to the Coroner (Form A) 15.2.2018, tab 2; Iredell WS 4.11.2019, tab 11.
106 Westmead Imaging Report 13.1.2018 at 1:11 pm.
107 Iredell WS 4.11.2019, tab 11.
108 Iredell WS 4.11.2019, tab 11.
109 Iredell WS 4.11.2019, tab 11.

Passing on 15 February 2018

133. On 15 February 2018, at about 5:08 pm, his tracheostomy was removed. Dr Anubhav pronounced life extinct at 5:38 pm.

Cause of death

134. In the opinion of Professor Iredell, death was caused by a severe intracranial infection (left temporal abscess) which resulted in intracranial spread of infection, systemic sepsis, and major neurological injury. The left temporal abscess was associated with mastoid osteomyelitis and extensive associated intracerebral venous sinus thrombosis. The origin of the cerebral abscess was *"almost certainly his left middle ear infection"*.[110]

135. The mastoid bone is positioned in the back part of the temporal bone behind the inner ear. Bacteria spreads from the middle ear to the mastoid's air cells (within the bone) where inflammation causes damage to bony structures.[111] Cerebral venous sinus thrombosis occurs when a blood clot forms within the brain's venous sinuses which prevents blood draining from the brain.[112]

Final

136. Ms [redacted][113] and his aunt, [redacted], were present for Mootidjah's passing. Formal prayers were conducted by an Aboriginal pastor. Police attended the hospital on 15 February 2018 at about 7:55 pm and interviewed Mootidjah' relatives and declared a crime scene.[114]

END

110 Iredell WS 4.11.2019, tab 11.
111 https://en.wikipedia.org/wiki/Mastoiditis.
112 https://en.wikipedia.org/wiki/Cerebral_venous_sinus_thrombosis.
113 Also referred to as Ruby Douglas.
114 Incident report, S. Paszek SCO 15.2.2018.

ANNEXURE – TIMES IN CUSTODY

Period in custody	*Approx. duration in custody*
9 May 1997 to 12 Mar 1998	10 months
28 Apr 1998 to 25 May 1998	1 month
15 Aug 2001 to 5 Oct 2001	1 ½ month
21 Aug 2002 to 14 Apr 2004	½ month (combined)
21 Jul 2004 to 23 Aug 2004	1 month
4 Oct 2005 to 30 Nov 2005	2 months
14 Mar 2006 to 23 May 2006	2 months
24 Jul 2006 to 6 Oct 2006	2 ½ months
20 Jun 2007 to 3 Jul 2007	½ month
4 Mar 2011 to 17 Sep 2011	6 months
13 Mar 2013 to 11 Aug 2015	2 ½ years
23 Oct 2015 to 18 Nov 2015	1 month
3 Mar 2017 to 15 Feb 2018	11 months

Annexure B: Submissions on behalf of the family

THE DEATH OF MOOTIJAH

SUBMISSIONS IN THE INQUEST INTO HIS DEATH IN CUSTODY
FOR THE FAMILY

1. Mootijah was a son, a brother, a father, a nephew and a cousin. He was a Budjiti and Muruwarri Man. He had a powerful name: Mootijah, the "strong one", a warrior.

Memorial

Mootijah's Aunt [redacted] - a farewell (see annexure 1 below):

[O]ur brother Mootijah may your journey to the dream time was a blessed one with all his families. Douglas Mootijah Shillingsworth, your life isn't measured by the years you have lived it's measured by the love you gave and the little things you did.

To live in the hearts of people who loved you is never to die. Because deep down those whose lives you have touched during your journey through life will each have their own special memories of you. Maybe something you said, the way you looked at them. The tone of your voice, the memories you may have shared or the yarns you told and or made up. The songs you liked to listen to, the photos they may have with you in them. You will be remembered Brother in more ways than one. May peace be with you. For you are gone but not forgotten. To some you are a memory, to others just a name, but to those who loved and lost you, Your memories will remain

We will miss you in our lives Mootijah.
The [redacted] and [redacted] families of Whalan and Minto.
A special thank you to Narrelle Holden at Westmead Hospital
for her enormous support, strength and kind words during our time of sadness,
with our brother Mootijah at Westmead.
May God Bless you abundantly.
And a big thank you to Pastor George Mann of Bourke
Pastor Rick and Sister Josephine Manton of Mt Druitt
and cousin [redacted] also
May you rest in Peace Our Brother Douglas Mootijah Shillingsworth for you are loved, sadly missed and forever walking the corridors of our heart and minds.

[redacted]

ANNEXURE 1

FAMILY IMPACT STATEMENT

Yaama Gurra - Hello and Welcome
Mukinj – halkaa ngura maying kalkaangura
(Many ladies and gentleman)

Firstly I would like to acknowledge the Dhurak clan of the Eora Nation on whose land we are convening on today. I would also like to acknowledge my Elders past, present and upcoming and my ancestors who have walked this land before it was colonised.

Unfortunately our families, the [redacted] and [redacted] families of Brewarrina, Bourke, Enngonia and Weilmoringle realise that we will never get full justice for our beloved Brother, Uncle, father, nephew, son and cousin, Douglas Mootijah Shillingsworth. From here on; hence I will refer to Douglas by his tribal name which is "Mootijah" meaning "strong one" – a warrior in Murrawarri language.

Although, there will be no justice, we sincerely hope that his Death in Custody will bring about change. His death has left his family devastated to the core in all forms of incapacity; it leaves a soul searching sense of why such an enormous impact from a general health issue that plays a significant stance in Aboriginal social health and of which is a generalised health issue in most Aboriginal communities across this vast continent. Ottis Media – a simple ear infection which caused an abscess on the brain, can be and normally would be treated with antibiotics medication plus antibiotic eardrops and pain relief tablets.

Mootijah's death has left a devastating impact on our families and leaves us in a state of anguish, disbelief, heartbreak and utterly dismayed and so overwhelmed and very disappointed in knowing that Mootijah's health issues has been left untreated and caused his demise in custody. We often question each other as to all the ifs and buts and whys. Why was his death so premature? We might easily find the answer to this question but that still doesn't compensate us for his death in custody.

Like I said previously all our families are still hurting more so from the disbelief and awe inspiring questions that haunt us when we think of Mootijah; when we see his totem (moiety), when we see, listen or tell Mootijah stories and hear his song on the breeze. We will look at his photos and not get any answers but a great sense of numbness, shock and lost. Mootijah was a son, a brother, a father, a nephew and a cousin.

I want to acknowledge the River people of the Ngemba/Weilwan Nation on the Barwon/Darling River, who's land we are laid to rest our brother Douglas aka Mootijah.. I would like to acknowledge the Budjiti and the Murrawarri Nations of which Douglas is a descendant. , I would like to pay respect to our Creator who in Murrawarri language is Bidju Ngulu.

We must consider two daughters – [redacted] and [redacted], his son [redacted], and especially his niece [redacted]. We think of his extended families of [redacted] and [redacted] families and their descendants which includes the [redacted] and [redacted] families.

I want to say upfront; Douglas Mootijah Shillingsworth is now another statistic in Aboriginal Deaths in Custody, which is a very sad state of affairs and one that could easily have been prevented had he been properly monitored by Justice Health and had his legal issues addressed appropriately. These issues are what bring us to this untimely and unfortunate circumstance where we now, as Douglas' extended

families have to mourn for our father, Brother, uncle, cousin and nephew.

Douglas was born on the 6th August 1973 to Aunty [redacted] and Uncle [redacted]. He was the final member of a family of five, who had all succumbed to the Heavenly Dreamtime at an early age. Mootijah spent his early years growing up in Enngonia mostly, with some time spent with his family in, Bourke, Brewarrina and Weilmoringle. Some of his early years were also spent in Kinchella east of Kempsey on the Mid North Coast of NSW, where his dad: Uncle [redacted] was a Drug & Alcohol Councillor, Mentor and bus driver for Benelong Haven. When Douglas was old enough he would always venture back to Enngonia, Brewarrina and Bourke where his extended families lived. So that he could continue with Weilmeringle cultural practises and family cultural traditions. Like going out hunting wild animals to cook up for family gatherings and celebrations. Mootijah especially loved fishing in the rivers and catching booglies aka crayfish in the billabongs and waterholes out at Enngonia, Weilmoringle and Bourke with his families.. Although Mootijah didn't say much, he always participated in cultural events wholeheartedly and gave his all.
"Mootijah" meaning Strong One- A Warrior but I know that during his many stop overs at Dodge City with our families, my Mum & Dad called him Muginj man, Muginj means "woman" in Murrawarri, so I take it that he was referred to as a ladies man maybe because of his smile and his good looks. When I think of Mootijah, I smell Bryl hair cream and picture a little black comb he used to pull out of his back pocket or jacket, his dad, Uncle [redacted] was the same, as was his Uncle [redacted] who was his Dad's baby brother, even though they all ended up going bald on top, they shared that same trait.

Mootijah was a very quiet man, he was very shy but there always was a smile or a slight grin on his face. He loved having a yarn up if he felt comfortable with you. If he didn't know you very well or just met you for the first time, you wouldn't get "BOO" out of him. You know how some people loved having family around them all the time, well at times Mootijah was the opposite. He was a bit of a loner, who was with you one minute and then off on an adventure somewhere else the next. If Mootijah chose to hang out with you then that was a special privilege.

Mootijah's personality was that of his Mum, Aunty [redacted] who was small of stature very softly spoken and spoke only if she was comfortable around you. Mootijah's physical attributes were that of his Dad, Uncle [redacted] who was tall and of big build and could be loud and boisterous at times. Mootijah had smiling eyes and a very soft laugh and like I said, he would let himself go and open up if he felt comfortable being around you.

One thing I can say about Mootijah is that he held his Aunties in very high esteem. Aunty [redacted], Aunty [redacted], Aunty [redacted], Aunty [redacted], Aunty [redacted], Aunty [redacted] and my Mum the Bushqueen, these beautiful ladies weren't his Aunties, they were his "Mummas" and that's what he called them all Mootijah, like his eldest brother [redacted] and sister [redacted] called our old Dad, Dad or Pop out of love and respect. Mootijah;s love for all his uncle and aunties who had passed were unconditional, he was very fond of his Uncle [redacted] & Aunty [redacted], Uncle [redacted], Aunty [redacted], Aunty [redacted], Aunty [redacted], Aunty [redacted] and Aunty [redacted]. He always said that he loved his old people. Mootijah adored his elders and placed them on a pedestal and said nothing should happen to our old people for they are our Universities.; meaning that they are our teacheers our educators.

Sometime during his journey through life Douglas met and fell in love with [redacted], they went on to have two children a girl they named [redacted] after his grandmother [redacted] and he's other Mumma Aunty [redacted]. After [redacted] came his son [redacted]. [redacted] They were reared up [redacted] in the Northern Territory. This was the most painful part of Mootijahs life. He craved and pined to be with his two children. This left him a very lonely man, heartbroken and deserted. But being the strong warrior he was. He overcame this. Even though it hurt him as much as losing his parents and eldest brother and his one and only sister. But to him life prevailed and he soldiered on. Then a couple of years later he met [redacted], they had a very brief relationship and along came his second daughter [redacted] Mootijah loved his children very much and would often say "Gee I wish I could see my kids and spend time with them", he was

always hurting for the family he lost contact with but loved so very much.

Before Mootijah moved down to Mt Druitt, he spent some time living in Dubbo with his Cousins' [redacted] who he called Sister on [redacted] and his big Cousin/brother [redacted] & [redacted] in [redacted], he felt very much welcomed and loved in these two homes in return he loved and respected their families so very much too. The last couple of years of Mootijah's life were spent in Whalan, Mt Druitt with his Whalan & Minto [redacted] families. He lived at his cousin [redacted] place on [redacted] Whalan. He loved spending time with [redacted] & his little family, and with [redacted] and [redacted] Mootijah once told his cousin [redacted] that he had no family any more, that he was one out on his own like a bird on a biscuit tin and [redacted] told him "We'll be your family. We'll love you and treat you as one of our own. Mootijah had his own space in the backyard shed which he converted into a bedroom and the families used to gather in the backyard for family time together. Mootijah and [redacted], who he regarded as his little Sister used to fight like cats and dogs. One time [redacted] pups got into his room and made a mess, so he picked them up and slung them around the yard. [redacted] rang the police for him but they made up and laughed it off. Mootijah loved and respected Sister [redacted] and her family very much. One thing I can say about Douglas Mootijah Shillingsworth was that if you showed him love and affection, he returned it tenfold.

I was informed by Wayne Cook - the prison Chaplan that a couple of months ago Mootijah requested a Bible, he mentioned that Douglas would go through the bible find versus, then quote them back to him on his next visits and they would discuss them. I truly believe that Mootijah handed his life over to Jesus and our Creator as he saw them. I contacted Pastor George Mann to bless us with his prayers over the phone, I also invited Sister Kaylene and Pastor Rick Manton of the Aboriginal Fellowship in Tregear, Mt Druitt to come visit Douglas for a Prayer meeting. It was during these prayers that tears started rolling down Douglas' Cheeks as well as mine and [redacted] We knew in our hearts then that he was being welcomed with open arms of his family that were already waiting for him in the Heavenly Dreamtime. Mootijah is now re-united with his Mum Aunty [redacted] Dad Uncle [redacted] big sister [redacted], and big Brother [redacted] and all his extended families who have passed before him.

We know that our brother Mootijah may your journey to the dream time was a blessed one with all his families. Douglas Mootijah Shillingsworth, your life isn't measured by the years you have lived it's measured by the love you gave and the little things you did.

To live in the hearts of people who loved you is never to die. Because deep down those whose lives you have touched during your journey through life will each have their own special memories of you. Maybe something you said, the way you looked at them. The tone of your voice, the memories you may have shared or the yarns you told and or made up. The songs you liked to listen to, the photos they may have with you in them. You will be remembered Brother in more ways than one. May peace be with you. For you are gone but not forgotten. To some you are a memory, to others just a name, but to those who loved and lost you, Your memories will remain

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with our brother Mootijah at Westmead.
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and cousin [redacted] also
May you rest in Peace Our Brother Douglas Mootijah Shillingsworth for you are loved, sadly missed
and forever walking the corridors of our heart and minds.

[redacted]

I like to acknowledge the traditional owners of this country the Dhurak people on which this court is sitting today and their elders, past, present and ongoing.

My name is [redacted]. I have been [redacted] partner husband and carer for the last 30 years. I am a vegetation ecologist and cultural mapper having worked with Aboriginal nations in Western and North Western NSW in documenting their cultural values for plants.

In seeking to address this court, I do so not for these nations, nor for Mootijah's family but for the Aboriginal men, like Mootijah that have died in custody and for the loss that it is having and has had, on young Aboriginal boys and adolescences.

First of all let me explain something that has not been told about Mootijah. Mootijah was an Aboriginal/Budjui man who spent most of his life, growing up and around on Murrawarri Country – Brewarrina, Ennonia, Weilmoringle and Bourke.

The Murrawarri like most Aboriginal nations in NSW are known by their country for example, the Wiradjuri are the people of the three rivers. The Ngaampa are the back country people. The Gamilaroi are the people of the Narran. The Murrawarri are the people of the Gidgee Country. Gidgee grows almost exclusively in NSW, North of the Barwon River which us white people know call the Darling. For the Murrawarri it is a plant of exceptional value that not only defines them, but along with Mulga and Beefwood are their tool making trees. For the Murrawarri do not have art sites, like the Ngaampa on the south side of the Barwon, they have their tools.

From Gidgee and Mulga, the Murrawarri made tools that were highly prized by all their neighbours, spears and womens digging sticks. For us ecologists, botanist, there is only one Gidgee tree Acacia,Cambagie but for the Murrawarri, there are two Gidgee common and ring, ring Gidgee was prized amongst all other tool making trees of ring gidgee were traded amongst NSW into Victoria and SA and Murrawarri were master craftsmen and toolmakers and tools made by them were highly prized.

For Mootijah growing up in a traditional environment, he would have been aware of all of this. He would have seen Men hunt for Kangaroo and Emu, seen them skin them and cook them in traditional ovens, with special plants to lessen the gamey taste. He would have been shown how to identify ring gidgee and to shape and cut it into prized tools. As has been told by my wife, he would have walked his country, visiting family in Bourke, Brewarrina, Weilmoringle and Enngonia. He would have heard the stories of Bidjunugulu and known of the places sacred to the Murrawarri. His mothers and aunties would have sung the songs that told of country and culture. He grew up with Men who knew their culture and the culture of the Gidgee people.

In his own way, Mootijah, was a knowledge holder, he knew his country, had walked it and seen it. He knew his culture and its stories. He had heard it from the old people and seen the places that matter and spoke to the knowledge holders. He was in everyway a walking encyclopaedia of Murrawarri culture.

For young boys the loss of men like Mootijah is like burning a library down. Mootijah's role was to pass these stories and cultural knowledge onto the young to teach them about country and culture. When traditional men like Mootijah die before their time, it is like a whole section of the library vanishes into the mist. Boys and young men, no longer have role models to teach them about culture and country and how to be strong Murrawarri men. They no longer have strong traditional cultural men to teach them, to show them country and learn about tool making, plants and animals that make up their cultural lands.

While my wife and Mootijah's family grieve for his loss, it is his loss that has the greatest impact on Murrawarri culture and men.

Mootijah's loss impacts boys and adolescences and this is the greatest loss for Murrawarri men. The institutionalisation of Aboriginal Men and their early death, leaves a hole in Aboriginal culture that is extremely hard to fill. While this court cannot deal with this issue – it needs to be raised and acknowledged. It needs to be spoken about and addressed with positive outcomes and solutions.

[redacted]