CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Daniel Munro Lewis Turnbull
Hearing dates:	22-25 July 2024
Date of findings	19 February 2025
Place of findings:	Coroners Court of NSW, Lidcombe
Findings of:	Deputy State Coroner, Magistrate Erin Kennedy
Catchwords:	CORONIAL LAW – Correctional inmate, failure to observe signs of illness, natural causes, need to deliver treatment, 24 hour surveillance cell, RIT, mental illness, schizophrenia, psychogenic polydipsia, hyponatremia.
File number:	2022/00317333
Representation:	Counsel Assisting the Coroner: Tamsin Waterhouse, instructed by Leanne Kohler, NSW Crown Solicitor's Office Counsel for the family: Rose Khalilizadeh instructed by Dawoud Ayache, Legal Aid NSW Justice Health and Forensic Mental Health Network (Justice Health): Emma Sullivan, instructed by Kate Hinchcliffe, Makinson D'Apice Commissioner of Corrective Services NSW (CSNSW): Alecia Wood, Department of Communities and Justice MTC Broadspectrum: Tim Hackett instructed by Shaun Bailey, Ash St St Vincent's Correctional Health: Seun Idowu, Hall & Wilcox Dr Hindol Mukherjee: Cameron Jackson instructed by Judith Alderson, Avant Law

Findings:	**Identity** The person who died was Daniel Turnbull. **Date of death** Daniel died on 20 October 2022. **Place of death** The location of Daniel's death was the Bathurst Correctional Centre. **Cause of death** The direct cause of Daniel's death was hyponatraemia, with psychogenic polydipsia and schizophrenia/schizoaffective disorder antecedent causes. **Manner of death** Natural causes due to an underlying psychotic mental health condition which resulted in excessive water consumption in circumstances where Daniel was remanded in custody in a 24 hour surveillance cell.
Recommendations:	***Recommendation 1*** ***To the Commissioner of Corrective Services NSW for consideration of the following:*** *That correctional officers in correctional settings are informed and education is provided that:* ▪ *excessive water intake, particularly in a short period of time, can be life threatening,* ▪ *intervention should occur before a person shows signs or complains of symptoms, and* ▪ *if the person does develop symptoms and/or signs, it is a medical emergency.* ***Recommendation 2*** ***To the Commissioner of Corrective Services NSW and to the Justice Health and Forensic Mental Health Network for consideration of the following:*** *That CSNSW and Justice Health and Forensic Mental Health Network policies, and the HPNF, be revised to reflect the fact that excessive water ingestion, particularly over a short period, can be life*

	threatening, and any symptoms and/or signs that suggest excessive water ingestion require immediate intervention regardless of whether an inmate identifies it as a concern. ***Recommendation 3*** ***To the Commissioner of Corrective Services NSW and to the Justice Health and Forensic Mental Health Network for consideration of the following:*** *That the Commissioner of Corrective Services NSW consider the production of a memorandum outlining what level of supervision/observation service is provided by CSNSW staff of any inmate placed in an observation cell (including a 24-hour surveillance cell) to clearly identify and communicate to Justice Health what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and how regularly it will be staffed and viewed, whether officers are aware/instructed about why an inmate has been placed in an observation cell, how this information is passed across shifts to new officers, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for circulation to clinical staff to enable the development and management of appropriate inmate treatment plans.*

INTRODUCTION AND FOCUS OF THE INQUEST

1. This is an inquest into the death of Daniel Munro Lewis Turnbull. In accordance with the wishes of his family, I will refer to Mr Turnbull by his first name, Daniel, throughout these findings. Daniel died on 20 October 2022 at Bathurst Correctional Centre. He was 35 years of age.

2. It has since become apparent that Daniel suffered psychogenic polydipsia as a result of his existing diagnosis of schizophrenia. This is a known, and not uncommon, symptom of schizophrenia. The danger of this condition is that if it remains unchecked, it is lethal. Psychogenic polydipsia is a condition that caused Daniel to continually drink water to the point that he shut down the ability of his body to function. This process occurred while he was in the Multi-Purpose Unit (MPU) at Bathurst Correctional Centre in a cell that had CCTV, meaning he was observable 24 hours a day.

3. Daniel had been identified as a person who was at risk given his psychiatric illness and had been placed in a specialised cell to keep him safe while he awaited a psychiatric review.

4. It was only the solicitor with carriage of this matter, Ms Kohler, who upon closely reviewing the evidence (including watching the CCTV) noticed an unusual pattern of behaviour, observing Daniel to fill his cup and drink continually over a 24 hour period. This critical observation enabled the forensic pathologist to identify Daniel's cause of death. It was not an observation made by any Correctives or Justice Health officer. Daniel's behaviour prior to his death was at times confused, inconsistent and difficult to manage. It is now very apparent that he was suffering from significant mental health issues.

5. Treatment is available for psychogenic polydipsia if the behaviours associated with it are identified early. A preventative for this condition is effective treatment for the underlying cause, that is, treatment for schizophrenia.

6. This inquest, thanks to the impressive work of Ms Kohler, was able to find the cause of Daniel's death and importantly focus on the real issue in the case; namely, how behaviour that was ultimately evident from CCTV footage was not observed nor apparent to those who were monitoring Daniel at the time.

7. Daniel was in the care of the State and his family particularly seek to understand the nature of his death. It was a difficult process for them to be involved in and asking the family to bear witness in this public way was a much added burden. They were of great assistance

during the inquest, were actively involved and provided very helpful submissions. They were extremely generous given the grief that they continue to suffer.

STATUTORY ROLE OF THE CORONER

8. Jurisdiction is found under s 21(1) of the *Coroners Act 2009* (*Coroners Act*) to conduct this inquest because Daniel's death was reportable. The term "reportable death" is defined in s 6(1) of the *Coroners Act* and includes where the reason for the person's death is unknown or the circumstances of the death are unusual.

9. The *Coroners Act* requires findings to be made pursuant to s 81(1) as to:

    a. the occurrence of the death;

    b. the identity of the deceased;

    c. the date and place of the death; and

    d. the manner and cause of the death.

10. Manner and cause of the death permits an inquiry into more than the medical cause of the death. The term "manner" includes the circumstances surrounding the death and, in this case, the actions of those responsible for Daniel's care.

11. Section 82 of the *Coroners Act* allows recommendations considered necessary or desirable in relation to any matter connected with the death to be made. One of the matters about which recommendations may be made is around public health and safety.

12. It is not the role of an inquest to determine whether there has been negligence, whether damages should be paid or whether any individual is guilty of a criminal offence. Those are matters which may be the subject of separate proceedings in other courts.

13. The statutory focus of this inquest is to determine the manner and cause of death, to make formal findings of fact and to decide whether to make recommendations.

14. In circumstances where Daniel's death occurred while he was in lawful custody, an inquest is mandatory pursuant to ss 23 and 27 of the *Coroners Act*. The legislation provides that inquests are mandatory when a person dies while in the custody of the State. It is the nature of imprisonment that a person who has been lawfully deprived of liberty and autonomy is necessarily thereafter limited in relation to making decisions about the type

of medical and allied healthcare they access, when they access it and whether they wish to present to hospital if they consider it necessary.

15. People in custody are reliant on the State, and the facility in which they are incarcerated, to provide an adequate level of care. A review of the circumstances of Daniel's death is an important safeguard against the State becoming complacent in the provision of custodial and healthcare services to inmates, or otherwise allowing a system to develop which does not honour or respect the expectation that healthcare services available in the criminal justice system be commensurate with those that are available in the community.

16. The *Coroners Act* provides, pursuant to s 81, that I must record formal findings, if findings can be made, with respect to Daniel's identity; the date and place of his death; and the manner and cause of his death. The identity, date, and place of death are not controversial:

    a. The deceased is Daniel Munro Lewis Turnbull;

    b. Daniel died on 20 October 2022; and

    c. The location of Daniel's death was Bathurst Correctional Centre.

17. The manner of Daniel's death requires a careful examination of the circumstances. He was one of the most vulnerable in our community. The legislation requires that those in custody are reviewed when they die in the system because the State is responsible for them.

18. Daniel was not a sentenced inmate but was being held on remand. He had not been found guilty of any offence. He was, at the time of his death, presumed to be innocent at law. It may have been that his charges proceeded to a defended hearing or that he pleaded guilty, however the matter would have been dealt with summarily. This means that he may have been able to proceed pursuant to the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* and have his matter diverted into the mental health system. There may have been sentencing options available to the Court other than a custodial penalty.

19. The Court received extensive evidence, including 7 volumes of material, which incorporated witness statements, medical and correctional records, policy documents and expert evidence, together with video footage (some of which was visual only).

20. Witnesses attended to give additional evidence for the assistance of the Court. Detective Senior Constable Wilson was the Officer in Charge who first attended the scene and put together the brief of evidence under the instruction of the Crown Solicitor.

21. Registered Nurse Abhishek Prashar, Psychologist Kellie Blake, Mental Health Nurse Practitioner Matthew James and Psychiatrist Dr Hindol Mukherjee all had professional dealings with Daniel. Clinical Nurse Specialist Lisa Hennessey reviewed Daniel on 18 October 2022 and Registered Nurse Laura Clarke attended upon him after his collapse and made attempts to resuscitate him. First Class Corrections Officers (FCCO) Nathan Murray and Jordan Davis were on shift at Bathurst Correctional Centre on the evening of 20 October 2022 and also gave evidence.

22. The Court also had the assistance of experts Dr Michael O'Leary, an intensive care specialist with expertise in hyponatraemia, and Dr Danny Sullivan, a forensic psychiatrist with expertise in psychogenic polydipsia and the treatment of persons with psychosis and extensive experience within correctional settings.

BACKGROUND

23. Daniel was presented with significant challenges in his life that would have been very difficult to overcome. It is important to reflect on his life and to acknowledge that Daniel was a part of the community and a person who was loved, cherished and is now very much missed. The inquest was attended by his mother and two sisters. His mother remained involved and committed to him and was supportive and advocated for him during his life. Daniel is recorded as saying that he lived a good life with his mother in Katoomba. He is fondly remembered by his loved ones for his sense of humour and as the giver of generous hugs, two very beautiful personal traits.

24. Daniel was born on 3 February 1987 at Royal North Shore Hospital, Sydney. He was taken into care when he was 7 years old given concerns the NSW child protection authority held for the safety of his sister. He was placed within the foster care system for several years, including under temporary care arrangements at various times. Daniel had a long history of mental illness. He was said to have been diagnosed with ADHD and conduct disorder as a child and expelled from 12 schools for poor behaviour.

25. Daniel first experienced paranoia and anxiety at just 16 years of age. He subsequently had over 40 admissions to psychiatric hospitals, where he was routinely involuntarily detained.

A number of these admissions were to Cumberland and Prince of Wales Hospitals, and he also spent time at Rozelle, St Vincent's, Sutherland and Campbelltown Hospitals. He also had a psychiatric history in New Zealand where he lived with his mother and his sister between 2005-2010.

26. Daniel attracted several diagnoses over the years including schizoaffective disorder, paranoid schizophrenia and anxiety disorder. His schizophrenia was largely characterised by persistent derogatory auditory hallucinations. There is extensive history in Daniel's family of very significant mental health diagnoses. He did not, however, show any previous symptoms of psychogenic polydipsia, nor were observations made of him drinking water to excess.

27. Daniel came to the attention of the criminal justice system on numerous occasions, although he had been dealt with 8 times by the *Mental Health (Forensic Provisions) Act 1990*. He had also been previously placed on a Community Corrections Order which required him to have psychiatric treatment.

28. Daniel's diagnosis was best categorised as schizophrenia with chronic alcohol abuse. He found needles very distressing and his previous non-compliance with depot medications was compromised in part because of this.

29. Daniel went before the Mental Health Review Tribunal on several occasions and was the subject of community treatment orders. He tried many different medications for schizophrenia including Clozapine, Risperidone and Flupentixol depot injections and high doses of Quetiapine. He had also been prescribed mood stabilisers with reportedly little effect. At the time of his death, Daniel was prescribed 10mg Olanzapine (morning) and 20mg Olanzapine (night).

30. Daniel had a history of violence and self-harming behaviours that usually corresponded with excessive alcohol consumption. There were also numerous apprehended violence orders taken out against him. On occasion, his matters were dealt with under section 32(3)(a) of the *Mental Health (Forensic Provisions) Act 1990* (Section 32). Prior to his most recent incarceration, it appears Daniel was last before the courts in 2018 having been charged with contravening an AVO. Those charges were dismissed pursuant to Section 32 subject to the conditions that Daniel continue to attend Lithgow Community Mental Health

Service and Dr Hilary Smith as directed, take his prescribed medication and not consume alcohol or illicit drugs.

31. Prior to his incarceration on 11 July 2022, Daniel was unemployed and in receipt of the disability support pension. His mental health is reported to have fluctuated dramatically based on his alcohol consumption and on his compliance with prescription medication.

DANIEL'S MOST RECENT INCARCERATION

32. Daniel was placed in custody on 11 July 2022. He was released that day, however, was again taken into custody on 15 July 2022. There was limited evidence about his circumstances in the lead up to his incarceration, although it is known that he was struggling with housing, mental health issues and substance use. He was bail refused following an appearance at Parramatta Local Court.

33. Daniel was placed at Parklea Correctional Centre (Parklea) on 16 July 2022, a centre operated by MTC-Broadspectrum (MTC). St Vincent's Correctional Health (SVCH) is contracted to provide health services to MTC. Upon his arrival at Parklea, Daniel had a Reception Screening Assessment (RSA) with registered nurse Abhishek Prashar (RN Prashar). He indicated that it was his first time in custody and answered "no" to all questions about mental health issues. RN Prashar gave evidence that he reconfirmed all questions with Daniel prior to finalising the RSA form. Information would have been available to RN Prashar about Daniel's mental health condition, but in accordance with policy, unless an inmate mentions their mental health history, a release of information form to obtain more information is not generated.

34. Six days later, Daniel undertook an intake screening questionnaire (ISQ) at Parklea recording that it was *not* his first time in custody and that he had unmedicated schizophrenia and wanted support for it. The ISQ noted that Daniel would require assessment by SVCH and a referral was made to psychology.

35. On 3 August 2022, Daniel was involved in a physical incident with a correctives officer. On 4 August 2022, he was clinically assessed and RN Blundy noted that Daniel had schizophrenia and that the plan was for a mental health review. Notwithstanding this, no referral was made at that time.

36. Parklea's Segregation Review Committee referred Daniel to psychologist Kellie Blake to seek support to move him to the clinic for a mental health assessment. Ms Blake saw Daniel on 17 August 2022 and noted that although cooperative, he was quiet, avoided eye contact and was sometimes confused and contradictory. She was of the view that a mental health assessment was appropriate. She undertook her assessment of Daniel "through the hatch", however she considered that she was able to gain enough information from him to determine that he should be assessed at a "psych 2" level, meaning that he would require assessment between 4 days and 12 weeks.

37. Mental Health Nurse Practitioner Matthew James (NP James) reviewed Daniel on 6 occasions at Parklea. He was also required to speak to Daniel "through the hatch" of his cell. NP James found that Daniel exhibited aggression, mood instability, impulsiveness and disorganised behaviours. He formed the view that Daniel had chronic and relapsing schizophrenia, but did not assess that he was a mentally ill person pursuant to the Mental Health Act.

38. NP James gave evidence that he relies minimally on an RSA given that it is based on an inmate's self-report. In his experience, the great majority of inmates with similar behaviours to Daniel would make claims to being schizophrenic or having a history of schizoaffective disorder.

39. NP James determined that Daniel was suitable for normal cell placement and put him on the psychiatry waitlist for review of his diagnosis and the need for medication.

40. From NP James' evidence, it was apparent that Daniel's history was not immediately and easily obtained. NP James found no mental health notes on JHeHS but found some notes from 2020 from the Community and Court Liaison Service. In evidence, he listed a few more documents that he located on 31 August 2022, but agreed that these were likely available when he first looked at Daniel's records on or around 30 August 2022.

41. On 31 August 2022, Daniel told NP James that he was not on regular medication prior to his incarceration, nor was he with liaising with a community health team. NP James was concerned about relapse and started Daniel on Olanzapine. NP James also issued a release of information form to Nepean Blue Mountains Mental Health Service (NBMMHS), being the most recent community team that Daniel had had contact with. NBMMHS contacted

NP James on 1 September 2022 and although they had no recent information about him, they were able to identify that Olanzapine was a consistent treatment for Daniel. Notwithstanding this, they noted Daniel's history of medication noncompliance, together with alcohol misuse, possibly more than 45 hospital admissions and that he had no current link with a Community Mental Health Centre. NP James had by this time determined that Daniel was acutely mentally ill and wanted to change him from oral medication to a depot as a way of ensuring better management once back in the community. NP James did not make any observation of excessive water consumption.

42. Psychiatrist Dr Hindol Mukherjee saw Daniel on 17 September 2022 and found him cooperative albeit with blunted affect. He ultimately formed the view that Daniel had schizophrenia with a chronic history. He did not observe any acute symptoms and considered medication may have started to take effect. He discussed the possibility of a depot injection with Daniel, but Daniel reportedly would not agree to it.

43. Dr Mukherjee gave evidence about the importance of a patient's rights to self-determination in medical treatment, which they do not lose by virtue of their incarceration. He also gave evidence that if Daniel did not agree to a depot injection, then it would not be possible to give it to him. He assessed Daniel and determined that he had capacity to make his own decisions about treatment (meaning he could not be medicated against his wishes). Given that Daniel refused a depot injection, Dr Mukherjee decided to increase his Olanzapine dose which was in keeping with previous treatment and his wishes.

44. Daniel was moved to Cessnock Correctional Centre on 1 October 2022, then back to Parklea for one night before being transferred to Bathurst Correctional Centre on 8 October 2022. He came before Katoomba Local Court three days later and his matters were adjourned for approximately six weeks.

45. From his arrival at Bathurst Correctional Centre on 8 October 2022 until 18 October 2022 Daniel raised no issues and there were no concerns about his behaviour. Specifically, there were no reports of excessive drinking, nor indications that Daniel was experiencing auditory hallucinations, thoughts of self-harm or paranoia.

46. At 8:39am on 18 October 2022, Daniel made a call from his cell for assistance (a "knock-up") and said he felt unsafe and wanted to move cells. He was assessed by RN Davidson

and then Clinical Nurse Specialist (CNS) Hennessey, who booked him in to see a psychiatrist in three days' time.

47. Daniel was thereafter moved to another wing within Bathurst Correctional Centre but within hours he wanted to be moved again. Senior Correctional Officer Hemming discussed Daniel's request with CNS Hennessey and, at 2:22pm on 18 October 2022, Daniel was transferred to a 24-hour assessment cell in the MPU. The MPU houses 10 inmates and is supervised by a single correctional officer during the evening shift.

48. At around 5:54pm on 20 October 2022, FCCO Davis spoke with Daniel at the door of his cell and noticed that he seemed "delayed" in his responses. He clarified in evidence that he did not know Daniel and thought that this was how he usually spoke, not that Daniel's responses were concerning.

49. Between 5:54pm and 6:47pm, Daniel can be seen on CCTV footage continually pacing and drinking around 47 cups of water, vomiting and ultimately losing balance and collapsing to the floor.

50. At 7:06pm, FCCO Murray notified FCCO Davis that Daniel was lying on the floor of his cell. FCCO Davis attended Daniel's cell at approximately 7:08pm and then again at 7:12pm and noted that he was lying on his side but responsive. He returned to Daniel's cell at 7:20pm, this time noting that he was lying on his stomach and making "snoring noises". Justice Health registered nurse Laura Clarke (RN Clarke) was ultimately summonsed and arrived at Daniel's cell at 7:31pm. CPR was commenced almost immediately upon RN Clarke's entry into Daniel's cell. At 7:49pm, 4 paramedics arrived and took over CPR and at 8:10pm, Daniel was pronounced dead.

51. At around 8:45pm, NSW Police attended, conducted a cursory search of Daniel and his cell and indicated that no items of interest were located, notwithstanding RN Clarke's recollection to paramedics that Daniel was found lying in vomit and urine. NSW Police photographed Daniel and his cell, and a forensic examination of the scene reportedly revealed that "nothing appear[ed] suspicious".

52. This was a sudden and unexpected death in custody. NSW Police investigated, took numerous statements and retrieved evidence such as the CCTV footage. The Officer in Charge also responded to the requests of the team assisting in gathering further evidence

as required. This is an important role that is performed by police and the coronial process was assisted as a result.

REVIEW OF EXPERT EVIDENCE

Dr Michael O'Leary

53. Dr O'Leary is an intensive care specialist who regularly manages patients with hyponatremia and gave evidence of the nature and effect of the condition. After reviewing Daniel's postmortem report, Dr O'Leary found that he had hyponatremia, noting that the concentration of sodium in his vitreous humour, a proxy for his blood, was well below normal. This had the result of disturbing the body's equilibrium. Low sodium in the blood triggers movement of water into cells to "restore the balance". This causes cells to swell which impairs cell functioning. It can affect cells anywhere in the body, however the main symptoms are neurological, due to the impaired function of brain cells. As the brain swells, there is increased pressure inside the skull which compromises the brain's blood supply and can cause the brain to herniate downwards.

54. Although Daniel also consumed a significant amount of water on 19 October 2022, his kidneys would have been capable of excreting it. Dr O'Leary gave evidence that research suggests the kidneys can clear a maximum of 850 millilitres per hour. He estimated that in a 9 hour period on 20 October 2022, Daniel consumed around 35 litres more water than he was capable of excreting. In evidence, he opined that Daniel's sodium level could have reduced to dangerous levels within at least a couple of hours of him commencing his excessive water intake. He also indicated that the body continues to attempt to deal with excess water until it can no longer do so. In Dr O'Leary's view, several hours would have needed to pass for there to have been a significant fall in Daniel's sodium levels. Nevertheless, he indicated that Daniel's sodium level was at dangerous levels quite some time before he collapsed and that this may well have been before he exhibited any visible distress signs.

55. Early symptoms of hyponatremia include nausea, vomiting and malaise and these are then followed by confusion, disorientation, restlessness, lethargy, obtundation, seizures, coma and respiratory arrest. In Dr O'Leary's view, a person can only be managed effectively in a correctional setting *before* they experience symptoms because once they are

symptomatic, it is then a medical emergency which requires expert treatment in hospital. He considered that stopping access to water once symptoms or signs begin is not sufficient because water in the gut is still being absorbed at this point and sodium levels in the blood will continue to fall.

56. The evidence supported that patients with hyponatremia require frequent blood tests to titrate them back to normal sodium levels because increasing sodium too rapidly is also dangerous. Dr O'Leary indicated that given that the initial symptoms of hyponatremia are nonspecific, if a patient is taken to hospital, it is very helpful to know that there has been a pattern of excessive water ingestion, but that information is not critical as hyponatremia would be detected on a standard blood test.

57. In Dr O'Leary's view, Daniel's gait became abnormal from around 4:30pm on 22 October 2022. At 6:00pm, he considered that Daniel was clearly unsteady, had moved past the early symptoms of hyponatremia and was most likely becoming confused in his thinking. In his view, even by as early as 4:30pm, intensive care treatments might have been too late to save Daniel. It was his opinion that the latest time by which Daniel needed to be transferred to hospital was around 6:00pm. He noted that once a person suffering hyponatremia seizes, the chance of recovery is almost nil. However, prior to that, they may recover with very aggressive treatment although this may still result in brain injury.

58. If Daniel had presented to Bathurst Hospital in an unsteady and confused state, Dr O'Leary was of the view that hyponatremia would not be the first cause considered. Notwithstanding this, he expected that a standard blood test would have been done upon such a presentation which would have detected low sodium levels. Although initial treatment could have occurred at Bathurst Hospital, Dr O'Leary noted that Daniel would have ultimately required transfer to an intensive care unit such as at Orange Hospital.

59. Doctor O'Leary was unsurprised that Daniel was still speaking at 7:15pm even though he needed intensive care by that stage and said that this is consistent with the way hyponatremia ordinarily progresses. He noted that the area of the brain responsible for Daniel's speech may well have still been functioning to a degree when he engaged with FCCO Davis, but it was clear (to Dr O'Leary) that the area responsible for movement was

compromised and that swelling and pressure was starting to cause significant harm to parts of the brain that controlled Daniel's breathing and circulation.

60. At 6:47pm when Daniel fell, Dr O'Leary found that he was at very high risk of seizure, brain herniation and sudden death without immediate emergency intervention. In his view, if an ambulance had been called at that time, it may have given Daniel a chance of survival. It was also his view, however, that by the time CPR is required in such situations, it is almost always unsuccessful. The fact that CPR did not commence until 7:20pm when Daniel became unresponsive was not material in Dr O'Leary's view, as he concluded that by that time no medical intervention (even at a major hospital), would have been sufficient to save Daniel's life.

61. The evidence supported the time it took to give Daniel CPR was well inside what would ordinarily be accepted as best practise outside an acute hospital, and that the quality of the CPR given by RN Clarke was equal to that given in teaching hospitals. Dr O'Leary was impressed with how RN Clarke managed the resuscitation prior to the arrival of paramedics and gave evidence that if she had administered adrenaline to Daniel it would not have altered his outcome. He went further in evidence and found it was probable that the adrenaline given to Daniel by paramedics led to the brief appearance of a non-shockable rhythm, but this rhythm could not be sustained. He also noted that modern defibrillators used in the community are very reliable and that if there is no shockable rhythm, it is simply not possible for such a machine to administer a shock.

62. As a side note, RN Clarke was a very impressive witness. She has been left very concerned by the fact that she did not receive additional clinical support that night to assist Daniel. Her evidence would be useful to review from the perspective of staffing at Bathurst Correctional Centre and what is expected during an emergency. She should have received assistance. Nonetheless she has received high praise from the expert review and deserves to be acknowledged for that.

63. Dr O'Leary was of the view that there would be benefit in educating correctional officers and nurses about the risk of excessive water intake and the need to intervene prior to when a person is symptomatic. In his view, knowing there are risks associated with excessive water consumption is at least as important as knowing what signs to watch for.

While he agreed that shutting off water to an inmate's cell may halt an acutely developing issue, he considered that the underlying cause must be urgently addressed. That is, merely removing an inmate's access to water will not necessarily be enough to resolve the problem and deprivation in these circumstances is very likely to cause additional distress, without the added assistance of medical intervention.

Dr Danny Sullivan

64. Dr Sullivan is a forensic psychiatrist who manages patients with schizophrenia. He also treats people with psychogenic polydipsia. Dr Sullivan provided extremely helpful evidence about the condition and noted that it often occurs for the first time many years after the diagnosis of a psychotic illness. It also commonly arises spontaneously without any previous indications, including in people who are partly medicated. He said that in the 136 bed hospital where he works, there are usually two or three patients with psychogenic polydipsia at any given time. He did not believe that research had been conducted about whether psychogenic polydipsia is more common within custodial settings. However, he did reflect that when an individual is in a state of psychosis without medical attention and locked in a cell with very few things to distract them, this could play a role in its development. Inmates have few liberties available to them in gaol, but one of them is to drink water freely.

65. The evidence was that the prevalence of people in custody with a psychotic diagnosis is between 8 and 15% internationally. By comparison, the rate of schizophrenia in the community is about 1% of males and 0.75% of females. That is, there is a much higher rate of schizophrenia in custodial settings than in the general population. Dr Sullivan was satisfied that Daniel had not experienced psychogenic polydipsia before, nor had he exhibited any hallmarks of risk. He could not draw any inference from the action Daniel took when flooding his cell at Parklea and did not draw any link with the subsequent development of his psychogenic polydipsia. At the time of the cell flooding, Daniel's motivations were explored and the involvement of mental illness was excluded. Dr Sullivan also gave evidence that Daniel's redundant hand washing whilst in the MPU was a form of compulsive behaviour. He cited this and Daniel's repeated requests to clean out up outside his cell as further examples of disorganised thought behaviour associated with psychosis.

66. Dr Sullivan was of the view that examinations through a cell door are not the preferred means of patient assessment, however he agreed that Dr Mukherjee had been able to adequately assess Daniel at Parklea on 17 September 2022 from the doorway of his cell. He did not feel that Daniel's transfers between correctional facilities were of concern, nor did he think that these played any role in what subsequently occurred. However, he did note the benefits of an inmate being in one location so that the same staff are able to observe behavioural changes. He assessed that Daniel was on adequate doses of Olanzapine and noted that this medication is potentially beneficial if a person with psychosis has polydipsia. He thought that Daniel's 5-week course of Olanzapine would have been long enough for a response to have been observed, however he agreed that some entries in the clinical notes suggested that Daniel had continuing symptoms and had missed some doses. Dr Sullivan reviewed the toxicology report and found that it did not detect Olanzapine, which he said would indicate that Daniel had not had it for at least a couple of days.

67. Following the evidence, the team assisting posed a further question to the forensic pathologist in relation to whether Olanzapine was specifically tested for in Daniel's postmortem blood sample. I accept that Olanzapine was tested for and not detected, although I cannot form a view about what this means given that I received no evidence about the possible effect Daniel's hyponatremia may have had on his Olanzapine concentration.

68. The symptoms of hyponatremia are headache, blurred vision, tremor, exacerbation of psychosis, muscle cramps and staggering gait. Dr Sullivan noted that it is often not detected until delirium, seizures or a coma occurs. He was not critical of the treatment Daniel received in his final days. He said that Daniel could not be forced to accept a depot injection and that there were no obvious symptoms of his level of water consumption in his last two days. He also said that there was nothing that suggested that Daniel required an urgent review by a psychiatrist during that time. He did not consider that Daniel would have met the threshold for compulsory treatment during August or September 2022, but did think that he may have in October. However, he reflected that with his fluctuating symptoms, Daniel may not have been prioritised for treatment elsewhere. Dr Sullivan

confirmed an inmate's right to refuse treatment in custody and considered that Dr Mukherjee's approach was appropriate.

69. In his report, Dr Sullivan indicated that he did not consider that there were any precautions or interventions that could have prevented Daniel's death in the absence of a known pre-existing diagnosis of psychogenic polydipsia. He maintained that view in evidence. He also noted that there was no indication that Daniel needed to be reviewed by a psychiatrist between 18 and 20 October 2022. In his view, he was on an adequate dose of medication and was thought to be mostly compliant in taking it. There were also arrangements for him to be assessed by a psychiatrist on 21 October 2022. Dr Sullivan considered this to be relatively fast for a custodial psychiatrist appointment. He also doubted that any earlier psychiatric review would have picked up Daniel's polydipsia because he anticipated the focus of the assessment would have been on his medication. He also was not satisfied that commencing medication earlier at Parklea would have necessarily made any difference.

70. Dr Sullivan gave some important evidence about the rights of inmates. Specifically, he indicated that, "we have to work with patient preferences. We can't simply do what we know to be most effective for patients because we know better". There can be an attraction to believing that the best treatment for a patient is what ought to be given. Instead, Dr Sullivan reminded us that a treatment plan can only be arrived at after consultation with a patient, who has lived experience and views and reasons why the ideal treatment might not be appropriate for them.

71. I accept the submissions that Daniel's psychogenic polydipsia could not have been prevented given that he had no history or signs of it in the lead up to its presentation at Bathurst Correctional Centre. The earliest symptoms and signs are difficult to detect. The only way to have assisted Daniel would have been early monitoring.

CONCLUSIONS FROM EXPERT EVIDENCE

72. The expert evidence was critically important in the inquest to explore the nature of Daniel's illness, the progression of his psychogenic polydipsia to hyponatremia, and whether this could have been prevented. Although areas of improvement were highlighted, the tenor of the evidence was that hyponatremia is a very sudden, insidious condition that leaves

few clues until it is almost too late. I accept the independent review by these experts and thank them for their thorough review and assistance.

WAS DANIEL'S CELL PLACEMENT APPROPRIATE?

73. The expert review leads then to the necessary consideration of what really amounted to the substantive issue in these proceedings. That is, how was Daniel's continual and excessive water drinking not detected when he was placed in a 24 hour CCTV cell while awaiting psychiatric review?

74. Daniel was placed in a surveillance cell following the assessment of CNS Hennessey and a subsequent discussion with Senior Correctional Officer Hemming about his continued desire to move cells. CNS Hennessey considered two placement options for Daniel. In her view, CSNSW is required to make the final decision about an inmate's cell placement based on a combination of factors including clinical recommendation, the patient's safety and security requirements. CNS Hennessey was concerned about Daniel, and she wanted him to be seen by a psychiatrist as a priority. She did not find that he presented a risk to himself or others, but she did want to protect him and ensure that he received psychiatric assessment. CNS Hennessey did what she could to support Daniel and her recommendation to place him in a secure setting was sensible.

75. Daniel presented as somewhat of an anomaly. He changed his position several times about whether he was experiencing hallucinations. At times, he appeared paranoid and confused, but other times not. Sometimes, he said that he was not any of those things and that he had made reports to get a benefit. From the evidence, it appears that he had good rapport with CNS Hennessey and that she managed his mental illness as best she could. I accept that CNS Hennessey did not want Daniel to "slip between the cracks and end up in a cell on his own either, because of his previous history".

76. CNS Hennessey gave evidence that was of great assistance to the Court. No party suggested any criticism of her treatment and her care for Daniel. To suggest there is no blurred line in relation to patient treatment is not reflective of the reality of presentations. Daniel did not clearly meet criteria in relation to self-harm or harm to others. Nonetheless, CNS Hennessey knew that he needed a mental health assessment in a timely manner. She

used her ability to keep him in what she thought was a greater protective environment by recommending his placement in the MPU. Hindsight supports her intuitive response.

77. There is a suggestion that what could have been added to Daniel's HPNF was information about the type and frequency of observations needed. This is a matter that is further addressed below. However, I have no issue with the CNS Hennessey's assessment and treatment of Daniel. She is thanked for her assistance in this difficult process and acknowledged for trying to take steps within a complex system to have Daniel protected and referred on for early intervention.

WHAT LEVEL OF OBSERVATION IS PROVIDED WHEN AN INMATE IS PLACED IN A 24-HOUR SURVEILLANCE CELL?

78. The Governor of Bathurst Correctional Centre indicated that inmates in the MPU, "are subject to 24 hour electronic monitoring" and even if an inmate is not under a RIT, significant observations are recorded[1]. Although a camera cell is different to an assessment cell and the relevant CSNSW Custodial Operations Policy distinguishes between the two, it appears from the evidence in these proceedings that at Bathurst those descriptions are used interchangeably. The effect of the Governor's evidence then is that MPU officers are to ensure that inmates in camera cells are observed and that significant observations are recorded, regardless of their RIT status or what is contained on their HPNF.

79. I accept that evidence, and as such CNS Hennessey was entitled to believe that Daniel would be observed at a reasonably high level. CNS Hennessy did not consider Daniel at risk of self-harm, however she expected that he would be constantly monitored by CCTV cameras to maintain his safety and to prevent (or to ensure intervention in) any self-harm attempt.

80. The evidence also supports a finding that, in practice, those responsible for monitoring the MPU CCTV cells at Bathurst Correctional Centre do not perform a monitoring role unless an inmate is "on a RIT" or specific observations are sought in their HPNF. FCCO Davis said RIT inmates are checked every half hour, on average, and that they will observe other

[1] Exhibit 1, Volume 1, Tab 12, pages 3-4.

inmates if told to do so. There are no set times to check on inmates who are not on a RIT. Correctives officers merely scan those cameras and record what they see for RIT inmates. It was FCCO Davis' evidence that inmates are only closely monitored if they are on a RIT.

81. FCCO Murray said if inmates are not "on a RIT" and are only in the MPU for housing they are not monitored at all. FCCO Davis said that he does not review inmates' HPNFs at the start of his shift and that they are not discussed during staff handovers. FCCO Davis also said that he would only retrieve an inmate's HPNF if he is made aware that there is an issue with that inmate.

82. There appears to be significant miscommunication between CSNSW and Justice Health about what observation service is provided in a CCTV cell. The evidence in this case supports that Daniel was receiving very limited benefit from being in the MPU. There was no evidence that any additional observations were made of him, or any additional care was being taken in relation to his wellbeing. In fact, in the general population Daniel would have had the benefit of a cellmate who may have had the opportunity to observe his excessive water consumption and alert correctives staff accordingly.

83. The HPNF in this case did not contain any details about the observations of Daniel that CNS Hennessey considered necessary. She indicated in her evidence that more information would potentially have "confuse[d] the issue". The HPNF policy, however, requires a clinical staff member (if placing a patient in a camera cell for a medical reason) to include on the HPNF the type, duration and frequency of observation required. I accept that it was difficult for CNS Hennessey, because as set out above, she was simply worried about Daniel. Correctives officers can make observations for specific behaviours noted on a HPNF or RIT management plan, however they are not medically trained. FCCO Davis gave evidence that he was given no training in mental health issues or the potential complications of schizophrenia.

84. Correctional officers are not mental health clinicians and have no training about the types of atypical behaviour to look for inmates. The evidence in this inquest was that FCCOs Davis and Murray had "learned on the job". CSNSW's Custodial Operations Policy requires correctives officers to report any unusual behaviour by inmates who are being observed in camera cells. However, even if an inmate's HPNF includes details of the duration and

frequency of required observations, this will not be helpful unless officers are aware that what they are observing is of significance.

85. On 20 October 2022, the MPU had its usual staff. The usual staff comprise three correctives officers and two senior correctives officers. One of the senior officers monitored the screens in the MPU office and the other would take over if they had to move away temporarily. Neither of the senior officers observing the MPU cameras that day made any notes about Daniel's water drinking, reported it to Justice Health nurses, or conveyed it to incoming staff during hand over. No one appears to have noticed Daniel drinking water excessively in any interaction with him that day.

86. The evidence supported a finding that drinking around 240 cups of water in a day is unusual behaviour and would therefore meet the criteria for reporting. Dr O'Leary reviewed the CCTV footage, recognising that this was done with the benefit of hindsight. He described Daniel pacing, stopping at his cell bubbler and drinking multiple cups of water in rapid succession as quite abnormal. Dr Sullivan noted that correctional officers might not have noticed that Daniel was drinking an excessive amount of water given that it is a seemingly innocuous behaviour that is not usually seen as a risk.

87. I accept on the evidence that Daniel was not being checked frequently because he was not under a RIT and there was nothing included on his HPNF to require particular observations of him. It may have been that officers noticed him drinking water and thought it unusual but did nothing about it given its benign nature. Both FCCOs Davis and Murray indicated that they did not know that excessive water ingestion could be harmful, let alone fatal. That said, I note that changes have now been introduced by CSNSW to the Custodial Operations Policy and Procedure which identifies excessive drinking as an issue that should prompt correctives staff to contact Justice Health if an inmate reports it.

FAMILY'S SUBMISSIONS

88. Mrs Lewis' submissions included some suggested amendments to counsel assisting's proposed recommendations. In relation to proposed Recommendation 1, Mrs Lewis suggested that it should also include what officers should be informed of and the level of education required to be provided to them. I agree with CSNSW that in relation to proposed Recommendation 1, going into further detail about what correctives officers

should do upon noticing any symptoms or signs of hyponatraemia goes beyond the scope and the necessity of these recommendations. I also note that the relevant review committee will have access to my recommendations and can themselves consider incorporating additional points into the education component.

89. Mrs Lewis also suggested that proposed Recommendation 1 be amended to include the potential restriction of an inmate's access to water. In my view, exercise of this power ought only be done in consultation with those who have appropriate medical training. Whilst Dr Sullivan gave evidence that it would be morally and legally justifiable to restrict water access to those known to have polydipsia, in my view, it would be inappropriate to deny water to someone who *may* develop polydipsia simply because they have schizophrenia.

90. In relation to proposed Recommendation 2, Mrs Lewis suggested the streamlining of language to amend the word "indications" to "signs" for consistency across policies and what is to be communicated to correctional and clinical staff. I have adopted Mrs Lewis' suggestion to clarify the terminology used in both Recommendations 1 and 2.

91. Mrs Lewis' submissions proposed a further 6 recommendations as follows:

Proposed Recommendation 3 – Amend the Reception Screening Tool to include the following questions under an additional heading "Mental Health History" : (1) Are there any active alerts on the JHeHS system? (2) Are there records showing a mental health history?

Proposed Recommendation 4 – Correctional staff should undergo specialist mental health training with respect to schizophrenia/psychotic disorders, excessive water drinking, the early signs of both polydipsia and hyponatraemia and what steps to take when such signs are detected.

Proposed Recommendation 5 – Corrective Services NSW revise policies applicable to emergencies to state explicitly and consistently when an officer may and should enter a cell (1) without permission from a senior officer/OIC (2) without a second officer present.

Proposed Recommendation 6 – The MPU is to be staffed by a minimum of two correctional officers at any one time.

Proposed Recommendation 7 – The MPU nurse staffing arrangements should be extended to 9pm.

Proposed Recommendation 8 – Encourage the availability of i-STAT machines for use in correctional centres.

92. Justice Health policy 1.225 *Health Assessments in Male and Female Adult Correctional Centres and Police Cells* addresses many of the family's concerns about the initial intake and ongoing Justice Health assessments. In relation to specific suggestions about correctional officer and nurse staffing and rostering arrangements, I do not consider that these are matters that this inquest should mandate or address. In relation to the availability of i-STAT machines in correctional centres, I consider that Justice Health has answered this concern, and I accept their submission that they can adequately manage a patient with a known diagnosis of polydipsia with a testing regime (involving regular blood tests) and management of access to water.

93. In relation to the additional recommendations proposed by Mrs Lewis, I note that they are of benefit to bring to the attention of both CSNSW and Justice Health, however I do not consider they arise from the scope of this inquest. As noted above, I also consider that they have been answered by the various parties.

94. This raises a general reflection on the inquest process and the importance of the family having the opportunity to voice concerns and raise issues that they would hope to have addressed. Of course, not all questions can be answered and not all recommendations that are raised will necessarily be made. The process involved in considering all proposals put forward is part of the productive nature of an inquest. This process has allowed the family to ventilate specific concerns for consideration, and they have had the opportunity to hear from both CSNSW and Justice Health as to how they can, and are, addressing those concerns.

SUBMISSIONS BY CSNSW

95. CSNSW took issue with the mistaken view of CNS Hennessey that Daniel would be constantly monitored. In my view, this is an area that Justice Health and CSNSW need to urgently resolve. A lay person might expect that an inmate in a 24 hour CCTV cell *would* be monitored to a higher degree than other inmates. I accept that CNS Hennessey

certainly considered so. It appears also that others at Bathurst Correctional Centre believed the same. However, CSNSW's submissions suggest to me that there will be no additional care/monitoring of a cell with 24 hour surveillance unless an inmate is noted as requiring it by being on a RIT or some other notification. Otherwise, it is submitted, standard observations are made – that is, electronic (CCTV) monitoring and regular physical observations.

96. I make no criticism of any of the Bathurst Correctional Centre staff in this regard. However, this indicates to me that confusion and misunderstanding exists between Justice Health and CSNSW as to the effect of CCTV in the MPU.

97. CNS Hennessey's evidence was raised by CSNSW in a critical fashion, suggesting that she decided to place Daniel in the MPU because she wanted him to be seen by the psychiatrist, rather than because he needed to be constantly monitored. I accept that CNS Hennessey was worried about Daniel and I took her evidence in that context. Regardless, it would be very helpful to nurses in CNS Hennessey's position to know what service or type of review they can expect a person to receive from correctives officers while in a CCTV cell. This would allow them to make clear decisions about what should be included on a person's HPNF. If CNS Hennessey knew that Daniel was to be afforded observations no greater than those received by the general inmate population, it may well have altered her completion of his HPNF.

98. The evidence also supports the need for the handover between correctional officers working in the MPU to clearly identify why each inmate has been placed in a 24 hour surveillance cell. CNS Hennessey's evidence was a very good example of this. That is, she had confirmed that Daniel was a person with a significant mental illness who needed psychiatric review as a priority, and she was concerned about his current mental health state. This information, conveyed in simple terms, would have been invaluable to those working in the MPU from 18 to 20 October 2022. That said, I am conscious of the issues CSNSW raises in relation to overloading correctives staff with information. What form this information takes will therefore need to be considered in the broader context of other information that is required to be imparted to officers.

99. CSNSW engaged positively with the inquest and it should be noted that it has taken several steps to improve communication between Justice Health and CSNSW staff and to inform CSNSW staff of the risks associated with excessive water consumption. Mr Shaun Connelly, Nurse Manager Operation, Access and Demand Management at Justice Health noted in his statement that the electronic HPNF (e-form) is now drafted in a way to maximise the quality of communications between clinical staff and correctional officers in respect of patient health conditions, and therefore patient safety.

100. New changes to the e-form ensure that if observations are needed, Justice Health must detail the frequency and type required. The e-form also now details the need to attend for physical observations and attend a cell for signs of life. Excessive water consumption has been included within the list of behaviours which may require intervention.

101. CSNSW supported in part proposed Recommendation 1 but had concerns about the addition of a recommendation which required urgent escalation of care if symptoms or signs of hyponatremia arise, given the evidence that these are similar to other health-related issues that may not indicate a medical emergency. In circumstances where the issue of excessive water drinking becomes known and an inmate also exhibits symptoms or signs of hyponatremia, I consider that it is reasonable for an urgent escalation of that inmate's care. In relation to the reference to signage in proposed Recommendation 1, I agree that this is a matter for CSNSW and Justice Health to determine. I therefore do not intend to make a recommendation that extends to this.

102. CSNSW does not disagree with proposed Recommendation 2 but says that it is not necessary given that the CSNSW and Justice Health Joint Recommendation Working Group has already considered the issue of excessive water intake and that CSNSW has made changes to COPP 5.2 and COPP 3.7 to address this issue. I am of the view that more can be done in this space. It appears not uncommon that a person suffering from a psychotic mental health condition might develop this condition. Dr Sullivan noted that at any given time, the hospital at which he consults might have two or three patients with polydipsia. Dr Sullivan also raised the complication of an inmate's confinement, the higher prevalence of schizophrenia within the custodial setting and the nature of psychosis generally.

103. We are discussing the most vulnerable of inmates. Daniel could not protect himself because of the impact of his mental illness. CSNSW is responsible for a much larger percentage of psychotic people as compared to the general population. Given that Dr Sullivan indicated that he sees several psychogenic polydipsia patients a week, it is not unreasonable to give specific attention to this issue. Recommendation 2 highlights this, as do the facts of this inquest. On that basis, Recommendation 2 will be made.

SUBMISSIONS OF JUSTICE HEALTH

104. Justice Health helpfully accepted the summary of evidence put before the inquest by Counsel Assisting. I agree that no criticism is to be made of either CNS Hennessey or RN Clarke. I consider that they each performed their role with compassion and professionalism, assisting Daniel in what ways they could.

105. Justice Health notes the disconnect between CNS Hennessey's understanding as to the level of monitoring Daniel would receive in an MPU cell, relative to the approach (and capacity) of MPU officers. Specifically, Justice Health notes the evidence of the Governor of Bathurst Correctional Centre regarding inmates in the MPU being subject to 24 hour electronic monitoring and regular physical observations. Of note, it is implicit in that evidence that it was standard for inmates in the MPU, not in the general population.

106. Justice Health is supportive of the need for change, but says that proposed Recommendations 1 and 2, in so far as they are directed at them, are not necessary nor desirable given that:

i. measures have been taken to enhance clinical awareness of psychogenic polydipsia (which was added in October 2023 as a health condition that can be entered into JHeHS when there is a known diagnosis);

ii. training programs have been updated to highlight and focus upon the nature of polydipsia and the potential severity of the condition. For example, the Justice Health NSW "Between the Flags – DETECT" training was updated as recently as September 2024, and includes the context of polydipsia in a delirium scenario. The updated simulation/case study has been provided as an education session at the Metropolitan Remand and Reception Centre and at Long Bay Correctional Campus (where all nursing staff were required to attend); and

iii. a new case study/simulation has been developed for in-service training on "Clinical Measurements in Acute Deterioration" involving a patient presenting with hyponatremia secondary to polydipsia, and this is available for Clinical Nurse Educators to deliver as needed. This case study, it is said, will serve to highlight the matters in proposed Recommendation 1.

107. These changes are very recent and I accept that their specific focus on psychogenic polydipsia supports a persuasive argument that Recommendations 1 and 2 need not apply to Justice Health. In addition, the facts of this case meant that Daniel's excessive drinking was not brought to the attention of Justice Health staff and there was therefore no evidence of a failure to act on their part.

108. However, the Justice Health HPNF policy that was published in February 2023 still suggests that inmates with mental health problems should be encouraged to drink water and does not refer anywhere to the risk of excessive water ingestion. The Justice Health submissions are silent on whether nurses at *all* correctional centres will complete the updated "Between the Flags – DETECT" training that nurses at the two nominated sites have attended, and if so in what timeframe. The option to use a case study "as needed" for in-services also relies on individual Clinical Nurse Educators to identify polydipsia as a priority relative to all the other in-service options available for them to deliver to staff.

109. In my view Justice Health needs to give further attention to ensuring that all relevant policies convey consistent information about the risk of excessive water ingestion, and that its workforce across the state has a clear understanding of what must be done if polydipsia is reported. Therefore, whilst Recommendation 1 will not apply to Justice Health, Recommendation 2 will apply to both Justice Health and CSNSW.

110. Justice Health's submissions relating to the issue of what 24 hour surveillance amounts to, compared with the position taken by CSNSW, raises the need for the final recommendation, which is not one that the parties were asked to address. The evidence in this inquest highlights that there remains confusion as to what is being provided in the way of observations. Recommendation 3 was in similar terms was previously made in the *Inquest into the Death of Simon Cartwright* and this is yet another opportunity to reinforce the need for there to be a clear understanding and more importantly a clear practice

followed between CSNSW and Justice Health as to what 24-hour surveillance means. Recommendation 3 is aimed at CSNSW providing, and Justice Health considering, the information presented to them in a clear and meaningful way. This will protect clinicians who need to understand with clear, unambiguous certainty what their patient can expect to receive in the way of monitoring. Clinicians will then be able to identify whether this level of monitoring is enough on a case by case basis. This distinction is so important. CSNSW are managing the person as an inmate and Justice Health are treating the person as a patient.

CONCLUSIONS

111. Based on the expert evidence, I agree with the submissions of Counsel assisting that a number of conclusions can be drawn:

a. Daniel's psychogenic polydipsia could not have been prevented given he had no history of this condition or hallmark signs that he was at risk of developing it.

b. Most early symptoms and signs of hyponatraemia are difficult to detect by observation and therefore depend on the person reporting them, but if they are psychotic they may not have the insight to know there is an issue.

c. Daniel's hyponatraemia could potentially have been prevented or mitigated if he had been closely monitored. However, those monitoring him would had to have known that excessive water ingestion over a short period of time can be dangerous and requires medical assessment and possibly transfer to a hospital.

d. The critical point for the best chance of survival without brain damage requires expert medical management before a person develops symptoms and signs indicating that they have hyponatraemia.

e. Stopping access to water when a person already has symptoms or signs of hyponatraemia is necessary but will not be enough to resolve the issue and may cause distress. The underlying cause and the effects of the hyponatraemia must be addressed.

f. By the time Daniel collapsed he was already at very high risk of sudden death even though he maintained some ability to talk more than twenty minutes later. By the

time he was unresponsive, no intervention (including CPR) was likely to have made a difference.

g. Caution needs to be exercised when reviewing these events with hindsight. The signs of hyponatraemia were very subtle and would not necessarily have been evident to those attending to Daniel.

112. I am satisfied as follows in relation to the issues:

i. Daniel received adequate and appropriate treatment in custody for his mental health condition between 11 July and 20 October 2022.

ii. Daniel's previous records should have been obtained sooner. Those records did not indicate a history that would have alerted anyone to the risk of Daniel developing psychogenic polydipsia and the references to his past medication non-compliance would not have changed clinicians' approach to his management.

iii. Forcing Daniel to take a depot injection was not an option. His wish to take oral medication was rightly respected.

iv. Reviewing an inmate through "a hatch" is suboptimal and, where it can be, should be avoided. However, Dr Mukherjee's assessment of Daniel from the doorway of his cell on 17 September 2022 enabled him to undertake an appropriate assessment.

v. In accordance with Dr Sullivan's view, transfers between facilities in this case did not make a difference to Daniel's treatment, as each facility was aware of, and took into account, his mental health condition.

vi. Given the toxicology results, it is possible that Daniel missed more doses of medication than staff realised and that he may have misled nurses on supervised medication rounds. However, Daniel had the right to refuse medication in any event, so any missed doses do not indicate his care was inadequate or inappropriate.

vii. The arrangement for Daniel to see a psychiatrist on 21 October 2022 was reasonable practice. I note Dr Sullivan's view that there was no indication that Daniel required a mental health review between 18 and 20 October 2022.

viii. CNS Hennessey did not give instructions about the observations Daniel required in the MPU. She assumed he would be observed by virtue of his placement in a 24-hour CCTV cell.

ix. Correctional officers at Bathurst do not monitor CCTV cameras closely for inmates who are not under a RIT unless they have been told of a particular need. They do not routinely review an inmate's HPNF for details of possible observations required.

x. There was limited observation of Daniel on 20 October 2022 by CSNSW and no documentation of what was observed before he collapsed. That said, Dr Sullivan did not believe correctional officers could have identified signs of Daniel's hyponatraemia that were subtle even with hindsight, and Dr O'Leary's evidence was that once these signs were apparent, medical intervention may have been too late to save Daniel anyway.

xi. There have been policy and training improvements since these events, and a new electronic HPNF will enhance communication between Justice Health and CSNSW staff. However, more can be done.

xii. Even if Daniel had received medical intervention immediately before or after he fell in his cell, it may have been too late. His best chance of survival was if intervention occurred before he showed signs or had symptoms of hyponatraemia.

xiii. CPR on Daniel commenced within an appropriate timeframe. By the time CPR was indicated, no medical intervention could have saved Daniel.

xiv. The availability of a defibrillator, pulse oximeter machine and/or adrenaline in the resuscitation response made no difference to Daniel's outcome.

xv. Daniel's psychogenic polydipsia developed quickly and progressed rapidly to fatal hyponatraemia.

xvi. Additional staffing at Bathurst Correctional Centre alone would not have avoided the outcome on current practice.

RECOMMENDATIONS

113. Section 82(1) of the *Coroners Act* provides for the Coroner to make recommendations considered necessary or desirable in relation to any matter connected with a death that is the subject of an inquest.

114. In Daniel's case, it appears that he was able to be cared for by Justice Health and by CSNSW, who performed complex roles according to usual practice and procedure. Lessons learned however from the loss of Daniel are that some improvements can be made, mostly in training, education and communication, all of which are simple matters.

115. It is difficult to see how correctives officers can look out for an inmate if they are not made aware of their vulnerabilities in a simple way. If any person is placed in a 24 hour surveillance cell, the reason for them being there should be the very first thing new shift officers are told.

RECOMMENDATIONS

Recommendation 1

To the Commissioner of Corrective Services NSW *for consideration to ensure that correctional officers in correctional settings are informed and education is provided that:*

That correctional officers in correctional settings are informed and education is provided that:

- *excessive water intake, particularly in a short period of time, can be life threatening,*
- *intervention should occur before a person shows signs or complains of symptoms, and*
- *if the person does develop symptoms and/or signs, it is a medical emergency.*

Recommendation 2

To the Commissioner of Corrective Services NSW and to the Justice Health and Forensic Mental Health Network for consideration of the following:

That the Corrective Services NSW and Justice Health and Forensic Mental Health Network policies, and the HPNF, should be revised to reflect the fact that excessive water ingestion, particularly over a short period, can be life threatening, and any symptoms and/or signs that suggest excessive water ingestion require immediate intervention regardless of whether the inmate identifies it as a concern.

Recommendation 3

To the Commissioner of Corrective Services and to the Justice Health and Forensic Mental Health Network for the consideration of the following:

That the Commissioner of Corrective Services NSW consider the production of a memorandum outlining what level of supervision/observation service is provided by CSNSW staff of any inmate placed in an observation cell (including a 24-hour surveillance cell) to clearly identify and communicate to Justice Health what types of physical checks will occur, how often these can reasonably be performed, how often the surveillance camera is expected to be on, who is watching that camera and how regularly it will be staffed and viewed, whether officers are aware/instructed about why an inmate has been placed in an observation cell, how this information is passed across shifts to new officers, and what the officers are instructed to look for. That memorandum is to be provided to Justice Health for circulation to clinical staff to enable the development and management of appropriate inmate treatment plans.

FINDINGS PURSUANT TO SECTION 81

Identity

The person who died was Daniel Munro Lewis Turnbull

Date of death

Daniel died on 20 October 2022

Place of death

The location of Daniel's death was Bathurst Correctional Centre

Cause of death

The direct cause of Daniel's death was hyponatraemia, with psychogenic polydipsia and schizophrenia/schizoaffective disorder antecedent causes.

Manner of death

Natural causes due to an underlying psychotic mental health condition which resulted in excessive water consumption in circumstances where Daniel was remanded in custody in a 24 hour surveillance cell.

ACKNOWLEDGEMENTS

The examination of Daniel's death has enabled the making of recommendations which will hopefully assist others in the future. This was achieved with the involvement and contribution of his family, who continued to advocate for him. I hope this inquest answers some of their concerns and questions, but I acknowledge that they are left with significant grief and loss.

The team assisting requires particular recognition in this matter. It is not often that the careful work of the solicitor with carriage of the matter will result, as it has here, in the cause of death being identified. Ms Kohler is to be acknowledged for her excellent legal and investigative work and importantly her commitment to Daniel and his family. Ms Kohler has demonstrated excellence in legal practice in the coronial jurisdiction.

Dr Waterhouse, Counsel Assisting, worked with Ms Kohler to ensure the expert evidence was presented in a manner that answered as many of the issues as was possible, and presented the inquest in a clear, effective and informative manner. I thank them both for their exceptional assistance.

My sincere condolences are extended to those who grieve the loss of Daniel, especially to his sisters and his mother.

I now close this inquest

Deputy State Coroner Erin Kennedy

19 February 2025