CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Mohamed Warwar
Hearing dates:	18 – 27 March 2024
Date of findings:	21 May 2024
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, natural causes, HPNFs, record keeping, communication between correctional officers and nursing staff
File number:	2021/302441
Representation:	Counsel Assisting the inquest: B Fogarty of Counsel i/b Solicitor, Coroner's Court of New South Wales. The Warwar family. The A/Commissioner, Corrective Services NSW: G Gemmell of Counsel i/b Department of Communities and Justice, Legal. The Chief Executive, Justice Health and Forensic Mental Health Network: K Holcombe of Counsel i/b Minter Ellison. Correctional Officers Achal Sood and Michael Fletcher: D Nagle of Counsel i/b McNally Jones Staff Lawyers. Registered Nurses Jilane Sarjeant and Rabiah Kasim: N Dawson, Solicitor Advocate i/b NSW Nurses and Midwives' Association.
Findings:	**Identity** The person who died is Mohamed Warwar. **Date of death**: Mr Warwar died on 23 October 2021 between 3:28am and 8:00am. **Place of death**: Mr Warwar died in cell 213 of Fordwick Pod 7, at the Metropolitan Remand & Reception Centre, Silverwater. **Cause of death:** The cause of Mr Warwar's death is cardiac arrhythmia with amisulpride toxicity, and myocarditis being contributory factors. **Manner of death:** Mr Warwar died of natural causes.
Non-publication orders:	Pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), non-publication orders have been made in this inquest. A copy of the orders can be found on the Registry file.

Introduction

1 Mr Mohamed Warwar died at the Metropolitan Remand and Reception Centre (**MRRC**) on 23 October 2021.

2 Because Mr Warwar died while in custody, an inquest is required by the *Coroners Act 2009* (NSW) (**the Act**).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

The Coroner's role

4 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

5 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act; namely:

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of death of the person's death.

6 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

7 Prior to holding an inquest a detailed coronial investigation is undertaken. Investigating Police compile a brief of evidence and a report is obtained from a forensic pathologist as to the cause of death. Given that Mr Warwar's death occurred whilst he was in custody in a correctional facility it was thoroughly investigated by Detective Senior Constable Catherine Micallef, who obtained correctional centre records, including medical records. The Police also interviewed correctional officers, medical staff and Mr Warwar's sister, SW.

8 The coronial investigation also obtained relevant policy documents, CCTV footage and received a Serious Incident Report undertaken by an investigator from the Corrective Services NSW (**CSNSW**) Investigations Branch.

9 All the documents and witness statements obtained during the investigation formed part of the brief of evidence tendered to the inquest. All that material has been considered in making the findings detailed below.

Witnesses

10 The following witnesses gave oral evidence in the inquest:

- Achal Sood, First Class Correctional Officer (**CO**), CSNSW;
- Michael Fletcher, First Class CO, CSNSW;
- Rabiah Kasim, Registered Nurse (**RN**), Justice Health & Forensic Mental Health Network (**Justice Health**);
- Jilane Sarjeant, Primary Health RN, Justice Health;
- Tenille McDowell, Mental Health RN & Clinical Nurse Consultant (Projects, Policies and Procedures), Justice Health;

- Therese Sheehan, Deputy Director of Nursing and Midwifery, Custodial Health, Justice Health;
- Adam Wilkinson, Custodial Director Metro East, CSNSW;
- Dale Ashcroft, Governor, MRRC, CSNSW;
- Malcolm Brown, General Manager, Statewide Operations, Security and Custody, CSNSW;
- Andrew Manousso, A/Manager of Security, CSNSW Academy;
- Professor Alison Jones, Court-appointed Specialist General Physician and Clinical Toxicologist;
- Associate Professor Mark Adams, Court-appointed Cardiologist;
- Conjoint Professor Matthew Large, Court-appointed Psychiatrist; and
- Dr Michael Robertson, Court-appointed Pharmacologist and Forensic Toxicologist.

Issues considered in the Inquest

11 A list of issues was prepared and circulated to the interested parties before the inquest commenced. These issues guided the coronial investigation and were considered at inquest. The issues examined included:

(1) the cause of death.

(2) the likely time and date of death.

(3) the adequacy and appropriateness of the care and treatment provided to Mr Warwar whilst detained at the MRRC from 17 October 2021 until 8am on 23 October 2021, including:

(i) the adequacy of the Health Problem Notification Forms (**HPNFs**) completed by Justice Health staff;

(ii) CSNSW officers' attention to and application of the HPNF's;

(iii) whether Mr Warwar was allocated a suitable cell placement;

(iv) whether the response of CSNSW staff to the two knock-up calls made by Mr Warwar on 22 October 2021, and to the knock-up call made by an inmate in a neighbouring cell on 23 October 2021 in relation to Mr Warwar, was adequate and appropriate;

(v) the adequacy of any communication between CSNSW and Justice Health staff on 22 and 23 October 2021 in relation to any request made by, and/or on behalf of, Mr Warwar for medical attention, including any action undertaken by staff in response to same;

(vi) the adequacy of any hand-over(s) done about Mr Warwar between staff by each of CSNSW and Justice Health staff internally (and the record-keeping of any such hand-over) on 22 and 23 October 2021;

(vii) the adequacy of CSNSW and Justice Health staffing responsive to Pod 7 from 11pm on 22 October 2021 until 8am on 23 October 2021; and

(viii) the general care and attitude of CSNSW and Justice Health staff towards Mr Warwar's physical and mental health condition and presentation from 11pm on 22 October 2021 until 8am on 23 October 2021.

(4) the adequacy of any records made by CSNSW staff and Justice Health staff about Mr Warwar from 11pm on 22 October 2021 until 8am on 23 October 2021.

(5) whether Mr Warwar's physical and mental health in the lead-up to his death on 23 October 2021, and any deterioration in same, was appropriately identified, responded to and managed by CSNSW and Justice Health from 11pm on 22 October 2021 until 8am on 23 October 2021, given:

(i) his history of drug-induced psychosis;

(ii) his prescription of Amisulpride (Solian);

(iii) his self-reported recent pre-custodial use of methamphetamine and benzodiazepine; and

(iv) his history of substance misuse.

(6) the inconsistency between the post-mortem serum level of Amisulpride detected in Mr Warwar's blood (being 4.4mg/L) and the recorded doses of Amisulpride administered to him whilst in custody and possible causes/explanations for this inconsistency.

Short Background

12 Mohamed Warwar was born in South West Sydney on 2 February 1986, one of two identical male twins. He was 35 years of age when he died. He had been in the custody of CSNSW for only five and a half days.

13 At the time he died he left behind his parents, his sister, his twin brother, his older brother, and a younger brother and their extended families. In a statement tendered into evidence in the inquest, Mr Warwar's sister speaks of her brother loving to play rugby league as a young man and his love of cars. After completing year 12 and having marks to enter university, she says her brother decided instead to start working and building a future. He did a fruit run at one stage and later opened two pizza shops, working each day from open to close to make them a success. He had much love from his family and much promise for his future.

Mr Warwar enters custody in October 2021

14 At about 9:20pm on the evening of Friday, 15 October 2021, Mr Warwar was arrested by NSW Police when pulled over in a vehicle outside his parents' house, conveyed to Bankstown Police Station and charged with 3 counts of possession of a prohibited drug in view of the following items having been found on him by Police: 1x bag containing 0.4grams of methamphetamine, 1x bag containing 0.5 grams of heroin and 1.8 grams of buprenorphine. He was also charged with common assault (DV), licence expired less than 2 years before and contravene ADVO. He was bail refused.

15 Mr Warwar's twin brother had attended the same station earlier in the evening of 15 October 2021, when a former partner of Mr Warwar was there making a report to Police. He told Police his brother (Mr Warwar) was probably having a mental episode, was '*not right*' and was drug affected.

16 When Mr Warwar came into custody at the station at about 9:30pm on the same evening, the Custody Management Record detailed that Mr Warwar was severely uncooperative, unwilling to answer Police questions and prone to random outbursts of yelling and aggression towards Police.

17 Mr Warwar is also recorded as having advised Police he had recently taken heroin and an unknown balloon. However later that evening, at approximately 11:00pm, he told Police he had lied about inhaling the unknown balloon because he wanted to go to hospital for an x-ray. Police did not transfer him to hospital.

18 On 16 October 2021, still in Police custody, Mr Warwar was refused bail on an AVL appearance before a Magistrate.

19 At about 10:20pm on Saturday, 16 October 2021, Mr Warwar was transferred to the custody of CSNSW at Surry Hills Cells.

20 Mr Warwar's sister said in her statement for the Coroner dated 20 May 2022 that *'[i]n August or September 2021, I got diagnosed with COVID. Mum, Dad and my children all tested positive. Mohamed was not living with us at the time, but we did have contact with Mohamed during this time. Mohamed did have some minor cold and flu symptoms but never did any tests*.'

21 On 17 October 2021 Mr Warwar was conveyed to MRRC and housed one-out and commenced mandatory 14 days of COVID quarantine in '*MRR-FORDWICK-UNIT 7-CELL 213-BED 1*'.

22 CSNSW had x-ray body scanning facilities being introduced at MRRC in 2021 and an accompanying Custodial Operations Procedure and Policy (**COPP**) in place. However, they were only in the initial stages when Mr Warwar came into custody on 17 October 2021. Current Custodial Director, Metro East, Mr Adam Wilkinson, gave helpful evidence about the machines, the history of their introduction and operation, as he was the Governor of MRRC in October 2021. He said that '*I think the machines were physically installed however I don't think we completed the radiation safety user licence or the training surrounding at that stage*'. There is no record produced that Mr Warwar underwent x-ray body screening at MRRC between 17 and 22 October 2021.

23 Mr Warwar had a swab for the covid virus which returned a negative result.

24 RN Sarjeant completed a Reception Screening Assessment (**RSA**) of Mr Warwar.

25 It was noted that Mr Warwar had a community GP, had used Benzodiazepines in the last four weeks including Alprazolam, with an indicated use frequency of less than monthly. In respect of his Stimulant Type Substance use in the last four weeks, it was noted that he smoked 2 points of Methamphetamine (e.g. Ice), most days and had last used yesterday.

26 In her statement for the Coroner dated 26 February 2022, RN Sarjeant said that while processing Mr Warwar's admission she asked him, '*Have you had any drugs or alcohol within the last month*?' and he replied, '*No miss. I've been off the drugs for six months', to which she replied, 'Actually Mohamed, you look well.*' RN Sarjeant had had contact with Mr Warwar on previous occasions and remembered him.

27 The RSA recorded in respect of 'Mental Health History': '*Have you ever been told or think you have Schizophrenia? Yes*' and in respect of '*Current medications: Yes*' '*Solian 200mg [Dose] nocte [Frequency]*'.

28 RN Sarjeant assessed Mr Warwar to not be intoxicated and made an appointment for an urgent mental health consult.

29 RN Sarjeant completed a Consent to Obtain Health Information for Continuation of Care Form to Aya Medical Centre (Mr Warwar's GP) for records for Mr Warwar from 2020. In that form, '*Consent is not able to be obtained because the patient is too unwell*' was ticked. Aya Medical Centre responded the same day. Its records detailed in respect of current medications, '*No long-term medications*' and in respect of prescriptions, '*None recorded*'.

30 RN Sarjeant completed a HPNF which noted symptoms to look for as '*Previous Custody, Mental Health Issues*' and recommended normal cell placement and review by a mental health nurse plus quarantine until cleared by nursing staff.

31 At 9:48am on Wednesday, 20 October 2021 a second HPNF was completed for Mr Warwar, this time by RN Tenille McDowell, (then) Clinical Nurse Specialist which noted symptoms to look for as '*Mental health issues, Aggressive behaviour, Risk of harm to females, Cleared from MH Nurse list*' and in relation to cell placement wrote '*Hold in MRRC until transferred to MHSU* [Mental Health Screening Unit]*, Must be 1-out (mental health*)'.

32 Later that morning and before 1:00pm, Dr Matthew Hearps, Forensic Psychiatrist Staff Specialist from the Adult Ambulatory Mental Health Team, assessed Mr Warwar and prepared a Subjective, Objective, Assessment and Plan (**SOAP**) Note. Parts of that SOAP read:

> …Objective / Observations: clean, cooperative. impaired attention/ concentration. Some disinhibition. talkative, tangential. appears excited but not agitated. may have grandiose delusions as per interview. mood relaxed, affect elated. doesn't appear hallucinating
>
> Assessment / Analysis: amphetamine induced psychotic disorder ddx primary psychotic disorder
>
> Plan: increase amisulpride to 600mg…

33 Dr Hearps endorsed Mr Warwar remaining 1-out, requested a further mental health nurse review in a week and a further psychiatric review in two weeks. He also increased Mr Warwar's dosage of Amisulpride (sometimes called 'Solian', by reason of its branding) by 400mg daily, with the first 400mg dose due that evening and then the next dose being 200mg the next morning. That decision, Conjoint Professor Large opined, was '*appropriate*' and '*perfectly reasonable'*. I accept the opinion of Professor Large.

Overnight on 22, 23 October 2021

34 At about 7:30pm on 22 October 2021 a Correctional Officer and a Justice Health staff member attended Mr Warwar's cell for the administration of his evening medication (400mg of Amisulpride), as part of what is commonly referred to as the 'pill parade'.

35 RN Rabiah Kasim and RN Jilane Sarjeant were the two-night shift nurses rostered from 9:30pm to 7:30am, overseeing the inmates in MRRC and Dawn de Loas – in all about 1,150 inmates.

36 First Class CO Achal Sood was rostered to work from 11:00pm on 22 October 2021 to 7:00am on 23 October 2021 as Observation Officer in Pod 7. He worked until about 6.30am, with no break other than toilet breaks. Observation Officers were put in place during the COVID-19 pandemic.

37 First Class CO Sood's night supervisor (or OIC) was First Class CO Michael Fletcher. He was rostered on duty as the OIC of B Watch (as the night shift is called) from 10:00pm on 22 October 2021 to 6:00am on 23 October 2021 and completed that shift with no break other than toilet breaks. He was based in the Darcy Unit Office.

38 At 11:34pm Mr Warwar made a knock-up call that was received by First Class CO Sood in the Pod 7 Office. Part of that call went for 1 minute and 52 seconds as follows:

> First Class CO Sood: Yes mate.
>
> Mr Warwar: Chief, something's wrong with me.
>
> First Class CO Sood: What's wrong?
>
> Mr Warwar: Can you come in?
>
> First Class CO Sood: Hey?
>
> Mr Warwar: Something's wrong with me.
>
> First Class CO Sood: What's your name?
>
> Mr Warwar: I need some med pills.
>
> First Class CO Sood: You want some medication.
>
> Mr Warwar: Yes some medical…for mental health.
>
> First Class CO Sood: For mental health.
>
> Mr Warwar: Yeah something's wrong with my neck and that like my mental health, my mental health's playing up.
>
> First Class CO Sood: Yeah alright. Are you feeling okay?
>
> Mr Warwar: My back keeps twitching.
>
> First Class CO Sood: Your back's twitching your neck's wrong.
>
> Mr Warwar: Yeah.
>
> First Class CO Sood: I'll let the nurse know but is there anything are you fearing for your safety like you're not going to hurt yourself or anything?

Mr Warwar: Mental health.

First Class CO Sood: Are you feeling like hurting yourself?

Mr Warwar: I need mental health mental health.

First Class CO Sood: I understand your mental health, I'll let the nurse know but I'm worried about your safety, are you safe, you guarantee safety?

Mr Warwar: I'm gone.

First Class CO Sood: You're gone are you?

Mr Warwar: I'm all good I'll survive but I'm not doing [? – word unclear could be "great" or "bad"].

First Class CO Sood: That's alright. So you'll wait till morning or you want me to get the nurse now?

Mr Warwar: Nah nah don't worry about a nurse.

First Class CO Sood: Don't worry about it? You ok?

Mr Warwar: I'll be gone by the morning.

FCCO Sood: Hey?

Mr Warwar: Be gone.

FCCO Sood: Do you guarantee your safety?

Mr Warwar: Hey I'm bleeding.

FCCO Sood: Hey? [silence] Mohamed?

Mr Warwar: Can you come see me?

FCCO Sood: When I do my next round I'll come and say hello to you yeah?

Mr Warwar: You'll see everything.

FCCO Sood: Hey?

Mr Warwar: Come.

FCCO Sood: Yeah half an hour.

Mr Warwar: Yeah when I'm dead.

FCCO Sood: Alright.

39 First Class CO Sood wrote in the C/B Watch OIC journal the following at or about 11.35pm, '*213, Warwar complained about neck pain plus back pain OIC B Watch attended, nurses informed inmate appears to have serious mental health issues*.'

40 A very short time after the knock-up call, First Class CO Sood called First Class CO Fletcher and asked him to come to Pod 7 so they could both assess Mr Warwar. First Class CO Sood was worried Mr Warwar might be at risk of self-harm or suicide because of Mr Warwar saying at the end of the call '*when I'm dead*'.

41 First Class COs Sood and Fletcher attended Mr Warwar's cell at 11:48pm. They remained outside the cell and made observations.

42 First Class CO Fletcher observed Mr Warwar to be '*elevated*', '*speaking very fast*' '*pacing his cell'* and '*verbal*'. He did not believe Mr Warwar was withdrawing from drugs, because his behaviour was '*elevated*'. He also said that Mr Warwar answered his questions '*without going off in a tangent*'. He assumed by the way he was acting, his mannerisms, that, he either had taken drugs, or he did have some sort of mental health condition.

43 First Class CO Sood recalled Mr Warwar '*screaming … small screams*' and screaming *'a couple of times*' during this interaction but thought it '*was more of mental health than withdrawing*.'

44 First Class CO Fletcher directed First Class CO Sood to contact a nurse to '*see if there was any medication that he was entitled to, and for them to come and have a chat to him themselves and see about his cramps in his neck and in his back*.'

45 First Class CO Sood called RN Kasim. RN Sarjeant heard parts of RN Kasim's side of the conversation.

46 The recollections of First Class CO Sood, RN Kasim and RN Sarjeant differ as to the content of the conversation. This is not surprising given no one made a note of the conversation, First Class CO Sood didn't make a statement until one month after the events, the nurses didn't make statements for a further 3 months and the nurses did not set out the conversation in their statements. Additionally, they were all impacted by the tragedy of Mr Warwar's passing, in particular First Class CO Sood who had time away from work and received counselling.

47 Finally, it should be observed that these factual witnesses were giving evidence some two and half years after the events took place.

48 I have not found it necessary to resolve many of the evidentiary disputes about events on the 22 and 23 of October 2021. I have been able to consider the issues by focussing on agreed matters and undisputed matters.

49 In relation to the conversation between First Class CO Sood and RN Kasim, First Class CO Sood fairly indicated '*I cannot exactly remember what I said or what was spoken but I would have just explained … he's complaining about the pain in the neck and the back*' and '*I cannot remember the conversation*'. First Class CO Sood also indicated that he asked RN Kasim to come and see Mr Warwar.

50 RN Kasim said that she conveyed to First Class CO Sood that she and RN Sarjeant were having a busy night and that they would go and see Mr Warwar at some time. First Class CO Sood and RN Sarjeant recall RN Kasim mentioning seeing Mr Warwar during rounds whereas RN Kasim disputes that is what she said and recalls saying they would see Mr Warwar when their work settled.

51 RN Sarjeant recalled mention of Mr Warwar yelling out and having thought that was a little unusual given his presentation when she saw him whilst completing the RSA.

52 Following the call RN Kasim and RN Sarjeant did not attend upon Mr Warwar.

53 At 11:59pm, Mr Warwar made another knock-up call, received by First Class CO Sood. It went for 19 seconds as follows:

> First Class CO Sood: Yes Warwar.
>
> Mr Warwar: Chief.
>
> First Class CO Sood: Yeah.
>
> Mr Warwar: I need your help.
>
> First Class CO Sood: Yeah I'm trying to help you. I told the nurse already ok.
>
> Mr Warwar: [Groaning] It's getting worse and worse.
>
> First Class CO Sood: Sorry?
>
> Mr Warwar: It's getting worse and worse.
>
> First Class CO Sood: I told the nurse. She is going to come and see you soon.
>
> Mr Warwar: Ah

54 First Class CO Sood did not call the nurses after the second knock-up call given he had spoken to RN Kasim a short time prior. He did however call First Class CO Fletcher and told him he had called the Justice Health nurses and he said one of them had told him Mr Warwar was withdrawing from drugs and they would see him when they did their medical rounds. There is no evidence that Fist Class CO Sood told First Class CO Fletcher that Mr Warwar had just told him twice, '*It's getting worse and worse*'.

55 When First Class CO Sood told First Class CO Fletcher in the call at about 12:00am that the nurses said Mr Warwar was withdrawing from drugs, this did not prompt First Class CO Fletcher to record a note of this call, or call or go and see the Justice Health nurses at that time or at any other time during his shift.

56 CCTV footage shows First Class CO Sood attending the outside of Mr Warwar's cell at 12:09am, 1:03am, 2:06am, and 3:06am. On some of those occasions he just glances in, on others, he pauses, appearing to look in for a little while. On all occasions the cell window is up, and the cell lights appear to be on. I am satisfied that each time First Class CO Sood looked in or glanced in, the lights were on, and the cell was visible, including Mr Warwar.

57 In First Class CO Sood's statement, not detailed any further by him at the inquest owing to his lack of recollection, he said the following about the period of time between 12:00am and about 3:00am:

> On a number of occasions when I walked past WARWAR's cell during the night, I looked through the cell window to check on WARWAR. I saw WARWAR to be hallucinating. He was talking to the wall, talking to the bed, talking to the shower curtain. He was standing up and he was on his feet.

58 Despite these observations First Class CO Sood did not at any time call First Class CO Fletcher or the nurses or make any record of the observations.

59 First Class CO Sood and five inmates in cells near Mr Warwar's reported hearing Mr Warwar screaming at various times during the night. First Class CO Sood's evidence was that he did not hear Mr Warwar scream after 3:00am.

60 This evidence is difficult to reconcile with the evidence that at 3:28am, an inmate in cell 209, which was a cell about four down from Mr Warwar's on the upper landing, made a knock-up call that reached the control room, complaining about noise another inmate was making in the pod.

61 An officer in the control room informed First Class CO Fletcher of the inmate's knock-up and First Class CO Fletcher relayed the information to First Class CO Sood that in a knock-up from a cell in Pod 7 it was indicated that '*the inmate next door to them is having some sort of medical condition*'. First Class CO Sood was advised of this by First Class CO Fletcher at about 3:30am. First Class CO Sood indicated to First Class CO Fletcher that the call was about Mr Warwar.

62 First Class CO Fletcher gave evidence that First Class CO Sood indicated that he was still checking on Mr Warwar when he was doing his rounds, that the nurses had not yet come to see him, and that Mr Warwar was yelling out from his cell wanting his '*meds*'. I am satisfied that Mr Warwar was screaming to at least some extent after 3:00am.

63 The audio recording of the third knock-up call (27 seconds in length) has been transcribed as follows:

> Inmate: Hello!
>
> CO: Yeah man.
>
> Inmate: We're in pod 7. Can you deal with that fuckwit that's fucking having a panic attack or something.
>
> CO: Sorry say it again?
>
> Inmate: Oh it's – We're in pod 7 some fucking dickhead's having a fucking panic attack. Can you go deal with him?
>
> CO: Where is it?
>
> Inmate: We're in pod 7. You'll hear him. Fuck the whole gaol can fucking hear him.
>
> CO: Yeah alright.
>
> Inmate: Alright thank you.

64 It is understandable that this relatively graphic knock-up call caused an officer in the control room to contact the OIC.

65 Directly after First Class CO Sood received the call from First Class CO Fletcher, he went to observe Mr Warwar in cell 213. The lights were on in Mr Warwar's cell and Mr Warwar was visible. First Class CO Sood confirmed at the inquest that there was no noise coming from Mr Warwar's cell at this time and he could see him kneeling on the floor, with his upper body on the bed, and faced down. First Class CO Sood said this was the first time he saw Mr Warwar in this position. First Class CO Sood said he thought he was sleeping because he had exhausted himself, in keeping with First Class CO Sood's experience of other inmates.

66 RN Kasim and RN Sarjeant gave evidence that at some time around 3 to 3:30am, they were in the vicinity of Fordwick Pod 7 when they paused and had a discussion about Mr Warwar. Once again, the versions of RN Kasim and RN Sarjeant varied significantly in relation to what was said in their discussion. Once again, I do not need to determine precisely what the conversation was, it is enough to know that the result of their discussion was that they determined that they would not attend upon Mr Warwar. It seems that they determined it was likely Mr Warwar had gone to sleep.

67 Based on the 3:28am knock-up call, and the joint assertion by the nurses that they could not hear any screaming it seems likely to me that this meeting occurred closer to 3:30am then to 3:00am.

68 CCTV footage shows that at 4:36am, 5:42am, and 6:24am, First Class CO Sood did his rounds past Mr Warwar's cell. On each occasion the lights were on, and the cell and Mr Warwar were visible. On those occasions First Class CO Sood observed Mr Warwar still kneeling on the floor, with his upper body on the bed, and faced down and that he appeared to him to still be sleeping.

69 First Class CO Sood was asked whether he looked in to check if he could see the rise and fall of Mr Warwar's chest such as would indicate that he was breathing. First Class CO Sood said that if an inmate is sleeping, he doesn't disturb them because the inmate will get up and start abusing you if you wake him up. First Class CO Sood said this was a general practice.

70 First Class CO Fletcher finished his shift at 6:00am and First Class CO Sood at 6:30am. First Class CO Fletcher did participate in a handover at the end of his shift, while First Class CO Sood did not.

71 First Class CO Fletcher did not write anything in his journal about Mr Warwar or any of his contact with or about him earlier in the shift, although he did say Mr Warwar was on his mind at the end of his shift.

72 First Class CO Sood said Observation Officers could not do a handover as the next Observation Officer was not yet on (they started at 7:00am) and he believed it was the responsibility of the OIC to do the end the of shift handover.

73 Neither First Class CO Sood nor First Class CO Fletcher made any written record the entire B Watch shift about Mr Warwar, save for First Class CO Sood's 11:35pm entry in the C / B Watch OIC's Journal.

74 At 7:00am nurses commenced the day shift in the J-block clinic. A handover took place however there was no mention of any incidents overnight.

75 Neither RN Kasim nor RN Sarjeant made any entry about Mr Warwar in any Justice Health record during their shift. Neither attended Mr Warwar's cell at any time during the shift.

76 At around 8:00am a Justice Health enrolled nurse attended Mr Warwar's cell as part of morning rounds and was accompanied by three COs. Mr Warwar was found unresponsive in his cell. A medical response was called. Mr Warwar was declared life extinct by a registered nurse at 8:05am.

77 Mr Warwar had been found kneeling on the floor with his arms resting on the bed. His head was resting on a towel on the bed. His feet were blue. He was rigid and immovable and cold to touch. An autopsy was conducted by forensic pathologist Dr Jennifer Pokorny at 8:30am on 26 October 2021. Toxicological analysis found Amisulpride at a level of 4.4 mg/L. Dr Pokorny noted that scene photos indicated Mr Warwar was in a kneeling position alongside his bed with his chest and head face down on the bed on top of a towel and bed sheet.

78 Dr Pokorny presented Mr Ward's case to the health protection New South Wales Covid-19 vaccine safety expert panel (**the panel**).

Findings in relation to the care of Mr Warwar

79 I shall now consider issue three and its various sub-issues as well as other issues that arise from the evidence at inquest.

80 Mr Warwar was appropriately assessed when he entered MRRC on 17 October, was seen by a mental health nurse on 20 October and was then referred by that nurse to a psychiatrist who saw Mr Warwar on the same day and appropriately assessed Mr Warwar, prescribed appropriate medication and made arrangements for a further appointment with the mental health nurse. There was no evidence in the inquest which suggested that there was any inappropriate attitude towards the care of Mr Warwar.

81 There were however a number of deficiencies in the dealings of both Correctional Officers and nursing staff in their dealings with Mr Warwar from 11:00pm on 22 October 2021 until 8:00am on 23 October 2021.

82 Whilst it cannot be said that any act or omission was causative of Mr Warwar's death, some of the deficiencies had the potential to impact significantly upon Mr Warwar's outcome. It will never be known what might have occurred if one or more of the steps which I shall shortly discuss had been taken. On the other hand some of the matters not attended to did not have the potential to impact upon Mr Warwar's health in the short term but were however outside required practice.

The failure of the Nurses to attend upon Mr Warwar

83 Ms Therese Sheehan, Deputy Director of Nursing and Midwifery Custodial Health with Justice Health, gave evidence that at the time of the call from First CO Sood the two RNs on shift should have asked more questions in order to make a clinical judgement as to the urgency of the situation, and that they should have gone and assessed Mr Warwar at some point during the shift. Both of those propositions were put to the RNs who frankly and appropriately accepted that that's what should have occurred and indicated, with the benefit of hindsight that they should have gone to see Mr Warwar as soon as First Class CO Sood contacted them.

84 It is difficult to comprehend how and why the nurses failed to attend upon Mr Warwar. This is particularly so given that RN Kasim's account of her conversation with First Class CO Sood is that she told him they were having a busy night and that they would go and see Mr Warwar (emphasis added) at some time after their work settled.

85 Counsel Assisting submitted, and Ms Holcombe, who appeared for Justice Health, embraced, that there was no competing work issue that was so urgent or so important that it stopped the nurses attending upon Mr Warwar, either, after their medical rounds were completed, or at any other time during their shift. That fact should not obscure the evidence of both nurses that the night was busy, and that the initial decision not to immediately go and see Mr Warwar after speaking with First Class CO Sood, was grounded in the perceived need to attend to the tasks currently being undertaken during a busy shift. Likely RN Kasim's lack of questioning of First Class CO Sood and RN Sarjeant's lack of curiosity about what she had overheard was grounded in the same concern.

86 Mr Dawson, who appeared for RNs Kasim and Sarjeant characterised the failings overnight as '*an overall example of errors of judgement upon errors of judgement, compounded by other people's errors of judgement*'. In my view, errors of judgement are far more likely to be made when workers feel burdened by their workload.

87 It will never be known what would have occurred, had the nurses attended upon Mr Warwar immediately following First Class CO Sood's call to RN Kasim or indeed if they had attended upon him when they stood outside Fordwick Pod 7, or at any time in between. I am satisfied that whilst it is true that their workload did not prevent them from seeing Mr Warwar, their concern about how much work they had to do played a significant role in them not attending upon Mr Warwar at any time earlier than after their medical rounds. In relation to their failure to attend upon Mr Warwar when they stood outside Pod 7, I accept that by then Mr Warwar had fallen silent, and they did not hear any noise coming from Pod 7. This should not however have stopped them checking in on him.

The failure of First Class CO Sood to contact the nurses (again) following the second knock-up call

88 When the second knock-up call was received about 11:59pm, First Class CO Sood said he was not any more worried about Mr Warwar, as the call was only shortly after the first one, and he and First Class CO Fletcher had just seen him, even though in the second knock-up call Mr Warwar said, '*It's getting worse and worse*'. For the same reasons he did not call the Justice Health nurses about it, he made no record of this knock-up call, and he did not go and conduct any specific observation of Mr Warwar directly following the second knock-up call, although he did go past the cell at 12:09am.

89 Custodial Director Wilkinson said the second knock-up call should have prompted First Class CO Sood to call Justice Health at that time, and General Manager Statewide Operations Security and Custody, Mr Malcolm Brown, gave evidence that CO Sood '*should have probably attended the cell and undertaken further observations*'.

90 First Class CO Sood should have conveyed the content of the second knock-up call to RN Kasim and sought confirmation that the nurses would be attending upon Mr Warwar. If First Class CO Sood could not then secure an indication that the nurses would attend upon Mr Warwar shortly after that call, he should have attended upon Mr Warwar himself to observe him and then taken whatever he determined to be appropriate further action.

91 It should be noted that First Class CO Sood would have known at all times whether the nurses had attended upon Mr Warwar as the nurses needed to be accompanied by him, when attending upon Mr Warwar. The evidence is that First Class CO Sood was effectively at his post during the whole shift.

92 There was a suggestion within the evidence of RN Kasim and RN Sarjeant that if the need to attend upon Mr Warwar persisted then First Class CO Sood should have contacted the nurses again or called a medical response. I find this evidence self-serving, wrong, and somewhat disappointing in that it was inconsistent with the attitude to their responsibilities displayed by both nurses in their other evidence. My finding that First Class CO Sood should have made a further call to the nurses (after the second knock-up call, and again, as I shall shortly develop at about 3:30am) does not in any way lessen the responsibility of the nurses to attend upon Mr Warwar. RN Kasim had told First Class CO Sood that they would go and see Mr Warwar, and RN Sarjeant heard RN Kasim's words. They were wrong to suggest their responsibility evaporated and that the only fault lay with First Class CO Sood. COs should be able to rely upon the word of nursing staff in relation to medical care of an inmate.

93 Whilst First Class CO Fletcher had appropriately directed First Class CO Sood to contact the nurses after the first knock-up call, when First Class CO Sood told him in the call at about 12:00am that the nurses said Mr Warwar was withdrawing from drugs, this did not prompt First Class CO Fletcher to record a note of this call or call or go and see the Justice Health nurses at that time or any other time during the shift. Because of the proximity and time of First Class CO Fletcher's own assessment of Mr Warwar, which was not that he was withdrawing from drugs, and the call back from First Class CO Sood to him and what CO Sood relayed to him in that call, I find that First Class CO Fletcher should have exercised a greater degree of curiosity and caution about what was happening with Mr Warwar and contacted Justice Health or asked First Class CO Sood to do so.

94 First Class CO Fletcher's lack of response fell below what was expected of him, noting his experience at the time and that he was the OIC.

The failure of First Class CO Sood to contact the nurses at (about) 3:30am

95 By shortly after 3:30am First Class CO Sood had on his own evidence, heard screaming from Mr Warwar's cell on three or four occasions, at times lengthy, seen Mr Warwar seemingly hallucinating, talking to walls, shower curtains, and windows between about midnight and 3:00am, had received the second knock-up call from Mr Warwar at 12:00am, had been advised at about 3:30am by First Class CO Fletcher of a third knock-up call made to the control room, with a complaint from another nearby inmate about Mr Warwar making noise, had been to check on Mr Warwar from 3:31am to 3:34am and observed him on the floor, on his knees, with his upper body on the bed, and knew no Justice Health nurse had attended upon Mr Warwar. First Class Sood should have called the Justice Health nurses again at or around 3:34am at the latest.

96 Similarly at 3.30am, because of First Class CO Fletcher's knowledge and actions in relation to the first knock-up call, his knowledge of the second and third knock-up calls, and First Class CO Sood's comments to him shortly after the third knock-up call, First Class CO Fletcher should have exercised a greater degree of curiosity and caution, and contacted Justice Health or asked First Class CO Sood to do so at that point. When asked about this, Custodial Director Wilkinson confirmed First Class CO Fletcher should have called Justice Health at that time. He said perhaps he should have contacted the J-block clinic and asked for a follow-up of where the nurses were at, or an estimated time of arrival for when they would attend Pod 7.

The failure of First Class CO Sood to appropriately observe Mr Warwar after 3:30am

97 At about 3:34am the lights were on in Mr Warwar's cell and Mr Warwar was visible. First Class CO Sood confirmed at the inquest that there was no noise coming from Mr Warwar's cell at this time, and he could see him kneeling on the floor with his upper body on the bed and face down. He said this was the first time he saw Mr Warwar in this position. He said he thought he was sleeping because he had exhausted himself, in keeping with First Class Sood's experience described as follows: '*Inmates hallucinating, shouting and carrying on is a regular occurrence when inmates are withdrawing from drugs and/or have mental health issues. It is an often occurrence for the inmates to scream throughout the night to 2.30am or 3am, and then they exhaust themselves and they go to sleep after that*.'

98 First Class CO Sood's failure at this point in time to check whether Mr Warwar was alive and responsive, as described by First Class CO Fletcher, Custodial Director Wilkinson, and Governor Ashcroft, was a missed opportunity and a deficiency in practice, and fell below what was expected of him in his role at the time.

Deficiencies in record keeping

99 The only record made by any CO or nurse in relation to the dealings with Mr Warwar overnight on the 22nd and 23rd of October 2021 was the entry made by First Class CO Sood in relation to the first knock-up call.

100 In respect of RNs Kasim and Sarjeant, records should have been made of, the call from First Class CO Sood to RN Kasim, the brief conversation the nurses had about that call and their conversation about the decision not to check on Mr Warwar between 3 and 3:30am.

101 In respect of First Class CO Sood, he should have made a record of, the second knock-up call and what he did or did not do in response to it, the screaming or yelling he heard coming from Mr Warwar's cell between 12:00am and about 3:00am, the third knock-up call and phone conversation he had with First Class CO Fletcher at about 3.30am and his observations of Mr Warwar at 3:34am.

102 First Class CO Fletcher should have made a record of his interactions in relation to the first, second and third knock-up calls as confirmed by Custodial Director Wilkinson.

103 The failure to make the records as set out above was in breach of the policies applicable to both the COs and the nurses. Whilst this failing did not impact directly on the care provided to Mr Warwar, the policies are in place for good reason. Amongst other benefits accurate records of what has occurred informs others who have to deal with an inmate. Furthermore, accurate records reduce the mischief of inaccurate recollections when events have to be revisited for legal or other purposes.

104 As has been pointed out above, both COs and both nurses were experienced in their roles. It is difficult to understanding why each of them failed to make records in breach of policy requirements.

105 In relation to the nurses, I find that their workload impacted upon them taking the time to make records of what had occurred.

Failure to participate in handovers

106 First Class CO Sood did not participate in a handover when commencing or ending his shift that night. First Class CO Sood said he did not recall participating in handover at the end of the shift, but he also said Observation Officers could not do a handover as the next Observation Officer was not yet on, they started at 7:00am, and he believed it was the responsibility of the OIC to do the end of shift handover. Custodial Director Wilkinson gave evidence that he expected the CO would participate in a handover at the start and end of shift. This was echoed by the current Governor of MRRC, Mr Dale Ashcroft, who noted this was set out in their Statement of Duties.

107 First Class CO Fletcher participated in a handover at the start and end of his shift.

108 It seems First Class CO Sood did not realize the need to attend handover, which is difficult to understand in light of the evidence of Custodial Director Wilkinson.

109 RN Sarjeant said in her statement that at the start of her shift, she counted schedule 8 medications and did not participate in any handover with staff from the afternoon shift. She said RN Kasim received handover while she counted drugs. At the inquest, she said the nurse in charge would tell her anything she needed to know, and she said the practice is that one nurse does the counting of drugs while the other does handover. She also said that if she is able she does handover, but she said it was a very busy shift and she and RN Kasim completed different jobs.

110 RN Kasim and RN Sarjeant both finished their shifts at the same time, 7:30am. RN Kasim said she did a handover at the end of her shift to the morning shift regarding the patients in MRRC. However, she made no reference to Mr Warwar. She made no written notes of the handover.

111 Justice Health policy is clear that all clinical staff are to participate in handover at the start and end of their shifts. This was confirmed by Ms Sheehan in her written and oral evidence.

112 The nurses both provided a clear explanation as to why RN Sarjeant didn't attend handover, despite it being policy that she do so. The explanation lay in the workload of both nurses.

Cell Placement

113 On the evidence in the proceedings Mr Warwar was appropriately placed in the quarantine area of the prison which was used for inmates when they first came into custody during the pandemic. In addition, Mr Warwar's presentation to the two RNs who assessed his cell placement did not warrant any different cell placement.

Health Problem Notification Forms (HPNFs)

114 RN Sarjeant completed a HPNF which noted '*symptoms to look' for* as *'Previous Custody, Mental Health Issues'*

115 A second HPNF was completed for Mr Warwar, this time by another RN which noted '*symptoms to look for*' as '*Mental health issues, Aggressive behaviour, Risk of harm to females, Cleared from MH Nurse list*'.

116 Training documentation relating to HPNFs indicates that:

> HPNFs are the primary mechanism by which Justice Health communicates patient clinical information to Corrective Services. They are, in effect, a written handover from Justice Health to Corrective Services regarding a patient's current health concerns' and "the HPNF" is a key tool health and custodial staff used to identify important health concerns and signs and inmate may be unwell and how to keep them safe.

117 The section in the HPNF which commences '*signs/symptoms to look for in the inmate*' continues '*CSNSW officers – please monitor the inmate for the following signs and report any observation of these JH&FMHN staff so that they can address the health issue'.* The next header is what '*signs/symptoms CSNSW officers need to look for*'.

118 The examples provided in the online training include:

(1) monitor for sweating tremors vomiting confusion or seizure;

(2) monitor for reports of nausea, stomach cramps, diarrhoea, insomnia;

(3) monitor for signs of excessive sweating, agitation, confusion;

(4) monitor if patient hard to rouse; and

(5) monitor if patient reporting feeling lightheaded or dizzy.

119 In addition to these examples there is also an appendix to the Justice Health Policy relating to HPNFs for adults which includes a non-exhaustive list of things that can be written so as to assist COs. Examples in that appendix include:

(1) inappropriate talking and laughing;

(2) isolative or over-familiar behaviour;

(3) decreased or over attention to self-care;

(4) mood swings; and

(5) agitation.

120 It can readily be seen that the forms completed in relation to Mr Warwar do not include appropriate *signs and symptoms* relevant to Mr Warwar's health.

121 The evidence provided in the inquest indicated that Justice Health are developing an electronic form of the HPNF which has extensive drop-downs listing appropriate signs and symptoms under relevant health issue headings.

122 Whilst it seems likely that the electronic form of the document will help reduce inappropriate content in regard to signs and symptoms there nevertheless is a broader issue arising from the manner in which the HPNFs were completed in relation to Mr Warwar.

123 Given the training provided and given the existence of the appendix, why were the forms filled in inappropriately?

124 Other HPNFs relating to Mr Warwar were also tendered in evidence and they were similarly deficient. Two HPNFs completed in April 2021 respectively detailed the following signs/symptoms CSNSW were to look for: *'Previous custody. Mental health issues'* and *'Previous custody. Mental health issues, denies any thoughts of self-harm or suicidal ideation. Guarantee own safety and others*'.

125 By way of comparison an HPNF was completed appropriately in May 2021 as follows:

> Inappropriate talking and laughing, Isolative or over-familiar behaviour. Decrease or over attention to self-care, Mood swings, Agitation. Changed level of risk from others. Possible – Anxiety, headache, insomnia, muscle aches, twitching, seizures, sweating, hot & cold flushes, gooseflesh, yawing, watery eyes, runny eyes, stomach cramps, nausea, vomiting, diarrhoea, disorientation, mood swings, seizures.

126 So far as HPNFs are concerned the evidence was that neither First Class CO Fletcher, nor First Class CO Sood viewed either of the October 2021 HPNFs which had been completed in relation to Mr Warwar. First Class CO Sood said, '*We usually don't look at HPNFs, only when we need to*'. First Class CO Fletcher said, '*The only times I generally check an HPNF is if they're on a RIT. If an inmate is on RIT, what their conditions are, whether they can have sharps, that sort of stuff*,' and he did not consider they were mandatory to read, although best practice is he probably should.

127 Counsel Assisting submitted that even if the COs had looked at one or both of the October 2021 HPNFs, it's unlikely it would have changed the way they responded to Mr Warwar as the (inadequacy of) the "signs or symptoms" listed, would not have meaningfully assisted them.

128 Mr Brown suggested that he did not know how looking at the HPNF would have assisted First Class CO Sood, as he called his superior officer and then did as his superior officer First Class CO Fletcher, directed.

129 Whilst First Class CO Sood clearly took an appropriate course in relation to the first knock-up call, I find that at some stage after the second knock-up call, including on one of the occasions that Mr Warwar appeared to be hallucinating, it would have been consistent with the importance and intent of the HPNF training to look at Mr Warwar's HPNFs.

130 Mr Brown gave evidence that the Joint Recommendation Working Group is working on a number of different projects including updating HPNFs so that they are clearer and more concise. Mr Brown indicated those projects are about 75% completed.

General observations regarding experienced employees failing to follow procedure

131 It is of very significant concern that so many breaches of policy occurred on 22nd and 23rd October at an extremely crucial time in relation to Mr Warwar's care.

132 I repeat that whilst no breach in policy can be said to have caused Mr Warwar's death, we will never know what difference would have been made by intervention by the nursing staff.

133 None of those who failed to follow policy were inexperienced. First Class CO Sood had been a Correctional Officer for over 20 years. First Class CO Fletcher had been a Correctional Officer for 16 years and had acted up as a Senior Correctional Officer from time to time, including as an OIC, as he was on 22nd and 23rd October 2021.

134 RN Kasim had 20 years in the private sector and 5 years with Justice Health as at 2021. RN Sarjeant had worked in nursing in NZ and Australia since 1974, including with Justice Health since 2005.

135 The first thing to recognise is that policies are generally put in place for good and specific reason, and it is important that they be followed.

136 Handovers and good record keeping both facilitate passing on relevant information to others who have to deal with an inmate either in the short term or the long term.

137 The HPNFs were not filled in appropriately by nursing staff and not looked at by Correctional Officers. As set out above, the HPNFs are a '*key tool health and custodial staff used to identify important health concerns and signs an inmate may be unwell and how to keep them safe*'.

138 The extent of the failure to apply policy suggests to me that training is either ineffective, at least in part and/or that auditing of processes and procedures are not as effective as they need to be.

139 Employees in all circumstances these days have much to consider as part of their work tasks. The training records of both correctional officers and both nurses show that they have participated in a significant amount of training in relation to both policies and Work Health and Safety.

140 Somewhat ironically the very volume of the training may itself tend to detract from its effectiveness.

141 This is not a simple issue, and it is an issue about which there was limited evidence during the inquest. Additionally, I did not call for any expert evidence on the topic.

142 As the inquest evidence revealed these issues but did not explore answers to them, I urge both Justice Health and CSNSW to explore how they can make training more effective in relation to their policies in general and in relation to handovers, HPNFs and record keeping in particular.

Time, manner, and cause of death

143 As set out above, at autopsy Mr Warwar's toxicological analysis found Amisulpride at a level of 4.4 mg/L.

144 Forensic pathologist Dr Pokorny concluded that death was, "unascertained" proffering three possibilities as to cause as follows:

> [firstly,] focal lymphocytic myocarditis was noted in the heart. This pattern of myocarditis may be seen as a result of viral infection, though no viral infection was detected by PCR. Post-viral myocarditis inflammatory changes may persist for some time after a virus is able to be detected. The absence of detected virus by PCR thus does not exclude a recent infectious ideology. Myocarditis can also occur following immunisation with the Pfizer COVID-19 vaccination. The typical pattern of myocarditis in these cases has not yet been well established in the literature and is thought to often be eosinophilic, though lymphocytic myocarditis has also been reported. [Secondly,] Amisulpride was detected at an elevated level. It is unclear how much of this elevation is due to the effects of post-mortem artefact, though it is noted that the deceased's Amisulpride dose had just been increased shortly before his death. The opinion of a forensic toxicologist may be helpful in clarifying this. [And thirdly,] even at therapeutic doses, Amisulpride may cause cardiac rhythm abnormalities including QT prolongation, bradycardia and tachycardia.

145 Given Mr Warwar had been administered his first dose of Pfizer COMIRNATY COVID-19 vaccine in custody on Friday 22 October 2021, the morning before he was found deceased, Dr Pokorny referred his death to the panel. The panel issued a case report for Mr Warwar dated 31 January 2022 in which it was concluded that death was likely caused by acute cardiac arrhythmia with Amisulpride toxicity, a potential contributor to death.

146 Associate Professor Mark Adams is the head of the Department of Cardiology at Royal Prince Albert Hospital and an Associate Professor of Medicine at Sydney University. Associate Professor Adams opined that the likely cause of death was a sudden cardiac death due to ventricular arrhythmia. He indicated the factors that may have contributed to this sudden death as:

> The combined effects of the presence of an area of focal myocarditis and QT interval prolongation secondary to Amisulpride which may have lowered the threshold for an arrhythmia to occur. The cause of the myocarditis is not clear. The most common cause for myocarditis is a viral infection. However, it is impossible to completely rule out other potential causes such as the toxic effects of Amisulpride and chronic effects of drug abuse with cocaine and methamphetamine.

147 Associate Professor Adams also proffered an opinion as to the manner of Mr Warwar's death as follows: '*the manner of his death in this case would have been sudden, likely with no prodromal symptoms and if it occurred whilst he was kneeling in his bed, it is likely he would have remained in his position following death*.'

148 Professor Alison Jones is the Executive Director at the Sunshine Coast Health Institute and Consultant Specialist Physician, Sunshine Coast University Hospital, Queensland. Having been a Specialist General Physician and Clinical Toxicologist since 1998, her evidence also assists the Court in determining likely cause of death, with a focus on Mr Warwar's post-mortem analytical toxicology report and the reported blood concentration of Amisulpride.

149 Like Associate Professor Adams, Professor Jones concluded that Mr Warwar most likely died as a result of cardiac arrhythmias causing cardiac arrest. On cause of death, Professor Jones opined in her report as follows:

> The overall conclusion of the expert panel was that COVID-19 vaccine related myocarditis was unlikely, but another viral cause of myocarditis to account for the localised cardiac post-mortem finding was possible. If present, this could have contributed to arrhythmia risk in the deceased. I support this view. I also support the two toxicologist expert opinions expressed that Amisulpride, even accounting for likely post-mortem effects in this case, was likely a major contributor to Mr Warwar's death. I agree with the expert panel that death most likely occurred due to cardiac arrhythmia resulting in cardiac arrest because of the sudden nature of Mr Warwar's demise and the post-mortem position (kneeling) in which he was found.

150 Dr Michael Robertson is the Director and Senior Consultant of Independent Forensic Consulting with over 30 years' experience as a pharmacologist and forensic toxicologist. His expert evidence focused on Amisulpride toxicity as a contributor to Mr Warwar's death. On cause of death, Dr Robertson concurred with the panel's case report, in particular, its conclusion that death was likely caused by acute cardiac arrhythmia, Amisulpride toxicity, a potential contributor to death. He also noted that there was a reading of 0.05 milligrams per litre of methadone detected in Mr Warwar's post-mortem toxicology report, but opined, '*I do not believe the presence of methadone caused or contributed to his death.*'

151 The fourth expert who gave evidence before the inquest was Professor Matthew Large who is the Conjoint Professor, School of Psychiatry, University of New South Wales, Senior Staff Specialist at the Prince of Wales Hospital Sydney, and Clinical Director of Mental Health in the Eastern Suburbs Mental Health Service. The evidence in his two reports and in evidence traversed firstly the appropriateness of the decision to increase Mr Warwar's Amisulpride dose on 22 October 2021, and secondly, the likely cause of Mr Warwar's death. He opined with respect to the latter, that cardiac arrhythmia was the most likely cause of death and myocarditis and Amisulpride were contributing factors, with the level of Amisulpride detected in Mr Warwar's blood at post-mortem being, in his words, '*Unexplained and of an unexpectedly high level*.'

152 In terms of the level of Amisulpride detected post-mortem, he wrote, '*Mr Warwar likely ingested more Amisulpride than was prescribed or seems to have been administered to him in the days before his death. The extent of over-ingestions is not likely to have been small*.' In his supplementary report, and echoed in oral evidence, Professor Large expressed an opinion about whether Mr Warwar's death was likely to be self-inflicted, that is, deliberate. He said:

> The medical records strongly suggest that Mr Warwar consistently denied suicidal ideas. This makes suicide less likely, but it is also the case that most suicide ascendants do not disclose suicide ideas. Contemporaneous indicators that Mr Warwar was suicidal, such as a note or third-party accounts of communicated suicide ideas, would make suicide more likely. And even if it could be established that additional doses of Amisulpride were taken by Mr Warwar deliberately, this alone would not lead me to believe that his death was a suicide.

153 I find that Mr Warwar died from a cardiac arrhythmia with Amisulpride toxicity and myocarditis being contributing factors.

154 In relation to the level of Amisulpride in Mr Warwar's toxicological results it was argued on behalf of the Acting Commissioner that the high level was due to postmortem redistribution rather than consumption of an amount of Amisulpride well beyond that which was prescribed.

155 Postmortem redistribution refers to the changes that occur in drug concentrations after death. It involves the redistribution of drugs into blood from solid organs such as the lungs, liver, and myocardium.

156 It was argued that the experts Professor Jones and Dr Robertson in describing postmortem redistribution as a '*magic pudding*' and commenting that '*strange things can happen*' accepted the inexact parameters of dealing with postmortem analysis of drug toxicity.

157 Both Professor Jones and Dr Robertson also agreed with the proposition that the prompt collection of specimens for analysis is always preferable, and that much redistribution occurs in the first two hours following death, although changes can and do continue after that time.

158 It was further noted, in developing the argument:

> Importantly though, your Honour, is that Dr Robertson said that his calculations of the level of Amisulpride in Mr Warwar's blood, based on his statement and hence belief, that the autopsy took place two days after death, and, your Honour, that is simply not correct, and that's why I'm going to come to the issue of time of death. Your Honour, the autopsy commenced, according to the papers - and I'll give you the reference in a moment - at 8.30am on 26 October 2021. It's volume 1, tab 4, page 10. It's on the front page of the autopsy report. If the time of death was between 3.30 and 4am - and I'll address you on that in a moment, your Honour - that is a delay between time of death and commencement of autopsy of three days and approximately five hours.

159 Firstly, Dr Robertson was never taken to his error as to the time at which the autopsy was done, so that he could express a view as to whether that would impact upon his opinion.

160 Secondly the following evidence of Dr Robertson suggests the one day 5 hours difference would not have changed his view:

> I think in a circumstance where an individual is found deceased shortly - so within hours of death - and then treated in such a way that they're transported to the mortuary, they're usually refrigerated at that point. That is a fairly normal process. That is a fairly normal length of time. We're not talking about someone who is sitting in a situation of an elevated temperature for an extended period of time as they might be if they were discovered a day or two later in a warm environment.
>
> That to me is a more significant variable than a few hours in a correctional centre - those circumstances I've just described, that facilitates post-mortem putrefaction and decomposition - that under those circumstances, we may have more significant and unpredictable changes in blood concentrations. In this situation I don't think there's anything unusual about - whether he was refrigerated an hour or two earlier- I don't think would have made a material difference to any redistribution that may or may not have occurred.
>
> We're dealing with post-mortem toxicology. In this instance, as I alluded to earlier, this is, with all due respect to the deceased, a fairly routine process. There was a death. There was transportation in a timely fashion, I presume, to the mortuary and an autopsy that took place two days later. So I - I wouldn't expect anything beyond what we know from the science to have occurred. When I refer to post-mortem toxicology, we talk about bacterial influence and so on and so forth, which is usually more relevant in a - in a decomposed person, someone that's perhaps been found in the water. There's a range of other possibilities that aren't, strictly speaking, relevant to this matter. That to me is a more significant variable than a few hours in a correctional centre
>
> I am confident that the issue of redistribution - did it occur? It probably did. We can't predict the extent but it's very unlikely, given the fact that this individual hadn't been using the drug for an extended period of time prior to, that the - the magnitude of redistribution was such that it could conceivably have been in the therapeutic range at the time of death and then increased to 4.4 milligrams per litre at autopsy. I think that's very unlikely. I think it's most likely that we're dealing with an elevated concentration, a toxic concentration, whether that was 2 milligrams or 3 milligrams or 4 milligrams, I can't be certain but it's likely in that range.

161 Thirdly, Professor Jones, clearly explained the parameters of the analysis by both herself and Dr Robertson, as follows:

> …..what we have both done - both toxicologists in this matter - is assume the worst-case scenario for maximum post-mortem redistribution in this case, and made our assessment on the impact of this Amisulpride in a worst-case scenario modelling. So we are putting in a margin of safety, considerable margin of safety in our analysis that tells the Court - that advises the Court, sorry - that this is a toxic range of drug, not a therapeutic range of drug.

162 I found both Professor Jones and Dr Robertson to be impressive witnesses. I accept Professor Jones' explanation of the approach taken by each of them.

163 A further argument developed on behalf of the Acting Commissioner was that the current science is limited in that the studies did not consider issues such as age, BMI, gender, and ethnicity. It was shortly after this line of questioning that Professor Jones provided her explanation of the approach taken, as set out above. Furthermore, neither expert was specifically asked if the absence of the identified matters in the study would have changed their analysis.

164 It was also asked whether there were studies as to the interaction of Amisulpride and the Pfizer vaccine. Professor Jones confirmed there were no such studies and Dr Robertson answered as follows:

> Looking at first principles, post-mortem redistribution is a physico-chemical type scenario that is drug specific. So I wouldn't anticipate that there would be any material - if there is material interaction, I wouldn't expect it would alter the extent of post-mortem redistribution or the timing of post-mortem redistribution.

165 A further matter relied upon by the Acting Commissioner to establish that postmortem redistribution was the true cause of the high Amisulpride reading was the contention that Mr Warwar displayed '*few, if any, of the commonly reported symptoms of Amisulpride toxicity*'.

166 The symptoms of Amisulpride toxicity include agitation, insomnia, and anxiety. Mr Warwar was clearly agitated throughout the night of the 22nd into the 23rd of October and based upon the third knock up call he may well have been suffering from quite severe anxiety, given the callers reference to "panic attack". I am unable to conclude that there was such a lack of symptoms as to exclude the possibility of Amisulpride toxicity.

167 I am satisfied that the toxic level of Amisulpride in Mr Warwar's blood, postmortem, was because he had ingested a very significant amount of that substance and not because of postmortem redistribution.

168 That finding raises the issue of how Mr Warwar, having been in custody for such a short period, could have accessed Amisulpride in a quantity necessary to cause toxicity. The evidence at inquest suggested that Mr Warwar either took the Amisulpride into custody, most likely in a balloon of some description which he swallowed, and later passed, or Mr Warwar purchased the Amisulpride from another inmate. Clear evidence was given of both the possibility and capability of these means of accessing Amisulpride in custody, including by an experienced CO, and no party challenged that evidence.

169 As to time of death, it is clear that Mr Warwar was alive after 3:00am.

170 At 3:04:27 CCTV footage shows movement in the cell window of Mr Warwar's cell.

171 At 3.28am, the inmate in cell 209, which was a cell about four down from Mr Warwar's on the upper landing, made the knock-up call in which he complained of the very loud screaming of, as I find it to be, Mr Warwar.

172 The only time at which it is clearly known that Mr Warwar was deceased is after he was discovered at about 8:00am. I accept that at the point of discovery it is clear Mr Warwar had been dead for some time, in the sense that he had not stopped breathing moments before discovery given he was rigid, immovable, and cold to touch.

173 Professor Jones gave the following evidence as to time of death:

> We can never be sure about time of death from video footage of an individual. They may appear to be moving or not moving, but I, as a clinical person, can't diagnose death in an individual without being able to work out that their breathing has stopped, and their heart has stopped. So that is the definition of death, and the brain death accompanies that, sadly. So I don't think any of the clinicians, experts in the room, can diagnose death at a distance. Let's be really clear about that. The most expected demise from a toxic concentration of Amisulpride, given that it's most likely to be a cardiotoxic death, would be a sudden death without much warning, would be my best interpretation of the evidence that we see before us. So there wouldn't be a long prodrome of appearing unwell and then finally passing. The individual would, sadly, but also peacefully probably, suddenly stop heart beating.

174 The evidence of First Class CO Sood is that he did not check to see if Mr Warwar's chest was moving at any time after 3:30am.

175 In her postmortem report Dr Pokorny does not opine on time of death.

176 The fact that Mr Warwar stopped screaming at some point in time between 3:00am and 3:30am is a factor pointing towards the conclusion that death occurred around that time. Counsel Assisting submitted such a finding was open to me.

177 On behalf of the Acting Commissioner, it was submitted that as both Associate Professor Adams and Professor Jones expressed the opinion that death would have been sudden, combined with, the evidence of First Class CO Sood that he did not observe whether or not there was rising and falling I would be satisfied that death probably occurred between 3.30am and 3:40am or at the latest 4:00am.

178 The submission as to the relevance of First Class CO Sood's lack of observation was not further developed beyond confirming '*we don't know*'. In my view First Class CO Sood's lack of observation does not assist with the determination as to timing of Mr Warwar's death.

179 I accept the evidence of the expert witnesses that it is very difficult to assess time of death without direct information as to whether breathing has stopped. Mr Warwar may well have fallen asleep at some time approaching 3:30am and died at some time between then and 8:00am. I have no medical evidence to determine time of death beyond that time period, even on the balance of probabilities.

180 As to manner of death, I am persuaded by the evidence of Conjoint Professor Large, as set out above. No party submitted that Mr Warwar deliberately caused his own death.

Recommendations

181 During closing submissions, a number of recommendations were discussed. Following completion of oral submissions finalised proposed recommendations were distributed.

To the Acting Commissioner, Corrective Services New South Wales and Chief Executive, Justice Health & Forensic Mental Health Network

(1) *Consideration be given by the Corrective Services NSW (CSNSW) and Justice Health & Forensic Mental Health Network (Justice Health) Joint Recommendation Working Group to:*

(a) *Health Problem Notification Forms (HPNFs) being included in electronic form in an inmate's Offender Integrated Management System (OIMS) record; and*

Consideration and Conclusion:

182 The recommendation was directed to both Justice Health and CSNSW in view of the existence of the joint working group. As Justice Health correctly pointed out, however, in its response it is not able to give effect to this recommendation.

183 CSNSW indicated that following inquiries made with a third-party systems developer, CSNSW has been informed that at this stage an automated system between Justice Health's system and CSNSW's OIMS would be cost prohibitive. However, CSNSW will investigate alternative options to ensure HPNFs are more easily available to staff managing inmates in accommodation areas.

184 I will amend the recommendation to accommodate CSNSW's approach and direct the recommendation to the Acting Commissioner CSNSW solely.

(b) *HPNF training for Justice Health clinical staff covering the 'Health Problem Notification Form (Adult) – Guide to Descriptions in Lay Language', which is an appendix to Justice Health 'Policy 1.231 - Health Problem Notification Form (Adults)', with particular focus on Justice Health clinical staff including more details in the descriptions they enter in the 'signs/symptoms for CSNSW officers to look out for' part of HPNFs.*

Consideration and Conclusion:

185 CSNSW pointed out the importance of signs and symptoms being in lay language, without opposing the recommendation. In opposing the recommendation Justice Health pointed to the training already provided and further explained Justice Health is developing an HPNF e-form that will be hosted on the Justice Health Electronic Health Record (JHeHS). The e-form provides prescriptive direction as to the lay terms which can be used to describe a patient's signs and symptoms. The e-form utilises drop-down boxes to click on the prescribed terms, rather than having an open text form for the description of signs and symptoms, however a free-text option is also retained if required. It is hoped that the e-form will be operational in mid-2024.

186 I have already observed that the proposed e-form provides an extensive list of signs and symptoms and the likelihood that it will improve the listing of signs and symptoms. The broader issue of effective training will be dealt with in recommendation 3 and as such the proposed recommendation will not be made.

(2) *That the development by the CSNSW and Justice Health Joint Recommendation Working Group of the purpose built form titled 'Cell call alarm medical request and physical response register' and the CSNSW policy accompanying it (noting the current review of CSNSW 'Custodial Operations Policy and Procedures 5.5 - Cell security and alarm calls') include that, where a request is made by CSNSW to Justice Health to come and assess an inmate in a cell following a cell call alarm, and Justice Health do not go and assess that inmate within a certain interval of time (being no later than, say, 2 hours) of the request having been made, then a CSNSW officer will follow-up by contacting Justice Health.*

Consideration and Conclusion:

187 The recommendation was directed to both Justice Health and CSNSW in view of the existence of the joint working group. As Justice Health correctly pointed out, however, in its response it is not able to give effect to this recommendation.

188 CSNSW responded by informing the Court that amendments to the COPP which would require COs to follow up with Justice Health staff, when an hour has elapsed and no instruction or Justice Health action has occurred, have been drafted, and are expected to be put in force once industrial consultation has been finalised.

189 Given that changes to the COPP have been drafted, and are expected to be put into force, subject to industrial consultation no recommendation is required.

(3) *Consideration be given to:*

(a) *the deficiencies in practice and procedure revealed in the evidence;*

(b) *the qualifications, training, and experience of those responsible for the deficiencies;*

(c) *the policies and/or other documentation directing attention to the correct practice and procedure; and*

(d) *the volume of policies and training that employees are currently exposed to;*

with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated.

Consideration and Conclusion:

190 Justice Health does not oppose the making of the recommendation.

191 CSNSW responded as follows:

> CSNSW does not support these recommendations in their current form. It is submitted that in their current form, the recommendations are lacking in appropriate detail and an appropriate and practical response by CSNSW would be difficult, were they to be made. Reference to specific practice and procedures, qualifications, training and experience would assist CSNSW target those areas of specific concern to the Court.
>
> …. Without seeking to pre-empt any findings, it is difficult to see how these recommendations would assist in circumstances of a deficiency (if found) of "I forgot" (T 255.40) or the decision made not to enter the pod because it was "dead quiet" (T402.4).

192 I accept the point made that individuals' errors of judgement and poor decisions are not deficiencies in practice and procedure, there was no suggestion in the recommendation that they were.

193 The recommendation is directed at deficiencies in practice and procedure by experienced employees, including in relation to matters for which there has been extensive training as set out in some detail above.

194 I propose to make the recommendation, but to include some specificity as to the relevant deficiencies.

<u>To the Acting Commissioner, Corrective Services New South Wales</u>

(4) *That the redesigned Certificate III in Correctional Practice (Adult Custodial) (that is to begin in July 2024) include training on HPNFs.*

Consideration and Conclusion:

195 CSNSW informed the inquest in written submissions that training on HPNF from July 2024 will be included in Certificate III Primary Training. The HPNF content will be comprehensively covered in a theory, scenario and assessment component in order to maximise student learning outcomes.

196 There is no need for the recommendation to be made.

(5) *That training on HPNFs (as a minimum, completing the 20-minute course titled 'Health Problem Notification Form Online Course') be made mandatory for all current and future serving Correctional Officers (COs).*

Consideration and Conclusion:

197 Rather than this recommendation being made, CSNSW requested that the Court note that as part of the Cell Placement Decision review, CSNSW intends to roll out a broader mandatory training package which will include training for custodial officers on HPNFs. Subject to consultation with stakeholders including Justice Health, CSNSW intends to align the new training package with instructions arising from the Cell Placement Decision review and replace the existing optional online HPNF training.

198 On the indication the proposed broader training is mandatory there is no need for the recommendation to be made.

(6) *That there be mandatory refresher training on HPNFs at least once every 2 years for all current and future serving COs.*

Consideration and Conclusion:

199 CSNSW informed the inquest, in written submissions that it is the present intention of CSNSW that mandatory training (of which HPNF will be a part) will require regular refresher training, pending stakeholder consultation as to the regularity.

200 Given the stakeholder consultation has not yet been explored I will tailor the proposed recommendation to accommodate the information regarding regularity.

To the Chief Executive, Justice Health & Forensic Mental Health Network

(7) *That consideration be given to the circumstances of Mr Warwar's death (with appropriate anonymization and conditional upon reasonable steps being taken to consult with Mr Warwar's family, but not contingent upon the family's consent) being used as a case study as part of training provided to Justice Health clinical staff in relation to assessment of inmates who are the subject of a request for assessment to Justice Health made by CSNSW.*

Consideration and Conclusion

201 Justice Health opposes Proposed Recommendation 7:

> It is respectfully submitted that the obligations on Justice Health staff to follow-up following a request from Corrective Services NSW to assess a patient, and the importance of that follow-up, is not well-illustrated through a case study.
>
> The circumstances of Mr Warwar's death do not lend themselves to a clinical case study. Clinical case studies presented within Justice Health are directed at determining where a clinical decision/ judgment has a causal relationship to a patient's adverse outcome. The evidence before the Coroner did not establish any such link between the deficiencies in this case and Mr Warwar's death.

202 As I shall touch on briefly below there is no legal need for there to be a causal link between recommendations and death. As such, I am of the view that limiting clinical case studies to circumstances where a causal connection with an adverse outcome can be established may be an inappropriate limitation. Furthermore, as I have been at pains to point out whilst no causal link has been drawn between Mr Warwar's death and the failings of the nurses we will never know what the outcome would have been, had the nurses attended upon Mr Warwar as soon as they were contacted, as they both determined they should have, with the benefit of hindsight.

203 Nevertheless, I see little point in recommending a case study in circumstances where it is opposed, and I will not make the recommendation.

(8) *That there be mandatory refresher training on HPNFs at least once every 2 years for all current and future serving Justice Health clinical staff at the MRRC.*

Consideration and Conclusion:

204 Justice Health agrees with Proposed Recommendation 8, save that the recommendation should not be limited to clinical staff at MRRC, but rather for Justice Health clinical staff state-wide.

(9) *That a copy of the findings be forwarded to the Ministry of Health for Justice Health to use to support seeking an allocation of funding for additional staff on the afternoon shift at MRRC, with a view to reducing spill-over work from that shift to the night shift.*

205 Justice Health opposes Proposed Recommendation 9.

206 Justice Health contended that the recommendation does not arise on the evidence for the following two reasons.

207 First, the evidence of RN Kasim and RN Sarjeant was that the evening shift was busy. Neither gave evidence that the shift was so busy that they did not have time to attend to see Mr Warwar. To the contrary, both nurses gave evidence that if they had considered Mr Warwar was experiencing a medical emergency they would have attended immediately. Further, both RN Kasim and RN Sarjeant gave evidence that later in the shift they had time and an opportunity to go and see Mr Warwar but made a decision not to do so.

208 Secondly, the evidence of Ms Sheehan was that a shadow study is necessary to determine what work is required on a regular evening shift, where time pressures arise, and what support would best assist staff on evening shift. Ms Sheehan's evidence was that this is required before resources could be appropriately assigned, with a view to targeting the identified issues.

209 As I have found above the workload of nurses Kasim and Sarjeant did play a role in their failure to attend upon Mr Warwar and in the failure of Nurse Sarjeant to participate in handover and the failure to make appropriate records of relevant events.

210 I do however accept the approach of Ms Sheehan and will make a recommendation to that effect.

211 The findings I make under section 81(1) of the Act are:

Identity

The person who died is Mohamed Warwar.

Date of death

Mr Warwar died on 23 October 2021 between 3:28am and 8:00am

Place of death

Mr Warwar died in cell 213 of Fordwick Pod 7, at the Metropolitan Remand & Reception Centre, Silverwater.

Cause of death

The cause of Mr Warwar's death is cardiac arrhythmia with Amisulpride toxicity, and myocarditis being contributory factors.

Manner of death

Mr Warwar died of natural causes.

Recommendations pursuant to s 82

212 Section 82 reads as follows:

> (1) A coroner (whether or not there is a jury) or a jury may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.
>
> (2) Without limiting subsection (1), the following are matters that can be the subject of a recommendation—
>
> (a) public health and safety,
>
> (b) that a matter be investigated or reviewed by a specified person or body.

213 In Conway v Jerram at paragraph [63] Justice Barr noted:

> The power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death.

214 In dismissing an application for leave to appeal, the Court of Appeal noted Justice Barr held that:

> before the power to make recommendations became exercisable, there first had to be proper grounds for holding an inquest.

215 It is clear that matters for recommendation do not need to be causally related to Mr Warwar's death.

216 It is In that understanding of the state of the law that, the following recommendations are made.

<u>To the Acting Commissioner, Corrective Services New South Wales</u>

(1) Consideration be given to ensuring HPNFs are easily available and accessible to staff managing inmates in accommodation areas.

(2) Consideration be given to:

(a) the deficiencies in practice and procedure revealed in the evidence such as,

(i) not attending handover;

(ii) failing to keep appropriate records; and

(iii) correctional officers not referring to HPNFs,

(b) the qualifications, training, and experience of those responsible for the deficiencies,

(c) the policies and/or other documentation directing attention to the correct practice and procedure, and

(d) the volume of policies and training that employees are currently exposed to,

with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated.

(3) That there be mandatory refresher training on HPNFs for all current and future serving Correctional Officers. The frequency of the mandatory refresher training is to be determined after consultation with relevant stakeholders.

To the Chief Executive, Justice Health & Forensic Mental Health Network

(4) Consideration be given to:

(a) the deficiencies in practice and procedure revealed in the evidence such as,

(i) not attending handover;

(ii) failing to keep records; and

(iii) not filling in HPNFs appropriately;

(b) the qualifications, training, and experience of those responsible for the deficiencies,

(c) the policies and/or other documentation directing attention to the correct practice and procedure, and

(d) the volume of policies and training that employees are currently exposed to,

with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated.

(5) That there be mandatory refresher training on HPNFs at least once every 2 years for all current and future serving Justice Health clinical staff statewide.

(6) That a shadow study be undertaken to determine what work is required on a regular evening shift at MRRC, where time pressures arise, and what support would best assist staff on evening shift.

(7) That once the shadow study has been undertaken, steps be taken to put in place the identified support requirements.

217 Finally, I would like to thank all the participants in the inquest for the helpful way in which it was run. In particular I thank the assisting team. Counsel Assisting for his thorough, even and balanced approach which brought thanks from all other parties. Ms Livanos did an extraordinary job in preparing the inquest and assisting right up until the day of these findings. The inquest would not have progressed as smoothly as it did without her hard work.

218 On behalf of the Coroner's Court of New South Wales, I offer my sincere and respectful condolences, to Mr Warwar's family and friends.

219 I close this inquest.

Magistrate David O'Neil
Deputy State Coroner
21 May 2024
Coroner's Court of New South Wales