CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Phair
Hearing date:	22 to 25 July 2024
Date of findings:	17 September 2024
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Elizabeth Ryan, Deputy State Coroner
Catchwords:	CORONIAL LAW – death of a person in Parklea Correctional Centre - can cause of death be established – was nursing and medical care appropriate and adequate.
File number:	2017/371691
Representation:	Counsel Assisting the inquest: J Davidson of Counsel i/b K Tuialii, Crown Solicitor's Office. Justice Health and Custodial Mental Health Network: B Bradley of Counsel i/b B Ferguson, Hickson's Lawyers. The Commissioner, Corrective Services NSW: M Katawazi, Department of Communities and Justice Legal. GEO Group Australia Pty Ltd: T Berberian of Counsel i/b E Lee, Sparke Helmore Lawyers Registered Nurses F Balagtas, J Gallagher, T Nguyen, J Nuevo, R Stratten; and Enrolled Nurse Sara Day: N Dawson, Nurses and Midwives Association

Findings:	**Identity** The person who died is Robert Phair. **Date of death**: Robert Phair died between 6 and 7 December 2017. **Place of death**: Robert Phair died at Parklea Correctional Centre, **Cause of death:** Robert Phair died as a result of cardiomegaly giving rise to lethal cardiac arrhythmia in the setting of drug toxicity. **Manner of death:** Robert Phair died of natural causes while he was in lawful custody.

Non-publication orders

The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009.*

Details of these orders can be found on the Registry file.

Section 81(1) of the Coroners Act 2009 (NSW) [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death.

These are the findings of an inquest into the death of Robert Phair.

Introduction

1. Robert Phair was aged 37 years when he died at Parklea Correctional Centre, at some time between the night of 6 December 2017 and the morning of 7 December 2017.

2. On 5 December 2017 Mr Phair had been arrested on criminal charges, and he was refused bail. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

3. The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death.

4. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The issues at the inquest

5. The inquest examined the following issues:

   - Can the cause of Mr Phair's death be established on the evidence?
   - Was the medical care provided to Mr Phair at Parklea Correctional Centre [Parklea CC] adequate and appropriate?

6. I note that the evidence did not give rise to any concerns about the conduct of correctional officers at Parklea CC and their interactions with Mr Phair.

7. This was not the case with some of the health staff who were involved in his care. At the time of Mr Phair's death, staff employed with the Justice Health and Custodial Mental Health Network [Justice Health] provided medical and nursing care to inmates of Parklea CC. As a result of Mr Phair's death, six nurses were the subject of mandatory notifications to the Australian Health Practitioner Regulation Authority [AHPRA].

8. Following AHPRA's investigation, the Health Care Complaints Commission commenced proceedings against the six nurses in the NSW Civil and Administrative Tribunal [NCAT].

9. In 2022 and 2023 the NCAT conducted disciplinary proceedings and handed down decisions regarding the professional conduct of the six nurses. All six nurses were found guilty of unsatisfactory professional conduct. Two of the six nurses were also found guilty of professional misconduct.

10. The NCAT hearings were comprehensive and addressed many of the issues that would otherwise have been examined in this inquest. Therefore this inquest did not re-examine those matters. Where relevant however, in these findings I have had regard to the NCAT's decisions.

11. A further consequence is that this inquest could not commence until the NCAT proceedings had been finalised. This explains the length of time that has elapsed between Mr Phair's death, and his inquest.

Background

12. Mr Phair was born on 15 January 1980, the second of three children. His parents Robert and Christina separated in the late 1980's, and Christina Phair moved to Innisfail in northern Queensland with the children. Mr Phair later moved to Brisbane to live with his father. As an adult he had three children with a partner, Moana, before moving to Sydney around 2007 or 2008. His children are now in the care of Moana's mother.

13. Christina Phair, although unable to attend the inquest, wrote a statement in which she expressed her love for her son Robbie. As a child he had been *'the kindest kid you would ever want in your family'.* She spoke of her sadness at the way her son's drug dependence had affected his life. It was clear that Christina loved Robert and that she misses him deeply.

Arrival at Parklea CC

14. During his teen years Mr Phair started to use illicit drugs, and this led to him being convicted of drug-related offences. On 5 December 2017 he was again charged with criminal offences and he was refused bail. He was next due to appear in court on 30 January 2018.

15. The day after his arrest, Mr Phair was transferred to Parklea CC in northwestern Sydney. At that time Parklea CC was operated by the company GEO Pty Ltd.

16. On arrival, Mr Phair told Correctional Officer Mark Collalti that he was *'coming off'* ice and heroin. CCTV shows him stumbling and falling, but correctional officers found him to be speaking clearly and coherently, and not apparently in need of urgent medical attention.

17. Enrolled Nurse Lynda Steel commenced a health assessment of Mr Phair at 2.07pm that day, but she did not complete it because she considered he was too unwell. She did however record that he had a medical history of hypertension, epilepsy, asthma and nerve damage. He was prescribed various medications for these conditions.

18. At the inquest EN Steele said it had been clear to her that Mr Phair was very unwell. He was very pale, didn't want to talk much, and wanted to lie in a ball on the floor. He was dry retching and had been vomiting.

19. EN Steel contacted the Main Clinic at Parklea CC and spoke with Clinical Nurse Consultant Karen Scrivener. RN Scrivener is a specialist nurse in drug and alcohol care. RN Scrivener said she could assess Mr Phair straight away, and that Dr Darren Hong Sing Lee would also be able to see him. Dr Lee is now a staff specialist in psychiatry, but at that time he was an advanced trainee in addiction psychiatry employed with Justice Health.

The drug and alcohol assessment

20. Dr Lee and RN Scrivener performed this assessment at about 2.30pm on 6 December 2017.

21. Dr Lee had accessed Mr Phair's Justice Health records. There he saw medical alerts for opioid dependence, hypertension, asthma, epilepsy/seizures and Crohn's Disease. He said that these conditions *'could potentially destabilise each other'*.

22. Mr Phair told Dr Lee that he had injected $1,000 of heroin two days before. He also said that he had a daily use of 15 xanax or 10 diazepam tablets, in addition to alcohol.

23. Dr Lee found Mr Phair to be sedated and irritable. He formed the impression that he was suffering opiate withdrawal, but was doubtful that he had the symptoms typical of benzodiazepine withdrawal, namely tremors and skin clamminess. However he thought there were some symptoms of methylamphetamine intoxication in that Mr Phair was hypertensive and irritable, and his pupils were slightly enlarged.

24. The plan which Dr Lee formed for Mr Phair was as follows:

    1. To be placed in a detoxification cell

2. To receive panadeine and thiamine regularly as well as Stemetil for his vomiting, and symptomatic medications as required
3. Clinical observations to be repeated in four hours' time
4. Drug and Alcohol ROAMS to be called if Mr Phair needed benzodiazepine loading
5. To be reviewed the next day by a Drug and Alcohol medical officer
6. To obtain current information from his medical practitioner.

25. Remote/Offsite/Afterhours Medical Services [ROAMS] is a medically staffed, state-wide, after hours on-call service available to all Justice Health clinics as part of their Drug and Alcohol services. According to the evidence of Dr Lee, the ROAMS on-call clinician is often a Drug and Alcohol Doctor or a Senior Drug and Alcohol Nurse Practitioner.

26. In directing that Mr Phair be placed in a detoxification cell, Dr Lee's purpose was to ensure that he received close observation by the nursing staff. Dr Lee considered it very important that repeat observations be performed four hours after his assessment. As Dr Lee said in his evidence:

> *'There were so many complicating factors – veracity, multiple substances, multiples comorbidities. I was uncertain how his clinical progress would appear'.*

27. As to why he had prescribed panadeine, Dr Lee explained that he had wanted to ascertain Mr Phair's level of opiate tolerance. Mr Phair's clinical signs in response to panadeine would give an indication of this. Dr Lee selected panadeine because it was short term in its effects. There was a risk that a stronger opiate would increase Mr Phair's level of sedation.

28. Dr Lee further explained that Mr Phair would need a review by a Drug and Alcohol medical officer the following day, given the complexity of his current withdrawal. For this reason, after his assessment Dr Lee took care to provide a phone handover to the Drug and Alcohol ROAMS clinician. He also asked that Mr Phair's details be placed on the ROAMS handover document, to ensure that the night doctor was aware of his case.

29. RN Scrivener agreed with Dr Lee on the necessity for four hourly observations. In her opinion, follow up observations were critical in order to monitor how Mr Phair's condition developed overnight. She said further that the Parklea CC nursing staff were clear they needed to continue the four-hourly observations overnight, regardless of whether there was any concern about Mr Phair's clinical condition after the first set of follow up observations at 7.00pm.

30. After the assessment, RN Scrivener spoke with Registered Nurse John Gallagher to give him a brief overview of the plan. RN Gallagher was the rostered Nursing Unit

Manager, and at Dr Lee's instruction he had administered to Mr Phair an intramuscular dose of Stemetil at about 2.45pm.

31. Just prior to completing her shift, RN Scrivener also spoke in person with Registered Nurse Rhonda Stratten, who was the rostered afternoon Clinic nurse. The NCAT findings confirmed that RN Scrivener informed RN Stratten that Mr Phair was detoxing and was unwell, and that he required four hourly observations with the next set due at 7.00pm.

32. After this, Mr Phair was placed in a detoxification cell known as 'Step Down Cell 34'.

The evening of 6 December 2017

33. In the NCAT proceedings, there was no dispute that on 6 December 2017 none of the afternoon or night shift nurses had read Mr Phair's progress notes or health records. The progress notes contained Dr Lee's treatment plan and its specific requirement that Mr Phair receive four hourly clinical observations. The nurses' failure to do so was found to be not in accordance with specified Justice Health policy.

34. It was also not in dispute that despite Dr Lee's treatment plan, no clinical observations were taken after those which RN Scrivener took at 2.30pm that afternoon. This was a further non compliance with Justice Health policy.

35. Just after 7.00pm that evening Mr Phair was woken for his medication by Registered Nurse Tanya Nguyen. She gave him his prescribed Panadeine, but he refused to take the Epilim medication which had been prescribed to him for his epilepsy. RN Nguyen told RN Stratten of this, then completed her shift some time after 8.30pm. RN Stratten did not take any action in relation to Mr Phair's refusal of his Epilim.

36. After the 7.00pm attendance Mr Phair went back to sleep, awaking at 8.26pm to stand up and drink a glass of water.

37. The NCAT found that RN Stratten had not informed RN Nguyen of the requirement to carry out Mr Phair's observations when she brought him his medication. In the NCAT proceedings RN Stratten said that when driving home from her shift that night she had suddenly recalled that observations had not been performed for one of the patients (she could not recall which one). She did not call the night shift about this.

38. Ultimately the NCAT proceedings found that RN Stratten's conduct constituted professional misconduct. This finding was based on her failure:
    - to implement Dr Lee's treatment plan and in particular to perform clinical observations
    - to provide a clinical handover of his care to the night shift

- to take follow up action when informed by RN Nguyen that Mr Phair had refused his Epilim
- to record clinical information about his care.

39. At the inquest, RN Stratten was questioned about Justice Health's *Drug and Alcohol Procedure Manual*, and specifically its requirement that if a patient refuses treatment and there are concerns about their clinical presentation, health staff are to contact staff of the Drug and Alcohol Service for advice. Health staff are also to document the incident. The relevant part of this Manual instructs staff as follows:

> *'If the intoxicated or withdrawing patient is refusing treatment, and there are concerns about the patient's clinical presentation, there is a duty of care to ensure their wellbeing. Contact the on call D & A Medical Officer/Nurse Practitioner or the D & A Clinical Director for advice. Document any proceedings in the patient's current health record'.*

40. RN Stratten said that at the time, it had not occurred to her to do either of these things.

41. On this point, the court was assisted with evidence from Mr Hellal Hussein, the State-wide Service Director of Drug and Alcohol Services within Justice Health. Mr Hussein was asked if it had been a non compliance with the *Drug and Alcohol Procedure Manual*, for staff not to have followed up on Mr Phair's refusal of his Epilim.

42. Mr Hussein replied that in Mr Phair's case the lack of follow up '*raised a concern'*, given that he was in the process of drug withdrawal and therefore may not have been in a fit state to decide to refuse his medication. In addition, little was known about his clinical condition at that early stage. For these reasons, his refusal warranted escalation to a nursing senior manager or the on call doctor.

43. Mr Hussein clarified that the term *'refusing treatment'* in the above extract could include a refusal to take medication that was not medication specific to drug and alcohol treatment.

The night of 6 December 2017

44. For the night shift of 9.30pm to 7.30am, the rostered nurses were Registered Nurse Jeremy Nuevo and Enrolled Nurse Sara Day. They received a handover from RN Stratten between 9.30pm and 10.00pm, just before she (RN Stratten) ended her shift. The NCAT found that in her handover, RN Stratten did not alert staff to the requirement that Mr Phair receive clinical observations.

45. At no stage during that evening or night were clinical observations performed on Mr Phair. The sole clinical record was entered by RN Jeremy Nuevo at 5.55am. This recorded that Mr Phair had been *'settled overnight. Nil issues raised'*.

46. But this record was misleading and inaccurate. At about 10.18pm on the night of 6 December 2017 Mr Phair had used the communication device in his cell known as the 'Steno phone'. This device allows an inmate to call for assistance from correctional officers.

47. Mr Phair's call was answered by Correctional Officer Ravinder Sarin, who was rostered in the Clinic that night. Mr Phair asked to see a nurse, but according to Officer Sarin he declined to say why. When Officer Sarin informed RN Nuevo of the request, he (RN Nuevo) told Officer Sarin to find out the reason for it.

48. Officer Sarin then walked to Mr Phair's cell and turned on his cell light from the outside. Again Mr Phair would not say why he wanted to see a nurse, and he *'verbally abused'* Officer Sarin.

49. After this, Correctional Officer Florence Foisa was asked to call Mr Phair back on the Steno phone and ask him why he wanted to see a nurse. According to Officer Foisa, she phoned Mr Phair and asked if he was alright, to which he replied that everything was okay. Officer Foisa asked if he was sure, and he replied that he was.

50. There is no record of this exchange, as the recording feature on the Steno phone had been disabled some weeks earlier.

51. I will note at this point that the NCAT found RN Nuevo guilty of professional misconduct. This finding was based on his failure to implement Mr Phair's treatment plan, to respond adequately to Mr Phair's requests to see a nurse, to document Mr Phair's clinical notes, and to provide the incoming morning shift with a clinical handover.

The morning of 7 December 2017

52. Correctional Officer David Stankowski commenced his shift in the Clinic at midnight.

53. Officer Stankowski's routine was to walk around the Clinic cells at intervals of thirty minutes to one hour. After this round, he would sit in the Clinic station and keep watch of the cells via two camera monitors.

54. There were two types of cells in the Clinic. Observation cells contained night vision cameras which enabled their interior to be seen on the Clinic station monitor. But the detoxification cells (in one of which Mr Phair had been placed) did not have these cameras, and at night their interior could not be seen on the monitor.

55. Officer Stankowski said that during his shift Mr Phair did not call out; nor did he make any calls on the Steno phone. Nor, apart from Officer Sarin's brief visit

referred to at paragraph 48 above, did any correctional or health staff attend Mr Phair's cell that night. This was confirmed by CCTV footage.

56. At 7.11am Officer Stankowski and Registered Nurse Lynda Steel entered Mr Phair's cell to give him his medication. They found Mr Phair unresponsive, lying faced to the wall on his mattress. His face was half buried under his pillow.

57. Officer Stankowski immediately called an emergency medical response, and clinical staff arrived. But Mr Phair could not be revived, and he was pronounced deceased.

The autopsy report

58. Forensic pathologist Dr Lorraine DuToit-Prinsloo performed an autopsy. In her expert report she stated that Mr Phair did not have any significant or suspicious injuries. Dr Du Toit-Prinsloo could not determine the cause of Mr Phair's death to the level of medical certainty. However in her opinion, cardiomegaly (an enlarged heart) in the setting of drug toxicity could be considered as the cause of death. She confirmed this in her oral evidence at the inquest.

59. On examination Mr Phair had a markedly enlarged heart, a feature which Dr Du-Toit-Prinsloo said was associated with sudden death mostly as a result of a lethal cardiac arrhythmia. An enlarged heart was also associated with chronic methamphetamine use.

60. Other risk factors for a fatal cardiac arrhythmia were use of methamphetamine and heroin. Toxicological analysis of Mr Phair's blood sample had detected amphetamine and methamphetamine, as well as indications of heroin use. Regarding the amount of methamphetamine detected, Dr Du Toit-Prinsloo considered that this was within the reported range of drug levels in fatalities.

61. The court also had the benefit of a report and oral evidence of forensic pharmacologist Dr John Farrar. Dt Farrar agreed with Dr Du Toit-Prinsloo that it was *'quite reasonable'* to conclude that Mr Phair had consumed heroin. He added that consuming stimulant drugs simultaneously with a respiratory depressant such as heroin increased the risk of a drug-related death. This was because the effect of one drug could mask the effect of the other, causing the person to consume more of that drug.

62. Dr Farrar had considered the concentration of methamphetamine in Mr Phair's blood sample, and thought it unlikely it was high enough to have been an acute cause of his death. But he noted that the long term cardiovascular effects of methamphetamine use could well have contributed to Mr Phair's death.

63. An expert opinion as to cause of death was also sought from emergency physician Associate Professor Anna Holdgate. She could not determine the cause of Mr

Phair's death with any certainty, but she offered possible causes of a sudden cardiac arrhythmia, a prolonged seizure due to epilepsy or drug withdrawal, or Sudden Unexpected Death in Epilepsy [SUDEP].

64. In light of this evidence, Dr Du Toit-Prinsloo was asked if SUDEP was a possible cause of Mr Phair's death. But she replied that in her opinion this was not an appropriate finding in circumstances where as here, there were other potential causes such as cardiomegaly and drug toxicity. She considered that cardiomegaly in the presence of drug toxicity was a *'significantly more likely'* cause of death.

The cause of Mr Phair's death

In my view the evidence enables a finding on the balance of probabilities, that the cause of Mr Phair's death was cardiomegaly giving rise to lethal cardiac arrhythmia in the setting of drug toxicity.

65. I now turn to the second issue.

Was the medical care provided to Mr Phair appropriate and adequate?

66. The evidence established that the nursing and medical care provided to Mr Phair by EN Steel, Dr Lee and RN Scrivener was both appropriate and adequate.

67. However, and consistent with the NCAT findings, the evidence established that in important respects the care provided by other nurses was neither appropriate nor adequate. There were significant failures to:
    - read Mr Phair's clinical notes and health records
    - provide adequate handovers on Mr Phair to incoming nursing staff
    - implement the treatment plan for Mr Phair which had been ordered by Dr Lee, in particular the performance of four hourly clinical observations
    - follow up on Mr Phair's refusal of his Epilim
    - (in the case of one nurse) follow up on Mr Phair's request to see a nurse
    - (in the case of the same nurse) record accurate entries about Mr Phair.

68. These were significant failures in the care of Mr Phair. It must have brought significant distress to Mr Phair's family to hear of them again in the inquest.

69. The findings made in the NCAT, and the sanctions imposed on the six nurses, obviate the need for this inquest to recommend any further action in relation to those failures of care. Furthermore, at the inquest three of the nurses (RN's Nguyen, Stratten and Nuevo) offered apologies to Christina Phair for the way in which their care for her son had fallen short of what was required. They wished his family to know that they had reflected deeply on their actions, regretted them, and had worked to become better practitioners.

70. Notably, in his closing submissions Mr Bradley expressed a sincere apology on behalf of Justice Health. He said that Justice Health accepted that individual nurses had fallen short in their professional conduct and had not complied with Justice Health policies.

71. Before leaving this issue, I will make clear that on the evidence, the above failures were not due to any deficiencies in relevant Justice Health policies. They were rather, failures on the part of individual staff members to comply with those policies.

Changes made within Justice Health

72. The court also heard evidence from Mr Hellal Hussein, the Director of Drug and Alcohol Services within Justice Health. I note that Mr Hussein attended court on each day of the inquest. His attendance throughout the inquest was appreciated, as was his apology to Mr Phair's family, on behalf of Justice Health.

73. Mr Hussein told the court of changes that have taken place since Mr Phair's tragic death. These include reforms to Justice Health's handover practice, which make clear the expectations that are held of staff when providing information about individual patients to incoming shifts.

The question of recommendations

74. It had been proposed by Counsel Assisting that the CEO of Justice Health consider amending the part of the Justice Health *Drug and Alcohol Procedure Manual* which is quoted at paragraph 39 above, such that after the word '*treatment',* the following words be inserted: '*including for their co-morbidities'*.

75. This proposal arose from the circumstance that the medication which Mr Phair had refused was not specifically for treatment of a drug and alcohol disorder. In his evidence, Mr Hussein had not disagreed when it was suggested to him that such a clarification could be beneficial.

76. In closing submissions however Mr Bradley said that on reflection, Justice Health did not support the proposal. It was, he said, a significant and expensive process to amend Justice Health policies, which should not be undertaken unless the amendment had the potential to bring about a clear improvement to public health and safety. In Mr Bradley's submission, professional Justice Health staff understood that the term *'treatment'* adverted to all treatment applied to a patient.

77. In reply submissions Counsel Assisting acknowledged that Justice Health had given consideration to the proposed recommendation, and had reached the conclusion that it was not desirable. In these circumstances it would be open to the court not to proceed with the proposal.

78. Taking into account the above submissions, I accept that there is insufficient evidence that the proposed recommendation is necessary or desirable.

Conclusion

79. In closing, I express to Christina Phair and her family my sincere and respectful sympathy for the loss of her son Robert.

80. I thank Counsel Assisting Ms J Davidson and the NSW Crown Solicitors for their excellent assistance in the preparation and conduct of the inquest. I express my appreciation for the professional and cooperative approach taken by all Counsel and parties involved in the inquest. And I thank the Officer in Charge of the coronial investigation, Detective Inspector Joshua Palmer for his preparation of the brief of evidence.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity
The person who died is Robert Phair.

Date of death:
Robert Phair died between 6 and 7 December 2017.

Place of death:
Robert Phair died at Parklea Correctional Centre,

Cause of death:
Robert Phair died as a result of cardiomegaly giving rise to lethal cardiac arrhythmia in the setting of drug toxicity.

Manner of death:
Robert Phair died of natural causes while he was in lawful custody.

I close this inquest.

Magistrate E Ryan
Deputy State Coroner
Lidcombe

17 September 2024