New South Wales

CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Amanawel Ayai
Hearing date(s):	22 to 26 June 2026
Date of Findings:	7 August 2026
Place of Findings:	Coroner's Court of New South Wales, Lidcombe
Findings of:	Judge Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, cause and manner of death, inmate patient with previous abdominal complaints and abdominal surgery, small bowel obstruction, clinical assessment, contemporaneous clinical documentation, progress note entry, transfer to Main Clinic, transfer to hospital, intravenous fluids, impact of COVID-19 protocols in custody
File number:	2022/00008755

Representation: Ms B Epstein, Counsel Assisting, instructed by Mr T Holcombe & Mr G Martin (Crown Solicitor's Office)

Mr S Barnes for Dr P Tsui, instructed by Ms A Basha (Avant Law)

Mr J Harris for St Vincent's Correctional Health and Registered Nurse T Nguyen, instructed by Ms S Idowu & Ms Z Santos (Hall & Wilcox)

Mr P Madden (NSW Nurses & Midwives Association) for Registered Nurse D Moodley

Mr T Hackett for MTC-Broadspectrum instructed by Mr S Bailey (Ash Street)

Mr H Roberts for the Family of Amanawel Ayai, instructed by Mr T Mathew (Unite Legal)

Mr T Saunders for Dr M Tattersall, instructed by Ms P Callander (Meridian Lawyers)

Findings: Amanawel Ayai died on 8 January 2022 at Westmead Hospital, Westmead NSW 2145.

The cause of Amanawel's death was complications of bowel obstruction by adhesions.

Amanawel died whilst being held in lawful custody at Parklea Correctional Centre. Although Amanawel died of natural causes, his presentation on 7 January 2022 was not adequately assessed or investigated by clinicians involved in his care. After Amanawel's condition was correctly diagnosed on 8 January 2022, adequate steps were not taken to transfer him to hospital or institute appropriate treatment. Although different steps taken in Amanawel's management would have provided for the best possible outcome it is not possible to determine if any of these steps would have prevented Amanawel's cardiac arrest on 8 January 2022 or averted the eventual outcome.

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1. Introduction

1.1 On 7 January 2022, Amanawel Ayai, a 23-year-old man who was in custody at Parklea Correctional Centre (**Parklea**) reported having chest and stomach pain and vomiting. He was assessed by a nurse and it was considered that Amanawel was experiencing indigestion or food poisoning. He was prescribed medication to prevent nausea and vomiting.

1.2 At around midday on 8 January 2022, correctional officers attended Amanawel's cell where he suddenly collapsed. An emergency response was initiated and Amanawel was taken to the Main Clinic at Parklea. He was assessed by a doctor who formed the view that Amanawel had a bowel obstruction and needed to be transferred to hospital.

1.3 Arrangements were made for the transfer to occur. However, prior to transfer Amanawel collapsed for a second time and went into cardiac arrest. Resuscitation efforts were initiated but Amanawel could not be revived and was later pronounced deceased at 3:25pm.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of correctional staff.

2.4 In Amanawel's case, the circumstances of his death raised a number of questions regarding a clinical assessment of him that was performed on 7 January 2022, the management of his symptoms and presentation, the timeliness of his transfer to the Main Clinic, and his proposed transfer to hospital on 8 January 2022.

2.5 In January 2022, MTC-Broadspectrum (**MTC**) was retained by the Commissioner of Corrective Services New South Wales (**CSNSW**) to privately operate and manage Parklea under the direction and control of the Minister for Corrections and the Commissioner of CSNSW. Health services for inmates at Parklea were provided by St Vincents Correctional Health (**SVCH**).

2.6 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one.

3. Amanawel's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge Amanawel's life in a brief, but hopefully meaningful, way.

3.2 Amanawel was born in South Sudan on 9 September 1998 to his parents, Rigina Manyang and Aber Major. He was their second child.

3.3 After living in South Sudan for about five years, Amanawel moved to Egypt in 2003 with his mother and two sisters. In 2005, Amanawel and his family migrated to Australia and began living in Mount Druitt. Amanawel attended Sacred Heart Primary School and later Emmaus Catholic College in Kemps Creek. From a young age Amanawel had a great passion for football.

3.4 In 2010, Amanawel moved to Bathurst where he attended a different high school. Later that year, Amanawel moved back to Sydney and lived in St Marys.

3.5 At the end of 2015, Amanawel's mother and siblings moved to Melbourne. Amanawel remained in Sydney and lived with relatives. However, towards the end of 2016, Amanawel joined the rest of his family in Melbourne.

3.6 In 2017, Amanawel moved back to Sydney and lived in Shalvey.

3.7 Amanawel was deeply loved by his family. Although Amanawel had previously faced challenges and had several interactions with the justice system, he deserved an opportunity to learn from his mistakes, return home and have a second chance at life. However, Amanawel's life ended tragically when, as a young man, he had his hopes, dreams and future all ahead of him.

3.8 Birthdays, special events, family gathering and milestones are no longer the same for Amanawel's family. His loss is deeply and profoundly felt as is the grief that his family have experienced in conjunction with navigating the unfamiliar and often bewildering coronial system. Amanawel's younger sister will never have a chance to know her older brother whilst Amanawel's nephew will miss his uncle. Amanawel's entire family have been deprived of a lifetime of joyous moments, experiences and memories that could have been shared with Amanawel.

3.9 The last moments of Amanawel's life are not how his family and friends would want him to be remembered. Amanawel and his life mattered, especially to his loved ones. Amanawel was much more than the circumstances of his death and his life is not defined by it. Rather, how greatly Amanawel is missed is a testament to the lasting connection that Amanawel had with so many family and friends and how deeply he was, and still is, loved.

4. Amanawel's medical history

4.1 On 25 March 2018, Amanawel was involved in a motor vehicle accident and sustained chest trauma, a pneumothorax, lung contusions, and fracture of the L1 traverse process. He was taken to Westmead Hospital where an exploratory midline laparotomy was performed for possible abdominal injuries. This revealed tears to the sigmoid colon which were surgically repaired. Amanawel was later discharged on 2 April 2018.

4.2 Following the surgery, Amanawel continued to experience ongoing abdominal pain. Two weeks after his discharge from Westmead Hospital, Amanawel was again admitted to a hospital in Victoria overnight.

4.3 In December 2018, Amanawel was admitted to Nepean Hospital with abdominal pain and vomiting. He was diagnosed with a severe small bowel obstruction (**SBO**) and underwent a second laparotomy. This revealed that the small bowel was adhered to the abdominal wall by a band of scarring. The adhesion was surgically divided and Amanawel was discharged after a five-day admission.

4.4 In December 2020, Amanawel was taken by ambulance to Westmead Hospital with abdominal pain, nausea and severe vomiting. He was diagnosed with a SBO and managed conservatively with intravenous hydration and nasogastric tube feeding. After four days, Amanawel's condition improved and he was discharged.

5. Amanawel's custodial history

5.1 On 12 December 2021, Amanawel was remanded in custody after being arrested and charged with property and driving offences. He was next scheduled to appear before Mt Druitt Local Court on 20 January 2022.

5.2 After being received into custody at Amber Laurel Correctional Centre, Amanawel was transferred to the Metropolitan Remand & Reception Centre on 14 December 2021. He spent two weeks in COVID-19 isolation before being transferred to Parklea on 3 January 2022. Amanawel had alerts on the Offender Integrated Management System for being a young offender and having previously been diagnosed with asthma.

6. The events of 7 and 8 January 2022

7 January 2022

6.1 Between 10:31am and 10:35am on 7 January 2022, Amanawel used the emergency call system in his cell (known as a "knock up") to make two calls. On each occasion he spoke with Correctional Officer (**CO**) Justin Hurst, reported that he was feeling severe "burning pain", "stabbing pain" in his chest and stomach which he rated an "8 out of 10 so far", that he could not stop vomiting and asked to see a nurse. CO Hurst informed a SVCH nurse and called Amanawel back a short time later.

6.2 At around 11:00am, Registered Nurse (**RN**)[1] Tania Nguyen attended Amanawel's cell accompanied by CO Hurst and assessed him. RN Nguyen noted that Amanawel reported centralised chest pain, had started vomiting one day earlier and that his vital signs were normal.

6.3 RN Nguyen advised Dr Paul Tsui of her assessment. By around 11:20am, Dr Tsui charted metoclopramide for Amanawel.

6.4 At around 3:02pm, Amanawel called out from his cell to CO Hurst who at the time was escorting a pharmacist in the wing where Amanawel was housed. Amanawel asked for some paracetamol. The pharmacist gave Amanawel some Panadol and he took it.

6.5 However, at around 6:15pm, Amanawel made another knock up call and spoke to a correctional officer. He asked for paracetamol and anti-nausea medication. The correctional officer told Amanawel he would advise the SVCH nurses.

6.6 At around 11:00pm, Amanawel made another knock up call and spoke to a different correctional officer. Amanawel reported severe chest and stomach pain and said he could not stop vomiting. He indicated that he had been given paracetamol and told by nursing staff to make a report if his condition got worse. The correctional officer told Amanawel that he had already been given paracetamol and expressed doubt that he would be given any more. After Amanawel mentioned that he had contracted COVID-19, the correctional officer told him that he was "*just suffering from the side effects* ". The correctional officer eventually told Amanawel that he would pass on his request to SVCH staff.

6.7 The correctional officer reportedly called the Main Clinic and spoke to a correctional officer with the radio call sign, "Mike One", which is the callsign for the afternoon shift Clinic Officer. The correctional officer was reportedly told that Amanawel had been given paracetamol and that if he made another knock up call arrangements could be made for him to attend the Main Clinic.

8 January 2022

6.8 At around 8:50am on 8 January 2022, two SVCH staff attended Amanawel's cell accompanied by correctional officers. Amanawel was given some medication and advised that it was for nausea.

[1] Although Ms Nguyen was no longer registered as a nurse in in June 2026, she has been referred to by her former title in these findings for clarity and convenience. No disrespect is obviously intended.

6.9 At 12:02pm, CO Andrew Gardner was conducting a head check and lunchtime muster with other correctional officers. At around 12:03pm, Amanawel reported feeling unwell, then collapsed backwards. A medical emergency response (known as a Code Blue) was activated and SVCH staff attended Amanawel's cell. Amanawel was still conscious and reported nausea and repeated vomiting.

6.10 At 12:12pm, Amanawel was assisted from his cell, helped downstairs, placed in a wheelchair and taken to the Main Clinic. There Amanawel was assessed by Dr Mark Tattersall. Metoclopramide and morphine were charted for Amanawel.

6.11 At 12:27pm, RN Nguyen began filling out a document for Amanawel to be transferred to an external hospital which was completed at 12:42pm.

6.12 At 1:10pm, Amanawel was given the metoclopramide. He later asked for some water which was given to him by SVCH staff.

6.13 At 1:13pm, Amanawel was noted to be in the clinic bathroom. He was given a vomit bag and later slumped over in his wheelchair. Resuscitation efforts commenced and a Triple Zero call was made to emergency services.

6.14 At 1:35pm, NSW Ambulance (**NSWA**) paramedics attended the scene. Amanawel was taken by ambulance to Westmead Hospital. Resuscitation efforts continued but Amanawel could not be revived and was later tragically pronounced deceased.

7. Post-mortem examination

7.1 Amanawel was later taken to Forensic Medicine Sydney where Dr Dianne Little, forensic pathologist, performed a post-mortem examination on 13 January 2022. This identified the following relevant findings:

(a) adhesions in the abdomen with obstruction of the mid part of the small bowel by an adhesion;

(b) dilation of the proximal small bowel and dusky appearance of the mid small bowel with features of ischaemia on microscopy;

(c) biochemical evidence of acute kidney injury, liver dysfunction and high C reactive protein (in hospital tests); and

(d) toxicological analysis of preserved femoral blood detected a metoclopramide and morphine within the reported therapeutic ranges.

7.2 In the post-mortem examination report dated 30 June 2022, Dr Little opined that the cause of Amanawel's death was complications of bowel obstruction by adhesions.

8. What issues did the inquest examine?

8.1 Before the inquest commenced, a list of issues was circulated amongst the sufficient interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues for consideration:

(1) The adequacy of the nursing and medical care (including assessments, investigations, plans and treatment) provided to Amanawel on 7 January 2022 and 8 January 2022.

(2) The adequacy and appropriateness of steps taken by correctional officers to respond to Amanawel's presentation, complaints and requests for assistance.

(3) The adequacy of systems, policies and procedures governing the operation of Parklea with respect to managing inmates with pre-existing medical conditions, including with respect to:

(a) creation and maintenance of, and access to relevant health records;

(b) communication of any significant changes in an inmate's health status, between correctional officers and health staff, and by outgoing to incoming rostered staff; and

(c) Inmates' access to health care, including the circumstances in which an inmate may be transferred to the Main Clinic for review.

(4) The impact of COVID-19 protocols upon the provision of health services to inmates.

8.2 For convenience, some of the issues have been dealt with together below.

8.3 To assist with consideration of some of the above issues, opinions were sought from the following independent experts as part of the coronial investigation:

(a) Associate Professor Cherry Koh, colorectal and general surgeon and Director at the Surgical Outcomes Research Centre, Royal Prince Alfred Hospital;

(b) Professor Anne-Maree Kelly, senior emergency physician and Academic Head, Emergency Medicine, Western Health, Footscray; and

(c) Tracy Kidd, senior emergency and critical care nurse and nurse educator and College of Emergency Nursing Australasia education and trauma consultant.

9. Nursing care provided to Amanawel by RN Nguyen

RN Nguyen's assessment of Amanawel on 7 January 2022

9.1 RN Nguyen gave evidence that she only had a "*vague recollection*" of her interactions with Amanawel on both 7 and 8 January 2022. RN Nguyen gave evidence that:

(a) prior to attending Amanawel's cell on 7 January 2022 she had been told that Amanawel had been complaining of central chest pain;

(b) on assessment, Amanawel reported vomiting after breakfast and asked for medication to stop vomiting;

(c) she used a machine to check Amanawel's blood pressure and oxygen saturations;

(d) she took Amanawel's temperature and respiratory rate;

(e) she told Amanawel she would speak to the doctor to see if some medication could be charted for him; and

(f) she could not recall Amanawel mentioning anything about abdominal pain.

9.2 RN Nguyen gave evidence that the interaction was "*very quick*" and that CO Hurst was "*standing outside the door, like just at the door*". RN Nguyen said that normally she would "*feel really quite scared if the officer's standing outside and [she was] in a cell by [her]self with a patient*". RN Nguyen gave evidence that due to her apprehension at the time her assessment of Amanawel might have been "*a bit rushed*".

9.3 RN Nguyen gave evidence that if she felt scared she knew that she could ask a correctional officer to come into the cell and stand with her whilst performing an assessment. However, RN Nguyen gave evidence that she could not recall whether she did so on 7 January 2022.

9.4 CO Hurst was unavailable to give evidence at the inquest. However, in his statement dated 24 January 2022, CO Hurst described Amanawel as appearing very weak, unable to stand properly, moaning and groaning in pain with laboured breathing and asking for Panadol several times. RN Nguyen gave evidence that she could not recall observing any of these features during her assessment of Amanawel.

9.5 RN Nguyen also gave evidence that:

(a) she could not recall whether she asked Amanawel about his bowel or urine movements;

(b) she did not palpate Amanawel's stomach or perform any other physical examination because her assessment was "*based around the chest area, like, for cardiac issues*";

(c) she ruled out that Amanawel's presentation was cardiac-related; and

(d) because Amanawel had described vomiting after eating she "*assumed that it could possibly just be food poisoning or something that he's eaten [that] morning and was unsettled*".

Discussion between RN Nguyen and Dr Tsui on 7 January 2022

9.6 RN Nguyen gave evidence that she could not recall her conversation with Dr Tsui on 7 January 2022 but expressed belief that she provided Dr Tsui with her observations of Amanawel. RN Nguyen said

that she could not recall what her preliminary assessment of Amanawel was. However, RN Nguyen agreed that in her statement she said that Dr Tsui agreed with her preliminary assessment of food poisoning and/or dehydration.

9.7 RN Nguyen gave evidence that Dr Tsui charted metoclopramide for Amanawel at around 11:20am and that it was her usual practice to dispense medications immediately. However, RN Nguyen said that she later became busy and did not administer it to Amanawel by the time her shift ended at 2:30pm. RN Nguyen gave evidence that it was her usual practice to inform nursing staff at handover of the need to administer medication to a patient but conceded it was possible she did not do so on 7 January 2022.

9.8 At 11:21am on 7 January 2022, RN Nguyen completed the following progress note entry regarding Amanawel:

> PCC nursing: pt c/o centralised chest pain and x1 emesis.
> onset 1/7 ago
> BP – 112/82
> SATS 99%RA - talking in full sentences
> Temp. 36.2
> HR: 83
>
> D/W MO:: charted 10mg metoclopramide

9.9 This entry was updated three times by RN Nguyen with the first update at 3:44pm on 8 January 2022 recording the following:

> PCC nursing: pt seen for nausea and vomiting in AREA 3C.
> reported x1 Emesis this morning post breakfast.
> onset 1/7 of vomiting 1/7 ago
>
> A- patent, maintaining own airway
> B-RR 18, SATs 99%RA - talking in full sentences, bilateral air entry
> C- BP - 112/82 , 83HR, peripheries warm and well perfused, pulse strong and regular
> D- Temp. 36.2, Gait NAD, dry mucosa,
>
> imp: food poisoning?, ?dehydration,
>
> D/W MO - ?indigestion, charted 10mg metoclopramide, handed over to PM nurse to deliver medication.
> advised to notify medical staff of worsening symptoms, pt. Acknowledged [emphasis added].

9.10 The second update occurred at 3:47pm on 8 January 2022 and recorded the following:

> PCC nursing: pt seen for centralised chest pain nausea and vomiting in AREA 3C.
> reported x1 Emesis this morning post breakfast.
> onset 1/7 of vomiting 1/7 ago
>
> A- patent, maintaining own airway

B-RR 18, SATs 99%RA - talking in full sentences, bilateral air entry
C- BP - 112/82 , 83HR, peripheries warm and well perfused, pulse strong and regular
D- Temp. 36.2, Gait NAD, dry mucosa,

imp: food poisoning?, ?dehydration,

D/W MO - ?indigestion, charted 10mg metoclopramide, handed over to PM nurse to deliver medication.
advised to notify medical staff of worsening symptoms, pt. acknowledged [emphasis added].

9.11 The fourth and final update occurred at 5:56pm on 8 January 2022 and recorded the following:

PCC nursing: Due to lock down, writer was asked by MTC officer to review pt. in the cell for centralized chest pain and nausea, vomiting in AREA 3C.
reported x1 Emesis this morning post breakfast. stated he needed medication to stop the vomiting. onset 1/7 of vomiting ago

A- patent, maintaining own airway
B-RR 18, SATs 99%RA - talking in full sentences, bilateral air entry
C- BP - 112/82 , 83HR, peripheries warm and well perfused, pulse strong and regular
D- Temp. 36.2, Gait NAD, dry mucosa,

imp: food poisoning?, ?dehydration,

D/W MO - ?indigestion, charted 10mg metoclopramide, handed over to PM nurse to deliver medication.
advised to notify medical staff of worsening symptoms, pt. acknowledged [emphasis added].

9.12 RN Nguyen gave evidence that she would write down her assessments on a primary health list which is a printout of the names of patients and their concerns for the day. RN Nguyen described the reason for the four different versions of her progress note entry in this way:

I may have - I believe I rushed it, the first entry, by remembering what I've stuck in - what I have assessed by the top of my head, and then I believe the next day I would've gone back into my notes and re - yeah, re-updated it.

9.13 RN Nguyen gave evidence that in the first update she "probably" included matters that were part of her usual practice.

9.14 Counsel Assisting suggested to RN Nguyen that she made the amendments to the progress note because she was concerned about her assessment of Amanawel on 7 January 2022. RN Nguyen gave this evidence:

I believe that my intention to updating the progress notes would purely be from, like, transparency. And I know that - I know they redact when custody goes to coroners, so I understand that if - I had to put in the full information so it would help serve and bring up a clearer picture of or paint a picture of what actually happened. But solely, my intention was just to be completely honest and transparent of - as to what actually happened that day, and just to put in as much information as possible and just make sure that it covers everything.

Expert evidence

9.15 Ms Kidd expressed the following opinions regarding RN Nguyen's care of Amanawel:

(a) RN Nguyen's assessment of Amanawel on 7 January 2022 was not comprehensive but rather incomplete, "*piecemeal and inadequate*";

(b) RN Nguyen did not obtain a complete medical history which should have been used to inform a focused assessment;

(c) RN Nguyen did not physically examine Amanawel despite him displaying "*three of the four cardinal features of intestinal obstruction*" (abdominal pain, vomiting, constipation);

(d) RN Nguyen's assessment did not demonstrate the application of critical thinking;

(e) RN Nguyen's assessment demonstrated evidence of confirmation bias ("*a cognitive tendency to selectively accept information and support existing beliefs or experiences while ignoring or undervaluing other information*") and premature closure; and

(f) RN Nguyen did not document her assessment of Amanawel contemporaneously and did not explain in her multiple progress note entries the reason for any amendments.

9.16 Associate Professor Koh expressed the opinion that RN Nguyen's interaction with Amanawel on 7 January 2022 was "*relatively brief*" and that "*perhaps a more thorough assessment would have been beneficial*". Associate Professor Koh also expressed the view that RN Nguyen's documentation of her assessment was lacking in detail and more in-depth history taking of Amanawel's symptoms could have been undertaken.

9.17 Professor Kelly similarly expressed the view that RN Nguyen elicited an inadequate and inaccurate history from Amanawel and specifically failed to elicit Amanawel's risk factor of previous abdominal surgery. Professor Kelly also expressed the opinion that only a limited physical examination was performed and inadequate regard was given to Amanawel's complaint of central chest pain.

9.18 During her oral evidence, RN Nguyen was taken to each of the above opinions expressed by the experts. She gave evidence that she accepted each of the opinions expressed regarding the adequacy the care she provided to Amanawel.

Consideration

9.19 Counsel for RN Nguyen submitted that the concessions made by RN Nguyen need to be considered in the context of three matters:

(a) the impact of COVID-19 is a factor that should be taken into account when considering the adequacy of RN Nguyen's assessment and RN Nguyen "*at the very least felt there was less of an opportunity to take Amanawel to the clinic that otherwise would've been the case*";

(b) RN Nguyen's assessment of Amanawel was opportunistic or unplanned;

(c) as RN Nguyen was alone in the cell with Amanawel with CO Hurst outside the cell, her fear "*may have caused her to be rushed in her assessment*".

9.20 First, RN Nguyen did not in her oral evidence refer to the COVID-19 pandemic having any bearing on her assessment of Amanawel. When asked about the impact of COVID-19, RN Nguyen gave evidence that she explicitly was not concerned about assessing patients in their cells or the transmission of COVID-19 within Area 3. Further, there is no direct evidence that on 7 January 2022, RN Nguyen considered that Amanawel's transfer to the Main Clinic may have been warranted but was not effected due to COVID-19 restrictions.

9.21 Second, Professor Kelly gave evidence describing RN Nguyen's assessment of Amanawel as unplanned given that it was done at the request of a correctional officer about a person complaining of an acute illness. Notwithstanding, Professor Kelly gave evidence that RN Nguyen had a responsibility to acquaint herself, as much as she could, with what was known about Amanawel and his background health. Professor Kelly also gave evidence that the nature of an unplanned review makes it more important for a clinician to perform a structured and thorough assessment of the patient including eliciting a comprehensive and accurate history.

9.22 Third, it is acknowledged that RN Nguyen gave unchallenged evidence that her apprehension at being alone in a cell with Amanawel may have caused her assessment to be "*a bit rushed*". However, this answer was not initially given by RN Nguyen during her evidence in chief and only elicited by Counsel for Amanawel's family with a leading question in cross-examination. Further, the available evidence does not allow for any qualitative assessment to be made about the extent to which RN Nguyen's feeling of being "*a bit rushed*" compromised the adequacy of her assessment of Amanawel.

9.23 **Conclusions:** The expert evidence and concessions made by RN Nguyen establish that her assessment of Amanawel on 7 January 2022 was incomplete and inadequate. RN Nguyen did not appropriately investigate Amanawel's presenting complaint and symptoms by performing a physical examination and obtaining a complete medical history. RN Nguyen's assessment demonstrated an absence of critical thinking and confirmation bias.

9.24 There is no direct evidence that the adequacy of RN Nguyen's assessment was adversely affected by either the impact of COVID-19 and any related restrictions or the fact that the assessment was unplanned. Indeed, the unplanned nature of the assessment, without any awareness of Amanawel's medical history, made it more critical for a thorough assessment to be performed.

9.25 The evidence indicates that RN Nguyen's apprehension at being alone in a cell with Amanawel may have caused her to rush aspects of the assessment. However, it is not possible to identify the extent to which this factor impacted upon the adequacy of the assessment.

10. Nursing care provided to Amanawel by RN Moodley

10.1 In her statement of 25 September 2023, RN Moodley stated that she responded to the Code Blue for Amanawel shortly before 11:40am on 8 January 2022. It was the first occasion that RN Moodley had responded to a Code Blue. She stated the following about her attendance:

(a) Amanawel was speaking in full sentences (which reassured her), not actively vomiting and not in acute respiratory distress;

(b) Amanawel's blood pressure could not be measured but his heart rate was recorded as 45;

(c) she and RN Nguyen agreed to transfer Amanawel to the Main Clinic to be assessed by Dr Tattersall;

(d) after Amanawel arrived in the Main Clinic she had no further interaction with Amanawel because she was rostered to work in a different area and was attending to patients there;

(e) at around 1:15pm, she saw Amanawel being carried from the bathroom back to the Main Clinic, appearing to be limp and unconscious, and offered her assistance.

10.2 However, RN Moodley gave evidence agreeing that based on CCTV footage from the Main Clinic she was moving in and out of the treatment room where Amanawel was located from about 1:00pm. RN Moodley gave evidence that she could not recall anything that happened during this period.

10.3 The *Correctional Health: SVCH Clinical Emergency Response Team (CERT) Procedure* (**CERT Procedure**) defines an A-G Assessment to be a structured approach to systematically assessing a patient using an algorithm (**A**irway, **B**reathing, Circulation, **D**isability, **E**xposure, **F**luids, **G**lucose). The CERT Procedure also provides that one of the responsibilities of SVCH staff when responding to a CERT call is to document an A-G Assessment in the clinical notes, together with the treatment initiated and ongoing management plan.

10.4 Ms Kidd expressed the opinion that it was a reasonable observation to note that Amanawel was not in acute respiratory distress at the time RN Moodley attended his cell, However, Ms Kidd considered the assessment performed in response to the Code Bue to be incomplete given that an A-G Assessment was not performed. Further, Ms Kidd expressed the view that if this had been performed, "*other indicators of serious deterioration would have been obvious and documented*".

10.5 In her oral evidence, RN Moodley agreed with the opinion expressed by Ms Kidd but sought to explain "*there was a team effort at that point in time*" and that it was not "*one person's response*". However, RN Moodley acknowledged that the response "*could have been done properly […] and more efficiently*" and agreed that the care provided to Amanawel could have been better.

10.6 The electronic medical records indicate that RN Moodley did not document her attendance at the Code Blue until 5:42pm on 8 January 2022 after Amanawel had gone into cardiac arrest. This progress note entry was amended twice at 6:17pm and 6:21pm.

10.7 These matters were acknowledged by RN Moodley in her oral evidence. When asked why she did not document her observations contemporaneously, RN Moodley gave this evidence:

> It probably was trying to recollect after the incident and trying to put in the notes as accurately as possible and then it would have been - I was in shock at the time. I remember being really upset about the incident, about the patient being Amanawel, and passing. Yes, so it would probably been those events that would have led to me reviewing the notes and writing them - re-writing.

10.8 **Conclusions:** The expert evidence and RN Moodley's concessions together establish that a thorough A-G assessment of Amanawel was not performed on 8 January 2022 by RN Moodley or any other nursing staff. Further, the assessment that was performed was not documented contemporaneously.

10.9 RN Moodley had not previously responded to a Code Blue. Further, her involvement in Amanawel's care was limited given that she responded together with RN Nguyen (who was the team leader in the Main Clinic), that she was not working in the Main Clinic on 8 January 2022, and that she appears to have been intermittently in the treatment room with Amanawel for approximately 15 minutes. Notwithstanding, RN Moodley's involvement was a part of the overall nursing response and therefore RN Moodley had a responsibility to ensure that her role, however limited, was performed effectively and adequately.

11. Medical care provided to Amanawel by Dr Tsui

Discussion between Dr Tsui and RN Nguyen on 7 January 2022

11.1 In her report, Professor Kelly expressed the opinion that Dr Tsui did not take adequate and appropriate steps to investigate Amanawel's presenting complaint because he failed to:

(a) assess Amanawel who was reporting a high risk symptom (chest pain), abdominal pain and vomiting with signs suggestive of significant dehydration which were inconsistent with a single episode of vomiting;

(b) consider Amanawel's past medical history and therefore failed to consider a sufficiently broad differential diagnosis;

(c) exclude other serious causes of Amanawel's symptoms and instead concluded that he had indigestion/reflux;

(d) document his reasoning regarding why he considered that Amanawel did not require assessment by a medical officer or an ECG;

(e) institute an appropriate follow-up plan to ensure Amanawel's condition was not progressing.

11.2 During his oral evidence, Dr Tsui accepted each of the opinions expressed by Professor Kelly if in fact Amanawel's complaint of chest pain had been reported to him.

11.3 Professor Kelly gave evidence that her opinion carried an important caveat, namely that it was "*not completely certain*" whether RN Nguyen told Dr Tsui that Amanawel had complained of chest pain. Professor Kelly explained that it is "*quite a different story*" between Dr Tsui being told that Amanawel was experiencing abdominal pain and had vomited once as opposed to being told that Amanawel was complaining of chest pain and having vomited multiple times. Professor Kelly emphasised that the issue centred around the quality of RN Nguyen's assessment of Amanawel and whether she communicated enough detail from that assessment to Dr Tsui to allow him "*to make a reasonable judgment*".

11.4 In a statement made on 20 October 2023, Dr Tsui stated that he had no independent recollection of Amanawel and that the contents of his statement was based on his retrospective interpretation of medical records and his usual practice. Dr Tsui gave this evidence regarding his discussion with RN Nguyen on 7 January 2022:

> I would say that I don't think or I remember being told that he had chest pain. So my kind of assessment of the patient was based on what I was told.

11.5 Counsel Assisting asked Dr Tsui how it was possible for him to give evidence that he did not think RN Nguyen told him Amanawel was complaining of chest pain if he did not even remember the conversation with her. Dr Tsui gave evidence that he relied on his usual practice, namely that if he had been told a patient was reporting chest pain he would arrange for the patient to be brought to the Main Clinic to be assessed. The fact that that he did not ask for Amanawel to be transferred to the Main Clinic suggested to Dr Tsui that RN Nguyen did not inform him that Amanawel was complaining of chest pain.

11.6 During his oral evidence, Dr Tsui acknowledged that RN Nguyen had recorded in the first version of her progress note entry that Amanawel had complained of chest pain. However, Dr Tsui gave evidence that it was "*hard to say*" whether he made his clinical decisions knowing of this complaint. Dr Tsui explained that he did not review the progress note entry before formulating a management plan for Amanawel. Instead, Dr Tsui gave evidence that he spoke with RN Nguyen and together they formulated a plan to give Amanawel metoclopramide to relieve his vomiting symptoms.

Consideration

11.7 Counsel for Dr Tsui submitted that acceptance of the opinions expressed by Professor Kelly regarding the adequacy of the care provided by Dr Tsui is entirely contingent upon accepting that RN Nguyen told Dr Tsui that Amanawel had complained of chest pain. It is therefore convenient to now consider whether RN Nguyen did in fact tell Dr Tsui that Amanawel had complained of chest pain.

11.8 First, prior to her assessment RN Nguyen was made aware that Amanawel had complained of chest pain. Her evidence was that her assessment was focused on determining whether the reason for Amanawel's presentation was cardiac related. In the first version of her progress note entry recorded after her discussion with Dr Tsui, RN Nguyen documented that Amanawel had complained of chest pain. Given how prominently the complaint of chest pain occupied RN

Nguyen's interactions with Amanawel, it appears unlikely that she would not have told Dr Tsui about this complaint.

11.9 Second, in her statement made on 17 July 2023, RN Nguyen stated that when she returned to the Main Clinic after assessing Amanawel she "*told Dr Tsui of [her] review and preliminary assessment of [Amanawel]*". As noted above, RN Nguyen gave evidence that she based her assessment of Amanawel around the chest area for potential cardiac issues and that she had ruled out his presentation as being cardiac related. Again, given the focus of RN Nguyen's assessment it seems unlikely that she would not have informed Dr Tsui about this and why she considered that a cardiac-related cause for Amanawel's presentation had been excluded.

11.10 Third, the most contemporaneous record made by Dr Tsui regarding his discussion with RN Nguyen is an email sent by him at 5:40pm on 8 January 2022 in response to an email sent by Dr Tattersall at 5:25pm on the same date advising of the "*need to document [a] conversation around [Amanawel] [on 7 January 2022] that [Dr Tsui] had with [RN Nguyen]*". In his email reply, Dr Tsui relevantly wrote the following:

> On the 7/1/22 Tania spoke to me stating he had epigastric burning pain like reflux. Vitally he was stable. Had been nauseated and vomiting and requested some metoclopramide.
>
> He could not be brought to the clinic or have an ECG due to the current covid situation and lockdown.
>
> Metoclopramide was charted and advised to notify MO if any further issues.

11.11 Dr Tsui gave evidence that it is possible that the first sentence of the above email could correctly be read as conveying his interpretation of what RN Nguyen had described to him about Amanawel's presentation. In other words, Dr Tsui acknowledged it was possible that RN Nguyen had told him that Amanawel had complained of chest pain but that he interpreted Amanawel to be experiencing epigastric burning pain.

11.12 Fourth, in his email of 8 January 2022, Dr Tsui referred to an inability to bring Amanawel to the Main Clinic or to have an ECG performed. These matters suggest that Dr Tsui on 7 January 2022 contemplated both steps being taken. This in turn suggests that, consistent with his usual practice, Dr Tsui was only contemplating taking these steps because RN Nguyen had told him that Amanawel had complained of chest pain. In other words, transferring a patient to the Main Clinic for assessment following a report of chest pain would have been consistent with Dr Tsui's usual practice and an ECG would have been a likely investigation for a complaint of chest pain.

11.13 **Conclusions:** Neither Dr Tsui nor RN Nguyen have a clear recollection of their conversation on 7 January 2022 regarding Amanawel's presentation. However, Dr Tsui acknowledged the possibility that his most contemporaneous record, the email sent to Dr Tattersall at 5:40pm on 8 January 2022, could be interpreted to mean that whilst RN Nguyen had told him that Amanawel had complained of chest pain, Dr Tsui's impression was that he was experiencing gastric burning pain like reflux. This is consistent with Dr Tsui's own reference to the inability of bringing Amanawel to the Main Clinic to perform an ECG. It is also consistent with the most contemporaneous record made by RN Nguyen of her assessment and its focus on possible cardiac pathology.

11.14 Overall the available evidence establishes that it is more probable than not that RN Nguyen told Dr Tsui that Amanawel had complained of chest pain. This means that RN Nguyen communicated enough detail from her assessment of Amanawel to allow Dr Tsui to exercise reasonable judgement regarding Amanawel's management. Dr Tsui indicated his qualified acceptance of the opinions expressed by Professor Kelly. That qualification has now been removed having regard to the matters set out above. The evidence therefore establishes that Dr Tsui did not take appropriate steps to investigate Amanawel's presentation, did not sufficiently exclude other serious causes of Amanawel's symptoms, and did not consider a sufficiently broad differential diagnosis.

11.15 Counsel for Amanawel's family submitted that consideration should be given to making a recommendation that every phone conversation involving two or more SVCH clinicians should be recorded to "assist in a general way in ensuring that there is an appropriate record of such conversations rather than simply having to rely on the memory of witnesses". Counsel for Amanawel's family referred directly to the conversation between RN Nguyen and Dr Tsui and their inability to recall the details of it.

11.16 The evidentiary basis for making this submission is unclear given that RN Nguyen and Dr Tsui conversed in person rather than over the phone. Even leaving that matter to one side, the making of such a recommendation would immediately raise privacy concerns regarding the recording of discussions between clinicians about patients and their care. Further, the mechanism by which such recordings could be made and the potential impact that such a process might have on patient care is entirely unclear. In all the circumstances it is neither necessary nor desirable for such a recommendation to be made.

Follow-up plan instituted by Dr Tsui

11.17 Dr Tsui acknowledged that RN Nguyen's first progress note entry made no reference to any follow up plan. Instead, the only plan referred to was charting metoclopramide for Amanawel. References to Amanawel being told to notify medical staff of any worsening symptoms are only found in subsequent versions of the progress note entry made on the afternoon of 8 January 2022. Dr Tsui gave evidence that it was therefore possible that there was no plan for Amanawel other than charting metoclopramide on the morning of 7 January 2022.

11.18 In his statement, Dr Tsui acknowledged that he did not record his treatment plan for Amanawel in the electronic medical record. He also acknowledged that best practice would have been for him

to document his conversation with RN Nguyen in the progress notes. Dr Tsui gave evidence about the difficulties with not doing so:

> It's very difficult to have a, for example, the opposite is to have a conversation with a nurse for how many seconds or minutes and then they infer what the plan is and what my thoughts are and my impression.

11.19 In both his statement and in his oral evidence, Dr Tsui sought to explain that Parklea is a busy work environment and that he is required to make around 200 decisions each shift. He stated that the "*administrative burden that would be attached to documenting every single interaction or involvement I might have with a custodial patient in JHEHS would erode the time I have available to deliver health care*".

11.20 Dr Tsui gave evidence that there are now two doctors at Parklea which allows for more detailed assessments to be undertaken, and for doctors to see patients themselves and make their own assessments, resulting in increased patient safety. Dr Tsui gave evidence that in contrast, in 2002, he was "*having to make assessments on patients that [he had] never seen based on conversations that [he did not] recall*".

11.21 Counsel for Dr Tsui submitted that it was not unreasonable for Dr Tsui to expected that if Amanawel's condition did not improve or deteriorated he would be informed. Professor Kelly gave evidence that the central issue was how any follow-up plan for Amanawel would be "operationalised", meaning whether nursing staff were performing regular reviews to ensure that Amanawel's condition improved and facilitating correctional staff to notify the clinical team if his condition did not improve. Professor Kelly agreed that to an extent these were matters for nursing and correctional staff rather than Dr Tsui. However, Professor Kelly expressed the view that "*it would have been helpful*" if Dr Tsui had instructed nursing staff to check on Amanawel during the afternoon of 7 January 2022 "*to make sure things are okay*".

11.22 **Conclusions:** Following RN Nguyen's assessment of Amanawel and discussion with Dr Tsui on 7 January 2022, any management plan instituted by Dr Tsui was limited to charting metoclopramide. Whilst Dr Tsui reasonably expected that he would be informed if there was no change or any deterioration in Amanawel's condition, he still bore some responsibility to ensure that there was a degree of follow-up. This could have been accomplished by Dr Tsui requesting nursing staff to check on Amanawel during the afternoon of 7 January 2022 which would have represented optimal care being provided to Amanawel.

11.23 Dr Tsui conceded that he did not document his conversation with RN Nguyen or his management plan for Amanawel in the electronic medical records. Dr Tsui frankly acknowledged that this would have represented best practice. However, the evidence indicates that due to his clinical workload and the possibility of compromising patient care, it would not have been reasonable for Dr Tsui to document every interaction he had with clinical staff regarding a patient.

12. Medical care provided to Amanawel by Dr Tattersall

Transfer of Amanawel to hospital

12.1 In his first statement of 10 February 2024, Dr Tattersall stated that he considered that using MTC officers to transport Amanawel to hospital would be quicker than calling an ambulance. Dr Tattersall explained that due to the COVID-19 pandemic at the time, he was concerned that if an ambulance was called its arrival would be delayed particularly because Amanawel was haemodynamically stable at the time. Dr Tattersall stated that that he instead spoke to the MTC Shift Supervisor and explained that Amanawel needed to be taken to hospital as soon as possible.

12.2 Dr Tattersall gave evidence that he was aware that if Amanawel was taken to hospital by MTC officers they would not be accompanied by any nursing or medical staff. Dr Tattersall gave evidence that his understanding of the practicalities of such a transfer was limited to the following:

> [T]hey would put him in the van, take him straight down to the hospital. It's 20 minutes away. They give the paperwork they've got straight to the Emergency Department triage nurse and then the triage nurse would start the process when he got there.

12.3 In his second statement of 5 June 2026, Dr Tattersall elaborated and stated that he was aware that an ambulance had been called on 7 January 2022 for another patient with chest pains and was told that the ambulance "*took hours to arrive at Parklea*". Information provided by SVCH indicates that overnight on 5 January 2022, another inmate was transferred to the Main Clinic after sustaining a traumatic injury from a fall down some stairs. The inmate required transfer to hospital. However, the information provided by SVCH did not disclose when an ambulance was called or when it arrived at Parklea.

12.4 The evidence indicates that Dr Tattersall's recollection of another patient transfer to hospital by ambulance shortly before 8 January 2022 was correct. However, it is not possible to determine from the available evidence whether there was any inordinate delay involved in that earlier transfer. Further, any inordinate delay present on that earlier occasion did not necessarily mean that inordinate delay was also likely to have been repeated on 8 January 2022. Regardless, Dr Tattersall conceded in his oral evidence that this earlier patient transfer was not part of this thinking at the time on 8 January 2022 although he asserted that "*there were issues around delay in transfers*".

12.5 Dr Tattersall acknowledged that the ambulance that was eventually called for Amanawel took about seven minutes to arrive. However, Dr Tattersall sought to explain that the ambulance was responding to Amanawel being in cardiac arrest at the time. Dr Tattersall also sought to explain that with Amanawel's symptoms and observations, calling an ambulance earlier "*would have taken too long*".

12.6 In her oral evidence, Professor Kelly expressed some sympathy for the position that Dr Tattersall was in and gave evidence that in her experience ambulance response times are "*under pressure*" nationally. However, Professor Kelly also gave this evidence:

> [M]y experience has also been that if you ring an ambulance and explain the circumstances, and in this case the particularly abnormal vital signs and severe dehydration and serious concern that Dr Tattersall clearly had for Amanawel, that an ambulance can often be accessed quite properly.

12.7 Three further aspects Professor Kelly's evidence are relevant to this issue:

(a) Taken in isolation, Professor Kelly described Amanawel's pulse rate and blood pressure to be "*okay-ish*" but that one of the concerns in Amanawel's case was over reliance on interpretation of apparent normal vital signs. Professor Kelly explained that there were reports "*from various people at various times*" indicating that Amanawel looked "*really sick*". Professor Kelly therefore emphasised that whilst vital signs are "*part of the story*", they are not the "*whole story*" and there is a need to look at the "*whole patient*";

(b) Amanawel's heart rate of 45 ought to have led to him being placed on a cardiac monitor which would have showed an abnormal trace. Professor Kelly gave evidence that this would have provided "*absolute grounds for calling an urgent lights and sirens ambulance*"; and

(c) Amanawel's heart rate of 45 was "*clearly abnormal*" and if he had been transferred by MTC officers he was at risk of bradycardia with the officers having "*no skills, no equipment, or anything to do anything about any of it*".

12.8 Professor Kelly gave evidence there "*are too many variables*" for her to express an opinion regarding whether Amanawel's transfer to hospital would have been prioritised or expedited if an ambulance had been called. Notwithstanding, Professor Kelly also gave evidence that as a matter of patient safety, it would have been best practice to effect Amanawel's transfer to hospital by ambulance and, if possible, provide treatment to him whilst that occurred.

12.9 Counsel for Dr Tattersall took Professor Kelly to an extract from the submission made by NSW Health (in September 2022) in the *Inquiry into Impact of Ambulance Ramping and Access Block on the Operation of Hospital Emergency Departments in New South Wales*. The submission noted the following:

> EDs in NSW have been impacted by waves of acute respiratory infections which peaked in mid-January 2022 during the height of the initial Omicron COVID-19 outbreak with up to 1,400 presentations each week. These rates have not yet returned to the low inter-wave levels seen in 2021.
>
> Ambulance volumes have been similarly impacted. The most recent results show that, in January to March 2022, there were 326,544 ambulance responses, up to 17.8% compared with the same quarter in 2017. Of these, 9,360 were responses to priority 1A cases for patients with life-threatening conditions - the most since BHI began reporting in 2010.
>
> Of patients presenting to EDs, 169,250 arrived by ambulance, up 13.0% from 149,729 five years earlier.

12.10 Counsel for Dr Tattersall explored this extract with Professor Kelly in her oral evidence. Professor Kelly gave the following evidence regarding the number of new presentations each week to emergency departments:

> That doesn't actually necessarily impact ambulance response times. It depends on - ambulances prioritise who they respond to and how, and it depends on the information that they're given as to how they prioritise that, and then there are - as well as that, there's issues about how many other cases are on the go, et cetera. It's a quite complicated matrix. COVID-19 did have some impact on ambulances all across Australia, but it evened out with time.

12.11 **Conclusions:** The expert evidence establishes that on 8 January 2022, Amanawel was not as haemodynamically stable as Dr Tattersall considered him to be. This meant that Dr Tattersall ought to have arranged for Amanawel's transfer to hospital by ambulance rather than transfer being effected by MTC officers without nursing or medical support. The available evidence does not allow for any conclusion to be reached as to whether transfer by ambulance, if an ambulance had in fact been called, would have occurred more promptly. The evidence introduced regarding the submission made by NSW Health does not assist in this regard given its high level of generality which cannot be applied to the particular features of Amanawel's case.

12.12 Rather, the issue concerns the indication for calling an ambulance rather than relying upon transfer by MTC officers. The expert evidence establishes that Amanawel's heart rate was abnormally low and warranted an urgent call being made for dispatch of an ambulance with the highest priority. Further, Amanawel's heart rate placed him at risk of bradycardia. Therefore, as a matter of patient safety, transfer ought to have occurred by ambulance so that appropriate medical support and treatment, if possible, could be provided.

Administration of intravenous fluids

12.13 Dr Tattersall gave evidence that administering intravenous (**IV**) fluids to Amanawel was not part of his management plan given Amanawel's presentation at the time. Dr Tattersall gave evidence that he considered that Amanawel's blood pressure had not deteriorated and that he was not "*critically unwell where he needs [sic] fluids immediately*".

12.14 Dr Tattersall also gave evidence that an IV pump was not available at the time and that instead a fluid bag would have needed to be hung. However, Dr Tattersall sought to explain that such a bag could not be hung at "*any great height*", meaning that administration of fluids would have taken some time.

12.15 Associate Professor Koh gave evidence that IV fluids would have sustained Amanawel's haemodynamic status, maintained blood pressure, kept his heart rate within a normal, acceptable range and stopped further problems from developing. Associate Professor Koh acknowledged that in a dehydrated patient it is possible that their vascular access is so collapsed it is diffident to insert a cannula. However, Associate Professor Koh explained that in a "*straightforward patient*" gaining vascular access and instituting IV fluids could be done "*pretty quickly*".

12.16 Associate Professor Koh gave evidence that even in the absence of a pump a saline bag can be squeezed to facilitate the administration of fluids. Associate Professor Koh also gave evidence that the time to transfer would not have been an obstacle for Amanawel:

> [W]ith Sydney traffic, even if you have siren[s] and everything on it's going to take a little bit of time to get a patient from point A to point B. I think that starting intravenous fluids as soon as possible would be very helpful.

12.17 Dr Tattersall gave evidence that he was comforted by the fact that Amanawel's heart rate had increased from 45 to 60 at around 1:00pm shortly before he left the main clinic to attend to another patient, and that Amanawel was sitting upright and conversing and had a stable blood pressure of 98/70.

12.18 Associate Professor Koh gave evidence about what comfort, if any, could be drawn from this presentation:

> I think one of the issues that we have when we're dealing with otherwise well patients is the fact that, as I said, is they can compensate right up until that critical event of something happening. He was certainly not changing from minute to minute. In fact over a five-minute period, over a 15 minute period, he seemed relatively stable and, you know, maybe the arrest would never have happened but may it would happen the next five minutes.
>
> It's difficult to tell sometimes with young patients who just, as I say, can compensate right up until the last minute. Sometimes we can get sort of lulled into a false sense of security because, as you say, the patient is conversing which means to say the airway's fine, the breathing's find, the circulation is fine. So these are very crude assessments, though.

12.19 Associate Professor Koh gave evidence that she could not say whether instituting IV fluids would have prevented Amanawel's cardiac arrest or the eventual outcome. However, Associate Professor Koh gave evidence that the earlier treatments are implemented the better the outcomes.

12.20 Professor Kelly gave evidence that a heart rate of 45 is "v*ery unusual and suggests something untoward is going on*" and that whilst Amanawel's blood pressure was "*technically okay on the range chart*" male blood pressures under 100 are "*quite unusual*". Ultimately, Professor Kelly gave evidence doubting that "*just the numbers can be used to justify stability*". Professor Kelly emphasised that Amanawel was aided down the stairs from his cell and witnesses reported him as looking terrible.

12.21 In this regard, Professor Kelly gave evidence agreeing with Associate Professor Koh that a young person's physiological reserve can complicate their presentation so that other observations are required:

> [T]here are often other clues like conscious state, like how a person looks, like skin turgor which is the elasticity of the skin and how quickly it bounces back and the mucous membrane. So it's not just the numbers. It's the whole patient.

12.22 Professor Kelly gave evidence that two readings is not a trend but rather "*two dots in space*". Professor Kelly also gave evidence that to rely on such a "*trend*" to show the Amanawel was haemodynamically stable was "*ill-advised*".

12.23 Dr Tattersall gave evidence that in hindsight it would have been preferable if IV fluids had been commenced for Amanawel given his severe dehydration.

12.24 **Conclusions:** Whilst Dr Tattersall correctly diagnosed that Amanawel was suffering from a bowel obstruction, he did not correctly recognise the severity of Amanawel's condition and therefore respond entirely appropriately. An appropriate response would have included commencement of intravenous fluids to maintain blood pressure and sustain haemodynamic stability.

12.25 This was not instituted by Dr Tattersall because he considered that Amanawel was not so critically unwell as to immediately require intravenous fluids, and manual administration of fluids would have taken some time. The expert evidence establishes that Dr Tattersall likely did not account for Amanawel's physiological reserve suddenly "*crashing*" and placed over reliance on what he perceived to be a reassuring trend with Amanawel's vital signs.

12.26 Dr Tattersall conceded that, in hindsight, he ought to have commenced intravenous fluids for Amanawel. It is acknowledged, as Counsel for Dr Tattersall submitted, that in January 2022, Dr Tattersall was relatively inexperienced generally and had little experience with the management of patients with a bowel obstruction. It is also acknowledged that Amanawel's dehydration at the time may have made vascular access challenging. However, if access could have been gained, it is likely that administration of fluids, even manually, could have been achieved.

12.27 The expert evidence also establishes that administration of intravenous fluids would have provided the best possible outcome for Amanawel. However, it is not possible to determine whether administration of intravenous fluids would have prevented Amanawel's cardiac arrest or averted the eventual outcome.

Point-of-care blood testing

12.28 Although a handheld blood testing device was available in the Main Clinic on 8 January 2022, Dr Tattersall gave evidence that he did not consider point-of-care blood testing for Amanawel for the following reasons:

> [M]y decision was he's already leaving to hospital very promptly, so I was anticipating he would be at hospital very quickly, and based on how he was presenting, I wasn't going to delay transfer or anything like that. It's just, like, he's got to go, this is the decision.

12.29 Dr Tattersall gave evidence that he would have used point-of-care blood testing if he considered that would contribute to or change Amanawel's management. However, Dr Tattersall gave evidence that it did not play a part in his decision-making at the time.

12.30 Associate Professor Koh gave evidence that blood testing would have measured Amanawel's pH, lactate and potassium levels and likely would have indicated how severely deranged his

physiology was. Associate Professor Koh described these as "*serious findings*" in a hospital "let alone a place where there is little medical support". Associate Professor Koh explained that such results provided an indication of the need to transfer Amanawel to a medical facility urgently by ambulance or initiate resuscitation as soon as possible.

12.31 Professor Kelly gave evidence that if blood testing had been performed she would have expected Amanawel's pH and lactate levels to be elevated, indicating shock and poor circulation. Further, Professor Kelly also expected Amanawel's potassium level to be high and expressed the view that if treatment had been instituted in a timely way (by administering salbutamol or insulin to move potassium out of the bloodstream) this would have further protected Amanawel from the possibility of a cardiac arrest. However, Professor Kelly expressed some hesitation about whether Amanawel's cardiac arrest could have been avoided given that she suspected he already had an abnormal heart rhythm whilst in the Main Clinic and he was already in a "*high-risk phase*" of his clinical trajectory.

12.32 Dr Tattersall gave evidence that, again with the benefit of hindsight, point-of-care blood testing for Amanawel ought to have occurred in the Main Clinic on 8 January 2022.

12.33 **Conclusions:** Although point-of-care blood testing was available for Amanawel on 8January 2022, Dr Tattersall took no steps to conduct it. This is because Dr Tattersall considered that it would not have contributed to or changed Amanawel's management and that he anticipated that Amanawel would be transferred to hospital "*very promptly*".

12.34 The expert evidence establishes that such blood testing, had it been performed, likely would have identified significant derangement of Amanawel's pH, potassium and lactate levels. These results could have then informed Amanawel's management and the administration of medication to protect him against cardiac arrest. However, it is not possible to determine whether, even if such medication had been administered, it is likely that cardiac arrest could have been prevented.

13. Adequacy of response by correctional officers

13.1 In April 2023, MTC employed an investigator and commissioned and "*arm's-length investigation*" into the circumstances of Amanawel's death. A final investigation report was produced which relevantly found that [redacted]

13.2 One recommendation made by the principal investigator who authored the final investigation report was that consideration be given to issuing a "*Governor's Memorandum reminding staff that the MTC Corporate Philosophy, BIONIC, should be reflected in all interactions between staff and inmates*".

13.3 Governor Brian Gurney (who held that position at Parklea in 2026 but not in 2022) gave evidence that he agreed with the above findings. In relation to the above recommendation, Governor Gurney gave evidence that he did not believe that issuing a Governor's Memorandum or Instruction directing staff to comply with BIONIC was the "*right manner*" to address the issue. Instead, Governor Gurney gave evidence that he considered it more important for the BIONIC philosophy to be "*communicated on a day-by-day basis*" with demonstrated "*learning from the top*" in order to develop an appropriate culture amongst staff. Governor Gurney also gave evidence that his observations of the interactions between staff and inmates demonstrated the BIONIC philosophy being put into practice which was supported by statistics (lower rates of alleged assaults by inmates on staff) and anecdotal evidence (staff reports of the workplace being a "calm environment").

13.4 Governor Gurney was also asked about the continuation of the BIONIC philosophy upon Parklea's eventual return to management by CSNSW and gave this evidence:

> [W]e're becoming part of that again in the future and something we'll hope to continue with BIONIC philosophy both now and after transition. So I think it's something that we've talked about and that we've expected of our staff and that we do by holding staff to account when they aren't acting in a BIONIC manner. So, you know, sort of getting back to the first point about giving people instruction or a direction to be BIONIC I don't think is the most effective way. I think you've got to better for me, as far as leading from the top end, setting examples which, you know, whilst you've said the words, it's what my philosophy is that I act and it's how I expect our staff down the line to act.

13.5 **Conclusions:** [redacted]

13.6 [redacted]

14. Adequacy of MTC and SVCH policies

14.1 The inquest identified three matters relevant to this issue.

14.2 First, the expert evidence established that a patient's previous medical history is a key part of any clinical assessment. In Amanawel's case, interrogation of his previous medical history would have revealed information regarding his previous complaints of abdominal pain and previous abdominal surgery.

14.3 Second, there was no MTC or SVCH policy or procedure in place at the time which prevented interrogation of Amanawel's previous medical history. Indeed, Procedure 6.3 of the *Parklea Standard Operating Procedure* provides for the comprehensive screening of all new custodial patients. It provides that all custodial patients new to custody will have a comprehensive health screening within 24 hours of arrival to the centre, and this screening is to include, relevantly, obtaining the patient's medical history. Further, Procedure 6.3 also provides that relevant alerts are placed on a patient's electronic medical record.

14.4 Third, during the course of the inquest the possibility of having an alert within Amanawel's clinical file to draw attention to his previous abdominal history and surgery was explored with several witnesses. Associate Professor Koh gave evidence that such an alert would "*facilitate the process of providing medical care*" to a complex cohort of patients. Professor Kelly gave evidence that the presence of such an alert would more efficiently and prominently identify relevant aspects of a patient's medical history. Nicola Smith, the SVCH Operations Manager, gave evidence that there would be "*many advantages*" with an alert system to ensure that a patient's full history is obtained during an assessment.

14.5 In addition, it should be noted that following Amanawel's death, SVCH developed an *Abdominal Pain Clinical Pathway*. This provides that a patient's medical and surgical history should be obtained and reviewed, and that if previous abdominal surgery is identified from such a review a team leader and medical officer is to be notified immediately.

14.6 **Conclusions:** The available evidence does not establish that any deficiency existed in any MTC or SVCH policy material that was relevant to Amanawel's care and treatment. Rather, as already explained above, any deficiency or missed opportunity regarding Amanawel's care and treatment was a result of the actions taken, or not taken, by the clinicians who interacted with him. The evidence establishes that a critical aspect of Amanawel's management was eliciting a comprehensive medical history from Amanawel and available medical records which likely would have identified information about Amanawel's previous abdominal complaints and abdominal surgery. Extant policy material already provided for this to occur.

14.7 This policy material also provided for relevant alerts to be placed in a patient's medical record. The absence of such an alert regarding Amanawel's history of abdominal complaints and abdominal surgery most likely made no difference to his management. This is because prior to Dr Tattersall's diagnosis, the clinicians involved in Amanawel's care did not access his medical records.

15. Impact of COVID-19 protocols

15.1 RN Nguyen gave evidence that she held no concerns about providing appropriate care to Amanawel because of any COVID-19 protocols. RN Nguyen also indicated that it was common for inmates to be assessed in their cells. Rather, as noted above, RN Nguyen gave evidence that she was mainly apprehensive about assessing patients alone in a cell.

15.2 The Parklea *COVID Pandemic Plan* approved in September 2021 provided that continuation of essential health service was designated as a priority 1 to be to be maintained at all times. Dr Tsui gave evidence that he had never previously seen this document. He explained that any patient for whom a Code Blue was called would be transferred to the Main Clinic but for any other patient transfer would depend on clinical assessment of that patient.

15.3 Dr Tsui also gave evidence this was based more on practice than policy and that the COVID-19 lockdown added a "*layer of complexity*" without being more specific. He gave evidence that COVID-19 restrictions impacted patient care by making patient transfers to the Main Clinic "*a bit more complicated*" and "*more difficult*" which might result in few patients being seen in the Main Clinic absent any COVID restrictions. Dr Tsui did not elaborate further about these complications or difficulties.

15.4 Governor Gurney gave evidence that in January 2022 there was no policy in place that prevented an inmate patient being transferred to the Main Clinic if this was required for their primary care. Governor Gurney confirmed that health services continued and did not reduce during the COVID-19 pandemic. Governor Gurney also confirmed that Area 3C was not a lockdown area but rather used as a quarantine area so that the same cohort of inmates (those that entered custody within a day or two of each other) were kept together. He went on to explain:

> The circumstances that occurred then, similar to now, as far as I can - when inmates' locked in - when a certain area's locked in cells, moving them to the clinic is based on a risk or needs. But at that time, with COVID, it would've been just the heightened risk or another consideration. But if the inmate - if the medical staff requested that he may go to the clinic, then that should have occurred.

15.5 **Conclusions:** The inquest received evidence that the COVID-19 pandemic had a general impact on the management of inmate patients at Parklea in January 2022 However, there is no evidence that the pandemic itself, or any policy instituted in relation to the pandemic, directly affected Amanawel's management.

15.6 The area where Amanawel was housed was quarantined from other inmate cohorts but not in lockdown. It does not appear that the movement of inmates within the area was restricted beyond ordinary operational requirements. Indeed, the principal COVID-19 pandemic plan at Parklea at the time provided that it was a top priority for essential health services to be maintained at all times.

15.7 The evidence does not suggest the pandemic itself or any related policy requirement had any bearing on the consideration given by RN Nguyen or Dr Tsui to whether Amanawel ought to have been transferred to the Main Clinic on 7 January 2022. This consideration appears to have been entirely based on RN Nguyen's assessment of Amanawel and her discussions with Dr Tsui. The evidence given by Governor Gurney establishes that no policy in January 2022 prevented the transfer of a patient who required medical care to the Main Clinic. Whilst Dr Tsui's evidence indicates this may have been more a practical than a policy consideration, there is no evidence of its effect in Amanawel's case.

16. Findings

16.1 I acknowledge and express my gratitude to Ms Belinda Epstein, Counsel Assisting, and her instructing solicitors, Mr Tom Holcombe and Mr Gareth Martin. I am also grateful to the assistance provided by the previous solicitor with carriage of the matter, Ms Rachel Karrour. The entire Assisting Team has provided exceptional assistance during the conduct of the coronial investigation and the inquest. I am extremely grateful for their commitment and efforts, and for the sensitivity that they have shown to the Amanawel's family throughout the coronial process.

16.2 I also thank Detective Senior Constable Bradley Jorgenson, the New South Wales Police Force Officer-in-Charge for his role in the investigation and for compiling the initial comprehensive brief of evidence.

16.3 The findings I make under section 81(1) of the Act are:

Identity

The person who died was Amanawel Ayai.

Date of death

Amanawel died on 8 January 2022.

Place of death

Amanawel died at Westmead Hospital, Westmead NSW 2145.

Cause of death

The cause of Amanawel's death was complications of bowel obstruction by adhesions.

Manner of death

Amanawel died whilst being held in lawful custody at Parklea Correctional Centre. Although Amanawel died of natural causes, his presentation on 7 January 2022 was not adequately assessed or investigated by clinicians involved in his care. After Amanawel's condition was correctly diagnosed on 8 January 2022, adequate steps were not taken to transfer him to hospital or institute appropriate treatment. Although different steps taken in Amanawel's management would have provided for the best possible outcome it is not possible to determine if any of these steps would have prevented Amanawel's cardiac arrest on 8 January 2022 or averted the eventual outcome.

16.4 On behalf of the Coroner's Court of New South Wales and the Assisting Team, I offer my sincere and respectful condolences to Amanawel's family, loved ones and friends for their tragic and devastating loss.

16.5 I close this inquest.

Judge Derek Lee
Deputy State Coroner
7 August 2026