STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Ms Vicki Higgins
Hearing date:	22-24 April 2024
Date of findings:	17 May 2024
Place of Inquest:	NSW State Coroner's Court sitting at Wagga Wagga Local Court
Findings of:	Magistrate Carmel Forbes, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – cause and manner of death – ischaemic bowel – death during COVID-19 outbreak at Junee Correctional Centre – adequacy of care – adequacy of response to medical emergency
File number:	2022/27663

Representation:	Counsel Assisting: Mr J Harris, instructed by Ms I Pearson (Crown Solicitor's Office) Family of Ms Higgins: Ms T O'Rourke, instructed by Ms S Sarang (O'Brien Criminal and Civil Solicitors) GEO Group Australia Pty Ltd: Ms T Berberian, instructed by Ms M Shanahan (Sparke Helmore) Dr D Corbett: Mr T Hackett, instructed by Ms L Kearney (Avant Law) Registered Nurses Cooke, Duddy, Treloar and Kelly: Mr B Thompson (NSW Nurses and Midwives' Association) Commissioner of Corrective Services NSW: Ms A Heritage (Department of Communities and Justice, Legal) Justice Health and Forensic Mental Health Network: Mr H Norris (Justice Health and Forensic Mental Health Network)

Findings:	Identity of deceased: The deceased person was Vicki Higgins Date of death: Vicki Higgins died on 29 January 2022 Place of death: Vicki Higgins died in the Female Transition Unit at Junee Correctional Centre, Junee NSW Cause of death: Vicki Higgins died as a result of an ischaemic bowel. Coronary artery disease, diabetes and Crohn's disease were other significant conditions that contributed to her death. Manner of death: Vicki Higgins died of natural causes whilst she was in lawful custody. She was received into custody at Junee Correctional Centre on 12 January 2022 in the middle of a COVID-19 outbreak at the Correctional Centre and she did not receive a medical screen before her death on 29 January 2022. Non-publication order: A copy of the non-publication orders made on 9 October 2023 are available from the Registry.

REASONS FOR DECISION

Introduction

1. Ms Vicki Higgins died on 29 January 2022, at Junee Correctional Centre, Junee, NSW. She was 48 years of age. On 11 January 2022, she had been arrested by police, who had attended her property to arrest her son. She was bail refused and arrived at Junee Correctional Centre on 12 January 2022. It was her first time in custody.

2. Ms Higgins had longstanding serious health issues, including diabetes and a history of Crohn's disease, which had resulted in the removal of a portion of her bowel. She used an ileostomy bag.

3. At the time of her incarceration there was an unprecedented outbreak of COVID-19 in Junee Correctional Centre which necessitated strict lockdown and severe staff shortages that impacted upon the ability of staff to deliver health and operational services.

4. Throughout her time in custody, Ms Higgins was laying on a mattress on the floor in her cell and complained to staff and fellow inmates about feeling unwell and nauseous, and told them she was unable to eat or drink. Although she was seen frequently by correctional and nursing staff, and briefly by a doctor, her care was never escalated.

5. Ms Higgins was last seen alive when receiving breakfast on 29 January 2022, 17 days after her admission to custody. She was found deceased about an hour later. The cause of death was found on autopsy to be an ischaemic bowel.

Inquest

6. At inquest a coroner's primary role is to investigate and make findings as to the identity of the deceased person, the date and place of the death, and the manner and cause of death. A further role for a coroner is to assess whether there has been an appropriate response to the death and whether more needs to be done to protect others from a similar death.

7. When a person dies whilst being held in lawful custody s. 23 of the *Coroners Act 2009* makes an inquest mandatory as there is an expectation that the death will be independently investigated and that there will be a detailed account of the circumstances surrounding the death.

8. The focus of this inquest has been on the events that occurred at the Correctional Centre, and in particular the adequacy of care that was provided to Ms Higgins. Independent expert opinions from Dr Cameron Bell, Gastroenterologist, Director of Endoscopy at Royal North Shore Hospital, Sydney and Dr Emery Kertesz, General Practitioner (**GP**), were obtained to assist with consideration of this issue.

Background

9. Ms Higgins was born on 21 March 1973 at Deniliquin. Her parents were Beverly and Lawrence Higgins. She had three siblings.[1]

10. She was a sporty child and excelled at swimming. However, she developed Crohn's disease as a teenager, and left school in Year 8 or 9 due to that illness. In 1995, she had a colectomy (removal of colon) at St Vincent's Hospital, and an ileostomy bag was fitted.

11. Ms Higgins developed a hernia near to the stoma site in about July 2020, and was referred for specialist opinion. Conservative treatment was advised, although Ms Higgins also asked for a second opinion. Ultimately, it does not appear that this condition was connected to the cause of her death.

12. She also developed diabetes and required insulin injections.

13. Ms Higgins suffered poor mental health, with diagnoses of bipolar disorder, anxiety, and depression. During 2021, she was receiving treatment from Deniliquin Community Mental Health.[2]

14. When Ms Higgins was 17 or 18, she formed a relationship with Paul Sartore. They married in 1995 when she was in her early 20s. They had three children together, Tyson,

[1] Tab 54, Statement of Paul Sartore.
[2] Tab 63, Ochre Medical Health Centre Medical Reports (Part 1), pgs 447 to 448.

Kodi and Blair, all now adults. She had a bubbly personality and her family and children's friends affectionately called her "Mama Bear Vic". She separated from Mr Sartore in about 2005, although they remained married and were in contact until shortly prior to her death.

15. Ms Higgins re-partnered with Peter McCann, with whom she had a child, Deeon, in 2010. Tragically, Deeon died in 2013, aged 2½ years, following a dog attack at his maternal grandmother's home. Ms Higgins stopped speaking to her mother after this, and her relationship with Mr McCann did not survive. The death was, understandably, still affecting Ms Higgins at the time she entered custody.

16. Furthermore, her son Tyson was diagnosed with carcinoma in 2018 and given two months to live. He moved to Melbourne for an immunotherapy drug trial and did not get to see his mother throughout due to the COVID-19 restrictions that came into place. This hit Ms Higgins very hard.

17. The boys could not understand why their mother did not ring them from the Correctional Centre. Their attempts to make contact were unsuccessful. They did not realise that she was sick on the floor of her cell and unable to ring them.

18. Her death has taken a grave toll on them. They miss her dearly.

Arrest

19. Prior to Ms Higgins's arrest, there was an Apprehended Violence Order ("AVO") in force against Kodi, protecting Ms Higgins, with a condition that required Kodi not to reside with Ms Higgins. Despite this, there was some evidence that they had been staying together (on reports from the family they were soul mates that had occasional flare up arguments).

20. On Tuesday 11 January 2022, police attended Ms Higgins' house. They found Ms Higgins and Kodi present. They informed Kodi he was going to be arrested for breaching the AVO. Kodi attempted to return inside the property, and Ms Higgins tried

to intervene in the arrest. She struggled with police officers. The events are captured on Body Worn Video.

21. Ms Higgins was arrested and taken to Deniliquin Police Station, where she was charged with assault police, resist police, and common assault. She had failed to appear on bail in relation to previous charges and the police did not grant her bail. (None of her charges were ever finalised and she has no convictions on her record).

22. She appeared at Albury Local Court that afternoon and was bail refused. At 5:34pm, she was transferred into the custody of Corrective Services NSW.

23. She remained at the Albury Court Cells overnight. The following morning, on 12 January 2022, an ambulance was called to the cells at 8:32am to check her insulin levels.

24. Ms Higgins was then transferred to custody at Junee Correctional Centre, arriving at reception at 6:25pm.

Junee Correctional Centre

25. At the time of these events, and currently, Junee Correctional Centre was a privately managed prison. It has been operated by GEO Group Australia Pty Ltd (**GEO**) since 1993. Correctional officers and health staff at the Correctional Centre are employed or engaged by GEO.

26. On 3 November 2023, the Minister for Corrections announced that Junee Correctional Centre will return to the control of Corrective Services NSW at the expiry of the existing contract, in March 2025.[3]

27. A transmission period has commenced and from 1 April 2025 all policies and procedures applicable to State managed correctional centres will apply to Junee Correctional Centre.

[3] Exhibit 5, Letter of Ass Cmr Contracts and Commissioning Craig Mason re de-privatisation of Junee CC dated 24 April 2024.

28. In mid-to-late January 2022, there was a major COVID outbreak at the Junee Correctional Centre. There were 200 positive cases over a period of 10 days, and there were large staff shortages, with a reduction of nursing staff from 13 to 5.[4] In addition, one of two doctors who visited the Correctional Centre, Dr Darren Corbett, tested COVID-positive on 16 January 2022. He was required to isolate and did not return to work until 27 January 2022. There were no medical officers at the Centre replacing him while he was in isolation.

29. Dr Corbett is a GP who worked at Junee Correctional Centre and in private practice. Dr Corbett worked at the Centre initially as a locum from 2007 to 2015 and then on a permanent part time basis from 2015 until 2023.

30. As at January 2022, all new inmates were required to be screened and then enter a 14-day isolation period, with COVID-testing on day 1 and day 12.[5] Staff were also required to wear personal protective equipment (**PPE**) when interacting with inmates and use social distancing where possible.[6]

31. Ms Higgins was received at reception at 6:25pm on 12 January 2022. Registered Nurse (**RN**) Duddy saw Ms Higgins just prior to finishing her shift. She noted that Ms Higgins was a diabetic and had a colostomy. She checked Ms Higgins's Blood Sugar Level (**BSL**) which was low, at 3.3mmol/L. Nurse Duddy contacted the on-call GP, Dr Wahba, who advised giving Ms Higgins glucose and withholding insulin until her BSL rose to 6.0. Ms Higgins did not want solid food but agreed to drink cordial and a sweet hot drink. Nurse Duddy also offered to help Ms Higgins with her ileostomy bag, which was partly full, which she declined. Nurse Duddy's notes described Ms Higgins as "*very uncooperative".* In her evidence in court Nurse Duddy explained that Ms Higgins did what she was asked but was not happy about doing it.

32. Ms Higgins was not medically screened that evening, or indeed at any point prior to her death. Nurse Duddy completed a Health Problem Notification Form (**HPNF**)[7] stating

[4] Tab 14, Statement of Dr Darren Corbett at [1].
[5] Tab 100, Junee Correctional Centre Operating Manual, Management of Inmates in COVID-19 Quarantine ("COVID-19 Quarantine Manual") at [5.7].
[6] Tab 100, COVID-19 Quarantine Manual at [5.15], [5.22.1].
[7] Tab 62, Health Problem Notification Form ("HPNF") Adult, pg 4.

that there were no nursing staff available to screen. She recommended Ms Higgins be placed under the High-Risk Assessment Team (**HRAT**) protocol, with hourly observations, because she had not been medically screened. The HRAT protocol is generally used for inmates who are at risk of self-harm.[8] She also noted that a COVID swab had been taken. The result of that swab was negative for COVID[9] and the second swab was due on 24 January 2022.

33. Ms Higgins was placed in a cell in the Female Transition Unit (**FTU**).[10] The FTU is used to temporarily house female inmates who are in transit to appear before Court or en route to other centres. Ms Higgins was there pending her medical screen and pending her second COVID swab due on 24 January 2022. Neither of these occurred. She remained there until her death.

34. In relation to her medical screen, it appears that there were initially insufficient staff members to do it. Ms Higgins was also resistant to being screened, although when it was explained to her what it entailed on 16 January 2022, she agreed to it.[11] Medical screening was eventually planned for 29 January 2022, the day of her death, and over two weeks (17 days) after her reception at the Correctional Centre.

35. Ms Higgins remained in COVID isolation for 17 days without a second COVID swab being done. She was alone in her cell throughout her whole time in custody.

36. Ms Higgins was seen frequently by correctional officers. The relevant policy requiring hourly checks[12] requires officers to open the cell door and ask the inmate to stand up and confirm verbally they are okay. The available CCTV footage does not support that this occurred. Instead, officers viewed Ms Higgins through the cell door hatch. The hourly observations reported that Ms Higgins spent most of her time lying on her mattress or on the floor.

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[8] Tab 101, Junee Correctional Centre Operating Manual, High Risk Assessment Team (HRAT) Policy ("HRAT Policy Manual") at [1.1].
[9] Exhibit 4, Laverty Pathology Records.
[10] Housing Location 73 – records Ms Higgins was initially placed in Cell 1, and moved into Cell 6 on 26 January.
[11] See Tab 18, Statement of RN Kelly at [5] and Tab 61A, General Interim Progress Notes at pg 5.
[12] Tab 98, Junee Correctional Centre Operating Manual, Accounting for Inmates and Muster Routines Policy at [4.3.1.2].

37. Ms Higgins was seen frequently by nursing staff. She was seen twice daily, to receive medication, check her BSL and have a "welfare check". Despite this, she did not receive any medical assessment by a doctor until the day prior to her death. Only one nurse, RN Peter Cooke, took her vital signs, first on 19 January 2022, and then again on the day prior to her death.

38. Ms Higgins refused food and drink. The records are unclear as to whether she ate any food at all or ate only some food. It seems clear that her intake was limited. Containers of uneaten food built up in her cell.

39. From 14-18 January 2022 she used her cell call alarm to report health concerns and requested medical attention on about 15 occasions.[13] In those calls she complained of not eating, vomiting, being dehydrated, pain, her ileostomy bag not functioning, wanting medication, wanting to see a nurse and for an ambulance to be called. Other inmates also called for assistance to be given to Ms Higgins.

40. Nurse Treloar, a mental health nurse, attended Ms Higgins on 13 January 2022 and noted that she was "*distressed and sad*".[14]

41. She saw Ms Higgins again the following day, 14 January 2022, when Ms Higgins appeared well but pale. She said she had not eaten since Monday (four days prior). She said her ileostomy bag had not worked since she had come in.[15]

42. Ms Higgins was reviewed by a psychologist. This was the first of five psychology reviews. Ms Higgins said she had been told to drink water, but it made her nauseous, as she drank soft drinks in the community. She said she had never felt as ill as she currently did. She denied thoughts of self-harm.[16]

43. On 15 January 2022, she made a cell call asking to see a nurse.[17] She said she had not eaten or drank since Monday, five days prior, and had not had her medication. The

[13] Tab 55, Serious Incident Report of CSNSW Investigations Branch, pgs 20-27.
[14] Tab 61A, General Interim Progress Notes, pg 2.
[15] Tab 61A, General Interim Progress Notes, pg 3.
[16] Tab 69, Corrective Services OIMS Case Note report, pg 3.
[17] Tab 53B, Vicki Higgins Cell Call Recordings, pgs 2-3.

notes record she had brought a Webster pack of medication into the Correctional Centre, and staff recorded that they provided medication, although it is unclear what.

44. There is a note stating a nurse did attend, and conducted a welfare check, although no further note about what assessment, if any, was undertaken.[18]

45. On 16 January 2022, Nurse Kelly reviewed Ms Higgins at about 12:30pm. Ms Higgins complained of blurred vision and a headache and expressed that she was unable to walk to the toilet and felt she would pass out. She said she was having flashbacks about a previous miscarriage. She said she still hadn't eaten since Monday, although the colostomy bag had worked two to three days prior and she had urinated. Ms Higgins agreed to participate in a health screen.[19]

46. A medical screen would include taking an extensive history from Ms Higgins and making referrals to specialist nurses, allied health and the GP.

47. On Monday 17 January 2022, a mental health nurse reviewed Ms Higgins. Ms Higgins said she was not eating and did not want to live, although did not want to hurt herself. The nurse reported concerns about Ms Higgins not eating and raised it in HRAT meetings.[20]

48. Nurse Kelly stated that she asked Correctional Officers on several occasions about Ms Higgins's eating. She was told that food was regularly being delivered, and at least a portion of that food was missing when leftovers were collected. This information, as well as Ms Higgins's BSL readings, led her to believe Ms Higgins was eating.[21]

49. A separate review was performed by psychologist Mr Don. Ms Higgins was on a mattress on the floor and appeared unwell. She again reported not eating and having only drinks since she arrived. She reported flashbacks about her son, Deeon. She was offered counselling and the chaplain was also informed.[22]

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[18] Tab 69, Corrective Services OIMS Case Note report, pg 4.
[19] Tab 18, Statement of RN Kelly at [8]. See also Tab 61A, General Interim Progress Notes, pg 5.
[20] Tab 17A, Supplementary Statement of RN Treloar at [16].
[21] Tab 18A, Supplementary Statement of RN Kelly at [15].
[22] Tab 69, Corrective Services OIMS Case Note report, pg 4.

50. That evening, Ms Higgins made a cell call, asking for a soft drink and saying she was dehydrated. She wanted to make an outside phone call because she knew she was "*going to end up in the ground".*[23] She said she was vomiting. She asked for an ambulance. It appears a nurse responded but did not see Ms Higgins as her eyes were shut and the nurse thought she was asleep.[24] There is no nursing entry about this.

51. On Tuesday 18 January 2022, Nurse Cooke contacted Dr Corbett, the on-call doctor, to have Ms Higgins's medication chartered.[25]

52. At 6:44pm that day, Ms Higgins made a cell call asking for an ambulance, saying she was dehydrated. She was told an ambulance would be called.[26] It wasn't.

53. On Wednesday 19 January 2022, Nurse Cooke saw Ms Higgins twice to administer her morning and evening medication. Ms Higgins said she felt nauseous. Nurse Cooke took her observations, which were normal. He provided an anti-emetic, Maxolon, and hydrolyte.[27] A case note also records that Ms Higgins had dinner that day.[28]

54. On Thursday 20 January 2022, Nurse Cooke again provided morning and evening medication, and checked Ms Higgins's BSL.[29]

55. Nurse Treloar reviewed Ms Higgins later that day. She was physically unwell, with nausea and vomiting.[30] A review by psychologist also noted she was "*very sick*", was in tears and appeared to be in pain. She reported vomiting and wanted to go to hospital to be put on a drip. The psychologist tried to inform medical staff, but none were available.[31]

56. A decision was made that afternoon that Ms Higgins could be released from HRAT, once medical screening was completed.[32] The medical screening never occurred.

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[23] Tab 55, Serious Incident Report of CSNSW Investigations, pg 25.
[24] Tab 53B, Vicki Higgins Cell Call Recordings, pg 6. See also Tab 55, Serious Incident Report of CSNSW Investigations, pgs 20-27.
[25] Tab 15, Statement of RN Cooke.
[26] Tab 53B, Vicki Higgins Cell Call Recordings, pg 6.
[27] See Tab 61A General Interim Progress Notes at pg 8 and Tab 15, Statement of RN Cooke at [8].
[28] Tab 69, Corrective Services OIMS Case Note report, pg 5.
[29] Tab 15, Statement of RN Cooke at [9].
[30] Tab 61A, General Interim Progress Notes, pg 10.
[31] Tab 69, Corrective Services OIMS Case Note report, pg 5.
[32] Tab 62 JH&FMHN Medical Records at pgs 3 and 6; Tab61A, General Interim Progress Notes, pg 10.

57. On Friday 21 January 2022, Nurse Cooke provided medication in the morning and evening and checked Ms Higgins's BSL. Ms Higgins complained of nausea, and he provided Maxolon.

58. There are limited entries in the records over the following week. In particular there are no nursing notes recording any substantive attendance on Ms Higgins between 21 and 28 January 2022. The only records relate to medication and BSL checks.

59. On Saturday 22 January 2022, the notes record that Ms Higgins remained in her cell on floor all day and made a "*fuss*" about coming to the hatch for meals and BSL checks.[33]

60. On Monday 24 January 2022, Ms Higgins was due for her second COVID swab since entering the Correctional Centre. It was not taken, and there is no reason recorded as to why this did not occur.

61. Psychologist Ms Ainsworth reviewed Ms Higgins that day. She presented as distressed. She said she could not shower or use the toilet, although she appeared well-groomed. Ms Ainsworth noted a build-up of rubbish in the cell (food containers plus two bags Ms Higgins said contained vomit). Ms Higgins reported she had not been able to eat or drink and wanted to be transferred to hospital.[34]

62. On Wednesday 26 January 2022, Ms Higgins was said to be lying on the mattress on the floor at the cell door, and the cell was full of rubbish and uneaten meals. Ms Higgins cleared the rubbish into a rubbish bin at lunchtime.[35]

63. On Thursday 27 January 2022, a case note also records, "*Ms Higgins remained quiet today, observed sleeping during security checks."*[36]

64. On that day Dr Corbett returned to Junee Correctional Centre. He returned from isolation after being sick with COVID. He spent the first day and a half catching up on medication charts and pathology results. He only saw one patient.

Friday 28 January 2022

[33] Tab 69, Corrective Services OIMS Case Note report, pg 5.
[34] Tab 69, Corrective Services OIMS Case Note report, pg 6.
[35] Tab 69, Corrective Services OIMS Case Note report, pg 7.
[36] Tab 69, Corrective Services OIMS Case Note report, pg 7.

65. On Friday 28 January 2022, Dr Corbett saw Ms Higgins for the first and only time. The circumstances were pressured. He had a clinical handover at 12:30pm for 15 minutes, and then had to review all 20 patients who were on HRAT (some of whom required a suicide assessment) prior to the HRAT meeting at 1:30pm. He saw Ms Higgins through the cell door hatch.

66. Ms Higgins was lying on the floor. She reported she had not eaten anything for three weeks and had pain "*all over*". Dr Corbett did not examine her, due to time restraints and because he did not want to break quarantine. However, he spoke to correctional officers, who said Ms Higgins had been "*drinking fluids and picking at her food eating the things she liked"*. Dr Corbett did not think Ms Higgins was suicidal. He noted her stoma was working, she was urinating, and her observations had been *"okay"*.

67. Dr Corbett's attendance was a HRAT self-harm screen not a medical assessment. In hindsight Ms Higgins desperately needed a medical assessment by a doctor and it was a shame that did not happen when the doctor saw her. He explained to the Court that he only wished he had had more time on the day. That upon his return to work he was under enormous pressure. When he saw Ms Higgins, he was in the process of assessing 20 patients for self-harm risk. He ordered blood tests for Ms Higgins and an abdominal X-ray and noted she was due for a full medical screen at 9:00am the following day.

68. The expert, Dr Bell gave evidence that the results of a physical examination of Ms Higgins's abdomen on that day was unknowable because the underlying process is unknown. He stated that there may have been no significant signs or red flags of the ischaemia leading to an urgent transfer to hospital.

69. That evening, a "Code White" (medical emergency) was called and Ms Higgins informed staff that she kept vomiting and needed to be on a drip.[37] Nurse Cooke attended. He saw Ms Higgins lying on her left side on a mattress. She said she had fallen over. She was able to move from side to side on the mattress. She did not stand. He took observations, he said they were normal, and she was speaking in short sentences. It

[37] Tab 51, Correctional Officer Body Worn Video Files – Code White, 28 January 2022. See also Tab 96, Junee Correctional Centre Code White – Medical Emergency Policy.

appeared she was able to protect her own airway. Nurse Cooke deemed her safe to remain in the FTU.[38]

70. Dr Kertesz described Nurse Cooke's assessment of Ms Higgins as appropriate and consistent with that being required in an emergency scenario where a patient is deemed to be unresponsive.

Saturday 29 January 2022

71. At about 4:30am on 29 January 2022, Ms Baxter in Cell 3 of the FTU heard Ms Higgins crying. Ms Higgins told her, "*it feels like I'm shutting down*". Ms Baxter made three urgent cell calls. They were recorded. She reported that Ms Higgins was really sick, was unable to drink, and that she was really concerned about her and that Ms Higgins needed to go to hospital. She also asked for a nurse or doctor to attend.[39] The control room contacted Corrections Officer James Kelleher to attend upon Ms Higgins. There is no record of what was said by the control room to Corrections Officer Kelleher. He gave evidence that he was not aware of the circumstances of his requirement to attend. He said he attended with Corrections Officer Kyle Peters and saw Ms Higgins asleep and continued with his duties. He didn't recall talking to Ms Baxter and the records record him making hourly observations until 6:00am.

72. A review of the statement of Corrections Officer Chloe Middleton, who reviewed the CCTV from the FTU, indicates that Corrections Officer Kelleher is seen doing a check alone at 5:00am, a check with Corrections Officer Peters at 5:38am and a check alone at 6:00am possibly talking to Ms Baxter in Cell 3.[40]

73. It is unsatisfactory that we do not have a recording of the time and the contents of the message Corrections Officer Kelleher was given by the control room. He should have been told the reason why he was he was required to check on Ms Higgins. Corrective Services NSW do not record conversations between their staff. In this case the available evidence is that at 4.30am an inmate called for urgent medical attention for another

[38] Tab 15, Statement of RN Cooke at [14]. See also Tab 61A, General Interim Progress Notes, pg 14.
[39] Tab 55, Serious Incident Report of CSNSW Investigations at [11] pg 29; See also Tab 53A Cell Call Recordings.
[40] Tab 34, Statement of Correctional Officer Chloe Middleton, 11 February 2022, pg 1.

inmate who, as things transpired, died later that day. The evidence from the Corrections Officer is that he was not told by the control room that there was any urgency, and he did not know why he was required. The first relevant check he is seen doing on her was at 5am. There is a problem in the system here. There will always be an independent investigation into a death in custody and Corrective Services NSW should keep an available recording of the time and contents of information relayed by the control room to correctional officers responding to a call for urgent medical attention. I propose to make a recommendation in that regard.

74. At around 7:00am, Corrections Officer Craig Meiklem and Corrections Officer Nigel Paton did the morning muster in the FTU. At 7:11am, they opened Ms Higgins's cell door. Corrections Officer Meiklem asked if Ms Higgins was okay, and she reportedly said "*yes*". He then closed the door. She was not required to stand up as required by the policy.

75. About an hour later, at 8:03am, Corrections Officer Paton checked through the cell door hatch of Cell 6 (the cell Ms Higgins was in).[41]

76. At 8:10am, there was a change of the guard. Corrections Officer Meiklem and Corrections Officer Patrick Campbell attended. Corrections Officer Paton told him that hourly checks were required in both the medical unit and the FTU.[42]

77. At 9:04am, Corrections Officer Paton checked through the Cell 6 door hatch again.[43]

78. At 9:42am, Corrections Officer Paton and Corrections Officer Campbell began to provide breakfasts in the FTU. Corrections Officer Paton passed Ms Higgins's food through the cell door hatch. She was on her mattress on the floor, and initially appeared to be asleep. He asked if she wanted hot water, and she said, "*no hot water*".[44] That was the last time she was seen alive.

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[41] Tab 40, Statement of Craig Meiklem; Tab 38, Statement of Nigel Paton. See also Tab 32 Incident Report of Correctional Supervisor Anthony Turner.
[42] Tab 38, Statement of Nigel Paton, pg 1.
[43] Tab 55, Serious Incident Report of CSNSW Investigations at [14].
[44] Tab 32, Incident Report of Correctional Supervisor Anthony Turner; see also Tab 38, Statement of Nigel Paton, pg 2.

79. There was then a gap of about one hour and 20 minutes, during which there was no contact with Ms Higgins.

80. At 10:52am, Corrections Officer Meiklem returned to the FTU. After performing other duties, he asked Corrections Officer Campbell if the hourly check had been performed. It had not. Corrections Officer Campbell thought he had checked on Ms Higgins's cell by looking at the cameras. However, her cell did not have a camera.

81. At 11:10am, Corrections Officers Meiklem and Campbell attended Ms Higgins's cell. Corrections Officer Meiklem looked through the cell door hatch and saw Ms Higgins slouched on the toilet. He called to her, but there was no response. He and Corrections Officer Campbell returned to the office and put on PPE.[45]

82. They returned to Ms Higgins's cell and found Ms Higgins was not breathing and called for a Centre Emergency Response Team ("CERT") team via radio.[46]

83. A number of staff members attended from this point. CPR was commenced. An ambulance was called at 11:14am.

84. Paramedics attended promptly at 11:26am. Attempts at CPR, defibrillation and IV adrenaline by the ambulance officers were all unsuccessful.

85. The expert evidence is that it is highly unlikely that different action on 29 January 2022 by correctional staff would have led to a different outcome.

86. Ms Higgins was declared deceased at 11:44am.

Cause of Ms Higgins's death

87. An autopsy was conducted by Dr Alison Ward on 2 February 2022. There were no signs of trauma or injury. The acute cause of death was "*ischaemic bowel*". Ms Higgins had extensive adhesions throughout her abdominal cavity, and the end of the small bowel

[45] Tab 40, Statement of Craig Meiklem, pg 1.
[46] Tab 40, Statement of Craig Meiklem, pg 1; Tab 31, Incident Report of Correctional Manager Operations Amanda Hyder, pg 1; Tab 32, Incident Report of Correctional Supervisor Anthony Turner, pg 1.

(ileum) was ischaemic/infarcted near to the site of the ileostomy. A portion of the ileum had herniated through the opening of the stoma site and was visible externally.

88. Ms Higgins also had severe coronary artery disease, with a 90% occlusion to her right coronary artery. There was no evidence of myocardial infarction.

89. Dr Ward determined the cause of death as "*ischaemic bowel*" with significant conditions contributing to death listed as coronary artery disease, Type I diabetes mellitus and Crohn's disease.

Expert review

90. Dr Cameron Bell, gastroenterologist, explained that very little external ongoing care is required for a person who has an ileostomy bag. He explained that Ms Higgins had a parastomal hernia in about July 2020, but that this is not uncommon, and he considered it largely irrelevant to the events that led to Ms Higgins's death. He noted that the autopsy found extensive adhesions, secondary to Ms Higgins's surgery. He considered it unusual for adhesions to cause the extensive ischaemia. The extent of the ischaemia he opined was suggestive of further vascular compromise. This could have been either heart failure, arrythmia, or possibly an undetected COVID infection.

91. He noted that Ms Higgins reported non-specific symptoms during the period she was in custody and that the symptoms were consistent with ischaemic bowel.

92. Ultimately, he opined that Ms Higgins was clearly unwell for many days. In his view, her condition warranted escalation and transfer to hospital even though hospitalisation may not have ultimately prevented her death, due to the extent of the ischemia in her bowel.

93. Dr Emery Kertesz, general practitioner, explained that if Ms Higgins had presented to a local medical practice three to four days after the onset of her symptoms, a doctor would have taken a history, performed an examination, ordered urgent pathology and imaging, and would have referred the patient to the emergency department. He was

of the opinion that the care given to Ms Higgins while she was in custody was inadequate.

94. In his opinion the care given to Ms Higgins was inadequate, incomplete, and inappropriate when considering the duration of her symptoms and signs. The fact that in 17 days of incarceration there were eight entries made in the nursing notes by various nursing staff regarding her symptoms of nausea, vomiting, malaise and dehydration, the staff noticing that uneaten food was piling up in her cell and her constant requests for transfer to hospital were being ignored amounted to poor intra institutional management.

Issues

95. An issues list was prepared prior to the inquest commencing to provide structure to the hearing. Some of the issues are no longer of great relevance and have fallen away. I have considered all the submissions made by the parties and I am of the view that the following matters are the relevant issues that require comment.

1. What was the impact of the COVID outbreak at Junee Correctional Centre during January 2022?

96. The Health Services Manager at Junee Correctional Centre gave evidence that on 14 January 2022 there was an outbreak of COVID-19 and the centre was locked down. There were approximately 240 inmates who had tested positive to COVID-19 or who were deemed to be close contacts of confirmed positive cases both of which required daily observations. This was an enormous additional amount of extra work for medical staff to take on, outside of their usual duties. Further to this, as of 28 January 2022, 31 staff members were in isolation after testing positive to COVID-19 and a further six staff members were in isolation due to being close contacts, resulting in a total of 37 staff members being off work at this time. Throughout the month of January 2022, a total number of 96 staff members tested positive to COVID-19, resulting in enormous pressure on the provision of services at the centre.

97. There is no dispute that the effect of the COVID-19 outbreak at Junee Correctional Centre in January 2022 was an unprecedented event for the correctional staff and the medical staff. The witnesses that gave evidence during this inquest reported extreme staff shortages and working extra hours as a result. During this inquest there has been evidence of various breaches of standard procedures and policies and I have considered those breaches in light of the unusual circumstances the Centre was operating under.

2. Was adequate care provided to Ms Higgins by health staff during her time in custody at Junee Correctional Centre?

98. The consensus of the expert evidence is that Ms Higgins should have been screened, assessed and transferred to hospital during her incarceration. Whilst they both agree that a transfer to hospital may well not have saved her life there is no doubt that spending her last days in hospital receiving the comfort of a bed, pain relief and human contact and care would have been a huge improvement upon how her life did end.

99. The failure to perform a reception screen was a significant missed opportunity that may have led to her transfer to hospital, and it was a breach of the prevailing guidelines.

100. The Health Services Manager ("HSM") from Junee Correctional Centre gave evidence that the following measures have been put in place since Ms Higgins's death to ensure that this oversight does not occur again. The Reception Screening Assessment Policy has been updated as follows:

    a. The Centre has created a position of Reception Registered Nurse (**RRN**) to ensure a dedicated position is available for reception and screening activities.

    b. The Reception Screening Assessment Form (**RSA**) is the primary form to be completed during the reception and screening activities.

    c. The RRN must attend all 'new to custody' inmate patients within 24 hours of their reception into the Centre in order to conduct a comprehensive

health screening assessment. If the RRN is not available an Enrolled Nurse has delegation to conduct the assessment. The assessment aims to identify early intervention if an inmate patient has any primary health, mental health, drug and alcohol issues or population health issues so a referral and health plan can be developed.

d. Case notes reflecting the findings of the screening and assessment process are uploaded into the Justice Health database (**JHeHS**). Paper based forms that are required to be completed include an Authority to Disclose Information, self-medication risk assessment tool, medication chart, observation chart and an immunisation screen. In some cases, it may be appropriate to utilise the Alcohol Withdrawal Scale or the Edinburgh Depression Scale.

e. Female inmate patients must undergo a pregnancy test within 24 hours of their reception into the centre. Any female inmate patient who has a history of drug/alcohol use, will be assessed by the Medical Practitioner (within 12 hours) and will consider screening for cervical and breast health, which will be again reviewed within three days by the Medical Officer.

f. If any inmate patient requires a referral to a specialist service, the referral is to be entered into the Patient Administration System (**PAS**) to enable monitoring of the waitlist for all patients. This function is conducted by the RRN who will also enter details of any medical condition, alters including Auslan, interpreter requirements, dietary requirements, EpiPen use and any Opioid Substitution Treatment medications.

g. If there are any dietary requirements identified, the Therapeutic Diet form is completed and an alert placed on PAS.

h. The RRN will forward the Release of Information form to relevant

community health practices in order to collect and collate relevant information about the patient's health status.

i. The RRN will also ensure medications are prescribed by consulting with the Doctor.

j. The RRN must ensure a Health Problem Notification Form (**HPNF**) is completed to inform Custodial Staff of actual or potential health problems, cell placement directions and other recommendations. A copy of the completed form is to be part of the custodial file, and another copy must be provided to Custodial Staff in the Intake unit (who will then forward it to the receiving unit). The HPNF must identify if Mental Health and or Drug and Alcohol referrals have been made.

k. If an inmate patient refuses (or is unable) to engage with the reception and screening activities, the Reception Nurse must ensure observations are recorded along with any reason provided by the inmate patient for not engaging and a plan to re-engage the patient moving forward. The lack of engagement at this time can also be communicated with relevant stakeholders including the Medical Officer and/or the HRAT Team with a strong focus on efforts to engage the inmate patients as soon as possible. Processes have been implemented to ensure that health services management is notified of any patients refusing medical screening.

l. If any inmate patients continue to raise concerns at reception (including when an RSA identifies an inmate patient with complex medical needs), this information will be shared during the clinical handover. If the concerns are acute, this will generate a discussion with senior management regarding whether the Centre is an appropriate placement or whether an alternative Centre may be more suitable to the medical needs of the inmate patient. It is also expected that advice from the Medical Officer will be sought in these

instances.

m. The RRN will then perform a number of administrative tasks that ensure all required forms and data bases have all relevant information recorded on them. Importantly, the RSA must be printed and filed within 24 hours of completing the RSA. The hard copy is to be scanned and added to JHeHS within 24 hours.

101. Additional to the above, health services staff at the Correctional Centre are regularly reminded of the policy which allows them to call for an ambulance (without a doctor's approval) where this is indicated by an inmate patient's condition. Training regarding 'at risk patients' has been implemented for health services staff at the Centre reinforce the need to identify, assess and manage any inmate patients that present risks of self-harm or other risk factors.

102. The Centre has embarked on a review of its service delivery model with a focus on primary care nursing requirements. This model change has resulted in changes to roles and functions including the new Nurse Unit Manager (**NUM**) position which has a focus on ensuring the daily operations of the health services meet the needs of the inmate patients and provide safe and quality primary health provision. The NUM role replaced the Clinical Quality Co-ordinator role and acts as a second in charge to the Health Services Manager role and is present 'on the floor' directing the delivery of services.

103. In January 2024, the health services staff began mandatory electronic learning modules to ensure that health services staff are familiar with policies and procedures, including the policy on Recognition and Management of the Deteriorating Patient, introduced 31 May 2022.

104. A new local system has been implemented which alerts the Health Services Manager and RRN, on a daily basis, to any non-compliance in the Reception Screening process by both the Primary Health nursing staff and the Medical Compliance Administration Support Officer ("ASO"). This is performed in several ways including a 'Daily Priorities Update' email sent to all medical staff alerting them of any tasks outstanding (including RSAs) by the Medical Compliance ASO, verbal handover between night/day shift and a

daily ‘huddle’ run by the HSM/Clinical Quality Coordinator (“CQC”) in which inmates of concern and outstanding tasks are discussed.

105. Continued reviews of the COVID-19 pandemic management have been undertaken by Corrective Services NSW and filtered to the Correctional Centres via Management Protocols and Risk Matrixes.

Conclusion

106. Both experts gave the opinion that Ms Higgins’s health care should have been escalated and she should have been sent to hospital. I accept that evidence. While they also go on to say that if she had been taken to hospital it may not have saved her life there remains the position that a transfer to hospital would have greatly improved the quality to the end of her life. She should have been given the opportunity to have been in a hospital bed, with pain relief and continual medical care including palliative care.

107. Unfortunately, at the time of her death there was an unprecedented event at the Correctional Centre of a COVID-19 outbreak. There were extreme staff shortages, isolation policies in place and PPE restrictions. Staff were adjusting interactions with inmates in accordance with the prevailing circumstances. Many of Ms Higgins’s interactions with staff were brief and did not provide an opportunity for Ms Higgins’s condition to be appreciated.

108. GEO have made a made a series of significant and relevant systemic changes in response to Ms Higgins death (set out above). Furthermore, from March 2025 Junee Correctional Centre will cease to be privately managed and GEO will no longer be involved at the Centre. In those circumstances I do not propose to make any recommendations to GEO .

109. Hopefully the changes will work towards preventing a similar death in the future.

110. I extend my deepest sympathies to Ms Higgins's family.

Findings pursuant to section 81(1), *Coroners Act 2009*

Identity of deceased:

The deceased person was Vicki Higgins

Date of death:

Vicki Higgins died on 29 January 2022

Place of death:

Vicki Higgins died in the Female Transition Unit at Junee Correctional Centre, Junee NSW

Cause of death:

Vicki Higgins died as a result of an ischaemic bowel. Coronary artery disease, diabetes and Crohn's disease were other significant conditions that contributed to her death.

Manner of death:

Vicki Higgins died of natural causes whilst she was in lawful custody. She was received into custody at Junee Correctional Centre on 12 January 2022 in the middle of a COVID-19 outbreak at the Centre and she did not receive a medical screen before her death on 29 January 2022.

Recommendation pursuant to s.82, Coroners *Act 2009*

To the Commissioner of Corrective Services NSW

1. I recommend that Corrective Services NSW record information conveyed to correctional officers from the control room directing the correctional officer to attend to respond to an urgent cell call from an inmate for medical attention.

Carmel Forbes
Deputy State Coroner
NSW State Coroner's Court, Lidcombe

Date: 17 May 2024