



New South Wales

**CORONER'S COURT  
OF NEW SOUTH WALES**

**Inquest:** Inquest into the death of Patience Kuzmins

**Hearing date:** 25 to 27 May 2026

**Date of Findings:** 19 June 2026

**Place of Findings:** Coroner's Court of New South Wales, Lidcombe

**Findings of:** Judge Derek Lee, Deputy State Coroner

**Catchwords:** CORONIAL LAW – death in custody, cause and manner of death, Custodial Operations Policy & Procedures, searching inmates, reception procedures, body scanning, internally secretion of contraband, Silverwater Women's Correctional Centre, Court Escort Security Unit, detection of illicit drugs, methylamphetamine toxicity

**File number:** 2022/00338759

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Mr J Wilcox for the Commissioner of Corrective Services New South Wales, instructed by NSW Department of Communities and Justice

**Findings:**

Patience Kuzmins died on 10 November 2022 at Silverwater Women's Correctional Centre, Silverwater NSW 2128.

The cause of Patience's death was methylamphetamine toxicity.

It is most likely that the toxic levels of methylamphetamine detected following analysis of Patience's post-mortem blood sample was the result of contamination from a package of methylamphetamine that had been concealed internally within Patience's vaginal cavity. The available evidence does not allow for a conclusion to be reached as to whether Patience introduced the package of methylamphetamine into lawful custody herself, or whether it was given to her after she entered custody. After entering custody, Patience was not searched in accordance with the Custodial Operations Policies and Procedures on 7 and 8 November 2022. In addition, the body scan image of a fellow inmate who shared a cell with Patience on 9 November 2022 was not correctly interpreted for the presence of internally concealed contraband. However, it is not possible to conclude whether these omissions and misinterpretation allowed for the internal concealment of the package of methylamphetamine by Patience.

**Non-publication orders:**

See Annexure A

## Table of Contents

1. Introduction .....	1
2. Why was an inquest held? .....	1
3. Patience's life.....	2
4. Background to the events of 7 to 10 November 2022.....	3
5. The events of 7 to 10 November 2022 .....	3
6. Post-mortem examination .....	5
7. What issues did the inquest examine? .....	5
8. What was the manner of Patience's death? .....	6
9. Was Patience searched in accordance with CSNSW policies and protocols.....	7
7 November 2022.....	7
8 November 2022.....	11
9 November 2022.....	12
10. When and how did Patience come to acquire the internally concealed contraband? .....	14
11. Were appropriate steps taken after the body scan of Ms EC was performed? .....	15
12. Were appropriate steps taken after a body scan of Ms AL could not be performed? .....	16
13. Does CSNSW have appropriate procedures in place to detect, and mitigate the risk of dissemination of, illicit drugs?.....	16
14. Findings .....	17
Identity .....	17
Date of death.....	17
Place of death .....	17
Cause of death .....	17
Manner of death.....	17

## 1. Introduction

- 1.1 On 7 November 2022, Patience Kuzmins, a 23-year-old woman presented to Wollongong police station in relation to an outstanding warrant for her arrest. Patience later appeared at Wollongong Local Court where she was refused bail.
- 1.2 Patience was initially transferred to Amber Laurel Correctional Centre (**ALCC**) before arriving at Silverwater Women's Correctional Centre (**SWCC**) on the morning of 9 November 2022. There, a body scan was performed of Patience with the aim of detecting any internally concealed contraband. The scan revealed no such contraband. Later that afternoon, Patience was taken to a cell and another inmate was subsequently placed in the cell with her.
- 1.3 In the early hours of the morning on 10 November 2022, Corrective Services New South Wales (**CSNSW**) officers attended Patience's cell, heard noises from within and saw that Patience was in the shower. The CSNSW officers enquired about Patience's welfare and asked her to come out of the shower. Patience struggled to do so and was helped to the floor whilst showing signs of distress.
- 1.4 Emergency services were contacted and resuscitation efforts were initiated. However, despite these efforts, Patience could not be revived and was later pronounced deceased at 4:59am.

## 2. Why was an inquest held?

- 2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to be answered pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.
- 2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.
- 2.3 A coronial investigation and inquest seek to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. This type of examination typically involves consideration of, where relevant, the conduct of correctional staff.
- 2.4 In Patience's case, the circumstances of her death raised a number of questions regarding the reason for her sudden collapse and death in the early hours of the morning on 10 November 2022. It was later discovered that at the time of her death, Patience had a package concealed within her vaginal cavity. The package found to contain quantity of methamphetamine and syringes. This discovery in turn raised questions about when and how the package came to be concealed

internally within Patience, and whether appropriate searches of Patience had been conducted whilst she was in lawful custody.

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

### **3. Patience's life**

- 3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge Patience's life in a brief, but hopefully meaningful, way.
- 3.2 Patience was born on 7 May 1999 to her parents, Jacqueline and Siegfried. She had an older brother, Buck, and a younger brother, Cale, and younger sister, Sonnet. Patience also had an older half-sister, Renae.
- 3.3 Patience grew up in the Warrawong area in Wollongong and attended the local public school and high school. She had a love of dancing and music and was known to always have her headphones on listening to music. Patience was also a talented artist who would often take pictures to give as gifts to family and friends. Patience had a love of all animals, particularly her dog, "Storm".
- 3.4 After leaving school in Year 10, Patience found employment in different areas including working as a receptionist at a beauty clinic, fundraising for the Sun Cancer Council, and working at a childcare centre. At this last job, Patience impressed her employers with her work ethic and commitment to the children under her care.
- 3.5 Jacqueline describes her daughter as having a zest for life, a wicked sense of humour, and someone who was always the brightest life in a room. Patience had a special way of making those around her feel like the best and most important person.
- 3.6 Buck describes Patience as a larger-than-life personality who cared deeply for those around her. She would often go out of her way to generously help others in need and raise their spirits without ever seeking recognition or acknowledgement.
- 3.7 Sonnet describes Patience as her best friend, the glue that held the family together, and someone she could always count on to support and guide her through any situation. To Sonnet, Patience

was a one-of-a-kind, loyal and loving person who would do absolutely anything for those that she loved.

3.8 Patience's best friend, Mercedes, recalls that Patience was the light of her life and those of many others. Patience conveyed enormous warmth and comfort to those around her, she lifted the energy in a room simply by being present, and she could always be counted on to make others smile and feel joy. Despite any challenges that Patience may herself have been grappling with, she always placed the interests of her family and loved ones first. Patience was very protective of her family, cared deeply about them, and sheltered Mercedes from negative influences, allowing her to grow and flourish. All of Patience's family describe how selfless, caring and genuine Patience was.

3.9 The words generously shared by Patience's family and best friend at the end of the inquest clearly show how proud they are of Patience, how much she meant, and still means, to all of them, and how their lives have been profoundly and deeply affected by Patience's tragic and untimely passing.

#### **4. Background to the events of 7 to 10 November 2022**

4.1 On 31 July 2022, Patience was arrested and charged in relation to a number of alleged offences. She was later granted conditional bail the same day. Between 31 July 2022 and 1 November 2022, the criminal proceedings were before Wollongong local Court on five occasions.

4.2 On 1 November 2022, Patience failed to appear at Wollongong local Court. She was convicted in her absence and a warrant was issued for her arrest.

4.3 On 6 November 2022, Patience spoke to her mother and told her that she was going to hand himself in at Wollongong police station.

#### **5. The events of 7 to 10 November 2022**

5.1 At around 2:15am on 7 November 2022, Patience presented to Wollongong police station and indicated that she wanted to hand himself in regarding the outstanding warrant, where she was arrested in accordance with the warrant. Patience was wearing a grey cardigan and a skintight dress at the time. Patience was subsequently refused bail by the NSWPF.

5.2 Due to the unavailability of cells at Wollongong Local Court, Patience was transferred to Lake Illawarra police station. Later that day, Patience appeared before Wollongong Local Court where she was bail refused. Her matter was adjourned to the following day. Patience was subsequently received at the Wollongong Court Escort Security Unit (CESU) and entered into the custody of CSNSW.

5.3 On 8 November 2022, Patience again appeared before Wollongong Local Court where she was bail refused. Her matter was adjourned to 22 November 2022 for sentence. Later that day, Patience was transferred to ALCC.

- 5.4 On the morning of 9 November 2022, Patience was transferred from ALCC to SWCC where she was placed in a holding cell with EC. Although Patience and Ms EC knew each other from primary school, this was the first occasion when they had seen each other in many years.
- 5.5 At around 9:20am, Ms EC was taken for a body scan which. The CSNSW officer operating the body scan machine did not identify anything unusual. Ms EC was subsequently returned to the holding cell.
- 5.6 At around 9:28am, Patience was also taken for a body scan which did not reveal anything unusual. She was subsequently returned to the holding cell.
- 5.7 Between around 9:37am and 10:40am, Patience and Ms EC remained in the holding cell together apart from an occasion at around 10:28am when Patience used the toilet.
- 5.8 At around 10:40am, Ms EC was taken from the holding cell before returning at 12:04pm.
- 5.9 At around 12:33pm, Ms EC was again taken from the holding cell and did not return.
- 5.10 At around 2:05pm, Patience was transferred to a cell within Block D of Area 2.
- 5.11 At around 2:57pm, AL was placed in the cell with Patience. Ms AL and Patience briefly discussed sleeping arrangements within cell, and Ms AL later saw Patience writing some letters. Ms AL subsequently fell asleep in one of the beds in the cell.
- 5.12 Ms AL later woke to sounds coming from the shower area in the cell and heard a bang which she believed was the sound of Patience falling over. Ms AL asked about Patience's welfare. Patience replied, "*I have a drop in me. I have to get out*".
- 5.13 At around 3:17am on 10 November 2022, two CSNSW officers approached Patience's cell after hearing noises coming from within. The CSNSW officers called through the cell door window to ask if Patience was OK. She replied, "*I'm OK, I'm OK*". The CSNSW officers asked Patience to leave the shower.
- 5.14 Patience struggled to leave the shower and was assisted by Ms AL. Patience was seen to be shaking and a call was made to Justice Health & Forensic Mental Health Network (**Justice Heath**) staff for assistance. A Justice Health nurse attended the cell and with the assistance of the CSNSW officers they attempted to place Patience into a wheelchair. Patience was distressed and unable to sit in the wheelchair. Accordingly, she was placed on the ground outside the cell and a call was made to Triple Zero. Patience observed to be showing seizure-like activity, rolling back and forth on the ground, frothing at the mouth, yelling in pain and not responding verbally.
- 5.15 At around 4:09am, NSW Ambulance (**NSWA**) paramedics arrived on scene and resuscitation efforts were initiated. These efforts were continued with the arrival of a second team of NSWA paramedics and the use of a LUCAS device, intubation and intravenous adrenaline.

5.16 However, despite the resuscitation efforts, Patience could not be revived and was tragically pronounced deceased at 4:59am.

## **6. Post-mortem examination**

6.1 Patience was later taken to Forensic Medicine Sydney where Dr Marna du Plessis, forensic pathologist, performed a post-mortem examination on 16 November 2022. This identified the following relevant findings:

- (a) foreign material present in the vagina consisting of two packages wrapped in plastic and a plastic wrapped package of insulin syringes, with the plastic coverings appearing intact on examination;
- (b) no readily apparent features of chronic venous access suggestive of chronic intravenous drug use; and
- (c) toxicological analysis of preserved femoral blood detected a potentially toxic concentration of amphetamine, an active metabolite of methylamphetamine.

6.2 In the amended post-mortem examination report dated 22 January 2024, Dr du Plessis opined that Patience's cause was methylamphetamine toxicity.

## **7. What issues did the inquest examine?**

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

- (1) Was Patience searched, and were body scans performed of her, in accordance with the relevant provisions of the CSNSW Custodial Operations Policy and Procedures and any Local Operating Procedure on:
  - (a) 7 November 2022;
  - (b) 8 November 2022; and
  - (c) 9 November 2022.
- (2) On 9 November 2022, following the body scan of another inmate in transit with Patience, were appropriate steps taken by CSNSW to mitigate the potential risk of dissemination of any concealed contraband to Patience?
- (3) On 9 November 2022, following the inability to perform a body scan of Patience's cellmate, were appropriate steps taken by CSNSW to mitigate the potential risk of dissemination of any concealed contraband to Patience?

- (4) Is it possible to determine when and how Ms Patience came to acquire the internally concealed contraband identified from investigations performed as part of the post-mortem examination?
- (5) Did CSNSW as at November 2022, and does CSNSW currently, have appropriate policies and procedures in place to:
  - (a) identify concealed contraband, namely illicit drugs, in inmates; and
  - (b) mitigate the potential risk of dissemination of any concealed contraband, namely illicit drugs, amongst inmates?

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

## **8. What was the manner of Patience's death?**

8.1 Whilst the post-mortem examination established the cause of Patience death, it raised a question regarding whether the toxic level of methylamphetamine that was detected was a result of the internally concealed package or self-administration, or both. This question is also relevant to consideration of the issues below.

8.2 Dr du Plessis gave evidence that:

- (a) the level of methylamphetamine detected in Patience's case was "one of the highest" that she had seen in her experience;
- (b) the level of methylamphetamine was in the "higher range" for cases involving self-administration; and
- (c) within the literature, very high concentrations of methylamphetamine had been reported in cases involving intravaginal concealment of methylamphetamine.

8.3 Dr du Plessis gave evidence of the mechanism by which methylamphetamine enters the bloodstream in cases involving intravaginal concealment:

So if methylamphetamine is in the vagina, the vagina is very rich in blood vessels and mucous membranes, so you will have if the methamphetamine makes contact with those mucous membranes, the absorption will go through those surfaces and it will go directly into the blood vessels, and then into the systemic circulation. Once it's in the systemic circulation it will be part of the femoral blood.

8.4 Dr du Plessis also explained that the longer a quantity of methylamphetamine is concealed intravaginally, the longer the period of absorption leading to higher methylamphetamine concentrations.

8.5 Ultimately, Dr du Plessis gave evidence that whilst she considered it likely that the level of methylamphetamine detected in Patience's case was a result of the internally concealed package, she could not exclude the possibility self-administration contributed to the level of methylamphetamine detected. In this regard, Dr du Plessis noted that if a small insulin syringe had been used to administer methylamphetamine, it is possible that a punctate mark or venous access would not be detected during the post-mortem examination. Dr du Plessis also explained that self-administration alone may not account for the concentration of methylamphetamine detected in Patience's case.

8.6 **Conclusions:** The toxic level of methylamphetamine detected from post-mortem analysis most likely resulted from contamination from internal concealment of the package of methylamphetamine. Whilst the possibility of self-administration of methylamphetamine cannot be entirely excluded, if this had occurred it is unlikely that it alone would have accounted for the concentration of methylamphetamine seen post-mortem. However, if self-administration had occurred it is possible that this, combined with contamination from the internally concealed package, could explain the concentration of methylamphetamine detected in Patience's case.

## 9. Was Patience searched in accordance with CSNSW policies and protocols

9.1 Examination of this issue involves consideration of three distinct periods of time whilst Patience was in lawful custody.

### *7 November 2022*

9.2 On 7 November 2022, First-Class Correctional Officer (**FCCO**) Jeffrey Stiff was working at the Wollongong CESU. His duties involved receiving inmates newly entered into lawful custody, searching these inmates, and completing a New Inmate Lodgement & Special Instruction Sheet (**New Inmate Sheet**) for each inmate.

9.3 FCCO Stiff asked Patience to empty her pockets, take off her cardigan and remove her shoes. He searched the cardigan, checked inside Patience's mouth and asked her to shake her hair and run her fingers through her hair. No contraband was identified from this process.

9.4 CSNSW Custodial Operations Policy and Procedures (**COPP**) 1.1 deals with reception procedures. Section 2.1 of COPP 1.1 relevantly provides:

On entering a police/court cell and correctional centre, all inmates must be body scanned (where practicable) or strip-searched and subject to scanning with a handheld metal detector for prohibited articles and contraband.

9.5 COPP 17.1 provides specifically for the searching of inmates and notes that the "*effective searching of inmates is important in maintaining security, good order and discipline*".

9.6 Section 4.1 of COPP 17.1 provides that where body scanning is not available or practicable, a strip search is undertaken and that inmates will be routinely strip-searched under the following circumstances:

- (a) on arrival from court;
- (b) on arrival from other correctional centres;
- (c) on arrival from any other place where they may have come into contact with the public or inmates another correctional centre; and
- (d) after a contact visit.

- 9.7 Section 1.1 of COPP 17.1 also provides that an “*inmate must not be strip-searched or body scanned by or in the presence of a person of the opposite sex, except in exceptional circumstances or in the case of an emergency*”.
- 9.8 FCCO Stiff gave evidence that on 7 November 2022, there were 10 female inmates and no male inmates newly received into custody which he described as “*highly unusual*”. FCCO Stiff also gave evidence that Patience could not be strip-searched as the only female CSNSW officer that was working (FCCO Leanne Oates) was occupied with duties in the District Court.
- 9.9 FCCO Stiff gave evidence that when an inmate cannot be strip-searched, it is usual practice to write their name on a whiteboard and indicate that a strip search has not been performed. FCCO Stiff gave evidence that he simply forgot to follow this procedure on 7 November 2022 regarding Patience.
- 9.10 FCCO Stiff gave evidence that he thought that once FCCO Oates had completed her duties in the District Court in the afternoon, she would attend to perform any strip searches of female inmates. Mr Stiff explained that even though CSNSW policies required two female CSNSW officers to search a female inmate, due to a shortage of female CSNSW officers it was usual practice for one female CSNSW officer to perform the search whilst a male CSNSW officer waited “*around the corner*”. FCCO Stiff gave evidence that staff had to “*cut corners*” to “*make it happen because that’s just what you do*”. However, FCCO Stiff gave evidence that because on 7 November 2022 he did not write Patience’s name on the whiteboard, FCCO Oates may have been unaware that Patience had not been searched.
- 9.11 The New Inmate Sheet contains a section headed “*Strip searched by CESU Staff?*” with two tick boxes, one marked, “*Yes*” and the other marked, “*No. If no, why?*”. FCCO Stiff gave evidence that as at November 2022, if a female inmate could not be strip-searched because no female CSNSW officer was available to perform the search, it was his usual procedure to tick the “*No*” box and write an explanation on the New Inmate Sheet to the effect of, “*Due to no female staff*”. FCCO Stiff gave evidence that on 7 November 2022, he did not tick any box on Patience’s New Inmate Sheet regarding whether she had been searched or not because he “*just never got back around to it*”.
- 9.12 FCCO Stiff gave evidence that ordinarily a handover would occur between the Senior Correctional Officer (SCO) of the day shift and the SCO of the night shift. During this handover, the SCOs would speak about topics such as whether any inmate had been recorded on the whiteboard as having not been searched. FCCO Stiff gave evidence that he could not recall advising the SCO on 7 November 2022 whether or not Patience had been strip-searched.

9.13 Darren Williams was the SCO at Wollongong CESU on 7 November 2022. He gave evidence that he could not recall whether he was told that Patience had not been strip searched that day. SCO Williams also gave evidence that it was not part of his role to review whether a New Lodgement Sheet had been correctly completed because he trusted “*staff to do their job*”. When asked what could be done to minimise the possibility of important information not being recorded, SCO Williams gave this evidence:

To tell you the truth, I don't know, particularly - had the senior keep on checking over everyone's work, micromanage - nothing would ever get done. You've got - they're employed by Corrective Services, they've been trained. You do have human error, which is in everything. You're going to have human error. I don't believe there's any 100% thing that can be done to stop it.

9.14 SCO Williams gave evidence that if there were insufficient numbers of female CSNSW officers rostered for a particular shift, a request could be made for additional female CSNSW officers to be provided (subject to approval from management) or for a casual CSNSW officer to be made available. SCO Williams acknowledged the description given by FCCO Stiff in using only one female CSNSW to search a female inmate as “*cutting corners*” but indicated that it was preferable to have one female CSNSW officer searching a female inmate rather than no search being performed at all.

9.15 FCCO Stiff gave evidence that the New Inmate Sheet is the only means by which it can be communicated to CSNSW officers transporting inmates between correctional centres and staff at correctional centres themselves that an inmate has not been strip-searched by CESU staff. FCCO Stiff confirmed that as at 7 November 2022 and currently, it is not possible to place a notification or an alert on the electronic CSNSW Offender Integrated Management System (OIMS) regarding whether an inmate has been searched or not.

9.16 FCCO Stiff gave evidence that having such an alert or notification system would be “*helpful*”. However, SCO Williams expressed doubt about whether such a system would be helpful. This is because existing CSNSW systems relies upon the New Lodgement Sheet and other documentation relevant to an inmate following that inmate upon transfer. SCO Williams explained that a receiving correctional facility checks the documentation accompanying an inmate and would not look up information on an electronic system.

9.17 Instead, SCO Williams gave evidence that one method to ensure that information regarding whether an inmate has been searched is not overlooked is to simply make the relevant information on the New Lodgement Sheet more readily identifiable. He explained:

Right where it is, probably make that a bit bigger. In hindsight, probably put more emphasis on that to make it a bit bolder in writing, so they can actually look at it, do it red, whatever, just so you can see "No, they haven't been searched," or "Yes, they have".

9.18 SCO Jasdeep Sawhney, who was Officer in Charge at ALCC upon Patience’s arrival on 8 November 2022 gave similar evidence to this effect:

I think the basic thing I would say is that the lodgement form being done, and like the other officer pointed out, put in bold red whether searched or not searched, will make it more prominent, instead of having a little box there. Make it more prominent on the lodgement form so it stands out more.

- 9.19 Malcolm Brown, CSNSW Manager of Security, State-wide Operations, gave evidence that whilst a change from a paper-based system to a more electronically based system would theoretically be possible the practical implications of such a change is unknown. In other words, Mr Brown explained that such a change would rely upon the availability of electronic equipment as well as the capacity of staff to perform data entry functions. He gave evidence that this is something that CSNSW would “*have to look at*”. In addition, Mr Brown gave evidence that the existing requirements of the COPP for inmates to be searched at “*every touch point*” likely reduce the need for an electronic based alert system:

[W]ith the alerts, it’s probably probably, you know, we have alerts for a number of things and that’s probably not one I would suggest that would be for the transfer of an individual which would be, as I say, relying on the policy which is every touch point, you should be searched.

[...]

A search should be undertaken whether it’s from court to Amber Laurel or Amber Laurel to Surry Hills or back in Silverwater Women’s. They should be searched on each occasion during that process.

- 9.20 **Conclusions:** The provisions of the COPP required that Patience be strip searched after being received by the Wollongong CESU and that such a search be performed by two female CSNSW officers. Only one female CSNSW officer was working at Wollongong Court on 7 November 2022 and she was unavailable to perform a search when Patience was first processed. In these circumstances and in accordance with local procedures, the fact that Patience had not been searched should have been recorded on a whiteboard. FCCO Stiff frankly acknowledged that he did not do so because of an oversight.

- 9.21 This had the consequence of FCCO Oates being unaware, and not being informed, that Patience had not been searched. If FCCO Oates had been aware it would have been possible for Patience to be searched, albeit by one female CSNSW officer instead of two, as required by the COPP. However, there is insufficient evidence as to whether Patience had in her possession or was concealing any contraband in the form of illicit drugs at the time. Therefore, whilst on 7 November 2022, Patience was not searched in accordance with CSNSW policies and procedures, it is not possible to conclude whether such a search would have detected any illicit drug in Patience’s possession or being carried by her.

- 9.22 The fact that Patience had not been searched was not recorded on her New Lodgement Sheet which accompanied her to ALCC. FCCO Stiff again frankly acknowledged that he omitted to do so. As discussed below, this omission meant that absence of any information about whether Patience had been searched or not was not recognised at ALCC. This in turn had the consequence that Patience was also not searched at ALCC.

9.23 The evidence established that, like any process that relies upon the documentation of information in a busy environment, completion of the New Lodgement Sheet is prone to human error or omission. The possibility of implementing an electronic alert or notification system was explored with several witnesses during the inquest. Different opinions were expressed regarding the utility of such a system given that the COPP already provides for inmates to be searched upon reception into custody or when transferred between correctional centres.

9.24 Further, within the limited scope of the inquest, it was not possible to explore the feasibility of transitioning from a paper-based system to an electronic based system, the practical considerations involved in such a transition, and whether such a transition might have unintended consequences on other facets of the respective systems. Instead, the evidence indicated that one way of addressing the propensity for human error or omission is to simply emphasise those parts of the paper-based system which are of importance. Therefore, it is desirable to make the following recommendation.

9.25 **Recommendation:** I recommend to the Commissioner of Corrective Services NSW that consideration be given to ways in which information required by the New Inmate Lodgement & Special Instruction Sheet relating to whether an inmate has been searched can be emphasised or highlighted to ensure that it is properly and accurately completed.

### ***8 November 2022***

9.26 SCO Sawhney gave evidence that he could not recall whether on 8 November 2022 he was the officer who received Patience into custody at ALCC. SCO Sawhney gave evidence that if he had been the receiving officer and if he had seen that the New Lodgement Sheet had not been ticked to indicate whether Patience had been searched, he would enquire of the transporting officers whether Patience had in fact been searched or not.

9.27 SCO Sawhney gave evidence that after arriving at ALCC, Patience was placed in a cell with another female inmate who was with her in the transport vehicle.

9.28 Section 3.1 of COPP 1.1 relevantly provides the following:

The reasons for failing to complete the full [inmate identification and observation form] at the police/court cell location should be noted on the form to alert the receiving correctional centre.

If an inmate is received at a correctional centre directly from police, or if the [inmate identification and observation form] is incomplete, the procedures normally undertaken at the police or court cells must be completed by the receiving officers at the correctional centre.

9.29 **Conclusions:** As Patience had not been searched on 7 November 2022, the COPP provided that she should have been searched upon arrival at ALCC the following day. However, this did not occur. As discussed above, ALCC was not provided with required information about whether Patience had been searched at Wollongong CESU. The absence of this information was not recognised meaning that no enquiry was made about whether a search had been performed or not.

9.30 The absence of a search on 8 November 2022 was therefore contrary to the provisions of the COPP. However, the evidence again does not allow for any conclusion to be reached as to whether a search of Patience on 8 November 2022 would have detected any contraband been carried by Patience or in her possession.

### ***9 November 2022***

9.31 On 9 November 2022, FCCO Dane O'Toole was the Acting SCO at SWCC. She was asked to assist in reception with 11 new inmates including Patience. After performing a non-invasive search of Patience, FCCO O'Toole told Patience that she would be put through a body scanner. FCCO O'Toole subsequently conducted a body scan of Patience and did not identify any abnormality. FCCO O'Toole gave evidence that prior to the body scan she had not been provided with the New Lodgement Sheet or any information regarding whether Patience had been strip-searched or not.

9.32 FCCO O'Toole also conducted a body scan of Ms EC on 9 November 2022. FCCO O'Toole gave evidence that after reviewing the body scan images she conducted a further lateral body scan due to concerns about a potential abnormality. FCCO O'Toole gave evidence that after performing the lateral scan, she believed that the apparent abnormality was faecal matter due to "*how high up the actual potential abnormality was located and it appeared that [Ms EC] had quite a substantive amount of faecal matter within her bowels*".

9.33 FCCO O'Toole gave evidence that she had completed body scan training in July 2022 and had operated the body scanning machine "*maybe 10 times*" between July 2022 and November 2022. FCCO O'Toole also gave evidence that as at 9 November 2022, she was relatively inexperienced and not "*super confident*" in using the body scan machine and interpreting any images.

9.34 However, FCCO O'Toole gave evidence that since November 2022, she has performed over 100 body scans and feels more able to confidently interpret a body scan image to identify any potential contraband. In this regard, FCCO O'Toole also gave evidence about what she considers to be most useful in assisting a CSNSW officer to interpret body scan images:

I believe that actually conducting the body scans and having somebody who's now more experienced [...] to have somebody who is more experienced kind of assisting younger staff that are doing it now is more beneficial. [...] To actually be able to read a body scanner and be confident with it, to have somebody else next to you saying, yes, you've picked that up quite well, good job, that's what we're looking for - is more beneficial, I believe, anyway.

9.35 Senior Assistant Superintendent (**SAS**) David Walker is the CSNSW Radiation Safety Manager, Body Scanning Operations Unit. On 9 November 2022, whilst performing the core functions of his role, SAS Walker reviewed the x-ray images from Patience's body scan. On 10 November 2022, at the request of the former Commissioner of CSNSW following Patience's death, SAS Walker reviewed the x-ray images from Patience's body scan a second time. On each occasion, SAS Walker formed the view that there was nothing in the images that gave rise to a suspicion that Patience was in possession of any contraband including by way of internal concealment.

9.36 SAS Walker also reviewed the images from Ms EC's body scan on 9 November 2022 and expressed these views:

(a) It is "*highly likely that contraband was secreted internally within Ms EC's vaginal cavity*" due to "*the appearance of an atypical horizontal shape in the lower pelvic region that is of similar shape and density to items in circumstances where contraband have previously been detected*"; and

(b) Ms EC is a lateral scan "*assists in ruling out the existence of contraband outside of the body (for example, tucked inside a underwear) and therefore increases the likelihood that the atypical horizontal shape is from internally secreted item/s*" [original emphasis].

9.37 SAS Walker described interpreting images from a body scan to be a "*perishable skill*", meaning that if a CSNSW officer is not interpreting images regularly their competency diminishes. SAS Walker explained that CSNSW officers can be rotated out of reception areas where body scanning is performed for periods of up to 6 or 12 months before returning. In this regard, SAS Walker gave evidence that whilst CSNSW does not provide formal refresher training for operators of body scanning machines, CSNSW officers may develop their skills by accessing online resources to review previously provided training material, consulting with colleagues, and asking questions of members of the Body Scanning Operations Unit who regularly visit correctional centres.

9.38 Mr Brown similarly gave evidence that body scanning e-learning modules and webinars are available at any time for CSNSW officers to review. When asked about ways to support less experienced operators of body scanning machines to identify subtle findings, Mr Brown expressed his belief that CSNSW "*can do probably a bit more in relation to that space*". Mr Brown gave evidence that it is possible to use emails to alert and educate operators of body scan machines about common themes to improve detection of anomalies or suspicious features. In addition, Mr Brown gave evidence that CSNSW would "*continue to look at how we can improve*" communicating the availability of online resources to operators of body scan machines.

9.39 **Conclusions:** On 9 November 2022, a body scan of Patience was performed in accordance with the COPP. This scan did not detect any abnormality or features suggesting that any contraband was being concealed internally, and there is no evidence to suggest that the body scan images were not interpreted correctly.

9.40 However, images from a body scan of Ms EC performed on the same day were initially not interpreted correctly. Instead, an apparent anomaly was interpreted as being faecal matter. It was only upon subsequent review by SAS Walker that the anomaly was identified as highly likely to be internally concealed contraband.

9.41 The effect of the misinterpretation of the images from Ms EC's body scan was that instead of being placed in a dry cell, Ms EC was returned to the common holding cell with Patience. There is insufficient evidence to conclude whether, during the time that Patience and Ms EC were in the holding cell together, any internally concealed contraband was passed from Ms EC to Patience although opportunities existed for this to occur.

9.42 The evidence established that misinterpretation of the images from Ms EC's body scan was a result of FCCO O'Toole's inexperience. At that time, FCCO O'Toole had operated a body scanning machine on less than 10 occasions. The evidence also established that the competency of body scanning machine operators can be maintained and improved in several ways: through regular operation of the machines, accessing online training resources, and education regarding issues relevant to body scanning. Whilst the evidence from Mr Brown indicates that such issues are being considered, it is desirable to make the following recommendation given that almost 4 years has passed since the events surrounding Patience's death without the issues progressing further.

9.43 **Recommendation:** I recommend to the Commissioner of Corrective Services NSW that consideration be given to the ways in which support can be provided to both less experienced operators of body scanning machines to improve detection skills, and more experienced operators to prevent degradation of existing detection skills. This should involve specific consideration being given to how best to communicate the availability of electronic and online resources, and any common themes, issues or trends, relating to body scanning.

## 10. When and how did Patience come to acquire the internally concealed contraband?

10.1 The available evidence indicates that there were several opportunities for Patience to have acquired the internally concealed packages that were identified during the post-mortem examination.

10.2 First, following Patience's death, her cell was searched and NSWPF officers located a letter written by Patience addressed to her most recent partner. In the letter, Patience wrote:

I thought I'd get bail in the morning after I handed myself in. I packed just in case but still wasn't prepared lol.

[...]

As I said before I packed just in case, but I didn't expect this, especially that it took 4 days to even get me on the truck to mulawa.

10.3 Detective Senior Constable Cameron Rollo, the NSWPF Officer-in-Charge, gave evidence that in his view the above references to "packed" could be interpreted as referring to internal concealment.

10.4 Second, it is evident that Patience was not strip searched on 7 November 2022 at Wollongong CESU or on 8 November 2022 at ALCC. It is also evident that at both of these locations, Patience was kept in a common cell with one or more inmates. Opportunities therefore existed for another inmate to pass contraband to Patience which was subsequently internally concealed.

10.5 Third, Ms AL gave evidence that she, Patience and Ms AL were all on the same CSNSW truck whilst being transported from Wollongong CESU to ALCC. SAS Walker gave evidence that there is video and audio recording equipment installed inside these trucks, and that recorded audio and video footage can be monitored live by the CESU and truck drivers.

- 10.6 However, SAS Walker also gave evidence that the CESU would not be “*realistically monitoring it in real time*”, that the footage would only be reviewed in the event of an incident inside the truck (such as an alleged assault), and that the footage is erased once the storage capacity of the recording equipment is reached. Therefore, there were opportunities whilst Patience was being transported to both ALCC and SWCC for contraband to have been given to her.
- 10.7 Fourth, between around 9:37am and 10:40am, and again between 12:04pm and 12:33pm, Patience and Ms EC were in the holding together at SWCC on 9 November 2022. These periods of time occurred after Ms EC underwent body scanning but before the x-ray images were correctly interpreted to identify an internally concealed item. Again, contraband could have been passed to Patience at these times.
- 10.8 Fifth, SAS Walker gave evidence that due to a data synchronisation issue, Ms AL did not undergo body scanning on 9 November 2022 prior to being placed in a cell with Patience at around 2:57pm. There was a similar opportunity from this point forward for contraband to have been given to Patience.

10.9 **Conclusions:** The evidence indicates that several opportunities existed for Patience to bring the internally concealed contraband into custody herself on 7 November 2022, and for contraband to have been given to her by another person at any time between 7 November 2022 and 9 November 2022. A review of CCTV footage that is available has not been able to identify when and how contraband might have been given to Patience although it is acknowledged that the CCTV footage does not include much of the period after Patience entered custody, and that some of the CCTV footage from the transport trucks was not available to review. Ultimately, the available evidence does not allow for any conclusion to be reached as to when and how Patience either introduced into custody, or acquired, the contraband that was later found to be internally concealed.

## 11. Were appropriate steps taken after the body scan of Ms EC was performed?

- 11.1 FCCO O’Toole gave evidence that if she had formed the view on 9 November 2022 that the body scan of Ms EC revealed an abnormality, Ms EC would have been placed in a dry cell, an incident reporting module would be completed, the CSNSW Immediate Action Team (IAT) would be notified, Justice Health & Forensic Mental Health Network (**Justice Health**) would be notified, and Ms EC would be kept in the dry cell until a repeat body scan was performed by the IAT.
- 11.2 FCCO O’Toole’s evidence is consistent with COPP 17.4 which deals with the internal secretion of contraband. Section 1.1 of COPP 17.4 relevantly provides:

If an inmate is suspected of internally secreting contraband, they should be clinically assessed to determine possible threats to their health. An inmate suspected of internally secreting contraband may be held in a dry cell pending a clinical assessment by [Justice Health].

Once assessed, [Justice Health] must issue a *Health Problem Notification Form* (HPNF) recommending how the inmate is to be managed.

Prior to placing an inmate in a dry cell, staff must consult with the Manager of Security (MOS), Functional Manager (FM) or Officer In Charge (OIC) to determine if there are any reasons why the

inmate should not be placed into a dry cell e.g. if the inmate is subject to a current Risk Intervention Team (RIT) management plan, or has a two-out cell placement.

11.3 **Conclusions:** FCCO O’Toole correctly recognised the steps that were required to be taken if she formed a suspicion that Ms EC’s scan revealed internally concealed contraband. These steps are in accordance with COPP 17.4 and appropriately provide for the management of the health and welfare of the inmate concerned as well as management of the inmate from a security perspective. There is no reason to doubt that these steps would have been taken if FCCO O’Toole had correctly interpreted the images of Ms EC’s body scan. However, they were not in fact taken on 9 November 2022 due to misinterpretation of the images.

**12. Were appropriate steps taken after a body scan of Ms AL could not be performed?**

12.1 SAS Walker gave evidence Ms AL’s Master Index Number (**MIN**) was supplicated in a Visitor Identification Number (**VIN**). This created a conflict meaning that Ms AL’s details could not be enrolled in the body scan system on 9 November 2022 to allow her to be body scanned. SAS Walker gave evidence that although he was notified of the issue within a matter of minutes and accessed the system to remove the obstacle to enrolling Ms AL’s details, an inability to synchronise this data across networked machines prevented Ms AL from undergoing a body scan.

12.2 Section 1.1 of COPP 17.5 relevantly provides:

Where it is assessed that a body scan cannot be undertaken, the person will be subject to alternative security screening practices as authorised in policy (refer to COPP section 17.1 *Searching inmates* and 10.4 *Stop, detain and search of visitors and contractors*).

12.3 SAS Walker gave evidence that as a body scan could not be performed on Ms AL, “*normal strip searching process should apply*”.

12.4 **Conclusions:** On 9 November 2022, a body scan of Ms AL was not performed due to an unexpected technical issue. Appropriate steps were taken to resolve the issue but this could not be completed prior to Ms AL being placed in a cell with Patience. Although COPP 17.5 provided for a strip search to be performed where a body scan cannot be undertaken this would not have identified any internally concealed contraband which could potentially have later be passed to Patience. Therefore, within the limitations that existed on 9 November 2022, appropriate steps were taken to search Ms AL and prevent dissemination of any possible contraband.

**13. Does CSNSW have appropriate procedures in place to detect, and mitigate the risk of dissemination of, illicit drugs?**

13.1 Mr Brown gave evidence of the following measures undertaken by CSNSW, apart from the searching of inmates which has already been described above, to prevent the introduction and dissemination of illicit drugs in correctional centres:

- (a) conducting systematic searches of correctional centres including random daily searches, monthly targeted searches, conducting searches outside of core hours, and inspecting infrastructure and assets weekly;
- (b) screening and searching entrants at the central access point of correctional centres;
- (c) the use of drug detection dogs and K9 teams;
- (d) intelligence gathering to identify “hot spots” where there is an increase in contraband; and
- (e) maintenance of a database to track search activities to identify contraband trends and types to assist targeting particular areas within correctional centres.

13.2 **Conclusions:** The evidence established that where the steps provided for by the COPP regarding the searching of inmates are correctly followed, appropriate procedures exist within CSNSW to detect, and reduce the risk of dissemination, of illicit drugs. In addition, through the use of random and targeted searches, drug detection dogs and intelligence gathering CSNSW appropriately applies other methods and resources to prevent the introduction of illicit drugs into correctional centres.

## 14. Findings

- 14.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Ms Karissa Mackay, Coronial Advocate Assisting the Coroner for the assistance provided throughout the coronial investigation and inquest, and the sensitivity shown to Patience’s family.
- 14.2 I also thank Detective Senior Constable Rollo for his role in the NSWPF investigation and for compiling the initial brief of evidence.
- 14.3 The findings I make under section 81(1) of the Act are:

### *Identity*

The person who died was Patience Kuzmins.

### *Date of death*

Patience died on 10 November 2022.

### *Place of death*

Patience died at Silverwater Women’s Correctional Centre, Silverwater NSW 2128.

### *Cause of death*

The cause of Patience’s death was methylamphetamine toxicity.

### *Manner of death*

It is most likely that the toxic levels of methylamphetamine detected following analysis of Patience’s post-mortem blood sample was the result of contamination from a package of

methylamphetamine that had been concealed internally within Patience's vaginal cavity. The available evidence does not allow for a conclusion to be reached as to whether Patience introduced the package of methylamphetamine into lawful custody herself, or whether it was given to her after she entered custody. After entering custody, Patience was not searched in accordance with the Custodial Operations Policies and Procedures on 7 and 8 November 2022. In addition, the body scan image of a fellow inmate who shared a cell with Patience on 9 November 2022 was not correctly interpreted for the presence of internally concealed contraband. However, it is not possible to conclude whether these omissions and misinterpretation allowed for the internal concealment of the package of methylamphetamine by Patience.

14.4 On behalf of the Coroners Court of New South Wales, I offer my sincere and respectful condolences to Mr Patience's family, loved ones and friends for their tragic and devastating loss.

14.5 I close this inquest.

Judge Derek Lee  
Deputy State Coroner  
19 June 2026

## Inquest into the death of Patience Kuzmins

### Annexure A: Non-publication orders

1. Pursuant to section 74(1)(b) of the *Coroners Act 2009* (**the Act**), the following material contained within the brief of evidence tendered in the proceedings is not to be published:
  - (a) the names, Master Index Numbers, date of birth, and other personal information, including images, of any persons in the custody of Corrective Services New South Wales (**CSNSW**), other than Patience Kuzmins (aka Cuzmins).
  - (b) The Visitor Index Numbers of any visitors to Silverwater Women's Correctional Centre (**SWCC**).
  - (c) The names, addresses, phone numbers, date of birth, Visitor Index Numbers and other personal information that identifies or might identify any family member, friend or person who visited Patience Kuzmins (aka Cuzmins) while in custody (other than legal representatives or visitors acting in a professional capacity).
  - (d) The names, identifying information, and contact details of the relatives of any persons in the custody of CSNSW other than Patience Kuzmins (aka Cuzmins).
  - (e) The names and identifying information of any victims of Patience Kuzmins (aka Cuzmins).
  - (f) The direct contact details, including telephone numbers and email addresses, employee identification codes and Offender Integrated Management System (**OIMS**) usernames and staff identification numbers of CSNSW employees and offices that are not publicly available.
  - (g) The shift times of correctional officers.
  - (h) Body scan imaging of Patience Kuzmins (aka Cuzmins) and of any other person in the custody of CSNSW.
  - (i) Photographs of areas within SWCC.
  - (j) CSNSW body-worn camera footage, including any still images from that footage.
  - (k) CSNSW Closed Circuit Television (**CCTV**) footage, including footage from within any correctional centre or vehicle escort, and any stills from that footage.
  - (l) Portions of the following documents identified in the appended Schedule:

- i. Statement of Jeffrey Stiff dated 10 May 2024 and annexures;
- ii. Statement of Govind Rai dated 2 February 2024 and annexures;
- iii. Statement of David Walker dated 7 May 2024 and annexures;
- iv. Statement of Sunil Sareen dated 15 April 2024 and annexures:
- v. Statement of Adam Riddell dated 11 September 2025 and annexures; and
- vi. Statement of Kenneth Pese dated 9 September 2025 and annexures.

(m) Portions of the following sections of the Custodial Operations Policy and Procedure (**COPP**) identified in the appended Schedule:

- i. COPP 1.1 Reception Procedures, Version 1.9;
- ii. COPP 13.1 Serious Incident Reporting, Version 1.2;
- iii. COPP 13.2 Medical emergencies, Version 1.2;
- iv. COPP 13.3 Death in Custody, Version 1.6;
- v. COPP 13.9, Video evidence, Version 2.1;
- vi. COPP 13.11, Discovery and disposal of drugs (under review), Version 1.0;
- vii. COPP 13.12, Body-worn video, Version 1.0; and
- viii. COPP 17.5, Body scanning, Versions 1.2 and 1.9.

(n) The entire contents of the following Local Operating Procedures (**LOP**):

- i. LOP 2019/06 – Inmate Identification and Observation Form (IIO); and
- ii. LOP 2019/015 – Searching offenders received from NSW Police.

(o) The entirety of the following documents:

- i. The daily schedule of Amber Laurel Correctional Centre dated 8 November 2022.
- ii. The daily schedule of Silverwater Women’s Correctional Centre dated 10 November 2022.
- iii. Inmate Accommodation Journal dated 9 November 2022.
- iv. Control Room B Watch Journals dated 10 November 2022.

2. Pursuant to section 65(4) of the Act, a notation is to be placed on the Court file that if an application is made under section 65(2) of the Act for access to CSNSW documents on the Court file, that material shall not be provided until the Commissioner of CSNSW has had an opportunity to make submissions in respect of that application.

Judge Derek Lee  
Deputy State Coroner  
19 June 2026

### Schedule to Non-publication order

Order No.	BOE Vol & Item No.	Document	Relevant portion of document
1(l)	Vol 2 – 5	Statement of Jeffrey Stiff dated 10 May 2024	Entirety of Annexure marked JS-2
1(l)	Vol 2 – 6	Statement of Govind Rai	Entirety of Annexures marked GR-7, GR-8, and GR-9
1(l)	Vol 2 – 10	Statement of David Walker dated 7 May 2024	Entirety of Annexures marked DW-2, DW-3, DW-4, DW-7, DW-8, DW-9, and DW-12
1(l)	Vol 2 - 12	Statement of Sunil Sareen dated 15 April 2024	Entirety of Annexure marked SS-2
1(l)	Vol 2 – 18	Statement of Adam Riddell dated 11 September 2025	Entirety of Annexure marked AR-10
1(l)	Vol 2 – 20	Statement of Kenneth Pese dated 9 September 2025	Entirety of paragraphs numbered 5, 6, 7, 8 and 9  Entirety of Annexure marked KP-2
1(m)	Vol 3 – 7, p. 221-259	COPP 1.1 Reception Procedures, Version 1.10	At [3.1] on page 8, the contact email At [3.2] on page 9, the contact email within the table in the second column titled ‘Procedure’
1(m)	Vol 2 – 18, p. 494 – 532 Vol 2 – 9, 205 – 243 Vol 2 – 18 p. 494 – 532	COPP 1.1 Reception Procedures, Version 1.09	At [3.1] on page 8, the contact email At [3.2] on page 9, the contact email within the table in the second column titled ‘Procedure’
1(m)	Vol 3 – 7, p. 284-295 Vol 2 – 6, p. 68 – 79	COPP 13.1 Serious Incident Reporting, Version 1.2	At [2.5] on page 5, the contact numbers in the first and third paragraphs At [2.6] on page 6, the email address in the second paragraph At [3.1] on page 7, the contact number in the second paragraph At [4.1] on page 9, the email address in the second paragraph
1(m)	Vol 3 – 7, p. 297 – 310	COPP 13.2 Medical emergencies., Version 1.2	At [2.5] on page 7, the contact email At [2.6] on page 8, the contact email

	Vol 2 – 8, p. 41 – 55  Vol 2 – 7, p. 151 – 165		At [2.9] on page 10, the 24-hour phone number and contact email  At [2.10] on page 10, the contact email
1(m)	Vol 3 – 7, p. 311-327	COPP 13.3 Death in Custody, Version 1.6	At [3.10] on page 9, the first contact email  At [6.1] on page 12, the contact number
1(m)	Vol 2 – 6, p. 122 – 142.	COPP 13.9 Video evidence, Version 2.1	At [4.6] on page 11, the contact email  At [4.7] on page 12, the contact email  At [5.4] on page 16, the contact email
1(m)	Vol 2 – 18 p. 533 – 538	COPP 13.11 Discovery and disposal of drugs (under review), Version 1.0	Email address on page 1
1(m)	Vol 2 – 6 p. 80 – 92.  Vol 2 – 7 p. 166 – 178	COPP 13.12 Body-worn video, Version 1.0	At [2.4] on page 6, the contact email
1(m)	Vol 2 – 10 p. 302 – 327  Vol 2 – 18 p. 439 – 464	COPP 17.5 Body scanning, Version 1.2	At [1.5] on page 7, the contact email  At [1.8] on page 8, the contact email  At [1.9] on page 9, the contact email contained in the table titled ‘Procedure’  At [4.3] on page 12, the contact email contained in the table titled ‘Procedure’  At [6.2] on page 17, the contact email beneath the table  At [8.3] on page 20, the contact email
1(m)	Vol 2 – 19 p. 645 – 669  Vol 2 – 16 p. 358 – 382	COPP 17.5 Body scanning, Version 1.9	At [1.5] on page 7, the contact email  At [1.8] on page 8, the contact email  At [1.9] on page 9, the contact email contained in the table titled ‘Procedure’  At [4.3] on page 12, the contact email contained in the table titled ‘Procedure’  At [6.2] on page 17, the contact email beneath the table  At [8.3] on page 20, the contact email