STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Robert Bickerstaff
Hearing Dates:	11, 14, 15, 16, 17 and 18 October 2024
Date of Findings:	24 April 2026
Place of Findings:	Coroners Court of New South Wales at Lidcombe
Findings of:	Magistrate David O'Neil, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody – Parklea Correctional Centre – 88 year old inmate in poor health-provision of health care in custody – provision of health care by St Vincent's Correctional Health – insufficient GP services – lack of support for GP – excessive hours worked by GP-ineffective GP waitlist – "vanishing inmate patients" – systemic issues in relation to nursing care – failure to monitor or audit medicine charts-failure to administer prescribed medication – failure to follow GP direction re daily weight checks – failure to record observations – inexplicable failure to provide reading glasses, walking frame, physiotherapy in a timely fashion-unexplained and inexplicable lack of any review of 88 year old unwell inmate patient from December 2 , 2020 to Jan 15, 2021, impact on quality of life- end of life care-unjustified interruption of inmates decision in relation to end of life care by CSNSW – inmates lawful right to retain autonomy over end of life care decisions whilst in custody
File Number:	2021/0018103
Representation:	Mr A Wong, Counsel Assisting the Coroner, instructed by Mr M Tanazefti of the Crown Solicitor's Office Mr M Windsor SC instructed by Ms S Idowu of Hall & Wilcox, for St Vincent's Correctional Health Mr J Wilcox, instructed by Ms J Holmes of the Department of Communities and Justice, for The Commissioner, Corrective Services NSW Mr T Hackett, instructed by Mr S Bailey of Ash Street Partners, for MTC-Broadspectrum Mr T Saunders instructed by Ms P Callander of Meridian Lawyers, for Dr Mark Tattersall

Findings:

Identity:

The person who died was Robert Bickerstaff.

Date of death:

Robert Bickerstaff died on 20 January 2021.

Place of death:

Robert Bickerstaff died at Blacktown Hospital, New South Wales.

Cause of death:

The direct cause of Mr Bickerstaff's death was multiple organ failure, with antecedent causes of death being Group G streptococcus, sepsis and exacerbation of congestive cardiac failure.

Manner of death:

Whilst Mr Bickerstaff ultimately died from natural causes his death occurred in circumstances where he, as a significantly unwell 88 year old inmate patient, was not seen by any general practitioner and was not appropriately medicated, nor was his weight appropriately checked during the period 2 December 2020 to 15 January 2021, leading to his admission to hospital on 16 January 2021 and death on 20 January 2021.

Non-publication orders:

Pursuant to section 74(1)(b) of the *Coroners Act 2009* (NSW), non-publication orders have been made in this inquest. A copy of the orders can be found on the Registry file.

Recommendations:

To **St Vincent's Correctional Health**

(1) That St Vincent's Correctional Health, in consultation with MTC, Justice Health and Forensic Mental Health Network, and Corrective Services New South Wales, explore options for real-time documentation of medication administration and / or supply in the Electronic Medication Administration Record.

To **MTC Broadspectrum**

(2) That MTC ensures that the Parklea Correctional Centre Governor, Deputy Governor and persons who may from time-to-time act in such positions, are made aware and reminded, that inmates (who are mentally capable) maintain, at all times,

patient autonomy and decision-making in respect of any end-of-life medical care or palliative care decisions.

To **Corrective Services NSW**

(3) That consideration is given by Corrective Services New South Wales to include in the Custodial Operations Policy and Procedure (COPP) set out at 6.13: End of Life Care for Inmates a clear statement that mentally capable inmates, maintain at all times, patient autonomy and decision-making in respect of any end-of-life medical care or palliative care decisions.

Introduction

1 Mr Robert Bickerstaff was born in Sydney on 26 July 1932. Mr Bickerstaff was aged 88 when he died. When Mr Bickerstaff entered custody on the 29th of August 2019, he was aged 87 and had a number of pre-existing health issues. While Mr Bickerstaff was in custody, there were six separate occasions where he was transferred to hospital. Mr Bickerstaff died on 20 January 2021 after having been sent to hospital from prison on 16 January 2021. On arrival at hospital Mr Bickerstaff was found to be grossly oedematous in his lower limbs and scrotal area and suffering from sepsis.

2 Because Mr Bickerstaff died whilst in custody, an inquest was required by the Coroners Act 2009 NSW (the Act).

3 When someone is in lawful custody they are deprived of their liberty, and the State assumes responsibility for the care and treatment of that person. In such cases the community has an expectation that the death will be properly and independently investigated.

4 The focus of this inquest was on the adequacy of care that was provided to Mr Bickerstaff in custody, whether there was an appropriate response to his death, and whether more needs to be done to protect others from a similar death.

The Coroner's role

5 An inquest was held on 11, 14, 15, 16, 17 and 18 October 2024.

6 An inquest is a public examination of the circumstances of death. It provides an opportunity to closely consider what led to the death.

7 The primary function of an inquest is to identify the circumstances in which the death occurred, and to make the formal findings required under s 81 of the Act, namely;

- the person's identity;
- the date and place of the person's death; and
- the manner and cause of the person's death.

8 Another purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances.

9 Prior to holding the inquest a detailed coronial investigation was undertaken. The investigating Police Officer in Charge (OIC), Detective Senior Constable Adam Brown compiled a brief of evidence, and a report was obtained from a forensic pathologist as to the cause of death. The brief included statements from correctional and nursing staff and CCTV footage.

10 During the Coronial investigation the OIC also obtained relevant policy documents and received a Serious Incident Report undertaken by a senior investigator from the Corrective Services' Investigation Branch.

11 Documents and witness statements obtained during the investigation formed part of the brief of evidence tendered during the Inquest. All that material has been considered in making the findings detailed below.

Witnesses

12 The following witnesses gave evidence at the hearing:

a. Sue Pedersen, Senior Next of Kin;

b. Dr Mark Tattersall, Visiting Medical Officer – St Vincent's Correctional Health;

c. Dr Hester Wilson, Expert General Practitioner;

d. Associate Professor Mark Adams, Expert Cardiologist;

e. Katya Issa, Operations Manager – St Vincent's Correctional health; and

f. Brian Gurney – MTC-Broadspectrum, General Manager at Parklea Correctional Centre

Issues

13 An issues list was distributed to the parties as guidance as to the issues to be considered at inquest.

14 An issues list is neither determinative nor limiting. In the inquest further issues arose which will be dealt with later in these findings. The issues set out in the issues list were:

Issue 1 – Determination of the statutory findings required under s 81 of the *Coroners Act 2009* (NSW), including manner and cause of death.

Issue 2 – The adequacy of the medical care and treatment provided to Mr Bickerstaff while he was in custody at Parklea Correctional Centre, including:

a. Whether appropriate actions were taken to properly manage Mr Bickerstaff's pre-existing health issues while he was in custody considering the fact that Mr Bickerstaff's manner of death arose as a result of his pre-existing health issues.

b. Whether appropriate actions were taken to address Mr Bickerstaff's inability, whether deliberate or otherwise, to restrict his fluids as directed;

c. Whether he was given all necessary medications during his time in custody and were such medications prescribed in a timely fashion;

d. Whether Mr Bickerstaff's provision of mental health care was adequate given concerns as to whether he was engaging in acts of self-harm through non-compliance with medical advice as to fluid intake;

e. Whether Mr Bickerstaff should have been hospitalised at an earlier point in time prior to his hospitalisation on 19 May 2020 and 19 August 2020; and

f. Whether Dr Mark Tattersall had available to him appropriate supervision, support and clinical oversight, with respect to his management of physical health conditions affecting inmates at Parklea Correctional Centre noting that between August 2019 and January 2021 he was not a general practitioner (nor a specialist in any other medical discipline) and his direct supervisor was a psychiatrist.

Issue 3 - Whether any recommendations are necessary or desirable arising from any matter connected to Mr Bickerstaff's death pursuant to s 82 of the Act.

Personal Background

15 Mr Bickerstaff was born on 26 July 1932. He had two older brothers and sisters.

16 Mr Bickerstaff attended Drummoyne High School and from a young age he was a very talented singer. When he was aged around 22, he won a scholarship in Paris for singing. This led to him moving to Europe and he ultimately became a baritone singer with the Sadler Wells Opera in London.

17 After living in Europe for a period of time, he was offered a job at the Conservatorium of Music in Sydney. The job did not eventuate and instead Mr Bickerstaff taught singing in his own teaching business. Ms Pedersen described Mr Bickerstaff as "a gifted singer who did not seek fame but preferred to sing and pass on his knowledge".

18 Mr Bickerstaff married Renee Goosens in his early forties. They separated after a year of marriage and in the thirty-five years prior to his passing, Mr Bickerstaff spent a lot of time with Ann Howard. Mr Bickerstaff would assist Ms Howard in editing her writing work and help her maintain her property and large garden. During his time in custody, Ms Howard visited him three times prior to Covid-19 leading to a suspension of visits and maintained communication with him by phone.

19 Mr Bickerstaff's niece, Sue Pedersen, gave evidence during the inquest. It is clear that during Mr Bickerstaff's incarceration, Ms Pedersen acted as a consistent vocal advocate on behalf of her uncle's needs. She was very close to her mother (Patricia Pedersen, Mr Bickerstaff's sister) and as her mother could not advocate on behalf of Mr Bickerstaff, Ms Pedersen took on this role.

Mr Bickerstaff's time in custody

20 Mr Bickerstaff was 87 when he was arrested on 29 August 2019 on an arrest warrant issued in the United Kingdom (UK) from the Westminster Magistrates Court. The offences listed on the warrant included Indecent Assault on a male person (12 counts), Indecency with a child (2 counts) and Buggery (2 counts).

21 Mr Bickerstaff had a number of pre-existing health issues at the time he entered custody including:

a. mild neurocognitive disorder;

b. hypertension;

c. keratosis on his right wrist;

d. in 2009: an inguinal hernia;

e. in 2010: a right lacunar stroke or infarction;

f. in 2013: a pulmonary embolism and deep vein thrombosis followed by a pacemaker being inserted;

g. in 2014: a bilateral anterior tibial artery occlusion (a blockage of blood flow in his leg artery) together with postural hypotension (low blood pressure when standing up) and lumbosacral radiculopathy (or pain resulting from compression of nerves in the lumbosacral region of the spine);

h. Raynauds Phenomenon (a condition where blood vessels (usually in fingers/toes) overreact to cold or stress, constricting (vasospasm) and causing temporary colour changes (white, blue, red), numbness, and pain due to reduced blood flow);

i. enlarged prostate;

j. congestive heart failure (CCF); and

k. atrial fibrillation (AF).

22 Upon reception into Parklea on 30 August 2019 Mr Bickerstaff underwent a reception screening assessment (RSA) conducted by a nurse.

23 Mr Bickerstaff requested to be placed into the Special Management Area Placement (SMAP) and the approval forms noted, "*frail, first time in custody, dementia*". A Health Problem Notification Form (HPNF) of the same date noted he was to be for "*2 out cell placement*" and "*bottom bunk*". A progress note of the same date indicated that Mr Bickerstaff had denied any mental health issues or thoughts of self-harm or suicide.

24 Mr Bickerstaff was initially housed in the prison medical clinic given his health issues. In addition to the steps taken Mr Bickerstaff should have been referred for a chronic disease screen and placed on a chronic health care plan, however this was not done.

Provision of Health Services at Parklea in 2019

25 It is necessary to set out some background matters as to the delivery of medical services in Parklea in 2019.

26 St Vincent's Correctional Health (whom for convenience shall be referred to throughout these findings as St Vincent's) had commenced providing medical services at Parklea on 31 March 2019. Previously those services had been provided by the Justice Health and Forensic Mental Health Network Justice Health). St Vincent's were not provided with access into Parklea until 4:00 pm on 31 March 2019. That is, as Justice Health ended providing medical services, St Vincent's commenced. The evidence in this inquest is that there was no handover from Justice Health to St Vincent's. Given that the prison population was in the vicinity of 1000 to1250 inmate/patients at any time, this presented St Vincent's with a significant challenge. The lack of handover arrangements were not the subject of close consideration in this inquest. The detail of what occurred has not been examined and Justice Health have not been represented in this inquest. Nevertheless, I note that there should have been an extensive handover. As I found in the Inquest into the death of James Cunneen the formal handover from one entity to the other should not have occurred until staffing levels and administrative arrangements enabled the delivery of appropriate and adequate medical services from day one.

27 It is uncontroversial that the prison population is one of the most challenged populations in the community in terms of mental and physical well-being. The health requirements of the prison population are extensive.

28 It is against this background that Mr Bickerstaff entered custody in late August 2019.

Hospital Admissions

29 Mr Bickerstaff was admitted to hospital on six occasions during his time in Parklea.

30 The first of these admissions was on 11 January 2020 when Mr Bickerstaff suffered a middle cerebral artery clot which resolved without complication. An admission on 8 July 2020 was for an echocardiogram to be conducted. The results of the echocardiogram did not require any change to the treatment being provided to Mr Bickerstaff.

31 The admissions on 19 May 2020, 19 August 2020 and 19 October 2020 all related to Mr Bickerstaff's weight gain through fluid retention. I shall return to this topic below.

32 The final admission was on 16 January 2021 at which time Mr Bickerstaff was suffering from sepsis, leading to his ultimate demise.

Issues

33 The evidence at inquest is best considered by reference to the issues and sub issues identified above.

Issue 2(b) Whether appropriate actions were taken to address Mr Bickerstaff's inability, whether deliberate or otherwise, to restrict his fluids as directed;

Issue 2(d) Whether Mr Bickerstaff's provision of mental health care was adequate given concerns as to whether he was engaging in acts of self-harm through non-compliance with medical advice as to fluid intake;

Issue 2(e) Whether Mr Bickerstaff should have been hospitalised at an earlier point in time prior to his hospitalisation on 19 May 2020 and 19 August 2020.

34 An ongoing issue in relation to the care of Mr Bickerstaff was his oedema (fluid retention in the body tissues).

35 Oedema can of itself be an indicator of heart disease and can be extremely uncomfortable. In Mr Bickerstaff's case it was pronounced in his legs and extended at times up to his lower stomach area including his scrotum.

36 In addition, Mr Bickerstaff's excess fluid meant his heart had to work harder which was a significant issue given his congestive cardiac/heart failure.

37 As Associate Professor Adams confirmed, excessive consumption of both salt and water can lead to exacerbation of heart failure.

38 Sodium, which makes up 40% of salt, acts like a magnet for water in the body. The body retains water to help dilute sodium.

39 Mr Bickerstaff's medications for removing excess fluid and salt from his body were indapamide and frusemide. Associate Professor Adams' evidence was that these drugs will not extend someone's life expectancy, but they do improve quality of life.

40 At one stage Mr Bickerstaff held the view that he could wash away the water by drinking more water. Ms Pedersen frankly indicated that she had encouraged him to "*drink a lot of water to wash everything out*".

41 On 12 May 2020, a registered nurse recorded that Mr Bickerstaff had refused administration of frusemide. Dr Tattersall attended to review Mr Bickerstaff later the same day and recorded that Mr Bickerstaff was attempting to wash away extra fluid, had worsening leg swelling, understood

that he had a history of congestive cardiac failure and had excessive fluid retention. Dr Tattersall further noted that Mr Bickerstaff voiced concerns regarding the medical care available in UK prisons whilst accepting that he would in due course be deported to the UK.

42 Dr Tattersall then recorded a plan for daily weight checks, fluid restriction to 1500ml, 40mg Frusemide, increased Spironolactone to 25mg daily. (Spironolactone which seemingly replaced Indapamide was prescribed for hypertension, heart failure and oedema), Doctor Tattersall also ordered an echocardiogram and subsequent review by a cardiologist. In the period that immediately followed, Doctor Tatersall also told Mr Bickerstaff to consume two cups of water at breakfast, two cups at lunchtime, and two cups at dinnertime.

43 On 16 May 2020, Dr Tattersall noted "*its difficult not to have conversations without thinking (sic) that the pt has a hidden agenda, most likely avoiding extradition on medical grounds and sees admission to hospital as a way of doing this. I do not believe that he is compliant with fluid restriction, he reports drinking till not thirsty, when questioned on how many cups, he reports that he tries to stop at 6 but often exceeds.*"

44 On 19 May 2020 Mr Bickerstaff's weight had increased to 101kg and he was transferred to Blacktown Hospital for further review and investigation. He was observed to have swelling in his legs and scrotum, and the diagnosis was noted to be "*exac [erbation] of CCF likely secondary to excess fluid intake/non- compliance*." He was managed with IV and oral frusemide, a 1200ml fluid restriction and low salt diet. It was noted that upon discharge on 28 May 2020, he had dropped to 85kg.

45 On 30 May 2020, Dr Tattersall reviewed Mr Bickerstaff and recorded amongst other information that Mr Bickerstaff thought he (Doctor Tattersall) was "cruel /odious".

46 Mr Bickerstaff told his niece that Dr Tattersall had told him, that he, Mr Bickerstaff, was odious. The relevance of this is that it tended to confirm Ms Pedersen's view that Dr Tattersall had a strong adverse attitude towards her uncle which compromised Dr Tattersall's care of Mr Bickerstaff.

47 Dr Tattersall is no shrinking violet. He would not record that a patient referred to him as cruel and or odious unless he honestly believed that had been said. Furthermore, in my assessment he would not make that entry in clinical notes for his own protection but rather to ensure a complaint by a patient was recorded.

48 In my view there is a real possibility that Mr Bickerstaff misunderstood or misheard a reference to him being oedematous or suffering oedema and took offence to what he thought he had heard.

49 There was clear tension in the relationship between Dr Tattersall and Mr Bickerstaff and Dr Tattersall was clearly concerned that Mr Bickerstaff was self-sabotaging. However, I am satisfied this view did not interfere with or impact upon Dr Tattersall's approach to caring for Mr Bickerstaff.

50 On 30 May Dr Tattersall advised Mr Bickerstaff that if he was non-compliant with fluid restrictions and taking his medications such actions would be seen as self-harm and Mr Bickerstaff may be transferred to a dry cell. This was likely upsetting to Mr Bickerstaff.

51 Dr Tattersall directed there to be regular weigh-ins between 10 June 2020 and 11 July 2020. Despite this direction, between 10 June 2020 - 8 July 2020, Mr Bickerstaff's weight increased from 84kg to 92kg. Despite Mr Bickerstaff's weight increase, Dr Tattersall was not notified.

52 In this period Mr Bickerstaff's weight was recorded on 10,11,13, 16, 17, 18, 24 and 27 June 2020 and 4,6,7,8,10 and 11 July. As expert general practitioner, Dr Wilson observed, "*the daily weigh-ins appeared not to be daily."* Mr Bickerstaff had not been weighed on 12,14,15,19,20,21,22,23,25,28,29 June or 1,2,3,5 July 2020.

53 On 12 July 2020, it was noted that Mr Bickerstaff weighed 96kg, that his weight had been increasing daily since 6 July, and he had shortness of breath. Mr Bickerstaff's abdomen was distended, scrotum swollen, and both legs were oedematous to above his knees. Dr Tattersall advised he should be given 20mg Frusemide daily for one week, and that he be housed in the clinic for monitoring.

54 On 18 July 2020, Dr Tattersall was still concerned as to whether Mr Bickerstaff continued to comply with fluid restriction albeit that his weight had reduced to 92kg and was 90 kg by 20 July 2020.

55 By 7 August 2020, however Mr Bickerstaff's weight had increased to 96kg and he complained of chest pain. He was seen by Dr Tattersall on 8 and 10 August 2020. On 19 August 2020, Dr Tattersall reviewed Mr Bickerstaff for concerns on his weight gain of 6kg in the past week. Mr Bickerstaff was subsequently transferred to Blacktown Hospital. He was diagnosed with heart failure with preserved ejection fraction[1] with exacerbation of congestive cardiac failure and low Vitamin D. As per his previous admission, Mr Bickerstaff was treated with IV Frusemide, with a plan on discharge for an increased dose of 40mg Frusemide to be administered. He was discharged to Parklea on 24 August 2020.

56 Following daily monitoring in the clinic after his return on 24 August 2020, Mr Bickerstaff was cleared by Dr Tattersall for "*two out cell placement, bottom bunk placement*" on 27 September

[1] A condition where the heart pumps a normal percentage of blood but is too stiff to fill properly, causing symptoms like breathlessness and fatigue.

2020. Dr Tattersall noted that Mr Bickerstaff was keen to go to the wing and reported he had been taking his medication.

57 On 19 October 2020, Dr Tattersall noted that Mr Bickerstaff was unwell with poor mobility and was fluid overloaded. His weight had increased to 100kgs with a 4 kg increase in the preceding 4 days. Mr Bickerstaff was transferred to Blacktown Hospital in order to be treated with IV diuretics. Upon admission, ED staff recorded he "*was not very compliant with fluid restriction*, *swelling in his legs and left hand had been worsening over the past two weeks, and he had not opened his bowels for the past week (had not been taking Coloxyl)".* The plan for treatment was 40mg IV Frusemide, an abdominal X-Ray, and Movicol and Coloxyl with Senna. Mr Bickerstaff was discharged the following day and was to take Frusemide 40mg twice a day for the next five days after which he would take his normal dose of 40mg once a day.

58 Mr Bickerstaff remained in the clinic upon his return and was regularly seen, however on 19 November his weight was 99kgs. His frusemide was increased for the following 14 days.

59 Mr Bickerstaff's weight was not taken between 20 November and 2 December 2020, however, on 5 December 2020, Dr Tattersall made a retrospective entry regarding 2 December and noted a marked improvement in fluid overload (emphasis added). Dr Tattersall opined that this improvement was unlikely to be due solely to the increased dose of Frusemide but more likely that Mr Bickerstaff was being compliant with fluid restrictions (emphasis added). Mr Bickerstaff was cleared for the wing and daily weights were to be taken and nursing staff were to ensure Mr Bickerstaff's weight was less than 95kg (emphasis added).

60 Mr Bickerstaff was not seen by a GP or any other Doctor between 2 December 2020 and 15 January 2021 and there are no entries in the nursing notes in that period.

61 On 16 January 2021 at 1:30pm, Mr Bickerstaff presented to the clinic with complaints of "*shivering, dizziness, hardly walking due to oedema in bilateral lateral legs*". He weighed 100kg. Dr Tattersall was informed over the phone and ordered 40 mg Frusemide, to maintain 1.2L fluid restriction and for housing in the main clinic under GP hold.

62 At approximately 7:30pm, Dr Tattersall directed Mr Bickerstaff be transferred to Blacktown Hospital by ambulance for the following reasons: "*SOB, hypotensive, increased respiratory rate, fluid overload/exacerbation of CCF*".

63 I will comment more fully on the final hospitalisation and the period from 2 December 2020 to 16 January 2021 below.

64 Four specific issues arise:

a. Was Mr Bickerstaff self-sabotaging?

b. Was the mental health care sufficient?

c. Was the clinical intervention sufficient?

d. Should Mr Bickerstaff have been sent to hospital sooner in relation to the May 2020 and August 2020 admissions?

Was Mr Bickerstaff self-sabotaging?

65 As is evident from the extracts above Dr Tattersall was concerned that Mr Bickerstaff may have been deliberately self-sabotaging so as to avoid extradition to the UK. There was evidence of Mr Bickerstaff expressing a reluctance to return to the UK and of him feeling so down at times that he felt he could not go on.

66 I have no doubt that Mr Bickerstaff did not wish to return to the UK. He turned 88 whilst in custody, he was in very poor health, and as Dr Wilson pointed out, he no doubt found the situation extremely difficult.

67 The conclusion that Mr Bickerstaff did not want to return to the UK does not however necessarily indicate that Mr Bickerstaff was self-sabotaging.

68 The evidence clearly indicated that Mr Bickerstaff was relatively well controlled in relation to his fluid intake when he was in the clinic. If he was determined to self-sabotage he could have achieved this even when in the clinic.

69 The misunderstanding regarding washing away excess fluid and salt which arose in the first part of 2020 arose from completely innocent and undoubtedly well intentioned suggestions from Ms Pedersen and did not suggest self-sabotage in any way.

70 The most likely cause of Mr Bickerstaff consuming too much water when in the general prison population is a combination of his age, poor health, genuine thirst and his cognitive impairment impacting on his memory.

Was the mental health care sufficient?

71 The issue of Mr Bickerstaff's mental health was not pursued at inquest beyond a consideration of his cognitive impairment which, though mild, did have an impact upon his memory and was likely a factor in him not appropriately attending to the amount of water he drank.

Was the clinical intervention sufficient?

72 In terms of appropriate intervention by clinicians the weight of the evidence from Dr Wilson and Associate Professor Adams was that if options were available such as a measuring jug or a water diary they could have been helpful.

73 Dr Tattersall gave evidence that he did not know whether a jug could have been provided to Mr Bickerstaff and that he had not asked if one could be provided.

74 The availability of a measuring jug and a water diary should have been investigated, however they were not and as such it is unknown whether they would have been permitted or, if permitted, effective. Similarly, a low salt diet may have been available and of assistance if it had been requested.

75 Dr Tattersall also gave evidence that he felt it was inappropriate to place Mr Bickerstaff in a dry cell, albeit that he told Mr Bickerstaff he may have to place him in a dry cell to achieve compliance with the indicated daily water intake.

76 A dry cell is an extremely austere environment. In it there is no access to water at all. If a patient goes to the toilet in a dry cell, arrangements have to be made for there to be flushing. Water is served at times to comply with the daily limit but otherwise there is no access to water at all including for showering. Dr Tattersall's reluctance to place Mr Bickerstaff in a dry cell was well-placed.

Hospitalisation on 19 May 2020 and 19 August 2020

77 Both Dr Wilson and Associate Professor Adams were of the view Mr Bickerstaff was sent to hospital in a timely fashion in relation to the May 2020 and August 2020 admissions.

78 I accept this to be the case.

Issue 2(c) Whether Mr Bickerstaff was given all necessary medications during his time in custody and were such medications prescribed in a timely fashion

79 Medications were provided to St Vincent’s from an external pharmacy. St Vincent’s did not have a license to operate a pharmacy on the prison premises.

80 Pharmacists and pharmacy technicians would work through the medication charts and gather the medication necessary for patients to receive on a daily basis.

81 The medication prepared by the pharmacy technicians would be placed on a trolley to then be placed in bags which the nurses, accompanied by a pharmacy technician, would take to the patients on the medication rounds.

82 The pharmacy had its own worksheets, known as medication sheets or more commonly as signing sheets. Pharmacy technicians were required to mark on each sheet the medication that had been placed on the trolley.

83 When the medication round was undertaken nurses were to mark the medication chart indicating that the medication had been administered to the patient. The medication chart was completed by nurses whereas medication/signing sheets were completed by pharmacy technicians.

84 A practice developed whereby the medication charts would be filled in by nurses in advance of the medication round and amended as necessary at the end of the round to reflect any instances when medication had not been administered and the reason for the failure to administer the medicine which may, for example, include a refusal by the patient or the patient being unavailable.

85 In order to amend the medication chart at the end of the medication round the nurses carried what was referred to as a handover sheet for the purpose of taking notes as to any failures to administer.

86 It was accepted by Ms Issa in giving evidence in her role as operations manager that this was not best practice although her understanding was that it was common practice across correctional facilities in New South Wales.

87 The medication charts were contained within a medication booklet issued by Justice Health.

88 In Mr Bickerstaff's case the record-keeping in relation to the medication charts was characterised by insufficiency, confusion and gaps.

89 The insufficiency of the record-keeping regularly related to a failure to accurately indicate the year in which the medication was being administered. The medication chart had space for a year to be indicated close to the top on the left-hand side of the page but the medication charts regularly either failed to indicate any year or had a year at the top of the page that did not necessarily reflect the year in which the medication was being administered.

90 An example of confusing recordkeeping was when the pharmacy signing sheet indicated medication had been packaged and the medication charts reflected that the medication had been administered in the evening but there was no entry at all in the medication chart in relation to morning administration of medicine. On occasions there was no entry as to morning administration of medication for days or weeks at a time.

91 The mischief in relation to this failing lay in the fact that looking back at the charts and sheets it is impossible to discern what actually happened. As Dr Wilson, expert general practitioner, pointed out in oral evidence "*the options included that the pharmacy technician signing sheet may have been wrongly completed, the morning medication may not have been administered, or the morning medication may have been administered but the nurse failed to complete the sheet".* The inability to determine what had actually occurred completely undermined the very purpose of the pharmacy medication sheet and the medication chart which was to keep an accurate record of what the patient had been administered.

92 The gaps in the record keeping occurred in circumstances where despite a prescription being in place for daily medication the pharmacists' signing sheet indicated no medication had been placed on the trolley and the medication chart reflected that no medication had been administered.

93 I am left with uncertainty as to what occurred in relation to Mr Bickerstaff on the days on which the pharmacist medication sheet indicated his medications were made available, but the medication chart does not reflect the administration of medication in either the morning or the evening or both.

94 For the days on which the pharmacy medication sheet and the medication chart both indicate the medication was not available and it was not administered I am satisfied medications were not administered on those days.

95 The failings in relation to the administration of medication to Mr Bickerstaff are obviously highly relevant to the care and treatment provided to him. The failings in relation to medication sheets and charts reveal systemic issues in relation to delivery of nursing services to Mr Bickerstaff.

96 When the pharmacy signing sheets and/or the medication charts reflected that medication had either not been available or had not been administered then this issue should have been picked up by the pharmacy technician the next morning or at handover of nursing shifts and, if not discussed at handover, by the nurse on the next shift who was due to administer medicine and, in the absence of that nurse picking up the issue, the nursing team leader should have picked up the issue.

97 Despite all these opportunities the errors were not rectified during the time Mr Bickerstaff was in custody.

98 In relation to the issue of when Mr Bickerstaff missed medication, there were competing submissions from counsel assisting and Saint Vincent's in relation to the period between early December 2020 -16 January 2021.

99 In reply submissions, Counsel Assisting withdrew relevant primary submissions but pressed that there were dates during that period as well as other periods on which medications were missed.

100 I am satisfied Mr Bickerstaff was not provided his medications as follows.

(1) The morning dose of Frusemide and Spironolactone was not administered on 21 and 25 August, 14,19,20 October, 24–30 November and 1, 2, 4, 5, 24, 30 December 2020 and 2, 4, 5, 10, 12, 13 January 2021;

(2) Amlodipine, Apixaban, Carvedilol, Senna, Magnesium, Perindopril and Atorvastatin were not administered on 21–25 August 2020;

(3) Magnesium, Perindopril and Amlodipine were not administered on 14, 19 and 20 October 2020;

(4) Apixaban, Carvedilol and Atorvastatin were not administered on 20 October 2020; and

(5) Amlodipine, Apixaban, Carvedilol, Senna, Magnesium, and Perindopril were not administered on 24–30 November 2020 and 1,2, 4, 5 December 2020.

Panadol Osteo and Meloxicam

101 On 16 November 2019, Dr Tattersall saw Mr Bickerstaff and made a note that *Mr Bickerstaff fell two days ago and had mild left sided pain on palpation and was unable to straight leg raise due to pain* (emphasis added). He recommended Mr Bickerstaff be prescribed *Panadol Osteo twice a day for ten days and Meloxicam 7.5mg, for five days.*

102 Neither medication was administered as recommended. The medication chart shows Panadol Osteo was administered for only three days and Meloxicam was administered on only two days.

103 Doctor Tattersall stated that there would not have been a supply issue in relation to these medications, rather it appeared Mr Bickerstaff just wasn't given the medication.

104 Dr Tattersall was of the view there were no systems in place as far as he was aware to double-check if a patient had been administered medication.

105 I am satisfied that Panadol Osteo when subsequently prescribed was not administered on August 12, 13, 21, 22, 23, 25 September 24–30, October 14,19,20,21, November 24–30 and December 1–5, 2020.

106 It bears repeating that Mr Bickerstaff turned 88 on 26 July 2020, was in extremely poor health and yet for unexplained reasons the relatively simple task of administering medication was not reliably completed.

107 There was no evidence that Mr Bickerstaff's medications were not prescribed in a timely fashion.

108 I am satisfied the evidence establishes that the administration of necessary medication to Mr Bickerstaff was missed on the above identified occasions despite timely prescription of same.

109 The unexplained inability to administer prescribed medication with the required regularity was accompanied by a disturbing lack of attention to detail by the nursing staff in relation to completing medicine charts.

110 Furthermore, there was a lack of auditing/checking of medicine charts.

111 It is axiomatic that Mr Bickerstaff's prescribed medication should have been administered to him.

112 Associate Professor Adams gave evidence about the importance of various medications. He stated that there were only a few interventions in people with heart failure that are shown to increase length of life, and they included three medications Mr Bickerstaff was prescribed:

(1) Carvedilol, a beta blocker that improves both symptoms and lifespan.

(2) Perindopril as an ACE inhibitor that can improve life span as it is a type of blood pressure medication that helps with heart remodelling and de-stressing the heart.

(3) Frusemide, a diuretic to help remove excess fluid and sodium from the body.

(4) Spironolactone acts upon a whole different system that controls the balance of salt and water and potassium in our body called the renin-angiotensin system and will lower admission to hospital and improve lifespan.

113 Associate Professor Adams referred to the medication Apixaban and stated that it was a blood thinner which helps prevent strokes in someone like Mr Bickerstaff who had previously had an embolic stroke. He went on to say that "*he was at quite high risk of having a significant stroke whilst off that".*

114 In relation to Frusemide and Spironolactone Dr Tattersall agreed they were critical medications for Mr Bickerstaff as the aim of those medications was to ensure there was not an excess of fluid build-up. The retaining of excess fluid meant that Mr Bickerstaff's heart had to work harder which was a significant issue in the context of his congestive cardiac failure.

115 Another benefit of Frusemide was that in being helpful in reducing fluid it also reduced the likelihood of skin infections, which would in turn reduce the risk of Group G Streptococcus recurring and sepsis. Dr Wilson gave evidence of the interplay between breakdown in skin and bacterial infection. Dr Wilson stated, "*with the stretching of the skin with the fluid sitting under the skin in the kind of fatty space between the blood vessels and the muscles and the skin, it stretches the skin….[a]nd we've all got bacteria sitting on our skin all the time and when you have breaks in it and when you have all these other issues going on with your health, and you're elderly, you know, you are at high risk of infection anyway but with the potential for skin to be really poor quality it absolutely increases your risk of the bacteria on your skin finding their way in and causing infection*".

116 Dr Wilson said the failure to administer Frusemide over a period of weeks would have impacted Mr Bickerstaff's health. Dr Wilson gave evidence that Frusemide reduces fluid and while it doesn't change the trajectory of an illness, if you've got lots of fluid in your legs it means the skin of your legs is not as well nourished, and you're more likely to have issues with skin infections and with that a breakdown of skin can be incredibly uncomfortable. The extra fluid also places extra strain on the body and can cause shortness of breath and reduced mobility.

117 The failure to administer medication as prescribed had the potential to reduce Mr Bickerstaff's life expectancy, reduce his quality of life and added to his risk of stroke.

Access issues

118 In Mr Bickerstaff's clinical notes there were a number of entries which indicated that there were "*access issues"* or "*MTC access issues*".

119 Dr Tattersall gave evidence that around July 2020 there were "*always access issues with MTC".*

120 Dr Tattersall suggested that "*there was a lot of indifference, I think, from a lot of correctional officers to health needs and that's driven, I guess, by multiple factors, but there was a sort of indifference, I think to sort of health issues. They were not sort of prioritised"*

121 Ms Issa shared Dr Tattersall's concerns indicating "*because officers have competing priorities and they have their own 'to do' list and I feel that certainly for the officers on the ground the access to health care for patients is an add-on responsibility*". Ms Issa indicated that despite an improvement in the early part of 2020 after a meeting with the Governor, access issues persisted as at the time of inquest, in 2024.

122 Deputy Governor Gurney denied any cultural issues with staff attending to medical needs of inmates and was of the view that any perceived access issues would normally resolve. Importantly the Deputy Governor pointed out that even when there is a lockdown this does not and should not prevent inmate patients being taken to the clinic.

123 The Deputy Governor noted that there were many movements of inmates on a daily basis and that access issues are usually resolved informally and quickly by direct communication between St Vincent's staff and MTC staff.

124 It is not possible to definitively resolve the question of whether, either in 2020 or in 2024, [when the evidence was given] there were cultural issues inhibiting officers properly facilitating the delivery of medical services.

125 What is clear is that access issues were identified in relation to Mr Bickerstaff on a number of occasions and St Vincent's and MTC both accept the need to communicate directly and fully in relation to access issues as they arise and work co-operatively to limit their impact on delivery of health services.

Ancillary issues relating to Mr Bickerstaff's care

126 A number of issues relating to Mr Bickerstaff's care were raised by his niece, Ms Pedersen. These issues included delays in provision of reading glasses, summer clothing, a walking frame, a winter doona and physiotherapy treatment.

127 It is important to consider these delays in the context that Mr Bickerstaff was a vulnerable 88-year-old with numerous health issues when he entered Parklea.

128 After Mr Bickerstaff entered custody at Parklea (30 August 2019), it took five weeks for him to be provided with his own reading glasses which had been part of his property when he was arrested. It was only after Ms Pedersen sent three formal requests, made five phone calls to Parklea and sent an email to executive services requesting that Mr Bickerstaff be provided with his glasses that he finally received them on the 10th of October 2019.

129 Deputy Governor Brian Gurney indicated that the normal time for glasses to be delivered to an inmate was 1 to 2 days.

130 When Mr Bickerstaff was hospitalised at Blacktown Hospital between 19 - 28 May 2020, the records show that on 23 May 2020, an occupational therapist from the hospital contacted SVCH and the following note was made, "*inmate needs a walking frame and over toilet seat. OT advises that inmate will not be able to cope without these items. NUM (*nurse unit manager*) emailed"*.

131 Dr Tattersall noted Mr Bickerstaff mobilising independently on 3 June 2020 and noted "*pt does not believe needs a 4ww to mobilise, given no hx of falls in correctional centre and having observed his mobility I would agree not required at this stage*". However, by 10 August 2020, Dr Tattersall was clearly aware that Mr Bickerstaff had mobility issues as he wrote the following note: "*Patient brought into room in wheelchair. Has difficulty mobilising with pain*"

132 Despite the original assessment and Dr Tattersall's note of 10 August, nothing had happened in relation to providing Mr Bickerstaff with a walking fame as at 31 August 2020 when Ms Pedersen wrote to Katya Issa or by 7 October 2020 when Ms Pedersen sent Ms Issa a follow up email. Ms Pedersen then emailed Governor Paul Baker on 17 October requesting a walking frame.

133 On 22 October 2020 Ms Issa, advised Ms Pedersen she could deliver a walking frame for Mr Bickerstaff, and the frame was delivered by Ms Pedersen to Parklea the next day.

134 The delay was not adequately explained in the evidence.

135 Mr Bickerstaff suffered a significant injury to his back in November 2019 when he fell whilst exiting an escort van. He was prescribed Panadol Osteo shortly after the incident but pain persisted and on 26 December 2019 he filled in a self-referral request for physiotherapy treatment, however Mr Bickerstaff did not receive physiotherapy until 17 March 2020 following a decision by Doctors Tattersall and Canessa to refer Mr Bickerstaff to a physiotherapist to assess if Mr Bickerstaff could be referred to a prison which catered better for someone of his age.

136 In the intervening period Mr Bickerstaff's self-referral request had not been addressed or advanced. The document itself had been marked "referred to GP waitlist". Dr Tattersall gave evidence that at that time an entry in the GP waitlist had "no value" due to the large number of acute presentations. Doctor's evidence was that the waitlist could have 300- 400 appointments listed on it and "*you would never have time to get to anyone on that list"*, and further anyone added to the waitlist "*would effectively vanish because who's going to see them, nobody".*

137 Whilst Ms Issa insisted the waitlist was the appropriate procedure used throughout the prison system the fact is the waitlist was ineffective in this instance. I am satisfied that there were insufficient GP services for the number of inmate patients to enable timely attention to the GP waitlist.

138 There were also issues around Mr Bickerstaff having his pacemaker checked annually. On 16 December 2019 Mr Bickerstaff filled in a self-referral request form wherein he stated his annual pacemaker check was overdue.

139 As matters transpired the pacemaker was checked on 16 January 2020 when Mr Bickerstaff was hospitalised.

140 Whilst Dr Tattersall indicated he assumed that a check would have taken place at some stage whilst Mr Bickerstaff was under the care of cardiologists he did not know whether or not the check had taken place and consequently it was never communicated to Mr Bickerstaff that his pacemaker had been checked.

141 On the evidence there was no system to follow through on the pacemaker check request Mr Bickerstaff had completed. Ms Issa gave evidence that there is now a system in place to ensure annual pacemaker checks occur.

Issue 2(f) Whether Dr Mark Tattersall had available to him appropriate supervision, support and clinical oversight, with respect to his management of physical health conditions affecting inmates at Parklea Correctional Centre noting that between August 2019 and January 2021 he was not a general practitioner (nor a specialist in any other medical discipline) and his direct supervisor was a psychiatrist.

142 At inquest the focus in relation to this issue was upon the supervision of Dr Tattersall in relation to his cardiac care of Mr Bickerstaff.

143 Associate Professor Adams stated that he did not expect Doctor Tattersall or his direct medical supervisors to provide tertiary level cardiac care, and rather he would expect Dr Tattersall to escalate cardiac care to other providers such as Blacktown Hospital when required. I am satisfied Dr Tattersall appropriately escalated Mr Bickerstaff's cardiac care at all times other than in the period December 2020 to January 2021 to which I shall turn shortly.

144 Dr Tattersall referred Mr Bickerstaff to Blacktown hospital appropriately and kept in sufficient contact with Blacktown Hospital's cardiologists up until December 2020.

145 For example, on 9 June 2020, Dr Tattersall wrote to the Cardiology Team at Westmead Hospital requesting a review of Mr Bickerstaff in light of his May 2020 admission to Blacktown Hospital. He noted that Mr Bickerstaff "*has remained compliant with medications and fluid restrictions under threat of a dry cell*".

146 As set out above Mr Bickerstaff returned to Blacktown Hospital on 8 July 2020 when an echocardiogram was conducted.

147 Whilst cardiologists at St Vincent's were available to be contacted Dr Tattersall indicated his preference was to deal with the Blacktown Hospital cardiology team given they were treating Mr Bickerstaff. I am satisfied this was an appropriate approach.

148 Dr Tattersall's supervision <u>as a GP</u> was not closely considered in this inquest. His direct supervisor, Dr Canessa was not called to give evidence. It is noted Dr Canessa is a psychiatrist, with no GP training. Dr Wilson indicated she was concerned about the level of support given to Dr Tattersall.

149 Dr Wilson was also concerned about the long hours Dr Tattersall was working. While she noted Dr Tattersall was an older medical graduate who seemed very sensible, he was not an experienced general practitioner, was also travelling long distances and was on call for extended

periods of time. Dr Tattersall was concerned about the potential for fatigue and noted that extensive on-call hours meant little down time and indicated it was stressful emotionally and psychologically. Dr Wilson said the organisation had a responsibility as "*fatigue effects people's ability to make good decisions, and that's my concern".*

150 It is clear St Vincent's was aware of the long hours Dr Tattersall was working and the time he spent on-call and that they shared the concerns raised by Dr Wilson. Ms Issa said steps taken to address the concerns included:

(1) Encouraging Dr Tattersall to take leave on two separate occasions;

(2) Attempting to employ more GPs; and

(3) When additional emergency doctors were employed, Dr Tattersall's on-call hours were reduced, including the Thursday and Friday on-call duties no longer being his responsibility.

151 I am satisfied, that between August 2019 and January 2021, during Mr Bickerstaff's time at Parklea, Dr Tattersall worked excessive hours in that he was either working or on call at all times. While it may have been the case that Dr Tattersall chose to work long hours for his own reasons, the onus was on St Vincent's to ensure the hours he worked were sustainable and unlikely to cause fatigue. Even accepting there were a particular set of circumstances that gave rise to Dr Tattersall being the only GP employed at SVCH for a period of time, those circumstances do not justify the excessive hours he was working.

152 Doctor Tattersall worked excessive hours because St Vincent's were unable to employ sufficient, or indeed, any other GPs for substantial periods of time. Some issues that were a direct result of this and impacted directly on the care delivered to Mr Bickerstaff were the inability to see all the inmate patients who needed to be seen, whether or not they were listed on the GP waitlist, and the lack of timely and appropriate review of nursing notes.

2 December 2020- 15 January 2021

153 As set out above Mr Bickerstaff was not seen by a GP or any other Doctor between 2 December 2020 and 15 January 2021. In addition, whilst nurses would have attended upon Mr Bickerstaff when administering his medication <u>not one entry appears in the medical records records between 5 December</u>, when Dr Tattersall made his retrospective entry regarding Dec 2, <u>and 15 January 2021</u>.

154 By way of comparison Mr Bickerstaff had been seen on 3,5,11,19,25,26 November and 1, 2 December 2020, whilst in the clinic, and entries were made in the clinical notes relating to attendances on each of those days.

155 When Mr Bickerstaff was cleared for group cell placement on 2 December 2020 the health problem notification form (HPNF) included the following "*allow access to medical team for daily weight checks*" (emphasis added). The HPNF was available to both correctional officers and nursing staff, indeed it was completed by nursing staff, and yet not one nursing note and not one entry regarding his weight was made in that period.

156 Not only was his weight not taken but there is nothing to indicate there was any assessment of Mr Bickerstaff's oedema, his blood pressure or any other observation provided for on the SAGO charts. There was no notation as to whether Mr Bickerstaff was suffering shortness of breath. In that same period medications including frusemide and spironolactone were not administered on December 1,2,4,5,24,30 or January 2,4,5,10,12 or 13.

157 There is no record of Mr Bickerstaff's weight being taken at all in that period. On the days in that period when medications were administered nurses who attended upon Mr Bickerstaff failed to record any observations at all, including any record of Mr Bickerstaff's weight. Dr Tattersall's note requiring Mr Bickerstaff's weight be kept below 95kgs had been paid no regard.

158 The very purpose of clinical notes is to inform other clinicians what is required in relation to the particular patient.

159 Not only did nurses fail to follow what Dr Tattersall required be done, there was no evidence to suggest there was any oversight of delivery of nursing services by any NUM or senior nurse and nothing to suggest there was any auditing of what was occurring or more accurately not occurring.

160 As set out above at [61] Mr Bickerstaff presented to the clinic on 16 January 2021 with complaints of "*shivering, dizziness, hardly walking due to oedema in bilateral lateral legs*". He weighed 100kg.

161 Dr Wilson's evidence is pertinent:

> *I was puzzled by that (absence of notes indicating attendances) …..This is an elderly man with multiple chronic illnesses who'd had multiple hospital admissions. It seemed very odd that there was, there was nothing"*. She agreed that she would have expected there to be regular checks given Mr Bickerstaff's previous hospital admissions and his general health at the time. She then reiterated her concerns by stating, "*it puzzled me that in that, you know, more than a month period over the Christmas period that there was there was nothing for an elderly man with significant illness who'd been very unwell*."

162 Dr Tattersalls evidence was "it was as if Mr Bickerstaff had vanished".

163 Dr Wilson's comments on the potential impact of the lack of appropriate care were:

We don't know, but if he had started to deteriorate some days or weeks before, if he had been seen, if there'd been an assessment and in the elderly, it's important to look at those non-specific markers, so it might be that somebody is just not able to walk around as easily, is a bit more confused, is not eating, is, you know, that they're not able to get themselves out of the chair. They're much less specific, and they're really important in the elderly. And certainly, in the elderly, they really are at risk of infection, they are really at risk of multi organ failure and of dying as a result. So, we don't know what happened in that time, but potentially, if there had been observation and if it became clear that he was deteriorating, then he could have been admitted earlier and potentially, the outcome may have been different. I mean, I you know, I think he was I mean, he was elderly, he had multiple chronic illnesses, he had a limited lifespan, you know, so I can't say with any certainty, but potentially, he might have lived some months, potentially years, longer.

164 Professor Adams said it was quite possible, that the failure to provide Mr Bickerstaff Frusemide and Spironolactone in the lead up to Mr Bickarstaff's hospitalisation on 16 January 2021, contributed to the deterioration in his health.

165 On 16 January 2021 at approximately 8:44pm, Mr Bickerstaff was admitted to Blacktown Hospital. The clinical impression was noted to be "*sepsis with an unclear source, neutropenic and acute kidney injury on chronic kidney disease".*

166 An ICU nursing note at 2:22am noted that Mr Bickerstaff was grossly oedematous on lower limbs and scrotal area, as well as having a temperature of 35.6 degrees.

167 The failure to record even one clinical observation of Mr Bickerstaff in the December 2-January 15 period is inexplicable and represents a gross failure in the provision of medical care to Mr Bickerstaff.

Overall assessment of care provided

Issue 2(a) Whether appropriate actions were taken to properly manage Mr Bickerstaff's pre-existing health issues while he was in custody considering the fact that Mr Bickerstaff's manner of death arose as a result of his pre-existing health issues.

168 Issue 2(a) draws attention to the overall care of Mr Bickerstaff.

169 It is helpful to summarise the failings identified above.

Weight Control

170 On a number of occasions nursing staff failed to follow Dr Tattersall's direction that there be daily weigh-ins. Most notably Mr Bickerstaff's weight was not recorded once between 2 December 2020 and 15 January 2021.

171 Dr Tattersall's further requirement that Mr Bickerstaff's weight be below 95kgs was ignored in the 2 December 2020 to 15 January 2021 period.

Medication

172 The flawed record keeping in relation to the medication completely undermined the very purpose of the pharmacy medication sheet and the medication charts.

173 In addition to the failures in relation to the record keeping, I am satisfied Mr Bickerstaff was not provided with medication on multiple dates, including a failure to provide him with Frusemide and Spironolactone, which were essential for preventing him becoming oedematous and putting on weight.

Personal items

174 The delays in relation to delivering Mr Bickerstaff's personal items and physiotherapy were inexplicable. They were suggestive of a lack of care for a very unwell, elderly inmate patient. I doubt the items would have been delivered at all without the perseverance of Ms Pedersen.

175 Additionally, there was no system to follow through on a check of Mr Bickerstaff's pacemaker.

2 December 2020 to 15 January 2021

176 As set out in detail above, the lack of provision of care in this period represented a gross failure.

177 I have no doubt that the failure to provide medication during this period exacerbated Mr Bickerstaff's conditions.

Dr Tattersall

178 Dr Tattersall was clearly overworked, had far too many patients to attend to and could not meet all their needs. Dr Wilson also observed that fatigue affects people's capacity to make good decisions.

179 Dr Tattersall worked excessive hours. He was either working or on call at all times. This made him likely to make mistakes and, I find, impacted directly on the care delivered to Mr Bickerstaff

in that Mr Bickerstaff was not attended upon as regularly as he should have been and in particular was not seen at all between 2 December 2020 and 15 January 2021.

Nursing failures and errors

180 In the inquest no individual nurses gave evidence and as such there was no evidence as to what happened on any particular shift nor any first-hand explanation as to why basic errors repeatedly occurred.

181 Ms Issa did however address the issues in general terms. She indicated that there has been a very high turnover of staff since the 2019 to early 2021 period. Ms Issa indicated that many of the staff who worked for St Vincent's in that period had been staff who had previously worked at Parklea with Justice Health. Many of these staff members had since moved on. The current nursing staff (as at the time of inquest) had all applied to work at Parklea with St Vincent's. The suggestion inherent in this evidence was that they had a positive attitude to the prospect of working in that challenging environment.

182 Ms Issa also gave evidence of a St Vincent's initiative in joining with the Australian Catholic University (ACU) to provide postgraduate study in Correctional Centre Nursing. Furthermore, the St Vincent's network generously provided a number of scholarships to selected nurses.

183 The overall effect of Ms Issa's evidence in relation to nursing staff is that the current nursing staff are very committed and well trained.

184 The steps taken by St Vincents are to be respected however, as I have said above, the requirement was that appropriate nursing services be provided from day one and this demonstrably did not occur, not just at the start of Mr Bickerstaff's time in custody but it extended right up until his last day in custody.

Cause of death and end of life care

185 Mr Bickerstaff was admitted to the ICU at 12:29am on 17 January 2021. The treatment plan was to manage him with invasive monitoring, vasopressors, antibiotics, oxygen therapy and other ICU supportive care. Mr Bickerstaff was grossly oedematous on his lower limbs and scrotal area.

186 Mr Bickerstaff's family were unsure if interventions were in his best interests and asked if he could be palliated.

187 On 18 January 2021, at 9:35am during morning rounds, Mr Bickerstaff declined ongoing treatment, wanted to say goodbye to his family and expressed that he wanted to be comfortable.

Accordingly, a plan was recorded for comfort measures to be implemented and for contact to be made with Parklea to confirm the situation.

188 At 9:29pm, a call was received in ICU from Parklea advising that "all medication was to keep running". A short time later a nurse made a note of a further phone call, wherein it had been conveyed to the nurse that Parklea were, "*unaware if the decision to withdraw treatment overnight will be construed as an unnatural death in custody and they may require legal input for this".*

189 It was further noted that it was accepted that Mr Bickerstaff had agreed that he was not for CPR or intubation, but his current management was to continue. It was stated that as far as Parklea was concerned the patient could not make end of life decisions for himself whilst he was under custody.

190 Another clinical entry recorded another discussion between ICU staff and a Parklea representative, reiterating that Mr Bickerstaff had "*no authority to decide about end of life decisions/withdrawal of care while he was still under the jail (sic) custody*.

191 This approach on behalf of Parklea was completely wrong.

192 The hospital obtained separate legal advice and the advice it was given was that patient autonomy remained valid despite him being in custody.

193 Subsequently, Parklea indicated it had received advice that it was not within their power to make decisions to continue treatment and that the end-of-life pathway should be followed.

194 At 12:03pm on 20 January 2021 Mr Bickerstaff was found to be in Pulseless Electrical Activity arrest with no heartbeat heard, no spontaneous breathing noted, no breath sounds heard and pupils fixed and dilated. He was declared deceased.

195 The intervention of Parklea caused great distress to Mr Bickerstaff's family. It was, to say the least, most unfortunate that Parklea intervened in this way.

196 At inquest the evidence was that it was well known to MTC that the inmate patient retained autonomy to make end of life decisions so long as he was sound of mind.

197 It is to be hoped that such an ill-based intervention as occurred in Mr Bickerstaff's case is never repeated.

198 There was no dispute at inquest that the cause of Mr Bickerstaff's death was multiple organ failure, with antecedent causes of death being Group G streptococcus sepsis and exacerbation of congestive cardiac failure

Manner of death

199 Whilst Mr Bickerstaff's death was due to natural causes it is important to record that Mr Bickerstaff's entry to hospital occurred after the failings identified during the period 2 December 2020 to15 January 2021. There can be no doubt that Mr Bickerstaff's chances of survival were reduced by the lack of appropriate medical care during that period.

Whether any recommendations are required pursuant to s 82 of the Coroners Act

Issue 3 Whether any recommendations are necessary or desirable arising from any matter connected to Mr Bickerstaff's death pursuant to s 82 of the Act.

200 In assessing whether to make any recommendations it is fundamental to consider improvements made between the date of Mr Bickerstaff's death and the Inquest.

201 Ms Issa gave evidence of a number of improvements. There is now a system for pacemaker checks. In relation to GP services, further GPs have been employed when possible and emergency Doctors from St Vincents have assisted when required.

202 Carolina Basaly was employed as a senior pharmacist at PCC between 27 November 2020 – 23 June 2021. She agreed that there was a deficiency in the medication administration process in 2021 as there were a multiplicity of documents, namely a medication chart, unsupervised medication signing sheet and supervised signing sheet and this led to occasional errors being made. In other evidence it was suggested the system had improved with the transition to the electronic system by May 2024.

203 Ms Issa advised of the recruitment of specialty positions including a clinical nurse educator to provide clinical supervision and education for staff, to ensure understanding of the "*right person right medication, right time, every single time"* approach. There was also recruitment of a clinical practice nurse, to improve the clinical practice of SVCH's workforce.

204 Ms Issa also gave evidence of, reporting requirements in relation to, and audits of, the documentation, prescription and administration of medication.

205 A health delegate committee was established whereby Saint Vincent's staff met with their patients once a month to seek feedback. This was complemented by an animation video for the patients which set out their rights in terms of how to make a complaint and how to provide feedback. The aim of this was to help make staff accountable for their patients' experience of care.

206 Against that background of improvements made by St Vincents, counsel assisting proposed three recommendations. There was no resistance by any party to the recommendations being made. In those circumstances, I accept the following recommendations, as proposed by counsel assisting:

(1) That St Vincent's Correctional Health, in consultation with MTC, Justice Health and Forensic Mental Health Network, and Corrective Services New South Wales, explore options for real-time documentation of medication administration and / or supply in the Electronic Medication Administration Record.

(2) That MTC ensures that the Parklea Correctional Centre Governor, Deputy Governor and persons who may from time-to-time act in such positions, are made aware and reminded, that inmates (who are mentally capable) maintain, at all times, patient autonomy and decision-making in respect of any end-of-life medical care or palliative care decisions.

(3) That consideration is given by Corrective Services New South Wales to include in the Custodial Operations Policy and Procedure (COPP) set out at 6.13: End of Life Care for Inmates a clear statement that mentally capable inmates, maintain at all times, patient autonomy and decision-making in respect of any end-of-life medical care or palliative care decisions.

FINDINGS

207 For all the above reasons I make the following findings:

Identity: The person who died was Robert Bickerstaff.

Date of death: Mr Bickerstaff died on 20 January 2021.

Place of death: Mr Bickerstaff died at Blacktown Hospital, Blacktown Road, NSW

Cause of death: The direct cause of Mr Bickerstaff's death was due to multiple organ failure, with antecedent causes of death being Group G streptococcus sepsis and exacerbation of congestive cardiac failure.

Manner of death: Whilst Mr Bickerstaff ultimately died from natural causes his death occurred in circumstances where he, as a significantly unwell 88 year old inmate patient, was not seen by any general practitioner and was not appropriately medicated, nor was his weight appropriately checked during the period 2 December 2020 to 15 January 2021, leading to his admission to hospital on 16 January 2021 and death on 20 January 2021.

CLOSING

208 I acknowledge and express my gratitude to Mr Wong of counsel and Mr Tanazefti for their much valued assistance in this inquest. I also thank the Officer-in-Charge of the investigation, Detective Senior Constable Adam Brown for his work in putting together the comprehensive brief.

209 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to the family of Mr Bickerstaff and thank Sue Pedersen for her attendance at and participation in the hearing.

210 I close this inquest.

Judge David O'Neil

Deputy State Coroner

Coroners Court of New South Wales

24 APRIL 2026