STATE CORONERS COURT OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dushyanthan Visvanathan
Hearing Dates:	29, 30, 31 July 2024; 1 August 2024
Date of Findings:	5 September 2025
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 - alcohol withdrawal - inadequate information - level of care provided
File Number:	2019/00302386
Representation;	Counsel Assisting the Coroner: K Holcombe of Counsel instructed by Ms C Hill of the Crown Sollcitor's Office [redacted]H Dean, Trial Advocate instructed by Ms S Webb of Legal Aid NSW The Commissioner of Corrective Services NSW: K McKinlay, Solicitor Advocate instructed by Ms R Gonzalez of Department of Communities and Justice, Legal. Registered Nurses Natalie Boorer, Jilane Sarjeant and Alice Mhonda: Benjamin Thompson, Legal Officer, Nurses and Midwives' Association Justice Health and the Forensic Mental Health Network

(Justice Health): J Harris of Counsel instructed by Kate Hinchcliffe of Makinson d'Apice Lawyers

Findings:

Identity:

The person who died was Dushyanthan Visvanathan.

Date of death:

Mr Visvanathan died between 3:08am and 6:21am on 26 September 2019.

Place of death:

Mr Visvanathan died in cell 52 of Darcy Unit at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales.

Cause of death:

Complications of alcohol use disorder.

Manner of death:

Mr Visvanathan died of natural causes.

Recommendations:

To Justice Health and Forensic Mental Health Network

1. That the drug and alcohol substance withdrawal monitoring form used by Justice Health be amended to incorporate, firstly, guidance regarding the frequency of observations recommended for patients in alcohol withdrawal, and secondly, a field which can be used by practitioners to indicate the plan for the frequency of observations for the patient.

2. That consideration be given to sending out or publishing a short communication to Justice Health staff which emphasises the importance of proper ventilation during CPR.

3. Consideration be given to seeking an allocation of funding from the Ministry of Health, for the staffing of

drug and alcohol remote offsite and after-hours medical service shifts until 11pm with an on-call service to continue to be provided from 11pm onwards.

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.

Introduction

1 Mr Dushyanthan Visvanathan (Dushy) died at the Metropolitan Remand and Reception Centre (MRRC) at Silverwater on 26 September 2019.

2 Because Dushy died while in custody, an inquest is 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.

The Coroner's role

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

5 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.

6 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.

7 Prior to holding an inquest a detailed coronial investigation is undertaken. Detective Senior Constable Tim Marshall, the officer in charge of the initial

coronial investigation (OIC) 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 as well as other material.

8 During the coronial investigation relevant policy documents and a Serious Incident Report undertaken by a senior investigator from the Corrective Services' Investigation Branch were also obtained

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

10 The following agencies and individuals were identified as having a sufficient interest in the proceedings, received notification and were represented:

(1) [redacted]

(2) The Commissioner of Corrective Services NSW

(3) Justice Health and the Forensic Mental Health Network

(4) Registered Nurse Natalie Boorer, Jilane Sarjeant and Alice Mhonda

(5) Registered Nurses Natalie Boorer, Jilane Sarjeant and Alice Mhonda

Witnesses

11 The following witnesses gave evidence at the hearing:

a. Registered Nurse, Natalie Boorer

b. Registered Nurse, Jilane Sarjeant

c. Registered Nurse, Alice Mhonda

d. Correctional Officer Amanda Bezzina

e. Dr Katerina Lagios, Clinical Director Population Health and Co-Clinical Director Drug and Alcohol, Justice Health and Forensic Mental Health Network

f. Professor Paul Haber, Specialist in Addiction Medicine, Gastroenterology and Hepatology

g. Professor Anthony Brown, Senior Staff Specialist in Emergency Medicine

h. Dr Judith Meldrum, Remote Offsite Afterhours Medical Services (ROAMS) Drug and Alcohol doctor.

Issues

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

13 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:

i. Did Mr Visvanathan receive appropriate and adequate care on the night of 25/26 September 2019 given his recognised likelihood for alcohol withdrawal? In particular:

a. Was Mr Visvanathan appropriately monitored at the Metropolitan Remand and Reception Centre (MRRC) or should he have been transferred to Hospital?

b. Were the observations of Mr Visvanathan by Justice Health staff:

i. sufficiently frequent

ii. adequately recorded in his medical records

iii. adequately performed

c. Did Mr Visvanathan receive adequate doses of diazepam throughout the evening?

ii. Was the emergency response to Mr Visvanathan appropriate, timely and in accordance with relevant policies, procedures and practices?

Factual Background

14 Dushy was a much-loved husband and father of three. He was born in Sri Lanka on the 3rd of October 1963. Dushy was 55 years old when he died.

15 Dushy had worked in the banking industry with significant success. He was a charismatic, friendly, gregarious and respected man as was revealed when a video was shown to the inquest on behalf of his wife [redacted]

16 Dushy struggled with alcohol addiction for a number of years leading up to his death. His problems with alcohol became worse after Dushy lost his job in 2015.

17 Between February and June 2019 Dushy presented to Hospital on four occasions for health issues related to intoxication. Dushy's presentations included suicidal ideations while intoxicated, falling over while intoxicated and an associated subdural haemorrhage.

18 In May 2019 Dushy was charged with the driving offence for which he was ultimately incarcerated. On 18 June 2019 Dushy was admitted to Westmead Hospital for gastrointestinal bleeding secondary to alcohol use and he was referred to the Westmead centre for addiction medicine. On 19 August 2019 Dushy was brought to the emergency department by police after being found intoxicated and suicidal in a public place. During this admission he had a witnessed alcohol withdrawal seizure and was admitted until 27 August. Dushy missed a follow up appointment on 2 September but attended on 9 September in

a state of intoxication. Dushy was sent away and was provided with a further follow up appointment date, however he did not attend.

19 On 25 September 2019 Dushy was sentenced to 12 months imprisonment at Parramatta Local Court.

20 When Dushy was sentenced, the sentence warrant had noted upon it "Justice Health are to monitor and supervise the offender as he will likely (sic) to withdraw from alcohol."

21 In the cells at Parramatta Local Court Dushy was seen by an interviewing officer who completed a "new inmate lodgement and special instruction sheet". The interviewing officer noted on that sheet "accommodation-mental health/disability" as an immediate temporary management or placement issue. He also wrote on the sheet "inmate withdrawing from alcohol".

MRRC-Factual Background

22 Dushy was transported from the cells at Parramatta Local Court to the Metropolitan Remand and Reception Centre at Silverwater (MRRC) arriving at 5:36pm. At MRRC Dushy was interviewed by a services and programmes officer (SAPO). The SAPO was an employee of Corrective Services NSW (CSNSW). That interview was completed by 7.13pm. In that interview it was identified that Dushy suffered from depression and anxiety and that he consumed alcohol to help with his depression. The SAPO had available to her the documents that the interviewing officer had completed at the Parramatta cells.

23 At 7:54pm Registered Nurse (RN) Boorer commenced a reception screening assessment (RSA) of Dushy. In that assessment it was noted that Dushy had been suffering from hypertension for about 10 years, had suffered a subdural brain haemorrhage three to four months prior, had a blood pressure reading of 190/100 and that he used alcohol daily. Dushy's weight was 45 kilograms and his BMI was 17. Both the weight and BMI readings were outside the normal range. During the assessment Dushy had incorrectly indicated that he had never suffered from a withdrawal related seizure.

24 Despite recording that Dushy had suffered a subdural brain haemorrhage three to four months prior, Registered Nurse Boorer also entered that Dushy had not been to Hospital in the last six months.

25 RN Boorer conducted an alcohol withdrawal scale (AWS) assessment and recorded a score of "2" for Dushy. In accordance with applicable policy, RN Boorer then contacted a remote offsite after-hours medical services (ROAMS) general practitioner and separately a ROAMS drug and alcohol (D&A) medical officer, being Dr Meldrum. The form on which the AWS was recorded, set out at its foot the steps to take dependent on the determined score. As Dushy's withdrawal score fell in the mild category (1-4) the requirement of RN Boorer was to "contact medical officer/nurse practitioner regarding frequency of monitoring required".

26 It was RN Boorer's responsibility to record in the clinical notes the advice of Dr Meldrum, including the advice in relation to frequency of observations. RN Boorer failed to make any such record.

27 RN Boorer who had called the ROAMS general practitioner in order to request a script for medication to treat Dushy's hypertension made appropriate notes of that conversation, noting that the GP indicated there was to be "vital signs review overnight". There was also appropriate notation in the clinical notes that Dr Meldrum had prescribed 10 milligrams of diazepam to be taken forthwith together with a thiamine regime. Diazepam is prescribed to help prevent seizures and reduce blood pressure. It was accepted by all clinicians that seizures could occur during withdrawal from alcohol. It was accepted at inquest that the prescription of 10 milligrams of Diazepam, whilst a moderate dose, was appropriate ***(issue 1(c))***.

28 RN Boorer's clinical note indicated that Dr Meldrum had directed placement (of Dushy) in a *medical obsetvation* cell. RN Boorer queried in the note whether Dushy was understating his alcohol use. However, as indicated above, there was no note about the frequency of monitoring to be undertaken, despite that being the very issue identified in the guidance material at the foot of the AWS.

29 Dr Meldrum gave evidence that her usual practice was to recommend four hourly "observations" for patients in circumstances identical or similar to Dushy's situation. "Observations" referred to taking a set of medical or vital sign observations which were then entered on the standard adult general observations (SAGO) chart.

30 **RN** Boorer completed a Health Problem Notification Form (HPNF). One purpose of the HPNF is to inform Corrective Services NSW that the inmate has been assessed and to provide relevant information to correctional officers. Under the heading "signs/symptoms to look for in the inmate" the following appears on the form:

> *CSNSW officers please monitor the inmate for the following signs and report any observations of these to JH&FHMN staff* so *that they can address the health* issue.

There is then provision for recording the signs and symptoms to look for. RN Boorer listed the following signs and symptoms:

> *first custody, MH* issues, *guarantees safety denies thoughts of DSH/suicide, AOD* Use--- *in withdrawal, may have seizures, high blood pressure, health cat 1.*

31 Another purpose of the HPNF is to make a recommendation to Corrective Services NSW as to cell placement. The relevant policy in September 2019 was titled *"Accommodation - Clinical Recommendations (Adults)"* policy number 1.340. The listed placement options were:

> *normal cell placement, ground floor placement, shared or group cell placement, one out cell placement,* assessment *cells and camera cells, medical placement, detoxification placement, risk intervention team cell placement.*

32 The advice under the heading "detoxification placement" was that:

Patients experiencing acute substance withdrawal, or who are expected to develop substance use withdrawal symptoms or who are intoxicated must be considered for placement either in a *Camera Cell, Assessment Cell or* a *Clinical Observation bed, depending on resources at the Centre. Placement facilitates increased access by health staff where there is* a *need to monitor the overall health status of the patient. Clinical need and judgement will determine how often the patient will require reviewing. However, twice daily must be the minimum. These reviews must be documented in the patient's health record and on the standard adult general observation chart ... Clinical staff must specify on the JH&FMHN Health Problem Notification form (Adults) JUS005. 001 whether the patient needs* a *Camera Cell, Assessment Cell or* a *Clinical Observation bed and what observations are needed.*

33 Under the heading *"Shared or Group cell placemenf'* reference was made to patients who may not be able to use the cell call button (knock-up) system due to a number of conditions including *substance withdrawal.* If a patient was suffering a seizure he would not be able to make a knock up call.

34 The HPNF policy at appendix 1, referred to "special features" for identified health conditions. For both high blood pressure and alcohol withdrawal "group cell accommodation" was recommended with the alternative of an "assessment cell" being recommended for alcohol withdrawal. Within the policy an assessment cell is defined as follows:

An assessment cell offers fewer opportunities for a *patient to self-harm. All fixtures are recessed and all furniture is fixed to reduce the number of possible hanging points. Each assessment cell is equipped with CCTV and clear panels for observation purposes.*

35 RN Boorer recommended the cell placement as follows:

Medical obs cell in Darcy until cleared by detox, GP/PHCN

36 RN Boorer finished her shift at 10:00pm. At 12:07am RN Sarjeant took Dushy's vital observations and found that his blood pressure had reduced from 190/100 to 163/98. Dushy's heart rate was 106, his temperature 36.6 and his score on the AWS was "1".

37 In addition to the medical or vital observations taken at midnight RN Sarjeant made clear in her evidence that she observed Dushy to be very frail. She observed his very slight frame and noticed him hanging on to the railing as he walked down the stairs from the level where his cell was, to the lower level where she took his observations.

38 In the progress notes, RN Sarjeant wrote:

> *patient looks older then stated age, possibly understating his ETOH intake. Very thin and frail states he does not eat very much, instead drinks. Encouraged to push fluids, for review by detox in AM.*

39 Subsequently RN Sarjeant walked to the door of Dushy's cell at 1:51am and looked through the cell "window".

40 Based on CCTV footage, RN Sarjeant was at the cell window for six seconds. RN Sarjeant's evidence was that during that time she knocked on the cell window and Dushy, who was in his bed, moved his foot in recognition of the knock on the cell window.

41 Such a movement indicated that Dushy was awake. Despite Dushy being awake, RN Sarjeant did not take any medical observations.

42 In evidence, RN Sarjeant described what occurred when she was at the cell door/window as "gross observations" which were in her view compliant with the term "medical observations". I reject this description. The gross observations were not medical observations. Notably, no other clinician in the inquest considered these gross observations to be medical observations.

43 Inmates housed in the cells adjacent to Dushy reported hearing low groaning or moaning and a call for help sometime between 2:00am and 5:00am. Neither of the inmates knocked up to call for assistance. Dushy did not use the knock-up system to call for help at any time.

44 Correctional Officer Bezzina looked into Dushy's cell at 3:08am and observed him to be lying on his bed. Correctional officer Bezzina did not observe anything to be out of order.

45 No further checks of Dushy occurred overnight. At 6.21am when correctional officers were performing their morning head checks, Dushy was discovered unresponsive on the floor. The correctional officers commenced CPR and called for medical assistance. At approximately 6.24am RNs Boorer, Sarjeant and Mhonda attended and took over CPR.

Issue 1(a) Was Mr Visvanathan appropriately monitored at the Metropolitan Remand and Reception Centre or should he have been transferred to Hospital?

46 This sub-issue brings attention to the "monitoring" of Dushy, whereas issue 1(b) focuses upon "observations". At inquest there was some focus upon the inconsistency of language in various Justice Health policies.

47 The words "monitor", "observation", and "review" seemed to be used without always drawing any clear distinction between them.

48 In sub issue 1(a), the word "monitoring" includes watching or observing the patient, assessing the patient and taking what are referred to as medical (or vital) observations which are recorded on a SAGO chart.

49 In relation to whether Dushy should have been sent to Hospital, it was accepted at inquest that Dushy would have been better off in Hospital but the real question was whether he should have been transferred given the information known to medical staff at MRRC.

50 The first person who may have referred Dushy to Hospital was RN Boorer. The relevant information known to RN Boorer at the completion of her reception screening assessment was that Dushy:

(1) had been suffering from hypertension for about 10 years;

(2) had suffered a subdural brain haemorrhage three to four months ago;

(3) had a blood pressure reading of 190/100;

(4) used alcohol daily;

(5) scored 2 on the alcohol withdrawal scale (AWS); and

(6) was at risk of suffering an alcohol withdrawal seizure.

51 Additionally, RN Boorer was of the opinion that Dushy may have been understating his daily consumption of alcohol. RN Boorer did not have available to her any hospital or medical records. As such she was completely dependent upon Dushy's answers as to his medical background. An issue arose at inquest as to why in those circumstances RN Boorer did not speak to a family member in order to get further information. I accept the evidence of RN Boorer and Dr Lagios that the practice at the time was to only contact family members in extremely limited circumstances and none of those circumstances applied to Dushy's situation. The issue of family contact will be further discussed below.

52 The lack of information available meant that RN Boorer and Dr Meldrum did not know that Dushy had suffered a previous alcohol withdrawal seizure, they did not know the true extent of his daily drinking and they did not have any detail as to his prior results when he underwent blood tests.

53 In his written report, Professor Haber was of the view that there were enough clues to suggest that Dushy should have been sent to hospital. However, in evidence he expressed the view that the area was "quite grey". Professor Brown was of the view that Dushy's very slight weight and low BMI may well have been

enough to lead a doctor armed with all the information available to RN Boorer to send Dushy to hospital however he would not expect a nurse to do so.

54 There can be no doubt that Dushy should have been sent to hospital and equally that his chances of survival would have been better in hospital. It is also clear that no blame can be attributed to either RN Boorer or Dr Meldrum for the failure to send Dushy to hospital.

55 The next potential opportunity for Dushy to be transferred to hospital was upon assessment by RN Sarjeant at 12:07am. When RN Sarjeant undertook Dushy's medical observations, Dushy's blood pressure had reduced to 163/98 (from 190/100) and his AWS score reduced to "1". The reduced blood pressure suggested that the diazepam had been effective. No criticism can be levelled at RN Sarjeant for not sending Dushy to hospital based upon the medical observations taken at approximately midnight and the information available to her at that time.

56 In relation to "monitoring", Professor Haber's opinion was that once the risk of seizure was recognised, the patient should have been placed in an appropriate place for continuous clinical observation. Appropriate observation, Professor Haber opined, required a direct and continuous line of sight. I accept that custodial settings cannot replicate hospital settings and that, as Professor Brown pointed out, even in hospital settings it is not always possible to have line of sight observations of every patient overnight.

57 According to RN Boorer's clinical note, when she spoke with Dr Meldrum, the doctor advised that Dushy be placed in a "medical observation cell". Dr Meldrum, who impressed as a truthful witness and caring practitioner (now retired), had never been at MRRC at the time she was giving her advice as a ROAMS *on call* D&A doctor. Whilst acting in that capacity she had responsibility for the entire state.

58 When RN Boorer completed the HPNF she recommended that Dushy be placed in a *"Medical obs cell in Darcy until cleared by detox, GPIPHCN".* The term *medical observation/obs cell* does not appear in policy 1.340 (Accommodation -

Clinical Recommendations (Adults)). The term appears to be a combination of *"medical placemenf"* and *"clinical obsetvation bed".*

59 It was not suggested at inquest that the terminology *"medical obs celf"* was misunderstood by correctional officers or that correctional officers placed Dushy in the wrong cell. However, whatever words were actually used in the discussion between RN Boorer and Dr Meldrum, it is clear that RN Boorer thought that what she described in the HPNF as the *"medical obs cell in Darcy"* was a camera cell.

60 Camera cells enable correctional officers to view inmates via monitors whilst the inmates are in their cells. The applicable policy required RN Boorer to specify that Dushy was to be placed in a "camera cell" and to indicate on the HPNF what type, duration and frequency of observations were required to be made by correctional officers, (via the monitor/s), however she did not do this.

61 Not only was the cell not a camera cell, it was also 100 metres away from the very medical staff who were required to care for Dushy, monitor him and take medical observations of him.

62 The wording of the HPNF prepared by RN Boorer combined with the fact that Dushy was not in a camera cell meant that the only monitoring of Dushy overnight would be by the way of observations conducted by nursing staff. This left correctional officers with no role to play in observing Dushy, despite correctional officers being placed within Darcy unit and Dushy's cell being 100 metres away from nurses who needed to negotiate two security doors and to be accompanied by correctional officers to attend upon Dushy.

63 Dr Katarina Lagios, Clinical Director Population Health and Co-Clinical Director Drug and Alcohol, as part of her considered and helpful evidence, provided an executive statement on behalf of Justice Health and also gave oral evidence. Dr Lagios was of the view that Dushy being placed in a cell 100 metres away from the nurses was *"less than ideal"* and said that it would be preferable for *medical obsetvation cells (as* referred to) to be located closer in proximity to the Justice Health clinic. The Commissioner for Corrective Services shared this view.

64 Before making a final comment on the appropriateness of the monitoring of Dushy I will turn to *Issue 1b,* as it is intimately connected with the monitoring issue.

Issue 1 b. Were the observations of Mr Visvanthan by Justice Health staff:

i. sufficiently frequent?

ii. adequately recorded in his medical records?

iii. adequately performed?

65 The expert evidence was that medical observations should have been performed during the night. However, there were some differences within the expert opinions as to the frequency of the observations. Professor Brown was of the firm view that medical observations could be up to six hours apart. Professor Haber was of the view that the observations should be four hours apart with a "check" in between. It was accepted that if Dushy was asleep at the four-hour mark and there did not appear to be any issues, it would be appropriate to wait a further two hours before conducting medical observations rather than interrupt his sleep to take medical observations.

66 As indicated above, Dr Meldrum's practice was to require four hourly checks. In evidence, Dr Meldrum accepted that if the patient was sleeping at the four-hour mark during the night, further medical observations could be delayed until six hours or "before the end of the shift".

67 Given the location of the cell in which Dushy was placed, the acceptance by all clinicians that there was a risk of Dushy suffering an alcohol withdrawal seizure, the concern of both RN Boorer and RN Sarjeant that Dushy had understated his level of alcohol consumption I prefer the view of Professor Haber that medical observations should have been conducted four hourly with an additional "check" in between.

68 RN Sarjeant's medical observations were taken at about midnight which was approximately four hours after RN Boorer had taken her observations. I find it to be likely that Dr Meldrum indicated that there should be four hourly observations, consistent with her usual approach. This should have been communicated to

RN Sarjeant by RN Boorer. However, given that there was no note made by RN Boorer on this issue and given that RN Sarjeant conducted medical observations at about midnight and gross observations (as I have found them to be) at 1:51am, as was her invariable practice, I am unable to conclude that the need for four hourly medical observations was passed on by RN Boorer to RN Sarjeant.

69 I find that the observations of Dushy by Justice Health staff were not sufficiently frequent. Medical observations should have been performed four hourly with a check in between. If Dushy was observed to be sleeping soundly during the night, then the medical observations could have been delayed until approximately the six-hour mark as long as they were conducted before the end of the night shift. As RN Sarjeant was not going to conduct any medical observations after 2:00am, she could have conducted them at 2:00am, when, on her evidence, Dushy was awake, rather than her inadequate gross observation. The medical observations conducted at 8:00pm by **RN** Boorer and midnight by **RN** Sarjeant were adequately performed and adequately recorded in the medical records.

70 In relation to monitoring by correctional officers, firstly the HPNF should have more accurately indicated what correctional officers were to look for and how frequently they were to check on Dushy. In my view, if Dushy were in a camera cell the ease of access should have allowed for checks every 15-20 minutes. If Dushy were in a non-camera cell one out (as he was) he should have been checked by a correctional officer every hour. Such a check would be of the same nature as the check conducted by Correctional Officer Bezzina at 3:08am.

71 I find that both the monitoring and the medical observations of Dushy were insufficient.

Issue 2 Was the emergency response to Mr Visvanathan appropriate, timely, and in accordance with relevant policies, procedures and practices?

72 After Dushy was sighted by Correctional Officer Bezzina at 3:08am, he was next found at 6:21am face down on the cell floor, not breathing and with no pulse. A "medical response" was called and RNs Sarjeant, Boorer and Mhonda quickly were on the scene and commenced CPR.

73 While compressions were performed adequately, there was an eight-minute delay in the attempt to insert a guedel. A guedel is a rigid plastic tube which sits along the top of the mouth and ends at the base of the tongue. Its purpose is to keep the airway open. The nurses each gave evidence that Dushy's mouth and tongue were swollen making it difficult, and ultimately, not possible, to insert the guedel. The nurses commenced external cardiac compressions immediately and at 6:27am a call was made to "000" for an ambulance.

74 After eight and a half minutes, the nurses accepted the guedel could not be inserted. An oxygen mask was applied. However, for two and a half minutes, the mask was inadequately sealed. This left Dushy without adequate ventilation for over 11 minutes.

75 At 6.47am, ambulance officers attended to take over Dushy's care. Despite their continued efforts Dushy did not become responsive and at 7:21am he was declared deceased.

76 The ambulance officers had been delayed for a period as they sought to enter the correctional centre, due to two trucks being in the airlock prior to it being freed up for two ambulances to be provided access.

77 Whilst there were delays on this occasion, I am satisfied that the relevant Custody Operations Policy and Procedure (COPP) 13.2 is appropriate and provides for the immediate access of ambulances, when safe to do so.

78 Professor Brown was critical of the delays in providing ventilation to Dushy and the ineffective way in which the oxygen mask was initially applied to Dushy.

79 Each of the nurses who performed CPR on Dushy that morning accepted that the 11-minute delay whilst attempting to achieve an open airway and deliver ventilation was not good enough.

80 Professor Brown was clear in his evidence that the delay in providing ventilation did not cause or contribute to Dushy's death. Professor Brown's evidence was that Dushy was at very high risk of sudden death and his chance of surviving a

sudden cardiac event depended on his collapse being witnessed, him having a shockable rhythm and there being a spontaneous circulation return within 12 minutes. Professor Brown explained in his evidence that Dushy did not have any of these factors and therefore Dushy's chance of survival was negligible.

Cause of death

81 As set out above Dushy was seen in his cell at 3:08am, sleeping, and was found unresponsive at 6:21am.

82 An autopsy was conducted upon Dushy on the 1st of October 2019 by Dr Thompson. Toxicological analysis found beta hydroxybutyrate in Dushy's blood in femoral and heart serum at severely elevated levels, indicating Dushy was suffering from alcoholic ketoacidosis which is a potentially lethal condition which can lead to death by cardiac failure.

83 Examination of the heart revealed thickening of the left ventricular wall and moderate narrowing of the left anterior descending and right coronary arteries. There was also thickening of muscular tissue, which can impair electrical conductivity in the heart and predispose a person to a fatal arrhythmia.

84 Dr Thompson concluded that the cause of death is best described as "complications of chronic alcoholism".

85 At inquest the experts agreed that Dushy's death was a sudden cardiac death. As Dushy's collapse was not witnessed and it was not possible to determine at autopsy whether the cause of Dushy's cardiac arrest was a withdrawal seizure, electrolyte-related or alcoholic ketoacidosis-related, the appropriate finding is that the cause of death was "complications of alcohol use disorder".

Further issues

86 A number of issues arose during the inquest which are worthy of consideration and comment.

Failings by nurses to comply with policy ---missed opportunities---inappropriate---inadequate provision of care

87 The evidence revealed a number of areas in which the actions of the nursing staff were outside Justice Health policies and/or inappropriate and/or inadequate ("failings")

88 A number of aspects of the nurses' failings have been identified above. I will now comment further on particular areas of concern.

The Reception Screening Assessment

89 RN Boorer should have inquired further when Dushy indicated he had not been to hospital in the last six months. It is difficult to understand how an experienced nurse conducting an RSA would not immediately know that the answer provided could not reasonably sit together with the separate answer that Dushy had suffered a subdural haemorrhage within the last three to four months. This was a missed opportunity. It will never be known what additional information may have been gleaned from further questioning of Dushy in relation to hospitalisation.

The failure to record the frequency of medical obse,vations overnight

90 It was suggested on behalf of Justice Health that I could not be satisfied that Dr Meldrum did indicate the frequency of observations overnight. It is no answer to the failure of RN Boorer to record the required frequency to suggest the fault lay with Dr Meldrum. Firstly, I have indicated I am satisfied with the evidence of Dr Meldrum as to her practice and find on balance that she directed that there be four hourly observations. Secondly, the AWS document indicated clearly at its foot that the very purpose of the call to the ROAMS Doctor was to establish the frequency of observations. Thirdly, both RN Boorer and RN Sarjeant had a responsibility to make sure that they knew what direction or guidance had been given about the frequency of monitoring overnight. The obligation upon RN Boorer in this regard is obvious. In relation to RN Sarjeant, she had the clinical notes prepared by RN Boorer which indicated an AWS of "2" and she conducted her own AWS resulting in a score of "1" which required her to discuss with the

ROAMS D&A Doctor the frequency of observations if that frequency was not already known to her.

The failure to correctly complete the HPNF

91 As set out above there were a number of significant failings in relation to the manner in which RN Boorer completed the HPNF. Some of the detail of those failings is set out above. In addition to those failings, RN Boorer failed to use appropriate terminology in relation to the signs and symptoms correctional officers should look for when they were observing Dushy, when she recorded in the HPNF *"first custody, MH issues, guarantees safety denies thoughts of DSH/suicide, AOD use -- in withdrawal, may have seizures, high blood pressure, health cat 1*".

92 It is of note that, despite the standard form HPNF directing attention to Appendix 1 of Policy 1.231, which contains a list of signs and symptoms under identified conditions and further invites lay terms and clear language, RN Boorer failed to follow any of this guidance material. The listed signs and symptoms to look for in relation to alcohol withdrawal *are "anxiety, agitation, sweating, tremor, vomiting, stomach cramps, insomnia, headaches, disorientation, confusion and seizures".* The only one of these symptoms referred to by RN Boorer was seizures. Despite thinking she had indicated to correctional officers that Dushy be placed in a camera cell, she had failed to indicate appropriate symptoms to look for or the required frequency of observations.

93 I had cause to discuss this issue in my findings in the inquest into the death of Mohammed Warwar. In that inquest I was advised that:

> *Justice Health is developing an HPNF e-form that will be hosted on the Justice Health Electronic Health Record (JHeHS). The e-form provides prescriptive direction as to the lay terms which can be used to describe* a *patient's signs and symptoms. Thee-form utilises drop-down boxes to click on the prescribed terms, rather than having an open text form for the description of signs and symptoms, however* a *free-text option is also*

retained if required. It is hoped that the e-form will be operational in mid-2024.

94 In the inquest into Dushy's death, the evidence contained within correspondence for the solicitor for Justice Health dated 16 August 2024 indicates that the *HPNF e-form* is currently in the "test environment" and it is hoped to be in use across the network by the end of October 2024.

95 It is to be hoped that the indicated time frame has been met.

A joint statement

96 Following Dushy's death each of RNs Mhonda, Sarjeant and Boorer was required to make a statement setting out what they had observed and what they had done.

97 Whenever someone dies in custody an investigation follows. Each nurse should have made her own statement setting out her independent recollection of events. Rather than take that approach, the RNs made the one entry in the clinical notes, which they each signed. This was an inappropriate course.

Summary in relation to failings.

98 The identified failings, may be listed as follows:

(a) RN Boorer failed to ask further questions when Dushy indicated he had not been to hospital in the last 6 months, despite his subdural haemorrhage.

(b) RN Boorer failed to make a record of the frequency of the observations to be made overnight as recommended by Dr Meldrum.

(c) RN Boorer failed to recommend in the HPNF that Dushy be placed in a camera cell but rather indicated a cell placement category that did not exist.

(d) Thinking that Dushy was to be placed in a camera cell, RN Boorer failed to provide appropriate information in the HPNF as to the type, duration and frequency of the observations to be made by correctional officers.

(e) Registered Nurse Boorer failed to use appropriate terminology in the HPNF to indicate the signs and symptoms that correctional officers should look for.

(f) RNs Sarjeant and Mhonda failed to take timely and appropriate medical observations after midnight on 25 September 2019.

(g) RNs Boorer, Sarjeant and Mhonda were present when CPR was incorrectly administered. The three nurses then made a joint statement in relation to their attendance upon Dushy after his collapse, rather than setting out their independent recollection of events.

99 The identified failings all occurred between 8:00pm on the 25th of September and 6:21am on the 26th of September. RN Sarjeant and RN Boorer are very experienced nurses, and it should not be expected that they would fail in the ways set out above. None of the failings of the nurses have been established to have caused Dushy's death. Nevertheless, the fact that a failing is not established to have been causative is not a reason to ignore it nor reason not to take steps to ensure the failing is not repeated. It will never be known how the course of Dushy's incarceration may have been changed if RN Boorer had been more inquisitive about Dushy's hospitalisation or if medical observations had been taken during the night or if Dushy had been placed in a camera cell or if there were more frequent observations made.

100 There is no doubt that Justice Health has many policies in place and takes steps to provide training for its staff. Despite the steps being taken it is clear that policies are not being followed in some circumstances and knowledge is lacking in other circumstances. This presents a significant problem for an organisation as large as Justice Health. In evidence, Dr Lagios accepted that there may be a problem in terms of the number of policies employees need to consider. Dr Lagios indicated she had given the matter a lot of consideration and was of the view that

there were deficiencies in the governance of policies and it was an area she would like to see improved, including through condensing information, cataloguing policies, standardising the titles to permit easier searching and reviewing, better search engine functionality and continuing in-services to educate nurses on the policies. This is such a broad topic that I do not propose to make a recommendation about it. Nevertheless, I anticipate that, consistent with Dr Lagios' evidence, Justice Health will continue to examine ways to ensure policies are understood and applied.

101 A further issue potentially impacting upon the manner in which nursing staff perform their duties is the question of workload. It was submitted that there was no evidence in this inquest that workload prevented anyone from attending to a task they were required to undertake. That is a separate consideration to the possibility that it was workload which led to the various tasks not being attended to properly.

102 RN Boorer gave evidence that the afternoon shift is a busy shift and on occasions she did not have time to take her tea break. In my view her failure to explore the issue of whether Dushy had been in hospital in the last six months may have been a product of her heavy workload. In the inquest into the death of Mr Mohammed Warwar, I recommended to the Chief Executive of Justice Health & Forensic Mental Health Network that consideration be given to the deficiencies in nursing practice which were identified in that inquest as well as the volume of policies and training that employees were exposed to, with a view to exploring and implementing better ways to minimise the risk of employees not following policy and deficiencies being repeated. Mr Warwar died in MRRC in October 2021. I do not see any point in making the recommendation again, but it is obvious from the evidence in this inquest that heavy workload has been an ongoing issue for Justice Health staff at MRRC.

Delivery of telehea!th services to prisoners

103 Dr Lagios gave evidence that all incarcerated patients are to be provided with an iPad with access to a Justice Health portal. Additionally, Justice Health continues to promote virtual medical consultations. This is an expanding and developing

area which has the potential to improve the delivery of medical services to incarcerated patients.

Preparing statements for inquest

104 In her statement provided to the OIC, RN Sarjeant represented that when she attended upon Dushy at 2:08am, she was accompanied by RN Mhonda. In her statement made about one month after RN Sergeant's statement, RN Mhonda represented that she accompanied RN Sergeant to the door of the cell where Dushy was housed at 2:08am, that she recalled seeing Dushy sleeping on his bed and then move his legs when "we taped on the window".

105 CCTV footage subsequently confirmed that RN Mhonda was not with RN Sarjeant when RN Sergeant attended Dushy's cell.

106 The statement of RN Mhonda was not made for or with the assistance of the OIC.

107 Each statement, when signed, respectively in July and August 2020 contained the following first paragraph:

> *This statement made by me accurately sets out the evidence that I would be prepared, if necessary, to give in court as a witness. The statement is true to the best of my knowledge and belief and I make it knowing that if it is tended in evidence, I will be liable to prosecution if I have wilfully stated in it anything that I know to be false, or do not believe to be true*

108 The question of wilful falsehood raised by paragraph one was not vigorously pursued at inquest and there is no suggestion that the wrong representations in each statement were made deliberately. It is timely however to remind professionals involved in coronial proceedings of the serious responsibilities involved in helping a witness prepare a statement.

109 It is both fundamental and essential that a statement accurately reflect the recollection of the person making the statement. Not only does this apply to the

issue of what is remembered of a past conversation but also applies to recollections of events.

110 It is not the job of a legal practitioner to insert into a statement either the legal practitioners understanding of what happened or some other witnesses' understanding of what happened.

111 A failure to take the appropriate approach does not only risk traversing ethical responsibilities but also raises the possibility of an adverse credit finding in relation to the maker of the statement.

112 In regard to adverse credit, Ms Dean, on behalf of the family correctly pointed out that the notes of Nurse Sarjeant regarding the gross observation at 2am did not include any reference to Dushy moving his leg. The absence of this detail, and its subsequent appearance in the two statements written some ten months later, was, in Ms Dean's submission a cause for some caution in the evaluation of that evidence. Ms Dean went on to submit "your Honour has watched that video and your Honour will need to consider the reliability of that evidence in the context of the surrounding evidence about how that impression was produced".

113 The submission was well made and has substantial force. However, in this instance I have not found a need to determine the credit issue as I found the "gross observation' to be wholly insufficient in any event and accepted the evidence of CO Bezzina that she saw Dushy in his bed asleep at 3:08 am.

114 I should make it clear that the representative of the nurses in these proceedings was not involved in the preparation of the statements of any of the nurses. Additionally, there can be no suggestion that whoever did assist RN Mhonda with her statement did anything improper or inappropriate. That issue was not explored at inquest.

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

115 Counsel assisting suggested I make five recommendations. I will deal with those suggested recommendations in order.

Recommendation 1

That Justice Health review its existing policies relevant to the treatment of patients in alcohol withdrawal for the purpose of considering whether those policies could be simplified. including through the use of plain language. and standardised.

116 Counsel assisting submitted that there were numerous Justice Health policies which contain overlapping and at times potentially confusing or inconsistent messaging because of infelicity of language.

117 By way of example, medical observations were variously referred to as *"full", "vital", "medical",* and *"standard adult general" (observations)* whilst gross observations were referred to as "a *welfare check",* "a *check" and "proof of life".* Such variability in descriptors is unlikely to lead to consistency of approach, as exemplified by RN Sarjeant's faulty belief that her *gross* observation was properly described as a *medical* observation.

118 Dr Lagios indicated in her evidence that the governance of policies was an area she would like to see improved, including through condensing information, cataloguing policies, better search engine functionality and "in-services" to continue educating nurses on the policies.

119 Justice Health opposed the recommendation being made because it reviews its policies on an ongoing basis guided by a framework established in policy 2.135 which commenced in May 2023.

120 It was further submitted on behalf of Justice Health that it was currently reviewing drug and alcohol policies and that review includes policy in relation to patients with alcohol withdrawal. Furthermore, those conducting the review were already addressing issues of standardisation, simplification and use of plain language. In those circumstances it was submitted that there was no need to make the recommendation.

121 I accept what has been put on behalf of Justice Health and rely upon the factual matters as to what steps Justice Health is taking set out in the submissions which are now in evidence as an exhibit. In those circumstances I will not make the recommendation.

122 Before leaving the issue however I do want to comment on Justice Health's submission that whilst it accepted that recommendations need only be "connected to the death" (as distinct from causative) however, as the submission went, it is nonetheless instructive to consider what impact any proposed recommendation would have on a similar case in the future. It was then submitted that there was no evidence that any of the staff in the present matter were confused by the language of policy, misled by its complexity or forced to choose between competing policies and further that Mr Visvanathan did not die from any lack of observations.

123 In my view these submissions do not convey the full picture. It was clear, for example, that Registered Nurse Sarjeant completely misunderstood what medical observations entailed in her satisfaction that an asserted mere raising of the foot by Dushy was a medical observation. It will never be known what properly taken observations (either at that time or within the next two hours) may have revealed and what steps may have followed. If properly taken observations revealed readings in the red zone a medical emergency was required to be called. If properly taken observations revealed readings in the yellow zone the situation needed to be escalated. Similarly, RN Boorer did not undertand the terminology in relation to cell placement. If Dushy had been placed in a camera cell the outcome may have been very different.

124 It is commonly the case, as referred to above, that whilst it cannot be established that a "failing" or a "missed opportunity" was of itself a cause of death, conversely it can't be known what the outcome would have been if the failing had not occurred or the opportunity (to do a task in accordance with policy/the correct way) had not been missed.

Recommendation 2

That the drug and alcohol substance withdrawal monitoring form used by Justice Health be amended to incorporate, firstly, guidance regarding the frequency of observations recommended for patients in alcohol withdrawal, and secondly, a field which can be used by practitioners to indicate the plan for the frequency of observations for the patient.

125 Counsel assisting submitted that in his evidence Dr Brown considered that the current alcohol withdrawal form is deficient because it does not include any of the possible recommendations on observations or a space to write down the plan for frequency of monitoring and that Dr Lagios agreed that those inclusions would be useful. Additionally, counsel noted that as a matter of common sense, if there is a prompt for this information to be written on a form, there is a greater chance that it will be recorded.I accept those submissions.

126 There was no opposition to the recommendation being made. I shall make it, in the suggested form.

Recommendation 3

That consideration be given to sending out or publishing a short communication to Justice Health staff which emphasises the importance of proper ventilation during CPR.

127 Counsel assisting submitted that the evidence before the Court was that all Justice Health medical staff have CPR training on a yearly basis. The three nurses who performed CPR on Dushy had received training just a few months prior to his death. Each were experienced nurses.

128 Counsel further submitted that whilst the deficiencies in CPR in this case are unlikely to reflect a lack of training, they do nevertheless provide a basis for a reminder of the importance of ventilation. This is particularly so given Professor Brown's criticism.

129 In supporting that the recommendation be made Justice Health noted that whilst up to date training materials are currently provided to staff in Basic Life Support

Training the circumstances of Vishy's death dictated that an appropriately worded "important notice" should be sent to staff.

130 I will make the recommendation in the suggested form.

Recommendation four

Consideration be given to seeking an allocation of funding from the Ministry of Health. for the staffing of drug and alcohol remote offsite and after hours service shifts until 11pm with an on-call service to continue to be provided from 11pm onwards.

131 The evidence established that the D&A ROAMS staff performing on-call services (as distinct from being on shift) both in 2019 and continuing to the date of inquest, were not required to create clinical records and were not required to access patient records, although post-COVID the majority of staff have the ability and in fact do access patient records. An issue focussed on at inquest was the deficiency in the clinical records concerning the conversation between RN Boorer and the D&A ROAMS doctor, Dr Meldrum.

132 Dushy entered into MRRC, the largest reception centre in the state, at 8pm on a Friday. He was one of 40 new receptions. RN Boorer gave evidence that on reception at MRRC up to 50% of arriving inmates present with some form of drug and alcohol use or withdrawal. Dr Meldrum was "on call" rather than working a designated shift.

133 Dr Lagios' evidence was that the introduction of a D&A ROAMS shift until 11pm with an on-call service after 11pm is a change she would like to see. The proposed recommendation is phrased as it is because counsel assisting acknowledges that the creation and staffing of positions is dependent on sufficiency of resources.

134 Justice Health agreed that the recommendation should be made. I will make the recommendation with a slight wording change (adding the word medical).

Recommendation five

That Justice Health give consideration to the type of observations which are appropriate for patients in MRRC, assessed as being in alcohol withdrawal.

135 Counsel assisting submitted that this recommendation arises in light of the evidence of Professor Brown that everyone in alcohol withdrawal is at risk of seizure and it's not possible to predict which of those patients fall within that 5% who will suffer seizures.

136 The evidence made clear that RN Boorer did not understand the terminology used for the various cell placement options. Advice within the relevant policy indicated that patients suffering alcohol withdrawal symptoms or who were intoxicated should be placed in either a camera cell, an assessment cell or a clinical observation bed. Despite this written policy Dushy was placed in a cell which was 100 metres from where the nurses were stationed, and no appropriate information was conveyed to correctional officers as to what they should look for in the patient inmate or how frequently they should observe the patient. Self evidently nursing staff could only know of a medical event or relevant behaviour by a patient if that behaviour or event was seen by them or reported to them.

137 In the circumstances revealed at inquest counsel assisting submitted that closer consideration should be given as to what are appropriate observations in relation to someone withdrawing from alcohol. Counsel Assisting emphasised that the proposal included consideration of what should be done by both nurses and by correctional officers.

138 Justice Health opposed the recommendation being made and submitted that it was not necessary or desirable. Justice health pointed to the differing circumstances that might apply for example as between a patient in the clinic during the daytime as compared to a patient who enters prison overnight on a weekend, Justice Health further noted that pursuant to the current policy each situation requires discussion with medical officers or clinical nurse consultants as to what are the appropriate observations.

139 The clear intent behind the proposed recommendation is to draw attention to the practical and logistical issues at MRRC once a patient in withdrawal is placed away from the clinic. The evidence at inquest made it clear that this was a significant issue.

140 As at the conclusion of written submissions Justice Health were undertaking a review of each drug and alcohol policy including parts of the policy relating to patients in alcohol withdrawal. The review was expected to take 6 to 12 months.

141 In those circumstances I will not make a recommendation in the terms suggested but rather urge upon Justice Health that in its ongoing consideration of the appropriate approach to patients in alcohol withdrawal that it gives specific consideration to the circumstances at MRRC and the practical problems of completing effective observations in relation to patient inmates who are in cells a substantial distance away from the clinic.

142 A recommendation was submitted on behalf of the family in the following terms:

That consideration be given to amending justice health policy 6.029 [or current equivalent] to recommend attempting contact with a patient's family where on reception to a correctional centre

a) the person appears to be experiencing substance withdrawal

b) the person appears to be understating or minimising their alcohol use

c) any of the person's vital signs are within the yellow and or red zone of the standard adult general observation chart and

d) there is a lack of other third-party information relating to health concerns or medical history

143 The unfortunate reality of Dushy's situation was that:

(1) Community Corrections, an arm of CSNSW had available to it extensive information in relation to Dushy's medical history including his recent medical history and his struggles with alcohol consumption. This information was available on the CSNSW offender integrated management system (OIMS).

(2) A representative of Community Corrections made a call to Parramatta Court to notify them of the risk of withdrawal

(3) The sentence warrant noted that *"Justice Health are to monitor and supervise the offender as he will likely (sic) to withdraw from alcohol."*

(4) The interviewing officer in the parramatta cells noted *"accommodation-mental health/disability"* and *"inmate withdrawing from alcohol"*

(5) During the interview with the SAPO it was identified that *"Dushy suffered from depression and anxiety and that he consumed alcohol to help with his depression"* although there is no specific notation re Dushy's recent hospital admissions (which were available in the OIMS)

(6) Nursing staff at MRRC thought Dushy may be understating his alcohol consumption

144 Thus, important information about Dushy's recent medical history was both known to the family and known to CSNSW and yet that information was not received by the clinicians who had to make decisions about Dushy's care overnight in circumstances where they thought he was not providing full information.

145 It is in this context that the family propose the above recommendation.

146 Justice Health opposed the recommendation indicating it was neither necessary nor desirable.

147 I do not accept the submission on behalf of Justice Health that adding the recommendation to the current policy would unnecessarily complicate that policy. However, given that the specific focus of the recommendation is the provision of medical information two pieces of evidence at inquest are highly relevant.

148 Firstly, Justice Health commenced using the electronic net system *"HealtheNef"* in March of 2024. The system is a secure statewide clinical portal which shares summary level patient and clinical information across New South Wales Health Service. Dr Lagios explained that by using a patient's medicare number Justice Health, through this system, can view a patient's pathology results and discharge summaries as well as other material within their health record.

149 Secondly Justice Health will in due course be linked to the statewide single digital patient record.

150 The single digital patient record is a New South Wales Health project through which Justice Health staff will gain access to clinical records from New South Wales Public Hospitals for patients in custody. This is anticipated to launch in March 2026 with Justice Health, together with the Hunter and New England Local Health District being in the first wave of participants.

151 The single digital patient record is also based on a medicare number and provides access to all of the participating LHD's notes and records for the patient.

152 Each of those steps when taken and effective will mean that contact with the family will not be needed to find out medical history.

153 Having said that, each of these programs depends on the patient being able to provide a medicare number and it is likely there will be instances where a patient who has recently come into custody will not be able to provide that number. In my view the current wording of the policy actually allows for contact with the family in situations such as Dushy's. As emphasised in written submissions on behalf of Justice Health the current policy includes:

"It is important to remember that you do not need patient consent to listen to a family member's concerns, gain collateral information or to talk to someone where you are not disclosing specific details about a patient's health condition treatment'

154 In circumstances where I am delivering these findings one and a half years after Justice Health's access to *"HealtheNet"* commenced and as the commencement of the single digital patient platform approaches, I do not propose to make the suggested recommendation. Rather, I encourage Justice Health to keep a close eye on how the access to Healthenet is working in regard to gathering patient health information expeditiously once a patient enters custody and, to the extent it considers necessary, continue educating staff on the means by which collateral information can be gathered without consent in situations where a clinical judgement is made that additional information may be important.

Section 81 findings

155 For all the above reasons, the findings I make pursuant to section 81(1) of the *Coroners Act* 2009 (NSW) are:

Identity	The person who died was Dushyanthan Visvanathan
Date of death	Mr Visvanathan died between 3:08am and 6:21am on 26 September 2019.
Place of death	Mr Visvanathan died in cell 52 of Darcy Unit at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales
Cause of death	Mr Visvanathan died as a result of complications of alcohol use disorder
Manner of death	Mr Visvanathan died of natural causes

Recommendations

To Justice Health and Forensic Mental Health Network

1. That the drug and alcohol substance withdrawal monitoring form used by Justice Health be amended to incorporate, firstly, guidance regarding the frequency of observations recommended for patients in alcohol withdrawal, and secondly, a field which can be used by practitioners to indicate the plan for the frequency of observations for the patient.

2. That consideration be given to sending out or publishing a short communication to Justice Health staff which emphasises the importance of proper ventilation during CPR.

3. Consideration be given to seeking an allocation of funding from the Ministry of Health, for the staffing of drug and alcohol remote offsite and after-hours medical service shifts until 11pm with an on-call service to continue to be provided from 11pm onwards.

Conclusion

156 Before closing this inquest, I would like to express my sincere and respectful condolences to Dushy's family and friends and thank Dushy's wif[redacted]or her participation in the inquest.

157 I would like to acknowledge and thank Detective Senior Constable Tim Marshall for conducting the police investigation.

158 I thank the lawyers involved for the sufficient interest parties for the helpful and respectful manner in which they represented their clients.

159 Finally, my thanks go to the assisting team of Ms Holcombe of Counsel and Ms Hill of the Crown Solicitor's office for their dedicated work in garnering and presenting the evidence for inquest. I also am indebted to Ms Jeffares for her recent assistance.

160 I close this inquest.

Magistrate David O'Neil

Deputy State Coroner

5 September 2025