**CORONERS COURT**
**OF NEW SOUTH WALES**

| | |
|---|---|
| **Inquest:** | Inquest into the death of Alfonso Ceniccola |
| **Hearing date:** | 3 – 7 June 2024 |
| **Date of findings:** | 24 February 2025 |
| **Place of findings:** | NSW Coroners Court - Lidcombe |
| **Findings of:** | Magistrate Elizabeth Ryan, Deputy State Coroner |
| **Catchwords:** | CORONIAL LAW – death in custody – care and treatment – requirements and frequency of physical observations – policies, procedures, and training applicable to supervision and management of inmates in the Acute Care Management Unit |
| **File number:** | 2021/00261563 |
| **Representation:** | Counsel Assisting the Inquest: R Rankin of Senior Counsel i/b the NSW Crown Solicitor<br><br>Justice Health and Forensic Mental Health Network: K Holcombe of Counsel i/b Makinson d'Apice Lawyers<br><br>The Acting Commissioner, Corrective Services NSW: B Fogarty of Counsel i/b Department of Communities and Justice<br><br>M Gligoroski: D Nagle of Counsel i/b Nikolovski Lawyers<br><br>M Gillespie: T Howell of Counsel i/b McNally Jones Staff Lawyers |

| | |
|---|---|
| **Findings:** | **Identity**<br>The person who died is Alfonso Ceniccola.<br><br>**Date of death**:<br>Alfonso Ceniccola died in the early morning of 12 September 2021.<br><br>**Place of death**:<br>Alfonso Ceniccola died at the Long Bay Correctional Centre, Sydney.<br><br>**Cause of death:**<br>Alfonso Ceniccola died as a result of ischaemic heart disease due to coronary atherosclerosis. A significant contributing factor was emphysema.<br><br>**Manner of death:**<br>Alfonso Ceniccola died due to natural causes while he was in lawful custody. |
| **Recommendation:** | To the Acting Commissioner of Corrective Services NSW:<br><br>That consideration be given to implementing a formal induction process for all officers working in the Complex Placement Unit at the Metropolitan Remand Reception Centre, which has replaced the Acute Care Management Unit. The induction should emphasise to officers the importance of familiarising themselves with the requirements of Risk Intervention Team management plans and other information about inmates, particularly regarding the requirements and frequency of physical observations. |
| **Non publication orders:** | The Court has made orders for non-publication of certain evidence, pursuant to section 74 of the *Coroners Act 2009.*<br><br>Details of these orders can be found on the Registry file. |

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

These are the findings of an inquest into the death of Alfonso Ceniccola.

# Contents

## Introduction

1. Alfonso Ceniccola was aged 82 years when he died at Long Bay Correctional Centre, between 12.20am and 12.57am on 12 September 2021.

2. At the time, Mr Ceniccola was housed in a cell within the Acute Crisis Management Unit [ACMU] at Long Bay Correctional Centre. In April 2011 he had been sentenced to a term of imprisonment following his conviction for a very serious offence. He would not have been eligible for release on parole until April 2025.

3. At the time of Mr Ceniccola's death he was in lawful detention, and for that reason an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the Act.

## The role of the Coroner

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

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

## Background

6. Mr Ceniccola was born on 9 June 1939 in Naples, Italy. As a very young child he was adopted by a family in a country town, but he kept in contact with his birth family. Growing up, Mr Ceniccola worked on the land of his adoptive family.

7. Mr Ceniccola married his wife Rosaria in 1958 and they had two children Bernice and Silvio, before the family migrated to Australia in 1964. They settled in Sydney and had two further children, Jane and Eric. At the time of his passing Mr Ceniccola had fourteen grandchildren and seven (now thirteen) great-grandchildren.

8. Mr Ceniccola worked as a milkman for many years, then took a job with Qantas. Prior to his retirement he was working as a storeman. In her statement his daughter, Jane Clarke, said that her father was always working, and had a second job as a taxi driver to ensure that his family had all that they needed.

9. At the close of the evidence, Ms Clarke spoke about her father on behalf of the family. She said that the greatest joy in his life was his family, who '*meant*

*everything to him'*. Sundays had always been spent surrounded by extended family and friends. Ms Clarke said that while in custody her father lived for nothing but to be eventually released to be amongst them again.

## Issues at the inquest

10. During his time in custody Mr Ceniccola was treated for various health conditions, including heart disease and depression. He suffered a heart attack in 2005, and was treated for this including a stenting procedure in 2015.

11. In February 2021 Mr Ceniccola was transferred from Lithgow Correctional Centre to Long Bay Correctional Centre. There he was placed in the Metropolitan Special Purposes Centre due to his high level medical needs. Mr Ceniccola was very unhappy to be moved from Lithgow Correctional Centre, where he had been accommodated for some years and felt relatively comfortable.

12. Mr Ceniccola was frail, and he used a walking stick to move around. However, despite his risk for cardiac events, Mr Ceniccola refused to be placed in a cell with any other inmate. In addition, he periodically refused to eat or to take his prescribed medications, stating that he did not care if he lived.

13. The inquest into Mr Ceniccola's death examined the following issues:

    - Did Mr Ceniccola receive appropriate care and assistance from correctional officers on the night of 11 and 12 September 2021?

    - If assistance including resuscitation had been provided to Mr Ceniccola at an earlier time, would he likely have survived?

    - Were the relevant policies, procedures, and training applicable to the supervision and management of inmates in the ACMU adequate and sufficient to ensure the safety and well-being of the inmates?

### The time, cause and manner of Mr Ceniccola's death

14. An autopsy was performed by forensic pathologist Dr Rianie Janse Van Vuuren. Dr Van Vuuren concluded that Mr Ceniccola had died as a result of ischaemic heart disease which was due to coronary atheroschlerosis.

15. At the inquest Dr Van Vuuren explained that a person suffering ischaemic heart disease cannot receive enough oxygen into the heart, which can lead to a heart attack. Ischaemic heart disease is commonly caused by the condition of coronary atheroschlerosis, which is the collection of fat inside the walls of the

arteries. This impedes the flow of blood through the arteries, preventing blood and oxygen from flowing to the heart.

16. Dr Van Vuuren found Mr Ceniccola's heart to be enlarged, with the walls of his coronary arteries heavily calcified. This indicated moderate to marked atheroschlerosis. In addition, Dr Van Vuuren noted indications of a thromboembolus, or blood clot, in a branch of Mr Ceniccola's left coronary artery.

17. Dr Van Vuuren also found evidence of emphysema, a chronic lung condition which impedes the movement of air into and out of the lungs. Dr Van Vuuren explained that this would have caused a decrease in the amount of oxygen going into Mr Ceniccola's heart. For this reason, in her opinion this condition had contributed to his death.

18. The court heard further evidence which was relevant to the cause of Mr Ceniccola's death, from Associate Professor Mark Adams. Dr Adams is a specialist cardiologist and Head of the Department of Cardiology at the Royal Prince Alfred Hospital.

19. Dr Adams assisted the inquest with an expert report, and gave oral evidence. Dr Adams commented on the presence of the thrombus inside Mr Ceniccola's left circumflex artery. This, he said, would have caused a sudden and rapid blocking of that artery, quickly leading to myocardial infarction and arrhythmias which could cause sudden death. Dr Adams noted that Mr Ceniccola appeared not to have been using aspirin, which can help in the prevention of thrombus.

20. Dr Adams stated that Mr Ceniccola's underlying medical conditions put him at increased risk of an acute cardiac event. However, in his opinion it was not possible to predict when this might occur. Once cardiac symptoms such as chest pain and dizziness began to appear, he would need a rapid response because when the cardiac arrest did occur it was likely to be a fatal event. This was because of the severity and extent of his heart disease. I will describe this evidence in more detail later in these findings.

21. As to the precise time of Mr Ceniccola's death, this cannot be known with certainty. However, based on footage captured from a closed circuit television [CCTV] camera inside his cell, Mr Ceniccola's last independent body movement took place at 12.20am on 12 September 2021. At about 12.57am, Correctional Officer Matthew Gillespie entered Mr Ceniccola's cell and touched his hand, finding it to be cold to his touch.

22. When nursing staff arrived at the scene at 1.06am, it was immediately apparent to them that Mr Ceniccola was deceased. He did not respond to resuscitation

efforts. Ambulance paramedics then arrived and measured his body temperature. They found it to be 33.8 degrees, suggesting that he had been in cardiac arrest for some time.

23. On the basis of this evidence, it can be accepted that the time of Mr Ceniccola's death was at some point between 12.20am and 12.57am on 12 September 2021.

24. I now turn to the events which led to Mr Ceniccola's death, starting with a description of the unit within which he was accommodated at that time.

## The Acute Crisis Management Unit

25. At the time of his death, Mr Ceniccola was housed in Long Bay Correctional Centre's Acute Crisis Management Unit [the ACMU]. This Unit formed part of the Correctional Centre's Metropolitan Special Programs Centre [the MSPC].

26. The ACMU was intended to provide specialised care for inmates considered to be at chronic high risk of suicide or self harm, or who were in poor health. Many of its inmates were subject to Risk Intervention Team management plans, which are further described below.

27. In his statement the then Governor of the MSPC, Governor Adam Schreiber, described the objective of the ACMU as:

> *' … to assess and improve the inmate's presentation, decrease the incidents of self harm and suicidal behaviour, take appropriate crisis actions and discharge the inmate to the appropriate level of case management'*.

28. At the time of this inquest, the ACMU had not been in operation for some time. According to closing submissions on behalf of the Acting Commissioner of Corrective Services NSW, the ACMU is now permanently closed. The cohort of inmates who would have been housed there is now accommodated in a separate unit at Silverwater's Metropolitan Remand and Reception Centre [MRRC] which, according to the Acting Commissioner's submissions, offers '*significant advantages in terms of infrastructure, staffing and services'*.

29. On the night Mr Ceniccola died, the ACMU was staffed with two correctional officers who were rostered on 'N Watch', which is a twelve hour night shift commencing at 6.00pm. They were Correctional Officer Matthew Gillespie, and Correctional Officer Mile Gligoroski.

30. The ACMU had eight cells, each fitted with a CCTV, allowing for 24 hour monitoring by correctional officers. In keeping with Governor Schreiber's above

description of the ACMU's function, the purpose of 24 hour monitoring was to minimise the inmates' risk of physical harm. Each ACMU cell was also furnished with a bed, a toilet and a 'knock up' button. This was an intercom which the inmate could use to directly communicate with ACMU correctional officers.

31. Adjoining the ACMU cells was a staff room or office, for the use of correctional officers on shift. This officers' room had a desk above which two CCTV monitors were mounted. One monitor showed the inside of each ACMU cell; the other showed the common area and yard. The officers' area also had a desktop computer and a couch, and an adjacent area where meals could be prepared.

32. ACMU staff were split across three shifts. These were 'L watch' which was a 12 hour shift with a single correctional officer; 'A watch' which was an 8 hour shift with a single correctional officer; and 'N watch' which was a 12 hour shift staffed by two correctional officers who were supervised by the Night Senior officer for that area.

## The duties of correctional officers rostered on 'N Watch'

33. The duties of 'N watch' correctional officers at the time of Mr Ceniccola's death were summarised in the closing submissions of Counsel Assisting at paragraphs 33 to 39. Neither at the inquest, nor in closing submissions on behalf of the interested parties, was there any dispute as to the content of these paragraphs. I adopt the content of these passages, and reproduce them as follows.

> *'[33] Correctional Officers undertaking duties in 'N Watch' were required to comply with the Commissioner's instructions as well as a direction given pursuant to cl 242 of the Crimes (Administration of Sentences) Regulation 2014* ***('N Watch' Direction****). The 'N Watch' Direction included a formalised 'Statement of Duties' that relevantly includes the following:*
>
> ***Security and Accountability***
> *• …*
> *• Ensure that security patrols occur at irregular intervals and these patrols are recorded in the log,*
> *• …*
> ***Administrative/Legislative Requirements***
> *• Maintain accurate records as required or directed,*
> *• …*
> *• Maintain a log in an accurate and professional manner,*
> *• Comply with the requirements of the Daily Security Reporting procedures.*

*…*
***Offender Management***
*• Apply 'Duty of Care' when dealing with inmates,*
*• Participate in Case Management and undertake all duties associated,*
*• Special needs inmates to be catered for,*
*• Strict adherence to inmate management plans,*
*• Maintain current knowledge of inmate alerts and association issues.*

*[34] The 'N Watch' Direction also specified the Correctional Officers were to undertake the following post duties:*
*• Inmate head checks are to be conducted as per [Risk Intervention management plan] RIT management plan, Inmate management plan or any other specified interval.*
*…*
*• Ensure familiarisation with RIT management plans, inmate management plans or any other specific interval;*
*• Ensure all head checks are recorded electronically as per unit routine.*
*• Continue scheduled physical observations.*
*• Facilitate medical access as required.*
*…*
*• Case notes are to be completed prior to completion of duty.'*

## Risk Intervention [RIT] management plans

34. A 'RIT management plan' is formulated by a team consisting of a RIT Coordinator (being a senior correctional officer), a Justice Health staff member, and a Services and Programs Officer who is employed by CSNSW. An inmate's RIT management plan is regularly reviewed by the RIT team.

35. The purpose of a RIT management plan is to ensure ongoing assessment of an inmate's risk of suicide or self harm, and to provide a plan for the management of that risk. Thus, it typically contains a direction that correctional officers make physical and electronic checks of the inmate, and specifies the frequency of those checks.

36. As noted by Counsel Assisting in closing submissions (and not disputed by any interested party):

> *'[35] The requirements to strictly adhere to inmate management plans and to ensure familiarisation with RIT Management Plans and to conduct inmate head checks as per RIT Management Plan and to continue scheduled physical observations are of particular significance. In the first instance, persons like Mr Ceniccola who were housed in the ACMU on a RIT were the subject of a RIT Management Plan, which must be recorded on Part 3: Risk Management Plan and communicated to all staff involved with the management of the inmate.'*

37. Counsel Assisting went on to describe the manner in which directions as to observations were typically set out in RIT management plans:

> *'[36] One of the matters to be considered as part of the RIT Management Plan is the level and frequency of observations, and the required form provides for the specification of both physical and electronic (ie CCTV) observations as follows.*
> *---*
> ***Observations:*** *¨* ***Physical*** *¨ Constant ¨ Periodic, if periodic, frequency (minutes) ____*
> *¨* ***Electronic*** *¨ Constant ¨ Periodic, if periodic, frequency (minutes) ____*
> *---*
> *On the face of that part of the Part 3: Risk Management Plan, the RIT appeared to require the person completing it to first specify whether the inmate is to be subject to physical and/or electronic observations and then in each case, whether the observations are to be constant or periodic. It is only if periodic observations are selected that the frequency of observations is required to be specified.*
>
> *[37] Although it is not specified in any policy or direction, there was evidence that, due to the nature of the circumstances in which inmates are referred to ACMU, CCTV monitoring is always marked as 'constant' (in the sense of regular observations of the ACMU CCTV monitor) over a 24-hour period.*
>
> *[38] As far as physical observations are concerned, that required at least one correctional officer to go through the unit and look into each cell that was occupied by an inmate to sight each inmate directly. In cross-examination by Mr Howell, [Mr Gligoroski] agreed that the purpose of conducting physical observations as opposed to electronic observations was to look for signs of distress such as erratic behaviour, screaming and distressed breathing, disorderly conduct and self-harming behaviour. In re-examination, [Mr Gligoroski] also accepted those were matters that can only be assessed by making physical observations, particularly as the CCTV monitors do not have any sound and are silent.'*

## Health Problem Notification Forms [HPNF's]

38. In addition to RIT management plans, NSW correctional officers receive guidance on an inmate's physical or mental health from Health Problem Notification Forms [HPNF's]. These forms are completed by Justice Health and Forensic Mental Health Network [Justice Health] staff. Among other things they provide correctional officers with basic information about an inmate's general health, and warning signs to look out for.

39. The submissions on behalf of the Acting Commissioner rightly described HPNF's as *'critical documents'* which correctional officers are expected to read at the commencement of their shifts.

## Mr Ceniccola's RIT management plans and HPNF forms

40. Mr Ceniccola had been suffering an ear infection for some time, and was refusing to accept medical treatment for it. In addition, he was refusing to eat meals or take his prescribed medication. He told Justice Health staff that he had '*thoughts of self harm to stop the pain'* and as a result, he was made the subject of a RIT management plan on 28 August 2021 and moved to Cell 5 for RIT supervision.

41. A HPNF was also completed on 28 August 2021 which provided correctional staff with the following information about him:

> *'Multiple health conditions including cardiac*
> *Falls risk*
> *Behavioural issues – [history] of hunger strike and acts of self harm.*
> *Watch for fatigue, dizziness, speech impediment, loss of balance.'*

42. To manage these risks, the HPNF advised that correctional staff should take the following measures:

> *'RIT cell management as per team discussion*
> *Monitor for agitation and distress, non responsiveness*
> *Constant CCTV monitoring plus 30 min physical [observations]*
> *Access to showers, exercise, phone calls as per OIC*
> *Inform nursing staff if any concerns.'*

43. When the RIT was reviewed on 30 August 2021, Mr Ceniccola reiterated his complaints about his ear infection and that the antibiotics prescribed by Justice Health were not effective, despite him refusing to take new antibiotics prescribed by Justice Health. Mr Ceniccola was then moved to the ACMU on 30 August 2021 where he remained until his death.

44. When Mr Ceniccola's RIT management plan was again reviewed on 9 September 2021, it directed that correctional officers make a physical check of him every 15 minutes. The HPNF which was completed that day advised the following:

> *'Multiple health conditions including cardiac*
> *Falls risk*
> *Behavioural issues – [history] of hunger strikes, history of self harm.*
> *Hunger strike commenced - watch for dizziness, nausea, fatigue.'*

45. This HPNF went on to specify the following measures:

> *'Camera cell placement*
> *Nil sharps*
> *Monitor for agitation and distress, non responsiveness*
> *24 hrs CCTV and physical [observations] as per RIT management plan'*

46. Notably, the RIT management plan, which was created two days later, that is on 11 September 2021, directed that physical checks of Mr Ceniccola by correctional officers be performed only every 60 minutes – a significant reduction from those of the previous days.

47. The Justice Health representative for the 11 September RIT management plan was Registered Nurse Mei Ling Kan. At the inquest, she was asked why the frequency of physical observations of Mr Ceniccola was reduced on 11 September 2021.

48. RN Kan stated that the reduction was made that day because, although Mr Ceniccola was not engaging with staff, he '*was presenting as alert and relatively energetic on the day'.*

49. At the inquest RN Kan agreed that this reduction of frequency for physical observations was a significant one, but she believed the team had decided on this because Mr Ceniccola was *'not a high risk to suicide'*. She added that her expectation had been that Mr Ceniccola would continue to receive constant monitoring via the CCTV system, in accordance with his current RIT management plan.

50. I have considered this evidence, and I accept the submission of Counsel Assisting, that it was neither unreasonable nor inappropriate for the RIT team to have reduced the frequency of physical monitoring of Mr Ceniccola on 11 September 2021.

51. I will now describe the events which took place on the night of 11 September 2021, which culminated in Mr Ceniccola's death in the early hours of 12 September 2021.

## Events on the night of 11 September 2021

52. Tendered into evidence at the inquest was CCTV footage which had been captured by the camera within Mr Ceniccola's cell on the night he died. This provided valuable and objective evidence as to his physical movements that night. I have summarised these below, and note that neither at the inquest nor in submissions was there any dispute as to what I now outline.

53. The evidence from the CCTV footage establishes the following:

- at 7.30pm, Mr Ceniccola can be seen sitting on the side of his bed. Eight minutes later he stood up, partially pulled down his pants, and sat back down on his bed. He then lost his balance and fell to the floor. Still on the floor, he moved himself to the cell wall and sat against it

- Mr Ceniccola remained in that position until 9.23pm, a period of 105 minutes

- at 9.23pm, Mr Gillespie, Mr Gligoroski and two other officers (all four dressed in PPE clothing) entered Mr Ceniccola's cell and helped him to his bed. His pants and underwear remained partially down

- at 9.39pm, Mr Ceniccola stood up from his bed and attempted to pull up his pants. He lay back down and pulled up a blanket

- Mr Ceniccola pressed the knock up alarm in his cell at 10.26pm. Mr Gligoroski answered the call, asking *'What's up?'* The only audible response from Mr Ceniccola was the sound of groaning

- at 10.36pm, Mr Gligoroski can be seen standing outside Mr Ceniccola's cell door for approximately four minutes. He did not enter the cell. In his evidence, Mr Gligoroski said that several times he asked Mr Ceniccola what was wrong, but did not receive any response other than Mr Ceniccola waving his arm slightly

- at 11.25pm, Mr Ceniccola can be seen getting off his bed and sitting on the toilet in his cell. He leaned forwards and remained in that position for the following twenty minutes. Then using his walking stick to support himself, he stood up and used toilet paper to wipe his bottom. He then resumed his position on the toilet, leaning forwards

- at 11.53pm, Mr Ceniccola stood up from the toilet and leaned over towards his bed, before sitting on the toilet again

- at 11.56pm, Mr Ceniccola's upper body fell backwards, such that he was lying backwards on the toilet. He made an attempt to pull himself up, but was apparently unable to. Thereafter he remained leaning backwards over the toilet, occasionally moving his arms and legs slightly. The last such movement was at 12.20am and thereafter he remained motionless

- at 12.50am, Mr Gillespie can be seen standing outside Mr Ceniccola's cell door. He appeared to knock on the door. He walked away and at 12.57am he returned with Mr Gligoroski, both dressed in PPE clothing. Mr Gillespie entered the cell, approached Mr Ceniccola and touched him on his right hand

- both officers left the cell and returned a minute later with a blanket which they laid on the floor. They looked at Mr Ceniccola for a minute, then

attempted to move him from the toilet and onto the blanket, but were unable to do so. Both then left the cell, neither having commenced any attempts to resuscitate him

- at 1.03pm both officers returned to the cell with Correctional Officer Sanmeet Grewal. They managed to place Mr Ceniccola onto the blanket. Still no CPR was attempted

- Registered Nurse Paul Sharah arrived at 1.05am and immediately commenced CPR. It was now fifteen minutes since Mr Gillespie attended the cell at 12.50am

54. Ambulance paramedics arrived soon afterwards and continued CPR efforts until 1.30am, when Mr Ceniccola was pronounced deceased.

55. I now consider the issues examined at the inquest.

## Did Mr Ceniccola receive appropriate care and assistance from correctional staff on the night of 11 and 12 September 2021?

56. In closing submissions, Counsel Assisting has asserted that to a very significant degree, on the night of 11 September 2021 officers Gillespie and Gligoroski failed to perform their professional duties and responsibilities as correctional officers. The evidence, Counsel Assisting asserted, would enable the court to conclude that Mr Ceniccola did not receive appropriate care and assistance that night from the two correctional officers.

57. Counsel Assisting particularised the alleged failings of the two officers as follows:

1. They did not familiarise themselves with the RIT management plan for Mr Ceniccola

2. They did not perform any routine physical checks as specified in Mr Ceniccola's RIT management plan

3. They did not maintain constant electronic observations using the monitors in the ACMU officers' room, as specified in Mr Ceniccola's RIT management plan

4. Between the period 7.38pm and 9.23pm, neither officer responded to Mr Ceniccola's plight as he lay on the floor of his cell with his pants down for a period of 105 minutes

5. Between the period 11.45pm and 12.50am, neither officer performed any observations of Mr Ceniccola, whether electronic or physical

6. When Mr Ceniccola used his knock up alarm at 10.26pm, Mr Gligoroski failed to advise the supervising Night Senior of this event

7. When the two officers found Mr Ceniccola lying across the toilet in his cell, they did not commence CPR in a timely manner.

58. I now examine the evidence in relation to each of these matters.

## The failure to read RIT management plans

59. As has been described in paragraph 33 above, it was a requirement of the 'N Watch' Direction that officers on shift at the ACMU familiarise themselves with the RIT management plan for each ACMU inmate. It was not disputed that officers Gillespie and Gligoroski did not read Mr Ceniccola's RIT management plan that night.

60. In his evidence, Mr Gligoroski said he was aware that RIT management plans for the ACMU inmates, including for Mr Ceniccola, were kept in a shelf in the ACMU officers' room. He did not deny that on the night of 11 September 2021 he had not read or familiarised himself with any of these documents. He agreed further that as a result, he did not know that he was required to perform physical observations of Mr Ceniccola every sixty minutes.

61. Mr Gillespie's evidence was similarly that he was aware that RIT management plans were kept in the ACMU officers' room, and that they included information about how frequently physical and electronic observations had to be carried out. He said that he sometimes read these, but not all the time. He agreed that on the night of 11 September 2021 he had not read the RIT management plan for any of the current ACMU inmates.

62. Notably, in his evidence Mr Gligoroski asserted that he had never been directed to read an ACMU inmate's RIT management plan, and had never seen other ACMU correctional officers do so. In addition, he said that he had not been provided with any training as to his duties and responsibilities when working in the ACMU, or been provided with any documents setting these out.

63. As to this, in his statement and oral evidence Governor Schreiber said that it was a fundamental expectation that all correctional officers familiarise themselves with the duties of the post to which they were rostered. He said that all relevant Statements of Duties were provided to correctional officers in hard copy, and were also available electronically.

64. At the inquest, other correctional officers who had been rostered to work in the ACMU gave evidence on these matters.

65. Correctional Officer Sanmeet Grewal said that before he commenced working in the Metropolitan Special Programs Centre, he had been taken around the Centre and was given an explanation of his duties. This introduction was not specific to the duties to be performed in the ACMU. Nor had he been shown any documents which set out his duties within ACMU, but he said that he had been told where to access these. He added that it appeared to be left up to him to read them if he chose. He had in fact read them. It had also been his practice to read the RIT management plan for each ACMU inmate when he was working there, and to carry out electronic and physical observations accordingly.

66. Correctional Officer Glenn Butterfield likewise said that he had not received an induction which was specific to ACMU work. He too was not shown any documents setting out his duties when working in the ACMU. He said however that he had in fact read the relevant duties documents, and like Officer Grewal, he was in the habit of reading the RIT management plans for ACMU inmates when he was working there. His practice also was to carry out electronic and physical observations accordingly.

67. Correctional Officer Brittany Day told the court that she had received an orientation when she started working shifts at the MSPC, and had been advised what the purpose of the ACMU was. She was made aware that there were relevant Statements of Duties for the various rostered posts, and she always read these when commencing in a new post.

68. Based on the above evidence, I accept that in all likelihood, officers Gillespie and Gligoroski had not received any induction or training which was specific to work within the ACMU.

69. But in my view the absence of specific ACMU training, or of any specific verbal instruction that ACMU officers must read inmates' RIT management plans, cannot excuse the two officers' failure to do so in Mr Ceniccola's case. This obligation is made very clear in the Statement of Duties contained within the N Watch Direction. The two officers' proffered explanation that they had not verbally been informed of it cannot mitigate this failing.

70. I find that on the night of 11 September 2021 officers Gligoroski and Gillespie failed to read and familiarise themselves with Mr Ceniccola's RIT management plan, and that this failure represented a non compliance with their duties as correctional officers.

71. There is a compelling public interest in ensuring that custodial officers are aware of inmates' requirements for physical and electronic observations. The health and safety of vulnerable inmates cannot be safeguarded if custodial officers do not bother to inform themselves of these.

72. The vital importance of physical observations to the welfare of 'at risk' inmates has prompted Counsel Assisting to propose a specific recommendation in this area. This will be considered later in these findings.

## The failure to perform routine physical checks

73. As noted above, the N Watch Direction specified that ACMU officers observe *'strict adherence'* to inmate management plans, including any *'scheduled physical observations'*. On the night of 11 September 2021, Mr Ceniccola's RIT management plan required that in addition to constant CCTV monitoring, he receive physical checks by correctional officers at intervals of sixty minutes.

74. In his evidence, Mr Gligoroski initially said that although he did not know at the time what frequency of physical checks had been specified for Mr Ceniccola, he and Mr Gillespie had nevertheless carried these out more frequently than every sixty minutes. Later in his evidence, he said that he could not recall how frequently he had performed physical observations that night. Soon afterwards, he conceded that he had not caried out *any* physical observations prior to 9.23pm, when he and his colleagues entered Mr Ceniccola's cell to help him onto his bed.

75. In his evidence Mr Gillespie accepted that he had not performed physical observations of Mr Ceniccola every sixty minutes, as required in his RIT management plan. He asserted however that apart from a period when he was preparing his evening meal that night, he was '*always looking at the camera'*. This claim will be examined later in these findings.

76. Although Mr Gillespie accepted that his failure to carry out hourly physical checks of Mr Ceniccola represented a non compliance with his duties, he claimed that his failure to do so was due to confusion as to what his observation duties were.

77. According to Mr Gillespie, he had been told that when working night shift at the ACMU, it was not necessary to actually attend the cell door of an inmate. This was because night cameras had been installed within each ACMU cell. His understanding was therefore that it was sufficient to make only electronic observations by means of the CCTV monitors in the ACMU office.

78. At the inquest, Counsel Assisting explored the assertion made by Mr Gillespie that he had understood there was no obligation to perform physical observations when on night shift in the ACMU.

79. When questioned about this, correctional officers Grewal and Butterfield said that no one had ever told them there was no obligation to perform physical checks at night in the ACMU. However, Mr Butterfield told the court that he had

heard other correctional officers expressing such an understanding. He himself considered that there was such an obligation, since the RIT management plans made this clear.

80. In his statement and evidence, Governor Schreiber said that it was *'a serious dereliction of duty'* for officers Gillespie and Gligoroski not to have carried out physical observations of Mr Ceniccola in accordance with his RIT management plan.

81. In his oral evidence at the inquest (but not in his statement), Governor Schreiber disclosed that in 2021 he had been aware of an understanding amongst some officers that they were not required to perform physical checks when on night shift in the ACMU. He said that he had certainly never issued any such instruction, and that he had not known that some officers were in fact not performing physical checks.

82. When Governor Schreiber was asked what steps he had taken to correct this misapprehension among his officers, he replied that he had raised concern about it with officers' union delegates, some of whom were senior ACMU officers. He had assumed that they had passed on his concerns. It does not appear that he took any further steps.

83. Based on the above, it can be concluded that the senior leaders of the MSPC did not issue any instruction that night-time physical checks in the ACMU were not required; and did not encourage any such understanding. However given Governor Schreiber's evidence that he had been made aware of this misapprehension, it is difficult to avoid the conclusion that the senior leadership missed an important opportunity to ensure that ACMU correctional officers were very clear about this important obligation.

84. Notwithstanding this, the evidence that some officers held a mistaken belief that night time physical checks in the ACMU were not required does not excuse this conduct on the part of officers Gillespie and Gligoroski. As noted, this obligation is made very clear in the statement of their duties in the N Watch Direction.

## The failure to respond in a timely way when Mr Ceniccola fell at 7.38pm

85. As described in paragraph 53 above (where I set out a summary of the evidence that the CCTV footage establishes), at approximately 7.38pm Mr Ceniccola fell from his bed to the floor, before moving himself to the wall and leaning against it. He remained there until 9.23pm, with his pants and underwear around his ankles. At that point four officers including Mr Gillespie and Mr Gligoroski entered his cell and assisted him back onto his bed.

86. In closing submissions, Counsel Assisting noted that Mr Ceniccola had remained slumped in the above position, unattended, for some 105 minutes. Counsel Assisting submitted that the two officers' failure to do anything to assist him during this time displayed '*a casual indifference'* to their professional duties towards a vulnerable inmate.

87. At the inquest Mr Gillespie and Mr Gligoroski were questioned about this.

88. In his evidence, Mr Gillespie thought it likely that he had first noticed Mr Ceniccola on the floor sometime soon after 7.38pm. He did not take any action until well after 9.00pm despite knowing, he said, that Mr Ceniccola was an aged and frail person. Mr Gillespie acknowledged to the court that an elderly man in such a position might have required assistance, but said that at the time he did not think any response was required.

89. On behalf of Mr Gillespie, it was submitted that there is insufficient evidence to positively conclude that at this stage Mr Ceniccola had commenced to suffer cardiac distress and warranted medical attention. I accept this is the case.

90. That said however, there cannot be any doubt that by not coming to Mr Ceniccola's aid at an earlier stage, Mr Gillespie behaved in a most unfeeling manner and furthermore, was in breach of his duty of care towards an inmate. This was acknowledged by Mr Gillespie at the inquest.

91. Mr Gligoroski's evidence about this incident was more problematical and contains significant inconsistencies.

92. In his statement to police Mr Gligoroski had said that he and Mr Gillespie went to help Mr Ceniccola immediately after seeing him on the floor. If this evidence is accepted, Mr Gligoroski had somehow failed to notice Mr Ceniccola in this position for the preceding 105 minutes.

93. In his oral evidence however Mr Gligoroski stated that he went to Mr Ceniccola's assistance '*within an hour'* of noticing him in this position. This would indicate that he first observed Mr Ceniccola on the floor at about 8.23pm, but did nothing about it for some time afterwards.

94. Later in his oral evidence Mr Gligoroski said he thought it possible he may have first noticed Mr Ceniccola on the floor sometime between 9.00pm and 9.23pm.

95. Regarding these inconsistencies, Mr Nagle of Counsel has urged the court to have '*due regard to the frailty of human memory in circumstances where nearly three years had elapsed since Mr Ceniccola's passing'*.

96. But the two versions offered by Mr Gligoroski as to his conduct over the period 7.38pm to 9.23pm are fundamentally at odds with each other, making it unlikely their incompatibility is the product of poor memory.

97. Ultimately, whichever version is the truth, the fact is that both reflect poorly on Mr Gligoroski and establish a clear dereliction of his duties. If, as asserted by Mr Gligoroski in his statement, he went to Mr Ceniccola's aid immediately after seeing him on the floor, it must be accepted that for the preceding 105 minutes he had not been paying any attention to the monitor in the ACMU officers' room. If on the other hand he had gone to Mr Ceniccola's assistance *'within an hour'* of seeing him on the floor, it must be asked why he did not assist him at an earlier stage.

98. Ultimately, Mr Gligoroski accepted that he had not been watching the monitors as regularly as he should. He denied however that he had not been watching them at all.

99. Notably, evidence at the inquest established that for a significant time during the above period, Mr Gligoroski was accessing various sites on the computer in the officers' room. His first log in was at 7.59pm, to the 'Ladbrokes' online betting site. Thereafter he accessed other sites, with the last user generated activity being at 8.51pm. This evidence reinforces the strong impression that he was paying scant, if any, attention to his duty to carry out constant electronic monitoring of Mr Ceniccola.

100. In my view it is neither possible nor necessary to determine which of Mr Gligoroski's versions is the more reliable. Whichever version is accepted, Mr Gligoroski's behaviour between 7.38pm and 9.23pm that night reflects poorly both on his conduct as a correctional officer, and on his credibility as a witness.

101. The evidence establishes a clear failure of care on the part of the two officers, in not responding in a timely manner to Mr Ceniccola's difficulties when he fell to the floor at 7.38pm.

## The failure to respond appropriately to the knock up alarm

102. As described above, at 10.26pm Mr Ceniccola activated the knock up alarm inside his cell, which he was able to reach from his bed. The audio recording of the call was obtained by investigating police. In it, Mr Ceniccola can be heard responding only with groans when Mr Gligoroski asked him *'What's up?'*

103. CCTV footage then shows an officer standing outside the door of Mr Ceniccola's cell. The officer did not enter.

104. In his oral evidence Mr Gligoroski acknowledged that it was he who had taken this call, and that it was possible that Mr Ceniccola was indicating a need for medical attention. He said further that he walked to the outside of Mr Ceniccola's cell and asked him several times what was wrong, but did not receive a verbal response.

105. In his evidence, Mr Gligoroski agreed that he ought to have brought this incident to the attention of the Night Senior on duty. He did not do so, he said, because he didn't think there was anything abnormal. He acknowledged further that it was possible Mr Ceniccola needed the help of a nurse, and that he (Mr Gligoroski) ought to have attended to this.

106. For his part, Mr Gillespie described the audio recording of the knock up call as *'disturbing'*. He said that at the time, he could not hear how Mr Ceniccola was responding in the call, and had thought that he might have been asking for a drink of water. He said further that had he taken this call, he would have gone to have a look at Mr Ceniccola and would also have notified the Night Senior of the incident.

107. In his evidence Governor Schreiber said that he regarded Mr Gligoroski's lack of appropriate response to Mr Ceniccola's knock up call as *'a serious dereliction of duty'.*

108. There can be no doubt that this is the case.

## The failure to carry out any observations between 11.45pm and 12.50am

109. Counsel Assisting has submitted that during the above period Mr Gillespie and Mr Gligoroski did not carry out any observations at all of Mr Ceniccola, whether electronic or physical, and thus:

> *' … were not performing their duties and responsibilities as correctional officers working in the ACMU.'*

110. Mr Gligoroski and Mr Gillespie did not attempt to deny that they had failed to perform any observations of Mr Ceniccola during this period. However, their respective accounts of what in fact they were doing differed significantly.

111. Mr Gligoroski's evidence was that around midnight he heated up some food for himself in the adjoining kitchen area. As this area is outside the ACMU officers' room, it does not afford any view of the CCTV monitor. Mr Gligoroski

said that he then took his food into the ACMU officers' room and ate it there while chatting to Mr Gillespie.

112. Mr Gligoroski thus maintained that apart from the short period when he was heating up his food, he and Mr Gillespie were in the officers' room for this entire period. He said that he did not look at the CCTV monitor until 12.50am, when he saw that Mr Ceniccola had collapsed and was lying across the toilet in his cell. He accepted that had he observed Mr Ceniccola in this position earlier, this would have been a matter of concern.

113. If Mr Gligoroski's evidence on this point is accepted, both he and Mr Gillespie were present in the ACMU officer's room from around midnight until 12.50am, but for this entire time did not look at the CCTV monitor.

114. According to Mr Gillespie however, from approximately 11.30pm or 11.45pm neither he nor Mr Gligoroski were in the officers' room at all. They had gone into the adjacent kitchen area and prepared and eaten food, remaining there until around 12.50am when they both returned to the officers' room.

115. Mr Gillespie asserted that apart from the above period when he was in the kitchen area, he was '*always looking at the camera'*. Even if this assertion is accepted, it remains the fact that both he and Mr Gligoroski left the officers' room and its monitor unattended for more than an hour. This, Mr Gillespie agreed, was contrary to what was expected of him as a correctional officer within the ACMU.

116. As submitted by Counsel Assisting, the accounts given by Mr Gligoroski and Mr Gillespie about their activities during this period are *'wholly inconsistent and irreconcilable'*.

117. Again, it is neither possible nor necessary to determine which of the two versions is the more reliable. The two correctional officers were either positioned where they were unable to view the CCTV monitor, or were able to view it but did not do so.

118. Either way, their conduct represented a significant dereliction of their duties as correctional officers working in the ACMU.

## The failure to provide timely CPR

119. Regarding the conduct of the two correctional officers, the final area for examination was their failure to make timely attempts to resuscitate Mr Ceniccola.

120. I have described at paragraph 53 above (where I set out a summary of the evidence that the CCTV footage establishes) what took place after 12.50am when Mr Gillespie went to Mr Ceniccola's door, returning some minutes later with Mr Gligoroski. It was to be several more minutes before anyone made any attempt to resuscitate Mr Ceniccola.

121. Mr Gillespie acknowledged that he ought to have provided Mr Ceniccola with a timely emergency response, but failed to do so. In his statement and oral evidence he said that he knew that he was obliged to commence first aid, but instead froze. He said this at the inquest:

> *'I had a lot of things stirred up at the time which it's still traumatic. There's certain events that have happened prior to that have brought back and I knew I had to do it and I just couldn't do it and I'm sorry ….'*

122. In his evidence Mr Gligoroski said that he could not commence CPR because of the difficulties he and his colleague experienced getting Mr Ceniccola off the toilet and onto the floor. He also told the court that he had been *'in shock'*, as he had not previously experienced the death of a person in custody.

123. I accept that the work which officers perform in specialised units such as the ACMU can be difficult and even traumatising. The two officers' response of profound shock on seeing Mr Ceniccola unresponsive and possibly deceased is a natural one.

124. Nevertheless, it cannot be forgotten that when it comes to their health and safety, inmates are very dependent on the actions of correctional officers who are usually the first responders. Corrective Services NSW recognises this fact, and has in place clear policies which require that if an '*inmate is found unconscious or seriously injured that an ambulance must be called for immediately on 'Triple Zero (000)'. Justice Health must also be called to provide urgent medical assistance.*'[1] The Medical Emergencies Custodial Operations Policy and Procedures further specifies that[2]:

- '*Immediately following a call for urgent medical assistance, first aid must be provided to an inmate. If there is more than one officer present, one officer must commence first aid while the other calls for medical assistance. Officers must use the appropriate Personal Protective Equipment (PPE) and follow infection control guidelines.*

- *Officers must start Cardiopulmonary Resuscitation (CPR) if the inmate is unresponsive and not breathing normally. If an inmate does not respond to*

[1] Exhibit 1 Tab 92 at p.4.
[2] Exhibit 1 Tab 92 at p.4.

*CPR, officers must continue CPR until JH&FMHN [Justice Health] personnel or paramedics arrive and take control.*

- *Responding JH&FMHN [Justice Health] personnel and paramedics may request correctional officers to continue first aid including CPR or to assist them, e.g. holding drip bags or resuscitation masks. Correctional officers must assist JH&FMHN personnel and paramedics if requested.'*

## Conclusion: did Mr Ceniccola receive appropriate care and assistance?

125. The evidence establishes that officers Gillespie and Gligoroski did not provide appropriate care and assistance to Mr Ceniccola on the night of 11 and 12 September 2021. I find specifically that the two officers:

- did not familiarise themselves with the RIT management plan for Mr Ceniccola
- did not perform any routine physical checks as specified in Mr Ceniccola's RIT management plan
- did not maintain constant electronic observations as specified in Mr Ceniccola's RIT management plan
- between the period 7.38pm and 9.23pm, did not assist Mr Ceniccola as he lay on the floor of his cell
- between the period 11.45pm and 12.50am, did not perform any electronic or physical observations of Mr Ceniccola
- did not respond appropriately when Mr Ceniccola used his knock up alarm at 10.26pm
- did not commence CPR in a timely manner when they noticed at 12.50am that Mr Ceniccola had collapsed.

126. These failures, individually and collectively, represent very significant non compliance with their professional duties. They also display a most unfeeling attitude towards a vulnerable inmate, for whose welfare and dignity they were largely responsible.

## If assistance had been provided to Mr Ceniccola at an earlier time, might he have survived?

127. Naturally, Mr Ceniccola's family were most anxious to know if he might have survived had officers Gillespie and Gligoroski performed their duties in an appropriate manner that night.

128. Counsels for Mr Gillespie and Mr Gligoroski have urged me to find that the deficiencies in the officers' care of Mr Ceniccola that night made no contribution to his death.

129. Mr Nagle submitted:

> *'It is almost beyond argument that even if steps had been taken earlier in the evening to have Mr Ceniccola taken to hospital he still would have suffered the life-ending heart attack which was his cause of death. In circumstances where his coronary disease was so advanced and given his underlying medical conditions coupled with his refusal to take medication his passing at the age of 82 was virtually unavoidable.'*

130. On behalf of Mr Gillespie, Mr Howell wrote:

> *' … [Correctional Officer] Gillespie does not shrink from his failures on the night, but the only available finding is nothing CO Gillespie did or did not do on the 'N' shift on 11/12 September 2021 contributed to the manner or cause of Mr Ceniccola's death'.*

131. At the inquest Dr Adams was asked his expert opinion on this issue.

132. Dr Adams was first asked if, given Mr Ceniccola's serious underlying coronary condition, he ought to have been accommodated in the ACMU at all.

133. Dr Adams replied that based on Mr Ceniccola's hospital records, he did not consider that his condition suggested cardiac risk at the level where, from the outset, he ought to have been placed in a hospital for monitoring. Although Mr Ceniccola had many underlying conditions which put him at high risk of a cardiac arrest, the acute event of his thrombus could not have been predicted by Justice Health staff unless he was suffering ongoing chest pains when at rest.

134. In Dr Adams' opinion, Mr Ceniccola's recent refusal of meals and medication was not material to a decision about where he ought to be accommodated. He had refused food and medication in the past without there being an adverse medical consequence. Thus, in his opinion:

> *' … it was not possible to predict when cardiac complications might occur'.*

135. I accept Dr Adams' evidence that there was no reasonable basis for Justice Health staff to have recommended that Mr Ceniccola be placed in hospital for monitoring of his cardiac condition, rather than in the ACMU.

136. Dr Adams was then asked if in his opinion, the events which took place on the night of 11 September 2021 might have indicated that Mr Ceniccola was at imminent risk of a cardiac arrest.

137. Dr Adams first considered what the situation may have been when Mr Ceniccola suffered his first fall at 7.38pm. He commented that it was difficult for him to assess if Mr Ceniccola's fall indicated a risk of later collapse, because there was no information as to whether at this stage, he was experiencing cardiac symptoms such as dizziness or chest pains.

138. Notably, Dr Adams commented that if the two officers had been aware that Mr Ceniccola had a history of serious heart disease (it appears likely that they were not, since they had not read his RIT management plan of HPNF), this fall might have raised concerns for them and caused them to bring it to the attention of Justice Health staff. Clinical staff might then have reviewed him and decided to take him to hospital for monitoring.

139. Dr Adams added that had Mr Ceniccola been taken to hospital at that point, further cardiac investigations would have taken place which would have detected the formation of the thrombus, prompting immediate treatment.

140. We do not know if, when he suffered this first fall, Mr Ceniccola was experiencing signs of an impending cardiac arrest and might have communicated these to the two officers. We do not know this because no officer attended upon him. It must be said however that when the two officers did attend upon Mr Ceniccola at 9.23pm, there is no evidence that he communicated any such symptoms.

141. As to events which took place later that evening, Dr Adams is clear that Mr Ceniccola's prospects of survival diminished significantly. His evidence on this point was underpinned by his opinion that once Mr Ceniccola suffered a cardiac arrest, this was likely to be a fatal event, with small chance of revival even with resuscitation attempts.

142. Thus, had Mr Ceniccola been suffering cardiac symptoms when he used the knock up alarm at 10.26pm, and had the correctional officers responded appropriately, there still may not have been enough time to avoid the cardiac arrest. This was because of the time needed for Justice Health staff to arrive on scene, assess him, and then have him transferred to hospital.

143. Nevertheless, Dr Adams said, such action might have at least given Mr Ceniccola a chance of avoiding the cardiac arrest which killed him.

144. Dr Adams then considered the situation when Mr Ceniccola collapsed at 11.56pm. In his opinion, if the correctional officers had intervened at that stage,

it would probably have been too late for Mr Ceniccola to receive the treatment that might have saved his life.

145. Given the above evidence, I do not accept the submissions of Mr Nagle and Mr Howell that whatever the officers did or did not do throughout the N shift, Mr Ceniccola's death was '*virtually unavoidable'*. Although this correctly characterises Dr Adams' evidence once Mr Ceniccola had suffered his cardiac arrest, and in the period leading up to it, Dr Adams did not rule out a more positive outcome for Mr Ceniccola had he been taken to hospital for monitoring at an earlier stage that evening. This of course would have depended upon the two officers being aware, from having read Mr Ceniccola's RIT management plan and HPNF, of his cardiac vulnerability and as a result, feeling a level of concern for him.

146. Dr Adams' evidence reinforces the necessity of correctional officers having a basic awareness of the medical conditions of inmates in their charge. This indeed is the purpose of the requirement that they read and familiarise themselves with RIT management plans and HPNF's, and comply strictly with the steps set out therein.

## The credibility of officers Gillespie and Gligoroski

147. In closing submissions, Counsel Assisting stated that the evidence of officers Gillespie and Gligoroski '*should be approached with a large degree of caution'*, and that they were *'unimpressive witnesses in both their written and oral evidence'.*

148. In support of this submission, Counsel Assisting relied on the following:

- evidence (described below) that the two officers colluded in the preparation of their incident reports immediately following Mr Ceniccola's death, and denied having done so
- Mr Gligoroski's initial assertion that on 11 September 2021 he and his colleague made physical checks more regularly than every sixty minutes, when the CCTV footage establishes that neither officer performed a single check of any inmate in the period 6.45pm to 9.22pm
- significant inconsistencies between the explanations which the two officers gave as to why they had failed to assist Mr Ceniccola for almost an hour, after he collapsed backwards across the toilet. These explanations have been described above.

149. Counsel for Mr Gillespie, Mr Howell, took issue with the relevance of the above submission that the two officers lacked credibility, in circumstances

where for the most part, neither denied having been in breach of his duties as a correctional officer.

150. It is the case that in their evidence Mr Gillespie and Mr Gligoroski, despite some prevarication particularly on the part of the latter, did acknowledge significant deficiencies in their conduct in relation to Mr Ceniccola.

151. I accept that the practical impact of any adverse finding about the two officers' credibility is limited, when considered against the issues examined at the inquest. There is ample evidence to support the findings I have made from paragraph 52 onwards. Much of this derives from the clear evidence of non compliance which is afforded by the CCTV footage. To this may be added the acknowledgements of non compliance made by the two officers themselves in their evidence.

152. In my view however, the question of whether the two officers colluded in the preparation of their incident reports is a significant one.

153. Regarding this claim, the evidence is as follows.

154. In the hours following Mr Ceniccola's death, the Night Senior officer appropriately directed both officers to prepare incident reports about the night's events. This they did, in a larger office within the MSPC. Notably, the incident reports prepared by the two officers are in identical terms except for the use in each report of each other's names.

155. At the inquest, Counsel Assisting put to each officer that they had colluded in the preparation of their incident reports. Mr Gligoroski denied having done so, while Mr Gillespie said that although he could not remember the circumstances in which he had prepared his report, he had done so without discussion with Mr Gligoroski.

156. But in the submission of Counsel Assisting, the two officers' denials ought not to be believed. In addition to the fact that the two incident reports were in virtually identical terms, Counsel Assisting pointed to the following evidence:

- that at about 3.25am the police officer in charge of the coronial investigation, Detective Senior Constable McNaughton, came into the MSPC officers' room and observed Mr Gligoroski seated at a computer, with Mr Gillespie standing over him and viewing the screen. Mr Gligoroski told Detective Senior Constable McNaughton that he was preparing his incident report

- at the same time, Constable Megan Drapalski who accompanied Detective Senior Constable McNaughton, likewise observed Mr Gillespie or Mr Gligoroski (she was unsure which) typing while the other stood over him and watched. She heard the correctional officer who was standing say to Detective Senior Constable McNaughton words to the effect: '*He's just writing his incident report and I'm just spell-checking it'*.

157. In my view, the evidence strongly supports Counsel Assisting's claim. It follows that I do not accept the evidence of the two officers that they had not colluded in the preparation of their incident reports.

158. Without doubt their denials reflect poorly on their credibility as witnesses.

159. There is an additional significance to their conduct. Incident reports by involved officers after a death in custody are an important first step in the investigation of these matters. Collusion on their part not only reflects poorly on the integrity of the officers involved, but it in no way assists the Assistant Commissioner or investigating police, in their important task of preparing evidence for the coroner for the mandatory inquest which will follow.

## Did ACMU officers receive adequate training and instruction?

160. The final issue for examination was whether Corrective Services NSW had in place appropriate policies and training to ensure the safety and wellbeing of ACMU inmates.

161. The evidence establishes that Corrective Services NSW did have in place appropriate policies for the management of 'at risk' inmates like Mr Ceniccola. These included provisions for the formation and regular review of RIT management plans, as well as clear Statements of Duty which set out the responsibilities of staff who were to work in areas which housed 'at risk' inmates, like the ACMU. In particular, as I have noted, the N Watch Direction made clear the obligation of staff to adhere strictly to the requirements contained within an inmate's RIT management plan.

162. In his evidence, Governor Schreiber acknowledged that the conduct of physical observations of ACMU inmates was critical, and that he fully expected officers to comply with this requirement. Yet, as noted by Counsel Assisting, Governor Schreiber did not put in place a process of induction for officers who might be rostered in the ACMU. He expected that ACMU staff would read the N Watch Direction which contained their duties, but did not do anything to ensure compliance with this expectation. Counsel Assisting submitted that the absence of specific training for officers working in the ACMU represented a failure of leadership on the part of senior management within Corrective Services NSW.

163. I have noted above my view that Governor Schreiber missed an opportunity to ensure that ACMU officers were in no doubt about their duties, after he became aware that some officers had formed the belief that physical observations were not required on night shift.

164. However, in my view it was not unreasonable for senior managers such as Governor Schreiber to have a general expectation that correctional officers rostered to work in the ACMU would ensure they were aware of their duties and responsibilities and in particular, the necessity of conducting physical observations. Officers Gillespie and Gligoroski had undertaken mandatory online training in the management of 'at risk' inmates, which highlights this necessity. In addition, as has been seen, other officers who gave evidence at the inquest and had worked in the ACMU were not in any doubt about this requirement of their job.

165. Nevertheless, as the events in this inquest demonstrate, the conduct of physical observations is vital to ensuring the safety and welfare of vulnerable inmates. For this reason, I endorse the submission of Counsel Assisting that it would be desirable for Corrective Services NSW to consider implementing a formal induction process for officers who are working in the equivalent of the ACMU. This would emphasise the importance of the role of RIT management plans, and of ensuring strict compliance with their requirements for inmate observations.

166. This proposed recommendation is supported by the Acting Commissioner for Corrective Services NSW. In submissions, Counsel for the Acting Commissioner has stated that the Acting Commissioner will consider how this recommendation can be effectively implemented within the unit at the MRRC which has replaced the ACMU.

167. Counsel Assisting's further proposition was that the Acting Commissioner consider reintroducing the use of a device which was designed to monitor correctional officers' performance of physical observations. This device was known as a Morse Watchman. It was to be held up against a sensor unit outside each cell, to register the time that the correctional officer had attended that cell.

168. The court heard evidence that use of the Morse Watchman had ceased before September 2021. There was some evidence that it did not work properly, may have been broken on purpose by correctional officers, or was otherwise unavailable at times. This may also have been the case with a second device introduced by Governor Schreiber, known as a UniGuard.

169. In response to this second recommendation, Counsel for the Acting Commissioner advised of a trial currently underway at the MRRC, of a system known as the Telstra Automated Signs of Life Technology System [TASLT system]. The TASLT system uses an electronic system outside each cell to monitor for signs of life within the cell, and to alert monitoring staff of any abnormal readings. A 24 hour monitoring suite has been established to oversee all electronic observations. The submissions attached a copy of the Local Operating Procedure which provides the details of this trial.

170. Counsel for the Acting Commissioner submitted that the trial of this monitoring system made the second recommendation unnecessary.

171. The introduction of this trial evidences willingness on the part of the Acting Commissioner to improve the safety and wellbeing of inmates. Counsel for the Acting Commissioner submitted that:

> *'CSNSW is conscious that all of forms of monitoring technology have limitations and none are a substitute for CSNSW officers' duties to conduct physical observation checks and CCTV monitoring observations as required by their position duties and applicable inmate RIT plans. CSNSW will continue to train, remind and monitor officers to ensure they conduct physical observation checks and CCTV monitoring observations.'*

172. Having carefully considered the matter however, I have decided that it is not necessary or desirable to make this second recommendation, having regard to the evidence of other correctional officers at the inquest that they are well aware of their obligation to conduct physical observations, and diligently carried them out.

## Conclusion

173. I express to Mr Ceniccola's family my sincere sympathy for their loss. Without doubt it would have been most distressing for them to learn of the circumstances of his last night, and of the lack of empathy and care shown to him by the two officers who were supervising him.

174. I thank the excellent assistance provided to the inquest by Mr Ranken, now of Senior Counsel, and of the NSW Crown Solicitor's Office. I am also grateful to the Officer in Charge, Detective Senior Constable Luke McNaughten, for his preparation of the comprehensive coronial brief of evidence.

# Findings required by s 81(1)

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

### Identity
The person who died is Alfonso Ceniccola.

### Date of death:
Alfonso Ceniccola died in the early morning of 12 September 2021.

### Place of death:
Alfonso Ceniccola died at the Correctional Centre, Sydney.

### Cause of death:
Alfonso Ceniccola died as a result of ischaemic heart disease due to coronary atherosclerosis. A significant contributing factor was emphysema.

### Manner of death:
Alfonso Ceniccola died of natural causes while he was in lawful custody.

# Recommendation

176. Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death. I am of the view that the evidence supports that the recommendation outlined below is appropriate and is necessary or desirable to be made in relation to Mr Ceniccola's death.

To the Acting Commissioner of Corrective Services NSW:

*That consideration be given to implementing a formal induction process for all officers working in the Complex Placement Unit at the Metropolitan Remand and Remand Centre, which has replaced the Acute Crisis management Unit. The induction should emphasise to officers the importance of familiarising themselves with the requirements of Risk Intervention Team management plans and other information about inmates, particularly regarding the requirements and frequency of physical observations.*

177. I close this inquest.

**Magistrate E Ryan**
Deputy State Coroner
Lidcombe
24 February 2025