CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of James Joseph Cunneen
Hearing dates:	20 - 24, 27- 29 November 2023 and 2 - 4 April 2024
Date of findings:	23 July 2025
Place of findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Magistrate David O'Neil, Deputy State Coroner of NSW
Catchwords:	CORONIAL LAW — death in custody — inadequate staffing — one general practitioner for 1150 patients in custodial setting — chaotic delivery of health care in November and December 2019 — nurse led model — multiple failings by nurses
File number:	2019/00407715

Representation:

Counsel Assisting: Matthew Robinson instructed by Clara Potocki of the NSW Crown Solicitor's Office

Cunneen Family: Matthew Hutchings instructed by Christopher Wozniak of Smythe Wozniak Lawyers

Commissioner of Corrective Services NSW: Reg Graycar instructed by Anastasia Poulios of the Department of Communities and Justice

Management & Training Corporation Pty Ltd and Broadspectrum (Australia) Pty Ltd: Tim Hackett instructed by Shaun Bailey of Ash Street Pty Ltd

St Vincent's Correctional Health: Ben Wilson instructed by Seun Idowu of Hall and Wilcox Lawyers

Justice Health and Forensic Mental Health Network: Simon Grey instructed by Benjamin Ferguson of Hicksons Lawyers

RN Kim Alexander: Ben Wilson instructed by Seun Idowu of Hall and Wilcox Lawyers

Dr Mark Tattersall: Tim Saunders instructed by Phoebe Callander of Meridian Lawyers

Dr Jacqueline Canessa: Peter Aitken instructed by Juliette Paterson of Avant

Dr John Shephard: Dr Peggy Dwyer SC instructed by Andrew Davey of Unsworth Legal

Findings:

Identity: The person who died is James Joseph Cunneen.

Date: James died on 28 December 2019.

Place: James died at Blacktown Hospital in New Sout Wales.

Manner: James died of natural causes.

Cause: The cause of James' death was ischaemic heart disease with a bleeding duodenal ulcer being a significant contributing condition.

Recommendations:

1. The Inspector of Custodial Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

2. In tangent with Justice Health and Forensic Mental Health Network and considering existing between the flags guidelines, St Vincent's Correctional Health and other service providers operating in the custodial health space, including those for publicly and privately operated correctional centres, consider updating policy material to provide guidance regarding the timeframes required for medical practitioner review for a patient when medication has been prescribed for an acute condition.

3. The Commissioner of Corrective Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

4. The Commissioner of Corrective Services, having regard to input from Justice Health and Forensic Mental Health Network, take steps to ensure that Management and Training Corporation remains compliant with its contractual obligations with respect to the number of correctional and health staff it is contracted to provide.

5. The Commissioner of Corrective Services, and the State, give immediate consideration to the redevelopment of the Main Clinic at Parklea Correctional Centre, including the observation cells within the clinic, to ensure a clean, hygienic, and safe environment and one which is fit for the purpose of operating a medical clinic and accommodating patients in cells within the clinic.

Orders and Notations:

Non-publication orders pursuant to section 74(1)(b) of the *Coroners Act 2009* and notations pursuant to section 65(4) of the *Coroners Act 2009* have been made in this inquest. A copy of the orders and notations can be found on the registry file.

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Section 81(1) of the Coroners Act 2009 requires that when an inquest is held, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of James Joseph Cunneen.

INTRODUCTION

1. James Joseph Cunneen (**James**) died on 28 December 2019 at 10:11 hours. His place of death was Blacktown Hospital. James suffered a cardiac arrest on a background of ischaemic heart disease. A bleeding duodenal ulcer was a significant contributing condition.

2. James, who entered Parklea Correctional Centre on 1 November 2019 in relatively good health, became critically ill within eight weeks necessitating his hospitalisation. Bewilderingly James' deterioration went largely unrecognised.

3. Because James died while in custody, an inquest is required to be held pursuant to sections 23 and 27 of the *Coroners Act 2009* (**the Act**).

4. 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.

5. An inquest was held for 11 days in two tranches from 20 - 24, 27 - 29 November 2023; and from 2 - 4 April 2024. The inquest heard from 22 witnesses.

THE CORONER'S ROLE

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 section 81 of the Act as to:

    - 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.

CORONIAL INVESTIGATION

9. Prior to holding the inquest, a detailed coronial investigation was undertaken. Senior Constable Stephen Mitchell compiled a brief of evidence that contained custodial records, medical records, and statements from those involved with James during his time in custody. Expert evidence was also obtained which focussed on the cause and manner of James' death including reports from a gastroenterologist, a cardiologist / toxicologist / pharmacologist, a general practitioner, and an infectious disease expert. The experts, with the exception of the infectious disease expert, were retained by me. The infectious diseases expert was retained by the solicitors for Dr Mark Tattersall, being a doctor with a sufficient interest in the subject matter of the inquest.

10. All the documents, including witness statements and expert reports obtained during the investigation formed part of the brief of evidence which was tendered at the inquest. All that material and all the oral evidence and additional documentary evidence has been considered in making the findings detailed below.

11. The following agencies and individuals were identified as having a sufficient interest in the proceedings and received notification:

    I. The family of James

    II. The Commissioner of Corrective Services NSW

III. Management & Training Corporation Pty Ltd and Broadspectrum (Australia) Pty Ltd, which operates Parklea Correctional Centre by an agreement between itself and CSNSW

IV. St Vincent's Correctional Health, which provides medical services to inmates as a result of a contract between itself and Management & Training Corporation Pty Ltd and Broadspectrum (Australia) Pty Ltd

V. Justice Health and Forensic Mental Health Network, which has no direct role in the provision of healthcare, but has a supervisory role

VI. Dr Mark Tattersall, who was the only doctor to ever consult with James at Parklea Correctional Centre. He was, at the time, a junior doctor with no specialist qualifications

VII. Kim Alexander, who was a registered nurse and saw James on occasions when the evidence suggests he was acutely unwell

VIII. Dr Jacqueline Canessa, a psychiatrist who prescribed the first course of antibiotics to James for cellulitis, and who was Dr Tattersall's supervisor

IX. Dr John Shephard, who was the Deputy Director of Medical Services for the St Vincent's Health Network

ISSUES LIST

12. The inquest into James' death examined the manner of his death, scrutinising the circumstances that precipitated his deterioration and permitted that deterioration to go largely unrecognised. The inquest aimed to determine how James, who entered Parklea Correctional Centre in relatively good health, became critically ill within eight weeks necessitating his hospitalisation.

13. An issues list was circulated to the interested parties prior the inquest commencing. These issues guided the coronial investigation and were considered at inquest. The issues examined included:

1) Determination of the statutory findings required under section 81 of the Act, including manner and cause of death.

2) Why, on a number of occasions, James did not receive medication which had been prescribed to him, including doxycycline and trimethoprim / sulfamethoxazole (Bactrim), and whether the policies as in force at the time were followed in respect of (a) the documentation of the failure to administer the medication and (b) if there was an interruption in supply, attempts to obtain supply of the medication so as to fulfil the prescription.

3) Whether the failure to administer medication which had been prescribed to James caused or contributed to (a) the deterioration in his medical condition and (b) his death?

4) Whether doxycycline and trimethoprim / sulfamethoxazole (Bactrim) was an appropriate medication for management of James' cellulitis.

5) Whether James required hospitalisation prior to 25 December 2019, and whether hospitalisation at an earlier date would have avoided James' death.

6) Whether James received adequate medical care while in custody from 31 October 2019 until 25 December 2019, including in respect of:

    a) Actioning requests by James for review by nursing and medical officers;

    b) The adequacy of reviews of James by nursing staff, particularly the review on 13 December 2019, and whether there was escalation to a medical officer when required;

    c) The adequacy of reviews of James by medical officers.

7) Whether it was reasonable for James not to receive a prescription for pantoprazole (or some other proton pump inhibitor) either upon his admission to Parklea Correctional Centre (particularly bearing in mind the

notation of the registered nurse on 1 November 2019 that medication for gastroesophageal reflux disease was required) or at the time that he developed gastrointestinal symptoms in the nature of stomach cramps, vomiting, haematemesis, and constipation (among other symptoms).

8) Whether a provisional or differential diagnosis of duodenal ulcer ought to have been made prior to 25 December 2019 having regard to James' history of having experienced abdominal pain and discomfort and having vomited blood.

9) Whether James' history of vomiting, a history of haematemesis, and a history of having experienced chest pain and discomfort when [vomiting] was known to nursing or medical staff or otherwise known to staff at Parklea Correctional Centre (howsoever employed or otherwise engaged), in the period between 13 December 2019 and 25 December 2019.

10) Why, having regard to the history obtained on James' admission to hospital on 25 December 2019 of a two-week history of vomiting, a history of haematemesis, and a history of having experienced chest pain and discomfort when [vomiting], contemporaneous records of such matters are not contained in the St Vincent's Correctional Health Services records until 24 December 2019 at the earliest.

11) Whether a Chronic Disease Screen (**CDS**) was undertaken and, if it was not, whether the failure to undertake CDS caused a delay in recognising the severity of James' illness.

12) 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 he was not as at November 2019 (and is not now) a general practitioner (nor a specialist in any other medical discipline), and his direct supervisor was a psychiatrist).

14. As the oral evidence unfolded in tranche one of the inquest and further documentary evidence was gathered and tendered in tranche two, some issues fell away, and others arose.

15. The inquest also examined the contractual arrangements between Management & Training Corporation Pty Ltd and Broadspectrum (Australia) Pty Ltd and the Commissioner of Corrective Services and State of New South Wales; and the contractual arrangements between Management & Training Corporation Pty Ltd and Broadspectrum (Australia) Pty Ltd and St Vincent's Correctional Health, with regards to the provision of healthcare services to those held in custody at Parklea Correctional Centre.

16. The scope of the inquest did not extend to include evaluation of the treatment provided to James at Blacktown Hospital when he was transferred there from Parklea Correctional Centre on 25 December 2019.

WITNESSES CALLED TO GIVE EVIDENCE AT THE INQUEST

17. The following witnesses gave oral evidence at the inquest:

    a. Dr Varinda Sharma, General Practitioner

    b. Endorsed Enrolled Nurse Debbie Young

    c. Registered Nurse Tanya Nguyen

    d. Dr Marianne Martinello, infectious diseases doctor

    e. Kumar Sanjeev, correctional officer at Parklea Correctional Centre

    f. Registered Nurse Cheryl Chavaria

    g. Registered Nurse Dig Vijay Karki

    h. Registered Nurse Revesayi Mutede

i. Registered Nurse Sonia Herera

j. Registered Nurse Jilla Tehranchi

k. Registered Nurse Kim Alexander

l. Dr Mark Tattersall, junior medical doctor at the time

m. Dr Jacqueline Canessa, psychiatrist

n. Debbie Little, Acting Deputy Director Operations and Nursing Justice Health and Forensic Mental Health Network

o. Brian Gurney, Acting Governor at Parklea Correctional Centre

p. Julie Dyer, nurse manager at St Vincent's Correctional Health

q. Jenny O'Mahony, project director of the medical workforce at St Vincent's Health Network Sydney

r. Katya Issa, Operations Manager at St Vincent's Correctional Health

s. Expert witnesses: Dr Hester Wilson, general practitioner; Professor Lawrence Howes, cardiologist, toxicologist & pharmacologist; Dr Chrisopher Vickers, gastroenterologist; and Professor Michael Whitby, infectious diseases.

BACKGROUND

18. James was a New Zealand citizen born on 30 May 1959. As a young adult he pursued a career in theology and in 1987 he became a deacon at St Andrew's Catholic Church in Marayong, Sydney. He returned to New Zealand to be ordained as a Catholic priest in February 1988. Between 1988 and 1989, James held the role of assistant priest at St Mary's Catholic Church in Rydalmere.

19. In 1990, James returned to New Zealand where he worked as a priest in the public service and at TAB New Zealand. He remained in New Zealand until 2017.

20. On 23 November 2015, an arrest warrant was issued for James at the Parramatta Local Court in relation to alleged criminal offending between 1987 and 1989. On 31 July 2017, James was arrested in New Zealand on a New South Wales warrant. On 27 October 2017, he surrendered to the extradition process.

21. On 22 November 2017, he was extradited from New Zealand, departing Auckland, and arriving in Sydney. Upon his arrival in Sydney, he was arrested, cautioned, and entered into custody at the Mascot Police Station. He was subsequently transferred to the Metropolitan Remand Reception Centre (**MRRC**) before he was granted bail on 24 November 2017. It was a condition of his release to bail that he resides at an address in Blacktown.

22. Whilst residing in Blacktown, James was under the care of Dr Varinda Sharma, a general practitioner at Woodcroft Family Practice. From Dr Sharma's statement, and by reference to the clinical records, the following matters may be observed in respect of James' medical history:

    a) James had coronary heart disease and a history of unstable angina, for which we underwent coronary angiography in New Zealand in 2010;

    b) On account of James' coronary artery disease, Dr Sharma referred him to cardiologist; and

    c) James suffered from significant peripheral arterial disease with bilateral lower extremity pain syndrome.

23. Dr Sharma had referred James to a vascular surgeon, where he subsequently underwent bilateral common iliac arterial stenting in August 2019. James suffered from gastroesophageal reflux disease, also known as GORD, in

respect of which Dr Sharma records in her statement that he was treated with Pantoprazole 40 milligrams daily. James had type 2 diabetes, fatty liver disease diagnosed by deranged liver function tests, and he was obese. Dr Sharma advised James to lose weight and referred James to a dietitian to assist with weight loss and to manage blood sugar levels.

24. On 12 January 2018, James presented to Blacktown Hospital with community acquired pneumonia. He was admitted under the care of a respiratory physician and received treatment in respect of his pneumonia. During the period of his admission to Blacktown Hospital, he was found to have severe right leg cellulitis, and his care was transferred to the infectious diseases team on 15 January 2018. He was noted to have blistering at the side of the cellulitis. The blisters spontaneously burst, and his wounds were managed by a wound clinical nurse consultant. James was commenced on intravenous antibiotics, and clindamycin. His treatment was later converted to dicloxacillin when it was considered clinically appropriate. James made a complete recovery from his cellulitis with the benefit of the intravenous antibiotics and was discharged home on 18 December 2018. His cellulitis did not recur until his admission into custody in November 2019.

25. On 26 March 2019, on Dr Sharma's referral, James was reviewed by Dr Luhach, a cardiologist. The doctor obtained a history of coronary artery stenting in New Zealand performed on a semi urgent basis. The doctor noted that since stenting, James had not experienced any further episodes of chest pain, but did complain of laboured breathing. A subsequent echocardiogram demonstrated normal left ventricular size and systolic function, with no left ventricular hypertrophy and no significant diastolic dysfunction. The cardiologist made changes to James' medication, including increasing the dose of his anti hypertensive medication.

26. On Dr Sharma's referral on 2 and 9 April 2019, James underwent bilateral venous ultrasound, which demonstrated occlusion of venous arteries in James' legs. Thereafter, Dr Sharma referred James to Dr Di Mascio, vascular surgeon. Following further ultrasound of his legs, Dr Di Mascio performed bilateral

common iliac artery stenting to improve James' lower limb extremity pain and pain when walking. James was thereafter commenced on clopidogrel 75 milligrams daily, in addition to daily aspirin. Both drugs, although their mechanism of operation is different, operate to prevent clotting of the blood. On 27 September 2019, the vascular surgeon noted that James was walking without pain.

27. Despite this history, family and friends had reported that prior to James going into custody, he had been healthier than he had been for a long time. Evidence of that was seen in particular in the quantity of walking he was then undertaking. On 30 October 2019, James was convicted of a number of offences. He was remanded to Amber Laurel Correctional Centre before his transfer to Parklea Correctional Centre on 1 November 2019. He remained on remand at Parklea Correctional Centre prior to his transfer to Blacktown Hospital and his death.

PARKLEA CORRECTIONAL CENTRE

28. Parklea Correctional Centre (**Parklea**) is a managed correctional centre. It was, at the time of James' incarceration and death, managed by a consortium involving Management and Training Corporation Pty Ltd (**MTC)** and Broadspectrum Australia Pty Ltd, collectively MTC Broadspectrum, pursuant to an agreement between MTC Broadspectrum on the one hand, and the Commissioner of Corrective Services and State of New South Wales on the other. Healthcare services were provided by St Vincent's Correctional Health (**St Vincent's**) pursuant to a subcontract agreement between MTC Broadspectrum and St Vincent's.

29. As at 2025, Parklea remains a managed correctional centre under the management of MTC. That is, it is no longer operated by a consortium incorporating both MTC and Broadspectrum. St Vincent's continues to provide healthcare services.

30. The contract between the Commissioner of Corrective Services and MTC Broadspectrum was received into evidence, as was the contract between MTC

Broadspectrum and St Vincent's. Among other matters, MTC Broadspectrum was contractually obliged to:

a) Provide comprehensive health services to custodial patients;

b) Identify the health needs of patients and address them accordingly;

c) Improve the existing health status of custodial patients;

d) Improve the health of custodial patients through health education, promotion and development of skilled staff;

e) Work with its correctional operation team to improve the health of custodial patients.

31. Healthcare provided in the custodial setting is governed by the *Crimes (Administration of Sentences) Act 1999*. In accordance with section 236 of that Act, Justice Health and Forensic Mental Health Network (**Justice Health**) has a statutory function to monitor the provision of health services in managed correctional centres such as Parklea. Pursuant to part 12 of the Act, only the Commissioner of Corrective Services New South Wales, as distinct from Justice Health, can enter into an agreement with a non government entity for the private management of a correctional centre.

32. The standard of healthcare to which James was entitled while in custody was the standard available in the public health system, as if he were in the community. MTC Broadspectrum's contract with the State required the following:

"*Manage Co must ensure that healthcare facilities and services are provided for custodial patients to the standards of the public health system in compliance with New South Wales Health, and Justice Health and Forensic Mental Health Network policies and procedures, with special regard to the unique health needs of custodial patients."*

33. The contractual obligation was elsewhere stated as follows:

"*Custodial patients are to be provided with healthcare in the correctional complex comparable to the standard of healthcare provided in the public system in the community that reflects the health needs of patients in custody*."

34. To a similar effect, MTC Broadspectrum was required by the contract to comply with all relevant legislation and policies, including the United Nations Standard Minimum rules for the Treatment of Prisoners (1977), which provides at rule 24:

"*Prisoners should enjoy the same standards of healthcare that are available in the community, and should have access to necessary healthcare services free of charge without discrimination on the grounds of their legal status".*

35. This principle underscores the obligation to ensure that all custodial patients, including James, receive healthcare that reflects the intrinsic commitment to equitable and non-discriminatory medical practices, as mandated by the contractual terms and reinforced by legislation.

36. Consequently, in evaluating the adequacy of the healthcare services James received, it is necessary to apply a standard that is commensurate with that afforded to individuals within the public health system, notwithstanding James' custodial status.

ST VINCENT'S CORRECTIONAL HEALTH TAKES OVER THE PROVISION OF MEDICAL SERVICES AT PARKLEA CORRECTIONAL CENTRE

37. St Vincent's Correctional Health, who I shall refer to as St Vincent's other than where contractual references require more specificity, commenced delivering medical services at Parklea from 1 April 2019. The evidence at inquest was that prior to 1 April 2019, Justice Health had provided medical services at Parklea. Access to Parklea was provided to St Vincent's on the late afternoon of 31 March 2019. St Vincent's Health, a wholly owned subsidiary of St Vincent's Health Australia, operated St Vincent's Correctional Health as a correctional

primary health service at Parklea. St Vincent's Correctional Health operated pursuant to a services deed with MTC, which:

a) Outlined the scope of St Vincent's Correctional Health's role at Parklea;

b) Delegated the health services obligations owed by MTC under the management deed to St Vincent's Correctional Health; and

c) Explained St Vincent's Correctional Health's operations and funding of the health service, and the resources allocated to St Vincent's Correctional Health to perform that role.

38. St Vincent's Health is part of the St Vincent's Health Australia group of not for profit health and aged care organisations.

39. It was clear from the evidence that St Vincent's experienced significant difficulties in setting up the delivery of medical services during 2019. There was evidence that there was little to no cooperation between Justice Health and St Vincent's.

40. The evidence of Dr Canessa, psychiatrist, the senior clinical lead, was that there were staffing shortages, delays in setting up computer systems, and an absence of any administration system. Dr Canessa's evidence was that there was no cooperation from Justice Health. Whilst the issue was not explored in detail, there was no cross examination of Dr Canessa suggesting that she was wrong about this, and no evidence from Justice Health to the contrary. An additional issue was that St Vincent's did not have a poisons licence, which created difficulties in relation to the administration/provision of scripted medications.

41. Dr Canessa's understanding was that in the initial tender St Vincent's had indicated that there would be five career medical officers and two visiting medical officers providing services as medical officers. These services related to the provision of general medicine, as distinct from psychiatric services. The

reality was that initially there were two medical officers, and after a period of time one of those ceased working at Parklea. For a period of time, one medical practitioner, Dr Mark Tattersall, was providing general medical services to a prison population in the vicinity of 1,150 inmates. Dr Tattersall was a junior doctor requiring supervision at that stage of his career. Dr Tattersall initially worked seven days per week, up until a point in time during 2019 when he commenced working two days a week at South Mudgee under the supervision of a GP.

42. For convenience, reference to a GP within Parklea should be taken to include Dr Tattersall, as he was referred to in that way within the custodial setting. Once Dr Tattersall commenced working at Mudgee on Thursdays and Fridays, Dr Canessa provided general medicine services on those days. Dr Canessa was both a very experienced psychiatrist and had extensive experience in the criminal justice system; however, she was not a GP, and her ability to deliver general medical services was limited. It was her evidence that clinically Dr Tattersall was more knowledgeable than her in the general medicine area. Dr Canessa gave evidence that she was involved in seeking to recruit medical officers, and that it was extremely difficult to fill these positions.

43. The inquest did not examine in detail the arrangements in terms of setting up the handover from Justice Health to St Vincent's; however, it is trite to state that a handover should not have occurred until staffing levels and administrative arrangements enabled the delivery of appropriate and adequate medical services from day one.

JAMES' TIME AT PARKLEA

44. Much of the material I will now set out in relation to James' time at Parklea draws heavily and gratefully upon the written submissions of counsel assisting. There was very little dispute with the factual matters set out by counsel assisting. Where factual matters are disputed, I will refer to the differing submissions as necessary.

45. As noted above, James went into custody on 30 October 2019. On 31 October 2019 at 3.56pm, prior to James' transfer to Parklea, a health summary sheet was faxed by Woodcroft Family Practice to Justice Health. A variety of medications were noted to be required, and the nurse made a telephone call to a Dr Ette, a general practitioner at Long Bay Correctional Centre, who placed a telephone order for the requested medications. Relevantly, the health summary sheet produced by Woodcroft Family Practice did not list either Pantoprazole or Rabeprazole as a current medication, and as such neither was prescribed by Dr Ette.

46. On 1 November 2019 at 5pm, Registered Nurse Karki conducted a reception screening assessment upon James, following his transfer into Parklea. The healthcare summary from Woodcroft Family Practice which was available to Registered Nurse Karki indicated that James' current active problems were:

a) Diabetes;

b) GORD (gastro oesophageal reflux disease);

c) Hyperlipidaemia;

d) Hypertension;

e) Ischemic heart disease; and

f) Obesity.

47. In terms of past medical history, the documentation indicated that James has a history of impaired glucose tolerance, bilateral iliac stenting and peripheral vascular disease. As noted, the medication list did not include Pantoprazole or Rabeprazole. Pantoprazole and Rabeprazole are widely used medications to treat GORD. They are referred to as proton pump inhibitors or PPIs.

48. The reception screening assessment documentation, as completed by Registered Nurse Karki, reflected the information provided by the medical

centre. Following completion of the reception screening assessment, Registered Nurse Karki contacted Dr Tattersall by telephone, after which three prescriptions, including a script for Rabeprazole, were authorised by Dr Tattersall.

49. The next day, Dr Tattersall reviewed the paperwork returned by Woodcroft Family Practice and identified that it did not list medication for GORD, although it did list GORD as a current condition from which James was suffering. In the absence of the form listing medication for GORD, Dr Tattersall determined to discontinue the Rabeprazole. In evidence, Dr Tattersall indicated that he had some awareness of studies recommending caution in relation to the long-term provision of medications such as Rabeprazole. Dr Tattersall indicated he did not consult with James as he was simply too busy to do so, given the overwhelming demand of being required to attend to the needs of 1,150 inmates. Dr Tattersall indicated in evidence he would have attended to about 45 charts each day, and to get to a patient like James would have been next to impossible because he was tied up all day with acute presentations.

50. Dr Tattersall said he was drowning with patients in the main clinic who were acutely unwell, plus the walk-ins, and then he would have to get the patient to come across to be reviewed by him. He indicated getting the patient to the clinic "was another really big challenge at that site because he would not go to the wing". He had to get the officers to get the patient to bring them over to the clinic, which was separated from the wings, and at times, access was a real issue. Dr Tattersall indicated that even the diabetic patients who were really critical to be there three times a day were not brought across with sufficient regularity and timeliness. Dr Tattersall gave further evidence that the booking system to see a medical officer was useless due to it being impossible to meet the work burden, and issues regarding access to patients were endemic. Dr Tattersall further indicated the GP waitlist was meaningless.

DIAGNOSIS OF CELLULITIS AND COMMENCEMENT OF ANTIBIOTICS ON 8 NOVEMBER 2019

51. James remained in the clinic for two to three days and was then transferred to a cell in one of the wings away from the clinic. The next significant event in the management of James occurred on 8 November 2019. On that date, enrolled nurse, Debbie Young, saw James in the clinic. The only documentation of that consultation is an entry in the patient administration system or PAS, which records: "*Right leg sore. Red cellulitic in appearance. For GP review*." No entry was made in the progress notes, either written or electronic, and there was no recording of observations on the SAGO chart (standard adult general observations).

52. Enrolled Nurse Young explained PAS is the main system for booking the patients that you see for the day, and the other system, the JHeHS system is where you document your interactions. She indicated that the reason she did not document her review in JHeHS was because she "*was obviously just busy*".

53. Enrolled Nurse Young had no positive memory of James, and her account of what occurred was based on her usual practice. The doctor with whom Enrolled Nurse Young spoke was Dr Canessa. As indicated above, Dr Canessa was routinely required to practice general medicine. Her prescription of James' Bactrim on 8 November 2019 is one such example. Dr Canessa had no memory of James. She also gave an explanation based upon what she would have done. I am satisfied that, following her consultation with James, Enrolled Nurse Young then discussed James with Dr Canessa, who then prescribed oral Bactrim twice daily at 8am and 8pm for seven days for cellulitis, as charted in the short-term medicine orders.

54. Dr Canessa said cellulitis was so common in the prison that it was the first line treatment to start with the antibiotic, Bactrim. The antibiotic was sensitive to the variety of bacteria seen within the prison environment. Dr Canessa asserted that James would then have been placed on the GP waitlist for a formal review. However, no appointment was made. Dr Canessa had not consulted with James.

55. As at 8 November, no medical officer had seen James, despite, at this stage, three entries from nurses that James should be reviewed by a doctor. Registered Nurse Karki had made the first of those entries on James' admission. In that period of time, there had been ongoing administration of numerous medications, and the discontinuance of Rabeprazole.

56. The opinion of all the experts who gave evidence was that Dr Canessa should not have prescribed Bactrim without having seen James. There was some understanding of the pressing need to prescribe appropriate medication to treat the infection, but at the very least, Dr Canessa should not have done so unless completely satisfied James would be seen the next day. Given other evidence as to the workload upon Dr Tattersall, I find Dr Canessa could not have been so satisfied. Bactrim, having been prescribed and charted for seven days on 8 November 2019, was administered on 8 and 9 November, but not on 10, 11, or 12 November; that is six occasions of the medication not being administered as there were morning and evening doses, and both were missed on those three days.

57. It is trite to emphasise the importance of regularity and consistency with a course of antibiotics. I note, in using the term "administer", I mean making the medication in the form of the tablet available to the patient. Usually, that process would be on the medication rounds in the morning and the evening.

58. Unsurprisingly, on 13 November 2019 at 4pm, Registered Nurse Lee recorded that James had cellulitis on his right lower leg, which was not improving. There was a query in respect of missing antibiotics. Registered Nurse Lee recorded: "*Currently on Bactrim and same reported to Dr Tattersall*."

59. Dr Tattersall noted that a nurse visited him in the main clinic, reported that James' right lower leg was not improving, and informed him that James had missed antibiotics. Dr Tattersall determined, without reviewing James, to extend Dr Canessa's Bactrim prescription for a further five days to commence from 14 November. Bactrim appears to have been administered on 14 November, but it was not administered on 15 November.

60. On 16 November, Dr Tattersall prescribed doxycycline, twice daily for seven days, for treatment of James' cellulitis. There is no clinical entry which explains why Dr Tattersall did this. Additionally, no observations were taken at all over this period. Again, doxycycline was not administered on 16, 17 or 18 November. This represented another six occasions of failing to administer prescribed antibiotics. I note that it was clear on the evidence that doxycycline was not an appropriate treatment for cellulitis, in that it needed to be supplemented with an additional antibiotic such as amoxicillin to provide cover for streptococcus, which was said to be endemic at Parklea.

61. Dr Tattersall was informed by a nurse on 19 November that there was no supply of doxycycline, which likely explains why it had not been administered for the preceding three days but does not explain why it was not reported immediately to Dr Tattersall. He accordingly charted an order for Bactrim to be taken twice daily for five days. Again, Dr Tattersall did not consult with James.

62. James appears to have received his antibiotics in accordance with that prescription on 19, 20, 21, 22 and 23 November, but as noted, not to have received prescribed antibiotics on 10, 11, 12 and 15, 16, 17 and 18 November. That is a total of 14 occasions on which James did not receive prescribed medication.

63. In respect of this period of treatment, Dr Hester Wilson, expert general practitioner, expressed the following opinion, which I accept:

    a) Follow up on the presentation on 8 November and the following weeks was grossly inadequate;

    b) There was no consistent and planned follow up of this acute presentation. There did not appear to be good clinical governance of the management of acute presentations or safe handover of care.

64. Professor Howes opined that prescription of Bactrim on 8 November was not reasonable. James was a type 2 diabetic with severe peripheral vascular

disease, and as such, in Professor Howes' opinion, he should have been treated in hospital with intravenous antibiotics.

65. The therapeutic guidelines for management of cellulitis suggest early review of disease progress, with a change of treatment if there is no improvement in signs and symptoms within 48 hours. James was not medically reviewed for weeks. There was a short note on 13 November 2019 that suggested the cellulitis was not improving, but it is not clear if this issue was clinically assessed. Antibiotic doses were missed, and the antibiotic was changed due to unavailability of the prescribed antibiotics. All this was done without clinical assessment.

66. James' personal experience of this period can be ascertained from the recorded gaol calls. On 27 November 2019, he said to his mother, in connection with his treatment for cellulitis in November 2019:

"*They do nothing for you, and they do not care. My leg flared up again with cellulitis. I had to yell and scream and yell and scream, and the leg went more and more purple again. You know, with all that disease*."

His mother responded, "*Oh god*":

"The skin started breaking again. To get antibiotics I had to you've got to just ask and ask and ask and ask and ask and just worry them and worry them and worry them and worry with them your complaints and wear them down to do something. Thats the only way it happens, you know."

67. To say the least, it is most troubling that James was clearly indicating he was asking over and over again for his antibiotics, and yet nurses failed to supply them on 14 occasions in November. Endorsed Enrolled Nurse Young gave evidence that the failure to administer prescribed medication should have been recorded by the nurse unit manager, or someone at the nurse unit manager's direction, in the incident information management system (**IIMS**). There was evidence at inquest that there was a later version, IIMS+.

68. The failure to administer James' medication in accordance with the short-term medicine orders chart was never recorded in the incident information management system, IIMS, or its successor IIMS+.

Chronic Disease Screen

69. On 2 December 2019, Registered Nurse Cheryl Chavaria initiated a chronic disease screen (**CDS**) for James. Registered Nurse Chavaria booked the chronic disease screen to occur on 13 December 2019. The CDS is meant to occur within 29 days of a custodial patient's reception to Parklea.

70. Registered Nurse Chavaria stated in her evidence that she did not know why it did not occur within that 29-day period. Registered Nurse Chavaria noted that sometimes delays were the result of waiting for community treatment records to arrive, following requests for information to external providers; however, there is no suggestion there was an outstanding request in James' case. Registered Nurse Chavaria elsewhere noted: "*From previous experience, I recall that CDS appointments would sometimes occur later than 29 days if there were St Vincent's staff shortages*".

13 DECEMBER 2019

71. In a statement made on 4 May 2023, Registered Nurse Kim Alexander asserted that she saw James during the morning medication rounds on 13 December, had a conversation with James, observed James' right lower leg and made arrangements for James to attend the clinic later in the morning.

72. In significant contrast to this evidence, there are detailed reports that James fainted on the way to the AVL suite that morning, and, as a consequence, was taken to the clinic in a wheelchair.

73. A contemporaneously recorded offender integrated management system (**OIMS**) record notes:

"When inmate arrived at AVL for his Downing Centre he was fainted (sic) and emergency CERT call was activated, and nursing and clinic staff took him to clinic for further assessment. Received medical certificate from clinic and sent to Parklea records staff".

74. Correctional Officer Sanjeev Kumar gave evidence. He recalled that he was working a day shift in the main clinic at Parklea when he responded to an emergency call, also referred to as a CERT call. He understood that James had fainted. He collected a wheelchair and attended upon James at the location at which he had fainted. He attended with a nurse. James was on the floor at the time, and Correctional Officer Kumar arrived and observed him to be in shock, and that James was unable, under his own power, to get into the wheelchair. The nurse directed that James was to be taken to the main clinic, and Correctional Officer Kumar complied.

75. Registered Nurse Alexander gave oral evidence that she had no knowledge at all that James had fainted or that he had come to the clinic in a wheelchair. Registered Nurse Alexander had set out in her statement that, at approximately 9am, James presented to the clinic in accordance with her request. She says that in the intervening period between her medication round and James' presentation, he appeared to have deteriorated. She said he was now unable to stand for a moderate period. He provided further information about his overnight illness, stating that he had vomited four times since eating dinner at around 3.30pm the day before. Registered Nurse Alexander asserted in her statement that she was concerned about the cellulitis to James' leg which was red, swollen, and warm to the touch. She recorded his observations on a standard adult general observation chart. His blood pressure was a strikingly low 86 over 63. His heart rate was 122. His respiratory rate was 17, and his oxygen saturation was 97%.

76. Registered Nurse Alexander also indicated in that statement that she had spoken to Dr Tattersall after taking the initial observations, and that he had directed her to take further observations. Registered Nurse Alexander took some further observations at 11.15am. James' observations were recorded for

a second time, and his blood pressure had improved to 112 over 66. His heart rate was marginally lower at 111.

77. Registered Nurse Alexander asserted that James stated he was feeling a bit better and was happy to return to his cell. Registered Nurse Alexander asserted that Dr Tattersall confirmed he was satisfied for James to return to the wing, provided he rested in his cell for the remainder of the day. Registered Nurse Alexander wrote a medical certificate to inform MTC officers that James was to remain in his cell. The medical certificate recorded that James has presented to the clinic with low blood pressure. He was shaking and had low oxygen saturation.

78. Despite Registered Nurse Alexander's observations of James' cellulitis, he was not prescribed antibiotics. When it was revealed during the statement phase of the coronial proceedings that Dr Tattersall had not been working at Parklea on 13 December 2019 due to the fact he was working in Mudgee South, Registered Nurse Alexander provided a further statement in which she suggested there were three possible explanations for what had happened on 13 December. Firstly, Registered Nurse Alexander suggested that she may have contacted Dr Tattersall by phone, alternatively, she may have spoken to Dr Canessa, or thirdly, she may not have spoken to any doctor at all because none was available.

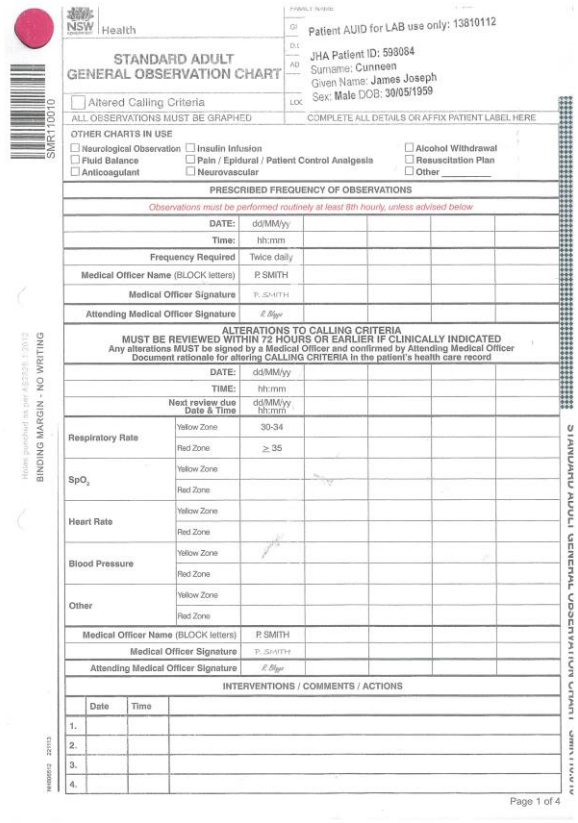
79. Dr Canessa indicated that she had no recollection of speaking to Registered Nurse Alexander on 13 December 2019. I did not find Registered Nurse Alexander to be a reliable witness in the sense that the evidence could not be relied on as accurate. I find that she was wrong in her assertion that she spoke to Dr Tattersall, and I am far from satisfied that she spoke to Dr Canessa. Registered Nurse Alexander had given evidence that she thought James' vomiting may have been due to the antibiotics he was taking. However, James was not on antibiotics as at 13 December. There is a strong possibility that reconstruction of events favoured her desire to not be criticised in relation to what transpired. In saying this, I am aware that Registered Nurse Alexander

made her first statement on 4 May 2023, some three and a half years or a little more after the incident.

80. At one level, the various inaccuracies about what actually happened on the morning of 13 November are of relatively little moment in the sense that the recorded information bespeaks a gross failure to attend to James' medical needs. On the objective evidence, Registered Nurse Alexander observed James to be pale in colour, unable to stand due to weakness and shaking, with a blood pressure reading of 86 on 63, and a heart rate which was elevated.

81. The first set of observations taken during the morning of 13 December required urgent action consistent with what's set out in the standard adult general observation (**SAGO**) chart at page 4, due to the blood pressure reading being in what is described as the red zone. The SAGO document relevantly reads:

"(a) if your patient has any red zone observations or additional criteria, you must call for a rapid response, as per local CERS, and initiate appropriate clinical care. CERS stands for clinical emergency response system: (b) inform the nurse in charge that you have called for a rapid response; (c) repeat and increase the frequency of observations as indicated by your patient's condition; (d) document an A-G assessment, reason for escalation, treatment, and outcome in your patient record; (e) inform the attending medical officer that a call was made as soon as it is practicable."



NSW Health

STANDARD ADULT GENERAL OBSERVATION CHART

Patient AUID for LAB use only: 13810112

JHA Patient ID: 598084
Surname: Cunneen
Given Name: James Joseph
Sex: Male DOB: 30/05/1959

Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

OTHER CHARTS IN USE

- Neurological Observation
- Fluid Balance
- Anticoagulant
- Insulin Infusion
- Pain / Epidural / Patient Control Analgesia
- Neurovascular
- Alcohol Withdrawal
- Resuscitation Plan
- Other

PRESCRIBED FREQUENCY OF OBSERVATIONS

Observations must be performed routinely at least 8th hourly, unless advised below

DATE:	dd/MM/yy
Time:	hh:mm
Frequency Required	Twice daily
Medical Officer Name (BLOCK letters)	P. SMITH
Medical Officer Signature	P. SMITH
Attending Medical Officer Signature	

ALTERATIONS TO CALLING CRITERIA
MUST BE REVIEWED WITHIN 72 HOURS OR EARLIER IF CLINICALLY INDICATED
Any alterations MUST be signed by a Medical Officer and confirmed by Attending Medical Officer
Document rationale for altering CALLING CRITERIA in the patient's health care record

DATE:	dd/MM/yy
TIME:	hh:mm
Next review due Date & Time	dd/MM/yy hh:mm

Respiratory Rate	Yellow Zone	30-34
	Red Zone	≥ 35
SpO_2	Yellow Zone	
	Red Zone	
Heart Rate	Yellow Zone	
	Red Zone	
Blood Pressure	Yellow Zone	
	Red Zone	
Other	Yellow Zone	
	Red Zone	
Medical Officer Name (BLOCK letters)		P. SMITH
Medical Officer Signature		P. SMITH
Attending Medical Officer Signature		

INTERVENTIONS / COMMENTS / ACTIONS

	Date	Time	
1.			
2.			
3.			
4.			

STANDARD ADULT GENERAL OBSERVATION CHART SMR110010

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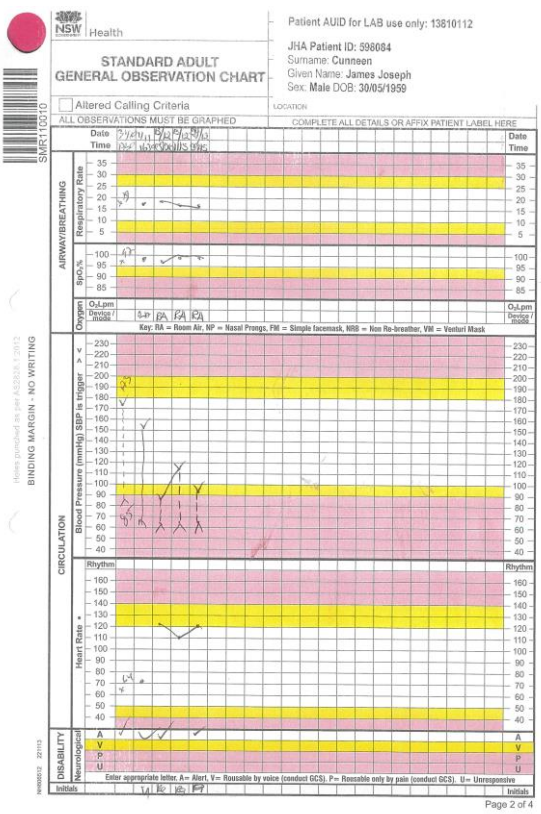

NSW Health

STANDARD ADULT GENERAL OBSERVATION CHART

Patient AUID for LAB use only: 13810112

JHA Patient ID: 598084
Surname: Cunneen
Given Name: James Joseph
Sex: Male DOB: 30/05/1959

Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

AIRWAY/BREATHING
Respiratory Rate
SpO2%
Oxygen O2 L pm Device / mode

Key: RA = Room Air, NP = Nasal Prongs, FM = Simple facemask, NRB = Non Re-breather, VM = Venturi Mask

CIRCULATION
Blood Pressure (mmHg) SBP is trigger > <
Heart Rate *
Rhythm

DISABILITY
Neurological
A V P U

Enter appropriate letter. A= Alert, V= Rousable by voice (conduct GCS). P= Rousable only by pain (conduct GCS). U= Unresponsive

Initials

SMR110010

BINDING MARGIN - NO WRITING

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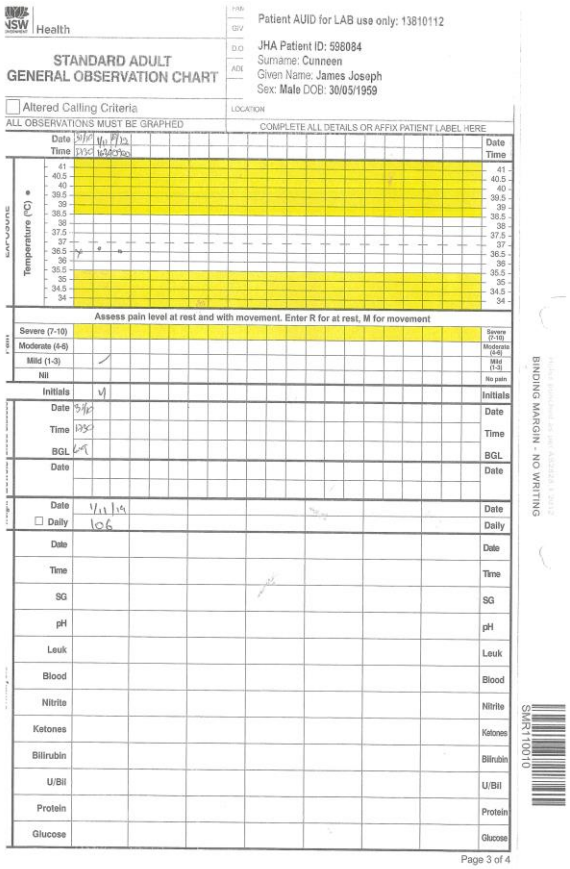

NSW Health

STANDARD ADULT GENERAL OBSERVATION CHART

Patient AUID for LAB use only: 13810112

JHA Patient ID: 598084
Surname: Cunneen
Given Name: James Joseph
Sex: Male DOB: 30/05/1959

Altered Calling Criteria

ALL OBSERVATIONS MUST BE GRAPHED

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

EXPOSURE
Temperature (°C) *

Assess pain level at rest and with movement. Enter R for at rest, M for movement

Severe (7-10)
Moderate (4-6)
Mild (1-3)
Nil
No pain

Initials
Date
Time
BGL
Date
Date
Daily
Date
Time
SG
pH
Leuk
Blood
Nitrite
Ketones
Bilirubin
U/Bil
Protein
Glucose

SMR110010

BINDING MARGIN - NO WRITING

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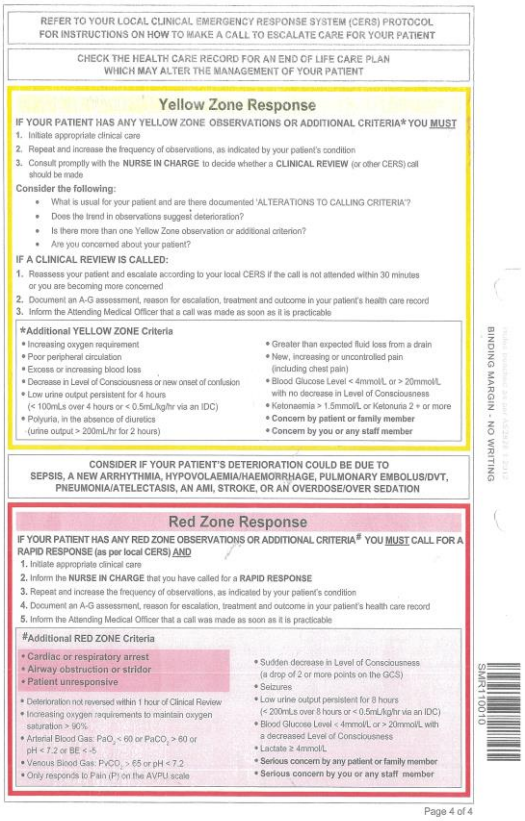

REFER TO YOUR LOCAL CLINICAL EMERGENCY RESPONSE SYSTEM (CERS) PROTOCOL FOR INSTRUCTIONS ON HOW TO MAKE A CALL TO ESCALATE CARE FOR YOUR PATIENT

CHECK THE HEALTH CARE RECORD FOR AN END OF LIFE CARE PLAN WHICH MAY ALTER THE MANAGEMENT OF YOUR PATIENT

Yellow Zone Response

IF YOUR PATIENT HAS ANY YELLOW ZONE OBSERVATIONS OR ADDITIONAL CRITERIA* YOU MUST

1. Initiate appropriate clinical care
2. Repeat and increase the frequency of observations, as indicated by your patient's condition
3. Consult promptly with the NURSE IN CHARGE to decide whether a CLINICAL REVIEW (or other CERS) call should be made

Consider the following:

- What is usual for your patient and are there documented 'ALTERATIONS TO CALLING CRITERIA'?
- Does the trend in observations suggest deterioration?
- Is there more than one Yellow Zone observation or additional criterion?
- Are you concerned about your patient?

IF A CLINICAL REVIEW IS CALLED:

1. Reassess your patient and escalate according to your local CERS if the call is not attended within 30 minutes or you are becoming more concerned
2. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
3. Inform the Attending Medical Officer that a call was made as soon as it is practicable

*Additional YELLOW ZONE Criteria

- Increasing oxygen requirement
- Poor peripheral circulation
- Excess or increasing blood loss
- Decrease in Level of Consciousness or new onset of confusion
- Low urine output persistent for 4 hours (< 100mLs over 4 hours or < 0.5mL/kg/hr via an IDC)
- Polyuria, in the absence of diuretics (urine output > 200mL/hr for 2 hours)
- Greater than expected fluid loss from a drain
- New, increasing or uncontrolled pain (including chest pain)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with no decrease in Level of Consciousness
- Ketonaemia > 1.5mmol/L or Ketonuria 2 + or more
- Concern by patient or family member
- Concern by you or any staff member

CONSIDER IF YOUR PATIENT'S DETERIORATION COULD BE DUE TO SEPSIS, A NEW ARRHYTHMIA, HYPOVOLAEMIA/HAEMORRHAGE, PULMONARY EMBOLUS/DVT, PNEUMONIA/ATELECTASIS, AN AMI, STROKE, OR AN OVERDOSE/OVER SEDATION

Red Zone Response

IF YOUR PATIENT HAS ANY RED ZONE OBSERVATIONS OR ADDITIONAL CRITERIA# YOU MUST CALL FOR A RAPID RESPONSE (as per local CERS) AND

1. Initiate appropriate clinical care
2. Inform the NURSE IN CHARGE that you have called for a RAPID RESPONSE
3. Repeat and increase the frequency of observations, as indicated by your patient's condition
4. Document an A-G assessment, reason for escalation, treatment and outcome in your patient's health care record
5. Inform the Attending Medical Officer that a call was made as soon as it is practicable

#Additional RED ZONE Criteria

- Cardiac or respiratory arrest
- Airway obstruction or stridor
- Patient unresponsive
- Deterioration not reversed within 1 hour of Clinical Review
- Increasing oxygen requirements to maintain oxygen saturation > 90%
- Arterial Blood Gas: PaO_2 < 60 or $PaCO_2$ > 60 or pH < 7.2 or BE < -5
- Venous Blood Gas: $PvCO_2$ > 65 or pH < 7.2
- Only responds to Pain (P) on the AVPU scale
- Sudden decrease in Level of Consciousness (a drop of 2 or more points on the GCS)
- Seizures
- Low urine output persistent for 8 hours (< 200mLs over 8 hours or < 0.5mL/kg/hr via an IDC)
- Blood Glucose Level < 4mmol/L or > 20mmol/L with a decreased Level of Consciousness
- Lactate ≥ 4mmol/L
- Serious concern by any patient or family member
- Serious concern by you or any staff member

SMR110010

BINDING MARGIN - NO WRITING

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82. Disturbingly, Registered Nurse Alexander did not believe she was required to initiate a rapid response and could not, when giving evidence, recall what the A-G assessment was. The evidence at inquest was that A-G is a regular assessment process which every nurse should be aware of.

83. The expert evidence is that James should have been taken to hospital on 13 December. It is likely that James suffered an episode of transient septic shock, according to Dr Vickers.

84. Dr Canessa's evidence was that had she been aware of James' vital observations, she would have directed that he be conveyed immediately to hospital. Dr Canessa was unequivocal in her evidence that a systolic blood pressure of 86 required a CERS call to be made. She said that had there been a CERS call, she would have been in the CERS because there was no one else there to do it. "*I would have gone, left my office and gone up to the top assessment room. I'd certainly done that previously*."

85. Dr Canessa's further evidence was, bearing in mind what was known and capable of being known about James as at 13 December 2019, he was acutely unwell, required treatment which exceeded that which was available at Parklea, and accordingly, transfer to hospital was the appropriate course. The experts regarded James' treatment on 13 December as wholly inadequate.

86. A further matter that arises from events on 13 December is that whilst there are records for MTC officers as to James' fainting and being returned to the clinic in a wheelchair, there is no St Vincent's record of this. This is a circumstance where there would be substantial benefit in MTC being able to pass on relevant medical information to St Vincent's in written form.

14 DECEMBER 2019

87. On the mornings of 14 and 15 December 2019, James was visited by his brother, Paul, and Paul's partner, Belinda Brand. Paul Cunneen provided a statement in which he observed:

"On the first day, James could hardly walk, was in pain, showed us his leg, which was a deep purple red and extremely swollen from ankle to top of thigh. James was sweating profusely and breathless. We spoke for an hour with him with some difficulty. When he started feeling faint his eyes would roll back in his head, and he would intermittently become incoherent."

88. Paul indicated that James said he was booked in to go to the clinic after the visit. Paul intervened and asked for the interview room to be unlocked and asked the duty guard that he get James to a doctor straight away. Paul's intervention on 14 December 2019 was effective. At 11.01am on 14 December, James was reviewed by Dr Tattersall. Notwithstanding James having been prescribed a number of antibiotic courses by Dr Tattersall the month before, notwithstanding the notes as to James requiring review, this was the first occasion on which James was seen by Dr Tattersall.

89. By this time, James:

a) In accordance with the note by Nurse Karki, following the completion of the RSA, should have been seen by a medical officer. In my view, this should have occurred within the first few days of James' detention, whilst James was in the clinic;

b) Should have been seen by Dr Tattersall in relation to doctor's decision to discontinue the prescription of a PPI;

c) Should have been seen by a medical officer in relation to the ongoing prescription of medications generally;

d) Should have been seen by a medical officer in relation to Dr Canessa's prescription for Bactrim;

e) Should have been seen by a medical practitioner on 13 December;

f) On the expert evidence, should have been seen by a medical officer twice a week, given he, as a diabetic, had cellulitis.

90. The failure of any medical officer to see James prior to 14 December 2019 represented a gross failure to deliver medical care to the requisite standard.

91. It was Dr Wilson's evidence that given James' health issues, the fact that he was first seen by a GP five weeks after his initial diagnosis of cellulitis was, at a very minimum, not timely. James likely required transfer to hospital on 14 December so that a number of investigations could be undertaken, including a full blood count and blood sugars at the very least, as well as cholesterol levels, liver and kidney function tests.

92. The fact that James was not seen by a doctor until after his family intervened graphically highlights the inadequacy of the care of James at Parklea in November and December 2019.

93. Dr Tattersall's note in the clinical records on 14 December includes as follows:

"*Patient seen in clinic with cellulitis to right lower limb, rigors yesterday. James' observations including blood pressure of 93/57 were recorded.* Dr Tattersall recorded a plan to *"keep in main clinic".* He prescribed doxycycline and noted there was to be a *"low threshold for hospital transfer if deteriorates*". He also ordered that James' observations be taken six hourly. The area of arrhythmia (redness of the skin) caused by the cellulitis was marked with a pen.

94. There is no record of Dr Tattersall recording his observations in the SAGO chart. Dr Tattersall did not take James' heart rate. In oral evidence, Dr Tattersall explained the basis for six hourly observations being because he was worried about James. He was on the verge of sending James to hospital, so he wanted to make sure that "*we have a very close review of the patient during the time that he's with us. I know that can happen because he's in clinic. That's the point of that*".

95. Dr Tattersall did not record a history of James having fainted the day before. Given the charted systolic reading from the previous day of 86 and heart rates of 122 and 111, it is difficult to understand how Dr Tattersall could not have

explored with James the events of the previous day, and indeed, sent James to hospital. James remained in the clinic on 14 December. At 10pm, Registered Nurse Mutede entered a note in the clinical records as follows:

"*Patient vomited a lot this PM after taking a stat (immediate) dose of doxycycline 200 milligram on an empty stomach for cellulitis. Vital observations checked at 3.30pm, temp 37.1 degrees Celsius, heart rate 82 beats per minute, oxygen 99%, blood pressure 128/82. Maxolon 10 milligram administered at 8.30pm. Patient to have another dose of 200 milligrams of doxycycline after eating some food. Obs at 8.30pm stable, and afebrile*".

96. Registered Nurse Mutede did not record James' 8.30pm observations in the SAGO chart. Indeed, they were not recorded anywhere. The only note in respect of those observations was a notation that the observations were stable, and that James was afebrile. Registered Nurse Mutede accepted that she ought to have entered James' observations on the SAGO charge. Dr Tattersall regarded it to be meaningless to have an entry which recorded observations as stable without knowing the actual results.

97. Whilst James' vomiting was attributed to the stat dose of doxycycline he had received, it is to be noted that he had been vomiting on 12 and 13 December, and it seems quite possible the vomiting was due to causes other than the asserted poor meal, which some witnesses suggest may have been the case, and/or the doxycycline. Registered Nurse Mutede went on to say that she gave James a maxolon injection at 9pm, and did not give him the 200-milligram dose of doxycycline because she wanted to allow time for the maxolon to work and stop the vomiting, and also for him to have something to eat.

98. Registered Nurse Mutede then asked the Corrective Services officers to get James some food. Registered Nurse Mutede then handed over to the night shift nursing staff for them to give the dose of 200 milligrams of oral doxycycline, however she observed that this was not signed for in the medication chart, but that someone has signed for the 8pm regular dose of doxycycline that Registered Nurse Mutede had not given.

99. On 15 December at 5.43am, Registered Nurse Ramiah entered a note in the electronic progress notes. It recorded that: "*James was responsive on morning round and no issues were said to have been voiced*". No observations were taken. Observations were taken by Registered Nurse Tanya Nguyen some time prior to Dr Tattersall reviewing James in the clinic at approximately 9:30am on 15 December. When Registered Nurse Nguyen took James' observations, she found he had a temperature of 38.3 degrees centigrade. Registered Nurse Nguyen knew that temperature to be elevated, notwithstanding it being between the flags on a SAGO chart, and Dr Tattersall relevantly accepted it to be abnormal. The opinion of each of the experts was that it was abnormal.

100. Dr Tattersall recorded that James' cellulitis was reducing compared with the area of arrhythmia that had been marked the day before. Dr Tattersall recorded a plan for James to return to the wing, i.e. be discharged from the clinic, notwithstanding the abnormal temperature reading. He noted doxycycline was to continue, and hydrozole and dermeze ointment were provided to James to apply to the skin to prevent skin breakdown. Dr Tattersall appears not to have taken James' blood pressure nor recorded his temperature. There is no information as to James' respiratory rate, nor his heart rate. Those observations do not appear in Dr Tattersall's progress note. They do not appear in the SAGO chart.

101. The day prior, Dr Tattersall had directed that James' observations were to be taken six hourly. Notwithstanding that direction, and notwithstanding the passage of nearly 24 hours since the direction was made, James' observations were recorded twice only, and Dr Tattersall himself failed to take James' observations. Dr Tattersall's rationale for keeping James in the clinic and directing six hourly observations was that James could be closely monitored for any change in his condition, and yet this did not happen.

102. Despite this, Dr Tattersall decided to discharge James from the clinic and explained in oral evidence his reasons for doing so as including his observations of James in getting off the top bunk, James expressing himself in quite logical terms, together with the improvement in his cellulitis, which he

could observe by the markings of the affected area having reduced. In addition, Dr Tattersall noted that James would have daily observations, and that would be a way of keeping an eye on what was happening.

103. I accept there had been some improvement in James' presentation. So much was confirmed by his brother Paul, who saw James on the 15th. However, Paul also noticed that James was still sweating profusely and extremely weak. It should be noted that James had said to his brother that the doctor wanted him to go to hospital overnight, but James had not wanted to as he felt uncomfortable about being handcuffed to the bed. I note also that the evidence of Dr Tattersall was that James wanted to go back to the wing, and the doctor indicated he weighed this in his decision making. Despite the improvement, and despite Dr Tattersall's explanation, each of Professor Howes and Whitby and Drs Vickers and Wilson regarded the decision to discharge James from the main clinic as unreasonable. Further, each considered that James required transfer to hospital on 15 December.

104. On 17 December at 11.37am, James was reviewed by Dr Tattersall. Dr Tattersall was informed that James had not been receiving his antibiotics regularly. In oral evidence, Dr Tattersall indicated that he was very unimpressed when he realised what had happened, and he said he basically lost it when James turned up and had not had his antibiotics. Dr Tattersall indicated he went down and spoke to Dr Canessa, showed Dr Canessa the chart, and talked to her about what had been going on, and then went and found the Nurse Unit Manager who was wandering down the corridor. Dr Tattersall indicated he grabbed the Nurse Unit Manager, took her into the office, and went over all the issues that he had been having with James, the fact that James had not got his antibiotics, that he was unwell, and that he had come back again.

105. The Nurse Unit Manager denied that she was informed of the medication errors and denies she was told to enter the errors on IIMS. No occasion of medication not being provided was ever entered on IIMS or IIMS+.

106. I find it unnecessary to resolve the factual and evidentiary dispute on this issue, although I am satisfied that Dr Tattersall did raise the issue of not giving prescribed medications to James with someone in authority at some stage. In my assessment of him, he would not have made that evidence up. Whether it was precisely in relation to this occasion in relation to James, and whether it was precisely that conversation with the Nurse Unit Manager in relation to James on that occasion is of little moment. There should have been an appropriate system to check medication was being provided, and there is no evidence of any effective system being in place during the time James was in Parklea.

107. Dr Tattersall did not record James' observations, and he initially accepted that he did not take them. Later in evidence, Dr Tattersall changed his position, indicating that he most definitely would have had a nurse take James' vital observations. Dr Tattersall accepted he had a responsibility to make sure the observations were taken. Ultimately, Dr Tattersall accepted that in the absence of any recorded observations, it could not be known whether James had a fever, an elevated temperature, hyper or hypotension, or tachycardia. All of these things were essential to know and act upon at that time, and it was essential that they be recorded.

108. In further evidence, Dr Tattersall accepted that the standard of healthcare provided to James in November and December was very, very poor. When asked whether James had available to him healthcare of an equal standard to that which was available in the community, Dr Tattersall indicated it was a nonsense to suggest that that was the case, and more generally indicated it was not true that the healthcare at Parklea was of the same quality to that which was available in the community, and further said: "*it is impossible. It just does not happen*".

109. In conversation with a friend, Allan Farlow, on 18 December James indicated that he'd been really, really sick, and the cellulitis had again gone right up his leg, up to his groin, and that it seemed "*impossible for this place to deliver a consistent course of antibiotics*". He confirmed he was just about fainting when

he had seen Paul and Belinda. James also confirmed it was ridiculous, because everybody knew that antibiotics had to be consistent. He also indicated that Dr Tattersall went nuts and got it all organised with the strongest antibiotic. James noted that he could end up in Blacktown Hospital if it got much worse, and he said: *"The prison has got their own ward at Blacktown Hospital, but I really don't want to go because you're handcuffed to the bed, and the feet are handcuffed to the bed"*. He indicated that he was hopeful the antibiotics would help. James said he could put weight on his legs and walk better. He was not stumbling and falling.

110. At that stage, James had only once received a consistent course of antibiotics, despite them being prescribed five times. It is trite to repeat that this was a gross failure in delivery of healthcare to James.

111. I find that Dr Tattersall was very close to sending James to hospital in December, around the 14th, 15th, and 17th, and that James was resistant to going to hospital, and desirous of returning to the wing, that is, leaving the clinic. In my view, it was likely the pain associated with James' cellulitis made him reluctant to go to hospital, given that he understood he would be cuffed by both hand and ankle. That would have been a very daunting prospect, given the pain James experienced from the improperly treated cellulitis. Nevertheless, the best medical approach remained unquestionably that indicated by the experts, that is, James should have gone to hospital.

112. There is a significant and tragic irony in James not wanting to go to hospital because of the pain he experienced from his cellulitis, as, if he had gone to hospital, the cellulitis likely would have been treated effectively, efficiently and rapidly, and earlier attention could have been given to James' ulcerated stomach.

113. Bactrim was administered to James on 17, 18, 19, 20, 21, 22 and 23 December, and the evidence confirms James' cellulitis substantially resolved. It was not observed on admission to hospital on 25 December, it was not observed during

autopsy, and inflammatory markers were generally normal following James' admission to Blacktown Hospital.

114. Allan Farlow observed that on 21 December the cellulitis was receding, and the tablets were working. Similarly, on 21 December, in a telephone call from James to his mother, James reported that his cellulitis was not 100%, but it was much improved, after reporting that he had been carted around in a wheelchair earlier in the week. He said: "*Oh yeah, it's been bad. Yeah, so, you know, to try and get your health needs met here is unbelievable. Unbelievable, but look, it's a lot better".*

24 DECEMBER 2019

115. The next entry in the progress notes is an assessment by Registered Nurse Kim Alexander on 24 December 2019 at 9.45am. Registered Nurse Alexander recorded in the progress note that James reported vomiting, nausea and lethargy. She noted that James provided a history that he had been taking antibiotics for the past week, that he had been sick, and that he had been vomiting. The antibiotic course was observed correctly to have been completed that morning. By reference to the progress note of the review on 24 December 2019, in respect of objective observations, Registered Nurse Alexander noted that James looked pale, was walking slowly, and had nil signs of vomiting.

116. In oral evidence, Registered Nurse Alexander explained that "*nil signs of vomiting*" was intended to indicate that at the time she saw James he wasn't vomiting. It was not intended to suggest that Registered Nurse Alexander doubted the reliability of James' account. When Registered Nurse Alexander reviewed James, she measured and recorded on the SAGO chart his vital observations. James' blood pressure was 99/66, which fell in the yellow zone. Similarly, in the yellow zone was his heart rate, of 120 beats per minute. The entry in the progress note recorded that the GP was consulted in respect of James' low blood pressure and elevated heart rate. In respect of assessment/analysis and plan (**SOAP**), Registered Nurse Alexander recorded

that James was to be reviewed by the GP. Elsewhere, the entry reads: "*Patient to be reviewed by primary health in five days*".

117. Registered Nurse Alexander did not obtain from James a history of him having pain on defecation, experiencing epigastric pain, severe or otherwise, having a history of gastrointestinal symptoms, nor did she elicit from him a history of haematemesis, vomiting blood. Having regard to the history James provided upon admission to Blacktown Hospital, and the history he provided the very next day to Dr Tattersall, one expects that same history was available to be elicited on 24 December.

118. Registered Nurse Alexander was questioned in respect of her notation recorded contemporaneously in the progress note that she had consulted with the GP on 24 December. Dr Tattersall denied that he was consulted in respect of James on that day. Registered Nurse Alexander's evidence was as follows:

"*Q. In your 24 December 2019 SOAP, subjective objective assessment and plan entry, you have recorded, GP consulted as to patient's low blood pressure and heart rate. Am I correct to understand you would not have recorded that unless you had consulted a GP?*

A. No. If I hadn't have seen a GP, I wouldn't have put that.

Q. Did you understand Dr Tattersall to be a GP?

A. Yes.

Q. Did you understand Dr Canessa to be a GP?

A. No.

Q. So when you wrote that a GP was consulted, which doctor do you believe you were referring to?

A. Dr Tattersall."

119. While Registered Nurse Alexander's progress note might be thought to support the conclusion that she consulted Dr Tattersall in respect of James, particularly bearing in mind her evidence that she would not have recorded that she spoke with a GP had she not spoken with one, her evidence when examined by counsel for Dr Tattersall was as follows:

"Q. And your account of speaking to a GP on the 24th is also wrong; I'm putting that to you.

A. I'm not sure if it was wrong.

Q. Well, you have no

A. No.

Q. memory; do you? To be fair, Dr Tattersall did not speak to you on 24 December about Mr Cunneen; what do you say about that?

A. I don't know if I documented the I spoke to Dr Tattersall on that day.

Q. Sorry?

A. I'm not sure if I spoke to Dr Tattersall on that day.

Q. Well, I'm putting to you that you didn't.

A. No.

Q. And do you agree, or disagree, or don't know?

A. I'm not sure if he was there, no.

Q. But do you accept that there are errors I've identified in your record which may support a proposition that you didn't speak to Dr Tattersall?

A. Yes."

120. Bearing in mind Registered Nurse Alexander's assertion that she is not sure if she spoke to Dr Tattersall on that day, and having regard to Dr Tattersall's unequivocal evidence that he was not consulted in respect of James on 24 December, and noting that Registered Nurse Alexander's entry included: "*Patient to be reviewed by primary health in five days*", I am unable to conclude that Dr Tattersall was consulted by Registered Nurse Alexander on 24 December.

121. It was submitted on Registered Nurse Alexander's behalf that I would place weight on the contemporaneous note and accept that Dr Tattersall was consulted; however, in the chaos that existed in November and December 2019 in Parklea, I could not place reliance on that entry. It may have indicated no more than that Registered Nurse Alexander intended to talk to Dr Tattersall.

122. It is to be noted that yellow zone SAGO chart readings, such as James' heart rate of 120 beats per minute, required that there be consultation with the nurse in charge and a determination of the appropriate clinical response. There is no indication that occurred.

123. The expert evidence was unequivocally to the effect that James required hospitalisation on 24 December 2019. Instead of hospitalisation, James was returned to his cell.

REVIEW BY DR TATTERSALL 25 DECEMBER 2019

124. On 25 December 2019 there was a further deterioration in James' condition. James was seen by Registered Nurse Tehranchi within his cell. He reported feeling sick. In what is necessarily a retrospective note entered at 12.29pm on 25 December, Registered Nurse Tehranchi recorded that James was taken to the clinic to be seen. At 12.13pm, in what must also be a retrospective note, James was reviewed by Dr Tattersall. Dr Tattersall recorded a one-week history of nausea, vomiting and light headedness. Dr Tattersall reported fevers, rigors, initially post eating a meal last week. By relevance to the chronology of events,

a reference to last week as the date of onset must in fact be a reference to the vomiting that commenced around 13 December. In respect of that history, Dr Tattersall observed the following:

"Q. You obtained a history, do you see, of Mr Cunneen presenting to the clinic with a one week history of nausea, vomiting and light headedness?

A. Mm.

Q. Do you accept that it might have been a two week history of nausea, vomiting and light headedness?

A. This is just documented from what he'd told me then, and really, at that time, I just documented what he tells me, but he's going to hospital. It doesn't really matter what the history is, you're going to hospital.

Q. This is by no means a deep dive into his background. You're getting the notes down quickly, and you're getting him off to hospital?

A. Yeah.

Q. Is that right?

A. That's it."

125. Dr Tattersall additionally recorded in a progress note: "*Pale, lethargic, febrile*". The abdomen was noted to be tender, and epigastric tenderness was also recorded. James was additionally noted to have burning epigastric pain. Dr Tattersall recorded an impression of GORD/gastritis/haematemesis? /gastric ulcer unclear infective cause?. He recorded a plan of:

1. Stat Gaviscon plus Rabeprazole.

2. Ambulance transfer.

126. Dr Tattersall's note was the first occasion on which the symptom of haematemesis (vomiting blood) was recorded. At 11.13am, Registered Nurse Cheryl Chavaria prepared a clinical summary transfer to external hospital following an assessment of James. In that document, Registered Nurse Chavaria noted that James had been experiencing epigastric pain and vomiting for a period of two weeks. James was noted to vomit four to five times a day with some blood now. Registered Nurse Chavaria further recorded about half a cup of blood in James' vomit. Registered Nurse Chavaria noted James to look very pale. He was noted to have blood pressure of 99 on 68, with a pulse rate of 110 beats per minute. He was noted to be afebrile but have mild chill and was very weak.

127. In her statement and in her oral evidence, Registered Nurse Chavaria asserted that she did not recall who communicated the clinical information in respect of James to her, including of the history of vomiting four to five times a day with some blood. She noted in her statement and confirmed in her oral evidence that she doubted that information was conveyed by James because he was seriously unwell. She thought it more likely the information was provided by a nursing colleague or Dr Tattersall. Against that, however, is the fact that Dr Tattersall was plainly able to elicit a history which suggests that the history obtained by Registered Nurse Chavaria may equally have been provided by James.

TRANSFER TO BLACKTOWN HOSPITAL

128. The care provided to James at Blacktown Hospital was not the subject of close examination at inquest. Upon transfer, James arrived at Blacktown Hospital at about 12.15pm and was triaged by a registered nurse. The registered nurse noted a 2-week history of vomiting, and from the records, appears to have observed James vomit to be dark brown with blood. At 3.20pm, James was reviewed by Dr Abedin, who discussed James with Dr Bahin, gastroenterologist. Dr Abedin recorded that James required a proton pump inhibitor infusion and was to be nil by mouth from midnight for endoscopy on 28 December 2019.

129. On 26 December 2019 at about 5.30am, James was reviewed by Dr Daniel David. Dr David noted that James had been scheduled for endoscopy. He obtained a history of severe epigastric pain rated at nine out of ten. He noted that: "*James states pain is similar to what he has been having now for two weeks*." James was subsequently reviewed by Drs Chandra Kumar and Lee as part of a cardiology consult. They obtained a history of having been unable to keep food down for at least a few weeks. They noted that James reported excruciating abdo/epigastric pain after vomiting. James reported ongoing dizziness and gasping for air when having abdo pain. They also recorded: "*Reports has been vomiting fresh blood last week*".

130. The doctors recorded an impression of Type 2 Non-ST Elevation Myocardial Infarction from anaemia due to GI bleeding. At 1.40pm, James underwent upper endoscopy performed by Dr Bahin. Dr Bahin diagnosed LA grade A reflux, oesophagitis, chronic gastritis, a single non-bleeding duodenal ulcer with non-bleeding visible vessel. Dr Bahin directed that James be returned to the high dependency unit for ongoing care. A proton pump inhibitor intravenous infusion of 72 hours was charted, together with an order that aspirin be restarted in two days and Clopidogrel be started in five days. Dr Bahin recorded that haemoglobin, troponin and stool output be monitored daily.

131. On 27 December 2019, there was a further cardiology consult. The doctors noted concerning findings on the angiogram, which reflected significant triple vessel disease. They, again, recorded an impression of type 2 NSTEMI and observed: "*Will need inpatient coronary artery bypass graft unless contraindication from gastro point of view*." At 10.28am, there was a further cardiology review by Dr Bhat. Dr Bhat had been contacted by a Dr Ghelani, intensivist, who advised that James' troponin level was greater than 19,000. Dr Bhat recorded: "*Impression is of a high risk NSTEMI*." Dr Bhat recorded that James required coronary angiogram today. Dr Bhat spoke with Dr Hsu, consulting cardiologist, and recorded: "*Approved for coronary angiogram plus/minus percutaneous coronary intervention.*"

132. Left and right coronary angiogram was performed on 27 December by Dr David Burgess. On 28 December 2019 at 1.52pm, James was reviewed by Dr Hashimi as part of the ICU ward round. Dr Hashimi noted that James was oriented to time, person, and place, but having visual hallucinations. At 9.32pm, James lost consciousness and had a blood pressure of 66 over 49. Cardiac arrest was diagnosed immediately. A MET call was activated, and CPR commenced. Thereafter, the MTC guards who were present removed James' ankle and wrist cuff to allow defibrillation. Various medications, including adrenaline, were administered, and CPR continued for a period of 45 to 50 minutes with no return of spontaneous circulation. Dr Ramon Seastres, ICU physician, provided a direction to cease CPR. All medical officers present agreed with that direction. James passed away at 10.11pm on 28 December 2019.

ISSUES EXAMINED AT INQUEST

133. A number of the issues set out in the issues list, which itself is set out at the start of these findings, have been examined above or will be examined in the balance of these findings. I do not propose to deal with them item. I will now examine the failings in relation to the delivery of care to James in some greater detail.

LIST OF FAILINGS

134. It bears emphasising that James was at Parklea for just short of two months, 1 November to 25 December 2019. Without claiming that the following captures every failing in relation to the care of James in that period, I now set out a list of failings in broad chronological order:

1) Failure of GP to review James in the clinic, despite a note made by the nurse who conducted the reception screening assessment that James required review by a GP.

2) Failure to see James to assess him before determining whether to continue or cease the PPI medication, Rabeprazole.

3) Prescribing antibiotics without seeing James, or, as a bare minimum, ensuring James was seen by a GP the following day (8, 13, 16, 19 November).

4) Failing to administer prescribed medication on 8, 11, 12, 15, 16, 17, 18 November (14 occasions).

5) Failing to prescribe an additional antibiotic with doxycycline to address the risk of staphylococcus infection.

6) Prescribing medication without any clinical entry to support the prescription.

7) Failure to make entries in either the written or electronic progress notes.

8) Failure to take observations during November.

9) When observations were taken in December, failure to enter those observations in the SAGO chart.

10) Failure to record in IIMS or IIMS+ any of the multiple failures to administer medication.

11) Failure to call for a rapid response or CERS on 13 December as required by the content of page 4 of the SAGO chart.

12) Failure to inform the nurse in charge of James' observations on 13 December.

13) Failure to undertake an A-G assessment.

14) Failure of any general practitioner to see James prior to 14 December.

15) Failure of any general practitioner to see James prior to James' family taking action in relation to the disturbing state of James' health.

16) Grossly inadequate follow up of cellulitis presentation.

17) Failure to enter appointments on the waitlist or PAS.

18) Failure to administer prescribed antibiotics on 15, 16 and 17 December (six occasions).

19) Failure to take observations at 6 hourly intervals despite Dr Tattersall's clear indications for this to be done whilst James was in the clinic in December (14 and 15 December).

20) Failure to take any observations after James returned to his cell in December despite the requirement for at least daily observations (16, 17, 18, 19, 20 December).

21) Signing documentation for having administered medication when in fact the medication had not been administered (one occasion, 15 December).

22) Failure to check that the direction to take observations was being complied with.

23) Failure to check that prescribed medication was administered.

24) Failure to regularly review James who, as a diabetic patient with leg cellulitis, should have been reviewed, on the expert evidence, at least twice a week.

25) Failure to send James to hospital on 14 December, 15 December, 17 December and 24 December.

26) Failure to conduct a Chronic Disease Screen within 29 days or at all.

135. Each one of the above failings represents a departure from expected clinical practice in the community. Making appointments, administering prescribed

medication, and making notes are simple and straightforward steps to be taken as part of the process of caring adequately for a patient. Ensuring that necessary steps have been taken requires an effective level of overview. It is clear no effective overview was taking place at Parklea in November and December 2019.

NOTE TAKING AND OBSERVATIONS

136. Accurate and consistent note taking facilitates communication among clinicians and supports patient care by tracking progress, identifying patterns, and aiding in follow up in decision making. It also ensures everyone has access to the same information. Observations and their accurate recording are crucial for timely diagnosis, treatment decisions, monitoring patient's progress and promoting continuity of care. The failure to take observations as required, and the deficiencies in note taking and record keeping detrimentally impacted upon the care of James to a significant degree.

CEASING MEDICATION FOR GORD

137. Dr Tattersall should not have ceased the GORD medication without discussing the issue with James. This was the proper and appropriate course. James had just come into a remand prison. The reception screening assessment indicated he needed medical review. The documentation from Dr Sharma indicated James suffered from GORD, and James was initially housed in the clinic and as such should have been readily accessible to Dr Tattersall. The expert evidence of Dr Vickers, gastroenterologist, was that medication for GORD would have allowed James to avoid the development of a duodenal ulcer, which was a significant contributing factor to his death. Professor Howes, and Professor Whitby, infectious diseases physician both agreed with that view. The evidence of Dr Vickers is that PPIs are very, very safe, and the benefits far outweigh the risks. No expert gave evidence to the contrary.

138. Given Dr Tattersall's evidence that it was not reasonably practicable to consult with James on 2 November, the evidence establishes that the prudent course of conduct was to continue the Rabeprazole until such time as James could be

seen by a doctor, and an assessment could be made as to his requirement for that medication. It should not have been discontinued on 2 November. The most likely reason for James not having a current script for a PPI when he entered custody was because his criminal trial immediately preceded his entry into custody.

139. Records obtained from the Pharmaceutical Benefits Scheme, as Dr Sharma's clinical records confirm, that James was prescribed medication for GORD on three occasions by Dr Sharma, with each script having five repeats. The third script was obtained in March 2019 and had five repeats. Approximately monthly, between May and September 2019, James filled his script for Pantoprazole. Sometimes there were longer than usual breaks between filling the script. On other occasions, he filled the script at considerably shorter intervals. The last date on which James filled the script was 2 September 2019. James' criminal trial proceeded in October 2019. The fact of the criminal trial is the likely explanation for why James did not again fill his script. Following his trial, he went straight into custody.

140. Dr Tattersall's discontinuance of PPIs on 2 November was exacerbated by the fact that James was not seen by a GP until 14 December. From 14 December onwards the main focus of James' care was his cellulitis. It is self-evident that in the consultation Dr Tattersall should have had with James on or about 2 November, Dr Tattersall should have explored with James the issue of medication for GORD. It is far more likely than not that, following such a conversation, the prescription in place would have been renewed and steps would have been taken for James to remain on a PPI.

FAILURE TO CONDUCT CDS

141. As noted, no chronic disease screening (**CDS**) was undertaken, let alone one within 29 days. The appointment made for 13 December did not take place, following James' taking ill that morning in the AVL suite. Despite James thereafter being in the clinic, there was no evidence of a further appointment

being made. The indicia that James needed a chronic disease screening included his:

a) Diabetes;

b) Ischemic heart disease;

c) Peripheral vascular disease; and

d) Gastro oesophageal reflux disease (**GORD**).

142. In the reception screening assessment, it was indicated that James' name had been added to the patient appointments for a chronic disease screen. However, no appointment was made until Registered Nurse Chavaria made an appointment for 13 December, despite the requirement that a CDS take place within 29 days. There was an interim draft CDS on 12 November. Dr Wilson said there was no new information in that document. The interim document did not, in any way, meet the need for a full chronic disease screen.

143. A CDS is important because it allows for early detection, and enables timely interventions, and improved health outcomes. Early detection can lead to less invasive treatments, better disease management, and potentially prevent or slow down the progression of chronic conditions. A CDS combined with reviews twice a week unquestionably would have enhanced James' care and increased his prospects of survival.

FAILURE TO ADMINISTER CHARTED ANTIBIOTICS

144. It is difficult to comprehend how it could be that prescribed and charted antibiotics were not administered on some 20 occasions during November and December 2019. The failure occurred on ten separate days. The fact that, at one stage, one or other of the available antibiotics was in fact not available is no excuse and provides no proper reason for the failure. If an antibiotic was unavailable, it should have been reported to Dr Tattersall straight away, and an

alternative antibiotic made available following prescription, as occurred when, belatedly, a shortage was reported to Dr Tattersall.

145. James, as a patient inmate, was present in his cell. There were medicine rounds, morning and evening, and yet his antibiotics were not consistently administered. The process of medication administration was explained comprehensively and helpfully by Julie Dyer, who joined St Vincent's Correctional Health in January 2020 on secondment as the nurse unit manager. In short, medication was administered either by pharmacy technicians or nurses. Close analysis confirmed that James was provided medication reliably by pharmacy technicians. In contrast, when nursing staff were required to pack and administer the medication to James, he regularly did not receive either Bactrim or doxycycline.

146. It bears emphasising that the failure to administer antibiotics occurred in the context of James telling his family he had to ask and "*ask and ask and ask and worry them and worry them and worry them*" with his complaints, and "*wear them down to do someth*ing", and "*that it seemed impossible to have them deliver a consistent course of antibiotics*". These comments paint a most disturbing and troubling picture. It is not as if James was unavailable. It is not as if James did not want his antibiotics. Indeed, he was asking for this medication over and over. He was in significant pain and discomfort from the cellulitis. Furthermore, the failures to administer the medication occurred whilst James' cellulitis was readily recognisable, as well as extremely painful.

147. Ultimately, antibiotics were appropriately administered only after James' family demanded he see the GP as soon as possible, and Dr Tattersall read the riot act about administration. The result after that intervention by Dr Tattersall, was observable improvement in James' extremely painful symptoms. However earlier opportunities for appropriate treatment of the symptoms had been missed. The failures bespeak a care system in total disarray.

FAILURE TO PROPERLY SUPERVISE DR TATTERSALL

148. As made clear above, Dr Tattersall had responsibility for somewhere between 1,100 and 1,200 inmates during November and December 2019. He was the only GP practising in Parklea in November and December 2019. He was a junior doctor. He had been practising for less than four years at the time he treated James, and as part of the Australian College of General Practitioners' pathway, he was required to be supervised in a practical placement which occurred in South Mudgee. St Vincent's point to the fact that Dr Tattersall was able to contact specialists within the St Vincent's Hospital Network, however this, in my view, did not remedy the absence of an appointed clinical supervisor who had direct supervision of Dr Tattersall.

149. Dr Canessa, a psychiatrist, was not someone who, in her position, could adequately supervise Dr Tattersall, and indeed, as previously indicated, some of Dr Canessa's evidence indicated that she, when placed in the position of having to attend to inmates, sought the advice of Dr Tattersall. Dr Hester Wilson, in her evidence as expert general practitioner, both orally and in her written report, spoke to the importance of clinical supervision. Her opinion was unchallenged. She considered Dr Tattersall to be a junior doctor and observed that he required clinical supervision by someone practicing in the same area of medicine as he was. She considered that such a person needed to be readily available in person or by telephone to Dr Tattersall. She rejected the notion that Dr Canessa was a suitable person to provide supervision to Dr Tattersall, and proceeded to observe:

"He was a GP in training, and you need to have a supervisor that's in the field that you are training in. If he is working as a trainee general practitioner, he needs an experienced general practitioner as supervisor. Generally, we (the College) would like them to be onsite, but we do understand that that may not be the case all the time. They do need to be in easy phone contact. In addition to that, we, in the college, ask that people actually have time that they set aside to look through cases, to have discussions, to really allow that trainee GP to learn their skills and learn a wide range of skills. Dr Tattersall was employed as

a GP. That was his substantive role, in that general practice setting, in the custodial setting, and he needed an experienced GP supervisor to support him."

150. Dr Tattersall gave evidence, in the context of the need for supervision and complexity of presentations at Parklea, that "*working there was like working in a jungle clinic in Myanmar".* Dr Tattersall went on*, "I've done that, right. So I've done that time*". This evidence underscores, if underscoring is necessary, and makes patently clear the need for appropriate supervision, in particular, in the demanding circumstances in which Dr Tattersall worked. Supervision to the level outlined by Dr Wilson was required.

CHAOTIC DELIVERY OF HEALTH SERVICES

151. I am satisfied that the delivery of medical services at Parklea in November and December 2019 was chaotic.

152. At one level, the identified failings speak for themselves in relation to the health care provided in that period. Nevertheless, in case there be any doubt as to the situation, the words of the staff members confirm what the failings suggest:

- "*There was no chronic disease nurse at the time, and it was not uncommon for chronic disease screening to be missed*", (Registered Nurse Chavaria).

- "*Staff shortages were common in 2019 and now*", (Registered Nurse Chavaria in evidence in 2023).

- "*There were barriers to getting chronic disease screenings done, and generally, to proper treatment*", (Registered Nurse Karki).

- "*Sometimes this was because of staff shortages, including staff shortages with the officers*", (Registered Nurse Karki).

- "*I am aware of circumstances in 2019 where patients would not receive medication*", (Registered Nurse Mutede).

- "*The failure to administer medications may have occurred because a nurse forgot to pack the medication, there were not enough officers to escort us, the nurse got caught up doing something else, or because there was nil supply*", (Registered Nurse Chavaria).

- "*A nurse might miss a telephone order for medication, or maybe an order was not handed over from one shift to the next*", (Registered Nurse Chavaria).

- "*I am aware that medication which had been prescribed to patients was not consistently administered at Parklea*", (Dr Canessa).

- "*There has always been a shortage of nurses at Parklea*", (Registered Nurse Alexander).

- "*There was inadequate time to spend with patients and inadequate time to consider the patient's history*", (Registered Nurse Alexander).

- "*There was a shortage of Nurse Unit Managers in Parklea in 2019*", (Registered Nurse Alexander).

- "*Shortages led to a strain on nursing staff*", (Registered Nurse Alexander).

- "*There was only one mental health doctor and one GP in 2019. There is need for more than one GP*", (Registered Nurse Alexander).

- "*There were many reasons for medication being missed. You are constantly interrupted*", (Registered Nurse Alexander).

- "*In relation to record keeping, you are constantly interrupted. I probably got up and down, and people - other people are allowed to share the computer*", (Registered Nurse Alexander).

- "*There were always shortages of nursing staff*", (Dr Canessa).

- "*The consequences of shortages among nursing staff included that everyone was just overworked and pressured to get through numbers, and people got missed because of tha*t", (Dr Canessa).

- "*Patients got missed*", (Dr Canessa).

- "*If nursing staff are even putting people on the waitlist or even seeing patients at their clinic nurse rounds, they were limited. Limited nurses, limited availability, limited access to patients. So that made it more difficult to see people as well*", (Dr Canessa).

- *"I don't have an exact figure, but I could say that on any given day in November and December 2019, we would be three nurses short or four nurses short, and the shortage was consistent in that period*", (Katya Issa, operational manager).

- "*The GP wait list was meaningless*", (Dr Tattersall).

- "*I was too busy due to patient demand. It was overwhelming*", (Dr Tattersall).

- "*I was drowning with the workload in the clinic*", (Dr Tattersall).

- *"even the diabetic patients who were really critical to be there three times a day were not brought across with sufficient regularity and timeliness",* (Dr Tattersall)

153. As earlier set out, Dr Tattersall indicated it was a nonsense to suggest that James had available to him in custody health care of an equal standard to that which is available in the public sector in the community. Dr Tattersall said, "*It's impossible. It just doesn't happen.*"

154. Ms Jenny O'Mahoney, project director of the medical workforce for the St Vincent's Health Network agreed that James came into the prison with

properly managed health concerns, and within a very short period of time, those health concerns were not properly managed, ultimately requiring his transfer to a hospital where he died. The heath care that he was provided was wholly inadequate for his need.

155. Importantly, neither Dr Tattersall, nor anyone else, suggested that the failings exposed by examination of James' circumstances were specific to James.

156. Counsel assisting submitted that no-one could credibly suggest that the multiplicity of errors, and the absence of any evidence that James was singled out or targeted to receive poor quality health care indicated other than that the failings extended to others.

157. Somewhat alarmingly, in the context of the evidence I've just set out, St Vincent's and MTC both repudiated the submission that in relation to the delivery of healthcare, the failings were not limited to James.

158. The number of inmate patients two GPs were left to treat in 2019, let alone Dr Tattersall being alone in November and December 2019, made it virtually impossible to deliver good care with any frequency or consistency. Furthermore, the evidence I have recently referred to makes it clear the deficiencies in delivery of adequate care were not limited to James.

159. Ms Issa herself gave evidence in relation to patients, plural, not receiving their medication in November and December 2019. Ms Issa accepted the proposition that James was not an outlier, and that the problem was more general, affecting inmates, plural, and in her own words: "*The problem was multifaceted*". Ms Issa expressed the view that: "*The constant catch up of transitioning into a new service, the lack of correctional health experience that our workforce had, and I think simple human error contributed to patients not receiving medication*".

160. Ms Issa indicated passionately in her evidence that good care was provided. Her meaning was that good care was provided to some of the inmates. Ms Issa did not deny many of the failings.

161. There may have been incidents of good care, but it seems highly unlikely to me that such incidents occurred with any frequency at all in any part of 2019, and in particular in November and December 2019.

162. In its submissions, MTC accepted that it is difficult to explain the extent and multiplicity of failings which occurred in James' care. It then submitted that the deficiencies in healthcare did not necessarily extend to others. It was further submitted that such a proposition involved some measure of speculation and did not directly inform my deliberations as to the manner and cause of James' death. Two things need to be said about these submissions.

163. Firstly, the submissions ignore the evidence to which I have just now referred. There was direct evidence of failures in relation to inmate patients, plural. It is overwhelmingly clear that the failure to deliver an appropriate level of care was not limited to James. Secondly, the submission that the relevant proposition did not directly inform my deliberations as to manner and cause, and consequently, as I took the submission to mean, any such proposition was not to be considered, misunderstands the jurisdiction.

164. It is clearly established that once a valid inquest is on foot, issues relevant to recommendations are highly relevant. The law in this regard was established in *Conway v Jerram*, where at paragraph 63 at first instance, Barr J noted in his 2010 decision: "*The power of a coroner to make recommendations about matters of public health and safety seems apt to enable the coroner to consider matters outside the scope of what may be considered necessary to determine the manner and cause of death*". In dismissing an application for leave to appeal, the Court of Appeal, in its judgment in 2011, noted: "*Barr J held that before the power to make recommendations became exercisable, there first had to be proper grounds for holding an inquest".* Section 82 of the Act authorises recommendations in relation to any matter connected with the death with which an inquest is concerned.

165. Appropriate care of prisoners is clearly an important public health and safety concern and is an issue relevant to potential recommendations and as such

can be of significant relevance at inquest in that, even if not directly related to manner and cause, they may ground recommendations.

IMPACT OF FAILURES IN JAMES' CASE

166. The cause of James' death was his ischaemic heart disease which resulted in his cardiac arrest. The medical cause is the ischaemic heart disease, with the bleeding duodenal ulcer being a significant contributing condition.

167. The forensic pathologist who conducted the postmortem examination indicated that although the duodenal ulcer appeared to no longer be actively bleeding by the time of death, the recent gastrointestinal haemorrhage would certainly have increased the risk of further ischemia, (inadequate blood supply,) and/or arrhythmia in James' already vulnerable heart.

168. James' diabetes and medical obesity also increased the risk of ischemia. It was imperative that they be adequately treated and that all steps be taken to minimise the prospect of these and other medical conditions contributing to the risk of further ischemia. It is in this context that the grossly inadequate care of James' cellulitis and the failure to prescribe a PPI must be considered.

169. The expert evidence was that long term use of aspirin can cause stomach ulcers. Dr Vickers, gastroenterologist, thought it likely a PPI was first prescribed for James to prevent ulcer disease from the prescription of aspirin following James having a stent inserted when he was in New Zealand. Thereafter, the PPI medication would have continued in Australia both to counteract the effect of aspirin on the stomach and to treat the symptoms of GORD. In this regard, Dr Vickers pointed out that diagnosis of GORD, as in the disease, requires specific testing. This is to be distinguished from having gastro oesophageal reflux. PPIs such as Pantoprazole and Rabeprazole are appropriate treatment for gastro oesophageal reflux as well as GORD. The prescription of PPIs would have undoubtedly significantly reduced the risk of James' duodenal ulceration and that ulcer haemorrhaging.

170. Dr Vickers also pointed out that recurrent infection, such as from cellulitis, in a patient on aspirin and who is diabetic, would increase the risk of stomach ulceration. On the expert evidence, there can be no doubt that the gross mismanagement of James' cellulitis increased the risk of James' ulcer disease becoming more aggressive and ultimately haemorrhaging. Professor Howes, cardiologist, toxicologist and pharmacologist, pointed out that James' chronic pain from the cellulitis and his ongoing infections would have resulted in an increased risk of developing ulcers and an increased risk due to the stress placed on the body, accompanied by an increase in cortisol and adrenaline. The inadequately treated cellulitis, in combination with other conditions, continued to cause metabolic stress, which contributed to James' stomach ulceration and ultimate bleeding.

WHEN DID JAMES START VOMITING BLOOD

171. An issue explored at inquest was "*when did James first started vomiting blood*? *Given the 25 December notes at Blacktown Hospital, why was it not known earlier that James was vomiting blood?"*

172. It's likely, I find, that James had been vomiting blood for two weeks prior to his admission to Blacktown. It should be noted, as Professor Howes said, that any history of vomiting blood indicates the need to admit the patient to hospital for semi urgent endoscopy.

173. I am of the view that the failure to elicit an accurate history can be put down to a number of factors. In the period James was vomiting, he was in extreme pain from his cellulitis, which continued to be inadequately treated up until the week leading into the 25th of December. It is to be noted that at Blacktown Hospital, by which time the severity of the cellulitis had significantly reduced, James reported his symptoms in some detail, including a history of severe epigastric (upper central region of the abdomen) pain rated at nine out of ten.

174. From around 13 December to 25 December, James was not seen regularly enough by the GP. He had extensive pain from his cellulitis, and his focus when he did talk to nurses was on receiving his antibiotics to treat the cellulitis.

Nurses who were either too busy or too disengaged due to being overworked were, in my view, unlikely to take a fulsome and accurate history. In this regard, the words of Registered Nurse Alexander are pertinent: "*there was inadequate time to spend with patients, and inadequate time to consider the patient's history".*

175. Nurses who were unable to administer antibiotics, take observations, despite the fact the GP had directed six hourly observations be taken, or to keep appropriate records, were highly unlikely to take a detailed history. It bears emphasising James' words to family and friends. He was consistently asking for antibiotics, and yet to him it seemed it was impossible to receive a consistent course. In that environment, in a situation that I have found to be chaotic, it was highly unlikely that James would be given the opportunity to provide a full and accurate account to the nurses who were attending upon him.

WHY WAS THE CARE PROVIDED TO JAMES SO GROSSLY INADEQUATE

176. St Vincent's provided evidence that it is a wholly owned subsidiary of St Vincent's Health Australia, and that it:

"*targets the disadvantaged sectors of community as priority populations for services and leans in when there are opportunities to help those populations, and that this focus dates back to the legacy of the sisters of charity".*

177. It was noted that the St Vincent's Health Australia website states that:

"*St Vincent's is committed to prioritising care for at risk populations, and that St Vincent's Health Australia genuinely tries to make a difference by way of the patient experience of care for those in contact with the criminal justice system."*

These words must ring hollow to James' family and friends. Whilst the lofty ambition can be respected, the extent of the failure was catastrophic.

178. St Vincent's failed a portion of the very target population it markets that it seeks to help. It was incumbent upon St Vincent's when tendering to provide

healthcare in a custodial setting to satisfy itself that it would be able to provide care to an adequate level. Further still, an adequate level of care was required straight away, 24 hours a day, seven days a week from 1 April 2019. James came into custody at Parklea on 1 November, some seven months into St Vincent's time at Parklea. St Vincent's were clearly underprepared for what lay ahead when they commenced their contract in April 2019.

179. In seeking to explain the situation, St Vincent's pointed to, amongst other factors, having no cooperation from Justice Health, having no poisons licence of their own, staffing shortage and staffing difficulties, including the constant catch up of transition into a new service, and the lack of correctional health experience amongst staff, as well as difficulties getting access to patients.

180. I should make clear that at inquest, there was no substantial time spent on the lead into St Vincent's commencing at Parklea, nor the detail of what Justice Health and St Vincent's did and did not do in relation to each other. To that extent the following comments are necessarily general in nature in regard to that issue.

181. The issues of asserted lack of cooperation from Justice Health, not having a poisons licence, the lack of correctional health experience amongst staff, and the constant catch up in transitioning into a new service can be dealt with together.

182. St Vincent's had not previously provided health services in a correctional setting in New South Wales; however, it had, in what it described in its submissions: "*a longstanding history in the custodial space in Victoria"*. St Vincent's indicated it had sent New South Wales staff to Victoria so that they could learn about what that work environment required.

183. St Vincent's had entered its agreement to provide primary health services on the assumption it would be able to operate at Parklea under its own poisons licence. That is, it would operate its own onsite pharmacy. This assumption was wrong, and on the evidence, only known to be wrong to St Vincent's on

19 March 2019, 12 days prior to St Vincent's commencing at Parklea. The solution reached was that St Vincent's operated at Parklea under a doctor's bag model, whereby an individual doctor, initially Professor Richard Day, and later, Dr Canessa, took responsibility for the ordering and storage of medication.

184. I accept that the lack of a poisons licence impacted upon how medication was supplied and impacted upon nursing resources. It does not explain, however, why in James' case in November and December 2019, medication administered by technicians was done so without any issues, and all the occasions of non-administration and inaccurate record keeping regarding medication were the fault of nursing staff.

185. As previously indicated, there was some evidence of lack of cooperation from Justice Health when St Vincent's commenced at Parklea. As also previously indicated, the issue was not explored in any detail, and as such, it is not appropriate to say any more than that it would be regrettable if any lack of cooperation impacted upon the delivery of care.

186. It is, however, timely to here note that the State government, subsequent to the evidence and submissions in this inquest finalising, announced that Parklea will return to public hands in October 2026. Laudably, the government has announced that there will be a six-month transition period commencing in March 2026 when MTC's current contract ends, leading into a full return to public hands in October 2026. It is to be hoped that this transition period assists with continuity of appropriate care for inmate patients.

187. A very significant risk was taken in changing the primary healthcare provider at Parklea from Justice Health to St Vincent's when MTC were awarded their contract. Given that, in relation to the provision of health to James in November and December 2019, Ms Issa, operations manager, observed the issues included catching up in transitioning to a new service and a lack of corrective health experience, a lead in period such as is contemplated for 2026 may well have been a much better option to what occurred in 2019 whereby Justice

Health finished up on 31 March, St Vincent's had access in the late afternoon of that day, and St Vincent's commenced to deliver primary healthcare the next day.

188. Given the chaos in relation to the delivery of care in November and December 2019, it would seem likely there were significant deficiencies in the delivery of care from day one. It's trite to observe that inmate patients did not require appropriate healthcare when St Vincent's could get its house in order, but rather morally and contractually were entitled to appropriate healthcare from the moment St Vincent's took over. In saying this, I do not mean to be critical of the individuals involved at a managerial level at Parklea or at a clinical level at Parklea. To target any individual in the absence of clear and specific evidence of wrongdoing would in itself be wrong, as it is clear that the clinicians and managers were not put in a position where they could deliver an appropriate level of care from day one.

189. What I would refer to as the underpinning reasons as to the failure in delivery of care by St Vincent's were not explored at inquest. What I mean by that is, there was no exploration of decisions at board level. Whether the relevant entity was St Vincent's Health Australia, St Vincent's Health, or St Vincent's Correctional Health was not explored. Such decisions as the application of funds, staffing levels, the extent to which clinicians and other resources at St Vincent's Hospital were made available to St Vincent's Correctional Health and the timing of those decisions were not examined. Similarly, the role of Justice Health was not examined. All that can be observed is that, patently, St Vincent's were not ready to provide appropriate healthcare from 1 April 2019, and the provision of care to James in November and December was, as Dr Wilson said, grossly inadequate. Ultimately, the responsibility for St Vincent's failure to be in a position to deliver appropriate care rests with it.

ACCESS ISSUES

190. Another issue said to have impacted upon the delivery of care was the purported difficulty in getting access to inmate patients. Dr Tattersall gave

evidence that it was difficult to obtain access to patients and referred to access issues as endemic. St Vincent's relied upon correctional officers to bring inmate patients to the clinic. Dr Canessa explained:

"Often access to patients was hindered by lack of MTC staff. Priorities like methadone, delivery of methadone would take priority over the other clinics. So if there was a methadone clinic, let's say five running, you wouldn't have a medical clinic or a doctor clinic operating, or a nurse clinic operating, because you didn't have enough security staff to manage the two. So you relied on corrections officers bringing people to and from the clinic itself. Sometimes there were lockdowns and there weren't enough staff."

191. Ms Issa, operations manager, agreed that in November and December 2019, there were often not enough officers to facilitate inmates being brought to the main clinic. In addition, she indicated: "*Medication rounds were very delayed often, and it took a longer period to complete because our nursing team and pharma techs require officers to ensure their safety on medication rounds, so that was a significant issue for us*".

192. MTC submitted the evidence of access issues given by Dr Canessa identified competing priorities such as the methadone clinic and occasional lockdowns and was a balanced account of those issues. MTC submitted that other evidence on the issue includes no quantitative analysis, and that the evidence of Dr Tattersall and Ms Issa on the issue was self-serving, and that the weight of the evidence confirms that whenever James was brought to main clinic, according to the chronology of events, he was brought into the main clinic without delay.

193. It is clear on the evidence there were delays in getting patients to the clinic in 2019. I accept the evidence of Dr Tattersall, Dr Canessa and Ms Issa on this point. However, I also accept that the issue could not be attributed to MTC staff shortages, and to the extent it's relevant, find that it was not as extensive a problem in 2024 as it was in 2019. In that regard, I accept the evidence of Acting Governor Brian Gurney, who, in the absence of the governor from 2019, was

called to give evidence and the issue of the more current situation was explored.

194. Whilst the MTC's submission that there was no quantitative analysis on the issue is accurate, it's a submission with little meaning. In the chaos, as I have described it, of delivery of care in November and December 2019, no one was recording times of when an inmate was required at clinic, and requested to be brought to clinic, and when the inmate actually arrived. As such there was no quantitative analysis of the delay, nor no quantitative analysis of the extent of any delay. On this issue, MTC also repeated its misguided submission that the issue was not related to manner and cause of death. I have above dealt with the reasons as to why I say this submission was misguided.

STAFFING ISSUES

195. I have already set out in some detail the evidence as to staff shortages for St Vincent's at Parklea in 2019.

196. Relevantly the model of care under which St Vincent's operated at Parklea was a nurse led model. A nurse led model of care is an approach where nurses take the primary responsibility for planning, delivering and managing patient care within a defined clinical framework. Under this model, there is significant onus on nurses as the first point of contact to bring matters to the attention of doctors. In my view it was incumbent upon St Vincent's to ensure they had sufficient appropriately trained staff from day one, let alone having insufficient staff, and concerns about the staff's understanding and capacity to work in the custodial environment as at November and December 2019.

197. Tendering to provide primary health care was accompanied by serious responsibilities, responsibilities St Vincent's failed to meet. The evidence revealed that nurses failed to follow doctor's requests to take and record observations and failed to administer antibiotics when required. This grossly inadequate level of care bespeaks a total inability of the nurses to play the role required of them in a nurse led model.

198. There was much general evidence from St Vincent's of the difficulty of finding and retaining appropriate staff. Again, St Vincent's must bear the responsibility for that failure. The difficulties do not excuse the failure of St Vincent's to provide an acceptable level of care.

REMEDIAL STEPS

199. St Vincent's did provide evidence of a number of steps it has taken in an effort to improve the level of care it provides at Parklea. These efforts should be acknowledged and set out in some detail. Following James' death, St Vincent's reviewed its medication management processes, with a view to establishing a robust medication safety program, monitoring medication safety and quality systems related to medicines management, and enhancing clinical performance and effectiveness. In November 2020, St Vincent's introduced a comprehensive medication management framework with the introduction of the medication reconciliation policy and procedure.

200. The MRPP, as it was termed, was updated and reviewed by St Vincent's Health for St Vincent's Correctional Health in 2022, which was the most recent update at the time evidence on that topic was given. Since 2019, St Vincent's has created additional positions to enhance the workforce at Parklea, including nurse educator in about March 19 part time, and full time in 2020; clinical practice registered nurse position was approved in 2021 and has been filled since. A chronic care nurse role commenced in about November 2020. This is a full time dedicated chronic care nurse role, improving the previous status where chronic care responsibilities were shared between the primary health nursing team. A patient journey nurse commenced in about October 2022. An Aboriginal chronic care nurse and medication management pharmacist commenced in about July 2022. A clinical nurse specialist in mental health role commenced in about June 2022; and clinical nurse specialist in drug and alcohol commenced in about June 2022.

201. In terms of improvements to the medical workforce, at inquest, the evidence was that St Vincent's now has further medical staff, including:

1) one GP rostered five days a week, Monday to Friday;

2) one GP rostered very Tuesday;

3) one GP with addiction medicine qualifications rostered every second Wednesday;

4) Thursdays and Fridays are covered by emergency department staff specialists through a bonded employment contract with St Vincent's Hospital;

5) one ED staff specialist rostered every Monday in a non-patient facing role, overseeing patient triage and allocation;

6) one dentist rostered three days a week;

7) one infectious diseases specialist rostered one day a week but also have availability when required for remote consults;

8) one forensic psychiatrist visiting medical officer rostered part-time and also available, when required, for telehealth and phone consultations;

9) a junior medical officer;

10) a medical on-call service operating from within St Vincent's Hospital Darlinghurst Emergency Department akin to the Remote Offsite Afterhours Medical Service, ROAMS, available to health service providers in correctional facilities, staffed by Justice Health.

202. There have been a number of significant improvements to the knowledge and capability of the nursing and medical workforce, including:

a) St Vincent's Health has developed a post-graduate certificate in correctional health for nursing staff;

b) additional funding has been obtained to employ a nursing clinical practice improvement nurse;

c) St Vincent's Correctional Health now employs a full-time nurse educator;

d) it has focused heavily on staff, clinical development, and education by leveraging off St Vincent's Health;

e) the St Vincent's Health Emergency Department staff specialists have contributed to nursing staff education by leading clinical sessions;

f) St Vincent's Correctional Health has ongoing support from St Vincent's Health Network, including the director of emergency medicine and an infectious diseases consultant;

g) St Vincent's Health has rewritten St Vincent's Correctional Health policies and procedures to ensure they are purpose fit for Parklea's remand environment and created policies that did not previous exist.

203. As I've indicated, there was no in-depth analysis of why additional steps were taken when they were taken. St Vincent's Correctional Health made it clear it was a not-for-profit organisation. The detail of when and why funding was increased to provide additional services, and why they weren't provided at an earlier time was not an issue considered in any depth at the inquest. Nevertheless, I accept these steps have been genuine and extensive, and Ms Issa expressed optimism about St Vincent's capacity for the future provision of care. Her evidence was:

"*It's changed significantly in terms of the stability of the workforce that we now have. There are a number of people that were there from 2019 who have grown with the service, contributed to its development, contributed to its model of care. We now have more robust policies and procedures in place that guard clinical practice. We have developed a lot of positions that sit outside the general*

funding provided to us to run our service through seed grants, funding grants, to develop positions to help the nursing workforce develop in skill."

204. Whether Ms Issa's optimism is well-placed cannot be determined based only upon documented evidence of what has been done in the years after James' death. The effectiveness of the steps taken post James' death will best be assessed over time, and if and when future inquests arise. For that reason, during the currency of this inquest, steps were taken by me to hear evidence in relation to other deaths at Parklea. I had hoped to be able to deliver the judgments one after the other. Circumstances have worked against that. Nevertheless, in due course, I will publish judgments in relation to the deaths of a Mr Cullen and a Mr Bickerstaff. James died in December 2019. Mr Cullen and Mr Bickerstaff each died in early 2021.

PROPOSED RECOMMENDATIONS

205. Counsel assisting has suggested five recommendations would be appropriate. They are as follows.

206. **Recommendation one**: The Inspector of Custodial Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

207. **Recommendation two**: Except in exceptional circumstances, St Vincent's eliminate the practice concerning the prescription of medication for an acute condition in circumstances where the patient has not been reviewed by a medical practitioner or is not to be reviewed by a medical practitioner within 24-hours of the prescription of the medication.

208. **Recommendation three**: The Commissioner of Corrective Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

209. **Recommendation four**: The Commissioner of Corrective Services take immediate steps to ensure MTC complies with its contractual obligations with respect to the number of correctional and health staff it is contracted to provide.

210. **Recommendation five**: The Commissioner of Corrective Services, and the State, give immediate consideration to the redevelopment of the Main Clinic at Parklea Correctional Centre, including the observation cells within the clinic, to ensure a clean, hygienic, and safe environment and one which is fit for the purpose of operating a medical clinic and accommodating patients in cells within the clinic.

211. In view of the State government's decision in relation to future arrangements at Parklea, I contemplated inviting further submissions, in particular, in relation to recommendation 2 and recommendation 4. However, given the delays in my delivery of my findings, I determined that course would not be appropriate. Rather, I provide all these recommendations, and particularly place emphasis on what I'm about to say in relation to recommendations 2 and 4, understanding, firstly, that, as is understood, they are recommendations to be assessed and considered by the entities (CSNSW, MTC, SVCH, JH), and in terms of the government entities, replied to.

212. The entities will best know the current circumstances at Parklea (in terms of the MTC contract ending in October 2026, having been extended from April to October). There will be focus, no doubt, amongst the entities on the current functioning at Parklea, as would be usual business, but also on the approach to the next 14 to 15 months, and the priorities of how each entity conducts its responsibilities in that period. I understand, in making the recommendations, that the entities will weigh the realities of the current situation in determining their responses.

213. I will say, my expectation is that the very best level of care that can be delivered will be delivered right up until the point of handover.

214. I will deal with the recommendations in order.

Recommendation 1

215. Counsel assisting submitted that it would be beneficial if the Inspector of Custodial Services (I**CS**) prioritised a further inspection of Parklea Correctional Centre. Counsel assisting noted that the office of the ICS Services was established by the *Inspector of Custodial Services Act 2012*, and that the mandate of the office is to provide independent scrutiny of conditions, treatment, and outcomes for people in custody, and to promote excellence in staff professional practice. It was further submitted that a prioritised inspection would be appropriate, given the systemic issues identified during the course of the inquest, so that the Inspector could determine the extent to which those systemic issues have been addressed.

216. All parties were given opportunity to reply in relation to all recommendations.

217. There were some submissions suggesting that its a matter for the ICS itself as to when the inspection occurs, and the timing of it. I accept that. The timing of any inspection is a matter for the ICS.

218. As discussed, Parklea will return to public hands in October 2026. It remains essential that appropriate healthcare services are provided to inmate patients up until management is handed over. It is in that context that I make the recommendation and leave it to the Inspector to determine when the next inspection of Parklea is to take place. I'll make recommendation one in the suggested terms.

Recommendation 2

219. The recommendation clearly arises on the evidence of multiple occasions of prescription without any review by a medical practitioner. St Vincent's submitted the terminology "acute condition" may be ambiguous and open to subjective interpretation with consequent unwanted outcomes in terms of the underlying principle of the proposed recommendation. St Vincent's suggested an

alternative wording for recommendation 2. The alternative was agreed to by counsel assisting, and I shall make a recommendation in the following terms:

"In tangent with Justice Health and considering existing between the flags guidelines, St Vincent's Health and other service providers operating in the custodial health space, including those for publicly and privately operated correctional centres, consider updating policy material to provide guidance regarding the timeframes required for medical practitioner review for a patient when medication has been prescribed for an acute condition."

Recommendation 3

220. As to furnishing a copy of the transcript to the Commissioner of Corrective Services and the Minister for Corrections the recommendation will be made.

Recommendation 4

221. This recommendation which relates to MTC complying with its contractual obligations with respect to the number of correctional and health staff was of some controversy.

222. Counsel assisting submitted in support of recommendation 4 that given the troubling extent of the shortcomings revealed at inquest, the Commissioner and the State must accept responsibility for the care of inmates it outsources to private providers such as MTC.

223. Generally, in relation to recommendation 4, MTC submitted that the proposed recommendation 4 focused incorrectly upon the number of staff MTC was to provide as there was no number of staff specified in the management or sub management agreement. Further, MTC noted it had a discretion in relation to the number of staff employed, as the agreement required it employ sufficient staff to enable it to discharge its obligation (emphasis added). Thirdly, MTC's performance, it was submitted, is measured with respect to how services are delivered. Fourthly, the manner in which recommendation 4 might be enforced

is opaque. Fifthly, several aspects of the shortcomings identified by counsel assisting involved matters beyond the control as MTC as head contractor. These included errors in medication, failure to take vital signs and backlog in the GP waitlist.

224. These submissions are misconceived and reflected MTC's ongoing position of not accepting its responsibility for its failure to meet its contractual responsibilities. MTC's contractual obligation was to ensure the delivery of healthcare services as follows:

*"Manage Co" (*which was MTC and Broadspectrum together in the original form) *"must ensure that healthcare facilities and services are provided for custodial patients to the standards of the public health system, in compliance with New South Wales Health and Justice Health and Forensic Mental Health Network policies and procedure, with special regards to the unique healthcare needs of custodial patients."*

225. It is no answer to that contractual responsibility to essentially argue that MTC was unable to meet the obligation to which it agreed, because it had no control over such issues as errors in medication, failure to take vital signs and backlog in the GP waitlist. In fact, shortly after the above written submission, MTC went on to submit that any perceived issues related to what it described as the "contractual framework" could be managed with cooperation between the parties and agencies, together with reporting to monitoring services and communication and cooperation. In my view, that accurately describes an effective approach to MTC meeting its contractual responsibilities. It is difficult to understand why it continues to seek to rely on a purported inability to meet those responsibilities.

226. By any measure, healthcare services were delivered to a disturbingly inadequate level during November and December 2019. There was extensive evidence suggesting the level of nursing and other medical staff was wholly insufficient. In any assessment of compliance with contractual obligations, both

the Commissioner of Corrective Services and Justice Health are, in my view, able to assess whether a sufficient number of staff are employed.

227. The Commissioner of Corrective Services submitted that the proposal should be amended to include Justice Health, as it was and is Justice Health who have the oversight in relation to the health aspect of MTC's responsibilities.

228. Justice Health, in reply submissions, said the recommendation was unnecessary, and that had also been the Commissioner's primary position. However, Justice Health did suggest an alternative wording to that raised by the Commissioner, in regard only to its, that is Justice Health's, role in any steps consequent upon the recommendation. I will make the recommendation in the following terms:

"The Commissioner for Corrective Services, having regard to input from Justice Health New South Wales, take steps to ensure that MTC remains compliant with its contractual obligations with respect to the number of correctional and health staff it is contracted to provide."

229. I see no reason at all why MTC cannot meet its contractual obligations by working cooperatively with the Commissioner and Justice Health New South Wales in their monitoring capacities by communicating appropriately, and by ensuring for the remaining 14 to 15 months there are sufficient staffing levels. I do feel it's appropriate to say again, I accept things have moved on substantially from when the evidence was taken, and the entities will know best how to respond, each in their own individual way, to this recommendation.

Recommendation 5

230. Counsel assisting noted the main clinic has been identified by both St Vincent's and the Australian Council of Healthcare Services as not fit for purpose. It has been described as "*filthy and putrid*" and "*such is the nature of the facility that a clean environment cannot be maintained*". It is trite to observe that inmates should not be exposed to filthy, putrid, and/or unhygienic condition. That they

should not be exposed to such conditions in a healthcare setting is axiomatic. St Vincent's Correctional Health was found on inspection, to meet NSQHS standards on the assumption that the main clinic was to be redeveloped. As at the time of that submission, that had not occurred and was not slated to occur. It was the submission of counsel assisting that it should.

231. There was no opposition to the underlying principle of the submission. I should note, in relation to recommendation 5 which I propose to make, I acknowledge that things may have moved on substantially. I hope that there have been some changes that can be readily identified by the appropriate authorities, and appropriate steps taken to make sure that the area of the clinic is appropriate in terms of cleanliness, hygiene, and being a safe environment, and fit for purpose. If that has not been attended to, it now should be.

TWO RECOMMENDATIONS SUGGESTED ON BEHALF OF JAMES' FAMILY

232. Firstly, the referral of St Vincent's Correctional Health as an entity licensed to operate a health facility under the *Private Health Facilities Act (2007)* to the secretary of the Ministry of Health for consideration as to whether the secretary should take action under division 6, suspension and cancellation of licences, of part 7, section 57.

233. St Vincent's submitted that it was not clear of the basis upon which the family sought referral under that provision. St Vincent's indicated that the legislation excludes an institution conducted by or on behalf of the State from the definition of private health facility, and further that there was no evidence before the Court that St Vincent's Health, operating St Vincent's Correctional Health, was in breach of a licensing standard at the relevant time, as required under the legislation. It next submitted that St Vincent's is not an entity that provides services of the kind requiring licensing under the *Private Health Facilities Act*, and accordingly, it is not so licensed. In those circumstances, I will not make the recommendation.

234. Secondly, the referral of St Vincent's Correctional Health to the Health Care Complaints Commission (**HCCC**), in respect of the healthcare received by James prior to his transfer to Blacktown Hospital on 25 December 2019.

235. St Vincent's submitted that the improvements it has made, the insights it has revealed, its engagement with the coronial process, and the transparent, and respectful way it conducted itself should impact on a determination as to whether there be a referral. I don't see those matters as relevant to the question of referral. I rely upon the decision of Deputy State Coroner Lee in the Inquest into the death of Adam Fitzpatrick, in that regard.

236. In further submissions, St Vincent's argued that it would be procedurally unfair to make any such recommendation because the legal representatives for the family did not raise in evidence an intention to seek such a recommendation. The submission was developed by noting that, if referred, individual practitioners could come under consideration by the HCCC, and no one at inquest had sought referral of any individual. The website of the HCCC includes the following:

"*When the commission receives a complaint about a health organisation, it will usually seek a response from that organisation. In some cases, during the management of a complaint, concerns about individual practitioners may also be identified. When this happens, the practitioners may be required to provide additional information to the commission to address those concerns."*

237. The submission was further developed as follows:

"noting the purview of the HCCC, if the proposed recommendation had been raised during the inquest, consideration may have been given by one or more individual witness to raising an objection under section 61 of the Act. That is an objection by which individuals can object to giving evidence unless they're provided with a certificate protecting them against use of that material in any civil or criminal proceedings against them. The question of whether to seek the application of section 61 of the Act was a forensic decision, for example, for

Registered Nurse Alexander, Dr Tattersall and others. Such a decision may have been informed by the disclosure of a possibility for a recommendation of referral to HCCC before or during the inquest".

238. The two witnesses referred to in the submission were both given sufficient interest letters, which, to some extent at least, flag that there may be criticism of them. However, what is not known is the detail of any conversations that may have occurred with their legal representatives, in terms of the possibility of them being referred.

239. It is not the submission of counsel assisting that any entity or individual be referred to the HCCC, and to my knowledge, neither of those witnesses, for example, or any other to my knowledge, was ever given an indication that I, as Coroner, was of a preliminary view I needed to consider whether I would or would not refer them, or refer St Vincent's, exposing them to the possibility expressed on the HCCC website.

240. Sometimes possible referral is foreshadowed by the assisting team, but whether it is or isn't foreshadowed specifically does not inform me in any way, as I have said, of any conversations that might have occurred between legal representatives and clients. In those circumstances, with some risk of referral by me being procedurally unfair, my view is I should not make any referral.

241. Procedural fairness is one of the most jealously guarded principles of any proceedings. I do note that counsel for St Vincent's fairly raised, at the end of his submission, that any person has the ability to make a complaint to the HCCC at any time.

242. I now come to the formal findings.

FORMAL FINDINGS – FINDINGS REQUIRED BY SECTION 81(1)

243. As a result of having considered all of the documentary and audio evidence, and the oral evidence given at the inquest, pursuant to section 81(1) of the Act, I make the following findings in relation to the death of James Joseph Cunneen:

1) The person who died is James Joseph Cunneen.

2) James died on 28 December 2019.

3) James died at Blacktown Hospital in New South Wales.

4) James died of natural causes.

5) The cause of James' death was ischaemic heart disease with a bleeding duodenal ulcer being a significant contributing condition.

RECOMMENDATIONS

244. Pursuant to section 82 of the Act, Coroners may make recommendations connected with a death. I am of the view that the evidence supports that the recommendations outlined below are appropriate and are necessary or desirable to be made in relation to James' death.

1. The Inspector of Custodial Services and the Minister of Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

2. In tangent with Justice Health and Forensic Mental Health Network and considering existing between the flags guidelines, St Vincent's Correctional Health and other service providers operating in the custodial health space, including those for publicly and privately operated correctional centres, consider updating policy material to provide guidance regarding the timeframes required for medical practitioner review for a patient when medication has been prescribed for an acute condition.

3. The Commissioner of Corrective Services and the Minister for Corrections be furnished with a copy of the transcript of these proceedings and the findings of the Coroner.

4. The Commissioner of Corrective Services, having regard to input from Justice Health and Forensic Mental Health Network, take steps to ensure that Management & Training Corporation remains compliant with its contractual obligations with respect to the number of correctional and health staff it is contracted to provide.

5. The Commissioner of Corrective Services, and the State, give immediate consideration to the redevelopment of the Main Clinic at Parklea Correctional Centre, including the observation cells within the clinic, to ensure a clean, hygienic, and safe environment and one which is fit for the purpose of operating a medical clinic and accommodating patients in cells within the clinic.

ACKNOWLEDGEMENTS AND CONCLUDING REMARKS

245. Before closing the inquest, I would like to thank James' family and friends for their participation in the inquest. Their attendance and attention pays due and fitting respect to James. They attended throughout the days of the inquest in numbers, and I thank them again for their participation.

246. On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to all James' family and friends.

247. I thank the assisting team. Various people from the Crown Solicitor's Office have assisted over time, but in particular Mr Robinson of counsel, and Ms Potocki. This, obviously, has been a relatively large inquest. Their diligence, perseverance, and attention to detail has been of great assistance.

248. I also thank the officer in charge of the coronial investigation, Senior Constable Stephen Mitchell, for his efforts in the investigation and work in compiling the initial police brief of evidence.

249. I thank all the parties for the manner in which they all conducted the inquest. Again, it was a large bar table. The inquest was conducted respectfully,

cooperatively, and helpfully, and that is all that can be asked of legal representatives.

250. I now close this inquest.

Magistrate David O'Neil

Deputy State Coroner, NSW State Coroner's Court, Lidcombe

30 July 2025