CORONERS COURT

OF NEW SOUTH WALES

Inquest:	Inquest into the death of Michael Sanderson
Hearing dates:	11-13 March 2025, NSW Coroners Court - Gunnedah
Date of findings:	16 April, 2025
Place of findings:	NSW Coroners Court - Lidcombe
Findings of:	Magistrate Rebecca Hosking, Deputy State Coroner
Catchwords:	CORONIAL LAW – Mandatory inquest pursuant to s 23(1)(d)(ii) of the *Coroners Act 2009* (NSW) – First Nations death in custody – communication and treatment of family during terminal phase.
File number:	2022/318454
Representation:	Counsel Assisting the Inquest: William de Mars instructed by Sarah Crellin of the Crown Solicitors Office Senior Next of Kin: Jacklyn Dougan-Jones, Aboriginal Legal Service Commissioner of Corrective Services NSW (**CSNSW**), Claire Dunn, Solicitor Advocate, instructed by Kathleen McKinlay, Department of Communities and Justice Justice Health and Forensic Mental Health Network (**JHNSW**), South Eastern Sydney Local Health District (**SESLHD**), Western NSW LHD (**WNLHD**) Kathryn Holcombe of Counsel instructed by Kate Hinchcliffe of Makinson d'Apice.

Findings:	Identity of deceased	Michael James Sanderson (known as Jamie)
	Date of death	22 October 2022
	Place of death	Prince of Wales Hospital, Randwick NSW 2031
	Cause of death	Metastatic Pancreatic Carcinoma
	Manner of death	Michael Sanderson was a Gamilaroi man who died of natural causes while in the custody of CSNSW

Recommendations:

To JHNSW, that consideration be given to:

(1) a requirement that JHNSW clinicians consult an inmate to see if they wish to provide a 'Consent to Liaise' with their next of kin concerning their health status, as soon as possible after an inmate receives an advanced cancer diagnosis and/or starts receiving palliative care; and

(2) that actioning such a requirement should occur prior to an inmate's transfer to Long Bay Hospital, and that if not done prior to transfer, must occur at the time of reception at Long Bay Hospital; and

(3) a requirement that consultation with an inmate to see if they wish to provide a 'Consent to Liaise' with next of kin must occur when an inmate is identified as suffering from a 'Chronic Condition' under

JHNSW policy and updated at subsequent Chronic Condition reviews.

To the Commissioner of CSNSW, that consideration be given to:

(1) amending the final paragraph of Part 6.2 of the COPP 19.6, concerning prohibitions on giving of items to inmates, to refer to the potential for exceptions to be made in the case of end of life visits or palliative care visits; and

(2) ensuring there is consistency between the COPP 19.6 and the current LOP in so far as they relate to end of life/palliative care visits.

Non-publication Orders: Non-publication orders apply to the evidence in this inquest. A copy of the orders made by Deputy State Coroner Hosking is available upon request from the Court Registry.

FINDINGS

Introduction

1 Section 81(1) of the *Coroners Act 2009* (NSW) (**the Act**) requires that when an inquest is held, the coroner must record in writing their findings as to whether the person has died and if so, the date and place of the person's death, and the cause and manner of their death.

2 In addition, the coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

3 These are the findings of an inquest into the circumstances of the death of Michael James Sanderson on 22 October 2022, then aged 53. He was called Jamie by his family and that is how I will refer to him in these findings. Jamie identified as a Gamilaroi man. He was a loved father, brother, son, cousin and friend.

4 This inquest is held pursuant to the jurisdiction conveyed by s 23 (1)(d)(ii) of the Act in circumstances where at the time of his death, Jamie was an inmate in a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW). The 'Secure Annex' of Prince of Wales Hospital (**PoWH**), where Jamie died, was considered to be part of the Long Bay Hospital Correctional Centre.

The issues examined at the inquest

5 An inquest into the circumstances of Jamie's death was held between 11 and 13 March 2025 in Gunnedah, NSW.

6 The issues identified in the coronial investigation to be explored in the inquest follow.

(1) Findings as required by s 81(1) of the Act.

(2) Whether Jamie's health was monitored and treated in accordance with applicable standards and policies while he was in custody between February 2021 and October 2022.

(3) The adequacy of contact and communication with Jamie's family, following his diagnosis in September 2022 and in relation to end of life visits.

(4) Whether any recommendations are considered necessary or desirable in relation to any matter connected with Jamie's death.

The evidence

7 Tendered to the court was a 6 volume brief of evidence compiled by the Officer in Charge of the coronial investigation, Detective Senior Constable (**DSC**) Jenaya Bodger.

8 At the inquest the court received oral evidence from:

(1) DSC Bodger, NSW Police Force (**NSWPF**), Officer in Charge.

(2) Malcolm Brown, CSNSW, General Manager of Statewide Operations, Security and Custody.

(3) Glen Piazza, CSNSW, then Manager of Security at Long Bay Hospital Correctional Centre and, at the time of Jamie's death, this included managing the secure area in PoWH known as the 'Secure Annex' which was controlled and run by Long Bay Correctional Centre.

(4) Brian Gough, CSNSW, Functional Manager – Security at Long Bay Hospital Correctional Centre.

(5) Sean Connolly, JHNSW, Nurse Manager Operations, Access and Demand Management. This includes Long Bay Hospital Operations,

After Hours Nurse Manager Service, Patient flow/Accesses and Integrated Care Service.

(6) Jamie's youngest daughter, also his senior next of kin (**SNOK**)[1].

Findings

9 As will be seen, I have concluded that:

(1) Jamie died on 22 October 2022 at PoWH from metastatic pancreatic carcinoma being a natural cause.

(2) The medical care provided to Jamie was inadequate in the ways that follow.

(a) JHNSW failed to review Jamie's July 2022 blood work in a timely manner and in accordance with their own policies and procedures which required them to be reviewed on or before 26 July 2022.

(b) In circumstances where the results of the July 2022 blood works was adverse, once reviewed, their contents should have been conveyed to Jamie as soon as possible.

(c) The failure to convey to Jamie the significance of the July 2022 blood work results caused or contributed to Jamie declining the abdominal ultrasound because it involved being transferred from Kirkconnell Correctional Centre, Kirkconnell[2] (**KCC**) when he had only just returned from Covid-19 isolation.

(d) On review of the July 2022 blood work on 22 August 2022, steps ought to have been taken for Jamie to undergo an abdominal

[1] Jamie had two daughters and two sons. His youngest daughter and SNOK is integral to the circumstances surrounding Jamie's end of life care and to the events described in this inquest. I will refer to her as Jamie's daughter and where I need to distinguish between both daughters, I will refer to his 'eldest daughter'.
[2] Between Bathurst and Lithgow.

ultrasound prior to his return to KCC following his Covid-19 isolation.

(3) Whilst the evidence does not indicate that an earlier diagnosis would have resulted in a different medical outcome, it may have enabled his family to spend significantly more time with him, for him to have been in palliative care for a longer period and for the potential of an earlier release or relocation in custody (including the potential of being able to die 'on Country') to be explored.

(4) JHNSW should have engaged with Jamie to complete his 'Consent to Release Information' and 'Consent to Liaise' as part of the process of advising him of his adverse blood results and engaging with him to determine his care plan.

(5) JHNSW should have made contact with Jamie's family, in particular, his SNOK, during the period in which he was in their care. Such contact should have included a clinician apprised with Jamie's medical condition and his care plan including plans for transfer.

(6) CSNSW's policies and procedures in respect of end of life visits were *ad hoc* and inadequate resulting in:

(a) unnecessary barriers placed on family members during the terminal phase which were prohibitive to family living in remote and regional areas wishing to visit their loved one

(b) the terms of approved visits not being adhered to by the 'Medical Escort Unit' (**MEU**)[3] guards causing distress to Jamie's SNOK and family

[3] The MEU was responsible for security when an inmate requires a medical escort within the metropolitan area if Long Bay Hospital officers were not available.

(c) a reduction in the time and the quality of the time Jamie was able to spend with his family members before he died.

Recommendations

10 As will be seen, I make the following recommendations:

(1) To JHNSW, that consideration be given to:

(a) a requirement that JHNSW clinicians consult an inmate to see if they wish to provide a 'Consent to Liaise' with their next of kin concerning their health status, as soon as possible after an inmate receives an advanced cancer diagnosis and/or starts receiving palliative care; and

(b) that actioning such a requirement should occur prior to an inmate's transfer to Long Bay Hospital, and that if not done prior to transfer, must occur at the time of reception at Long Bay Hospital; and

(c) a requirement that consultation with an inmate to see if they wish to provide a 'Consent to Liaise' with next of kin must occur when an inmate is identified as suffering from a 'Chronic Condition' under JHNSW policy and updated at subsequent Chronic Condition reviews.

(2) To the Commissioner of CSNSW, that consideration be given to:

(a) amending the final paragraph of Part 6.2 of the COPP 19.6, concerning prohibitions on giving of items to inmates, to refer to the potential for exceptions to be made in the case of end of life visits or palliative care visits; and

(b) ensuring there is consistency between the COPP 19.6[4] and the current LOP[5] in so far as they relate to end of life/palliative care visits.

Background

11 Much of the facts of this matter are not in dispute and I am grateful for the observations by my instructing solicitor and submissions by Counsel assisting from which I have drawn extensively and, in relation to non-contentious issues, directly at times.

12 Jamie was the eldest of 9 children born in Gunnedah. He spent his early years in Sydney before returning to Gunnedah with his mother. He also spent time in Katherine, Northern Territory, with his father.

13 Jamie and his wife had four children. Jamie was loved and supported by his children. Three of his children were able to attend and participate in the inquest including his daughter who gave evidence and his eldest son who shared memories of their father in a family statement.

14 Jamie's daughter described her father as an engineer, fabricator and a horticulturist. He enjoyed teaching his children about nature and Aboriginal culture. His children have fond memories of time spent walking up Bindea (Porcupine Hill) with their father.

15 In 2011, Jamie was diagnosed with diabetes.

16 On 19 October 2018, Jamie was arrested and charged.

17 On 6 November 2018, Jamie was granted conditional bail having shown cause that he had urgent and complex medical needs.

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[4] Custodial Operations Policy and Procedures 19.6 Medical Escorts – Ex 1, Vol 6, Tab 76A Annexure MB-3.
[5] Local Operating Procedure (LOP): Inmate visits under hospital guard – MEU effective 29 May 2024, Ex 3.

18 On 5 February 2021, Jamie was sentenced to a term of 6 years and 6 months imprisonment with a non-parole period of 3 years and 6 months. He was taken into custody at Amber Laurel Correctional Centre and placed in precautionary Covid-19 isolation. Jamie was then transferred to MRRC[6].

19 Jamie's intake screening noted that he had diabetes and peripheral neuropathy. A 'Health Problem Notification Form' indicated that Jamie was a diabetic on insulin, and should be observed for signs of confusion, decrease in level of consciousness, sweatiness, changes in pallor, shaking, or aggression.

20 Jamie's JHNSW records noted:

> The patient was received into custody with a history of Diabetes Mellitus Type 1, which was complicated by diabetic retinopathy and peripheral neuropathy, chronic pancreatitis due to alcohol dependence and Vit 812 deficiency. The patient also had a history of recurrent perianal abscess and anal fistulectomy performed in 2011. The patient was received into custody on the following medications: Ryzodeg 70/30, 15 midday, Novorapid 5-15 units TDS and Lyrica 75mg BO."

21 Jamie was assessed by the JHNSW Chronic Disease Team which noted Type 1 Diabetes since 2011, peripheral neuropathy for 2-3 years, a history of cigarette, alcohol and cannabis use, and chronic pancreatitis. It is noted that he had seen Diabetic Mellitus educators in the community. He also saw a diabetes educator at least once while in custody but sometimes declined this service when offered by JHNSW.

22 On 15 April 2021, Jamie was transferred to KCC having been classified as a C2 Minimum-security Inmate.

Events leading up to Jamie's death

23 On 12 July 2022, Jamie had a blood test (**July 2022 blood work**). This was a regular blood test undertaken because Jamie was considered by JHNSW to be an inmate with a chronic condition.

[6] Metropolitan Remand and Reception Centre, Silverwater.

24 On 8 August 2022, Jamie had contracted Covid-19 and was put in isolation. His daughter was advised that he had been moved to MRRC because he was in isolation.

25 On 22 August 2022, Jamie's blood tests were reviewed by Dr Chandrabalan, GP. Dr Chandrabalan noted abnormalities in respect of Jamie's liver function. A plan was formed for repeat blood tests to be undertaken and for Jamie to have an abdominal ultrasound. This review was undertaken in Jamie's absence. Importantly, at the time of this review, Jamie remained at MRRC.

26 On 23 August 2022 Jamie returned to KCC following his Covid-19 isolation.

27 On 2 September 2022, Jamie was to be transferred from KCC to Long Bay Hospital to have the abdominal ultrasound. There is no record indicating that anyone had explained to Jamie the purpose of the ultrasound or that anyone had advised him of his adverse blood test results. Jamie declined the transfer to Long Bay Hospital and did not undertake the abdominal ultrasound. The notes indicate that Jamie had not been told about the proposed transfer and did not want to go.

28 On 5 September 2022, a further blood test was performed.

29 On 24 September 2022, Jamie was seen at the KCC clinic for his sugar level check and morning insulin. Nursing staff noted that he appeared to be jaundiced, and Jamie reported feeling as though he had mild pancreatitis. He told staff that he had felt lethargic since contracting Covid-19. He agreed to review by a GP.

30 On 27 September 2022, Jamie was seen by a nurse at the KCC clinic. He was still looking jaundiced. Nursing staff then reviewed the blood results from 5 September 2022[7] and determined that Jamie should be sent to Bathurst Hospital for further review. Jamie was admitted to Bathurst Base Hospital on the afternoon of 27 September 2022. He reported: not feeling well since

[7] Again these tests were reviewed outside the required 14 day period for abnormal results.

recovering from Covid-19, decreased appetite, epigastric pain and dark urine. An assessment revealed: he was jaundiced, had abdominal distention, a tender upper abdominal area, and pain in the lower back. His medical background included severe bouts of pancreatitis since he was 18. Imaging was completed at Bathurst Base Hospital on 28 September 2022 revealing a hypoechoic lesion in the region of the head of the pancreas, indicating a primary pancreatic lesion, obstruction of the hepatic duct, multiple liver metastases, paraaortic lymphadenopathy and extensive ascites[8]. He was diagnosed with metastatic pancreatic carcinoma stage IV (**stage 4 pancreatic cancer**).

31 The Bathurst Base Hospital notes indicate that Jamie's daughter was telephoned and advised of the possibility that Jamie was suffering from 'pancreatic malignancy with liver metastases.' She was told that she would be updated once biopsy results were received. Jamie's daughter does not recall the gravity of her father's condition being explained to her on this occasion. However, she does recall a conversation with her father where he told her the doctors thought he may have pancreatic cancer, but they were 'waiting on test results.' She told him not to stress and to wait for the test results to come through.

32 A biopsy was conducted on 29 September 2022. The results were received at Bathurst Base Hospital on 6 October 2022. Despite the reassurance that she would be updated, these results were not conveyed to Jamie's daughter by JHNSW. She remained very worried knowing how aggressive pancreatic cancer can be.

33 On 30 September 2022, Jamie returned to KCC.

34 On 1 October 2022, Jamie spoke to his daughter on the phone regarding his diagnosis. He remained jaundiced and ascitic, KCC clinical staff decided he needed to be transferred to Long Bay Hospital. However, it was a long weekend and Long Bay Hospital did not staff admitting doctors over the long weekend.

[8] Meaning there was a build-up of fluid on Jamie's abdomen.

35 On 2 October 2022, Jamie was transferred to the Darcy Unit at MRRC awaiting acceptance to Long Bay Hospital. His case manager rang his *eldest* daughter to advise of this transfer, she confirmed she would contact her sister as the SNOK. His daughter recalls receiving a call from someone from KCC advising her of the transfer from KCC to Long Bay Hospital. She recalls being told her dad was "really unwell" and advised to call Long Bay Hospital as soon as she could. However, given JHNSW was not involved in these conversations, no update was being provided by a clinician as to Jamie's medical status. She was given the number for MRRC but it was not explained to her what MRRC was or that the transfer to Long Bay would be via MRRC. When she called MRRC it was explained that she had the wrong number and she was given another number. She then recalls speaking to a nurse that we now understand to be a JHNSW nurse at MRRC. This nurse told Jamie's daughter that she could not provide any information to her (beyond providing his location) for privacy reasons. At this point, Jamie had not completed a 'Consent to Liaise' form. When pressed, the nurse provided Jamie's daughter with a number for the JHNSW Client Liaison Officer. Given it was the weekend, this number went to voicemail. Jamie's daughter did not recall receiving a call back from the Client Liaison Officer but acknowledged there may have been a message left or a missed call during a period where lots of calls were being made.

36 Jamie's daughter then looked up the number for Long Bay Hospital, called the number and was told by a woman that answered that she should email the Client Liaison Officer and she was provided with the email address. Jamie's daughter felt that this woman was rude and reported that this woman ultimately hung up on her.

37 At this point, Jamie's daughter had been told she would be advised of the outcome of her father's tests. This had not occurred. She had no point of contact to ascertain any information about her father other than a phone number reverting to voicemail and an email address. She had been made aware of how gravely unwell her father was. One can only imagine how distressing this would have been.

38 On 5 October 2022, Jamie was transferred to Long Bay Hospital and placed in the Medical Sub-Acute Unit for management of his stage 4 pancreatic cancer. On 7 October 2022, he was seen by a palliative care nurse practitioner for end of life or palliative care planning to be undertaken. He was also seen by a cancer care nurse.

39 It was not until 7 October 2022 that 'Consent to Release Health Information' and 'Consent to Liaise' forms were completed (although only partially) allowing communication to flow to Jamie's next of kin, his GP and other nominated agencies. In his evidence Mr Connolly indicated that it was not a simple process to have these forms signed as they would usually like to be in a position to have a care plan in place before speaking to family and it was a multifaceted approach to engaging with the inmate in relation to obtaining their consent. This seems wholly inconsistent with the way in which the forms were ultimately executed. Jamie's signature is not witnessed, and his details have not been completed. Its completion was rudimentary at best.

40 The idea that a medical care plan is determined before an inmate is asked whether they wish for their family members to be apprised of their medical condition/s to my mind undermines the inmate's right to medical autonomy and decision making. In the community, more often than not, family members are apprised of serious medical conditions from the initial detection, through the diagnosis and treatment planning stage. The way in which the intended process was described by Mr Connolly suggested that the care plan would have been determined without his effective input and then presented to Jamie and his family.

41 On 10 October 2022, Jamie was transferred from Long Bay Hospital to PoWH. A CSNSW employee, telephoned Jamie's eldest son explaining Jamie was in the emergency department (**ED**). She telephoned him again on 11 October 2022 and indicated that a phone call would be facilitated by the head of the MEU. It was determined that surgery (an endoscopic retrograde cholangiopancreatography) was required. The hospital obtained consent for the surgery from Jamie's daughter as the SNOK. There had been no further contact

between JHNSW and the family since Jamie's daughter's conversation with the woman she described as having hung up on her on 2 October 2022.

42 After speaking with the clinician from PoWH, Jamie's daughter called the Long Bay Hospital to try and make arrangements to visit her father. They provided her with a number for the 'Department of Community Justice', 'Manager of Securities'. This number was not operational.

43 Late in the afternoon, as a result it seems of making contact with someone on the 'gate' at Long Bay, Jamie's daughter received a phone call from her father, who was under guard at the PoWH. She described her father as very unwell and delirious and could hear guards laughing in the background. She perceived them to be making fun of her father. She felt the experience was 'dehumanising'.

44 Jamie's daughter then left a voicemail message at the office of the Minister for Corrective Services. Following that she received a message from Mr Gough. He confirmed her father was at the PoWH and they were waiting on a bed in the oncology unit. She was given a number to speak to the oncology doctors.

45 On 11 October 2022, Jamie's daughter exchanged emails with Mr Gough arranging a visit for herself and Jamie's younger son which occurred on 13 October 2022.

46 Jamie's daughter described difficulties obtaining information from medical staff at PoWH because their records were ambiguous as to who was his SNOK.

47 Jamie's daughter described the 13 October 2022 visit as a positive one in terms of her interactions with the guard/s and her father. However, her father was clearly very unwell so she was unable to facilitate planned facetime calls with his sister and father during this visit. She managed to meet with the oncology team after she insisted they meet with her before she left. Not having been able to arrange accommodation in the short time period, she had to return to Gunnedah that evening and planned to return to Sydney the next day.

48 She received a call on 14 October 2022 from someone from the MEU. She says the caller kept insisting she provide a time she would be arriving to visit notwithstanding that she tried to explain she was driving from Gunnedah and was uncertain as to a precise arrival time. She described the caller as lacking compassion.

49 Jamie's daughter visited her father on 15 and 16 October 2022, however, her experience was very different to her visit on 13 October 2022. She described the guards refusing to allow her: to sit next to her father as they placed themselves at the head of the bed, approved phone calls/facetime calls with family members, to give him his favourite soft drink, to have her phone on, to bring her belongings into the room and to give photographs to her father. She tried to show them emails in which some of these things had been specifically approved by Mr Piazza, which proved fruitless. Her visit was suddenly time limited in the afternoon for no apparent reason.

50 Jamie's daughter indicated that she couldn't return to visit her father because of how mentally and emotionally drained she was by the treatment she received from the guards that weekend. She received an email from Mr Gough the next day in which he apologised and stated:

> Please understand that we are doing everything we can to assist you and your father in this difficult time for you and your family, but sometimes communication breaks down when it is outside our normal procedures. I hope this gives some clarification.

51 On 18 October 2022, Jamie was moved from Parkes 4 East to the Secure Annex at PoWH[9]. A discussion took place with Jamie's daughter about the potential for early release.

52 On 19 October 2022, Jamie and his daughter spoke on the phone and she told him she would return on the weekend. In attempting to do that, she was told she would have to call between 8-9am in the morning to 'see if she was

[9] The Secure Annex is permanently staffed by CSNSW guards for exclusive use for patients in custody. At the time of publication of these findings it is no longer operating.

approved.' This was notwithstanding that to make the visit, she would have had to drive from Gunnedah to Sydney which is a drive of more than 5 hours.

53 Jamie was declared life extinct at 4.52am on Saturday 22 October 2022.

54 In contrast to the difficulties Jamie's daughter had in obtaining information and support in attempting to spend time with her father prior to his death, she received an overwhelming number of phone calls in the aftermath of his death.

Post-Mortem

55 Dr Van Vuuren performed an external post-mortem examination on Jamie on 27 October 2022. She opined that he died from metastatic pancreatic carcinoma.

Issues

Findings as required by s 81(1) of the Coroners Act 2009.

56 I am satisfied on the balance of probabilities that Jamie died at 4.52am on 22 October 2022 at PoWH from metastatic pancreatic carcinoma being a natural cause.

Whether Mr Sanderson's health was monitored and treated in accordance with applicable standards and policies while he was in custody between February 2021 and October 2022.

57 It was apparent from the evidence adduced at the inquest that there was a failure to monitor and treat Jamie's health to the appropriate standard in at least one significant respect.

58 An issue of significance is the failure of JHNSW to review Jamie's July 2022 blood work in a timely manner and in accordance with its own policies and procedures. The tests were performed on 12 July 2022 and the results were not reviewed until 22 August 2022, approximately 6 weeks later.

59 JHNSW 'Pathology results Management Procedure' dated April 2017 provided that all abnormal results must be 'signed off' by a clinician within 14 days. In this case, they were not signed off for 6 weeks and even then there is no evidence that they were ever explained to Jamie. If advising the patient is not part of the 'sign off' procedure then it ought to be.

60 The review, when undertaken, occurred in Jamie's absence. A 'plan' was developed by Dr Chandrabalan. The plan was not subsequently communicated to Jamie. The doctor indicated that Jamie should have an abdominal ultrasound. At the time of the review, Jamie was at MRRC at the end of his Covid-19 isolation period. If the recommendation for an abdominal ultrasound was actioned when it was made, the procedure could have been undertaken prior to Jamie returning to KCC.

61 The abdominal ultrasound was ultimately not performed as Jamie did not want to leave KCC and return to Long Bay Hospital. There are no notes which indicate that the July 2022 blood work results were ever explained to Jamie, or that the purpose of the abdominal ultrasound was ever explained to him. While he may have made the decision to decline the abdominal ultrasound, on the evidence adduced, I could not find that it was an informed decision.

62 There was no evidence adduced of a medical nature which suggested that an earlier review of the July 2022 blood work would have changed the outcome for Jamie medically. However, that is not the only issue. The fact of someone's incarceration should not preclude appropriate access to their own medical information.

63 In their submissions, JHNSW advised that since Jamie's death, JHNSW has undertaken a significant Pathology Review Project to streamline pathology processes. As a result of the Project, the following policies and procedures were published:

(1) Procedure 9.054 Screening and Diagnostics Management: Pathology, Radiology, and Electrocardiogram dated October 2024. The key provisions follow.

(a) All normal and abnormal pathology results must be reviewed and signed off daily.

(b) Abnormal results and a care plan must be handed over to the most senior nurse at the patient's location.

(c) Critical results will result in the laboratory contacting Justice Health NSW. Clinicians who receive a call about critical results must immediately escalate those results to the treating clinician/team. All results must be reviewed and signed off immediately.

(2) Policy 1.444 Screening and Diagnostics Management: Pathology, Radiology, and Electrocardiogram dated November 2024, which provides that daily pathology results review and sign-off are mandatory.

Findings

64 I find that the medical care provided to Jamie was inadequate in the ways that follow.

(1) JHNSW failed to review Jamie's July 2022 blood work in a timely manner and in accordance with their own policies and procedures which required them to be reviewed on or before 26 July 2022.

(2) In circumstances where the results of the July 2022 blood works was adverse, once reviewed, their contents should have been conveyed to Jamie as soon as possible.

(3) Failure to convey to Jamie the significance of the July 2022 blood work results caused or contributed to Jamie declining the abdominal

ultrasound because it involved being transferred from KCC when he had only just returned from Covid-19 isolation.

(4) On review of the July 2022 blood work on 22 August 2022, steps ought to have been taken for Jamie to undergo an abdominal ultrasound prior to his return to KCC following his Covid-19 isolation.

65 Whilst the evidence does not indicate that an earlier diagnosis would have resulted in a different medical outcome, it may have enabled his family to spend significantly more time with him, for him to have been in palliative care for a longer period and for the potential of an earlier release or relocation in custody (including the potential of being able to die 'on Country') to be explored.

The adequacy of contact and communication with Mr Sanderson's family, following his diagnosis in September 2022 and in relation to end of life visits.

Communication in relation to Jamie's medical condition/s

66 Jamie's daughter/SNOK lived in Gunnedah, more than 5 hours drive from both PoWH and Long Bay Hospital. Visiting her father required planning in terms of travel, accommodation, family and employment commitments.

67 The evidence adduced at the inquest highlighted the difficulties faced by Jamie's family in obtaining helpful and accurate information in relation to his condition and the barriers they faced in supporting him at the end of his life.

68 The gravity of Jamie's condition was known by 28 September 2022 when he was diagnosed with stage 4 pancreatic cancer.

69 JHNSW 'Palliative Care Model of Care' describes Palliative Care as follows:

> Palliative care optimises the quality of life for individuals approaching and reaching the end of life, and their families and carers, with the aim of reducing suffering and promoting dignity. It is for those with a life-limiting condition and often for those in the last year of life. Care may also be needed for shorter or longer periods, depending on the individual needs of the person, and their family and carers.

70 In his evidence, Mr Connolly acknowledged that between 30 September 2022 and 10 October 2022 JHNSW failed to communicate with Jamie's family information regarding his medical condition/s.

71 Mr Connolly acknowledged in his evidence that more information could have been provided to Jamie's family, particularly his daughter and she could have been treated with more compassion.

72 Importantly, there was no effective single point of contact at JHNSW for Jamie's family to engage with to understand his medical status.

73 In relation to the call between the JHNSW nurse and Jamie's daughter, Mr Connolly conceded that the nurse had some relevant information having been involved in Jamie's transfer into the unit. However, he considered she was unlikely to have had a fulsome picture of Jamie's medical status such that she could have had a detailed clinical conversation with his family. He also asserted she would not have had the capacity to undertake such a conversation given the nature of her role. He ultimately conceded she could have been more helpful to Jamie's daughter during that phone call than she was. In particular, providing her with the number for the Client Liaison Officer on the weekend was an unhelpful way to respond.

74 Jamie was received into the ED at PoWH on the morning of 10 October 2022. During the course of that day, Jamie's eldest son and daughter made many phone calls to ascertain information about their father including his location and his medical status. At some point that afternoon, Jamie's son received a call from a CSNSW officer, who advised Jamie's son that Jamie had been taken to the ED at PoWH.

75 There does not appear to be any reason why a clinician at Long Bay could not have contacted the family on the morning of 10 October to advise the family as to the circumstances and reasons for his transfer from Long Bay to PoWH. A JHNSW clinician would have been the only person at that point in time with the capacity to discuss relevant health information with the family, bearing in mind

that by this stage they had a signed 'Consent to Liaise', and the Palliative Care Nurse was aware from Jamie that his daughter was his SNOK.

Facilitation of end of life visits and communication regarding same

76 In attempting to arrange visits, Jamie's daughter liaised with Messrs Piazza and Gough. Through their evidence, it emerged that the escort guards involved in guarding Jamie were from the MEU. The visit 'approval' process involved the passing on of 'approvals' given by either the Manager of Security, the Governor, or an authorised officer, to the senior officer (or Functional Manager) of the MEU, who would then provide the relevant information to officers on guard duty.

77 Mr Brown gave evidence that in his experience, the process did not necessarily involve the intermediary of the senior officer of the MEU, but that approvals would be passed on directly to the guards on escort duty by the person approving, for the day in question, and that the approval would be written on to the relevant daily log sheet.

78 Mr Gough's evidence was that the approvals were not documented, but were passed on by way of phone call, first to the senior officer MEU, and by that person, on to the guards.

79 In Jamie's case, it is clear that there was a breakdown in communication on the weekend of 15 and 16 October 2022. However, it is unclear where the breakdown occurred. The situation is not helped by the fact that CSNSW is not in possession of any escort daily log sheets for the period that Jamie was at PoWH which are required to be kept under the Medical Escorts Policy. As such, we do not know whether the guards on duty tried to contact a senior officer and if they did, what form the contact took.

80 On review of the experience of Jamie's daughter, it is clear that the process for approvals as well as the policies for their documentation and communication were, at the time of Jamie's death, unsatisfactory.

81 The 'terms' of the approvals conveyed by Mr Piazza relevant to the weekend of 15 and 16 October 2022 were simply conveyed to Jamie's daughter and copied to Mr Gough. No further action was taken to ensure that the relevant guards were notified or that the approvals would be acted on. Mr Piazza appeared to assume Mr Gough would do this though it is not apparent whether he did. This became very distressing for both Jamie and his daughter when items such as a photo board she had prepared could not be given to her father.

82 It is apparent that what is required is a system that enables tailored approvals to be given that stay in place for the duration of the admission of an end of life or palliative care inmate.

83 As the evidence in this matter has shown, the circumstances faced by families visiting inmates who are nearing death is extremely challenging. Ensuring that matters such as these are accommodated as smoothly and empathetically as possible can make the difference between a more positive experience, as Jamie and his family experienced on 13 October 2022, and one that is distressing and potentially traumatising.

84 COPP 19.6[10] which deals with visits, is silent on the issue of how the approval is conveyed.

85 The current LOP[11] provides that when an approved visitor turns up to visit an inmate, the Officer in Charge of the Hospital Guard Duty is responsible for contacting the Senior Correctional Officer of the MEU (**SCO/MEU**) to verify that the relevant visit has been approved. Thereafter the SCO/MEU can either verify the visit via OIMS[12], centre visits, or centre management. This seems to contemplate that, at least sometimes, the relevant approvals are logged on the OIMS system.

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[10] Custodial Operations Policy and Procedures 19.6 Medical Escorts – Ex 1, Vol 6, Tab 76A Annexure MB-3.
[11] Local Operating Procedure (LOP): Inmate visits under hospital guard – MEU effective 29 May 2024, Ex 3.
[12] Officer Integrated Management System

86 The logging of relevant approvals onto OIMS (or an alternative database), if adopted as a standard practice, may be a way of ensuring that a record is kept of the approval, and in a manner that is accessible to all relevant stakeholders.

87 Another possibility suggested to Mr Brown and supported by him, is that the relevant approval record would stay as a distinct document along with other key escort documentation that guards have with them throughout the duration of the person's admission, such as the escort assessment document.

88 Mr Brown described the circumstances of arrangements relating to visits to end of life and palliative care patients as unusual. He agreed that the numbers of such inmates each year is very small.

89 Creating clear rules that require the documenting of visit arrangement approvals both in OIMS and by way of a standalone document that stays with the key escort documentation would not be an arduous exercise, particularly given such small numbers. It would also be a way of ensuring that documented approvals are accessible directly to guards, and as a backup, accessible by someone who they may call, on the OIMS system.

90 If such a system were in place, there would not be a need for guards to check relevant approvals with the senior officer at all – this may well avoid the gaps in communication suffered by Jamie's family merely because it was the weekend or afterhours. Mr Gough considered that it should have been sufficient for Jamie's daughter to have shown the guards the approval emails, without recourse to the need to contact a senior officer. However, this was clearly not sufficient based on her experience.

91 In relation to the treatment of Jamie's daughter by the MEU officers on 15 and 16 October 2022, Mr Brown gave evidence that there was a formal investigation but somewhat surprisingly he had not inquired as to the outcome before appearing in court. He also indicated that trauma informed training was available to MEU guards but it was not mandatory and he could not provide an indication of how many guards have taken it.

92 Ms Dougan-Jones eloquently wrote in her submissions, 'there needs to be a clear pathway for loved ones to take when trying to urgently reach an unwell inmate. It would be helpful if there was a singular point of contact.'

93 Mr Brown gave evidence, supplemented in written submissions, as to the consideration of a policy around end of life care and the nomination of a particular CSNSW individual to contact families of inmates to ensure they are provided a single point of contact. He indicated this duty may fall within the 'Senior Service Integrations Officer' role.

94 Mr Brown indicated he would speak to the Aboriginal Strategy Unit Director about involving the Aboriginal Liaison Officers in communications with families at an early stage in inmate end of life care. It is imperative that these resources and supports are engaged as early as possible when a terminal diagnosis is received. For Jamie's daughter to have experienced such difficulties in communicating with JHNSW and CSNSW during the end of her father's life and then to be overwhelmed by phone calls after he passed is unacceptable.

Findings

95 I find that:

(1) JHNSW should have engaged with Jamie to complete his 'Consent to Release Information' and 'Consent to Liaise' as part of the process of advising him of his adverse blood results and engaging with him to determine his care plan.

(2) JHNSW should have made contact with Jamie's family, in particular, his SNOK, during the period in which he was in their care. Such contact should have included a clinician apprised with Jamie's medical condition and his care plan including plans for transfer.

(3) CSNSW's policies and procedures in respect of end of life visits were *ad hoc* and inadequate resulting in:

(a) unnecessary barriers placed on family members during the terminal phase which were prohibitive to family living in remote and regional areas wishing to visit their loved one

(b) the terms of approved visits not being adhered to by MEU guards causing distress to Jamie's SNOK and family

(c) a reduction in the time and the quality of the time Jamie was able to spend with his family members before he died.

Whether any recommendations are considered necessary or desirable in relation to any matter connected with Mr Sanderson's death.

96 I have given full consideration to the recommendations proposed by the Assisting team and Jamie's family and the submissions provided by the participants in relation to whether recommendations are necessary or desirable. Below I deal with the salient proposals considering the evidence and submissions as a whole.

JHNSW

97 In relation to the failure of JHNSW to comply with their own policy requiring all abnormal blood results to be 'signed off' within 14 days, I make no recommendations in circumstances where their current policy requires daily review of blood test results.

98 In relation to the failure of JHNSW to explain to Jamie the purpose of the booking for an abdominal ultrasound, Mr Connolly acknowledged that there was no record that the need for the abdominal ultrasound was explained. This was described in submissions as a 'missed opportunity for patient education.' In my view it goes further than that. It was a failure on the part of JHNSW to afford Jamie the autonomy over his medical information that he should be entitled to regardless of his status as an inmate. That said, absent evidence that this is a systematic failure, I make no recommendations in relation to this failure.

99 I note JHNSW has confirmed that the roles of Palliative Care Aboriginal Health Worker and Palliative Care Social Worker have been filled and that it is intended that these roles would facilitate contact between JHNSW and family members in the event of an inmate receiving palliative care. I accept the submissions from JHNSW that while JHNSW will work collaboratively with CSNSW given they exercise different functions; it is not appropriate that there be one point of contact for families across both institutions.

The timing of completing a 'Consent to Liaise' form

100 JHNSW were asked to respond to a proposed recommendation that they consider including in relevant policy:

(1) a requirement that JHNSW clinicians consult an inmate to see if they wish to provide a 'Consent to Liaise' with their next of kin concerning their health status, as soon as possible after an inmate receives an advanced cancer diagnosis and/or starts receiving palliative care; and

(2) that actioning such a requirement should occur prior to an inmate's transfer to Long Bay Hospital, and that if not done prior to transfer, must occur at the time of reception at Long Bay Hospital; and

(3) a requirement that consultation with an inmate to see if they wish to provide a 'Consent to Liaise' with next of kin must occur when an inmate is identified as suffering from a 'Chronic Condition' under JHNSW policy, and updated at subsequent Chronic Condition reviews.

101 JHNSW submitted against the making of the above recommendation citing, amongst other things, that it is the responsibility of the patient to keep their family apprised of any medical issues and their obligations to maintain patient confidentiality. To my mind the response of JHNSW to this proposal fails to consider the reality faced by an unwell patient in a custodial setting.

102 There was no suggestion in the evidence adduced at the inquest that the circumstances faced by Jamie in the lead up to his death were particularly

unusual. Such circumstances included multiple transfers and no clear point of communication for families.

103 The delay in obtaining Jamie's 'Consent to Liaise' with his family at various times precluded his family from being provided with accurate, timely and fulsome information in relation to his medical status.

104 The idea submitted by JHNSW that it was Jamie's responsibility to keep his family apprised of his medical condition and treatment fails to take into account the reality faced by an inmate faced with a terminal diagnosis.

105 In Jamie's case there was a failure to even update Jamie as to the outcome of his blood tests and the treatment/investigation plan (abdominal scan) which had been devised without his input. It defies belief that in the circumstances faced by Jamie he could have been expected to update his family as to the status of his condition.

106 Mr Brown indicated that the number of inmates receiving palliative care in custody is less than 10 per year. As such, the proposed recommendation is not onerous in terms of the number of inmates with whom JHNSW would be required to have an early conversation with about their 'Consent to Liaise.'

107 There is no suggestion that an inmate's right to privacy is to be breached. The proposed recommendation provides an avenue for an inmate to determine whether their family is to be kept informed of their medical status when they suffer from a chronic condition, receive an advanced cancer diagnosis or at the commencement of palliative care. In circumstances where an inmate's ability to communicate with their family is otherwise regulated, and they may be subject to imposed transfers, this would enable the family a channel of communication with those treating the inmate so that they can access accurate information in a timely manner.

108 In their submissions, JHNSW stated that, 'The timing of when a Consent to Liaise is raised with a patient is determined on a case by case basis.' To my

mind, this leaves too much scope for such conversations to be had at a late stage creating a lost opportunity to engage meaningfully with their loved one during their terminal phase.

109 I reject the submissions made by JHNSW and make the proposed recommendation.

CSNSW

110 The resounding issue in this inquest was the difficulties faced by Jamie's family in being able to respond to their father's terminal diagnosis because of a lack of a central point of contact, delays in consent being obtained from Jamie for JHNSW to share information with his family members and the agreed terms and conditions of their visits being circumvented by guards.

111 CSNSW advised that consideration is being given to:

(1) the utilisation of a *nominated officer* to undertake communications and other responsibilities in relation to inmates in end-of-life or palliative care

(2) the potential development of an end-of-life/palliative care document package to be provided to staff on the ground

(3) the potential development of a separate Protocol for Guarding Inmate Patients in End-of-Life or Palliative Care

(4) the amendment of existing policies for consistency

(5) consulting with JHNSW to develop a 'fact sheet' for families relating to inmates receiving end of life or palliative care.

112 CSNSW also confirmed that trauma informed training is now being provided to all Correctional Officers upon commencement with CSNSW.

113 CSNSW submitted that these measures, if and when enacted, would adequately identify and address the requirements and policies applicable to inmates in end of life or palliative care. The proposed *nominated officer* would, amongst other things, provide clarity and consistency as to how approvals that are given to family members are to be documented and made known to guards to ensure compliance.

114 Importantly, the *nominated officer* would be, from the CSNSW perspective, a single point of contact for family members of an inmate receiving end of life or palliative care. This would alleviate many of the difficulties faced by Jamie's family in the lead up to his death.

115 That these matters are in contemplation by CSNSW, makes it unnecessary for many of the recommendations foreshadowed in submissions to be made.

116 CSNSW has acknowledged inconsistencies in its own policy documents and supports the following recommendations be made to the Commissioner of CSNSW to address those inconsistencies:

(1) That consideration be given to amending the final paragraph of part 6.2 of the COPP 19.6, concerning prohibitions on giving of items to inmates, to refer to the potential for exceptions to be made in the case of end of life visits or palliative care visits; and

(2) That consideration be given to ensure there is consistency between the COPP 19.6 and the current LOP in so far as they relate to end of life/palliative care visits.

117 I make those recommendations.

Concluding remarks

118 I will close by conveying to the Sanderson family my sympathy for the loss of their much loved father particularly in circumstances where they could not be with him during his final hours.

119 I thank the Aboriginal Coronial Information and Support Program social worker, Nicolle Lowe for her invaluable work. The Court always relies on her great assistance and is grateful to receive it.

120 I thank the Assisting team for their outstanding support in the conduct of this inquest.

121 I thank the officer in charge, Senior Constable Bodger, for her work in conducting the investigation and compiling the brief of evidence which was supplemented by the Assisting team.

Statutory findings required by s 81(1)

122 As a result of considering all the documentary and the oral evidence heard at the inquest, I make the following findings:

Identity

The person who has died is Michael James Sanderson (known as Jamie)

Place of death

Prince of Wales Hospital, Randwick NSW 2031

Date of death

22 October 2022

Cause of death

Metastatic pancreatic carcinoma

Manner of death

Michael James Sanderson (known as Jamie) was a Gamilaroi man who died of natural causes while in the custody of CSNSW.

I close this inquest.

Magistrate R Hosking
Deputy State Coroner
Lidcombe

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