CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Emmett Brown
Hearing dates:	11 – 19 November 2024
Date of findings:	2 May 2025
Place of findings:	Wollongong Local Court
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – mandatory inquest – death of a First Nations man in custody – was custodial health care adequate – access to and use of unprescribed medication – access to drug and alcohol programs in custody – head-checks - compliance with serious incident response and reporting protocols and procedures – recommendations
File Number:	2022/00375404

Representation:	Counsel Assisting the Inquest: C McGorey of Counsel i/b Solicitors NSW Coroners Court. Counsel for Senior Next of Kin: S Rees, Aboriginal Legal Service. NSW Commissioner for Corrective Services: A Douglas-Baker of Counsel i/b Department of Communities and Justice Legal. Justice Health and Forensic Mental Health Network and CNS Rewell: K Holcombe of Counsel i/b Makinson d'Apice Lawyers. Correctional Staff Brander, Dunn, Hawe, McShane, Muzik, Papas and Ribaux: S Russell of Counsel i/b McNally Jones Staff Lawyers.
Non publication orders:	Non publication orders made on 19 December 2023 and 16 September 2024. Non-Publication and Pseudonym Order made on 24 September 2024. A copy of the orders (excluding the attachment to the Pseudonym Order) can be obtained on application to the Coroners Court registry.
Findings	**Identity** The person who died was Emmett Brown. **Date of death** Emmett died on 12 December 2022. **Place of death** Emmett died at Shortland Correctional Centre, Cessnock NSW. **Cause of death** Emmett died from the combined effects of acute bronchopneumonia and methadone toxicity with his high body mass and obstructive sleep apnoea being contributory factors.

	Manner of death Emmett died after consuming non-prescribed methadone whilst in custody at Shortland Correctional Centre.
Recommendations	<u>To the Commissioner of Corrective Services NSW (CSNSW)</u>: 1. CSNSW review its written procedures and training concerning the confirmation of an inmate's physical wellbeing during the conduct of "head-check" procedures having regard to the findings made in this Inquest. This extends to: a) Reviewing Custodial Operation Policy and Procedure 5.3 – *Musters, Let-go and Lock-in*, to provide more detailed instruction about how an officer is to confirm an inmate's physical wellbeing during head-check. That includes ensuring clearer instruction as to whether a verbal and physical response is required from the inmate and how the officer can satisfy him or herself. b) Reviewing the sufficiency of the training provided to recruits and serving officers with respect to the procedure referred above in (a) and conducting refresher practical training for all custodial staff who conduct head-checks on inmates. c) Reviewing the Local Operating Procedures (LOPs) that concern the conduct of head-checks / let go procedures, applicable at the Shortland Correctional Centre and other Correctional Centres operated by CSNSW, to ensure there is consistency between the LOPs, COPP 5.3 and the practices employed at those centres.

	2. CSNSW review its written procedures and training concerning incident response and reporting in the event of medical emergencies and/or deaths in custody. That extends to: a) Requiring the separation of each involved officers, as soon as reasonably practicable and subject to operational considerations for the safety and security of the facility, until each officer has completed and submitted his or her incident report (including providing non-exhaustive guidance as to the type of instances in which operation considerations might prevail and what other arrangements might reasonably be effected to avoid that occurring). b) Mandating that, wherever possible, involved officers are not to discuss the event with each another or be present when others are discussing the event or reviewing any video evidence or be present when that evidence is being reviewed, until completion and submission of his or her incident report. c) Requiring a senior officer to assume responsibility for managing and supervising the initial incident reporting process. d) Ensuring there is clear guidance about what constitutes a medical emergency and when the abovementioned requirements are expected to be followed. <u>To the Chief Executive Officer, Justice Health and Forensic Mental Health Network</u>: 3. Justice Health examine the arrangements and resourcing regarding the wait times for Drug and Alcohol assessments and reviews with the aim of reducing wait times.

Table of Contents

Introduction

1. This inquest concerns the death of Emmett Brown. At the time of his death, Emmett was only 25 years of age. He was a proud First Nations man with Yuin and Dunghutti heritage. He observed the Islamic faith.

2. Emmett died on 12 December 2022 at the Shortland Correctional Centre (**SCC**) in Cessnock.

3. Emmett came from a close family. His family described his beautiful smile, loving personality and joyful laughter. He is survived by his parents, Raahna and Colin, his grandmother Lorraine, his siblings Kolby, Meahala and Cameron and his young children, along with many other relatives and friends. Emmett's mother, grandmother, siblings, and various other relatives and friends attended the inquest each day. Their grief at Emmett's untimely death was profound and I have no doubt he will always be missed and remembered with love.

4. While the inquest focussed on the period of Emmett's final incarceration, the family shared information about the important place he had in all their lives over the years. The photographs displayed during the family statement showed the warmth and happy times they shared. His death, so young, should have been prevented.

5. I acknowledge and respect the family's participation in these difficult proceedings. One family member attended from custody, until his bail was granted, such was his commitment to this process and his respect for his brother. The family wanted to understand the exact circumstances of Emmett's death and were also clearly motivated to seek changes which might prevent others experiencing the death of a family member in similar circumstances. Once again, I offer Emmett's family my sincere condolences and thank them for their attendance.

The role of the coroner and the scope of the inquest

6. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[1] A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[2]

[1] Section 81 *Coroners Act 2009* (NSW).
[2] Section 82 *Coroners Act 2009* (NSW).

7. It should be noted that when a person dies in custody in NSW, it is mandatory that an inquest is held.[3] The inquest must be conducted by a senior coroner.[4] When a person is detained the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice it is especially important that the care they are offered is of an appropriate standard. Inmates should be provided with the same quality of care that they could access in the community.

8. Emmett was a prisoner with certain pre-existing health conditions. There are also indications that his health deteriorated whilst he was incarcerated. Certainly, his weight increased and his substance use continued and diversified to opiate use. It was necessary to examine the way in which his health issues were managed in custody to understand what relevance they had to his untimely death.

9. Unfortunately this inquest occurs at a time when Aboriginal people are still vastly over-represented in custody. It is an issue that has troubled me since I first sat in this court and one that I have raised on previous occasions[5]. Counsel for the family drew my attention to the most recent statistics in this regard. Aboriginal and Torres Strait Islander people are imprisoned at a rate that is over ten times higher than the general population. It remains a shameful statistic and one that I accept is grounded in the ongoing effects of colonisation. Until we can properly grapple with the broad causes of over-representation, we will not be able to reduce the disproportionate number of First Nations deaths in custody. First Nations people are also known to experience inadequate health care and poorer health outcomes. This issue is acknowledged by government and certain measures have been put in place to "close the gap." The gap has not closed. In this context the importance of consistently providing chronic disease screening (**CDS**) for all First Nations inmates should not be overlooked and it is an issue to which I will return.

The evidence

10. The Court took evidence over seven hearing days. The Court also received extensive documentary material in seven volumes. This material included witness statements, medical records, photographs, audio calls and video footage, operational documents, policies and procedures.

11. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

[3] Section 27 *Coroners Act* 2009 (NSW).
[4] Section 24 *Coroners Act* 2009 (NSW).
[5] See for example, Inquest into the death of Jonathon Hogan (6 May 2020); Inquest into the death of Kevin Bugmy (6 July 2022); Inquest into the death of Reuben Button (21 July 2023).

12. A list of issues was prepared before the proceedings commenced[6]. These issues guided the investigation. However, an inquest can tend to crystallise the matters which need attention and I intend to deal with the most important issues as they emerged during the proceedings under broad headings below.

Background and brief chronology

13. Prior to the commencement of proceedings, those assisting me drafted a chronological summary of the key events from the available documentary evidence. The parties agreed that this document, an Outline of Facts and Evidence (Non-Contentious) (**NCF**)[7], which was tendered, contained an accurate summary of the chronological events. I attach a copy of that document as an annexure to these reasons and do not intend to repeat all the material contained in it. I adopt its content.

14. Counsel Assisting also produced extremely comprehensive submissions summarising much of the oral evidence. I have also relied heavily upon this document in recording my written reasons, at times directly adopting the submissions put forward. I have reviewed the evidence carefully where differences in fact or emphasis are noted by the parties and in all matters the conclusions are my own.

Emmett's physical health and management in custody

Emmett's health / functioning

15. Counsel Assisting recorded the importance of understanding Emmett's health background in his closing submissions. He identified Emmett's health issues and vulnerabilities in custody during the relevant period. I accept his summary as accurate and re-produce it below:

> 1. *First, he had a history of substance dependency in the community. This concerned methylamphetamine ('ice'), cannabis and alcohol. This dependency arose against a backdrop of deprivation. Although he had no known history of opiate use in the community, in early 2022 Emmett reported that he would fall into a pattern of illicit buprenorphine use in custody. Emmett's experience in this respect is not unique.*[8]

[6] Issues List dated 6 November 2024.
[7] Exhibit 5 and Annexure 1 to these Findings: Outline of facts & evidence (non-contentious).
[8] Counsel Assisting's Closing Submissions 12 February 2025, pp 3-4. Witness A gave evidence that "*You see boys using ice on the outside and bupe is the total opposite. It's an opioid sort of drug. And they're coming off the streets using ice and they haven't - they haven't had it on the drugs so they go with the bupe*…" T18:13-16 (11.11.2024).

2. *Second, Emmett had difficulties in some areas of his intellectual functioning. Further investigation of this was recommended by Mr Sheehan in February 2022. These difficulties might have hindered his engagement in rehabilitation programs. It also put him at a disadvantage in seeking assistance for his health and other issues.*[9]

3. *Third, Emmett gained significant weight between August 2016 and December 2022. It increased from 83.6kg (BMI of 25) to 124kg (BMI of 38.75).*[10] *Postmortem investigations revealed Emmett had closed coronary arteries, a slightly fatty liver, a high BMI, and cardiac enlargement when he died. He was physically at greater risk of chronic conditions.*

4. *Lastly, although not formally diagnosed, Emmett suffered sleep apnoea.*[11]

16. I accept that these are the issues which should have been known to his health providers in custody and which should have informed the care Emmett received at the relevant time.

Chronic disease screening

17. Emmett's risk of developing a chronic condition should have been identified in custody. Justice Health and Forensic Mental Health Network (**Justice Health**) has a well-known procedure for CDS. This is directed to the identification of people with chronic condition(s), such as heart disease, diabetes, and asthma, and to ensuring the timely development of an individualised Multidisciplinary Care Plan for the patient. The procedure has been an important one in improving care for many inmates.

18. The evidence establishes that Emmett underwent a CDS at the SCC in 2016. He was noted to have a family history of diabetes and heart disease but otherwise was not himself considered to have a chronic disease at that time.[12]

---

9 In Witness B's view, based on his dealings with Emmett, he believed Emmett would have had difficulties with comprehending some things and found it difficult to speak to nurses: ERISP, BOE Tab 47 (Vol 2) A18-19 p. 284.

10 Emmett's August 2016 weight was recorded as part of a chronic disease screening performed at that time: see "*Adolescent Health Comprehensive Assessment"* (assessment dated 1.8.2016): JHeHS records: BOE, Tab 135 (Vol 5) pp.1327-1330. Emmett's weight at the time of his death is recorded in Dr Cala's Post-Mortem Report: BOE, Tab 2 (Vol 1) p12.

11 Observations included those of (a) Witness A ERISP: BOE, Tab 46 (Vol 1) pp.255-56 and T16-17 (11.11.2024) (observations of Emmett's snoring and choking while sleeping while both were placed at Hunter and Silverwater Correctional Centres) and (b) Witness B ERISP: BOE, Tab 47 (Vol 2) A220-233 pp.301-303 and T38-39 (11.11.2024) (observations of Emmett's snoring and choking while sleeping while both were placed at the Hunter Correctional Centre).

12 Connolly Supplementary Statement: BOE, Tab 169 (Vol 7) [616] p. 2165.

19. On 4 August 2020, Emmett entered the Parklea Correctional Centre and underwent a Reception Screening Assessment (**RSA**). This was a privately operated prison. St Vincent's Correctional Health provided health services in that centre. Emmett was not referred for a CDS on reception (noting there was no mandatory requirement for a CDS operating at this time).

20. In February 2021, Justice Health changed its protocol to mandate that all ATSI people entering custody, regardless of their age, undergo CDS with a repeat of that each year thereafter.[13] This is because of the higher incidence of chronic diseases in this cohort.

21. In June 2021, Emmett was transferred from PCC to the Hunter Correctional Centre. He was transferred to SCC on 18 June 2022 where he remained until his death. He was not referred for a CDS upon these transfers and a CDS was not performed before his death. Counsel assisting submitted that it is possible that a CDS in 2021 or 2022 *may* have led to the diagnosis of Emmett's sleep apnoea and the development of a plan to monitor and treat that condition.

22. Justice Health accepts there were missed opportunities for clinicians to identify Emmett's aboriginality, update the electronic system in this respect, and to refer him for CDS.[14] The error arose at three stages:

    (1) A system's issue that meant there was not an automatic entry of Emmett's aboriginality in Justice Health's electronic system (**JHeHS**) from the Corrective Services NSW (**CSNSW**) system. This meant that RSAs completed in this period did not automatically prompt a referral in Emmett's case for a CDS.[15]

    (2) Clinicians who performed RSAs, when Emmett shifted between Correctional Centres in this period, did not themselves identify or realise that Emmett's aboriginality had been incorrectly recorded within JHeHS.[16]

    (3) Clinicians who had contact with Emmett did not themselves identify or realise his aboriginality was not correctly recorded within JHeHS.

---

13 Connolly 1st statement: BOE, Tab 145 (Vol 5) [16] p.1485. Before this amendment a mandatory requirement for CDS for ATSI persons only arose for those aged 45 or over.

14 Ibid [21].

15 Ibid [20].

16 Emmett had been correctly identified by Justice Health during the 2016 CDS as Aboriginal as evidenced by a referral that as made to a Corrective Services Aboriginal "mentor" to assist him: JHeHS Records: BOE, Tab 135 (Vol 5) p.1319.

23. Without seeking to excuse the failure, Justice Health points to the significant challenges it was facing with the COVID-19 pandemic in this period.

24. In my view the failure to have Emmett's Aboriginality properly and consistently recorded is significant. Even if his status as an Aboriginal man had not been recorded on the system, it is incumbent upon clinicians to turn their minds to the issue and if necessary to ask the question. Had it been recorded it would have prompted a new referral for a CDS. As Counsel Assisting submitted a CDS may have identified the need to investigate the possibility of sleep apnoea. It could also have been important in identifying and treating Emmett's worrying weight gain and high BMI. These are factors that required investigation, and which have direct relevance to his ultimate cause of death.

Substance use in custody

Overall substance use

25. The widespread use of drugs in custody in NSW is not disputed. Illicit substances and non-prescribed medications were accessible to inmates within the SCC. This included buprenorphine strips, methadone (liquid and wafer form) and medications prescribed for the management of depression / mood disorders. This is a common occurrence in all correctional centres rather than it being a problem unique to the SCC.[17]

26. Buprenorphine "strips" are no longer prescribed to inmates at the SCC. The move to prescribing Buvidal as the first line opiate replacement therapy has been effective in reducing opiate replacement diversion throughout the system. The availability of Buprenorphine brought in from the community also significantly reduced in 2022 in the context of limited face to face visitations owing to COVID-19 restrictions.

27. The court heard that diverted Minipress tablets and Catapres tablets were available to inmates. These medications are prescribed for hypertension (high blood pressure) and sometimes other conditions such as sleep difficulties linked to post-traumatic stress disorder.[18]

---

17 One inmate told investigations in a record of interview that ""*See, see in gaol mate like you can get it ..... Methadone and Bupe and you know you can get it - - - Easier than you can get it outside in gaol. - - - And no matter how much they stop you it's, no matter how much like they, it's just the most easiest thing to get in here is Methadone or Bupe or…ice or smokes. - - - I mean like ..... you got, put it this way you got more drugs in gaol than you do outside*": ERISP: BOE, Tab 46 (Vol 1) pp.264-65. That same inmate, in oral evidence, said "…*You can get methadone any day of the week from any yard…It's – it's – it's currency. People use it for currencies. Like some people use it just to help their mates out":* T32 (11.11.2024).

18 Expert Report of Professor Jones: BOE, Tab 152 (Vol 5) p.1553.

28. Some inmates informed the court that they used diverted Minipress to achieve a drowsy or "stoned" state or to compound the effects of other substances like methadone.[19] This typically involves taking a dose beyond that recommended or which would ever be prescribed. It appeared that where no other drug was available inmates were prepared to use these substances.

29. Inmates holding prescriptions for Minipress collected small numbers of the tablets each day from the clinic.[20] In some, rarer, instances inmates can be issued larger quantities on a single occasion (e.g "*monthlies"*).[21] The taking of Minipress and Catapres tablets is rarely supervised as they will be taken by the patient in the morning or nighttime in their cell.[22]

30. The reduced availability of buprenorphine strips during COVID-19 may have contributed to an increase in the use of diverted methadone and Minipress / Catapres medications.[23]

Emmett's substance use in custody

31. Emmett used non-prescribed medications while placed at the SCC. This included non-prescribed Minipress / Catapres medication, buprenorphine (strips), mirtazapine and methadone. One witness close to Emmett in 2022 described their usage, and the reasons for their use, in these terms:

> "*…back then I was using as well so like was just on the bupe. Anything that came in, was just buying it. It is like - and it wasn't much because it was COVID, you know, and when there was no bupe around, like, was - like - like I said I was using with him. We were getting methadone drinks, we're…taking pills, we was doing everything we really could to get our head out of gaol because we do such a long time in here. We spend our whole lives in here. You know what I mean, it's - it's easier for us to get our head out of here when we're smashed, you know*…"[24]

---

19 A witness described the effects of Minipress / Catapres ("Caddies") as follows: "…*when you're on drugs like see I'm on the Bupe so I, and my, my dose of Caddies they, they make me more stoned so - - - … um the Minipress if you have enough like it puts you to sleep just, just knocks you out you know what I mean? Lowers your blood, blood pressure it lowers your heartrate*…": ERISP: BOE, Tab 46 (Vol 1) pp.261. In evidence, Witness A described it as "*If you're using at the time, it actually makes you feel like you're stoned. It just relaxes you. You just - it slows your heartbeat down. You're just relaxed, you know. Your body just goes into relax*": T20:29-37 (11.11.2024). Witness B described it as providing a "*day out"* where it "*sorta dulls you out a bit"* and lets you forget: ERISP: BOE, Tab 47 (Vol 2) p. 285.

20 Witness A's evidence T19-20 (11.11.2024).

21 Witness B's evidence T40-41 (11.11.2024); Witness F evidence T70 (11.11.2024).

22 According to Witness A's, he consumed his prescribed Catapres in his cell because of their effects: ""*Yeah well that' sit yeah like I'm prescribed to Catapres (sic) I mean two Catapres (sic) a day that's me every day you know? - - - And even then I have to take them when I'm in me cell because it makes me not alert you know? Like - - - I can't be out of my cell I'm not alert and then be in gaol you know what I mean so I don't take them until I'm in my cell you know?*...": ERISP, BOE, Tab 46 (Vol 1) p. 277.

23 T21:29 to T22:5 (11.11.2024).

24 T21: 29-36 (11.11.2024).

> *"…when we spend such a long time in gaol, bupe is like an everyday thing to us. Like - like, it shows that even Emmett was saying, like, we've both been in gaol a long time even just not this time but last time, like, we're always in, out, in, out, you know what I mean? We get - we get addicted to the gaol life and we get addicted to the drugs that are in gaol. You know what I mean? It's not just what we do on the outside. You know what I mean? It's the..(not transcribable)..that we do and it's the drugs that we take. It's the only ones that we can get..."*[25]

32. I am satisfied on the evidence before me that Emmett used diverted methadone on occasion. The regularity of this use cannot be reliably established.[26] In the community it is clear that Emmett was more likely to use amphetamine type substances, however there is no replacement substance available for amphetamine cravings in custody and it appears common for amphetamine users to develop a tendency to use opiate type substances in custody where nothing else is available and interventions by way of specific counselling are rare or non-existent.

33. It is also possible Emmett may have injected substances in custody on occasion. If so, he did not do so regularly. Counsel Assisting drew my attention to the following factors in this regard:

    (1) An inmate's report that he saw Emmett injecting on one occasion. [27]

    (2) The request for assessment of Emmett on 27 June 2022 (with another inmate's assistance) referenced his concern at catching "*Hep C by using with other inmates*".

    (3) Emmett's report during the assessment on 19 August 2022 he had injected two weeks earlier (although he declined a request to show the needle marking). It is possible this report was not true and was made to increase his chances of being assessed suitable for Buvidal. However, the possibility it occurred cannot be discounted.

---

25 T22:11-18 (11.11.2024).

26 Emmett was subject to a limited number of drug tests between 4 August 2020 and 11 December 2022 with only testing positive for opiates (buprenorphine) on 4 May 2022. Professor Lintzeris gave evidence that drug screens performed in this period does not provide a good understanding of the frequency / pattern of Emmett's use: T576:28-30 (19.11.2024).

27 An inmate described entering a cell once and witnessing Emmett and another inmate injecting. The inmate believed Emmett started doing so after he was denied entry to the Buvidal program "*because he wanted to get a track mark so he could get on the injection"*: T25-26 (11.11.2024). That inmate, in an OTC call, mentioned discussing with Emmett about "*shooting up*" and the risk of harm to themselves and their families in doing so, with Emmett's response indicating agreement (e.g. stating he agreed and would change once he was released).

(4) There is no report from anyone who was close to Emmett of him having markings on his body consistent with needle use. Nor were markings of this kind observed during autopsy.

34. Emmett's consumption of Minipress or Catapres tablets was not necessarily every day but was reasonably regular in the months before his death.[28] According to Witness B, Emmett began using three to five tablets at a time but this increased over time and he witnessed Emmett on occasion to take about ten tablets at a time.[29]

35. The evidence clearly established that it is common for inmates to take drugs in gaol to survive the boredom and pain of being in custody. Prisoners spoke of their drug use increasing while incarcerated, some tried drugs they would not have used on the outside. Drugs such as Catapres, not usually used for recreational effect in the community, were also well known. I have no trouble accepting that Emmett is likely to have had a different drug use profile in custody to in the community. In my view it is established that Emmett is likely to have used drugs whenever they were available to him in custody and that he used a variety of substances. On the outside it appears that Emmett may have chosen to primarily use an amphetamine type substance, but like many prisoners when incarcerated he used whatever he could get.

Emmett's request to be assessed for the Buvidal program

36. Emmett submitted three written requests to be assessed for the Buvidal program on 3 May, 25 May and 27 June 2022[30]. These forms were written by other inmates owing to Emmett's literacy difficulties.[31]

Opioid replacement therapy in custody

37. The history of opioid replacement therapy within NSW Correctional Centres is outlined in the report of Professor Nicholas Lintzeris (**Professor Lintzeris**)[32].

---

28 See accounts of Witness A ERISP: BOE, Tab 45 (Vol 1) pp.259-268; Witness B ERISP: BOE, Tab 47 (Vol 2) pp 293-300; and Witness F: CSNSW Investigator notebook summary of interview regarding their observations / knowledge of Emmett use of Minipress tablets (including on 11 December 2022): Summary of OTS Calls: BOE, Tab 104 (Vol 5) p953.

29 Witness B ERISP: BOE, Tab 47 (Vol 2) A112-124, A193 pp.293-94 and 299; and T43-44 (11.11.2024). Witness A also witnessed Emmett take between 7 to 8 tablets at once sometime before 11 December 2022: ERISP, BOE, Tab 46 (Vol 1) p.267.

30 Exhibit 5 and Annexure 1 to these Findings: Outline of facts & evidence (non-contentious): [35] – [35].

31 Witnesses B, G and I each assisted Emmett to write the forms (e.g. see T110, T146 (12.11.2024))3

32 Expert Report of Professor Lintzeris: BOE, Tab 155 (Vol 6) pp. 1599 – 1603.

38. Sublingual buprenorphine therapy was introduced in NSW Correctional Centres in about 2002. This therapy shifted to a combination of buprenorphine-naloxone known as *Suboxone* by about 2006-2007. This shifted from tablet to sublingual film ("*strips*") in about 2012-2013.

39. In about 2015, Justice Health shifted to methadone as its main opioid replacement therapy. This was to reduce incidences of diversion. In about early 2020, Justice Health introduced Buvidal as a routine opiate replacement therapy. This is a long acting buprenorphine injection administered monthly. It is now the predominant substance in opiate replacement therapy in custody in NSW.[33]

40. Professor Lintzeris' evidence points to Buvidal's efficacy in reducing the use of non-prescribed opioids in custody *and* at the time of release into the community. This accords with the experiences of some of the witnesses. Witness A said it "*makes you not even think about [cravings]….I don't get stoned on my injection….It just makes me not think about it."*[34] Witness B said this therapy, to him, meant "*You're not chasing drugs. You've got yourself settled"*[35] and it assisted him to remain abstinent after his release.[36]

Eligibility for Buvidal therapy

41. Buvidal is a Schedule 8 medication. It is indicated as a treatment for individuals with a diagnosed opioid dependence. Its use is governed by Therapeutic Goods Administration requirements and the *NSW Clinical Guidelines: Treatment of Opioid Dependence 2018* (**NSW OTP 2018 Guidelines**[37]).[38]

42. The standard for opioid dependence derives from the ICD-11 criteria[39] for opioid dependence or DSM-5 criteria[40] for Moderate to Severe Opioid Use Disorder.

43. An assessment for dependence typically considers a patient's reported history of use, physical examination, laboratory investigations (including urine screens) and collateral information such as reports from health care providers, family and real time prescription monitoring systems.[41]

---

33 Lintzeris, T579:26 to T560:3 (19.11.2024).
34 Witness A, T23:4-36 (11.11.2024).
35 Witness B, T44:41-46 (11.11.2024).
36 Witness B, T46: 42-50 (11.11.2024) and Witness F, T71:4-31 (11.11.2024)
37 Https://www.health.nsw.gov.au/aod/Publications/nsw-clinical-guidelines-opioid.pdf.
38 Referred to by Professor Lintzeris as "*NSW OTP Guidelines (2018*)": Lintzeris Report: BOE, Tab 155 (Vol 6) p.1604.
39 International Classification of Diseases.
40 Diagnostic and Statistical Manual of Mental Disorders (5th Edition).
41 Safescript / NSW Health Section 8 permit records.

Inmates reported experiences with being assessed for the program

44. While the need for practitioners to comprehensively assess an inmate patient for opioid dependence prior to starting them on an OTP is clear, the court heard of some of the difficulties which exist when this assessment occurs in custody.

45. Some inmates described difficulties in the assessment process for Buvidal therapy. Counsel Assisting summarised the evidence thus:

(1) Significant wait times in being assessed by Drug and Alcohol (**D&A**) clinicians to determine if they are eligible.[42]

(2) The belief that an inmate is more likely to be assessed as suitable if they can present 'track' marks (it is accepted this is not a specified requirement of Justice Health policy).[43] Some inmates find this to be confronting / degrading and may be reluctant to do so.[44]

(3) Concerns around being asked to supply urine samples for screening to show a "*dirty urine*". These urine samples are tested by Justice Health clinicians and are separate to those required from time to time by CSNSW. This distinction may not be understood or accepted by all inmates. Some are fearful about Correctional Officers learning of these screening results. Witness B said this was a concern of Emmett's after he lost his "*buy-up*" and phone privileges because of his dirty urine result in May 2022[45].[46]

(4) Concerns that Correctional Officers may become aware of their substance use. An officer may realise this if he or she escorts the inmate to the clinic for a D&A assessment or, potentially, from inadvertently hearing the inmates' reports during assessment from their position outside the clinic room.[47]

---

42 Witness A described the wait time being up to 300 days for some inmates: T22-23 (11.11.2024). Witness B described the delays he experienced in his ERISP: BOE, Tab 47 (Vol 2) A80-85 p.290.

43 Witness A gave evidence of his belief that: "*…You have to show them marks in your arms. Like I've got trenches in my arms. You know what I mean? Like, people that don't have track marks and actually have a bad habit can't get nothing. They get no help*…": T22: 33-45 (11.11.2024).

44 Witness B, T46:12-18 (11.11.2024) and Witness I, T146-147 (12.11.2024).

45 Emmett returned positive urine screen for amphetamines, non-prescribed mirtazapine and non-prescribed buprenorphine on 4 May 2022: Summary of Evidence and Facts (Non-Contentious) [24].

46 Witness B ERISP: BOE, Tab 47 (Vol 2) A42-43 p.286, A44-45 pp.286-87; and T45-46 (11.11.2024).

47 Witness B described the concern at Correctional Officer's learning of what was reported in assessment leading to "*your whole pod's getting flipped and your cells' getting flipped*": T45:11-18 (11.11.2024). Also see Witness I, T153-54 (12.11.2024) and Witness B, T56 (11.11.2024).

Ms Rewell's evidence about her assessment of Emmett on 19 August 2022

46. Emmett was placed on the waitlist for assessment on 21 May 2022[48] following the completion of his written request for assessment on 3 May 2022.

47. On 19 August 2022, Robyn Rewell (**Ms Rewell**), a Justice Health registered nurse and Drug and Alcohol Clinical Nurse Specialist, assessed Emmett's eligibility for the Buvidal program. This in-person assessment occurred at the SCC clinic.

48. Ms Rewell had been employed with Justice Health since 2015 and had held the Clinical Nurse Specialist role since 2018. She was primarily based at the Long Bay Correctional Complex but also attended Correctional Centres outside Metropolitan Sydney to conduct assessments. She attended the SCC once a fortnight for that purpose.

49. Emmett was one of several patients Ms Rewell saw at the SCC on 19 August 2022. On average she would have seen between 14 to 16 patients listed for review on a given day (not everyone scheduled to be seen would attend or be assessed).[49]

50. Ms Rewell reviewed the RSA completed on 4 August 2020 which noted Emmett's denial that he had used opiates in the community. It is unclear whether she had regard to other records within JHeHS.

51. Ms Rewell asked questions of Emmett around his drug use in custody.

52. Ms Rewell's noted that Emmett reported that he "*injected 2 weeks ago"* but declined her request to show injection markings on his arm.[50]

53. She did not record observing other symptoms, such as runny eyes, runny nose, dilated pupils, clammy skin, and slight perspiration, which may be indicators of drug use (the presence of these symptoms was not noted).

54. Ms Rewell's contemporaneous note that Emmett was an "*opportunistic drug user in custody*" suggests he reported some use of non-prescribed opiates although not sustained use.

---

48 This was assigned priority category 4 assignation (routine to be completed within 12 months).

49 Rewell, T420: 24-31 (15.11.2024).

50 In Ms Rewell's experience, persons injecting opiates will usually have "track" marks. The most likely area for those are the arms however other areas of the body may be used for those purposes: T431: 46-50 to T432: 2-6 (15.11.2024).

55. Ms Rewell was not aware of Emmett's positive urine result from 4 May 2022 when he had tested positive for non-prescribed buprenorphine.[51] However, that result on its own would not have established opiate dependence. Nor was she aware of Mr Sheehan's 2022 psychological report which noted Emmett's report that he tended to "*fall into smoking non-prescribed buprenorphine in custody, often becoming dependent on this substance. He used the drug to make the passage of time easier, to sleep, and not think about his problems*" (this report was not given to Justice Health).[52]

56. Ms Rewell had the option of asking Emmett to provide a urine sample for a Justice Health screening to check for the presence opiates. This testing is separate to that carried out by CSNSW from time to time. The results of Justice Health screenings are not available to CSNSW. Ms Rewell told the court that she did not request a sample as Emmett's last reported use was two weeks earlier. Any opiate in his system from that usage would have cleared in that time.[53]

57. Had Ms Rewell considered Emmett to be eligible for Buvidal therapy, she would have referred him for a consult with a medical officer to confirm that assessment and prescribe Buvidal. She did not do so as she was not satisfied that Emmett met the criteria for opiate dependence.

58. Ms Rewell documented a plan for Emmett to be reviewed in "*3 months*". Ultimately this review did not occur owing to Emmett's death. Ms Rewell said it wouldn't have been feasible to follow up with Emmett at her next clinic review in a fortnight's time as "*there's just too many people to be seen*."[54]

59. I accept that Ms Rewell worked under conditions which meant that she believed she could not make an earlier appointment. I identify this as a significant resourcing issue rather than a personal criticism of her approach.

Professor Lintzeris' evidence

60. In the opinion of Professor Lintzeris, who has extensive experience in the clinical treatment of opioid dependence:

    (1) It was reasonable for Ms Rewell to conclude Emmett did not meet the criteria for opioid dependence at the time she reviewed him.

---

51 Rewell, T430: 37-39 (15.11.2024) (Ms Rewell did not recall looking at this result).
52 Report of Patrick Sheehan: BOE, Tab 154 (Vol 6) p. 1591; T432: 32-41 (15.11.2024).
53 Rewell, T424:29-30 (15.11.2024).
54 Rewell, T433:50 (15.11.2024).

(2) It is reasonable for clinicians to approach self-reports with some measure of caution. This recognises that non-dependent people may seek Buvidal for its sedating effects.[55]

61. I have no trouble in accepting that custody is such an unpleasant environment that some inmates, without physical addiction would nevertheless seek opiate relief.

62. A person seeking opioid replacement therapy in the community can generally expect to begin that therapy within 7 to 14 days of them seeking out an assessment (assuming they are assessed as suitable).[56] That is significantly less than the three month wait time Emmett experienced while in custody.

63. If a person is assessed as ineligible, but is potentially on the cusp of dependence, the clinician can schedule follow-up reviews to monitor their progress. This can potentially involve urine screening. In my view the ability to keep monitoring a person who is potentially on the cusp of opiate dependence assumes critical importance in a custodial setting. There are very significant dangers inherent in a prison environment that may exceed the dangers existent in the community. These include the lack of clean injecting equipment, raising an increased risk of the transmission of serious diseases such as Hepatitis C and HIV, as well as dangerous blood and injection site infections. The fact that prisoners are locked away for hours, unobserved, also increases the risk of a person being unable to call for help if required.

64. As observed by Professor Lintzeris, Buvidal is licenced in Australia to treat opioid dependence. It is not licensed for use to prevent a person reaching the stage of dependence.[57] However in Emmett's case, there were some "flags" that pointed to the possibility that he was "sliding" towards dependence. Professor Lintzeris expressed his view about this as follows:[58]

> *"…from a Justice Health perspective…they can only use these medications where there is a diagnosis of opioid dependence. So there the challenge is - and you've identified the real risk here - that* ***in prison settings that there are people who may become dependent in prison, opioid dependent, who are not opioid dependent in the community****.*

---

55 Lintzeris, T583: 9-18 (19.11.2024). One inmate in evidence spoke of his awareness of some inmates seeking to be put on the Buvidal program even when they had no opiate use issues: T44:43-46 and T45: 7-8 (11.11.2024).

56 Lintzeris, T578:21-23 (19.11.2024).

57 Ibid, T585: 5-10 (19.11.2024).

58 Ibid, T585: 31 to T586: 23 (19.11.2024).

And that's associated with the availability of drugs in prison settings. So the real challenge there is how does a prison system, Justice Health in this case, ***how can they have adequate monitoring to be able to identify inmates at the point at which they meet criteria for dependence, as opposed to identifying someone who's at risk of developing dependence, and that really is the crux of the problem****.*

Now, where you also then have the complexity of limited resources, and where there are inadequate resources to put all the people who meet criteria for dependence and want treatment…when the system…doesn't have the resources to treat people who meet the diagnosis and already want treatment, you can see the futility of Justice Health trying to go and set up systems of early detection when they can't even treat - they don't have the resources to treat established cases…

…if you think about what happened with [Emmett], where he made a number of requests to seek treatment, he was assessed at that point in time, probably correctly…as not being opioid-dependent at that point in time, based on the information that the Justice Health nurse would have had available. No evidence of injecting, no signs of opioid withdrawal, a urine drug screening profile which was - some evidence of opioid use but not consistent use, and no community history of opioid dependence.

I can understand why the Justice Health clinician at that point made the assessment, probably not dependent at this point in time, ***but clearly [this was] a red flag that this person is at risk of developing dependence****. And then* ***that raises the question of what's the system's response to be able to monitor that person to be able to keep a close eye on them should they continue to slide towards dependence****."*

(Emphasis added)

65. As Counsel Assisting pointed out the issue to which Professor Lintzeris refers is not limited to Emmett's case. It likely arises for many others in custody. In my view there is a pressing need to provide adequate resources to Justice Health so that it can adequately monitor inmates, like Emmett who may be sliding towards dependence. A review in three months' time, in that atmosphere of heightened risk is wholly inadequate.

Capacity of Justice Health to carry out timely DOA assessments / follow up

66. I accept the thrust of Professor Lintzeris' opinion that the wait periods in custody for the initial Buvidal assessment, and follow up reviews, far exceeds that reasonably expected in the community.

67. It is possible that subsequent timely reviews by DOA clinicians, after the 19 August 2022 assessment, possibly with urine screening, *might* have revealed increasingly problematic use by Emmett.

68. I accept Counsel Assisting's submission that there is no basis to find that the delays result from a lack of diligence or concern by individual clinicians, nor that it necessarily results from inappropriate resource allocation by Justice Health. It is more probable that it is simply a result of the limited funding Justice Health receives relative to the services it is expected to provide and the number of people entering custody, which continues to grow.

69. It is very important to spell out the kinds of risks inherent in a system that does not follow up patients in custody who may be at risk of developing an opiate dependence. As I have stated, the risk is not just overdose or drug toxicity, although clearly that is an issue in this case, there are substantial risks of blood borne diseases such as hepatitis C and risks of dangerous infection from unsafe injecting practices. Craving for drugs has also been implicated in serious gaol violence and homicide.

70. In my view, it was not enough to reject Emmett's application to be considered for the Buvidal program without factoring in that he must be reviewed again in the following weeks.

71. Counsel Assisting submitted that it was open to me to consider a recommendation aimed at reducing wait periods for assessment and reassessment. It is an issue to which I will return.

Cause of Death

How did Emmett present on 11 December 2022

72. Various inmates who saw Emmett on 11 December 2022, when he was out of his cell, considered he was affected by substances. [59] I accept Counsel Assisting's submission that the exact substances and amounts he used earlier in the day, cannot now be ascertained with any accuracy.

[59] Witness A ERISP: BOE, Tab 46 (Vol 1) p.258; Witness F, T74:46 to T75:28 (12.11.2024); and Witness G, T114-115 (12.11.2024).

73. Shortly before he was locked down in his cell at 3pm, Witness A said he saw Emmett ingest tablets believed to be Minipress. He estimated Emmett consumed about ten tablets in one go. He was concerned at the amount Emmett took and tried persuading Emmett to hand over his remaining tablets.[60] Emmett declined this request and headed to his cell (numerous 'Minipress' tablets were subsequently located in Emmett's cell after his death.[61] [62]

74. In an interview with CSNSW Investigators on 1 February 2023, an inmate reported that Emmett had consumed "*20mg*" of Minipress and a "*big drink of 'done'*" before being locked down. It is not clear from that report whether the inmate saw this himself or that was something he was told after the event.[63] Clearly Emmett consumed methadone at some point but when this occurred cannot be established to the requisite standard on the available evidence.

75. None of the inmates observed Emmett on 11 December 2022 to have breathing difficulties such as wheezing or coughing. Nor is there evidence that any correctional officer noticed Emmett had breathing difficulties before lockdown.

Dr Cala and Professor Jones' evidence regarding cause of death

76. In the opinion of Dr Cala and Professor Jones, Emmett died from the combined effects of acute bronchopneumonia and methadone toxicity with high body mass index (**BMI**) and obstructive sleep apnoea being contributing factors.[64]

77. Given its severity at the time of his death, Emmett's bronchopneumonia would have onset no less than 24 hours beforehand.[65] That is so even though Emmett did not himself report having difficulties in breathing, and no one else noticed difficulties of that kind on 11 December 2022. The onset of bronchopneumonia is apparently sometimes "insidious". While to the lay observer it initially seemed incongruous with the descriptions of Emmett prior to lockdown, both Dr Cala and Professor Jones stated that bronchopneumonia can develop in a patient without it becoming obvious to the people around them.[66]

---

60 Witness A ERISP: BOE, Tab 46 (Vol 1) pp.258-263, 267; and T26-27 (11.11.2024).

61 Exhibit 5 and Annexure 1 to these Findings: Summary of Evidence and Facts (Non-Contentious), [111].

62 Plastic medication bags issued to inmates by Justice Health, in the name of another inmate were found containing 'Minipress' tablets (16 tablets). Additional Minipress tablets were found in blister packets was also found (one 2mg tablet and seven 1mg tablets): Forensic Analytical Science Services (illicit Drugs Evidence Unit) Certificate of Analysis: BOE, Tab 4 (Vol 1); OIC Statement: BOE, Tab 6 (Vol 1), p9.

63 Diary notes of Investigator Choy 1.2.2023: BOE, Tab 81 (Vol 3) pp.769-70.

64 Joint Expert Report [28]: BOE, Tab 153 (Vol 6) p.1580 [28].

65 Ibid [13]-[16]: BOE, Tab 153 (Vol 6) p. 1579 [13 – 16].

66 Jones and Cala Joint Evidence, T561-62 (19.11.2024).

78. Emmett's postmortem methadone blood concentration of 0.22mg/L was within the toxic range.[67] That takes into account his susceptibility[68] (high BMI, obstructive sleep apnoea and enlarged heart). Opioid-induced respiratory depression is the primary cause of opioid-induced death. It causes neural depression of the central respiratory drive which, together with a decreased level of consciousness and obstructive sleep apnoea causes ventilatory insufficiency.[69]

79. The severity of Emmett's bronchopneumonia, and the concentration of methadone in his system, each on their own, could have resulted in death.

80. Dr Cala and Professor Jones could not safely opine when Emmett stopped breathing by reference to the condition he was in when he was found by Overseer Michael Muzik (**OS Muzik**) at about 7:15am on 11 December 2022.[70]

Timing / quantity of methadone consumed

81. A single post-mortem methadone concentration does not, itself, permit findings as to the exact timing and quantities consumed in the period preceding death.[71]

82. It is certainly possible Emmett might have consumed methadone on 11 December 2022 before the 3pm lockdown. This is consistent with evidence given by other inmates who knew him.

83. Consumption of diverted methadone is well known in the prison system and usually takes place after an inmate on the methadone program retains the liquid in his or her mouth or vomits it up very soon after consuming it. That liquid can be stored in a cup or other container. While authorities have practices in place to observe dosing, diversion nonetheless occurs[72].

84. Counsel Assisting submitted that even if Emmett had some methadone before he was locked in, it is likely that Emmett also consumed methadone in his cell after his lockdown.

85. Counsel Assisting drew my attention to the following matters in relation to Emmett's toxicological results:

---

67 Joint Expert Report [20]: BOE, Tab 153 (Vol 6), p. 1580 [20].

68 Adverse effects include the risk of developing a fatal cardiac arrhythmia and depression of his central nervous system: Expert Report of Professor Jones: BOE, Tab 152 (Vol 5) p.1552.

69 Ibid, p.1551.

70 E.g., not breathing, face, hands and feet cyanosed and cold to touch but his torso still warm.

71 Expert Report of Professor Jones: BOE, Tab 152 (Vol 5) pp.1552 and T560 (19.11.2024).

72 Witness A, T31:36 to T32:17 (11.11.2024); Witness B, T57:32-34 (11.11.2024).

(1) It is difficult to conceive the postmortem concentration resulted from a single instance of use around 3pm on 11 December 2022 with no further consumption thereafter. This would have required an immense quantity of methadone to account for the concentration he still had when he was found deceased about 14 hours later.[73]

(2) In the view of Professor Jones, there is a reasonable likelihood that Emmett ingested some amount of methadone in the early hours of 12 December 2022, although it cannot be known exactly when and if there was one or multiple incidents of consumption.[74] In her view, Emmett likely experienced a progressive decline in his respiratory functioning and consciousness over several hours before he stopped breathing (I note that Dr Cala agreed with that view).[75]

86. Having considered all the available evidence I accept that it is not possible to ascertain the quantity of methadone Emmett might have consumed after lockdown on 11 December 2022, the exact time this occurred and whether it occurred once or multiple times. However, I found Professor Jones' evidence compelling, and I accept, on the balance of probabilities, that some methadone was consumed after lockdown. While Emmett's friend saw him "have a drink," he was not immediately incapacitated. Many hours passed prior to the discovery of Emmett and the high level found at autopsy strongly indicates further later use.

87. I pause to say for completeness, that there is no evidence that Emmett's death was intentionally self-inflicted. The evidence does not suggest that Emmett would have intentionally set out to consume a toxic amount of methadone, or that he had any intention of self-harming, when doing so. It appears that like many prisoners faced with the reality of the gaol environment, which can be both hostile and boring, he was looking for a way to forget his problems briefly, dumb the pain of his separation from family or just make the time pass more easily.

---

73 Professor Jones gave evidence at T569: 19 - 26 (19.11.2024): "So if he'd had a single ingestion sufficient to still give him a toxic range by the following morning, then the concentration of the methadone would have been really, really high the night before and he would have succumbed to the methadone - that would have been the cause of death. The fact that he - forgive me in my expression of this if it's not sensitive. The fact that he survived the evening and then is deceased in the morning is more compatible with it having been taken probably when he's in his cell, but I can't be certain."

74 Jones, T560-61 (19.11.2024).

75 Jones, T563: 9-18 (19.11.2024).

Whether Minipress medication contributed to death

88. The evidence suggests that it is likely that Emmett consumed Minipress tablets on 11 December 2022 before he was locked down in his cell. His presentation to others and what Witness A described seeing shortly before lock-down are evidence of this.

89. Counsel Assisting submitted that it is possible Emmett consumed more Minipress tablets after he was locked down in his cell, however he urged against a firm finding in this respect outlining the relevant evidence as:

    (1) Emmett likely consumed that medication earlier in the day.

    (2) Minipress tablets were found in his cell after his death (this medication was available to him in his cell after lockdown).

    (3) Post-mortem blood analysis revealed no signs of Minipress in Emmett's system. However, owing to its short half-life, this medication would not be detectable about 12 hours after use.

90. I have considered the evidence carefully. Without earlier toxicological results it is difficult to be certain if Emmett took Minipress after lockdown. In any event I accept Dr Cala and Professor Jones' joint opinion that Minipress is unlikely to have played a *significant* role in cause of death.[76]

Morning head-check on 12 December 2022

Head-check protocol and practice as of December 2022

91. The court heard detailed evidence about the conduct of the head-check which occurred on the morning of Emmett's death. Counsel Assisting summarised the relevant protocols accurately and I reproduce them below.

92. The SCC had a procedure for the conduct of morning head-checks and "Let Go". The latter concerns the unlocking of the cell.

93. The morning head-check / let go was formally governed by:

    (1) CSNSW's written procedure titled *COPP 5.3 Musters, let-go and lock-in* (9 Dec 2022) and,

[76] Joint Expert Report [13]-[16]: BOE, Tab 153 (Vol 6) p.1579 [13] – [16]; Expert Report of Professor Jones: BOE, Tab 153 (Vol 5) p.1556.

(2) The Local Operating Procedure (**LOP**) at the SCC for musters, head-checks and let goes. This is a written instruction issued by the SCC specific to that centre.

94. The COPP 5.3 requires correctional staff to confirm an inmate is in "*good health through verbal interaction and visual observation"* during "let go".

95. The process outlined in the COPP 5.3 and the LOP has the head-check and cell release at the same time.[77] However, in practice, the morning head-check / let go practice within Block C had two stages:

(1) *First,* a head-check at about 6:00am. This involves an officer attending each cell and sighting the inmates inside. The officer is expected to confirm the inmate's health during this check. This is typically done without entry into the cell. The officer will use the cell door window to sight the inmate.

(2) *Second,* a CO reattending at about 7:00am to unlock the cell door to release the inmate ("*Let Go*"), with many inmates heading off to work positions at this time (e.g. textiles, manufacturing, etc).

Towels in cell doorways

96. The court heard that from time to time in all custodial settings in NSW inmates try to get a bit of privacy, sometimes by hanging up towels or blankets to act as makeshift screens. It is easy to understand this impulse in an environment where privacy is scarce or non-existent and inmates are often crowded together. Sleep can also be impacted by bright light and using a toilet in full view is difficult for some.

97. The situation was no different at SCC. Many inmates in Block C hung towels inside the cell doorway. These were hung from paddle pop sticks glued to the top inside of the door frame.[78] The towel typically had inmate's favourite NRL rugby team's name / logo displayed.

98. The court was informed that the towel is typically hung to prevent other inmates / officers looking through the inmate's cell door window without notice (for privacy reasons), and to block light coming through that window at nighttime.[79]

---

77 This likely arose from Block C being working Pod, with the "head-check" at 6:00am provided to give inmates a chance to wake and ready themselves for work before "Let Go" at 7:00am.

78 Witness A, T24:20-23 (11.11.2024); Witness F, T73 and T8518 – T8611 (12.11.2024); Witness G, T112: 28 – T114: 9 (12.11.2024); Witness I, T148: 20 - 47 (12.11.2024).

79 Witness A, T24-25 (11.11.2024); Witness H, T130-132 (12.11.2024).

99. Emmett had a practice of hanging a NRL "Cowboys" towel in his doorway.[80]

100. If a towel covered the cell door window during head-check, an officer is expected to require the inmate to shift the towel to permit him to be seen. There were possibly occasions when a visual sighting was not in fact made as expected. However, for the most part, this was not the usual experience of most inmates who gave evidence in the hearing.[81] The Court heard evidence that inmates were typically told to remove the towel.

What CCTV showed as regards the towel

101. In trying to understand what happened on the morning Emmett was discovered the Court had the benefit of CCTV footage.

102. CCTV shows a towel hanging in Emmett's doorway when OS Muzik opened his cell door at about 7:15am.[82] It was dark in colour with white markings.[83]

103. Correctional Officer Hayden McShane (**CO McShane**) is seen in the footage pulling the towel down at about 7:17am. It appears that he deposited the towel in Emmett's cell after doing so.

104. Unfortunately, the towel is not available to enable confirmation of its dimensions. A "Cowboys" towel was found in Emmett's cell after his death. Its significance was not realised at the time and it was later disposed of by CSNSW personnel. This is regrettable, as knowing the dimensions would certainly have assisted the court in understanding how much of the cell was actually obscured.

CO Papas' evidence about his 'head-check' of Emmett at 6:15am

105. CCTV shows Correctional Officer Joel Papas (**CO Papas**) attending outside Emmett's cell to perform 'head-check' at about 6:15am.

106. CO Papas said his usual practice was to "*rattle the handle, open the window and then turn the light on"* to sight a response from the inmate.[84]

107. When he reached Emmett's cell he told the court he:

---

80 Witness A, T25-32 (11.11.2024) (described it to be like a beach towel); Witness G, T114:7-9 (12.11.2024).
81 See Witness B, T56:31-45 and T85: 50 – T86: 3 (11.11.2024); Witness G, T113:9-28 (12.11.2024); Witness H, T131:46 to T132:7, T137-138 (12.11.2024); Witness I, T148-149 (12.11.2024).
82 See image of towel in doorway in CCTV still: MFI A p.2 of 11.
83 Witness G, T114:6-9 and T118:16-18 (12.11.2024).
84 Papas, T169:44-45 (12.11.2024).

> "*…yelled out, "Head-check." Turned the light on. Opened the flap and turned the light on, yelled out, "Head-check" and rattled the handle. I did not get a response at that point. I looked at the cell card on the right-hand of the cell. I got the name. I yelled out, "Brown, head-check." Still did not get a response. I done that. I yelled out, "Brown, head-checks" and I proceeded to kick the bottom of the door.*"[85]

108. While there is no audio component, I accept that CO Papas' account up to this point is largely consistent with what can be seen on the CCTV.

109. CO Papas said he saw Emmett lying on his right hand side on the bottom bunk bed. Emmett's head was towards the rear wall, with his feet closer to the cell door.[86] He could not see Emmett's face from his position.

110. CO Pappas said he called out "*head-check*" three times before getting a response.[87] After the third call out, he stated that he saw movement of Emmett's left shoulder. He described this as a rolling motion like a shrug.[88] He did not hear Emmett say anything in reply nor did he see his face.

111. CO Papas said he believed Emmett moved his shoulder *in response* to him calling out (until that point he assumed Emmett had been asleep which is why he did not respond right away).[89]

112. When he saw that movement he said that he considered Emmett was physically okay, stating "*I felt like on the third call and he heard me on that third call, that was his response and indicated that he had heard me. I felt like that was enough. I would not have moved away from that window if I didn't get a movement*".[90]

113. CO Papas then closed the window flap, turned off the light (as was his practice) and moved on.[91] The footage shows this whole process took about 15 to 17 seconds. It is clear that CO Papas took longer at this cell than he did at the previous cells, which is at least consistent with his account that more was required of him to get what he believed was "*a response*".

---

85 Papas, T175:23-28 (12.11.2024).
86 Papas, T175:40-49 (12.11.2024).
87 Papas, T183: 4-21 (12.11.2024).
88 Papas, T175: 35 – T176: 42 (12.11.2024).
89 Papas, T232: 17-34 (13.11.2024).
90 Papas, T183: 37-39 (12.11.2024), T187: 24-38 and T233-235 (13.11.2024).
91 Papas, T170: 25-28 and T184:38-49 (12.11.2024).

114. CO Papas believed he was required to get a "*verbal <u>or</u> physical"* response from an inmate in head-check but not necessarily both.[92] He did not understand the procedure required a two way communication between him and the inmate (e.g. "verbal interaction"). This was CO Papas' understanding as of 12 December 2022 and, it appears, it remained his understanding when he gave evidence in these proceedings.

115. When asked if the COPP 5.3 must be read as requiring an inmate to give a "*verbal and physical response*", CO Papas replied, "*This is something that the department's going to have to - that I'm probably going to have to undertake more training with. And the department's got to look at the let go procedure*."[93]

116. CO Papas did not recollect seeing a towel hanging behind the cell door window inside the cell. He did not deny the possibility given it was hanging in that space, but he maintained that he had a line of sight of Emmett through the window and that he saw Emmett's shoulder move.[94]

117. Since Emmett's passing CO Papas has changed how he confirms an inmate's physical wellbeing during morning head-check. He told the court he now asks an inmate to move a particular part of his body such as a left arm or a right leg. He stated that he will not move on until the requested movement occurs. This gives him greater certainty that the inmate is consciously responding to his request.[95]

Alarm clock

118. When a handheld video recording of the emergency response in Emmett's cell began shortly after 7:17am (after the towel was pulled down), Emmett's alarm clock can be heard beeping inside the cell. This beeping stopped at 7:30am when the alarm apparently shut off on its own accord.

119. CO Papas did not hear or notice an alarm clock beeping when he performed the head-check at about 6:15am. This is consistent with the alarm having activated after the head-check.

120. Inmates in cells near to Emmett were asked about their knowledge of Emmett's alarm clock. There was variance in the inmates' evidence about the alarm setting.[96] The best evidence is probably the report made by Witness B, to CSNSW investigators soon after Emmett's death, that Emmett's alarm was set to activate at 6:30am.[97]

---

92 Papas, T233: 34-37 (13.11.2024).
93 Ibid, T233: 39-44 (13.11.2024)
94 Papas, T189:40-48 and T192-193 (12.11.2024).
95 Papas, T187-189 (12.11.2024) and T216:27-45 (13.11.2024).
96 Witness A believed the alarm was set for 6:00am: T26:9-10 (11.11.2024)
97 Diary notes: BOE, Tab 75 (Vol 3) (see also Witness B, T49:36-50 (11.11.2024)).

121. The significance of the alarm clock setting was not realised in the immediate aftermath of Emmett's death. It was later removed from Emmett's cell and disposed of by CSNSW staff. The clock's alarm setting was not examined before its disposal.

122. Counsel Assisting submitted that I can be satisfied the alarm likely activated at 6:30am. The alarm may have had a setting that caused it to automatically deactivate after one hour (e.g. about 7:30am). I accept that submission.

123. Emmett was likely unresponsive or otherwise incapable of switching the alarm off when it activated. If the alarm activated at 6:30am, it did so soon after CO Papas' performed his head-check at 6:15am.

124. The evidence has some relevance to my consideration of Emmett's likely condition when CO Papas did the head-check.

Other evidence regarding the towel's positioning

125. When OS Muzik first looked through the door window at about 7:15am, before opening the cell, the light was off and he could not see inside the cell. OS Muzik said in his evidence he did not recall the towel but he accepted it was present after watching the CCTV footage.

126. It can be seen in the CCTV footage that the towel was hanging across the top of the door frame, running almost the complete length of the horizontal door frame. From there it can be seen draping down on an angle from the top right corner to the lefthand side of the door frame.[98]

127. Counsel Assisting submitted that it is difficult to ascertain from the CCTV footage how much space the towel covered in the doorway and how much of the window it would have covered when the door was shut. This is owing to the angle of camera's viewpoint. Counsel Assisting submitted that it cannot be safely ascertained from the CCTV footage, on its own, that the towel would have covered the entirety of the window when the door was shut. I accept this submission.

128. OS Muzik accepted that he can be seen in the CCTV footage ducking or manoeuvring around the towel, to avoid contact with it, when he moved in and out of the cell. At one point he appears to have briefly had contact with it around his shoulder level.[99]

[98] From the point of view of looking into the cell.
[99] Muzik, T272:9-16 (13.11.2024).

129. CO McShane said in his evidence he did not recall seeing the towel in the doorway, however he accepted that the CCTV footage shows it was there and him pulling it down.[100] He also accepted the CCTV footage shows him leaning into the cell doorway, seemingly avoiding the hanging, to view what was unfolding inside. He considered he did this because the towel may have "partially" obstructed his view into the cell.[101]

130. CO McShane accepted that he may have pulled the towel down because it was impacting his view into the cell. However, he also considered it possible that he did it to enable emergency personnel to enter the cell without brushing past it.[102]

131. Senior Overseer Andrew Hawe (**SO Hawe**) arrived at the cell just after CO McShane pulled the towel down. He did not see the towel's position in the doorway.

132. Some inmates saw Emmett's towel in the doorway when the cell was opened. However, their view of the cell door opening, and the exact positioning of the towel in that space was limited.

133. The exact dimensions of the towel cannot be ascertained from an inspection of the towel as it has been disposed of by CSNSW. Counsel Assisting nevertheless submitted that it was likely the towel was of sufficient width and length to cover the cell window, as Emmett would have hung the towel with the intention of covering that window. I accept that submission.

Did CO Papas see Emmett during the head-check?

134. I have given the issue some considerable thought. I am satisfied that the towel covered much of the window and would have at least partially obscured the view into the cell. However, I cannot rule out that, on an angle, CO Papas may have seen Emmett or more accurately, *part* of Emmett on the bottom bunk. It seems to me that had CO Papas been completely indifferent as to whether he could see Emmett or not, he would have been likely to pass straight by. There is objective evidence that he did not. The CCTV shows he waited for a short period and then kicked the door, something he is not depicted doing at other cells. His decision to then move on indicates that he came to a view that he was by then satisfied that he had completed an adequate head-check.

[100] McShane, T307:8 to T308:46 (14.11.2024).
[101] McShane, T313:10-26 (14.11.2024).
[102] McShane, T312:42 - 45 (14.11.2024).

135. The family drew my attention to CO Papas' evidence that he had limited experience with the process but understood that its purpose was to "*ensure the inmate is alive and well*".[103] In his view the movement of Emmett's shoulder was sufficient. He told the court "*I had got movement from him. That was all I was looking for*"[104] I do not accept that what CO Papas reports having seen could possibly have given a reasonable person comfort that an inmate was alive and well.

Emmett's condition at the time of head-check

136. Counsel Assisting submitted that I would be satisfied that Emmett would have been unconscious and unresponsive, or very close to that state, when the head-check was performed at 6:15am. He drew my attention to the following matters:

(1) Emmett did not respond to the alarm which may have been activated then or shortly afterwards.

(2) Emmett was not breathing when he was found at about 7:15am, with his face and extremities cyanosed (although his torso was still warm).

(3) The opinion of Professor Jones as regards the likelihood that Emmett experienced a progressively worsening decline in his consciousness / breathing over a number of hours (She opined that this is more likely as opposed to a scenario of Emmett experiencing an acute collapse in his breathing after 6:15am).

137. Counsel Assisting submitted that it is open to me to accept CO Papas' evidence that he genuinely believed he saw movement in Emmett's shoulder. He suggested the possibility that CO Papas may be honestly mistaken about this cannot be excluded.

138. However, even if Emmett's shoulder did move at this time, he would have been close to unconsciousness (if not already unconscious) at this time.

139. The experience of Professor Jones in this regard is informative. In evidence, in reference to her own clinical experience in hospital settings, Professor Jones said:

> "*With every respect to the officer's observation, I don't think that's heavyweight evidence to support that view. That's - and the reason I say that is because, in clinical practice, when we observe patients, their nonresponse back to us doesn't mean necessarily that they're dead or deceased. Their non-response can mean that they simply don't want to communicate with us or they're drowsy or something else is going on from the psychological point of view. A shrug of the shoulder is a really*

[103] Papas, T169:35 (12.11.2024)
[104] Papas, T183:48 (12.11.2024)

difficult movement to be certain about and, in the absence of other movements such as sitting up on the bench or being seen to take a drink, it's really not very strong evidence of proof of life would be my clinical perspective from somebody that observes patients every day in a ward environment and gets their behaviours reported to me down a telephone by our nursing colleagues."[105]

…I'm not saying that, if somebody moves, there's no evidence that they're alive. I'm just saying that we commonly get reported through our nursing colleagues appearance or thoughts that somebody may have moved and, quite often, it is clear that they could not have moved, in fact, at that time because they had been deceased for a longer period of time. So I guess all I'm saying is movement - yes, of course - is compatible with life. But adding a load of caution that a single observation of "I thought I maybe saw a shoulder move" is not, in my view, definitive proof of life."[106]

140. I have considered the evidence very carefully and taken into account the evidence given by CO Papas and others on this issue. In my view, it has not been established that Emmett made an intentional movement in response to CO Papas either calling out or kicking the door. In the face of the toxicological and medical evidence I consider an intentional movement inherently implausible.

141. There was evidence before me that CO Papas was distressed as he left the facility that day. OS Muzik's statement records leaving the facility with CO Papas before the midday muster about 11.30am. He states "*CO Papas appeared flustered, and it appeared he was justifying the head-check that he did. He kept saying, "I'm sure he moved*". In my mind I was thinking if you're happy with the head-check – why are you going on about this…he just did a head-check." [107]When asked about the issue in Court, OS Muzik stated that he was questioning "*why [CO Papas] was so thingo with the head-check. I mean, I said to him, if you're happy with what you've seen, that's what you've seen*."[108] In his evidence before me, CO Papas was firm in his belief that he had seen a movement. Having considered all the available evidence I accept that there are many reasons why CO Papas, a fairly junior officer may have doubted himself after a critical incident of this kind. His flustered appearance as he left the facility and his apparent rumination over the head-check do not permit a positive finding that his evidence before me was false or misleading.

[105] Jones, T557:28-39 (19.11.2024).

[106] Jones, T559:5-12 (19.11.2024).
[107] Statement of CO Michael Muzik: BOE, Tab 16 (Vol 1), p.208 at [56]
[108] Muzik, T260:33-40

142. Counsel for CSNSW submitted that the evidence suggests CO Papas held a genuine belief that he had seen a movement. Further CSNSW submitted that "*it is possible CO Papas was honestly mistaken as to what he saw*." In my view, Professor Jones' evidence was compelling on this issue. She was unsurprised that someone could think they had seen movement in a person who was actually deceased.

143. Upon reflection, I accept that when CO Papas gave evidence before me he had a genuine, but mistaken, belief that he saw a movement. He appears to have taken his mistaken observation a step further by assuming the movement was also a *response* to his call. I do not accept this could be correct. CO Papas's assertion before this court "*I had got a movement from him. That was all I was looking for*"[109]demonstrates the flawed nature of his approach.

Sufficiency of the head-check and procedure

144. Emmett's passing shows that movement in and of itself is not a reliable means to confirm an inmate's wellbeing. Wellbeing should also be confirmed through verbal interaction or at least by a specific movement that is reliably responsive to a particular command.

145. The adequacy of the head-check was an extremely important issue to examine in the circumstances of this case. If Emmett took a further dose of methadone on the morning of 12 December 2022, as appears likely on Professor Jones' interpretation of the toxicological results, there *may* have been a missed opportunity to identify that Emmett was in significant difficulty during the morning head-check. It is *possible* that a medical response initiated at this time, rather than an hour later, could have increased Emmett's chances of survival but the experts made it clear that there are too many variables and unknowns to be certain. Unfortunately, I accept that given the available evidence it is difficult to make firm findings on this issue.

146. Nevertheless, the sufficiency of the head-check remains an important issue in these proceedings. Unfortunately, there is no evidence that CSNSW or the SCC has updated its procedures or training in relation to the conduct of head-checks since Emmett's death.[110] Counsel for the family were particularly concerned that despite there being "*institutional issues within CSNSW and SCC in relation to the policy, training and conduct of officers for the head-checks of inmate*s" nothing has changed. I understand their view and accept that it has caused additional distress and grief for family members. One of the family's clear motivations in participating in the inquest process was to ensure the safety of others in

[109] Papas, T183:48 (12.11.24)
[110] Papas, T216-217 (13.11.2024).

Emmett's position. I accept the family's submission that further clarity in relation to the meaning of the policy is called for. There must also be better training and oversight to ensure that policies are properly applied.

147. Counsel for the family drew my attention to the evidence before the court in relation to training. It appears that there may be some theoretical understanding of the head-check procedures at the academy or training centre.[111] This is supplemented by "*on the job*" training where a new officer shadows a more experienced officer on a shift.[112] However it was clear that different officers had different recollections of their training on this issue. CO Papas had no recollection of reading COPP 5.3.[113] CO McShane had no knowledge of any training or instruction being given at SCC about the conduct of head-checks and it was his understanding that either a verbal or a physical response was required[114].

148. Senior Assistant Superintendent Ribaux who had almost 20 years of service with CSNSW and had attained the role of Functional Manager also understood either a verbal or physical sign would suffice. She was satisfied, on that basis that the head-check in relation to Emmett had been completed properly. [115]

149. I accept the family's submissions that the evidence reflects a need for both policy clarification and re-fresher training.

150. This is an issue to which I will return when considering recommendations.

Emergency medical response

151. The response that followed Emmett being found unresponsive is set out in NCF [62]-[92]. Once the alert was raised other officers and nurses rapidly attended Emmett's cell. There was an extensive effort on the part of the involved officers, nurses and paramedics to revive Emmett. Counsel Assisting drew my attention to the particular efforts of OS Muzik and Senior OS Hawe. Their efforts were noted by several inmates on the day.[116] They should be commended for their first aid attempts.

[111] Papas, T222:7-38 (13.11.2024)
[112] Papas, T225:5-16 (13.11.2024)
[113] Papas, T223:26-37 (13.11.2024)
[114] McShane, T321:27 to T322:5 (13.11.2024)
[115] Ribaux, T390:40 – T394:4 (14.11.2024)
[116] Witness A's OTC call 13.12.2022 (referred to in CSNSW Serious Incident Report: BOE, Tab 37 (Vol 3) pp.756-57) (regarding OS Muzik's efforts); Witness B, T53:36-38 (11.11.2024) (regarding OS Muzik's efforts); Witness F, T78:34-48 (11.11.2024) (regarding OS Muzik and CO Hawe's efforts).

Serious incident response on 12 December 2022

152. The quality of the evidence gathered in the immediate period may be of significance to an investigation of a death and any related coronial proceedings. There is little doubt that most witnesses have their clearest recollection of important details soon after events.

153. I accept Counsel Assisting's submission that the quality of the evidence witnesses can provide, and the legitimacy of any conclusions based on it, may be jeopardised if lax standards are applied early on in the investigative process.

154. Further, I accept Counsel Assisting's submissions that there were unsatisfactory aspects in CSNSW's immediate incident response. Counsel Assisting drew my attention to the following factors.

155. *First,* no attempt was made to separate the involved officers, after they ceased direct involvement and until they had separately completed written incident reports.

156. CO Papas was called to the Block C office by Acting Governor Dunn while the emergency response was underway in Emmett's cell. After being asked about his head-check of Emmett that morning, CO Papas remained in the office and was present with other involved officers during a briefing in that office held by Acting Governor Dunn.

157. While in that office CO Papas prepared his incident report. CO McShane and other involved officers did the same. This occurred while other involved officers were present in the office and preparing their own incident reports.[117] CO McShane recalled discussion of names and timings occurring when he prepared his incident report.[118]

158. The preparation of incident reports in proximity to other involved officers, where discussions about the event are taking place, risks contamination of the individual officers' recollections. Counsel Assisting submitted that it is for that reason that involved officers should be separated wherever possible until their reports are completed. I accept that submission.

159. CO Papas said he prepared his incident report in this office as there was a computer available to him there.[119] It is difficult to conceive arrangements could not have been made for CO Papas to use a computer away from other involved officers to prepare his report. If there is a difficulty in this respect, I accept Counsel Assisting's submission CSNSW should take immediate steps to remedy it.

---

117 Papas, T166-167 (12.11.2024); McShane, T296-297 (14.11.2024).
118 McShane, T297-298 (14.11.2024).
119 Papas, T166:20 – T167:13 (12.11.2024).

160. CO McShane, in his evidence, said he could not recall being given specific instruction or training in responding to serious incidents namely separating from other officers, and not looking at footage, before the completion of an incident report.[120] If correct, I accept Counsel Assisting's submission that this points to a deficiency in training and instruction by CSNSW.

161. *Second,* some of the involved officers were also present in the office when Functional Manager Simone Ribaux (**FM Ribaux**) reviewed CCTV footage of the head-check.[121] There was nothing untoward in FM Ribaux reviewing that footage. The concern is that this took place in an area where other involved officers were using to prepare their statements. CO McShane said he himself checked the CCTV footage to "*get timings right*" while preparing his report in this office.[122]

162. Counsel Assisting submitted that it is preferrable involved officers do not review, or are not exposed to, CCTV footage of an incident before completing their incident reports. The primary purpose of the incident report is for the officer to document, hopefully proximate to the event, what he or she recalls happening. Viewing footage before completion of the report risks the report becoming a summary of what the officer has viewed in the footage rather than what they recall happening. Those charged with reviewing the event can themselves view the footage and raise queries with the officers if necessary.

163. I accept Counsel Assisting's submission that the justification that officers need to view footage to check "*timings*" lack cogency. The officer is able to provide an approximate or estimate of the time in the report (most if not all officers in their reports expressed the times as "approximate" in any event). If doubts arise about the timings estimated in a report, those responsible for the review of the incident can query the concerned officer with reference to the footage if necessary.

164. *Third,* it does not appear that a senior officer at the scene assumed responsibility for managing the separation of officers and the preparation of incident reports, let alone supervised how this occurred. I accept Counsel Assisting's submission that CSNSW procedure and training should ensure someone assumes this responsibility.

---

120 McShane, T320 (14.11.2024).

121 FM Ribaux was requested to view the CCTV footage to review the timeline and officers' responses: Ribaux, T381:26-40 (14.11.2024).

122 McShane, T303-305 (14.11.2024).

165. *Lastly,* some inmates saw the footage being reviewed in the Block C office when other officers were around.[123] They suspected there was potential 'coaching' or collusion amongst the officers about what occurred. This was subsequently communicated to others. Many inmates are distrustful of CO Papas' claim that he did sight Emmett at 6:15am. This is regrettable and may have been avoided if appropriate steps were taken to separate the involved officers and if the footage had been reviewed away from the Block C office.

166. CSNSW's procedures for deaths in custody (COPP 13.3) directs that:[124]

> (1) "*Officers must write their reports from their own recollection of events and independently from each other. Reporting officers should have adequate facilities to meet this requirement (e.g. access to computers in separate areas)*"; and
>
> (2) "*An officer must not view video footage including CCTV, handheld video (HHV) or body worn video (BWV) if a person has sustained life-threatening or fatal injuries. For more information about viewing footage to assist to write a report refer to COPP section 13.9 Video evidence*".

167. This procedure does not mandate that an involved officers should separate from each other, and not discuss the event or be present for discussions about the same, until the completion of their incident report. Nor does it direct a senior officer to manage and oversee this process. Requirements of this kind should operate whenever there is an unexpected serious medical event or death of an inmate. That is so even when there are no obviously suspicious circumstances at that time.

168. In evidence, Acting Governor Philip Dunn said, in response to questioning about his expectation of the involved officers viewing CCTV footage before completing their incident reports, that *"[i]n some cases, being that it was a medical emergency at the time they could have reviewed the footage. The COPP allows that to happen*" and that *"[t]he COPP allows [officers] to go back looking at footage so they can recall where they were in critical incidents*".[125]

169. In Acting Governor Dunn's view, a difference arose in the incident response and reporting requirements for a *medical emergency* versus that for *a death in custody*, stating[126]:

---

123 Witness C was performing "sweeper" duties in Block C Pod1 (not same Pod as Emmett's). This involved delivery of breakfast to the cells. While standing near to the Block C office windows, on the Pod 1 side, he saw officers (including the Functional Manager) viewing CCTV footage in the office. It appeared they were focused on the footage capturing the morning head-check. Witness C formed the view that one of the officer's was 'coaching' another by reference to the footage: T96-101 (11.11.2024). Witness J was also performing sweeper duties in Pod 1 and witnessed the viewing of the CCTV footage (including rewinding and fast forwarding of the footage) in the Block C office: T155-158 (12.11.2024).

124 M.Brown Statement: BOE, Tab 129 (Vol 4) [21]-[24] pp.1102-03.

125 Dunn, T498:35-42 (18.11.2024).

126 Dunn, T499: 7-14 (18.11.2024)

> *"The difference is a medical emergency is, at that point, it's a critical incident and staff respond. They do pretty much everything exactly the same. Go off, they do what they need to in that emergency, then they go off, they do the reports. After we've had a quick debrief and then head off, do the reports, and then compile them up to me. Being a death in custody, it's slightly different though. Obviously, they're not allowed to view any video footage but they're still significantly the same. They have to go off and write their reports independently."*

170. The procedure for responding to medical emergencies (COPP 13.2) was not tendered in evidence in the inquest. The version currently available online through the CSNSW's website contains identical directions as its death in custody's procedure (COPP 13.3).[127] The COPP for Video Evidence (COPP 13.9) states at [4.4]:

> *"An officer may seek approval from a Governor or MOS to view CCTV or HHV video recordings to assist them to write accurate inmate misconduct or incident report. Officers do not need the Governor or MOS in charge's permission to view their own BWV footage. Officers must only review the recording after it has been stored appropriately in evidence.com. Staff who are required to view footage and prepare reports must consult their supervisor to coordinate relief of their post, if necessary. it should be noted that an officer should be relieved to download the BWV and to write the report.*
>
> *If an officer reviews a video recording to prepare a report they must note this as a comment in their report. Where relevant they should also note that approval to review the footage was provided by the Governor or MOS in charge. Officers should distinguish between any statement in their report which is based on their honest belief and any statement which is derived from viewing footage.*
>
> *If an officer fails to record a relevant occurrence, ceases recording early, or there is a break in continuity of recording, then this must be explained in their incident report.*
>
> *Officers must write their reports from their own recollection of events and independently from each other.*
>
> *Officers must not view a video recording to assist them to write their report if the incident led to a person sustaining life-threatening or fatal injuries."*

171. The terms of COPP 13.2 and 13.9 does not appear to reflect the distinction made by Acting Governor Dunn in his evidence. It is also noted there is no evidence that any of the involved officers who viewed the CCTV sought approval before doing so.

172. In these circumstances Counsel Assisting submitted that it was appropriate to recommend CSNSW review its incident reporting procedures and training to ensure appropriate standards are adopted in the initial incident response and reporting stage.

---

127 https://correctiveservices.dcj.nsw.gov.au/correctional-centres.html: COPP 13.2 Medical emergencies at [3.1].

173. Counsel Assisting submitted that these standards should be adopted in response to in the case of serious unexpected medical events. In Emmett's case, the emergency response commenced at about 7:17am however he was not formally declared deceased until 9:01am. The process of obtaining incident reports was likely underway before 9:01am. I have no hesitation in accepting Counsel Assisting's submission that it would be concerning if the standards expected for incident response and reporting, in the case of deaths in custody (COPP 13.3), were only implemented once the fact of death was formally confirmed. The information gathered by that time may be of importance to a future investigations and inquest.

The need for recommendations

174. Counsel Assisting put forward two draft recommendations arising from the evidence directed at CSNSW. The first recommendation was drafted in these terms:

> *To the Commissioner, CSNSW:*
>
> *(1) CSNSW review its written procedures and training concerning the confirmation of an inmate's physical wellbeing during the conduct of "head-check" procedures having regard to the findings made in this Inquest. This extends to:*
>
> *(a) Reviewing COPP 5.3 to provide more detailed instruction about how an officer is to confirm an inmate's physical wellbeing during head-check. That includes ensuring clearer instruction as to whether a verbal and physical response is required from the inmate is required and how the officer can satisfy him or herself.*
>
> *(b) Reviewing the sufficiency of the training provided to recruits and serving officers with respect to the procedure referred above in (a).*
>
> *(c) Reviewing the Local Operating Procedures (LOPs) that concern the conduct of head-check / let go procedures, applicable at the SCC and other Correctional Centres operated by CSNSW, to ensure there is consistency between the LOP, COPP 5.3 and the practices employed at those centres.*

175. The recommendation arises from the evidence in this inquest which clearly demonstrated that there was considerable confusion about the appropriate way to conduct a head-check. Officers had different views, with some being quite certain that a verbal *or* physical response was adequate. Others like CO Papas appeared to have had little understanding that a movement *following* a request, did not necessarily indicate that it was *responsive* to that request.

176. CSNSW did not oppose the making of such a recommendation. Specifically, I note that Malcolm Brown, General Manager, Statewide Operations Security and Custody for CSNSW, accepted it would indeed be beneficial for CSNSW reviewing the Head-check / Let Go procedures.

177. Counsel for the family also drew my attention to the various accounts from very senior Correctional personnel such as Mr Brown. Mr Brown noted that a head-check was one of the core responsibilities of any base grade correctional officer. He gave evidence that he had a proper understanding of COPP 5.3 but thought there was "*a common belief across the organisation*" that either a physical *or* verbal response was sufficient for a head-check.

178. Mr Dunn, Acting Governor of SCC at the time of Emmett's death and currently Manager of Security for CSNSW stated that in his understanding a valid head-check required a response, either physical or verbal. He thought that this would be compliant with COPP 5.3. When he questioned CO Papas on the morning of Emmett's death, he was satisfied that given motion had been detected, an adequate head-check had occurred. He also placed reliance on Functional Manager Ribaux, who herself had a flawed understanding of the requirements of COPP 5.3.

179. Counsel for the family supported the recommendation put forward by counsel assisting but suggested it go further. The family drew the court's attention to the fact that there appeared to have been no change in the head-check COPP or related Local Operating Procedure, or in the practical conduct of head-checks at SCC since Emmett's death. There appears to have been no auditing or checking of the policy, no changes in every day procedure or any training to make sure officers understand the relevant policy and apply it. On the contrary, while individual officers may have changed their individual routine, a lack of clarity and procedural uniformity remained.

180. Counsel for the family suggested that CSNSW conduct refresher practical training for all custodial staff who conduct head-checks on inmates. I agree it is a sound suggestion and intend to incorporate it into the draft recommendation.

181. Counsel Assisting suggested a second recommendation aimed at improving procedures governing the early investigation and compilation of evidence in the event of serious unexpected medical events and/or deaths in custody. The recommendation arises out of the evidence in this inquest and was drafted in the following terms:

To Commissioner for CSNSW

> *(2) CSNSW review its written procedures and training concerning incident response and reporting in the event of serious unexpected medical events and / or deaths in custody. That extends to:*

(a) *Requiring the separation of involved officers, as soon as is reasonably practicable, until each officer has completed an incident report.*

(b) *Mandating that wherever reasonably possible involved officers are not to discuss the event with each other or be present when others are discussing the event or review relevant footage or be present when that is being reviewed, until the completion of their incident report.*

(c) *Requiring a senior officer assume responsibility for managing and supervising the initial incident reporting process.*

(d) *Ensuring there is clear guidance about what constitutes a serious unexpected medical event and when the abovementioned requirements are expected to be followed.*

182. Emmett's family supported the making of the recommendation.

183. Counsel for CSNSW did not disagree with the thrust of the recommendation, while making some suggestions for amendments. Counsel for CSNSW noted that a requirement for separating officers must take into account whatever operational considerations for the safety and security of the facility exist at the relevant time. I accept that prisons operate in a very particular environment where limited resources may sometimes be available to deal with any developing situation. I have no difficulty in making that amendment.

184. Counsel for CSNSW also expressed concern about a recommendation which calls for a senior officer to assume responsibility for "supervising" as well as managing the initial incident reporting process. Counsel for CSNSW submitted that supervision of the preparation of reports is not practicable and perhaps more importantly that it is "*inconsistent with the requirement that each involved officer is personally responsible for his or her own compliance with the COPP…*" I have considered the submission but I am confident that there is no likelihood that the proposal could be read so that it allows a supervising officer to improperly intervene in the process. In my view supervision of this important process is desirable.

185. Counsel for CSNSW also suggested that it is more appropriate to use the term "*medical emergency*" rather than "*serious unexpected medical event*." I accept this submission and intend to reflect it in the recommendation I make.

186. Counsel assisting also put forward a draft recommendation for Justice Health's consideration arising out of the circumstances of Emmett's D&A treatment. This issue was of great importance in this inquest. Emmett's use of diverted methadone was causally linked to his death on 12 December 2022. While I accept that he was not "drug dependent" at the time of his assessment on 19 August 2022, he demonstrated a number of "red flags" which signified he could be sliding towards dangerous drug use and dependence. I accept

Professor Lintzeris' evidence that best practice would have seen him re-assessed and monitored at an early time. I accept that Ms Rewell had no capacity to ensure this would happen.

187. On that basis Counsel Assisting suggested the following recommendation:

> *To the Chief Executive Officer, Justice Health and Forensic Mental Health Network*
>
> *Justice Health examine the arrangements, and resourcing, regarding the wait times for Drug and Alcohol assessments and reviews with the aim of reducing wait times.*

188. The recommendation was supported by Emmett's family.

189. The recommendation was regarded by Justice Health as unnecessary. Counsel for Justice Health submitted that Justice Health "*already engages in this process and is continually examining its procedures, practices and resources as to ways to improve its service, including in terms of reducing wait times*."

190. In this context Counsel for Justice Health drew my attention to the evidence of Dr Katerina Lagios, Clinical Director, Drug and Alcohol, that Justice Health would ideally be seeing non-urgent patients for D&A review much more quickly than the average wait of three months. She also described the practical resource challenges in achieving this.[128]

191. Counsel for Justice Health also drew my attention to a variety of ways Justice Health has worked to improve its services particularly for patients, like Emmett who report using methamphetamine in the community. The delivery of Brief Interventions and Groups[129] is an example of this, as is the implementation of an enhanced Model of Care which now establishes psychosocial interventions as a standard of care for patients with methamphetamine use disorder[130]. I was also taken to evidence that the D&A team has commenced Cognitive Behavioural Therapy Group Programs and developed new digital and print resources to be placed on the Health Information Portal for patients in custody.

192. Counsel for Justice Health also drew my attention to the fact that it is continuing to explore ways to collaborate with CSNSW for the benefit of patients, including exploring ways that Alcohol and Other Drug data collected via the RSA may be shared with CSNSW to assist in improving CSNSW's Alcohol and Other Drug program delivery.

193. A number of steps taken since the close of evidence were also referred to as evidence of Justice Health's demonstrated commitment to reducing wait times and improving service.

---

[128] Lagios, T464:15-25 (15.11.2024)
[129] Statement of K Lagios: BOE, Tab 144 (Vol 5), page 1461 [25]
[130] Ibid, p1461 [26]

194. This court has no trouble accepting that Justice Health is wholly committed to improving service and reducing wait times and is diligent and responsive in attempting to tackle these issues. I have no criticism of individual clinicians, nor do I suggest that those who manage Justic Health should be criticised in relation to the allocation of their limited resources. I also accept on what is before me, some of which was not available before the closing of evidence, that wait times may have been reduced from the time of Emmett's death. Nevertheless, I am not persuaded that a review of this issue is unnecessary.

195. If wait times cannot be reduced without the allocation of further resources then the relevant minister must act. Prisoners are entitled to the same level of care as they would receive in the public system in the community. I do not accept that they currently receive that level of care. I intend to make the recommendation and send a copy of these findings to the Minister of Health, for his information and review.

Findings and Recommendations

196. For reasons stated above I make the following formal findings pursuant to section 81 of the Coroners Act:

Identity

The person who died was Emmett Brown.

Date of death

Emmett died on 12 December 2022.

Place of death

Emmett died at Shortland Correctional Centre, Cessnock NSW.

Cause of death

Emmett died from the combined effects of acute bronchopneumonia and methadone toxicity with his high body mass and obstructive sleep apnoea being contributory factors.

Manner of death

Emmett died in custody after consuming non-prescribed methadone whilst in custody at Shortland Correctional Centre.

Recommendations pursuant to section 82 *Coroners Act 2009*

197. For reasons stated above I make the following recommendations pursuant to section 82 of the Coroners Act:

To the Commissioner of Corrective Services NSW

1. CSNSW review its written procedures and training concerning the confirmation of an inmate's physical wellbeing during the conduct of "head-check" procedures having regard to the findings made in this Inquest. This extends to:

   (a) Reviewing Custodial Operation Policy and Procedure 5.3 – *Musters, Let-go and Lock-in*, to provide more detailed instruction about how an officer is to confirm an inmate's physical wellbeing during head-check. That includes ensuring clearer instruction as to whether a verbal and physical response is required from the inmate and how the officer can satisfy him or herself.

   (b) Reviewing the sufficiency of the training provided to recruits and serving officers with respect to the procedure referred above in (a) and conducting refresher practical training for all custodial staff who conduct head-checks on inmates.

   (c) Reviewing the Local Operating Procedures (LOPs) that concern the conduct of head-checks / let go procedures, applicable at the Shortland Correctional Centre and other Correctional Centres operated by CSNSW, to ensure there is consistency between the LOPs, COPP 5.3 and the practices employed at those centres.

2. CSNSW review its written procedures and training concerning incident response and reporting in the event of medical emergencies and/or deaths in custody. That extends to:

   (a) Requiring the separation of each involved officers, as soon as reasonably practicable and subject to operational considerations for the safety and security of the facility, until each officer has completed and submitted his or her incident report (including providing non-exhaustive guidance as to the type of instances in which operation considerations might prevail and what other arrangements might reasonably be effected to avoid that occurring).

(b) Mandating that, wherever possible, involved officers are not to discuss the event with each another or be present when others are discussing the event or reviewing any video evidence or be present when that evidence is being reviewed, until completion and submission of his or her incident report.

(c) Requiring a senior officer to assume responsibility for managing and supervising the initial incident reporting process.

(d) Ensuring there is clear guidance about what constitutes a medical emergency and when the abovementioned requirements are expected to be followed.

To the Chief Executive Officer, Justice Health and Forensic Mental Health Network:

3. Justice Health examine the arrangements and resourcing regarding the wait times for Drug and Alcohol assessments and reviews with the aim of reducing wait times.

Conclusion

197. Emmett's death occurred in the context of using diverted methadone. His health care in custody was inadequate. He had been refused entry into an opiate replacement therapy program in August 2022 and despite exhibiting a number of red flags, had not been reassessed in a timely manner before his death. Emmett should also have been offered a Chronic Disease Screening after at least 2021. Systems in place to ensure a First Nations man received this essential care failed. A properly conducted CDS may have been useful in formulating an approach to treating his obesity and high BMI and identifying his sleep apnoea, both of which were identified as being contributing factors to his death. There were also inadequacies in the head-check which took place on the morning of his death. It is clear that there remains significant confusion about what is required for an adequate head-check. These are all matters which require close attention by the relevant organisations so that they do not impact the life of another inmate.

198. I offer my sincere thanks to Counsel Assisting, Chris McGorey and his instructing solicitor, Trinity Higgs for their hard work in relation to these proceedings.

199. I thank the OIC, Detective Senior Constable Christopher Walker for his assistance in these proceedings.

200. I thank Nicolle Lowe, Aboriginal Coronial Information and Support Program worker. Her role at this court is of the utmost importance and once again she has assisted a grieving family to make sense of these difficult proceedings. Her assistance to this court is once again invaluable.

201. I recognise the trauma and pain that come with proceedings of this sort. Emmett was clearly well loved. He was a young man with his life ahead of him. It must be recognised that the care available to him in custody was inadequate.

202. Finally, once again I offer my sincere condolences to Emmett's family. I have deep respect for the efforts they made to participate in these proceedings and the resilience they have shown. I respect their efforts to shine a light on what happened to Emmett so that another family will not suffer as they have done.

203. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner,
NSW State Coroner's Court, Lidcombe
2 May 2025

Annexure 1 – Outline of Facts and Evidence (Non-contentious)

Attachment 1

INQUEST INTO THE DEATH OF EMMETT BROWN

Outline of facts & evidence (non-contentious) (12 February 2025)

Introduction

1. Emmett, a First Nation's man (Yuin / Dunghutti) was born to Raahna and Colin on 18 June 1997.
2. Emmett grew up in the Wollongong area with his family.
3. Emmett is survived by many family members including three young sons; his mother (Raahna Brown); his father (Colin), his grandmother (Lorraine) and his siblings (Kolby, Meahala and Cameron).
4. The importance of his family to Emmett is demonstrated by his frequent contact with family while in custody and the numerous photographs he had affixed to his wall of family members (with a label affixed "family first") when he passed away.[1]

Emmett's functioning

5. Emmett was diagnosed with an intellectual disability and, in 2016, was assessed eligible for support through the National Disability Insurance Scheme (**NDIS**).
6. Emmett had difficulty with reading and writing and tended to rely on the assistance of others with these tasks.
7. In 2022, Emmett was assessed by a clinical psychologist, Patrick Sheehan. In Mr Sheehan's view, Emmett's intellectual functioning appeared at that time to fall "*within the borderline range*".[2]

---

1 Photos depicting family redacted in scene photos contained within the brief (with label "family first") at tab 500 p.1412.

2 Sheehan report 21.2.2022 Tab 154 (Vol 6).

Time in custody

8. Emmett had experienced periods of incarceration before late 2020, namely:

   (1) 26 February[3] to 25 July 2016: South Coast Correctional Centre.[4]

   (2) 13 March 2019 to 11 December 2019: various placements including at Junee Correctional Centre[5]; Bathurst Correctional Centre, Metropolitan Remand and Reception Centre and the Shortland Correctional Centre (**CCC**) (12 August to 11 December 2019).

9. On 11 December 2019, Emmett was released to parole to reside with his mother, Ms Brown, in Port Kembla (duration of his parole being 9-months).

10. On about 4 August 2020, Emmett was charged with new offending and returned to custody. He remained in custody thereafter until his death.

11. Between August 2020 and June 2021, Emmett was placed at Parklea Correctional Centre.[6]

12. On 15 June 2021, Emmett transferred to Hunter Correctional Centre (**HCC**).[7]

---

3 South Coast Correctional Centre Reception Assessment (26.2.2016): JHeHS records Tab 135 p.1312-1321 (Vol 4) (no history of cardiovascular or respiratory conditions reported: p.1313). Use of prescribed or non-prescribed opioids denied: JHeHS records Tab 135 p.1317 (Vol 4).

4 An "*Adolescent Health Comprehensive Assessment"* (assessment dated 1.8.2016): JHeHS records Tab 135 p.1321-1330. Weight recorded as 83.6kg (BMI 25).

5 Junee Correctional Centre Reception Screening Assessment (13.3.2019) recorded Emmett's report that he had used methamphetamine (e.g. 'ice') in the 4 weeks before entering custody (averaging 1 point every day or second day) (not assessed to be withdrawing at time of screening): JHeHS records Tab 135 p.1219-1220.

6 Parklea Correctional Centre Reception Screening Assessment (4.4.2020) recorded Emmett's report that he had used drugs in the preceding 4 weeks being on average "2 points" (1-gram) smoked daily (denied use of prescribed / non-prescribed opioids): JHeHS records Tab 135 p.1233-34. He also reported using 1-gram of cannabis daily in the preceding 4 weeks: JHeHS records Tab 135 p.1245 (Vol 4).

7 Transfer in and Out Screening completed at Parklea Correctional Centre (before transfer to Hunter Correctional Centre) is at JHeHS records Tab 135 p.1250-1256 (Vol 4). An interim transfer in and out form for Hunter Correctional Centre: JHeHS records Tab 135 p.1282-1289 (Vol 1)

Sentencing in April 2022

13. On 14 April 2022, Emmett was sentenced at the District Court of NSW (Wollongong) to 7 years imprisonment, with a 4-year non-parole period, set to commence on 4 August 2020. His earliest release to parole date was 3 August 2024.[8]

14. In remarks on sentence, the sentencing judge referred to the psychological assessment of Mr Sheehan (completed in February 2022) (Tab 154 Vol 6) and stated, amongst other matters, that:[9]

    (1) Mr Sheehan could not say one way or other if Emmett had a cognitive impairment but there were certainly indications of it.

    (2) Mr Sheehan had detailed a "*long history of profound deprivation*" and considered Emmett to be "particularly vulnerable to addictions".

    (3) Mr Sheehan had concluded that to improve Emmett required support, treatment and supervision including that for disordered substance abuse behaviour to assist his rehabilitation. Emmett's evident lower intellectual functioning required closer examination to exclude impairment and to properly understand his treatment and support needs. His low literacy may be an impediment to effective program participation. It was unlikely that he would be suited to the requirements of an intensive program such as the VOTP.

---

8 Offences for which sentence imposed described (in part) in 1st statement of the OIC Tab 6 [5]-[12] (Vol 1); also see NSW Police Criminal History – Bail Report (redacted) Tab 12 (Vol 1).

9 Copy of sentencing remarks can be provided on request (these remarks use pseudonyms and is subject to the operation of s 15A of the *Children (Criminal Proceedings) Act 1987*, which prohibits publication of identifying information that does identify or is likely to lead to identification of the person the subject of the sentencing remarks.

(4) His Honour intended that a copy of Mr Sheehan's report would accompany the warrant of commitment imposed for Emmett's sentence (at the time of Emmett's death a copy of this report was contained on CSNSW's warrant file).

Transfer to the Shortland Correctional Centre in June 2022

15. On 18 June 2022, Emmett transferred from HCC to the SCC.[10]

16. As of December 2022, Emmett was housed in a one out cell (Cell 290) within Block C, Unit 2 (also called Pod 2).[11]

17. Emmett had a "*B – medium security inmate*" classification.

Health

18. There is no evidence of Emmett reported, or was suspected to have, difficulties with his mental health during his placement at SCC: e.g. depression, anxiety, paranoia, psychosis.

19. Neither Correctional Services NSW (**CSNSW**), nor the Justice Health & Forensic Mental Health Network (**JH**), had active alerts for Emmett for self-harm, suicidal ideation or mental health difficulties during 2022.

20. At the time of his death, Emmett was 179cm tall, weighed 124kg and had body mass index (**BMI**) of 38.75.[12]

21. As of December 2022, Emmett was not prescribed medication for treatment of any condition.

---

10 Inmate Profile Tab 50 (Vol 2).

11 Block C housed inmates with SMAP designation, a designation which Emmett received in March 2019 and was ongoing until his death. Block C could house a maximum of 55 protected inmates: CSNSW Serious Incident Report [13] Tab 51 (Vol 2).

12 Autopsy report Tab 2 p.12 (Vol 1).

History of substance misuse

22. Emmett had a history of misuse of illicit and non-prescribed substances. The evidence of this includes the following.

23. *First,* substance misuse had been a feature in some offences for which Emmett received custodial sentences.

24. *Second,* Emmett provided positive urine samples while in custody, being:

    (1) 4 February 2021: positive for non-prescribed methadone and non-prescribed mirtazapine.

    (2) 4 May 2022: positive for amphetamines, non-prescribed mirtazapine, and non-prescribed buprenorphine.[13]

25. *Third,* evidence of self-reports made by Emmett. This included the following:

    (1) Report to a Community Corrections Officer on 2 August 2021 to the effect that he had "*a long history of illicit substance abuse and stated that he had been under the influence of ice, cannabis, and alcohol at the time of his offence. He stated that he has been smoking ice since the age of 18 and cannabis since the age of 16, further claiming this is when he started drinking alcohol. He expressed his willingness to engage in programs and interventions to address his substance abuse and claimed that he has had no previous treatment to address his addictions in the community*…".[14]

---

13 Conviction, Sentences and Appeals tab 88 (Vol 4).
14 OIMS note 2.8.2021 Tab 82 p.850 (p71 of 96) (Vol 3).

(2) Report to Mr Sheehan during an assessment in early 2022 (Mr Sheehan's report completed on 21 February 2022) that he would fall into smoking buprenorphine in custody often becoming dependent on it and his expectation was that he would probably return to this again in gaol.[15]

Buvidal program

26. As of 2022, Justice Health provided an opioid replacement therapy to inmates in custody (including at the SCC).

27. This included the injection of Buvidal, a prolonged released form of buprenorphine, once every 28 days.

28. It is intended to assist the person with the management of cravings and / or withdrawal.

Requests made in 2022 to be assessed for the Buvidal program

29. During 2022, three requests were submitted by or on Emmett's behalf for him to be assessed for the Buvidal (Suboxone) program.[16]

30. These were handwritten requests contained within Justice Health *Patient Self-Referral* forms.

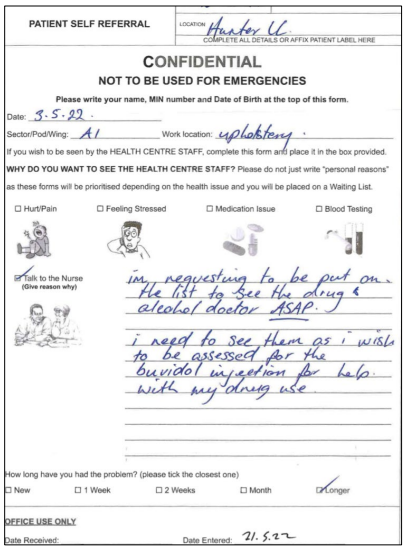
31. The handwriting in these forms differs.

32. Various inmates reported, after Emmett's death, that Emmett was helped to fill out the forms owing to his difficulties with reading and writing.

33. A request dated 3 May 2022, completed when Emmett was at the HCC, stated Emmett wanted to be included on a list to be assessed by the drug and alcohol doctor "ASAP" to be assessed for the "*buvidol injection for help with my drug use*":[17]

---

15 CSNSW Serious Incident Report [101] Tab 51 (Vol 2).
16 Suboxone opioid replacement therapy.
17 Patient Self-Referral dated 3 May 2022: Tab 136 p.1396 (Vol 4).



PATIENT SELF REFERRAL

LOCATION Hunter CC

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONFIDENTIAL

NOT TO BE USED FOR EMERGENCIES

Please write your name, MIN number and Date of Birth at the top of this form.

Date: 3.5.22

Sector/Pod/Wing: A1 Work location: upholstery

If you wish to be seen by the HEALTH CENTRE STAFF, complete this form and place it in the box provided.

WHY DO YOU WANT TO SEE THE HEALTH CENTRE STAFF? Please do not just write "personal reasons"

as these forms will be prioritised depending on the health issue and you will be placed on a Waiting List.

☐ Hurt/Pain ☐ Feeling Stressed ☐ Medication Issue ☐ Blood Testing

☑ Talk to the Nurse (Give reason why)

im requesting to be put on the list to see the drug & alcohol doctor ASAP.

i need to see them as i wish to be assessed for the buvidol injection for hep c with my drug use

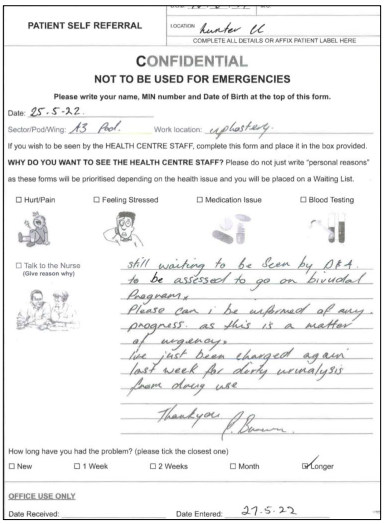
How long have you had the problem? (please tick the closest one)

☐ New ☐ 1 Week ☐ 2 Weeks ☐ Month ☑ Longer

OFFICE USE ONLY

Date Received: Date Entered: 21.5.22

34. A request dated 25 May 2022, completed when Emmett was at the HCC, stated Emmett was "*still waiting to be seen by D&A to be assessed to go on bivudal program"* and "*I've just been charged again last week for dirty urinalysis from drug use":*[18]



PATIENT SELF REFERRAL

LOCATION hunter cc

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONFIDENTIAL

NOT TO BE USED FOR EMERGENCIES

Please write your name, MIN number and Date of Birth at the top of this form.

Date: 25.5.22

Sector/Pod/Wing: A3 Pod Work location: upholstery

If you wish to be seen by the HEALTH CENTRE STAFF, complete this form and place it in the box provided.

WHY DO YOU WANT TO SEE THE HEALTH CENTRE STAFF? Please do not just write "personal reasons"

as these forms will be prioritised depending on the health issue and you will be placed on a Waiting List.

☐ Hurt/Pain ☐ Feeling Stressed ☐ Medication Issue ☐ Blood Testing

☐ Talk to the Nurse (Give reason why)

still waiting to be seen by D&A to be assessed to go on bivudal Program.
Please can i be informed of any progress as this is a matter of urgency.
Ive just been charged again last week for dirty urinalysis from drug use

Thankyou

How long have you had the problem? (please tick the closest one)

☐ New ☐ 1 Week ☐ 2 Weeks ☐ Month ☑ Longer

OFFICE USE ONLY

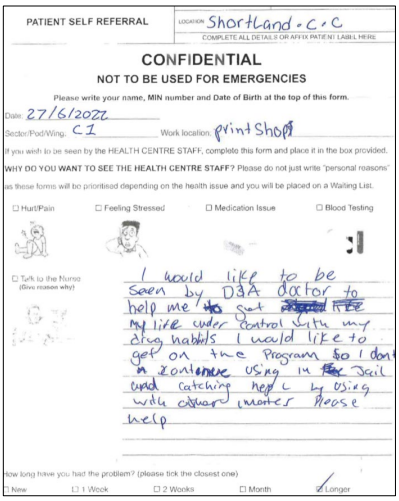
Date Received: Date Entered: 27.5.22

35. In a request (Patient Self-Referral Form) dated 27 June 2022, completed when Emmett was at the SCC, it stated Emmett wished to "*get on the program, so I don't continue using in jail and catching hep c by using with other inmates*":[19]

---

18 Patient Self-Referral dated 27 May 2022: Tab 136 p.1395 (Vol 4).

19 Patient Self-Referral dated 27.6.2022 (note Emmett listed as being in "C1"): JH Records Vol 1 Tab 136 p.1394 (Vol 4).



PATIENT SELF REFERRAL

LOCATION Shortland - C.C

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

CONFIDENTIAL

NOT TO BE USED FOR EMERGENCIES

Please write your name, MIN number and Date of Birth at the top of this form.

Date: 27/6/2022

Sector/Pod/Wing: C1 Work location: print Shop

If you wish to be seen by the HEALTH CENTRE STAFF, complete this form and place it in the box provided.

WHY DO YOU WANT TO SEE THE HEALTH CENTRE STAFF? Please do not just write "personal reasons" as these forms will be prioritised depending on the health issue and you will be placed on a Waiting List.

☐ Hurt/Pain ☐ Feeling Stressed ☐ Medication Issue ☐ Blood Testing

☐ Talk to the Nurse (Give reason why)

I would like to be seen by DOA doctor to help me get [redacted] my life under control with my drug habits I would like to get on the Program so I don't continue using in [redacted] Jail and catching hep c by using with other inmates Please help

How long have you had the problem? (please tick the closest one)

☐ New ☐ 1 Week ☐ 2 Weeks ☐ Month ☑ Longer

Assessment for the Buvidal program on 19 August 2022

36. On 19 August 2022, Robyn Rewell, a JH Clinical Nurse Specialist (**CNS**), reviewed Emmett at the SCC and determined he was not suitable to commence on the Buvidal program.

37. A progress note made on 19 August 2022 recorded:[20]

> *"review of patient- seen in shortland 5/6*
>
> *25 year old gent came into custody 2020*
>
> *erd 2024*
>
> *sentenced no more court*
>
> *wants buvidal*
>
> *no opioid drug use on rsa [Reception Screening Assessment]*
>
> *opportunistic drug user in custody*
>
> *refused to show me his injecting sites on his arms- said he injected 2 weeks ago*
>
> *plan*
>
> *no suitable for treatment at this stage*
>
> *review again in 3 months*
>
> *harm minimisation education on low tolerance overdose and intoxication"*

20 Progress note 19.8.2022: JHeHS records Tab 135 p.1373 (Vol 4).

38. Ms Rewell CNS made a plan for a review in three months, which did presumably had not occurred by the time of Emmett's death on 12 December 2022.

Emmett's circumstances as of December 2022

39. Emmett was in a one out cell.

40. He reportedly enjoyed good relationships with other inmates in Block C.

41. Block C Pod 2 was a "working" pod with inmates housed in that area working or having the opportunity to work.

42. While in Block C Pod 2, Emmett had worked in ground maintenance, the upholstery workshop and / or print shop.

43. On 6 December 2022 a correctional officer noted, after a case management review, that Emmett was considered to be "*supported by his family including mum and 3 siblings while in custody and states he has a good relationship with them. [Emmett] states he contacts his family daily by phone. [Emmett] reports he keeps busy working in facilities maintenance unit and exercising and is encouraged to continue for his wellbeing*". [21]

44. In the weeks preceding his death, Emmett also had phone calls with his grandmother (Lorraine Brown), a friend (Melissa Butler) and Crystal Emanuel (partner / ex-partner).[22]

45. In the 48 hours before his death on 12 December 2022, Emmett had several calls with his mother (Raahna Brown) and his brother (Kolby Langlo). His last registered call was to his mother (Raahna Brown) at 1:58pm on 11 December 2022.[23]

---

21 OIMS note 6.12.2022 tab 84 p.94 of 96 (Vol 3).
22 No further calls with Ms Emanuel were registered beyond 25 November 2022.
23 Detail Call Report Tab 99 p.981 (Vol 4).

Lockdown on 11 December 2022

46. Emmett was locked into his cell at 3:15pm on 11 December 2022 without incident.[24] The CCTV evidence, knock-up records or accounts given by witnesses do not suggest any report or request for assistance by Emmett overnight.

Block C layout

47. Block C (or "C wing") contained two separate units or pods being Pod 1 (or "Block 1" / "unit 2") and Pod 2 (or "Block 2" / "unit 2").

48. The layout of Block C can be found at Tab 121 p.1079 (Vol 4).

49. Block C consisted of two levels with cells along the perimeter of each Pod on both levels facing into a common area.

50. Cells located on the upper level were accessed via stairs from the common area to an upper landing.

51. Inmates in Pod 1 could not freely enter Pod 2 and vice versa.

52. An office was positioned between Pod 1 and Pod 2 and they adjoined each other with this office.

53. Windows on one side of the office faced into the Pod 1 common area, with windows on the other side facing into the Pod 2 common area.

54. Emmett's cell was located on the first (upper) floor in Pod 2 ("*Upper-Cell 290-Bed 1*"[25]): also see annotated schematic.

---

[24] Senior Correctional Officer Ozzie Zerdo incident report 13.12.2022 Tab 40 (Vol 1); Correctional Officer Caitlin Yallop incident report 15.12.2022 Tab 42 (Vol 1); Correctional Officer Lauren Wheatley incident report 12.12.2022 Tab 43 (Vol 1).

[25] Gaol List of Inmates and Wings; Tab 59 (Vol 3).

Head check procedure

55. CSNSW has written procedures for the conduct of musters, let-go and lock-in: *COPP 5.3 Musters, let-go and lock-in* (9 Dec 2022).

56. *"Let-go"* concerns the unlocking and releasing inmates from their cells.

57. With respect to "let-go", COPP 5.3 relevantly provided that prior to the "let-go process" taking place:[26]

    (1) The OIC of the accommodation unit will ensure inmates are identified using available records and *confirm the inmate is in good health through verbal interaction and visual observation*.

    (2) The procedure for "*let-go*" in "*non-dormitory style units*" requires the "OIC accommodation" to *"[o]pen the cell door and call the inmate(s) by name once the name(s) of the inmate*(s) have been established" and *"[a]ttempt to wake the inmate and see if they are in good health if the inmate does not respond*" ([2.2]).

    (3) Officers are to *"[a]ssume that some harm has come to the inmate and immediately implement the discovering officer procedures <u>if the inmate does not respond</u> (refer to COPP section 3.7 Management of inmates at risk of self-harm or suicide). Be mindful that any injury or harm to an inmate may not be self-inflicted, so consider managing the cell as a potential crime scene (refer to COPP section 13.8 Crime scene preservation)"* ([2.2]).

    (4) Any inmate showing signs of distress or harm must be assessed for risk of self-harm or suicide (*refer to COPP section 3.7 Management of inmates at risk of self-harm or suicide*).

[26] COPP 5.3 (in force as of 12 Dec 2022) Tab 117 (Vol 4).

(5) Staff must also be mindful that harm to an inmate may not be self-inflicted, so they must also consider managing the situation as a potential crime scene (*refer COPP section 13.8 Crime scene preservation*)" ([2.1]).

Head check on morning of 12 December 2022

58. At or about 6am, Correctional Officer Joel Papas (**CO Papas**) conducted "*head-checks*" within Block C Pod 2.

59. At about 6:15am, CO Papas attended outside Emmett's cell (cell 290) for that check. A CCTV still capturing this event is at Tab 121 p.1073 (Vol 4).

60. At 6:21am, inmate Witness E was performing sweeper duties in Pod 2 and placed an item on Emmett's lower door flap (breakfast item).

61. At 6:27am, Inmate Witness D, also performing sweeper duties in Pod 2, did the same.

Opening cell at about 7:15am

62. At about 7:15am, Overseer Michael Muzik (**OS Muzik**) was performing '*let-go'***,** which was the unlocking of cell doors permitting the inmates' release into the common area.

63. At about 7:16am, CCTV footage captured OS Muzik standing outside cell 290's door positioned near its window: a CCTV still capturing this event is at Tab 121 p.1074 (Vol 4).

64. CCTV footage captured OS Muzik unlock and open cell 290, briefly lean into the doorway and then enter the cell (7:16am).

65. Correctional Officer Hayden McShane (**CO McShane**) is seen moving to the outside of cell 290 as OS Muzik entered the cell.

66. On entry OS Muzik saw Emmett lying on his bed facing the wall. Emmett was shirtless with his back towards OS Muzik. He spoke to Emmett but received no response.

67. OS Muzik saw Emmett's digital clock displaying the time (7:15am). He heard the alarm going off loudly.

68. OS Muzik nudged Emmett's foot and yelled his name twice more with no response.[27]

69. OS Muzik found Emmett lying on his bed unresponsive.

70. OS Muzik then exited the cell onto the landing (CCTV 7:16:52am), where he called out to the effect "*we have an unresponsive inmate"*. A radio request for a medical response was made soon after.[28]

71. OS Muzik then re-entered cell 290 with CO McShane standing at the doorway (CCTV 7:16:59am).

72. CO McShane, while standing at the doorway, pulled a towel hanging just inside the cell at or near to its doorway (CCTV 7:17:57am): a CCTV still capturing this event is at Tab 121 p.1076 (Vol 4).

73. CO McShane then briefly entered the cell.

74. Senior Overseer Andrew Hawe (**SO Hawe**) arrived and entered the cell soon after (7:18:07am).

75. OS Muzik and SO Hawe moved Emmett to the cell floor and commenced chest compressions (OS Muzik commenced with SO Hawe thereafter relieving).

76. OS Muzik described Emmett to appear stiff around his face and neck, very pale with green mucous coming out of his nose and mouth.[29]

77. SO Hawe described Emmett's face and lips to appear grey.[30] Emmett's feet and wrist felt cold.[31] A pulse could not be found.[32]

---

27 OS Muzik statement 6.2.2025 Tab 16 (Vol 1).
28 1st statement of the OIC [55] Tab 6 (Vol 1).
29 OS Muzik incident report 12.12.2022 Tab 23 (Vol 1).
30 SO Hawe incident report 12.12.2022 Tab 17(a) (Vol 1).
31 SO Hawe statement 31.1.2023 Tab 17 (Vol 1).
32 SO Hawe incident report 12.12.2022 Tab 17(a) (Vol 1).

78. While performing chest compressions at one point and SO Hawe felt Emmett's torso to be warm.[33]

Hand-held camera recording commences about 7:20am

79. At 7:20:05am, CO McShane is seen on CCTV activating a handheld camera and to commence filming into Emmett's cell. At about this time Brown's cell was "declared a crime scene".[34]

Arrival of nurses at about 7:20am

80. At about 7:20:16am, Registered Nurse Lisa Chapman (**RN Chapman**) and Assistant in Nursing Madeline Schmidt (**AIN Schmidt**)[35] and Senior Correctional Officer Peter Ross arrived at the cell.

81. RN Chapman and AIN Schmidt became involved in resuscitation efforts being undertaken by OS Muzik and SO Hawe.

82. AIN Schmidt described Emmett as unresponsive, not to be breathing and warm to touch. He did not have a palpable pulse. A defibrillator was applied to Emmett.

83. Emmett's airway was cleared and oxygen applied through a bag valve mask while compressions continued. Emmett's oxygen saturation and heart rate were also monitored via a pulse oximeter (attached to finger/thumb).

84. At 7:22:06am, registered nurse Jade Reid (**RN Reid**)[36] and Endorsed Enrolled Nurse Kaitlyn Pay (**EEN Pay**)[37] arrived at the cell. EEN Pay then performed a "scribe" roll making a record of treatment and events.

85. The adrenaline and intranasal Narcan (naloxone) were also administered.

86. Throughout this time the defibrillator revealed there to be no shockable rhythm.

---

33 Description of CPR by OS Muzik in statement 6.2.2023 [32] and [35] Tab 16 (Vol 1).
34 CSNSW Serious Incident Report [26] Tab 51 (Vol 2).
35 AIN Schmidt entered a progress note at 3:30pm: JHeHS records Tab 135 p.1377-78 (Vol 4).
36 RN Reid entered a progress note at 3:20pm: JHeHS records Tab 135 p.1376 (Vol 4).
37 EEN Pay entered a progress note at 3:35pm: JHeHS records Tab 135 p.1379 (Vol 4).

Arrival of paramedics

87. At 7:35:50am, the first NSW Ambulance Service paramedics arrived at the cell door (included Paramedic Robert Jones).

88. At 7:43am, paramedics applied a LUCAS chest compression machine to Brown.[38] Intravenous access was also gained and intravenous adrenaline administered. Oxygen was administered with use of an i-Gel.

89. At 7:49:51am, a second tranche of NSW Ambulance Service paramedics (Intensive Care Specialist Lydon Brown and Paramedic Sophie Bonkowski), arrived at the cell.

90. Emmett presented as asystole on the defibrillator. After a second dose of adrenaline administered intravenously by paramedics, Emmett gained a return of spontaneous circulation.[39]

91. At about 8:27am, with the assistance of other Correctional Officers, Emmett was shifted from his cell to a stretcher on the ground level. After being placed in the stretcher Emmett went into ventricular fibrillation and cardiopulmonary resuscitation was recommenced (which included use of the LUCAS).[40]

92. At about 8:42am, paramedics left the wing with Emmett headed to an awaiting ambulance.[41]

93. At about 8:49am, Emmett was placed inside the ambulance at which time the handheld recording ceased.[42]

94. At about 8:57am, paramedics arrived at Cessnock Hospital with Emmett.

95. Shortly after his arrival at hospital resuscitation was ceased.[43]

---

38 CSNSW Serious Incident Report p. 7 Tab 51 (Vol 2).
39 Statement of Robert Jones [14] Tab 149 (Vol 5); Statement of Lyndon Brown Tab 148 (Vol 5).
40 1st statement OIC [62]-[63] Tab 6 (Vol 1); CSNSW Serious Incident Report [35] Tab 51 (Vol 2).
41 CSNSW Serious Incident Report [37] Tab 51 (Vol 2).
42 1st statement OIC [63] Tab 6 (Vol 1).
43 Statement of L Brown [18] Tab 148 (Vol 5).

96. At 9:01am, Emmet was declared life extinct by Dr Carmen Buchanan.[44]

Immediate scene preservation / examination steps

97. At about 8:40am, after Emmett was shifted by stretcher to the bottom landing, his cell was secured by Senior Correctional Officer Cory McCort.[45]

98. At about 8:50am, the critical incident log, which commenced about 7:20am, was ceased and a debrief took place led by Acting Governor Phillip Dunn in the C-wing office. [46]

99. At about 10:25am, Detective Senior Constable Christopher Walker (**OIC**) and Detective Chad Bower (**Det. Bower**) arrived at Cessnock Hospital and commenced their investigation (there until 10:44am). [47]

100. At about 12:00pm, the OIC, Det. Bower and Inspector Adam Summers attended the SCC and remained there until 1pm.[48]

101. At about 12:46pm, Crime Scene Officer Monique Bibija and Forensic Services Officer Fiona Gruber, NSW Police Force, undertook photography at Cessnock Hospital. [49]

102. At about 1:52pm, Ms Bibija and Ms Gruber attended the SCC.[50]

103. At about 2:15pm, Ms Bibija and Ms Gruber searched cell 290 and took crime scene photographs and exhibits. [51]

104. At about 2:20pm, CSNSW Investigators Hugh O'Reilly and Claire Cook attended cell 290 and took photographs, after which the cell was double locked and secured. [52]

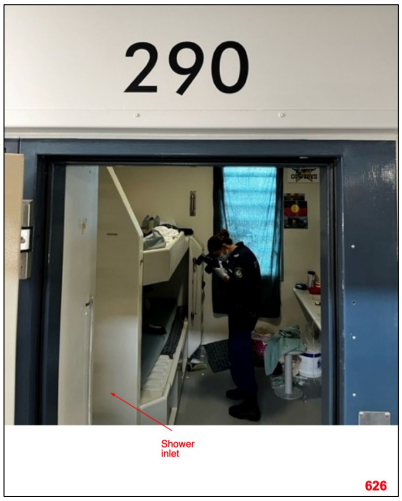
---

44 1st statement OIC [21] Tab 6 (Vol 1).
45 CSNSW Serious Incident Review [37] Tab 51 (Vol 2).
46 Ibid, [39]-[54].
47 Ibid, [39]-[54].
48 Ibid, [39]-[54].
49 Ibid, [39]-[54].
50 See Inmate Accommodation Journal Tab 58 (Vol 3).
51 Ibid, [39]-[54].
52 Ibid, [39]-[54].

105. At about 4:22pm, after advice from NSW Police Force that Brown's death considered not to be suspicious, cell 290 was deemed no longer to be a declared crime scene. [53]

Layout of cell 290

106. The basic internal layout of cell 290 is shown in the photograph below (taken by CSNSW Investigator O'Reilly on 12 September 2022):



What was seen / found in Emmett's cell

107. Scene examiners took photographs around the cell.

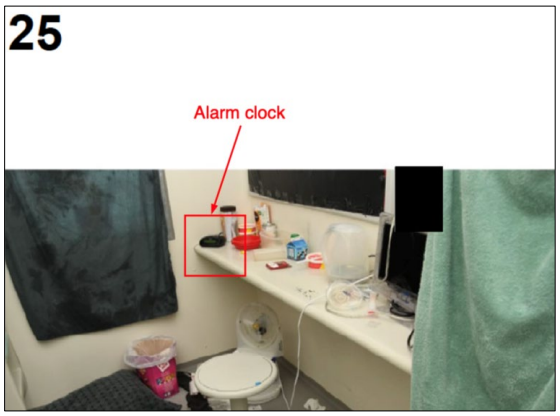
108. This included photographs taken of items on the floor of the shower inlet:[54]

(Note: it is presumed the yellow bag was placed in the cell sometime after emergency responders or scene examiners entered the cell)

53 CSNSW Serious Incident Report [39]-[54] Tab 51 (Vol 2).
54 Crime scene photos Tab 13 (Vol 1).

109. The items found in the shower inlet were not seized.

110. An alarm clock was positioned on a side bench at the rear of the cell:



111. The following unprescribed medications were found during the examination of Emmett's cell:[55]

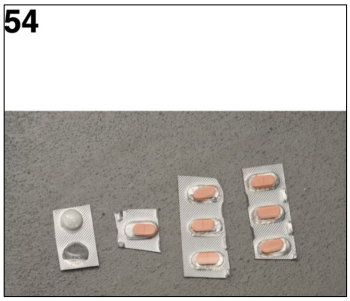
(1) 7 x 'Minipress' (Prazosin) 1mg tablets (orange/pink colour, oval shaped);

(2) 1 x 'Minipress' (Prazosin) 2mg tablets (white colour and circular in shape)

(3) 2 x plastic bags containing 4 and 12 unknown tablets respectively. 'Minipress' is also known as 'Prazosin' (typically prescribed to treat blood pressure).

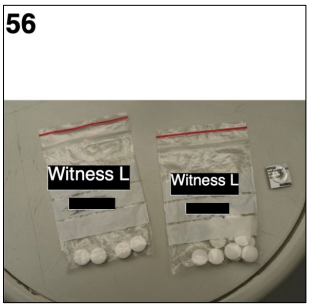
(4) 1 x single blister tab of Sandoz 30mg (Mirtazapine).

112. Photos of the medications include:[56]



55 1st statement of the OIC [37] Tab 6 (Vol 1).

56 Certificate of Analysis FASS certificate 7.2.2023 Tab 4 (Vol 1); NSW Police crime scene photos Tab 13 (Vol 1).



113. The two plastic bags appeared to have a scribbled-out name and MIN number. The OIC determined the MIN to be [redacted], which is that of Witness L.

114. The plastic bags are those typically used by Justice Health when dispensing medication to inmates.

115. Witness L was in cell 271 (Block C Pod 2, floor level) as of 12 December 2022. When interviewed, Witness L told police:

(1) The bags were given to him by Justice Health nurses for prescribed medication, namely Mirtazapine medication (small red coloured tablet). He was also prescribed Panadol, magnesium, and received monthly injections of buprenorphine.[57]

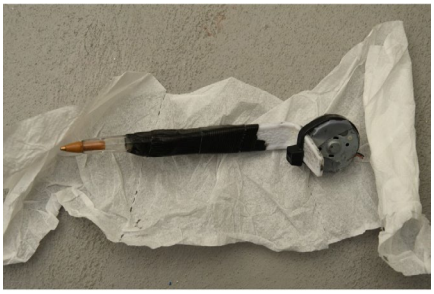
(2) He provided Emmett empty plastic bags at Emmett's request but denied doing so when they contained medication.[58]

(3) Sharing of non-prescription medications among inmates was '*common',* but he denied knowledge of drug use in custody and did not wish to provide police a statement (due to fear of being assaulted).[59]

116. An item was also found concealed in Emmett's cell:

---

57 1st statement of the OIC [41] Tab 6 (Vol 1).
58 Ibid.
59 Ibid, [42].



Medications

117. Minipress is a prescription only drug. It contains the active ingredient prazosin, a post-synaptic alpha-adrenergic blocking agent usually used to treat hypertension (high blood pressure). It can also be used "off-label" to management PTSD and sleep issues. The usual adult dose is 1 mg 2-3 times daily, increased as necessary.[60]

118. Catapres (generic name clonidine) is another prescription only medication used in the treatment of hypertension.

119. Mirtazapine (Sandoz) (30mg tablets) is a prescription medication typically used in the treatment of depression.

Beeping sound heard in the handheld recording

120. From the commencement of the handheld recording by CO McShane at about 7:20am) until about 7:29am (recording timestamp 9:27 minutes), a continuous beeping sound is heard within the cell. The OIC, after examining the footage, concluded as follows:[61]

> "*…in relation to review of audible alarm sound occurring during the first 10 minutes of handheld footage provided by CS in relation to the response to [Emmett] being found unresponsive within Cell 290. I have completed a review of this footage. It's my opinion the audible sound is that of an alarm most likely emitting from the digital alarm clock. During my observation, there is a flashing*

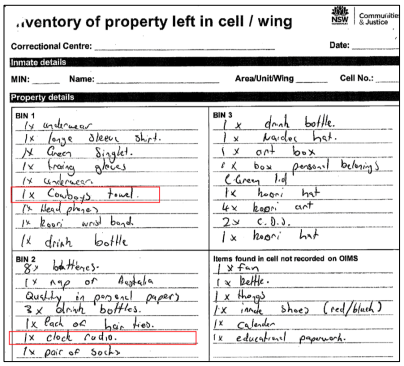
60 Expert report of Dr Alison Jones 4.5.2024 p.1153 Tab 152 (Vol 5).
61 3rd statement of the OIC 1.11.2024 [9] Tab 160 (Vol 6).

green light illuminated on the digital alarm clock display. At the time of 9:27 of the video file, the audible alarm sound stops, and I note that the illuminated green light ceases to flash and remains a steady illuminated light. Given the observation of the working digital alarm clock, the light flashing and the sound being consistent with that of a standard alarm clock, it's my opinion that the sound is that of the digital alarm clock contained within Cell 290.

In further support of my opinion, I note that the sound is occurring prior to any equipment, what appears to be a defibrillator machine, being taken into the cell by responding nurses and staff. I further note, the sound appears to be louder and clearer when the camera holder moves closer into the cell, for which appears to be recording from the door entry at a head height position / level."

Status of the alarm clock & towel

121. Emmett's belongings in his cell, which were not seized by NSW Police Force examiners, were subsequently collected by CSNSW personnel. Some items were returned to his family and other items were provided to the SCC reception room. A contemporaneous record was made of property removed from the cell which included reference to "*1 x cowboy towel*" and "*1 x clock radio*":[62]



Inventory of property left in cell / wing

Correctional Centre: _____ Date: _____

Inmate details

MIN: _____ Name: _____ Area/Unit/Wing _____ Cell No.: _____

Property details

BIN 1
1x underwear
1x large sleeve shirt.
1x Green Singlet.
1x boxing gloves
1x underwear.
1x Cowboys towel.
1x Head phones
1x koori wrist band
1x drink bottle

BIN 3
1 x drink bottle.
1 x hoodie hat.
1 x cont box
1 x box personal belongings
(Grey lid
1x koori hat
4x koori cart
2x C.D.'s.
1 x koori hat

BIN 2
8? batteries.
1x map of Australia
Quality in personal papers
3x drink bottles.
1x Pack of hair ties.
1x clock radio.
1x pair of socks

Items found in cell not recorded on OIMS
1 x fan
1 x Bottle.
1 x things
1x inmk shoes (red/black)
1x calender
1x educational paperwork.

122. The status of radio clock is not known but is believed to have been disposed of by reception staff as it was determined it was not registered to Emmett at the time (pursuant to COPP 4.6 *Confiscated and Unclaimed Property for Disposal*).[63]

[62] Disposed Offender Property Report Tab 72 (Vol 3).
[63] Letter on behalf of CSNSW 18.10.2024 Tab 156 (Vol 6).

123. The alarm setting of the alarm clock was not ascertained before disposal.

124. The status of the "cowboy towel" is not known but was possibly disposed of by reception staff.

125. This towel was not seized on 12 December 2022 nor specifically photographed (it is possibly one of the items depicted in scene photographs 13-14 and 44 in Tab 13 Vol 1) .

126. In the view of the OIC:[64]

> *"…it is highly likely the towel hanging [seen in CCTV in doorway of cell] could be that of a Cowboys Rugby League Club towel. Its my understanding that most towels provided by Corrective Services are green in colour and given the towel observed in CCTV appears to be mostly blue in colour, the information is potentially further supported. My opinion is based upon the CCTV and information provided to me. At no time did I physically observe a Cowboy's rugby league brand towel within Cell 290 when I attended the scene".*

Post-mortem findings / toxicology results

127. Dr Allan Cala, pathologist, carried out a post-mortem examination on 14 December 2022.

128. Key findings during this examination included:

(1) No antecedent causes of death were identified.

(2) 'Cardiac enlargement' was identified as a significant contributory factor that did not relate to the disease or condition causing death.

(3) Emmett was obese with a BMI of 38.75.

(4) Emmett had closely apposed coronary arteries.

(5) Emmett had heavy lungs, especially the right lung.

(6) Emmett had a slightly fatty liver.

(7) Emmett was noted to have extensive acute bronchopneumonia.

---

64 3rd statement of the OIC [11] Tab 160 (Vol 6).

(8) A CT scan showed Emmett had areas of micro-calcification in the basal ganglia and subcortical white matter in the brain, possibly due to Fahr's Syndrome.[65]

129. The results of quantitative tests revealed (blood preserved taken from femoral artery):

Urine	*Alcohol*	*Not detected.*
Blood Preserved	*Alcohol*	*Not detected.*
Blood Preserved	*Ibuprofen*	*<5mgl/L.*
Blood Preserved	*Methadone*	*0.22mg/L.*
Blood Preserved	*Quetiapine*	*<0.05mg/L.*
Vit. Humour Pres.	*Alcohol*	*Not detected.*
Blood Unpreserved	*Alcohol*	*Not detected.*

130. Prazosin (Minipress) is not routinely screened for in postmortem blood analysis and was not specifically examined in the first analysis (results set out above).

131. In early 2024 the Forensic & Analytical Science Service (**FASS**) re-examined the analytical data, obtained from the blood toxicology analysis in late 2022 / early 2023, for signs of the presence of Prazosin however none was detected. FASS advised:[66]

> *"The original analytical data collected during blood toxicology analysis in December 2022 and January 2023 has been reviewed for the presence of prazosin, which was not detected. Please note: Scientific literature indicates that prazosin has a very short half-life of 1-3 hours, and as such, a negative analytical finding cannot completely rule out the possibility that prazosin had been consumed, but no longer present in the body at the time of death."*

---

65 According to the National Institute for Neurological Disorders and Stroke, "Fahr's syndrome is a rare, genetically dominant, inherited neurological disorder characterized by abnormal deposits of calcium in areas of the brain that control movement, including the basal ganglia and the cerebral cortex". Symptoms may include deterioration of motor function, dementia and seizures".

66 FASS email 21.2.2024 Tab 4 (Vol 1).

CSNSW serious incident reporting / procedures

132. CSNSW had written protocol directed to securing of scenes and making of reports in "serious incidents".

133. *COPP 13.1 Serious Incident Reporting* (13 July 2021), relevantly provides:[67]

(3) A "serious incident" includes a "death in custody" ([1.1]).

(4) "Serious incidents must be reported through the chain of command" ([2.1]) and "reported immediately to the Governor or OIC" ([2.2]).

(5) A serious incident must also be reported to the respective regional Director, Custodial Operations who will then report it to the Assistant Commissioner, Custodial Corrections ([2.3]).

(6) A "briefing note" must be completed for all serious incidents as soon as practicable and within two hours of the incident occurring" ([2.6]).

(7) A serious incident must immediately be reported to the duty officer ([2.5]).

(8) Serious incidents must be reported through the "IRM" as soon as possible after the Governor or OIC becomes aware of the incident" ([3.1]).

(9) "In large and medium correctional centres, the Functional Manger (FM) is the Incident Reporting Module (IRM) reviewing officer (the reviewing officer)". The reviewing officer must not review an IRM incident report if they were the IRM reporting officer or were involved in the incident" ([3.3]).

(10) Officers are required to submit "Incident/witness reports to the OIC or Governor as specified in other subsections of COPP section 13 Serious Incidents" ([4.1]).

---

67 COPP 13.1 (in force as of 12 Dec 2022) Tab 118 (Vol 4).

134. *COPP 13.3 Death in Custody* (20 January 2021), relevantly provides:[68]

(1) Crime scene preservation procedures must also be initiated for coronial investigation scenes. However, the safety of persons and emergency medical assistance to the injured take precedence. Cellmates or suspected assailants must be separated and secured for forensic processing by police. For crime scene preservation procedures refer to COPP section 13.8 Crime scene preservation" ([2.4]).

(2) For deaths other than expected deaths from natural causes, a senior officer must be appointed as 'Liaison Officer' to liaise directly with police, emergency services, CSNSW investigators, JH&FMHN and any other relevant services." ([2.5]).

(3) Correctional officers (responding officers and witnesses) must remain on duty and be available to assist investigating police and CSNSW investigators unless permitted to cease duty by the Governor ([2.6]).

(4) An Incident/witness report must be submitted to the Governor or OIC by all staff who (a) responded to the incident; (b) last saw the inmate alive; witnessed an incident or event possibly related to the death (e.g. inmate complained of feeling unwell the previous day); or (c) witnessed an incident or event possibly related to the death (e.g. inmate complained of feeling unwell the previous day); or (d) were significantly involved in the management of the incident ([4.1]).

(5) An Incident/witness report must contain a detailed account of the officer's involvement including any actions taken, decisions made or directions given. The report must be submitted as soon as possible and before ceasing duty ([4.1]).

---

68 COPP 13.3 (in force as of 12 Dec 2022) Tab 119 (Vol 4).

(6) Officers must write their reports from their own recollection of events and independently from each other. Reporting officers should have adequate facilities to meet this requirement (e.g. access to computers in separate areas) ([4.1]).

(7) An officer must not view video footage including CCTV, handheld video (**HHV**) or body worn video (**BWV**) if a person has sustained life-threatening or fatal injuries. For more information about viewing footage to assist to write a report refer to COPP section 13.9 Video evidence ([4.1]).

(8) The report should include details (where relevant) as to (a) historical synopsis of the inmate (from the staff member's perspective); (b) overall involvement with the inmate; (c) significant and most recent contacts between the staff member and inmate; (d) unusual behaviours or comments by the inmate; (e) professional summary or comment; and (f) any other relevant information ([4.2]).

135. *COPP 13.8 Crime Scene Preservation* (12 March 2020*)* relevantly provided:[69]

(1) The following priorities take precedence over the preservation of evidence at a crime scene: (a) safety of persons (protect life and remove persons from danger), (b) emergency medical assistance (provide first aid and professional medical assistance to the injured ([2.1]).

(2) If an officer discovers or reasonably suspects that a serious incident has occurred, then the incident site must be treated as a crime scene ([2.2]).

(3) The Governor or Officer in Charge (OIC) must attend an incident site as soon as possible to: (a) debrief the first responding officer, (b) review crime scene perimeters and establish an exclusion zone if required and

[69] COPP 13.8 (in force as of 12 Dec 2022) Tab 120 (Vol 4).

(c) assign a correctional officer or officers to maintain crime scene security and a serious incident log ([2.2]).

(4) A correctional officer assigned to secure the crime scene and/or maintain a serious incident log must continue performing those duties until relieved of duty by another correctional officer or the Governor or OIC ([2.2]).

(5) Everything within a crime scene must be left in situ including rubbish and disposable medical products, e.g. cannulas, drip bags, electrode pads. The only exception is where an item is moved out of necessity or to protect it from damage or destruction (refer to subsection 3.2 Protecting evidence from weather of this policy). Where an item is moved out of necessity it should not be later repositioned, but a note should be made of its original position ([2.3]).

(6) Procedure for preservation of evidence includes: (a) not removing anything from the crime scene and leaving everything in situ and (b) if an item is moved out of necessity, do not reposition it but note its original position ([2.3]).

- END -