CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Dictor Dongrin
Hearing dates:	13-17 October 2025 & 23-25 March 2026, Coffs Harbour
Date of findings:	11 June 2026
Place of findings:	Coroners Court, Lidcombe
Findings of:	Judge R. Hosking, Deputy State Coroner
Catchwords:	Mandatory inquest, death in custody
File number:	2022/173058
Representation:	Counsel Assisting the Inquest: Ann Bonner of Counsel, instructed by Michael Tanazefti of the Crown Solicitor's Office (**Assisting team**) Serco Australia Pty Ltd (**Serco**): Jillian Caldwell and Phoebe Boyle of Counsel, instructed by Brianna Clark, Wotton Kearney The Dongrin family: Ian Fraser of Counsel, instructed by Sheeza Naz, Legal Aid Commission Dr Patricia Collie: Lorna McFee of Counsel, instructed by Kate Hickey, Barry Nilsson Enrolled Nurse Laura Beverley, Enrolled Nurse Donna Bird and Registered Nurse Kristy Foy: Benjamin Thompson, NSW Nurses and Midwives Association.
Findings:	Dictor Dongrin died on 13 June 2022 at or shortly after 11.31am in the Male Max Medical Unit (**MMMU**) at the Clarence Correctional Centre, Grafton, NSW (**CCC**).

The mechanism of Dictor's death was a cardiac arrythmia in the context of a state of alcohol withdrawal and a history of chronic alcohol misuse.

Timely and adequate medical treatment and management of Dictor's alcohol withdrawal at CCC could have prevented his death.

Recommendations: **To Serco**

(1) That an audit be conducted of health staff at CCC to assess the matters that follow.

a. Familiarity with Chapter 7 of the NSW Health December 2022: *Management of Withdrawal from Alcohol and Other Drugs Handbook*.

b. Knowledge of alcohol withdrawal symptoms and appropriate response to and management of those symptoms, depending on the severity of withdrawal.

c. Knowledge of and compliance with Serco's Local Operating Procedure, *Care of Patients in Clinical Observation Cells in Health Centres*.

d. Knowledge and utilisation of Serco's Local Operating Procedure, *Responding to, and Escalating, Health Concerns*.

If deemed necessary following the audit, that Serco revise and enhance training of health staff at CCC on the above resources and/or topics.

(2) That their Local Operating Procedures (**LOP**) at CCC be revised to remove ambiguity and clarify the matters that follow.

a. Who has authority to determine whether to place a patient in an observation cell and how that authority is exercised.

b. The allocation to, and scope of responsibility of, Drug and Alcohol (**D&A**) Service Staff, and primary healthcare staff, (in relation to drug and alcohol patients) for:

i. determining how custodial patients are referred to the CCC D&A Service

ii. clinical decision making, assessments, planning and treatment

iii. coordination, implementation and delivery of care, and

iv. effective communication between relevant health professionals, the patient, correctional officers and any third parties.

c. The requirement to administer ‘clinical’ observations including (where appropriate) the Alcohol Withdrawal Scale (**AWS**).

(3) If the Single Digital Patient Record (**SDPR**) does not enable the recording of comments in relation to a clinical observation in a reception screening assessment:

a. that Serco develop a procedure by which comments may be recorded (for example, in progress notes), and

b. that Serco take appropriate measures to ensure that health staff are familiar with and comply with that procedure.

To the SDPR Implementation Authority

(1) At an appropriate time, but as early as is reasonably practicable, consider providing health clinicians at privately operated correctional centres full access to the SDPR including records generated by Local Health Districts.

(2) If the SDPR does not include an option ‘Other (comment)’ to, amongst other things, enable the recording of a comment to accompany the recording of blood pressure in a reception screening assessment, take appropriate measures to enable a comment to be recorded.

To the Executive Officer, Nursing and Midwifery Council of New South Wales (Nursing and Midwifery Council)

(1) That the conduct of Cassandra Holland, Nurse Practitioner, between 1.30pm and 2.30pm on 13 June 2022 be reviewed by the Nursing and Midwifery Council, including but not limited to the matters that follow.

a. The statements made by Ms Holland at around 1.42pm:

> OK, declared dead, 13.42, just keep going for … OK, who's not done CPR?
>
> You've done it, this is a training exercise now only.
>
> Patient's deceased, just gently, just gently, don't break ribs.

b. The requirements of the *NSW Health Policy Directive – Verification of Death and Medical Certificate Cause of Death.*

(2) That the conduct of Kristy Foy, Registered Nurse and Clinical Team Leader, between around 7am and 12pm on 13 June 2022 be reviewed by the Nursing and Midwifery Council, as it concerned nursing services in relation to Dictor Dongrin.

To the Executive Officer, Medical Council of New South Wales (Medical Council)

(1) That the conduct of Dr Patricia Collie, D&A specialist, on 12 June 2022 from about 1.30pm and on 13 June 2022, be reviewed by the Medical Council as it concerned medical treatment and management of Dictor Dongrin including, in relation to the matters that follow:

a. The alcohol withdrawal symptoms, history and medical risk presented by Dictor Dongrin, as contained in information provided to Dr Collie.

b. The prescriptions written by Dr Collie for Dictor Dongrin.

c. The medical plan of management written by Dr Collie for Dictor Dongrin.

Provision of findings to the Justice Health Forensic Mental Health Network (JHFMHN)

(1) I direct that copies of the brief of evidence, the transcript of evidence and these findings be sent to the Risk and Monitoring team at JHFMHN.

Publication: Non-publication orders apply to the evidence in this inquest. A copy of the orders made by Judge Hosking are available upon request from the Court Registry.

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FINDINGS

Introduction

2 On 13 June 2022, Dictor Dongrin died tragically, aged 29.

3 An inquest into Dictor's death was held at the Coffs Harbour Court on 13-17 October 2025 and 23-25 March 2026.

4 These are my findings.

The role of the coroner

5 The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death[1]. A coroner may make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future[2].

6 This inquest was held pursuant to the jurisdiction conveyed by s 23 (1)(d)(ii) of the Act in circumstances where at the time of his death, Dictor was an inmate at CCC being a correctional centre within the meaning of the *Crimes (Administration of Sentences) Act 1999* (NSW).

The issues examined at the inquest

7 The issues below were identified in the coronial investigation.

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

(2) Whether Dictor's condition declined and, if so, how it declined, between about 11am on 12 June 2022 and about 1.30pm on 13 June 2022.

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[1] s 81 of the *Coroners Act 2009* (NSW) (**the Act**).
[2] s 82 of the Act.

(3) The adequacy of the assessment/s of Dictor by staff of the CCC during his admission to the CCC on 12 June 2022.

(4) The adequacy of the medical treatment, health care and management of Dictor by health staff at the CCC, taking into account his condition from time to time.

(5) The adequacy of the management of Dictor by correctional staff at the CCC, other than health staff, taking into account his condition from time to time.

(6) The adequacy and appropriateness of the emergency response by staff of the CCC upon Dictor being found unresponsive on 13 June 2022.

(7) The adequacy of applicable policies, procedures, staffing arrangements, resources and training for the medical treatment, health care and management of Dictor at the CCC.

(8) What, if any, measures may be taken to reduce the risk of a similar death occurring in future.

(9) Whether any recommendations are necessary or desirable arising from any matter connected to Dictor's death.

8 As the inquest progressed, it was apparent that some of the issues identified were more relevant than others and additional issues emerged.

The evidence

9 A 7 volume brief of evidence[3] was tendered at the inquest and marked Exhibit 1.

[3] Prepared by the officer in charge (**OIC**) of the coronial investigation, Senior Constable Paul Waddell, and supplemented by the Assisting team.

10 Oral evidence was also adduced from the following witnesses:

Serco staff

(1) Laura Beverley, EN[4]

(2) Elaine Ortiz, RN[5]

(3) Kristy Foy, RN and CTL[6]

(4) Cassandra Holland, SNP[7]

(5) Matthew Billingsly, RN

(6) Donna Bird, EN

(7) Angie Sparks, CTL

(8) Dr Patricia Collie, Addiction Medicine Physician

(9) Kahla Craig, then CCO[8]

(10) Joanne Mills, then CCO

(11) Harpreet Singh, CCO[9]

(12) Rhian Czech, Health Services Director

(13) Scott Jacques, General Manager, CCC

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[4] Enrolled Nurse.
[5] Registered Nurse.
[6] Clinical Team Leader. There was a factual dispute as to whether Foy was the CTL on 12 June 2022 however she conceded she was the CTL on 13 June 2022.
[7] Senior Nurse Practitioner.
[8] Correctional Case Officer.
[9] Correctional Supervising Officer.

Experts

(14) Professor John Saunders, Addiction Medicine Specialist: reports dated 7 March and 23 April 2025, obtained by the Assisting Team

(15) Associate Professor Luke Lawton, Emergency Physician: report dated 9 May 2025, obtained by Dr Collie

(16) Professor Paul Haber, Specialist in Addiction Medicine: report dated 11 May 2025, obtained by Dr Collie.

Findings

11 Having considered all the evidence and submissions in this inquest, I make the findings that follow.

(1) Dictor Dongrin died on 13 June 2022 at or shortly after 11.31am in the MMMU at the CCC.

(2) The mechanism of Dictor's death was a cardiac arrythmia in the context of a state of alcohol withdrawal and a history of chronic alcohol misuse.

(3) Timely and adequate medical treatment and management of Dictor's alcohol withdrawal at Clarence Correctional Centre could have prevented his death.

(4) From the completion of EN Beverley's intake until the time of Dictor's death, his treatment, healthcare and management by health staff at the CCC was wholly inadequate. The more significant deficiencies are summarised below:

(a) Despite Dictor's AWS score of 8, proper consideration was not given to whether he could be appropriately managed in a custodial setting or whether he ought to be transferred to hospital

to allow for appropriate high doses of diazepam to be administered.

(b) Scheduled observations were not charted for Dictor. This may not have been an issue if staff were adequately trained and supervised in undertaking clinical observations at appropriate intervals for all patients, including overnight.

(c) No clinical observations were taken from Dictor after the initial assessment by EN Beverley until the time of his death. This precluded appropriate identification of withdrawal symptoms.

(d) Staff outside of the D&A Service had an insufficient understanding of basic symptoms of alcohol withdrawal including insomnia.

(e) There was no understanding by those responsible for caring for Dictor overnight that a lack of improvement was, of itself, a concern. RN Billingsly was only looking for further deterioration.

(f) When EN Bird twice attempted to take observations and assess Dictor, she was turned away in favour of allowing him to sleep. This, and the failure to administer medication to him in the morning, reflects a lack of comprehension by CTL Foy and RN Billingsly of the risk Dictor was exposed.

(5) While it is clear on the evidence that more appropriate steps could have been taken by Dr Collie, RN Billingsly and CTL Foy to manage Dictor's symptoms and provide him with the basic health care he was entitled to, the evidence is indicative of systematic complacency and incompetence.

(6) While the CCOs were not medically trained, they ought to have had sufficient basic knowledge to protect against the deterioration of

seriously unwell patients. This would involve, at the very least, reading the Health Problem Notification Form (**HPNF**) and implementing it.

(7) Timely and adequate medical treatment and management of Dictor's alcohol withdrawal at Clarence Correctional Centre could have prevented Dictor's death.

(8) The failure by the CCOs to have any regard to the HPNF and to Dictor's care gave rise to missed opportunities to identify that Dictor was continuing to suffer alcohol withdrawal, raise concerns and elicit assistance.

Recommendations

12 Having considered the evidence and submissions in this inquest, I make the recommendations outlined on pages 2-4.

Background

13 A Statement of Facts/Chronology prepared by the Assisting team and agreed by the participants was helpfully tendered in the inquest. It has been extracted as **Annexure A** to these findings. I will only repeat the salient aspects herein.

14 Dictor was born in Kenya on 9 December 1992 to Rebecca Deng and Moses Dongrin. Dictor was granted Australian citizenship in 2007. Rebecca and Moses attended every day of the inquest.

15 Dictor was described by his family as being funny, caring and supportive. He believed that 'family comes first.'

16 On 11 June 2022, Dictor and his brother were consuming alcohol in the family home when an argument ensued. It is alleged that Dictor and his brother assaulted their father. The NSWPF were called. Dictor and his brother were arrested and charged at or around 6pm and conveyed to Coffs Harbour Police Station. Dictor was assessed as moderately intoxicated. He was unsteady on

his feet and had trouble exiting the police vehicle. His breath smelt of alcohol. It was noted that he was suffering from ‘kidney failure’ and that he was ‘not taking his medication’.

17 At 11pm Dictor was assessed as ‘not affected’ by alcohol by the custody manager, SC Ziesig.

18 Dictor was refused bail by the NSWPF and was transferred to the custody of CSNSW at 10.53am on 12 June 2022. He would be declared deceased at 2.29pm on 13 June 2022, some 26 hours later.

19 Dictor’s alcoholism was documented:

(1) at 11am on 12 June 2022, prior to his transfer, a ‘New Inmate Lodgement and Special Instruction Sheet’ was completed by a CSNSW Officer Osbourne at Coffs Harbour Police Station.

(a) Osbourne noted ‘alcohol withdrawal’ as a medical issue requiring Justice Health and Forensic Mental Health Network review on reception.

(b) When Dictor was asked whether he was prescribed medications he said Valium/Alcohol.

(c) Dictor answered yes to the question, ‘[a]re you an alcoholic, binge drinker, drink excessively, recreational drug user or take any other non-prescription medication.

(d) Dictor confirmed he had consumed alcohol in the 24 hours prior.

(2) At 1pm on 12 June 2022 at CCC, a ‘Reception and Accommodation Checklist’ was completed by CSNSW Officer Chapman.

(a) In response to the question ‘Do you have any immediate medical requirements?’ The noted answer was ‘Yes’, ‘Alcohol/detox.’

(b) In response to the question ‘Do you have a physical and/or intellectual impairment or disability?’ The noted answer was ‘Yes,’ ‘Seizures due to alcohol withdrawals.’

(c) The recorded ‘Accommodation decision’ was ‘Clinic cell due to detox.’

12 June 2022

Reception Screening Assessment (RSA)

20 In Dictor’s RSA, commenced at 12.51pm, EN Beverley noted that Dictor:

(1) had an existing active health condition of seizures (since 09-Dec-2018)[10]

(2) had a history of neurological conditions, namely, seizures with onset age 26 years

(3) reported using alcohol daily, with an average amount used (on days used) of 1x cask white wine, last used the day prior

(4) reported using benzodiazepines (Valium) daily, with the average amount used (on days used) of 10mg, last used the day prior

(5) had a history of withdrawal related seizures

(6) had been to the hospital in the 6 months prior for alcohol withdrawal.

21 EN Beverley recorded Dictor as being ‘in withdrawal’, exhibiting visible shakiness, sweatiness, and to be pale and withdrawn.

22 On her physical assessment, EN Beverley noted:

(1) respiratory rate of 15 breaths per minute

[10] This was pre-populated.

(2) Sp02[11] of 98%

(3) heart rate of 85 beats per minute

(4) temperature of 36.4 degrees

(5) blood glucose level of 4.7 mmol/L

(6) height 175cm tall, weight 61.9kg and BMI of 19 kg/m2

(7) urinalysis: awaiting sample back.

23 EN Beverley was unable to take Dictor's blood pressure because his shakiness and tremors prevented the blood pressure machine from working.[12] Similarly, she was unable to measure his waist as he was sitting down to relieve him from standing.

24 EN Beverley's 'Drug and Alcohol Substance Withdrawal Monitoring', AWS assessment of Dictor was of an initial AWS score of 8 out of 10.

25 EN Beverley issued an HPNF which stated that CCOs ought to monitor for signs of:

> [s]eizures, nausea, vomiting, decreased appetite, loss of consciousness, tremors, complaints of joint/muscle pain – 7 DAYS' and …[r]unny nose, cough, fever, loss of smell/taste – 10 days.

26 The HPNF instructed CCO's to report any observations of such signs to JHFMH staff, and for Dictor to be 'housed in medical until cleared by D&A.'

[11] Oxygen saturation.

[12] This reason could not be recorded on the form. It is expected that this issue will be addressed with the introduction of the 'Single Digital Patient Record' being rolled out by JHFMH.

Assessment by the D&A Service Staff

27 EN Beverley went to the D&A Service office and discussed Dictor's RSA with Dr Collie and EN Bird, being the then D&A Service Staff. EN Beverley told them that they had a new custody who was in active withdrawal.

28 EN Bird indicated that EN Beverley would regularly adopt this approach. On the contrary, Dr Collie said that it was uncommon for her to be handed information directly from reception because the process was to go through the CTL for review by the D&A nurse.

29 EN Beverley made an entry in PAS[13] to the effect of, fresh custody, active withdrawals, for a review. She sent it to chronic disease as well as D&A. She designated the entry 'category 3' because she had already spoken to the D&A Service Staff and Dictor was to be housed in medical cells.

30 EN Bird confirmed she understood that sweats and tremors were a significant indication of alcohol withdrawal and that previous seizures were a cause for major alert because of a concern it could cause death.

31 Dr Collie said a history of seizures meant it looked like there is a level of risk but she only accepted that it can be 'indicative' of severity in alcohol withdrawal. She did not believe she was advised that Dictor had been hospitalised for alcohol seizures previously.

32 Dr Collie was able to access the RSA on screen and said she would have reviewed the RSA briefly. She would have received the paper observation SAGO chart and the paper AWS assessment from EN Beverley.

33 Dr Collie noted the AWS assessment had a two for anxiety and agitation. She would have liked to see another AWS assessment undertaken once the patient

[13] JHFMH database.

was in the health cells. She considered the history of seizures indicated Dictor needed to be in the health cells for closer monitoring.

34 At 1.33pm, Dr Collie charted:[14]

> Notes review and discussion with nurse completing RSA.
>
> Known high levels of Etoh[15] use with resultant alcohol withdrawal seizures
>
> Current reports of 2L wine daily for past few months
>
> Regular use of diazepam 10mgs daily
>
> Is to be housed in medical cells for at least 5 days please
>
> Plan:
>
> Chart IM thiamine 300mgs daily ongoing
>
> Diazepam 10mgs bd for 12/6/22 (no access to oxazepam) From 13/6/22 chart 30mgs oxazepam bd and further 30mgs to have prn based on AWS (to maximum of 120mgs daily)
>
> Please liaise with D&A team and MO[16] if patient requires more than 90mgs oxazepam daily
>
> Will a need slow reduction in BZDs due to regular use in the community.

35 Dr Collie's evidence was that her charting of medication was, 'pending a comprehensive nursing review.' She charted oxazepam for the next day as a 'safety net'. This is not a drug kept onsite and if not prescribed in advance it would not have been available for administration.

36 Dictor was placed in Observation Cell 6 of the MMMU. He was monitored via CCTV but not subject to any observation schedule.

37 At 2.05pm on 12 June 2022, Dictor activated the duress alarm. RN Ortiz entered his cell, assisted him to a chair (noting that he was trembling) and administered 10mg of Valium and 300mg of Thiamine.[17]

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[14] Without seeing Dictor face to face and based on the discussion with Beverley.
[15] Abbreviation/chemical term for alcohol.
[16] Medical Officer.
[17] Vitamin B1.

38 EN Bird accepted that it was conveyed to her that Dictor was at a high risk for alcohol withdrawal which were serious, required constant monitoring and could cause rapid deterioration. EN Bird said she was not asked to review Dictor on 12 June 2022 (though Dr Collie said she was).

39 EN Bird believed she arrived at work on 13 June 2022 to a 'post it' note on her desk from Dr Collie to review Dictor. I accept EN Bird's evidence in this regard and consider that if she were asked to assess Dictor on 12 June 2022 she would have done so.

40 EN Bird went straight to the nurses' station at the start of her shift and sought to assess Dictor. She was told by RN Billingsly that Dictor had not slept overnight and he he had just gone to sleep. RN Billingsly told EN Bird that he did not want her to wake him. She asked RN Billingsly for Dictor's AWS scores and was told by RN Billingsly that he had no concerns and there was 'no change.' In fact, no observations had been taken overnight.

41 CTL Foy commenced her shift at 7am on 13 June 2022. EN Bird said that she told CTL Foy of her concerns and that she had been instructed by Dr Collie to do observations. EN Bird said that CTL Foy confirmed the direction from RN Billingsly not to wake Dictor and told EN Bird she would call her when Dictor woke. CTL Foy could not recall the conversation. EN Bird was a thoughtful and credible witness. CTL Foy was unimpressive. I accept EN Bird's evidence in this regard. At that time, EN Bird believed Dictor to be comfortable and safe. Later EN Bird was to go to the female section of the prison and she again approached CTL Foy to see if Dictor could be assessed prior to her leaving MMMU and she was told that Dictor had not woken (which was not true).

42 EN Bird believed Dictor was being monitored and that she would be called when he woke. He woke at 7.14am and again at 8.47am and she was not called. EN Bird also thought that Dr Collie had performed a D&A assessment because her signature was on Dictor's chart.

43 In fact, RN Billingsly had not attended on Dictor after 10.01pm on 12 June 2022. His evidence was that while he knew to conduct observations in a frequency requested by a medical officer, he was not familiar with the 'Observations in Beds Policy.' Frequency of observations had not been charted for Dictor.

Dictor's death

44 At 10.01pm. Dictor was given a second dose of diazepam by RN Billingsly and was noted to be 'very unsteady on his feet.' This was the last time he would be administered with medication or observed by RN Billingsly.

13 June 2022

45 Based on the CCTV footage, Dictor's last observed movement was at 11.31am.

46 At 11.35am, CCO Craig knocked on the door of the cell a couple of times and spoke through the access chute, she left a meal for Dictor on the access chute.

47 At 12.10pm, CTL Foy signed out oxazepam to give to Dictor and signed it back in when he was still asleep. At this stage, Dictor had received no medication for some 14 hours.

48 At 1.29pm, CTL Foy knocked on the cell door and tried to speak to Dictor. Receiving no response, she and Beverely entered the cell and called a code blue. NSW Ambulance (**NSWA**) were called at 1.34pm arriving at 2.04pm.

49 Dictor was declared deceased at 2.29pm by the attending NSWA paramedic.

50 At 7.30am on 13 June 2022 Dictor was seen to be asleep. He declined lunch at 11.30am. He was seen rolling over onto his left side using his arm as a pillow. That was the position he was found in, non-responsive at 1.29pmpm.

Issues

Statutory findings required under s 81 of the Coroners Act 2009 (NSW)

Post-mortem

51 A coronial post-mortem examination was conducted by Dr Donovan Loots on 17 June 2022. Dr Loots could not determine a direct cause of death. Dr Loots found, amongst other things: no significant injuries on the surface of the body; mild myocardial fibrosis (scarring) and occasional myocyte hypertrophy (enlargement of the cardiac muscle cells); mildly enlarged and fatty liver and mildly congested lungs.

52 Dictor's toxicology analysis revealed a non-toxic concentration of diazepam along with its metabolite nordiazepam.

53 Dictor was reported to suffer from alcoholism consuming 4-6 litres of wine per day. Significantly there was no alcohol detected in his toxicology analysis.

54 Dr Loots commented that:

> [the absence of alcohol combined with the history of alcoholism] raises the possibility of acute alcohol withdrawal which occurs following abrupt cessation of long term alcohol consumption…
>
> Serious withdrawal symptoms occur in approx. 10% of patients…
>
> Sudden unexpected death in alcohol misuse (**SUDAM**) is an increasingly recognised entity and refers to the 'sudden, unexpected… non-traumatic death in patients with a history of chronic excess alcohol consumption or evidence of hepatic steatosis or other alcoholic liver disease where postmortem examination does not reveal toxicological… or anatomical cause of death and there is no significant cardiac hypertrophy.
>
> …consideration should be given to a sudden fatal cardiac dysrhythmia[18]
>
> While the cause of death remains undetermined, complications of chronic alcoholism or [SUDAM] may be proffered as potential causes of death…

[18] An irregular heartbeat.

55 Dr Lorraine du Toit-Prinsloo provided a report dated 23 April 2025 to supplement the report of Dr Loots in circumstances where Dr Loots was no longer employed by NSW Health Pathology (Forensic Medicine, Newcastle).

56 Dr du Toit Prinsloo opined:

> that it is most likely that the death was due to complications of chronic alcohol misuse (alcohol withdrawal related seizure activity).

Professors Saunders, Haber and Dr Lawton

57 Professor Saunders opined that ultimately, death is due to cardiac arrhythmia (irregular heartbeat), which may be asystole (where the heart stops) or may reflect a malign ventricular arrythmia (chaotic heartbeat) such as ventricular fibrillation. Professor Saunders stated that a wide variety of arrythmias of sudden onset can occur in alcohol intoxication and alcohol withdrawal states.

58 Dr Lawton opined that the likely cause of Dictor's death was a sudden non-perfusing cardiac arrythmia caused by either an undiagnosed channelopathy or:

> a. Electrolyte abnormalities such as hypo-or hyperkalaemia, or disturbance of sodium or calcium levels, which might plausibly exist due to malnutrition in a patient with alcohol use disorder.
>
> b. R On T phenomenon, caused by underlying prolongation of the QT interval, which is the period shown on an ECG where cardiac myocyte contraction is maintained by calcium influx. If this interval is prolonged, it is possible for the next heartbeat…to occur while the heart is re-setting. This can generate a malignant dysrhythmia named Torsades-de-pointes, and a subsequent cardiac arrest…
>
> c. The presence of arrhythmogenic right ventricular dysplasia, which ius an inherited structural heart disease, and a common cause of sudden cardiac death, particularly in younger people.
>
> d. Hypoglycaemia, which can precipitate cardiac arrest.

59 In their joint report, Professors Saunders and Haber and Dr Lawton opined that Dictor's cause of death was a cardiac arrythmia, probably ventricular fibrillation, leading to circulatory failure, and for which he would be at risk because of uncontrolled hyperadrenergic state in a persistent alcohol withdrawal state.

60 They agreed that Dictor likely died about 11.31am after he ceased moving.

Findings

61 Dictor died on 13 June 2022 at or shortly after 11.31am in the MMMU at the CCC.

62 The mechanism of his death was a cardiac arrythmia in the context of a state of alcohol withdrawal and a history of chronic alcohol misuse.

The adequacy or otherwise of Dictor's treatment by health staff at CCC

63 As outlined above, I find that Dictor died at or shortly after 11.31am on 13 June 2022. I am unable to chart the path of Dictor's deterioration in circumstances where:

(1) his clinical observations were not taken

(2) no AWS assessment was undertaken

(3) his recent or extended medical and alcohol related history was not obtained or interrogated.

64 Having reviewed the CCTV footage, Professor Saunders explained that Dictor had persistent shaking of his hands, unsteady movements, restlessness and insomnia from the time of arrival at Clarence until at least 11am on 13 June. He did not improve, but remained in an alcohol withdrawal state, a prolonged and debilitating withdrawal and then unexpected death.

65 In his report, Professor Saunders explained the likely progression of alcohol withdrawal for Dictor.

(1) The onset of an alcohol withdrawal state typically becomes evident between 6 and 24 hours after the last consumption of alcohol. Dictor

would likely have been in significant alcohol withdrawal by 12pm on 12 June 2022, which is reflected in EN Beverley's AWS score of 8.

(2) By 2pm on 12 June 2022, Dictor's blood alcohol content would be expected to have reached zero, and his withdrawal state would have been worse. At this time, Dictor was in the MMMU.

(3) Once an alcohol withdrawal state develops, if untreated or inadequately treated, it increases progressively in severity over the first 48 hours and typically lasts for 3 to 7 days.

66 Professor Saunders emphasised that it is important to control alcohol withdrawal early. It was the joint opinion of the experts[19] that Dictor was in moderate to severe alcohol withdrawal when he was assessed by EN Beverley. I accept this view.

67 Withdrawal has a well-documented progression. At 1pm on 12 June 2022, Dictor was clearly progressing in alcohol withdrawal with an AWS of 8. He reported his history of seizures which made him high risk. He reported the significant amounts of alcohol that he had been consuming in the prior weeks. There was sufficient information for those responsible for caring for Dictor, to conclude that he needed a substantial diazepam regime as a matter of urgency.

68 The only assessment of Dictor while he was at CCC was undertaken by EN Beverley.

69 EN Beverley conducted a narrative interview, covering history of alcohol consumption and quantities, use of other drugs, medical history including previous hospital admissions for alcohol related seizures. EN Beverley used a structured questionnaire, performed nursing observations, administered the AWS and recorded her conclusions in clear terms and supported by entries. She also completed the HPNF form.

[19] Professor Saunders, Professor Haber and Dr Luke Lawton.

70 This assessment was thorough and appropriate and having identified the risks to Dictor associated with alcohol withdrawal, EN Beverley personally attended on the D&A Service to alert them to Dictor’s arrival.

71 Following that assessment, the treatment of Dictor was wholly inadequate.

72 During her consultation with Dr Collie about Dictor, EN Beverley stated that she discussed his presentation and history. I find that she was correct to consult with Dr Collie and this demonstrated proactivity and critical thinking about the high risk state of Dictor’s presentation.

73 EN Beverley also handed over to the registered nurse in-charge, RN Ortiz, advising that Dictor would be housed in a medical cell for withdrawal management and that the D&A Service Staff were aware of Dictor and were documenting his management plan.

74 I reject the suggestion that decision-making had to be deferred to obtain more or better information in a ‘full nursing assessment’. As highlighted by Professor Saunders, the treatment of alcohol withdrawal must be swift. Additional information may have been obtained in the fullness of time but no witness identified any critical information missing from EN Beverley’s comprehensive assessment that was required to make an informed decision regarding Dictor’s treatment. The information available raised an obvious risk and need for medical intervention in a progressing alcohol withdrawal that was moderate to severe in nature with well-known risks.

75 Those with the opportunity and/or responsibility to assess Dictor included: Dr Collie, CTL Foy, RN Billingsly and EN Bird. Despite this, no clinical observations or further assessment was carried out on Dictor before his death.

76 The failure to carry out any further assessment was grossly inadequate.

77 Dictor was vulnerable because of his chronic alcohol misuse. When taken into custody, he was (appropriately) deprived of alcohol and commenced

withdrawal. He was open about his consumption of alcohol and the risks posed by deprivation of alcohol were identified before he left the Coffs Harbour cells. He was powerless to protect himself and those charged with housing him, Serco, failed to provide appropriate care.

Dr Collie

78 There was a factual issue as to whether Dr Collie was on shift when Dictor arrived at the MMMU. The evidence established that while Dr Collie did not ordinarily work on a Sunday, that week she attended a conference on the previous Wednesday and then worked Sunday 12 June 2022 instead. It was not in contention that she was physically present at 1.24pm when Dictor arrived in the MMMU.

79 Dr Collie submitted that she was not required to personally conduct a direct assessment of Dictor. While I accept that a face to face assessment would have been preferable, her obligation was to ensure that Dictor received appropriate and adequate treatment and that if such treatment could not be provided in a custodial setting, to direct that he be transferred to a hospital where he could receive the treatment he needed.

80 Dr Collie confirmed that a loading dose of diazepam as described by the experts, could not be provided in a custodial setting. She considered that a loading dose is best done in a hospital environment where there is better monitoring. I accept that submission given the complete absence of monitoring Dictor received in CCC.

81 Dr Collie's evidence was that she was waiting for a full nursing assessment and, if Dictor was still unwell then she would have transferred him to hospital to enable him to receive a loading dose of diazepam. Dr Collie considered with the benefit of hindsight that she ought to have noted that the plan she charted was an 'interim plan'. Czech and Eason gave evidence that there is no policy or procedure regarding interim plans. Once a management plan is documented it becomes the active plan of care that nursing staff are expected to follow.

82 Dr Collie described her role as being responsible for providing clinical support. She described the structure at CCC as being a 'nurse led care' model.

83 Dr Collie presented as an evasive rather than a persuasive witness. Her evidence to the effect that the charted medication as an 'interim plan' pending further assessment seems wholly inconsistent with the expert evidence to the effect that swift treatment/management of alcohol withdrawal is imperative. On that basis, if the plan chartered for Dictor was interim, there was no timely follow up to ensure that this highly risky patient was promptly assessed and a comprehensive plan put in place. Given Dr Collie had reviewed the paperwork provided by Beverley and spoken to her about Dictor's care, I find her failure to follow up was a contributing factor in the overall inadequacy of the care provided to Dictor.

84 That said, Dr Collie's failings were not undertaken in isolation. The clinical structure in place at CCC created uncertainty and confusion about where responsibilities lay. A product of that uncertainty was that no one took ultimate responsibility for Dictor resulting in his preventable death (see paragraphs 116 to 118).

85 Dr Collie's evidence was consistent throughout that there was an established process that the clinical team leader would coordinate the care of the patient and that any clinical concerns should have led to asking for a review by the medical officer or nurse practitioner. She also referred to a usual handover practice of speaking to the clinical team leader, CTL Foy, about the medication she charted and the need for a comprehensive assessment of Dictor.

86 The process described by Dr Collie was not adequately documented. Serco's LOP: Care of Patients in Clinical Observation Cells in Health Centres which was included in the brief of evidence, post-dated Dictor's death. It was apparent from the evidence adduced that staff were not familiar with the JHFMH policy which preceded it. The LOP does give an impression in parts that the CTL has a coordinating role although it is ambiguous. Paragraph 4.4 for example refers

to D&A staff updating the CTL and the inquest received evidence to the effect that the role of a CTL is to oversee plans of care.

CTL Foy

87 CTL Foy did not recall having a conversation with Dr Collie on 12 June 2022 or of seeing Dictor that day at all despite her shift finishing at 5 or 5.30pm. She said inmates were to be seen once a day by a medical officer or nurse practitioner though she could not attribute that to a written policy. She was unaware that insomnia was a symptom of alcohol withdrawal. She did not know if Dictor had been assessed by the D&A Service Staff before her shift on 13 June 2022 or recall checking his records to see if an assessment had occurred.

88 CTL Foy was an unimpressive witness. It was apparent from the CCTV footage that she made no attempt to see Dictor during her shift on the morning of 13 June 2022 save for going to give him medication at 12pm and then not doing so because he was thought to be asleep. She failed to call EN Bird when he did wake up despite assuring EN Bird that she would (Dictor appeared to go to sleep at 6.37am and wake at 7.14am and then return to sleep at 7.59am waking again at 8.47am). Dictor, a patient suffering from moderate to severe alcohol withdrawal, had been provided no medication since 10pm the night before and had no clinical observations taken since around 1pm the day before.

89 In her role as CTL, there is no evidence that CTL Foy took steps towards coordinating the care of Dictor. In her role as a primary nurse, she did not take any initiative to attend to the welfare of Dictor. Having him on the CCTV screen at the nurses' station was not providing care and was no substitute for direct checks on his welfare. She failed to observe his ongoing alcohol withdrawal symptoms, and so never raised any concern with Dr Collie, a nurse practitioner or anyone else.

RN Billingsly

90 RN Billingsly asserted that he was 'keeping a close eye on' Dictor which involved keeping him up on the main screen, looking for 'obvious issues'

including for signs of deterioration. He said that if he saw signs of deterioration, he would have called an ambulance and sought to have him transported to hospital.

91 RN Billingsly indicated that he would ordinarily conduct clinical observations at a frequency stipulated by the medical officer (in this case there were none charted). He was unaware of the 'Observations in Beds Policy.'

92 The 'signs' RN Billingsly was looking for via the screen included increased shaking or not responding well, struggling to move or calling for excessive help.

93 RN Billingsly indicated that during the night he would usually only enter a cell if a patient was in distress or needed to go to a medical facility. Generally, he interacted with patients through the cell door only entering in extreme circumstances. RN Billingsly had limited knowledge of alcohol withdrawal he described it as not his 'thing.' He was not aware that insomnia, fever, hypertension and tachycardia are symptoms of alcohol withdrawal. He was not aware that Dictor ought to have been considered 'high risk.'

94 He did have course during the night to give Dictor Panadol with a CCO present. He could have taken the opportunity to take clinical observations and did not.

95 At the time, RN Billingsly asserted that it was ordinary practice not to record progress notes on patients.

96 RN Billingsly had no understanding that having received diazepam, Dictor's failure to improve was relevant, not just his lack of deterioration. He commented that there were no charted observations and appeared unaware of any baseline requirement of clinical observation taking.

97 RN Billingsly demonstrated a lack of initiative and independent thought and a minimal capacity to consider the potential needs of a patient who had been admitted with moderate to severe alcohol withdrawal. The overnight period was a significant period during which Dictor continued to suffer withdrawals but no

opportunity was taken to identify the risks that were presenting or to raise them with a qualified health professional who could make clinical decisions for his treatment.

98 RN Billingsly had some insight acknowledging that his lack of understanding of alcohol withdrawal contributed to the lack of care provided to Dictor on the night of 12 June 2022.

99 RN Billingsly's evidence was largely given in an honest and forthright manner. His care of Dictor on the night before his death was inadequate and his failure to take any clinical observations was wholly inappropriate. He made some concessions during his evidence.

100 That said, RN Billingsly's evidence is indicative of a system of inadequate training of staff; inadequate or unsocialised policies; inadequate or non-existent note taking and inadequate or non-existent clinical observations being taken from patients who had been placed in a medical unit because of their risk status.

EN Bird

101 EN Bird was an honest and forthright witness. She had a better recollection than CTL Foy of what occurred on the morning of 13 June 2022 at the handover. I accept that she was told by RN Billingsly and CTL Foy not to wake Dictor.

102 EN Bird gave evidence that a history of seizures was a concern and would be a major alert, to make sure the patient was closely monitored and that all the nursing staff would be made aware that the patient had a history of seizures. While this did not happen for Dictor, it does demonstrate that the risk presented by a history of seizures was well understood by the D&A Service Staff. EN Bird had never monitored from the CCTV, she would go into the cells to get a more accurate result. She often went in with one CCO.

Findings

103 From the completion of EN Beverley's intake until the time of Dictor's death, his treatment, healthcare and management by health staff at the CCC was wholly inadequate. The more significant deficiencies are summarised below.

(1) Despite Dictor's AWS score of 8, proper consideration was not given to whether he could be appropriately managed in a custodial setting or whether he ought to be transferred to hospital to allow for appropriate high doses of diazepam to be administered.

(2) Scheduled observations were not charted for Dictor. This may not have been an issue if staff were adequately trained and supervised in undertaking clinical observations at appropriate intervals for all patients, including overnight.

(3) No clinical observations were taken from Dictor after the initial assessment by EN Beverley until the time of his death. This precluded appropriate identification of withdrawal symptoms.

(4) Staff outside of the D&A Service had an insufficient understanding of basic symptoms of alcohol withdrawal including insomnia.

(5) There was no understanding by those responsible for caring for Dictor overnight that a lack of improvement was, of itself, a concern. RN Billingsly was only looking for further deterioration.

(6) When EN Bird twice attempted to take observations and assess Dictor, she was turned away in favour of allowing him to sleep. This, and the failure to administer medication to him in the morning, reflects a lack of comprehension by CTL Foy and RN Billingsly of the risk Dictor was exposed to.

104 While it is clear on the evidence that more appropriate steps could have been taken by Dr Collie, RN Billingsly and CTL Foy to manage Dictor's symptoms

and provide him with the basic health care he was entitled to, the evidence is indicative of systematic complacency and incompetence.

The adequacy or otherwise of the management of Dictor by correctional staff at the CCC

105 Notwithstanding that EN Beverley had completed an HPNF alerting correctional staff to symptoms to look for (see 25), CCO Craig and CCO Singh did not recognise signs of concern, nor did they attempt to engage with Dictor beyond his door.

106 CCO Singh did not recall checking Dictor's HPNF. He did ask why Dictor was in the medical unit and was told he was in alcohol withdrawal.

107 CCO Craig indicated that the 8am starter (as she was on 13 June 2022) never had an opportunity to read the HPNFs. She expected the earlier starter to provide a verbal handover.

108 When Dictor declined his breakfast, CCO Singh did not recognise a lack of appetite as a symptom of withdrawal.

109 In his evidence, CCO Singh indicated that while he was shown the muster procedure during his training, he could not recall seeing it after his first 6 weeks at CCC.

110 CCO Singh gave evidence that the muster procedure required CCOs to at least obtain a response from an inmate – they may raise their hand or respond verbally. This procedure was not complied with and, on the balance of probabilities it appears that Dictor was deceased at the time of the midday muster and this was not identified.

111 CCO Craig asserted that Dictor grunted when she attempted to take him lunch. She did not look for any symptoms of withdrawal as outlined in the HPNF at this

time or at all. At no time did she ask Dictor to stand by his door in accordance with the muster procedure.

112 CCO Craig acknowledged in evidence that she should have attempted to wake Dictor for the midday muster. She also acknowledged that given he was in a medical cell he was acutely unwell and this increases the need for observations.

113 CCO Craig asserted that the training she was provided by Serco was inadequate.

Findings

114 While the CCOs were not medically trained, they ought to have had sufficient basic knowledge to protect against the deterioration of seriously unwell patients. This would involve, at the very least, reading the HPNF and implementing it.

115 The failure by the CCOs to have any regard to the HPNF and to Dictor's care gave rise to missed opportunities to identify that Dictor was continuing to suffer alcohol withdrawal, raise concerns and elicit assistance.

Was Dictor's death preventable?

116 Professor Saunders' evidence was that Dictor's death was 'absolutely a preventable death' and Professor Haber's evidence was that Dictor's death was 'almost certainly' a preventable death. Dr Lawton indicated he would defer to Professor Saunders.

117 Somewhat ironically given that Dictor's observations while in the medical observation cell were largely limited to what was captured by CCTV, Serco submitted that I could not be satisfied that Dictor's death was preventable based on:

> The fact that the opinions of the experts are principally based on CCTV footage and a notes review.

118 I reject that submission in favour of accepting the opinions of Professors Saunders and Haber which form the basis of my finding on the balance of probabilities that Dictor's death was preventable.

	Findings
119	Timely and adequate medical treatment and management of Dictor's alcohol withdrawal at CCC could have prevented Dictor's death.

The adequacy or otherwise of the emergency response

120 At 1.29pm, CTL Foy went to Dictor's cell, knocked several times, spoke through the door and received no response. At 1.31pm the cell door was opened and CTL Foy and EN Beverley entered and a code blue was called. CPR was commenced.

121 We now know that Dictor had been deceased for some time.

122 The crash cart was rolled into cell 6 with the defibrillator at 1.32pm.

123 NSW Ambulance were notified at 1.34pm and arrived at 2.04pm. NSW Ambulance took over CPR and then Dictor was declared deceased at 2.29pm by the attending paramedic.

124 At approx. 1.42pm,[20] SNP Holland can be heard to say on the body work recording from J Parkinson:

> OK, declared dead, 13.42, just keep going for … OK, who's not done CPR?
>
> You've done it, this is a training exercise now only.
>
> Patient's deceased, just gently, just gently, don't break ribs.

[20] The body worn time was approx. 03.41 but it is apparent that the time shown on the camera was incorrect based on times being called out by those in the room.

125 It must have been highly distressing for Dictor's family to hear those words and to understand that CPR continued for approximately an hour after it was clear that Dictor was deceased.

126 Sparks gave evidence that she found this statement to be shameful and she was offended and left the room after the statement was made. At the time, the staff were unclear as to whether SNP Holland was empowered to declare life extinct. While there was capacity for health staff to declare life extinct,[21] ordinary practice was to wait for NSWA officers to make that declaration. This requires CPR to continue until NSWA officers to arrive. The purpose being to ensure that all steps are taken to preserve life – not as a training exercise.

The adequacy or otherwise of policies, procedures, staffing arrangements, resources and training for the medical treatment, health care and management of Dictor at the CCC.

Policies and procedures

127 Serco contracts with CSNSW and is contractually bound to apply JHFMH policies in its delivery of health services at CCC.

128 The key policies and Local Operating Procedures (**LOPs**) include:

(1) Procedure #6.029, Management of Alcohol Withdrawal, part of the D&A Procedure Manual which:

(a) sets out the purpose of withdrawal scales – which is not to diagnose, but guide severity of an already diagnosed syndrome, and

(b) identifies the signs and symptoms of alcohol withdrawal.

[21] The effect of the evidence at the inquest was that while SNP Holland could have made that declaration, she did not comply with the necessary requirements and her comment that the 'patient's deceased' did not amount to a 'formal' declaration of death and it was not intended by her to be a formal declaration of death.

(2) Procedure #6.001, Management of Drug and Alcohol Related Intoxication and Withdrawal which states at paragraph 3.1:

(a) half hourly observations should occur for the first two hours at a minimum

(b) in some instances, the patient may need to be transferred to hospital for ongoing management due to either access issues in the correctional centre, or level of clinical services required being unavailable at that site.

(3) Procedure #1.025, Clinical Observation Beds in Health Centres (Adult) which provides:

(a) at paragraph 2.1, as a mandatory requirement, prior to placement in a Clinical Observation Bed, a patient must have a treatment plan outlining the planned care documented in the patients' health record.

(b) at paragraph 2.2 2.2, once a decision has been made by a MO/NP[22] to place a patient in a Clinical Observation Bed, the MO/ROAMS[23]/NP must advise nursing staff of:

(i) the required level of observation

(ii) regularity of clinical measurements

(iii) any further investigations or follow up appointments, and

(iv) any symptoms that may indicate that the patient's condition is deteriorating and any action that may need to be taken in this event.

[22] Medical officer/nurse practitioner.
[23] Remote Offsite After Hours Medical Service.

(c) the NUM or delegate is responsible for the shift-by-shift overall co-ordination, clinical handover and management of patients placed in clinical observation beds and is the initial point of contact for staff with clinical concerns – they must review the treatment plan and co-ordinate any treatment ordered with the treating MO/ROAMS/NP.

Policy improvements since Dictor's death

129 Seco acknowledged that Dictor's death highlighted multiple shortcomings in his care and a need for improvements. Evidence was adduced as to development since Dictor's death.

130 Procedure #1.025 is now complemented by the LOP Care of Patients in Clinical Observation Cells which provides:

(1) that the NUM is accountable for overall care of these patients and can delegate to CTL or senior nurse on duty to ensure that a clinical care plan is followed.

(2) that the patient must have a thorough clinical assessment by a GP/NP/DOCTOR before placement in the clinical observation cells and must have a treatment plan outlining the planned care which, if this had applied at the time of Dictor's death, and been complied with, the assessment would have been conducted by Dr Collie before Dictor was transferred to the clinical observation bed.

(3) default frequency of 2 hourly observations pending medical assessment (if this had been in place in June 2022, Dictor's death may have been prevented if it had been complied with).

(4) night staff are to ensure that a set of observations are taken after the commencement of their shift and between 5am and 6am, prior to handover.

131 This policy has been communicated to all health staff by email, in-service training, by requiring staff to acknowledge in writing that they have read the policy and training involving case scenarios.

132 Additional developments since Dictor's death include:

(1) the introduction of a daily huddle and a daily round aimed at fostering communication in a way that was sadly lacking at the time of Dictor's death

(2) a dedicated handover for observation cells at 12pm every day accompanied by handover documentation

(3) a more holistic handover document, 'Daily Update' is now used and is updated continuously throughout the day to ensure accurate, real-time information is shared during handovers

(4) increased training to health staff on D&A withdrawal

(5) increased oversight of musters

(6) upgrading of the CCTV system

(7) 'townhall meetings' and 'tool box talks' for CCOs

(8) CCO training about the provision of health services which:

(a) introduces the health care team at CCC

(b) provides an overview of processes involved in administering medication in a custodial setting

(c) includes a section on the significance of the HPNF and explains what signs and symptoms to look for

(d) highlights the importance of communication and teamwork between CCOs and health staff.

Is it necessary or desirable to make recommendations?

133 The power to take away the liberty of a person and place them in custody encompasses a grave responsibility to ensure their health, safety and wellbeing. Quoting Mr Fraser for the family:

> …in circumstances where the system itself effectively triggers the health condition by removing alcohol, it's incumbent on that system to ensure that adequate care is provided in those circumstances…
>
> [and]
>
> There is also a cruel irony that Dictor died in a clinical observation cell in circumstances where no clinical observations were taken, at least following his placement in that cell.

134 Dictor's death was preventable and it occurred while he was in custody, powerless to protect himself.

135 Dictor's father Moses said in his family statement that:

> …everyone in this world has a role to play. If my son's role was to change the way people are treated, that's okay with me.

136 I hope to honour Dictor's memory in the recommendations I make.

Serco

137 While Serco has taken some steps to address the systemic failures brought to light by Dictor's death, there remains more work to do. The recommendations that were proposed by Counsel Assisting in relation to Serco are to address the following matters arising out of the evidence:

(1) inadequate training and a lack of familiarity with JHFMH and Serco's policies and procedures governing how Dictor was to be cared for

(2) a lack of access to Dictor's full medical history

(3) an inability to record why a clinical observation (Dictor's blood pressure) was not taken (see 23), and

(4) ambiguity surrounding: the role of the D&A Service Staff in caring for patients within the medical observation cells; clinical observation requirements; and the need to update the AWS assessment on an ongoing basis.

Single Digital Patient Record

138 It is notable here that the lack of transparency of a patient's full medical history is not a novel issue. NSW Health is introducing a 'Single Digital Patient Record (**SDPR**) to combat this issue. The SDPR is aimed at providing a secure, holistic and integrated view of the care a patient receives across the NSW Health system to enable a clinician to access a patient's medical information in real time from a single source.[24] The SDPR is being delivered under the leadership of the Single Digital Patient Record Implementation Authority (**SDPRIA**).

139 Once this initiative has been implemented, in a custodial setting operated by CSNSW, JHFMH would have access to an inmate's SDPR. In a privately run prison such as CCC, Serco staff would not. NSW Health advised with respect to Serco:

> Serco health staff are able to access health information entered by Clarence health services, as well as custodial health records that accompany patients moving through the NSW correctional system, including from facilities such as Parklea. However, Serco health staff are not able to view LHD-generated records in the SDPR. This position reflects current-state practice and may be reassessed once LHDs are incorporated into the SDPR.

140 Access to an in custody patient's records should not differ depending on whether the correctional centre is operated by CSNSW or by Serco. This is the basis for directing the recommendation below to the SDPRIA.

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[24] See https://www.ehealth.nsw.gov.au/solutions/clinical-care/electronic-medical-records/sdpr 19/5/2026 @12.27pm.

Recommendations

To Serco

141 That an audit be conducted of health staff at CCC to assess the matters that follow.

(1) Familiarity with Chapter 7 of the NSW Health December 2022: Management of Withdrawal from Alcohol and Other Drugs Handbook.

(2) Knowledge of alcohol withdrawal symptoms and appropriate responses to and management of those symptoms, depending on the severity of withdrawal.

(3) Knowledge of and compliance with Serco's Local Operating Procedure: Care of Patients in Clinical Observation Cells in Health Centres.

(4) Knowledge and utilisation of Serco's Local Operating Procedure: Responding to, and Escalating, Health Concerns.

If deemed necessary following the audit, that Serco revise and enhance training of health staff at CCC on the above resources and/or topics.

142 That their LOPs at CCC be revised to remove ambiguity and clarify the matters that follow.

(1) Who has authority to determine whether to place a patient in an observation cell and how that authority is exercised.

(2) The allocation to and scope of responsibility of Drug and Alcohol Service staff, and primary healthcare staff (in relation to D&A patients), for:

(a) determining how custodial patients are referred to the CCC D&A Service

(b) clinical decision making, assessments, planning and treatment

(c) coordination, implementation and delivery of care, and

(d) effective communication between relevant health professionals, the patient, correctional officers and any third parties.

(3) The ongoing requirement to administer ‘clinical’ observations, including (where appropriate) the AWS.

143 If the SDPR does not enable the recording of comments in relation to a clinical observation in a reception screening assessment:

(1) that Serco develop a procedure by which comments may be recorded (for example, in progress notes), and

(2) that Serco take appropriate measures to ensure that health staff are familiar with and comply with that procedure.

<u>To the SDPRIA</u>

144 At an appropriate time, but as early as is reasonably practicable, consider providing health clinicians at privately operated correctional centres full access to the SDPR including records generated by Local Health Districts.

145 If the SDPR does not include an option ‘Other (comment)’ to, amongst other things, enable the recording of a comment to accompany the recording of blood pressure in a reception screening assessment, take appropriate measures to enable a comment to be recorded.

CSNSW and JHFMH

146 Serco's provision of services is pursuant to an agreement with CSNSW. While the agreement is not in evidence, it details health outcome measures that need to be adhered to and maintained by Serco.

147 Pursuant to s 236A of the *Crimes (Administration of Sentences) Act 1999* (**CAS Act**), a function of JHFMHN is to monitor the provision of health services in managed correctional centres. I consider it appropriate for JHFMHN, in its monitoring capacity, to be apprised of the evidence adduced in this inquest and the manner and cause of Dictor's death. I understand that any findings of the Risk and Monitoring team at JHFMHN will be provided to CSNSW.

148 I direct that copies of the brief of evidence, the transcript of evidence and these findings be sent to the Risk and Monitoring team at JHFMHN.

Section 151A(2) of the *Health Practitioner Regulation National Law* (NSW) No 86a of 2009 (HPR)

149 It was submitted by Dictor's family that 'referrals' should be made in respect of both Dr Collie and CTL Foy. Counsel assisting also identified that I may wish to make a referral in respect of SNP Holland. It was submitted that any such referrals would be made pursuant to s 151A(2) of the HPR.

150 As a preliminary issue, it was submitted by those representing Dr Collie that to make such a referral would be procedurally unfair in circumstances where Dr Collie was not put on notice of the potential that a referral would be made. Dr Collie, amongst others, received a notice of sufficient interest pursuant to s 54 of the Act in which she was advised:

> While the Coroner has not formed any concluded views in relation to the various issues raised by this matter, it is possible that you may be the subject of criticism or adverse comments. Accordingly, you may wish to seek leave pursuant to s. 57 of the *Coroners Act 2009* to be represented at the inquest. If you are granted leave, your representative may examine and cross-examine any witnesses on matters relevant to the proceedings.

151 Dr Collie was legally represented at the inquest. She was on notice of the potential for adverse comments or criticism. The submission that a referral be made was made by Counsel for the family at the conclusion of the evidence, based on the evidence adduced. It was always possible that such a submission could be made. I reject the submission by those representing Dr Collie that the process was anything but procedurally fair.

152 The legislative regime was helpfully summarised by my colleague, Judge Lee, in the *Inquest into the death of Adam Fitzpatrick*. I have extracted his analysis below.

153 S 151A Referral of matters by courts [NSW], provides:

> …
>
> (2) If a coroner has reasonable grounds to believe the evidence given in proceedings conducted before the coroner **may indicate a complaint could be made** about a person who is or was registered in a health profession, the coroner may give a transcript of that evidence to the Executive Officer of the relevant Council for the health profession [my emphasis].
>
> (3) If a notice or a transcript of evidence is given to the Executive Officer under this section—
>
>> (a) a complaint is taken to have been made to a Council about the person to whom the notice or transcript relates; and
>>
>> (b) the Executive Officer must give written notice of the notice or transcript of evidence to the National Board for the health profession in which the person is or was registered.

154 Relevantly, the Medical Council and Nursing Council of New South Wales are both Councils established under section 41B of the HPR.

155 Section 151A does not explicitly define, or otherwise provide guidance as to, what may constitute ‘reasonable grounds.’ However, it is noted that the guiding principles set out at section 3A of the HPR provides the following:

> (1) The main guiding principle of the national registration and accreditation scheme is that the protection of the health and safety of the public must be the paramount consideration.

156 Similarly, section 3B of the HPR provides:

> **Objective and guiding principle**
>
> In the exercise of functions under a NSW provision, the protection of the health and safety of the public must be the paramount consideration.

157 Section 144 of the HPR sets out a number of grounds for complaint about a registered health practitioner and provides:

> The following complaints may be made about a registered health practitioner –
>
> (a) **Criminal conviction or criminal finding**
>
> A complaint the practitioner has, either in this jurisdiction or elsewhere, been convicted of or made the subject of a criminal finding for an offence.
>
> (b) **Unsatisfactory professional conduct or professional misconduct**
>
> A complaint the practitioner has been guilty of unsatisfactory professional conduct or professional misconduct.
>
> (c) **Lack of competence**
>
> A complaint the practitioner is not competent to practise the practitioner's profession.
>
> (d) **Impairment**
>
> A complaint the practitioner has an impairment.
>
> (e) **Suitable person**
>
> A complaint the practitioner is otherwise not a suitable person to hold registration in the practitioner's profession.

158 Section 139 of the HPR provides:

> **139 Competence to practice health profession [NSW]**
>
> A person is ***competent*** to practise a health profession only if the person –
>
> (a) has sufficient physical capacity, mental capacity, knowledge and skill to practise the profession; and
>
> (b) has sufficient communication skills for the practice of the profession, including an adequate command of the English language.

159 Section 139B of the National Law relevantly provides:

> **139B Meaning of ‘unsatisfactory professional conduct’ of registered health practitioner generally [NSW]**
>
> (1) ***Unsatisfactory professional conduct*** of a registered health practitioner includes each of the following –
>
> (a) **Conduct significantly below reasonable standard**
>
> Conduct that demonstrates the knowledge, skill or judgment possessed, or care exercised, by the practitioner in the practice of the practitioner’s profession is significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience.

160 Having regard to the legislative framework described above, if there are reasonable grounds to believe that evidence given during the inquest may indicate a complaint could be made about Dr Collie, CTL Foy or SNP Holland, then a transcript of that evidence may be given to the Executive Officer of the Medical Council or the Nursing Council as applicable.

161 Judge Lee stated:

> that the use of the words ‘*believe*’, ‘*may indicate*’ and ‘*could*’ in section 151A(2) of the HPR individually and collectively impose a relatively low threshold by which that provision might be engaged. Therefore, section 151A(2) does not impose any requirement that the evidence in actual or contemplated coronial proceedings establishes a complaint. Instead, section 151A(2) may be engaged if a coroner has reasonable grounds to believe that the evidence may indicate that a complaint could be made…
>
> …a complaint is not fettered by any consideration as to whether a registered health practitioner has, for example, demonstrated appropriate reflection or undertaken any additional education, training or personal and professional development following an adverse event which is the subject of a complaint. These matters are, in essence, matters which may bear upon how the Medical Council or Nursing Council may assess and deal with a complaint, utilising the powers available to the relevant Councils.

162 As a general proposition, Counsel Assisting also submitted as an argument against provision of the transcript to the relevant councils:

> …the evidence also establishes that these individuals were working within a system containing many deficiencies, some of which appear to have allowed apathy and lack of responsibility to perpetuate.

CTL Foy

163 CTL Foy was an unimpressive witness with little to no recall of what occurred while Dictor was in her care. While I appreciate there has been a significant passage of time since Dictor's death, a death in custody would be sufficiently unusual to ordinarily result in events being more memorable.

164 There was a factual dispute as to whether CTL Foy was the CTL on 12 June 2022 but it was accepted that she was the CTL on 13 June 2022.

165 It was submitted that CTL Foy's care for Dictor was inadequate in the ways that follow.

(1) Sparks confirmed in her evidence that even at the time of Dictor's death, it was policy that CTLs would review plans of care and ensure that observations were undertaken. However, CTL Foy could not recall even checking Dictor's folder.[25]

(2) While CTL Foy did not have a specific recollection, she did not deny the conversation asserted by EN Bird that she would call EN Bird on the morning of 13 June when Dictor woke up so that observations could be conducted. Effectively, CTL Foy acted as a barrier to clinical observations and an updated AWS assessment being undertaken by EN Bird.

(3) CTL Foy determined that Dictor should not be woken around midday on 13 June 2022 to be provided with his medication. We know understand that Dictor was most likely already deceased at midday when this occurred.

[25] There was a separate folder for each patient in an observation cell. However, this would not have contained Dictor's D&A Assessment which could be found online.

(4) CTL Foy's knowledge of the symptoms of withdrawal were inadequate to provide Dictor with the care he required – for example, she was not aware that insomnia is a symptom of withdrawal.

(5) Notwithstanding her role as CTL on 13 June 2022, there is no evidence that CTL Foy took steps towards coordinating Dictor's care. Having Dictor on the CCTV screen at the nurse's station was not providing adequate care and was not a substitute for direct checks on his welfare.

166 It was submitted on behalf of Dictor's family that CTL Foy's conduct was significantly below the standard reasonably expected of a practitioner of an equivalent level of training or experience. CTL Foy had responsibilities to take positive steps to care for Dictor including to review his medical plans and ensure he was being appropriately observed including by the taking of clinical observations and the administration of chartered medications.

167 I find that the above evidence constitutes reasonable grounds to believe that a complaint could be made about CTL Foy such that the transcript of evidence ought to be provided to the relevant Council pursuant to s 151A of the HPA.

<u>Dr Collie</u>

168 On 12 June 2022, Dr Collie knew that Dictor was on his way to the medical observation cells. It was her evidence that the plan she had formulated was an interim plan pending a further assessment. Initial medication had been prescribed.

169 Professors Saunders, Haber and Dr Lawton agreed that a 'loading dose' of medication was required to treat someone in moderate to severe alcohol withdrawal. It was not possible to give a loading dose in a custodial setting. On this evidence alone, serious consideration ought to have been given to Dictor being immediately transferred to a hospital where he could receive appropriate medical treatment and his required observation levels could be met.

170 On her own evidence, Dr Collie, CCC's only D&A MO, left the premises without ensuring that: a full assessment had been undertaken; a complete plan had been prepared; and consideration had been given to whether it was appropriate to transfer Dictor to hospital.

171 I find that the above evidence constitutes reasonable grounds to believe that a complaint could be made about Dr Collie such that the transcript of evidence ought to be provided to the relevant Council pursuant to s 151A of the HPA.

SNP Holland

172 The conduct of SNP Holland which it has been said may trigger s 151A(2) HPA is statements made by her at around 1.42pm on 13 June 2022 after Dictor was found unconscious (now understood to be deceased):

> OK, declared dead, 13.42, just keep going for … OK, who's not done CPR?
>
> You've done it, this is a training exercise now only.
>
> Patient's deceased, just gently, just gently, don't break ribs.

173 SNP Holland was not compelled to give evidence in relation to this conduct. However, she has sought to address it in written submissions filed at the conclusion of the evidence. In taking these submissions into account, I must be mindful that she was not subjected to cross examination.

174 It was accepted that SNP Holland's declaration of death was not formal or official or consistent with applicable policy or procedure. SNP Holland submitted, and it was not in contention, that it was the policy that CPR was to continue until NSWA arrived. I also accept that SNP Holland had sufficient experience to determine that Dictor was in fact deceased and that notwithstanding the continuation of CPR he was not going to be revived.

175 Dictor was a person, a son, a brother. He was entitled to be treated with respect and dignity while he was alive and after his death. It was inappropriate and improper for his body on his death to be treated as a 'training exercise'.

176 To some extent this is reflective of the lack of care and attention provided to Dictor following his assessment by EN Beverley. However, this does not absolve SNP Holland of the responsibility for her own conduct which I consider does not meet the standard reasonably expected of a practitioner of an equivalent level of training or experience.

177 I find that the above evidence constitutes reasonable grounds to believe that a complaint could be made about SNP Holland such that the transcript of evidence ought to be provided to the relevant Council pursuant to s 151A of the HPA.

Recommendations pursuant to the HPA

To the Executive Officer, Nursing and Midwifery Council of New South Wales (**Nursing and Midwifery Council**)

(1) That the conduct of Cassandra Holland, Nurse Practitioner, between 1.30pm and 2.30pm on 13 June 2022 be reviewed by the Nursing and Midwifery Council, including but not limited to the matters that follow:

(a) The statements made by Ms Holland at around 1.42pm:

> OK, declared dead, 13.42, just keep going for … OK, who's not done CPR?
>
> You've done it, this is a training exercise now only.
>
> Patient's deceased, just gently, just gently, don't break ribs.

(b) The requirements of the NSW Health Policy Directive – Verification of Death and Medical Certificate Cause of Death.

(2) That the conduct of Kristy Foy, Registered Nurse and Clinical Team Leader, between around 7am and 12pm on 13 June 2022 be reviewed by the Nursing and Midwifery Council, as it concerned nursing services in relation to Dictor Dongrin.

To the Executive Officer, Medical Council of New South Wales (**Medical Council**)

(1) That the conduct of Dr Patricia Collie, alcohol and drug specialist, on 12 June 2022 from about 1.30pm and on 13 June 2022, be reviewed by the Medical Council as it concerned medical treatment and management of Dictor Dongrin including, in relation to the matters that follow:

(a) The alcohol withdrawal symptoms, history and medical risk presented by Dictor Dongrin, as contained in information provided to Dr Collie.

(b) The prescriptions written by Dr Collie for Dictor Dongrin.

(c) The medical plan of management written by Dr Collie for Dictor Dongrin.

Concluding remarks

178 The findings that I make under s 81(1) of the Act are:

Identity
The person who died was Dictor Dongrin.

Date of death
Dictor Dongrin died shortly after 11.31am on 13 June 2022.

Place of death
Dictor Dongrin died in the MMMU at the CCC.

Cause of death
The mechanism of Dictor's death was a cardiac arrythmia in the context of a state of alcohol withdrawal and a history of chronic alcohol misuse.

Manner of death
Timely and adequate medical treatment and management of Dictor Dongrin's alcohol withdrawal at CCC could have prevented his death.

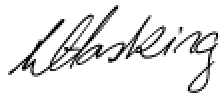
179 I thank Acting Inspector Paul Waddell, the officer in charge of the coronial investigation, for his work in the coronial investigation and for preparing the brief

of evidence which was supplemented by the Assisting team.

180 I thank the Assisting team for their assistance in this inquest.

181 On behalf of myself and the Coroner's Court of NSW, I express my sincere condolences to Dictor's family and friends for the tragic loss of Dictor.

182 I close this inquest.



Judge R. Hosking
Deputy State Coroner
Lidcombe

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ANNEXURE A

Agreed Facts

11 June 2022			
1.	About 17.22	Police car crew CHR33 responded to a police radio broadcast in relation to a domestic violence incident and proceeded to 5 Halls Road, North Boambee Valley.	Tab 14 [5] and [6]
2.	About 17.31	Police (Senior Constable Gregg Banks and Constable James Handebo, and Sergeant Leanne Bell) arrived at 5 Halls Road, North Boambee Valley. Shortly thereafter, they arrested Mr Dongrin for assault and transported him and his brother (Taban Dongrin (**Taban**)), to Coffs Harbour Police Station.	Tab 14 [6], [16], [17], [18], [24], [26] and [31] Tab 12 [4], [6]-[7] Tab 8 at [5], [20], [23], [32] at page 1, 8 and 12
3.	About 18.20	Police returned to Coffs Harbour Police Station with Mr Dongrin and Taban. Constable Will Smith escorted Mr Dongrin from the Police Vehicle. Sergeant Leanne Bell stated that he assisted Mr Dongrin in getting out of the caged vehicle. Constable Johnson, Smith and Lenthall all assisted Mr Dongrin with a search and removal of cords.	Tab 10 [6], [7], [8] and [10] at pages 1-2. Tab 12 [9]
4.	18.33	In Mr Dongrin's Custody Management Record, under "recovery", Constable William Smith recorded that Mr Dongrin was "well intoxicated. No longer intoxicated and could understand Part 9".	Tab 19, p 16
5.	18.42	Constable William Smith accepted Mr Dongrin into custody at Coffs Harbour Police Station.	Tab 19, p 4 and 21
6.	18.42	Constable William Smith recorded that "POI still well IP and uncooperative". Intoxication level was recorded as "moderately affected". In response to "Do you have any serious medical problems" Constable Smith recorded 'POI suffers from kidney failure and is not taking medication currently'.	Tab 19, p 16 Tab 19, p 11-12

7.	19.20	Constable William Smith recorded that “POI is well ip”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 17
8.	19.50	Constable William Smith recorded that Mr Dongrin was “asked if he was O.K.. lifted his head and opened his eyes” and “co-operative at the moment and is sleeping”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 17
9.	20.30	Senior Constable Peter Ziesig recorded that Mr Dongrin “appears fine and cooperative at this stage” and “meal given and consumed”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 18
10.	20.45-21.05	Senior Constable Peter Ziesig recorded that Mr Dongrin was “[g]iven meal and water”.	Tab 19, p 18
11.	21.00	Senior Constable Peter Ziesig recorded “advised forensic procedure will be taken. taken. asked if POI can read” and “nil issues. Appreared [sic] fine and understood request”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 19
12.	21.00	Constable Handebo states that he assisted the custody manager with fingerprints and photographs of Mr Dongrin.	Tab 14 [33]
13.	21.40	Senior Constable Peter Ziesig recorded “asked if [Mr Dongrin] was alright” and that Mr Dongrin had “said he was alright”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 19
14.	22.20	Senior Constable Peter Ziesig recorded “Part 9 read and explained” and “appeared to understand Part 9”. Intoxication level was recorded as “moderately affected”.	Tab 19, p 20
15.	23.00	Senior Constable Peter Ziesig recorded “spoken to and no longer appears to be intoxicated. Advised police that he is not intoxicated. This was done prior to PArt9 [sic] being read and explained”. Senior Constable Peter Ziesig recorded Mr Dongrin’s intoxication level on the Custody Management System as “not affected”.	Tab 19, p 20 Tab 9 [9] and [10] at page 2
16.	23.37-00.03	A buccal swab was taken from Mr Dongrin.	Tab 19, p 21
17.	23.54 – 02.25	The charges were completed and Mr Dongrin was refused bail by Police.	Tab 19, p 21

			Tab 15 at [4], page 1
12 June 2022			
18.	01.47	Senior Constable Peter Ziesig recorded that he woke Mr Dongrin and spoke to him. Intoxication level was recorded as “not affected”.	Tab 19, p 13 Tab 9 at [14] of page 2
19.	02.25 to 03.00am	Constable Jack Paltridge took over as Custody Manager.	Tab 13 at [4] page 1
20.	3:23	Constable Jack Paltridge recorded that Mr Dongrin was sleeping in his cell “nil issues”. Intoxication level was recorded as “not affected”.	Tab 19, p 4
21.	04.03	Constable Jack Paltridge recorded that Mr Dongrin was sleeping in his cell. Intoxication level was recorded as “not affected” on the Custody Management Record.	Tab 19, p 14 Tab 13 at [6] page 2
22.	04.13	Constable Jack Paltridge recorded that Mr Dongrin was sleeping in his cell. Intoxication level was recorded as “not affected” on the Custody Management Record.	Tab 19, p 14 Tab 13 at [6] page 2
23.	04.41	Constable Jack Paltridge recorded that Mr Dongrin was sleeping in his cell. Intoxication level was recorded as “not affected” on the Custody Management Record.	Tab 19, p 14 Tab 13 at [6] page 2
24.	06.00	Senior Constable Matthew Bennett commenced his shift and was assigned to Custody Manager duties. Senior Constable Matthew Bennett recorded that Mr Dongrin was asleep, “nil issues”. Intoxication level was recorded as “not affected”.	Tab 15 at [3] and [5] page 1 Tab 19, p 14
25.	07.10	Senior Constable Matthew Bennett recorded that Mr Dongrin was still asleep. Intoxication level was recorded as “not affected”.	Tab 19, p 15
26.	08.07	Senior Constable Matthew Bennett removed Mr Dongrin from Cell 3 and placed him in the AVL room at Coffs Harbour Police Station, where he spoke with John	Tab 15 [6]

		Hennesy, a Legal Aid solicitor.	
27.	08.41	Senior Constable Matthew Bennett recorded “nil issues”. Intoxication level was recorded as “not affected”.	Tab 19, p 15
28.	09.10	Senior Constable Matthew Bennett removed Mr Dongrin from Cell 3 and placed him in the AVL room at Coffs Harbour Police Station, where he appeared before the Local Court at Port Macquarie via AVL. Bail was refused.	Tab 15 [7]
29.	09.50	Senior Constable Matthew Bennett recorded “nil issues”. Intoxication level was recorded as “not affected”.	Tab 19, p 15
30.	10.10	Senior Constable Matthew Bennett provided Mr Dongrin with breakfast, which he ate.	Tab 15 [8]
31.	10.53	Corrective Services Officers removed Mr Dongrin from Cell 3 and placed him into Dock 3 within the custody room, where he was asked and answered some questions. He was transferred into the care of Corrective Services officers who transported him from the Coffs Harbour Police Station to the Grafton Correctional Facility.	Tab 7 [14] Tab 15 [9]-[10]
32.	11:00am	A New Inmate Lodgement and Special Instruction Sheet was completed by a Corrective Services New South Wales, interviewing officer (Osborne) at Coffs Harbour Police Station. The form noted that Mr Dongrin had a medical issue of “*alcohol withdrawal*” which required a Justice Health review on reception. The form also noted: • In response to the question “How do you feel at the moment?”, the answer was “No apparent Issues” • In response to the question “Do you take any prescribed medication?” the answer was “Yes”, “Valium/alcohol” • In response to a question “Are you an alcoholic, binge drinker, drink excessively, recreational drug user or take any other non-prescribed medication?” the answer was “Yes”. • In response to a question “Have you consumed alcohol in the last 24 hours”, the answer was “Yes”	Tab 76, pp 3-6

33.	12.35-12.36	Mr Dongrin and his brother arrived at Clarence Valley Correctional Centre (**CCC**). Mr Dongrin and his brother were placed in Reception holding cell 6.	Tab 7 [64(1)] CCTV footage
34.	12.44	Mr Dongrin was moved from Reception holding cell 6 to the search area where a search was conducted. At the same time, Mr Dongrin changed out of his normal clothes to prison greens. He was then taken to a medical room where he was assessed by a nurse who appears to have completed the medical examination at around 12:58pm. Following this, Mr Dongrin was placed into Reception holding cell 3, which was across the hall from the medical assessment room.	Tab 7 [64(1)]
35.	13.00	Reception and Accommodation Checklist completed by officer "C. Chapman", recording: • In response to the question "Do you have any immediate medical requirements?" the answer was "Yes", "Alcohol/detox" • In response to the question "Do you have a physical and/or intellectual impairment or disability?" the answer was "Yes", "Seizures due to alcohol withdrawals" • Under the "Accommodation decision" heading, "Clinic cell due to detox" was recorded.	Tab 83A, pp 1-2
36.	12:51 to 13:04	Laura Beverley, enrolled nurse (**EN Beverley**), commenced the reception screening assessment (**RSA**) at 12:51pm, and completed the assessment at around 13:04pm. EN Beverley recorded that Mr Dongrin, *inter alia*: • had an "existing active health condition" of "seizures" (since date 09-Dec-2018) • had a history of neurological conditions, namely, seizures with onset age 26 years. • reported using alcohol daily, with an average amount used (on days used) "1x cask white wine", last used "yesterday" • reported using benzodiazepines (Valium) daily, with the average amount used (on days used)	Tab 75 Tab 49A [12] Tab 37, Annexure A, pp 3-15, 27. Tab 80, p 1 Tab 81

		"10mg", last used "yesterday" • had a history of withdrawal related seizures • had been to the hospital in the past 6 months for alcohol withdrawals Ms Beverley recorded that Mr Dongrin's presentation was "in withdrawal", exhibiting visible shakiness, sweatiness, and to be pale and withdrawn. The following was recorded in relation to Ms Beverley's physical assessment of Mr Dongrin: • Respiratory rate was recorded at 15 breaths per minute. • Sp02% was recorded at 98%. • Heart rate was 85 beats per minute. • Temperature was 36.4 degrees. • Blood glucose level was 4.7 mmol/L • Was 175cm tall. • Weighed 61.9kg. • Had a BMI of 19 kg/m2. • Urinalysis: "Awaiting sample back" EN Beverley conducted a "Drug and Alcohol Substance Withdrawal Monitoring", "Alcohol Withdrawal Scale" assessment where Mr Dongrin scored an initial Alcohol Withdrawal Score of 8 out of 10.	
37.	13.06	EN Beverley recorded a progress note where she recorded that Mr Dongrin was: *Dressed in greens, engaging well* *Physically in withdrawals.* *Tremor, shakes, clammy and anxious.* *States has a history of withdrawal seizures last one 2 months ago.* *Hx of hospital admissions for alcohol withdrawals* *…* *CDS: Seizures – however alcohol related seizures* *…* *D&A: Extensive history of alcohol abuse and withdrawals – with admissions to hospital.* *Alcohol – Daily of a cask of white wine daily*	Tab 81, p 2

		– for the last few months. *Drugs – Valium 10mg a day.* *To be housed in medical as discussed with D&A.* *Plan* *Housed in medical unit until cleared by D&A.* *CDS.* *D&A.*	
38.	13.11	EN Beverley issued a Health Problem Notification Form (**HPNF**) which stated that Correctional Case Officers (**CCO**) ought to monitor for signs of *"[s]eizures, nausea, vomiting, decreased appetite, loss of consciousness, tremors, complaints of joint/muscle pain – 7 DAYS"* and "*[r]unny nose, cough, fever, loss of smell/taste – 10 days".* The HPNF instructed CCO's to report any observations of such signs to Justice Health staff, and for Mr Dongrin to be "housed in medical until cleared by D&A".	Tab 77, p 1
39.		EN Beverley discussed Mr Dongrin's reception screening assessment with Dr Patricia Collie and Donna Bird, enrolled nurse.	Tab 49A [14]
40.	13.23	Mr Dongrin was moved out of Reception Holding Cell 3.	CCTV footage
41.	13.24	Mr Dongrin was placed into the Male Max Medical Unit (MMMU), Observation Cell 6.	CCTV footage
42.	13.33	Dr Patricia Collie recorded a progress note where it was noted that: Notes review and discussion with nurse completing RSA. Known high levels of Etoh use with resultant alcohol withdrawal seizures Current reports of 2L wine daily for past few months Regular use of diazepam 10mgs daily Is to be housed in medical cells for at least 5 days please Plan: Chart IM thiamine 300mgs daily ongoing Diazepam 10mgs bd for 12/6/22 (no access to oxazepam) From 13/6/22 chart 30mgs	Tab 81, p 3

		oxazepam bd and further 30mgs to have prn based on AWS (to maximum of 120mgs daily) Please liaise with D&A team and MO if patient requires more than 90mgs oxazepam daily Will a need slow reduction in BZDs due to regular use in the community	
43.	13.35	Mr Dongrin engaged with staff through cell door.	Tab 7 [64(1)] CCTV footage
44.	13.41	Mr Dongrin engaged with staff through cell door. A staff member slid Mr Dongrin's MIN card under the door. He is seen to pick it up.	CCTV footage
45.	14.05	Mr Dongrin activated the duress alarm and had the following exchange with Justice Health.	Tab 84
46.	14.25-14.29	Registered Nurse, Elaine Ortiz (**RN Ortiz**), entered cell 6. She assisted Mr Dongrin to sit in a chair and administered an injection of Thiamine (300mg) via intramuscular injection into the deltoid muscle in his arm. She provided him Diazepam with water.	Tab 7 [64(1)] Tab 79, p 2 Tab 61 [24] at page 4
47.	14.30	Occurrence journal records "nurse assess inmates cells (2) + (6)" Initialed by "KC" (Kahla Craig).	Tab 72
48.	14.46	RN Ortiz recorded a progress note after seeing Mr Dongrin in cell 6 where she noted: *[c]ompliant, reactive & responding to writer normally. Involuntary trembling noted that he had to be assisted to sit on chair. Charted diazepam taken with water. Charted thiamine administered deep IM on left arm. Tolerated procedure well. Nil complaints or issues voiced and went back to bed to sleep.*	Tab 61, p 9 Tab 81, p 4
49.	15.40	A meal was provided via the cell door chute, which Mr Dongrin consumed. Mr Dongrin handed a staff member a cup which was then returned to him.	CCTV footage
50.	16.00	Corrections Case Officer Craig (**CCO Craig**) notes *'Dinner meals given out'.*	Tab 72
51.	16.05	Mr Dongrin stood up and activated the cell intercom for	Tab 7

		help with his device.	[64(1)]
52.	16.06	Mr Dongrin had the following exchange with [unknown]: *JH: State your medical emergency.* *D: Hello?* *JH: Hello.* *D: (inaudible)* *JH: What's wrong?* *D: Um I need your help.* *JH: Ok I'll come out and see you.* *D: (inaudible)*	Tab 84
53.	16.07	A staff member attended observation cell 6 in response to the intercom call.	Tab 7 [64(1)]
54.	17.40	CCO Craig notes the "Lock in Muster correct".	Tab 72
55.	22.01	Mr Dongrin interacted with a staff member through the cell door chute and was given a second dose of diazepam by Matthew Billingsly, registered nurse. *patient was interacting with staff appropriately but noted that he was very unsteady on his feet.*	Tab 7 [64(1)] Tab 62, Annexure A Tab 81, p 23
13 June 2022			
56.	03.39	Mr Dongrin stopped watching his tablet device and appeared to sleep.	Tab 7 [64(1)] CCTV Footage
57.	04.58	Mr Dongrin walked around the cell before lying down again.	Tab 7 [64(1)] CCTV Footage
58.	05.41	Mr Dongrin started watching his tablet device.	Tab 7 [64(1)] CCTV Footage
59.	06.37	Mr Dongrin stopped watching his table device and appeared to sleep.	Tab 7 [64(1)]

			CCTV Footage
60.	07.00	Clinical Team Leader, Registered Nurse Kristy Foy (**RN Foy**) commences shift	Tab 59 at [28] on page 4
61.	07.14	Mr Dongrin appeared to wake and had initial difficulty standing.	Tab 7 [64(1)]
62.	07.30	Progress note recorded by RN Foy: *Handed over from night shift RN, that pt. had been awake all night - observed one one-view screen - lying on stomach with head to side. Seen getting up to bathroom x1 during morning - did not note time. Observed to be Resting on mattress with tablet operating at various times.*	Tab 81, p 20
63.	07.43	Mr Dongrin interacted with staff through the cell door.	CCTV Footage
64.	07.49	The occurrence journal recorded that the “Let-Go Muster” took place in “medical”.	Tab 72 at p 2 Tab 57 [31] at page 5 Tab 57, Annexure A
65.	About 07.59	Mr Dongrin lay down and appeared to sleep or rest.	CCTV Footage
66.	08.14	Occurrence journal recorded “Let go muster correct”. Initialled by “HS” (Harpreet Singh).	Tab 72 Tab 57, Annexure A
67.	08.47	Mr Dongrin started watching his tablet device.	CCTV Footage
68.	About 11.00	Donna Bird returns to MMMU. Ms Bird states that Ms Foy indicated that Mr Dongrin had not woken so Ms Bird leaves MMMU.	Tab 65, [70]-[71]
69.	11.31	Mr Dongrin’s last known movement insofar as observable on CCTV	Tab 53 [87] at page 9 Tab 7

			[64(1)] CCTV Footage
70.	11.35	CCO Craig knocked multiple times on the door of cell 6 and spoke through the access chute. CCO Craig left a meal on the access chute.	Tab 7 [64(1)]
71.	11.42	CCO Craig looked into cell 6. The meal remained on the access chute.	Tab 7 [64(1)]
72.	12.02	Occurrence journal entry records “Midday muster commence, figures sent to master control, 3 in medical cells”. Initialed by “HS” (Harpreet Singh)	Tab 57, Annexure A
73.	12.10	Progress note recorded by Kristy Foy: *Signed out dose of oxazapam at 1200hrs, Dictor asleep - signed back into safe with EEN Beverely*	Tab 81, p 21 Tab 37, p 29
74.	12.25	Occurrence journal entry records “Midday muster correct”. Initialed by “HS” (Harpreet Singh)	Tab 57, Annexure A Tab 72
75.	13.29	Kristy Foy goes to Mr Dongrin’s cell and knocks several times and speaks through cell door. No response from Mr Dongrin.	Tab 7 [64(1)]
76.	13.31	Cell opened. Kristy Foy and Laura Beverley enter cell. A code blue was called in MMMU cell 6. CPR was commenced by Laura Beverley, with Kristy Foy.	Tab 7 [64(1)]
77.	13.32	The “crash cart” was rolled into cell 6, with defibrillator attached.	CCTV footage
78.	13.34	Call received by NSW Ambulance	Tab 29, p 1
79.	Approx 14.04	NSW Ambulance paramedics arrived at MMMU cell 6.	Multiple tabs incl. Tab 38
80.	14.29	Scott Acton, a NSW Ambulance Officer, declared Mr Dongrin deceased in accordance with a NSW Health Verification of Death Form.	Tab 3