STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Hayden Dawes
Hearing dates:	5 November 2024 – 8 November 2024
Date of findings:	16 April 2025
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate Kasey Pearce, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in Corrective Services NSW custody – whether adequate and appropriate medical care provided
File number:	2018/00400495
Representation:	Dr Tamsin Waterhouse, Counsel Assisting the Coroner, instructed by R Campbell, of the Crown Solicitors Office Ms M Gerace SC, instructed by A Pascoli of Makinson d'Apice Lawyers, representing the Justice Health and Forensic Mental Health Network, Leann Harmer-Annetts, and Alison Macgregor Ms S Pickard of Department of Communities and Justice Legal on behalf of the Acting Commissioner of Corrective Services NSW Mr C Jackson, instructed by A Antonini of Avant Mutual representing Dr Joanne Grimsdale Ms K Burke, instructed by S Wallace of Moray & Agnew representing Dr Marney Lyndon
Non-publication order	A non-publication order has been made pursuant to section 74(1)(b) of the *Coroners Act* 2009 (NSW) in relation to certain material contained within the brief of evidence. A copy of these orders is on the Registry file.

Findings:	**Identity** The person who died was Hayden Dawes. **Date of Death** Hayden Dawes died on 30 December 2018 **Place of Death** Hayden Dawes died at the Mannus Correctional Centre, Mannus, NSW **Cause of death** The cause of Hayden Dawes's death was acute myeloid leukaemia. **Manner of death** Hayden Dawes died of natural causes while in the lawful custody of Corrective Services New South Wales.

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1 Introduction

1.1 These are the findings of the inquest into the death of Hayden Dawes. In these findings I will refer to Hayden by his first name only, as his family indicated at the commencement of the inquest that this was their preference.

1.2 At the time of his death Hayden was serving the final weeks of a 5-month custodial sentence at the Mannus Correctional Centre (**Mannus**), a minimum-security facility that is owned and operated by Corrective Services NSW (**CSNSW**).

1.3 At about 11:40 pm on Saturday 29 December 2018, Hayden's cellmate discovered him convulsing and struggling to breath on the top bunk in his cell and activated the emergency call button. CSNSW officers attended and with the help of inmates carried Hayden outside and laid him on the grass. They commenced cardiopulmonary resuscitation (**CPR**), which ambulance officers continued when they arrived.

1.4 Unfortunately, Hayden could not be revived, and he was declared deceased at 12:30 am on Sunday 30 December 2018. He was 27 years old at the time of his death.

2 The nature of the inquest

2.1 Under the *Coroners Act* 2009 (**the Act**) a coroner is responsible for investigating all reportable deaths. This investigation is conducted primarily so that a coroner can answer questions that are required to be answered pursuant to section 81 of the Act, namely, the identity of the person who died, when and where they died, and the cause and manner of that person's death.

2.2 When a person is sentenced to a term of imprisonment, they are lawfully detained in the custody of CSNSW until their sentence has been served. By depriving that person of their liberty, CSNSW assumes responsibility for the care of that person as the person is unable to independently take steps to seek medical assistance or other care. The combined effect of sections 23 and 27 of the Act is that it is mandatory for a senior coroner to hold an inquest where a person dies while in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that CSNSW has cared for a person in its custody in a reasonable and appropriate way.

2.3 An investigation into Hayden's death was conducted by the NSW Police Force **(NSWPF**) and

the coronial team assisting the inquest. A significant volume of evidence was obtained, which was tendered at the commencement of the inquest in the form of a 6-volume brief of evidence, which included electronic material. Further documents were tendered during the inquest. In addition to the documentary evidence, oral evidence was heard from the following witnesses:

- Registered Nurse (**RN**) Leann Harmer-Annetts, who saw Hayden several times while he was at Mannus;
- Dr Marney Lyndon, the Remote Off-site After-Hours Medical Service (**ROAMS**) GP from whom RN Harmer-Annetts sought advice on 29 December 2018;
- Nurse Unit Manager (**NUM**) of the Mannus clinic, Alison Macgregor;
- Dr Joanne Grimsdale, a visiting GP who saw Hayden at Mannus on 11 December 2018;
- Dr Gary Nicholls, Executive Medical Director with the Justice Health and Forensic Medicine Health Network (**Justice Health**);
- Dr John Giannoutsos, Haematology Staff Specialist with NSW Health Pathology at Nepean Hospital; and
- Professor John Seymour, Director of Haematology at the Peter MacCallum Cancer Centre & Royal Melbourne Hospital.

2.4 The following issues were considered at the inquest:

1. The adequacy and appropriateness of the clinical management and oversight provided to Hayden by Justice Health from the time of his incarceration on 4 September 2018 until his death on 30 December 2018, including:
   (a) the effectiveness of handovers between correctional facilities each time Hayden was transferred; and
   (b) the adequacy of clinical review, investigation and/or intervention involving Hayden prior to 29 December 2018.
2. The adequacy and appropriateness of the response by staff at Mannus to Hayden's presentation on 29 December 2018, including a consideration of the following matters:
   (a) the care and treatment provided by Justice Health staff in the clinic on 29 December 2018 and whether the ambulance should have been called in light of Hayden's medical

history and presentation and/or whether Hayden should have been transferred to Tumbarumba Multi-Purpose Service for further review;

(b) the response from the ROAMS doctor, Dr Lyndon, on 29 December 2018;

(c) the level of follow up from Justice Health and CSNSW staff after Hayden was taken back to his unit; and

(d) whether the lack of an on-site doctor at Tumbarumba Multi-Purpose Service influenced the decision of Justice Health staff not to transfer Hayden to hospital or whether transfer was not considered regardless of this.

3. The adequacy and appropriateness of clinical systems generally at Mannus including:

(a) pathology collection processes; and

(b) access to clinical records for doctors contacted for advice when off site.

4. Whether any recommendations are necessary or desirable in relation to Mr Dawes' death pursuant to s 82 of the Act.

3 Hayden's life

3.1 Before moving to a consideration of the circumstances of Hayden's death, it is important to acknowledge his life in a brief and hopefully meaningful way.

3.2 Hayden was born on 22 May 1991 and was the only child born to the relationship of his parents, Natalie Hawkes and Craig Dawes. Hayden lived with his mother after his parents separated when he was one year old. He attended Sadler Primary School and then Miller High School and Ashcroft High School until he left school at the age of 15 years.

3.3 Hayden was an enthusiastic sportsperson. He played football and both local and representative cricket. During his time in custody, it appears that Hayden was a keen player of any sport. He was known as 'Dawsie' to friends he grew up with and to those who knew him during his time in custody.

3.4 After Hayden left school, he worked part time at an Oporto chicken outlet before starting an apprenticeship with his cousin. He didn't complete the apprenticeship and worked several jobs in the Sydney area over the ensuring years.

3.5 In September 2014 Hayden was diagnosed with Hodgkins Disease. His symptoms developed rapidly over a week or so and once diagnosed he was treated with a chemotherapy protocol called 'escalated BEACOPP.' He did not always comply with his treatment and sometimes

discharged himself when admitted for management of side effects from the chemotherapy. Hayden completed his chemotherapy in January 2016 and in March 2016 was advised that his Hodgkins Disease was in remission. Although his specialist recommended that Hayden attend for follow up, he did not do so.

3.6 On 13 November 2015, Hayden's daughter, Paige Elizabeth Eastwood, was born. Hayden had separated from Paige's mother, Renee Eastwood, prior to Paige's birth. Despite this, Hayden was able to spend time with Paige, including several Christmases. They shared a special bond.

3.7 After he completed his cancer treatment Hayden started working at a concrete pre-fabrication plant as a storeman. He was later promoted to a supervisor's role. He worked there for three years prior to going into custody. By this time Hayden had commenced a relationship with a school friend, Kimberley Ward.

3.8 It was apparent from the evidence of the inmates with whom Hayden spent his final months and from the heartfelt statements given at the close of the inquest, that Hayden was outgoing, likable, and had an energy that drew people to him. He is still loved and missed by those who were close to him.

4 CSNSW history

4.1 On 3 September 2018 police arrested and charged Hayden with domestic violence offences involving an ex-girlfriend. This put him in breach of a suspended sentence that he had received on 23 August 2018 at Liverpool Local Court. He was bail refused by police on 3 September and subsequently refused bail at Liverpool Local Court the following day.

4.2 After he went into CSNSW custody, Hayden was initially housed at the Metropolitan Remand and Reception Centre (**MRRC**) Silverwater, where, on 5 September 2018 he completed a Reception Screening Assessment (**RSA**). It is unclear exactly what information Hayden gave the nurse completing the RSA, but she recorded that Hayden had had non-Hodgkin's Lymphoma (**NHL**) with no follow up. A health condition entry was made on the Justice Health Electronic Health System (**JHeHS**), although the health condition Hayden was treated for was incorrectly entered as NHL as opposed to Hodgkins Disease, and an incorrect date of diagnosis of 2009 rather than 2014 was also entered.

4.3 Justice Health staff requested Hayden's records from Liverpool Hospital and received them

by the afternoon of 6 September. Among the documents uploaded to JHeHS was a copy of a medical alert card dated January 2014, which advised that if Hayden presented to hospital, he must be seen within 30 minutes, have blood tests and full observations conducted urgently, and that the registrar or consultant should be notified immediately.

4.4 On 7 September, while Hayden was still a remand inmate, nursing staff at MRRC put Hayden on the GP and Chronic Care Nurse (**CCN**) wait list for review and a blood test.

4.5 On 24 October 2018, the magistrate at Liverpool Local Court sentenced Hayden to a total of 12 months imprisonment with a non-parole period of 5 months. His release date was 8 February 2019.

4.6 On 28 October 2018 Hayden completed a Justice Health *Isolated Site Assessment Criteria Checklist*, a form completed when CSNSW identifies inmates for transfer to an isolated site like Mannus. Although the form records 'previously diagnosed non-Hodgkins Lymphoma 2014' because Hayden was in remission this was not a barrier to his transfer to an isolated site, and Hayden was assessed as suitable for transfer.

4.7 It is not clear what happened to Hayden's placement on the GP and CCN waitlists over the months between his initial nursing assessment on 7 September 2018 and his transfer to Mannus on 22 November 2018. During this time Hayden was transferred between custodial facilities on six different occasions. The brief contains four *Transfer In and Out (Adult)* (**transfer**) forms relating to these moves. Although the first transfer form completed on 14 September 2018, when Hayden was transferred from MRRC to Bathurst, appears to record him as being on a waitlist for a Primary Healthcare Nurse (**PHCN**), there is no mention of this in subsequent transfer forms. The transfer form for Hayden's move from Bathurst to Junee on 17 November 2018 notes 'Non-Hodgkin Lymphoma' and explicitly states 'No waitlist' even though he had not seen a GP or CCN since being placed on the waiting list. The transfer form completed on 22 November 2018, when Hayden was transferred from Junee to Mannus, similarly does not mention Hayden being on any waitlist.

5 Mannus Correctional Centre

5.1 On 22 November 2018 Hayden arrived at Mannus, a minimum-security facility about 10 km from Tumbarumba, and 110 km southeast of Wagga Wagga. Mannus is a working gaol on about 4000 acres with 165 beds.

5.2 At Mannus Hayden was housed with one other inmate in room 3 in housing unit 8. Hayden shared toilet, kitchen and other facilities with about ten other inmates housed in unit 8.

5.3 Because Mannus was a minimum-security correctional facility, although inmates were locked in their housing unit from about 5:00 pm till 7:00 am, they were free to move around in and socialise with other inmates in the unit block during the lock down period.

The Mannus clinic

5.4 The medical clinic at Mannus was run as a community-based clinic, which meant that inmates could approach the clinic at any time it was open if they required medication or medical attention. It was staffed between 8:00 am and 4:30 pm 7 days a week. On Monday to Friday two registered nurses were rostered to the clinic, one of whom was the Nurse Unit Manager (**NUM**). On weekends, the NUM was the sole nurse on shift. During Hayden's time at Mannus, Registered Nurse Allison Macgregor was the NUM. The clinic was not staffed or open overnight, although there was an After-Hours Nurse Manager (**AHNM**) available by telephone.

5.5 Nurses at Mannus also had access to an on-call doctor as part of the ROAMS service. This service is a telephone service provided to nurses in clinics in corrective facilities or police cells for them to call in relation to patients who are not critically ill and who do not require emergency treatment. During the week, this service was provided out of an office but on the weekends and after hours it was provided from a mobile telephone.

5.6 There was no resident doctor at Mannus. In 2018, GP Dr Joanne Grimsdale, who was based in Sydney, was available as a visiting Medical Officer **(VMO**) on an as needed basis. The decision as to when the VMO would attend MANNUS was in 2018 and currently, determined by Justice Health Primary Care in Sydney. The Sydney office had access to the GP wait list from the Justice Health Patient Administration System (**PAS**) and would determine visits based on demand.

6 Events between Saturday 22 November 2018 and Thursday 27 December 2018

6.1 In 2018, Justice Health was operating a hybrid system of hard copy and electronic medical records. Whenever an inmate was transferred between CSNSW facilities, a hard copy of their Justice Health file travelled with them. Medical staff were also able to check on JHeHS to ascertain if there were any recorded health conditions or medical alerts relating to an

inmate.

6.2 On 22 November, Hayden attended a clinic orientation on his arrival at Mannus. He expressed concern to RN Maclean about a lump on his right cheek, which was neither inflamed nor painful, although it had been there for about 12 months. RN Maclean placed Hayden on the clinic waitlist for review.

6.3 On 24 November, RN Harmer-Annetts saw Hayden in the Mannus clinic. She examined the lump on his right cheek. She also noted the alert in JHeHS for NHL and recorded that there had been no follow up. She put Hayden on the list to see the visiting GP via the PAS. The notes made by RN Harmer-Annetts on this occasion were that Hayden 'denies lethargy, appetite normal, no lymphadenopathy.'

6.4 On 11 December Hayden saw Dr Grimsdale, the attending GP at the Mannus clinic. Prior to seeing Hayden, Dr Grimsdale reviewed his medical records and correctly recorded his diagnosis of Hodgkins Lymphoma (IIB) and treatment with BEACOPP chemotherapy in 2015. When seen by Dr Grimsdale, Hayden denied any constitutional symptoms and advised that he had recently gained weight. He denied any other symptoms on system review. Dr Grimsdale recorded that on physical examination Hayden looked well. He had no palpable lymph nodes and examination of his heart and lungs was normal. She detected no enlargement of his liver or spleen. In her oral evidence, Dr Grimsdale went through the relevant constitutional symptoms for lymphoma which she had addressed in her examination of Hayden. Dr Grimsdale noted that there had been no follow up after clinicians advised Hayden that his cancer was in remission in 2016.

6.5 Although Dr Grimsdale suggested referral to a haematologist, Hayden declined the referral as he was expecting to be released from custody in early February, and he did not want to be transferred from Mannus to Sydney to see a specialist. Dr Grimsdale advised Hayden to arrange with his GP for follow up upon release. Because of Hayden's history of lymphoma, Dr Grimsdale also ordered blood tests, although her evidence was that she considered these to be routine as there was no clinical indication that the tests were required urgently.

6.6 According to NUM Macgregor, the practice at Mannus was to complete routine pathology on a set day, although this was flexible in cases where a doctor required a sample to be taken urgently. In 2018 the practice at the Mannus clinic was to collect pathology samples

on a Wednesday.

6.7 RN Harmer-Annett's took a sample of Hayden's blood on Wednesday 19 December at the Mannus clinic. On this occasion Hayden complained of a headache. RN Harmer-Annetts administered a 'pre-pack' of paracetamol, sufficient for 24 hours. There is no suggestion that the headache continued or that Hayden requested further attention due to headache over the following days.

6.8 Hayden's blood results were available by the afternoon of 19 December. RN Harmer-Annetts accessed the results on 20 December.

6.9 The CSNSW Pathology Results Management Procedure that was in place at the time of Hayden's death with respect to follow up of blood test results stated:

Initially and daily results are to be triaged by an RN and RNs are responsible for managing the actioning of any clinically significant results, or those returned for 'High Risk URGENT' patients by contacting an appropriate treating clinician.

All results must be reviewed, actioned and signed off within JHeHS by a treating clinician. This action will be taken, ideally, by the treating clinician, however this may not always be possible. If the treating clinician is not available to review the results, then the result should await review when a clinician is available.

This should not however delay the triaging and actioning of any clinically significant results, or those returned for 'High Risk URGENT' patients.

Also to note that Pathology Service Providers have the pathway of contacting the AHNM for unexpected and critical abnormal results.

All results must be signed off within JHeHS within a specified time period.

- *Critical results require **immediate sign off**.*
- *Abnormal results must be signed off within **14 days**.*
- *Normal results should be signed off within **30 days**.*

6.10 Pathology results are automatically uploaded to the JHeHS system so the ordering GP can follow up on and access them via their computer. According to RN Harmer–Annetts, it was her practice to check off receipt of all blood results. Hayden's blood results showed some slight abnormalities, although it was clear from her evidence that RN Harmer-Annetts did

not consider the abnormalities 'clinically significant.'. Although RN Harmer-Annetts could not interpret pathology results, her evidence was that if they were 'quite out' she would consider it a 'red flag' and would either call the ROAMS doctor or email the requesting doctor immediately to say, 'look I've got bloods that are out of whack, what do you want me to do?' Otherwise, her usual practice, which is what she believed she had adopted when she reviewed Hayden's results, was to send an email to the GP who ordered the pathology to remind them to review and sign off the results.

6.11 Neither RN Harmer-Annetts nor Dr Grimsdale could find any evidence that RN Harmer-Annetts sent an email to Dr Grimsdale in relation to Hayden's pathology results, and RN Harmer-Annetts conceded in her oral evidence that she may not have sent a notification email on this occasion. Although it appears to have been the practice at Mannus that nurses sent a notification email when pathology results were available, there was no policy that required that this be done except when results were urgent or 'clinically significant.'

6.12 Dr Grimsdale's evidence was that she was on leave from 22 December 2018 to 26 December 2018, and that she did not review Hayden's blood test results until 7 January 2019, about a week after Hayden's death on 30 December 2018. Her evidence was that if she had reviewed the results prior to Hayden's death, she would not have changed her management of him.

6.13 During the inquest, it became clear that Justice Health was in the process of implementing changes to its pathology collection procedures via a new procedures *Screening and Diagnostics Management: Pathology, Radiology and Electrocardiogram*. Relevant changes to procedure include:

- Clinicians ordering pathology have a responsibility to either collect specimens at the time of ordering or arrange (PAS Waitlist and handover) for collection by accredited staff within 7 days of ordering.
- Clinical specialities are responsible for managing the delegation of clinical resources to ensure all results allocated to their clinical specialty are reviewed and signed off daily.
- Nurses/midwives must escalate all abnormal results according to protocol.

6.14 On 22 December Hayden again attended the clinic and saw RN Maclean. He had a graze to his left knee and requested betadine and a band-aid, which the nurse provided to him.

7 Events between Friday 28 December 2018 and Sunday 30 December 2018

7.1 There is evidence from other inmates that in the days leading up to 29 December 2018 there had been a change in Hayden's behaviour. His appetite had not been what it had previously been, and he had lost motivation for doing some of the things that he usually liked to do. According to one inmate, although he didn't appreciate the significance of the changes in Hayden's behaviour at the time, looking back he thought Hayden 'had been feeling off for a while' although 'he just didn't whinge about being crook, so no one really picked up that anything was wrong.'

7.2 The first clear sign that Hayden was unwell was on the morning of Friday 28 December 2018 when he told his girlfriend, Kimberley, on an early morning call that he was tired.

7.3 Later that morning at around 10:00 am after they had been playing tennis in the heat for about two hours, Hayden complained to his cellmate that he was 'feeling crook.' Hayden stopped playing tennis and returned to his unit. Later another inmate heard Hayden vomiting and inquired if he was okay, to which he replied, 'I'll be alright, I just feel a bit sick.' According to others in unit 8, that evening Hayden appeared normal and played cards as usual. He did not complain further about feeling unwell that night.

7.4 On the morning of Saturday 29 December 2018, Hayden reported to his cellmate that he was feeling sick. At about 1:30pm that afternoon when the inmates went outside for the after-lunch muster, other inmates observed Hayden vomiting. He still managed to stand for the muster and did not bring his sickness to the attention of the CSNSW officers present. He was observed to vomit again after the muster had concluded.

7.5 According to other inmates from unit 8, despite their urging, Hayden resisted attending the Mannus clinic. Just before 2:00 pm inmates approached RN Harmer-Annetts at the clinic and advised her that Hayden was unwell. She said, 'tell him to come up to the clinic' and one of them said 'he can't walk' so they took the wheelchair from the clinic to get him. According to RN Harmer-Annetts, when the other inmates brought Hayden to the clinic, he stood up from the wheelchair, came into the clinic, and lay on the bed. Hayden reported that he had diarrhoea and vomiting about three times a day for the past 2 days. He was feeling nauseous, but did not vomit while he was in the clinic. He reported he had no appetite. RN Harmer-Annetts palpated his abdomen to check for abdominal pain. He had

no abdominal pain but had epigastric pain on palpation. He told her that 2 days prior to attending the clinic he had been playing sport out in the heat. She noted that his pallor was 'greyish' and that he 'did not appear to be too dehydrated, tongue moist, skin moist, urine patient states dark yellow.' She also noted he was '[d]iaphoretic +++', that is, sweating heavily.

7.6 Hayden was at the clinic for about 55 minutes. RN Harmer-Annetts' evidence was that she did a set of observations at 2:00 pm and again at 2:40 pm. She noted a respiratory rate of 16 on both occasions, oxygen saturation rates of 91% on the first occasion and 96-97% on the second, blood pressure of 123/79 on the first occasion and 109/92 on the second, a heart rate of 133 on the first occasion and 115 on the second, and a temperature of 34.7 degrees on the first occasion and 35 degrees on the second. I note, however, that the 2:00 pm handwritten notes made by RN Harmer-Annetts on Hayden's medical file do not reflect that she conducted two sets of observations and do not, in every respect, reflect what she recorded on the Standard Adult General Observation (**SAGO**) chart for Hayden at 2:00pm.

7.7 Although RN Harmer-Annetts made no mention of it in her clinical notes, or in her evidence, electronic records suggest that she also accessed Hayden's blood test results while he was in the clinic with her.

7.8 RN Harmer-Annetts called the ROAMS doctor, Dr Lyndon, while Hayden was in the clinic. The handwritten notes made by RN Harmer-Annetts record that Dr Lyndon did not want Hayden to have any antiemetic (medication to treat nausea and vomiting) and that she gave a phone order for Hydralyte.

7.9 It was unclear at what time RN Harmer-Annetts called Dr Lyndon, or exactly what information she provided to Dr Lyndon, although Dr Lyndon's evidence was that she was 'usually given the…full observations.' Dr Lyndon provided two statements during the coronial investigation, the first dated 29 October 2019, and the second dated 16 October 2024. However, it was clear during Dr Lyndon's oral evidence, that she had no independent recollection of the content of conversations she had had with RN Harmer-Annetts, either at the time she made her first statement or at the time she made her second statement, and that whatever contemporaneous notes she may have made of her conversation, if any, had not formed part of Hayden's medical records and had not otherwise been retained.

7.10 According to RN Harmer-Annetts, Hayden's clinical presentation improved in the time he was in the clinic. However, she agreed that two sets of observations within a 40-minute period did not necessarily indicate an improving trend because observations may fluctuate. RN Harmer-Annetts noted that there was no visual deterioration, Hayden did not verbally state any worsening symptoms, and he appeared stable, although she acknowledged she was still concerned which was why she called for Hayden's cellmates to collect him from the clinic in a wheelchair. She advised Hayden to shower and keep cool, rest, sip water and increase fluid intake. RN Harmer-Annetts advised him to return to the clinic for review in the morning. She completed a *Medical Officer/Nursing Certificate* recommending to CSNSW staff that Hayden be off muster that day and the next as he was unwell.

7.11 The Justice Health policy *Health Problem Notification Form (Adults)* that was in place at the time of Hayden's death, required that Justice Health clinicians complete a Health Problem Notification Form (**HPNF**) to advise CSNSW custodial officers of actual or potential 'at risk' health problems relating to inmates. The policy mandated that clinicians complete a new HPNF at reception or 'whenever a patient's clinical presentation changes.' RN Harmer-Annett did not complete a HPNF when Hayden left the clinic, something that NUM Macgregor said in her view 'absolutely' should have been done. NUM Macgregor noted that in relation to Hayden's case, she would have expected that the following would have been noted in the HPNF and flagged as triggers for CSNSW custodial officers to call triple zero: changes in the colour of Hayden's skin, whether he was sweating/perspiring, complaints of nausea or any episodes of vomiting or diarrhoea. With the benefit of hindsight, NUM Macgregor said she would have completed both an HPNF and given an informal verbal handover.

7.12 The evidence established that neither NUM Macgregor nor RN Harmer-Annetts were aware of, or sighted, the medical alert card that was included in Hayden's medical records.

7.13 When Hayden returned from the clinic he lay down on his bunk. Other inmates assisted him by wetting his T shirt so he could use it to keep cool and making sure he was drinking water. According to one inmate, Hayden 'looked pretty-bad, pale and contorting his face like he was in pain.' This inmate remembered that Hayden was panting and not breathing properly, although when he asked Hayden, 'Are you sure you're alright?' he replied, 'Yeah, I'm alright. I'm just hot.'

7.14 At about 4:30 pm on Saturday 29 December 2018 Senior Correctional Officer Bliss commenced the meal muster. Hayden was not at the muster as he had been issued a Nursing Certificate by RN Harmer-Annetts. At about 4:35 pm CSNSW officers attended unit 8 to check on Hayden. One officer asked him if he was OK to which he replied, 'Yes Chief.'

7.15 At 4:55 pm CSNSW officers locked in unit 8. Hayden stayed in bed and did not get up for the lock-in muster. After lock-in Hayden got up and had a shower to cool himself off. He returned to bed at about 8:00 pm Another inmate wet his shirt for Hayden and left him lying in his bed. He was still talking about how hot he was and that he was not feeling well. Although he was still pale, he did not vomit any more.

7.16 When his cellmate went to bed at about 10.30 pm/11:00 pm, Hayden was asleep. At about 11:30pm, Hayden's cellmate was woken by Hayden making noises that suggested he was having trouble breathing. Hayden's cellmate pressed the buzzer in the unit to alert CSNSW staff.

7.17 Officers immediately attended Hayden's cell and found his cell mate 'in a distressed state.' Hayden was lying on the top bunk, his eyes were rolled back and although he was breathing, he was making strange noises. One of the officers immediately called triple-0. CSNSW staff and inmates carried Hayden outside onto the lawn. At this point, Hayden was not breathing and did not have a pulse. Both officers and inmates commenced and continued cardiopulmonary resuscitation (**CPR**) until ambulance officers arrived.

Ambulance attendance

7.18 Ambulance records show that the initial triple-0 call in relation to Hayden was received at the ambulance call centre at 11:43 pm. An ambulance was dispatched at 11:58 pm. The evidence was that the delay in assigning an ambulance to the incident was because the ambulance was involved with transporting another patient to Tumbarumba Hospital. Once dispatched, the ambulance drove to Mannus under lights and sirens, arriving about 12:06 am on 30 December 2018. According to ambulance officers who attended, CSNSW staff and inmates were performing effective CPR on Hayden when they arrived. However, paramedics determined on arrival that Hayden had no pulse. At 12:30 am they ceased all efforts at resuscitation as Hayden was not responding. Hayden was pronounced deceased at 12:30 am.

7.19 The ambulance officers record the other inmates from Hayden's unit as being distraught and crying. It was clear that there was genuine affection between Hayden and the other inmates in unit 8. At 27 years old, Hayden was the youngest inmate in the unit. I acknowledge the distress and sense of loss felt by the MANNUS inmates who had come to know and care for Hayden in the months before his death.

8 After Hayden's death

Medical records

8.1 RN Harmer-Annetts made handwritten entries in Hayden's medical file after she was notified of his death when she arrived for work on the morning of 30 December. Electronic records suggest that she also created a Clinical Assessment Service **(CAS**) form 9 hours after Hayden's death, at 9:36 am on 30 December 2018, a document she finalised at 10:37 am the same day. Further evidence suggests that RN Harmer-Annetts also modified the PAS at 2:21 pm on the day Hayden died. Her evidence in relation to the latter issue was that she thought the changes she had made to JHeHS on 30 December may have carried over into PAS, although this was not supported either by the timing of the JHeHS changes, nor evidence as to the functional connections between both systems. Because Justice Health keeps metadata for PAS entries for only a limited period, it was not possible to obtain evidence as to what modifications had been made to the PAS by RN Harmer-Annetts on 30 December.

Postmortem examination

8.2 On 8 January 2018, forensic pathologist, Dr Leah Clifton, performed an autopsy examination on Hayden's remains.

8.3 She found no significant injuries to Hayden's body to suggest third party involvement in his death. Microscopic examination of Hayden's bone marrow showed features of acute myeloid leukaemia (**AML**) with secondary involvement of multiple organs including the brain, heart, lungs, liver, spleen, thymus, and lymph nodes. Postmortem toxicology testing was negative for alcohol, amphetamines, benzodiazepines, cannabinoids, opiates, cocaine metabolites and commonly screened for prescription medications.

8.4 Dr Clifton determined Hayden's cause of death to be AML. She commented that clinical manifestations of AML are non-specific and may evolve over many weeks and include

fatigue, anaemia, fevers, lethargy, recurrent infections, or spontaneous bleeding (such as in the gums) and diagnosis usually requires extensive blood and bone marrow tests.

9 The expert evidence

Acute Myeloid Lymphoma

9.1 Professor Seymour gave evidence that an intensive chemotherapy regimen such as escalated BEACOPP is recommended for a young patient like Hayden with advanced stage or poor prognosis Hodgkins Lymphoma. However, whilst escalated BEACOPP cures 80% of cases, about 3% of patients who have 6-8 cycles of it subsequently develop treatment related AML or myelodysplastic syndrome (**MDS**). Sadly, the median survival rate of AML/MDS is 7.2 months, and most who are diagnosed will die as a result.

9.2 There is evidence that Hayden did not always comply with his lymphoma treatment and that he had no follow up once he was in remission. In Professor Seymour's opinion, neither of these factors influenced Hayden's risk of developing AML.

Dr Grimsdale's examination of Hayden on 11 December 2018

9.3 Professor Seymour's opinion was that the examination Dr Grimsdale performed on Hayden on 11 December was a sound assessment for a GP to have performed in circumstances where Hayden did not complain of being unwell.

The blood test results of 19 December 2018

9.4 Professor Seymour's view was that in hindsight the headache Hayden complained of to RN Harmer-Annetts on 19 December was likely an early symptom of AML. Associate Professor Roche disagreed with this. Whether or not the headache was a symptom of AML, both experts agree that this was not a conclusion that RN Harmer-Annetts could reasonably have been expected to come to.

9.5 The evidence of haematologist, Dr Giannoutsos, was that none of the results of Hayden's blood test, either individually or collectively, fell within the parameters of 'critical results' such as to prompt a phone call to the requesting clinician in relation to the results. Professor Seymour agreed with this opinion.

9.6 Both Professor Seymour and Professor Fox described the results of Hayden's blood test conducted on 19 December 2018 as effectively 'normal'. Although there was a slightly low

white cell count and a lower-than-normal absolute neutrophil count, Professor Fox explained that 'many normal individuals show a cyclical nature of their neutrophil count, moving up and down and out of the lower normal range.' Both Professor Fox and Professor Seymour noted that Hayden's platelet count was 'virtually normal' and there were occasional reactive lymphocytes. They also noted that haemoglobin, urea, electrolytes, and creatinine and well as the C-reactive protein (CRP) were in the normal range, in circumstances where CRP is usually elevated in either inflammation, infection or malignancy. In addition, Hayden's lactate dehydrogenase level was normal in circumstances where this may be elevated in certain aggressive malignancies.

9.7 Professor Fox concluded that given the extensive bone marrow and organ involvement of Hayden's AML that was subsequently found at postmortem, it is 'remarkable and unexplained' why the blood results of 19 December were 'virtually normal.' He concluded 'this is a most extraordinary case, the like of which I have not seen in many decades of clinical practice in this field.' Professor Seymour concurred with this view, describing Hayden's case as 'truly vanishingly rare.'

9.8 The opinion of both Dr Giannoutsos and Professor Seymour was that the blood test results on their own, even against a background of Hodgkins Lymphoma, would not have prompted immediate further testing or specialist referral, but might instead have suggested that blood tests should be repeated in a further 2 months (in the case of Dr Giannoutsos) or 1-3 months (in the case of Professor Seymour).

Hayden's treatment on 29 December 2018

9.9 In Professor Seymour's opinion, although Hayden's history of lymphoma per se was not an indication to either do further blood tests or arrange a hospital transfer when he presented as clinically unwell on 29 December, the severity of his physiological compromise was an indication for prompt and detailed further evaluation and investigation, most suitably in an acute care hospital Emergency Department setting. He points to Hayden's 'substantial hypoxia' (91% at room temperature), 'significant tachycardia' (heart rate 133) and physical appearance (diaphoretic and grey pallor) as indicative of the degree to which his health was compromised. He agreed, however, that although it was a missed opportunity that he was not sent for further testing, it was not unreasonable to not send Hayden at that stage given the apparent improvement in some of his symptoms over the 40 minutes he had remained

in the clinic.

9.10 Associated Professor Roche suggested that Professor Seymour's interpretation of Hayden's symptoms on 29 December was affected by hindsight and by the fact of his being a specialist oncologist, as opposed to being a GP working in a rural custodial environment. In his evidence Professor Seymour seemed to accept that his specialist knowledge meant that he was uniquely attuned to recognising possible symptoms of AML. However, in Professor Seymour's view, by 29 December Hayden was facing an 'imminently life-threatening scenario with a high mortality rate' even in the face of optimal treatment.

The medical alert card

9.11 Included in Hayden's medical records was a medical alert card that said he should be seen within 30 minutes if he presented to hospital unwell. Professor Seymour was familiar with these cards. His evidence was that they are only clinically relevant for the period that a patient is undergoing chemotherapy because chemotherapy patients are at risk of neutropenia for which they need urgent antibiotics. Although a patient who has had BEACOPP has a higher risk of developing AML than the general population, their risk is still low at 3% and they would not need to be seen within 30 minutes for this. I accept Professor Seymour's evidence that the medical alert card was no longer clinically relevant by the time Hayden had completed his chemotherapy.

10 Conclusions

Issue 1 – the general adequacy and appropriateness of the clinical management and oversight provided to Hayden by Justice Health from the time of his incarceration on 4 September 2018 until his death on 30 December 2018

10.1 Although when he went into custody on 5 September 2018 Hayden's health condition was incorrectly recorded on JHeHS as NHL, his lack of follow up after treatment was also noted and on 7 September, he was placed on the GP and CCN waitlist. The evidence was unclear as to what happened to Hayden's listing on the GP and CCN waitlist between 7 September and when he arrived at Mannus on 22 November 2018. Hayden was, however, seen by nursing staff on his entry to each new CSNSW facility between these dates, and there is no record of him raising any concerns in relation to his health on any occasion.

10.2 The Justice Health policy *Health Assessments in Male and Female Adult Correctional Centre*

and Police Cells that was in place in 2018 provides that 'Health Centre staff are responsible for…reviewing received documents [from the patient's health care provider] in JHeHS. JHeHS must be updated accordingly in regard to health condition information.'

10.3 The evidence was silent as to whether any Justice Health clinician reviewed Hayden's medical records from Liverpool Hospital between their receipt on 6 September and when Dr Grimsdale reviewed them on 11 December.

10.4 Justice Health nursing staff assessed Hayden on his entry to Mannus on 22 November 2018 and again on 24 November 2018 and referred him to the GP clinic. Dr Grimsdale saw him on 11 December 2018 in relation both to what was identified by her as being a cyst on his right cheek, and the lack of follow up after his treatment for Lymphoma. Prior to seeing Hayden, Dr Grimsdale reviewed Hayden's medical records from Liverpool Hospital and correctly identified and recorded in his progress notes that Hayden had been treated for Hodgkins Lymphoma, rather than NHL. She did not, however, amend the health condition information on JHeHS to reflect the correct health condition with which Hayden had been diagnosed and treated.

10.5 Dr Grimsdale conducted a full systems check on Hayden focused on checking for evidence of the return of the lymphoma and did not identify any issues of concern. In Professor Seymour's view this was a sound assessment. Dr Grimsdale discussed with Hayden the possibility of referring him to a haematologist, although he refused this option. However, in view of the lack of follow up after treatment, Dr Grimsdale ordered a routine blood test and advised Hayden to follow up in the community on his release from custody. I accept that the review of Hayden conducted by Dr Grimsdale on 11 December 2018 was both appropriate and comprehensive.

10.6 RN Harmer-Annetts took Hayden's blood sample about eight days after Dr Grimsdale ordered it, on 19 December. In my view this was not a lengthy delay given Dr Grimsdale considered the blood test to be routine. Hayden complained of a headache that day. Although Professor Seymour's opinion was that this was the first sign of AML, no-one could reasonably have expected that RN Harmer-Annetts should have come to this conclusion. She treated the headache, and Hayden did not return to the clinic.

10.7 Hayden's blood test results were available on 20 December 2019 and were slightly

abnormal. The evidence both Dr Giannoutsos, Professor Fox and Professor Seymour was that Hayden's results were not such as should have prompted a telephone call from the pathology lab to the requesting clinician and were 'virtually normal.'

10.8 I am not satisfied that RN Harmer-Annetts emailed Dr Grimsdale to advise her that the blood results were available. However, Justice Health policy did not require that she do so. The policy in relation to abnormal results, and Hayden's results were slightly abnormal, required that a doctor review them within 14 days. Hayden died before the expiry of that 14-day period. The evidence from Dr Grimsdale, was that even if she had become aware of the results of the blood test before Hayden's death, it would not have changed her management of him. Similarly, the evidence from Professor Seymour and Dr Giannoutsos was not that Hayden's blood test results would have prompted immediate action, but that they would have felt the blood test was worth repeating within a few months.

10.9 Counsel for Justice Health conceded in her submissions that the apparent failure on the part of any Justice Health clinician to amend Hayden's health condition record on JHeHS when the records from Liverpool Hospital which correctly recorded his condition and treatment were available, constituted a breach of the relevant Justice Health policy. I accept, however, that there is no evidence to suggest that this had any impact on the treatment that Hayden received from Justice Health clinicians during his time in custody.

10.10 I find that despite the limited issues raised above, the clinical management and oversight of Hayden while in custody before he became unwell was both adequate and appropriate.

Issue 2 – The adequacy and appropriateness of the response by staff at MANNUS to Hayden's presentation on 29 December 2018

10.11 The evidence from the inmates in unit 8 was that despite Hayden's obvious illness on 29 December, he was reluctant to go to the clinic and attended only at the repeated urging of other inmates.

10.12 RN Harmer-Annetts recorded Hayden's vital signs at 2:00 pm and 2:40 pm and contacted the ROAMS doctor, Dr Lyndon, to discuss Hayden's case. It was clear that both RN Harmer-Annetts and Dr Lyndon considered it was most likely that Hayden was suffering from dehydration given that he had been playing sport in the heat the day prior to his presentation to the clinic on 29 December. RN Harmer-Annetts told Dr Lyndon that there

was no doctor at Tumbarumba Multi-Purpose Centre because, she said, it was her practice to 'hand over everything to the doctor.' There was, however, no discussion about transferring Hayden to Tumbarumba, so I am satisfied that the absence of a doctor at that facility did not influence any decision not to transfer Hayden to Tumbarumba.

10.13 While Dr Seymour felt that some of the vital sign readings RN Harmer-Annetts took of Hayden, particularly the oxygen saturation levels and low temperature, were a 'missed opportunity' for further investigation. He accepted, when it was put to him, that there were a range of responses to Hayden's presentation on 29 December which could be considered reasonable. He conceded that he viewed the symptoms that Hayden presented with on 29 December with the benefit of hindsight and through the lens of his specific expertise in Hodgkins Lymphoma, BEACOPP, and the potential risks of developing AML, following BEACOPP. His view was that even if Hayden had been taken to hospital on the afternoon of 29 December, it was unlikely that this would have changed the ultimate outcome.

10.14 Although RN Harmer-Annetts did not follow up with Hayden between when he was taken back to his unit shortly after 2:40 pm and when she finished work at 4:30 pm, she believed he had improved while in the clinic, that his cellmates would knock up during the night if there were any concerns, and she had asked him to return to the clinic the following morning. Although she could not specifically recall giving a verbal handover the CSNSW officers when she finished her shift at 4:30 pm on 29 December, RN Harmer-Annetts said that this was her usual practice, and she had completed a Nursing Certificate to excuse Hayden from musters on the basis that he was unwell. RN Harmer-Annetts did not, however, complete a HPNF, something that Justice Health policy required that she do in these circumstances. It was conceded by counsel for Justice Health that she should have done so.

10.15 The follow up by CSNSW staff once Hayden returned to his unit also appears appropriate. CSNSW officers checked Hayden at 4:35 pm because he was exempt from musters. They asked him if he was OK, and he replied that he was. They checked on him again at 4:55 pm when staff were locking the unit that night and he again replied that he was OK.

10.16 CSNSW staff responded immediately when Hayden's cell mate activated the alarm later that night to tell them he was concerned about Hayden. They contacted triple-0 and with the help of inmates, took Hayden outside, checked his pulse, and commenced what was

later described by attending ambulance officers as 'effective CPR.'

10.17 I am satisfied that the response of both CSNSW and Justice Health staff to Hayden's presentation on 29 December 2018 was both appropriate and reasonable.

Issue 3 – the adequacy and appropriateness of clinical systems generally at Mannus

10.18 There was initially concern about the possibility that Hayden's blood sample had been inadvertently switched with that of another inmate or mislabelled. However, the evidence established that there was no other sample in the pathology laboratory that day that was suggestive of AML and the possibility of the samples having been switched or mislabelled was ruled out.

10.19 In relation to off-site access to clinical records, Dr Nicholls explained that doctors did not have access to clinical records when off-site in 2018 although they now do. No further comment is warranted in relation to this issue.

10.20 It emerged from the evidence that it is possible to amend or update both Justice Health hard copy and electronic records after a person has died. This is significant, particularly in view of the police investigation and mandatory coronial inquest that must take place after any death in custody. I mention this only to stress the importance of maintaining medical and other records in the state they are in when an individual dies in custody to avoid any suggestion that clinicians have sought retrospectively to create a more favourable record of their actions in circumstances where those actions are likely to be subject to public scrutiny. I do not suggest that the additions or amendments to Hayden's medical records made by RN Harmer-Annetts on 30 December were made for this reason.

Recommendations

10.21 Inquests are conducted with the benefit of hindsight. The evidence given in the inquest indicates that although some things could have been done better or alternative actions taken, this would not have materially altered the outcome in Hayden's case. In my view the treatment provided to Hayden while he was in the custody of CSNSW was, in all the circumstances, both appropriate and reasonable.

10.22 The evidence given in the inquest did not lend itself to the making of any recommendations pursuant to s 82 of the Act.

11 Findings

11.1 I would like to acknowledge the exceptional work of Counsel Assisting, Dr Tamsin Waterhouse, and her instructing solicitors, Rebecca Campbell, and Kate Vitnell, from the Crown Solicitor's Office. I am grateful for all the assistance they have provided throughout the coronial investigation and during the inquest, and particularly for the empathy and sensitivity they have shown in their interactions with Hayden's family.

11.2 I also thank Detective Inspector Josh Broadfoot for compiling the initial brief of evidence and for his role in the investigation into Hayden's death.

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

Identity

The person who died was Hayden Dawes.

Date of death

Hayden Dawes died on 30 December 2018.

Place of death

The place of Hayden Dawes' death was Mannus Correctional Centre, Mannus, NSW.

Cause of death

The cause of Hayden Dawes' death was acute myeloid leukaemia.

Manner of death

Hayden Dawes died of natural causes while in the lawful custody of Corrective Services NSW.

11.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Hayden's parents, Natalie and Craig, to his daughter, Paige, to his extended family, and to his friends for their tragic loss.

11.5 I close this inquest.

Magistrate Kasey Pearce

Deputy State Coroner

Coroners Court of New South Wales

16 April 2025