CITATION: *Inquest into the death of Glen Dooley* [2024] NTLC 6

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0253/2022
DELIVERED ON:	12 June 2024
DELIVERED AT:	Darwin
HEARING DATE(s):	16 – 18 January2024
FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death in custody – adequacy of medical care – adequacy of NT Health and NT Corrections policy and procedures – ECG management – PCIS recall management – Medical Housing Unit – prisoner health communications – Aboriginal employees – health information in IRNA and SCATE records – completeness and timeliness of investigations**

REPRESENTATION:

Counsel Assisting:	Sandra Wendlandt
Correctional Services:	Taylah Cramp
Health:	Tom Hutton

Judgment category classification: A
Judgement ID number: [2024] NTLC 6
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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0253/2022

In the matter of an Inquest into the death of

GLEN DOOLEY

ON: 22 October 2022
AT: Royal Darwin Hospital

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Mr Dooley was a beloved son, brother, uncle and father who tragically died at the age of 37 in circumstances that were avoidable. He passed away on 22 October 2022 in the Royal Darwin Hospital surrounded by his family. Members of his family attended court and participated in his inquest including: niece Sherese Dooley, nephew Bartholomas Dooley, nephew Robert Williri, mother Lily Dooley, son Jake Dooley, and the mother of his children Davina Jentian. Additional family from Manyallaluk attended via AVL from Katherine Local Court. Some family travelled in from Jabiru. They all wanted to better understand what happened to Mr Dooley. I extend my condolences to Mr Dooley's family for their sad loss.

2. Mr Dooley was born on 23 November 1984 at the Katherine Hospital. He was a Mayali man and spent most of his life in Manyallaluk on Jawoyn country, growing up with his family who are custodians of the land. Manyallaluk lies approximately one hundred kilometres north east of Katherine and has a population of roughly one hundred people. He was raised by his mother, Lily, and was the youngest of 6 children. Except for one sister, his siblings have all passed away. As he was the last male elder in the Dooley family, his family have lost a person who played a critical role in ceremonies in the community. With Ms Jentian, Mr Dooley had two sons, Jake and Patrick, and he was stepfather to Jodena.

3. As a child he attended school in Barunga and when he was little enjoyed playing with tin trucks. As an adult he loved hunting and fishing and he was known to be a hard worker. He was part of the Community Development Program and was handy at fixing things. He was also artistic and painted on canvas and buffalo skulls. One of his painted buffalo skulls is on display in the Manyallaluk School.

4. Mr Dooley had been in a relationship with Ms Jentian for many years but that relationship was marred by terrible violence he inflicted on her. He had been sentenced to numerous terms of imprisonment in his adult life, and spent almost seven years in custody between 2004 and 2022. It was violence that caused the relationship to end, and it was the reason for his final period of incarceration in 2022. Mr Dooley was serving a term of imprisonment imposed for an aggravated assault against Ms Jentian at time of his passing. As Mr Dooley was in custody at the time of his passing, an inquest was mandatory.[1]

5. Mr Dooley was admitted to hospital from the Darwin Correctional Centre on 26 September 2022. Angiography revealed severe three vessel disease and he was flown to Flinders Medical Centre in Adelaide for surgery. He had stenting administered and received an intra-aortic balloon pump but he did not improve. He was transferred back to the Royal Darwin Hospital on 18 October 2022 where he was made comfortable in palliative care. He died of complications of atherosclerotic heart disease (ischemic heart disease). Dyslipidaemia (elevated cholesterol) was identified as a contributing condition.

6. The Department of Health (NT Health) undertook a Root Cause Analysis reviewing the medical care Mr Dooley had received and also provided an Institutional Response to the inquest. NT Health frankly acknowledged that Mr Dooley did not always receive the medical care to the standard that he was entitled to while in custody.

7. Northern Territory Correctional Services (NT Corrections) similarly conducted an internal review in the form of a Serious Incident Report and provided an Institutional Response to the inquest. Those responses addressed some of the operational issues concerning managing health needs and health crises in a custodial environment.

Mr Dooley's earlier prison health history

8. Mr Dooley's primary health care records indicate that he did not routinely engage with primary health care services outside of prison and the majority of his health care

[1] Section 15(1)(a) *Coroner's Act* (NT)

was provided by the Prison Health team at the Darwin Correctional Centre. This meant that by his choice his health care was intermittent, likely negatively affecting his chronic conditions.

9. On 21 October 2014, Mr Dooley was in custody when he was diagnosed with hyperlipidaemia (high cholesterol). This diagnosis was added as a 'Current Significant Problem' in the electronic medical records system, the Primary Care Information System (PCIS), and Mr Dooley was prescribed Atorvastatin, a drug to treat abnormal lipid levels. He was released from custody a few months later.

10. He returned to custody on 5 October 2015, and told a nurse during his reception health screen that he had not continued to take Atorvastatin in the community. He was again prescribed this medication, educated on its purpose and encouraged to take it. During this period of incarceration he underwent cardiovascular disease risk (CVR) testing and received a low risk score.

11. On 31 March 2016, Mr Dooley was again incarcerated and during the reception health screen his hyperlipidaemia and treatment was discussed. He was not rescripted Atorvastatin likely due to his previously identified low risk.

12. On 26 December 2017, Mr Dooley underwent another CVR assessment which again returned a low risk of cardiovascular disease (7%).

13. On 13 June 2019, during a further period of incarceration, Mr Dooley's CVR was assessed but this time his risk status was found to be high (30%) and he was recalled for review on 17 June 2019.

14. On attending for review, an ECG was performed by a nurse which returned abnormal results. The ECG was uploaded to PCIS without a doctor's signature (as required by policy and standard practice to demonstrate that it had been reviewed). During the inquest cardiologist, Dr Kenneth Hossack, gave evidence that the ECG showed Mr Dooley had suffered from an earlier "minor cardiac infarction" (a mini heart attack).[2]

15. Approximately one hour after his abnormal ECG, Mr Dooley was reviewed by a Rural Medical Practitioner (RMP) who was working at the gaol. Inexplicably, although his high CVR status had prompted the recall for doctor review, neither it, nor his abnormal ECG result, were considered or discussed during the review. As a

[2] T 197 Kenneth Hossack

result no action was taken by the RMP in respect of Mr Dooley's cardiovascular health.

16. According to Dr Hossack, given his high CVR status and his abnormal ECG, on 17 June 2019 Mr Dooley should have been referred to a cardiologist. Further assessment by a cardiologist would have revealed blockages in the arteries of his heart. Medical interventions designed to abate the disease progression would have followed, including: medications to lower his cholesterol and blood pressure, and/or angioplasty (a procedure to open his blocked coronary arteries).[3]

17. NT Health frankly concede that the failures on 17 June 2019, in particular, of the RMP to adequately review and refer Mr Dooley to a cardiologist, were *"serious and significant shortcomings in the care provided to him"*.[4]

Circumstances surrounding his passing

His health from 17 June 2022

18. As noted earlier, Mr Dooley was returned to custody on 17 June 2022 and received a six-month sentence of imprisonment from Katherine Local Court for an aggravated assault on Ms Jentian.

19. On 21 June 2022, he underwent an initial health screen at the Darwin Correctional Centre where his high cardiovascular risk was identified. On 24 June 2022, he was medically cleared to be housed in Sector 11 where he was motivated to work in the laundry.

20. A more detailed health review of his records, previously and perhaps aspirationally named the 'five day' health check but now called the Reception Review, was completed by 5 July 2022. The time frame for its completion is no longer 5 days due to resourcing pressures (NT Health staff have not increased in line with the prison population[5]), though a 5 day turn-around would be preferable. Non-compliance with medication by Mr Dooley was noted and a chest x-ray was ordered in light of his latent tuberculosis status.

21. On 9 August 2022, he attended the prison clinic for review by an RMP concerning a number of outstanding recalls on PCIS. Observations were taken including blood pressure, pulse rate and body mass index, and all were within normal limits. His

[3] T 197 Kenneth Hossack; see also NT Health Institutional Response [283]

[4] NT Health submissions, 15 April 2024, [35]; T 243 Lisa Vermeulen

[5] T 240 Lisa Vermeulen; NT Health Institutional Response [58-62]

chest x-ray and latent tuberculous were discussed and a script was generated for Rifampicin. His high cardiovascular risk was also discussed, as was the plan for him to recommence Atorvastatin, to which he agreed. However, the script for Atorvastatin was seemingly overlooked and the medication was not recommenced as planned. As a result, Mr Dooley did not receive this medication, as he should have done.[6]

22. The failure to recommence Atorvastatin was a shortcoming in the care provided to him. Dr Hossack considered that the medication should have been recommenced in June 2022,[7] when he first arrived into custody. Whether it would have had a positive impact on his condition if recommenced in June is unknown. In any event, I accept that the weight of the evidence establishes that it is unlikely that the error in August contributed to his health deterioration,[8] noting that he had not been taking this medication for some time while living in the community, and the short time between August and his passing.

23. Mr Dooley underwent an annual adult health check by a registered nurse (RN) on 13 September 2022. Observations were taken and were within normal limits. Because of his high cardiovascular risk his chronic health care plan required that an ECG be conducted. It returned an abnormal result. Although the RN was unable to further interpret the ECG, he noticed that Mr Dooley's 2019 ECG was also abnormal. While he did not look to see if the 2019 ECG had been reviewed by a doctor or actioned,[9] he printed the 2019 ECG and took both ECG printouts to the RMP, Dr L, for review.

24. Dr L had little recall of the matter but confirmed it was her hand writing on the new ECG as follows: *"Similar ECG 2019. High CVR no symptoms needs Dr review ? cardiology referral".*[10] Dr L said that there was nothing in the information provided to suggest that Mr Dooley was experiencing a cardiac event or that he needed to be seen urgently that day.[11] However, she considered that Mr Dooley should be reviewed by a doctor to obtain his consent for a referral to a cardiologist and to assess him for any *"unrecognised ongoing cardiac symptoms (eg. chest pain or shortness of breath with exertion), determine what he understood of his risks and offer measures that could reduce those risks".*[12] Further, as she personally did not enter the notes from the ECG into PCIS, she concluded that she had not seen Mr Dooley

[6] NT Health Institutional Response [103]; NT Health submissions, 15 April 2024, [40]

[7] T 200-201 Kenneth Hossack

[8] T 205 Kenneth Hossack

[9] T 87 RN

[10] T 213 Dr L

[11] T 214 Dr L

[12] Additional documents Folio 5, Affidavit of Dr L, 21/12/2023, [28]

in person.[13] Instead she returned the ECGs to the RN who made an entry into PCIS as follows:

> *Discussed routine ECG with clinic GP as part of care plan. Recalled for GP review T+1. Similar to previous ECG 2019. High CVR. Nil chest pain. Consider +/- referral to cardiology?*

25. Although Dr L considered the 2019 and 2022 ECGs were similar, Dr Hossack disagreed. He said they were different and the difference was significant. He said:

> *At a minimum, the person recording the ECG should have discussed it with a cardiologist….[because] there was evidence of ischemia, or not enough blood supply to the heart occurring at that point in time. So my opinion is that on the 13/9/2022 a cardiologist should have been contacted and advice given as to how the management should have proceeded.*[14]

26. I give greater weight to Dr Hossack's expertise on this matter.

27. When he received the annotated ECG from Dr L, the RN entered the recall in PCIS for the following day as instructed, but he did not select the 'High Priority Recall' icon on PCIS. In hindsight, he agreed he should have.[15] With the benefit of hindsight, if the ECGs had been correctly identified as different from each other, if that difference had been properly identified as clinically important, if a cardiologist had been consulted (as Dr Hossack considered necessary) and the ischemia was identified, it seems likely that Mr Dooley would have been recalled that same day or at least his recall would have been identified as a 'High Priority Recall'.

28. The recall lists are long and subject to triage and adding 'T+1' may not (and did not) ensure that Mr Dooley was recalled the following day. Ultimately, due to competing demands on the prison clinic and the triaging of recalls, Mr Dooley was not recalled until 26 September 2022, 12 days after his recall was due, and by which time he was already experiencing a cardiac event.

29. Dr Hossack opined that had Mr Dooley been seen by a cardiologist on (or about) 13 September 2022 there is a 50% probability that he would have survived.[16] I accept

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[13] Due to the passage of time between the event and making her statement, Dr L had almost no recollection of 13 September 2022, T 213. RN made his statement on 11 December 2023 and indicated that he had some recollection, but it was incomplete due to the passage of time, T 83

[14] T 198 Kenneth Hossack

[15] T 94 RN

[16] T 202 Kenneth Hossack

the family's submissions that the failure to have him recalled on 13 or 14 September 2022 was a significant oversight in his care.[17] In its submissions, NT Health acknowledged that due to the delay in his recall Mr Dooley did not receive timely care, which constitutes inadequate care.[18]

Mr Dooley seeks assistance

30. In the mid-morning of Sunday 25 September 2022, Mr Dooley felt unwell. He was in the company of Bartholomas Dooley, a nephew, both being housed in Sector 11 at the prison. Bartholomas considered Mr Dooley to be a 'little father' to him. Bartholomas gave evidence and said he had a clear recollection of the last time he saw his little father, although a statement was only belatedly taken from him on 8 January 2024 (after a family member identified him as the person who had likely assisted Mr Dooley). According to Bartholomas, Mr Dooley told him he was feeling unwell, and that he felt dizzy. Bartholomas got him his lunch and, as Mr Dooley didn't feel well enough to eat it, he put it in the fridge. Bartholomas assisted him to lie down on a mattress and gave him a plastic bag as Mr Dooley was vomiting. He approached a Corrections Officer to tell him about Mr Dooley's condition and asked if he could go to the clinic.[19] He told the Corrections Officer that Mr Dooley had been vomiting and that he felt dizzy,[20] but he did not think that the Corrections Officer saw Mr Dooley vomiting.

31. The Corrections Officer recalled being approached by a young indigenous man about Mr Dooley. He had been rostered on to work at Sector 11 due to staffing issues. It was not the sector he usually worked. The Corrections Officer, himself an Aboriginal person, thought that it was normal and respectful for a young indigenous man to speak on behalf of an older indigenous man.[21] The Corrections Officer said he was first approached during the morning hygiene inspections. He checked on Mr Dooley and, as he didn't think that he "*look[ed] sick at all",* suggested he take it easy and drink some water. Around lunch time he was approached again. The younger indigenous man told him that Mr Dooley "*couldn't eat his lunch and he's vomiting*." The Corrections Officer had another look at Mr Dooley. He didn't notice any change in his appearance and he didn't see any signs of vomit but he went back to his station and rang the nurse on duty. He recalled reporting words to the effect of, "*this fella's dizzy, crook and apparently he's been vomiting. Do you want me to send him up?*"[22]

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[17] Family submissions, 8/4/2024, [18]

[18] NT Health submissions, 15/4/2024, [55]; T 245 Lisa Vermeulen

[19] T 38 Bartholomas Dooley

[20] T 40 Bartholomas Dooley

[21] T 50-51 Corrections Officer. Note: Bartholomas was 33 at the time and Mr Dooley was 37.

[22] T 56-57 Corrections Officer

32. According to the Corrections Officer, the nurse told him that Mr Dooley was on new medication that was 'kicking in' and probably making him feel sick and dizzy and said he should tell him to relax and keep the water up.[23] The Corrections Officer delivered the message, "*the nurse said you're on new medication and that's probably kicking in. That's making you crook and dizzy, so just relax and keep the water up*." Mr Dooley did not reply and, indeed, had not spoken a word to the Corrections Officer at all.[24] The Corrections Officer said that Mr Dooley was standing up outside on the patio where the metal tables and chairs are when he returned[25] but he had no contemporaneous records of any of the conversations or events and relied on his memory.

33. In accordance with his normal practice, the RN said he made notes on an A4 page during the conversation and later transferred those notes into PCIS. The PCIS records read:

> *Note date 25/09/2022; Entered Date: 25/09/2022 @ 18.50*
> *Received call from CO around 12.30PM.*
> *Reports that client complained of being dizzy and was unable to stand up and go to clinic to be checked out.*
> *Asked officer to have client rest first; see how he goes in an hour or two.*
> *If dizziness persist and if worried to call back again.*
> *On Rifampicin since 8/9; unlikely cause of dizziness.*
> *Nil call received after.*

34. In its Institutional Response, NT Health accepted that dizziness in combination with an inability to stand, as documented in the PCIS notes, were red flags that should have prompted an in-person review in the Prison Clinic.[26]

35. In evidence, and no doubt in part relying on those notes, the RN said he recalled receiving a phone call from the Corrections Officer and being told that Mr Dooley "*complains of being dizzy and unable to stand up and go to the clinic to be checked out*." The RN recalled he asked about other symptoms and the Corrections Officer confirmed that Mr Dooley was *"not experiencing chest pain, had no shortness of breath, was conscious, and was speaking in full and coherent sentences"*, and also

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[23] T 58 Corrections Officer

[24] T 55, 61 Corrections Officer

[25] T 55-56 Corrections Officer

[26] Affidavit Lisa Vermeulen, 5 January 2024, [119]

confirmed that Mr Dooley did not seem to be acutely unwell.[27] (However, the Corrections Officer had not asked Mr Dooley about chest pain or shortness of breath and, if he provided that information to the RN, as recalled by the RN but not recalled by the Corrections Officer, then it seems he was making an assumption or relying on observations he was not qualified to make). The RN, who had a special responsibility for prisoners with tuberculosis, knew that Mr Dooley had commenced medication, and recalled telling the Corrections Officer that it was "*probably the medication that is causing [the dizziness]."*[28] He recalled telling the Corrections Officer that Mr Dooley should rest and have some fluids and to let him know if it resolves or not.

36. There was seemingly a loose plan to follow up on Mr Dooley after rest and fluids. In its Institutional Response NT Health noted that *"it was incumbent on the RN and the Correctional Officer to 'close the loop'*, *to confirm Mr Dooley's condition had resolved,"*[29] this did not occur, and it should have.

37. In his evidence the RN sought to clarify certain aspects of his evidence. He explained that:

- when he recorded in PCIS that Mr Dooley was "*unable to stand up*" what he actually understood was that Mr Dooley was unwilling to stand "*because he was dizzy. I presumed that he didn't want to get up to make the dizziness worse or maybe, yes lose his balance or something like that*"[30];
- when he entered the notes into PCIS later in the day he saw that Mr Dooley was on day 17 of the new medication and, on re-consideration, considered it was of low likelihood that the reported dizziness was a side effect of the medication;
- vomiting is a significant symptom and if he had been told of it he would have recorded it in his notes. As it was not in his notes (and as he had no recollection of being told about it), he does not believe he was told of the vomiting; and
- he presumed (and may have been told) the Corrections Officer had spoken to Mr Dooley and, therefore, assumed (incorrectly) that Mr Dooley was speaking in full and coherent sentences.

38. Given the limited contemporaneous records and the fallibility of memories it is difficult to know with any certainty exactly what occurred. However, I am comfortably satisfied that the evidence established that Mr Dooley was unwell over the course of the morning and past lunch time, he complained to Bartholomas of

[27] Exhibit 1 Folio 12, Affidavit of RN, 14 March 2023, [34]

[28] T 174 RN

[29] Affidavit Lisa Vermeulen, 5 January 2024, [123]

[30] T 169 RN

dizziness, he was sitting or lying down and was not standing up,[31] he was unable to eat, he was vomiting and he was not responding verbally to the enquiries or advice of the Corrections Officer. My understanding is, that if those circumstances had been fully appreciated by the RN, Mr Dooley should have been seen that day, either by attending the clinic or, if he could not make his way to the clinic, via the calling of a 'Code Blue'.[32]

39. Although the Corrections Officer followed the Sector 11 Guidelines for non-urgent medical matters when he called the clinic on Mr Dooley's behalf,[33] he was not medically trained (though held a current First Aid certificate) and was relying, at least in part, on second-hand information. In light of those limitations, I consider that neither a full nor accurate clinical picture was conveyed by him to the RN. The Corrections Officer, who knew nothing of Mr Dooley's health risk factors, likely mistakenly underestimated the potential seriousness of Mr Dooley's condition. Additionally, the RN wrongly conveyed that Mr Dooley's dizziness was attributed to new medication, potentially incorrectly reinforcing the Corrections Officer's view that there was no real cause for concern. In all the circumstances, it is unsurprising that the communication was incomplete and inaccurate, and both NT Corrections and NT Health conceded that the communication of prisoner health complaints to the clinic should be improved.

40. These events occurred on a Sunday. Although there was no RMP rostered on site a medical practitioner (DMO or On-Call Manager) was available on-call[34], in accordance with recommendation 150 from the Royal Commission into Aboriginal Deaths in Custody.

His recall on 26 September 2022

41. On 26 September 2022, Mr Dooley was on the recall list for his abnormal ECGs of 19 June 2019 and 13 September 2019. It is unknown whether he received assistance to get to the prison clinic, and CCTV, which may have assisted in determining this, was not retained or seized. However, he was seen by the RMP, Dr P, at about 11am and walked into her room without assistance or any apparent difficulty.

42. While Mr Dooley had been recalled because of the two abnormal ECGs, no discussion about them took place. Dr P, a highly experienced GP (although only a locum for about four days at that time at the Darwin Correctional Centre), gave

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[31] In so finding I prefer the contemporaneous records over the undocumented recollections

[32] T 246-247 Lisa Vermeulen (and commentary by Coroner and Counsel for NT Health)

[33] DCP Operations Manual Accommodation Sector 11 Pre-Release Work Village Version 2 p 26

[34] NT Health Institutional Response, LV 8, Nurse and Manager On Call Prison Health Procedure 1.2.2

evidence that she observed Mr Dooley to be quiet. He told her he was normally more energetic, he was feeling nauseous and dizzy since the previous day, and he was worried it might be linked to his medication which he stopped taking two days earlier because he was feeling sick.[35] It seems likely that Mr Dooley thought he was at the clinic because of his complaints the previous day. It seems likely he did not know that he was recalled to discuss his abnormal ECGs.

43. Dr P conducted an abdominal examination which appeared normal. She then attempted to take Mr Dooley's blood pressure, but the reading was so low that the machine was twice unable to detect it. She then tried a manual one and ultimately requested the assistance of the Nurse Team Leader who obtained a reading of 80/40. At that point Dr P considered Mr Dooley's presentation to be an emergency, likely due to dehydration, which required the urgent administration of fluids. As Mr Dooley had not complained of other symptoms such as shortness of breath or chest pain, Dr P did not consider a cardiac origin to his presentation.[36] She did not complete any other vital observations, and in evidence agreed this was a failure on her part. She accepted that a full set of observations should have been taken to complete his clinical picture.[37] A full set of observations, together with a better appreciation of the significance of his abnormal ECGs, would likely have alerted her to the possibility of a cardiac origin for his presentation.

44. Dr P requested that the Nurse Team Leader administer intravenous fluid to treat his alarmingly low blood pressure and asked to be kept informed of his blood pressure readings.[38] The Nurse Team Leader tasked an RN to administer the IV fluid. Inconsistent with his training, the RN failed to take a full set of vitals, as he should have done, before commencing the IV (but said he assumed that Mr Dooley had been fully assessed by the doctor).[39] The RN also failed to take clinical observations during the infusion, as he should have done, however, the RN sat with Mr Dooley for about 15 to 20 minutes and no issues were noted. When Mr Dooley complained that the bed was uncomfortable in the resuscitation bay, after discussing the matter with the Nurse Team Leader, the RN moved him to the Medical Housing Unit to make him more comfortable. Dr P was not informed that he was moved.

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[35] T 147 Lisa Vermeulen

[36] T 150 Dr P

[37] T 151 Dr P

[38] T 148-151 Dr P

[39] T 104 RN

45. The Medical Housing Unit consists of two rooms, each containing two beds, located near the Corrections Officers and nurses stations. They are cells where prisoners needing some medical care or treatment can be safely housed, for example, cancer patients, patients with injuries, or, as in this case, patients receiving some treatment where it is deemed constant monitoring by a nurse is not required. I understand that a nurse does not normally remain with a patient in these rooms.

46. A Corrections Officer assisted the RN to unlock the unit. The RN explained to Mr Dooley that there was an intercom if he needed assistance. The RN believed Corrections staff could monitor this room via CCTV, but the default cameras on the screens at the Corrections Officer's desk prioritised the at-risk patients.[40] One of the Corrections Officers on duty provided a statement and gave evidence. She said that Corrections Officers did not normally monitor the Medical Housing Unit and believed CCTV monitors in the nurses station covered this area.[41] The RN did not request that any Corrections Officer monitor the room. The RN felt comfortable to leave Mr Dooley, the door was locked and the RN went on a lunch break.

47. It was during this time that Mr Dooley rapidly deteriorated. Before the lunch break was up, about twenty minutes later, the RN went to check on Mr Dooley. As he approached the room he heard Mr Dooley calling out, *"help, help, I can't breathe"*.[42] It seems none of the Corrections Officers heard anything (or saw anything on the CCTV). It seems likely that the Corrections Officers were monitoring the at-risk rooms on their CCTV and not the Medical Housing Unit and it seems likely that there were no nurses in the nurse's station during the lunch break.[43] A Corrections Officer assisted to unlock the door.

48. Mr Dooley was rushed to a resuscitation room. He was distressed, restless and was complaining of being cold. His heart rate was 117 beats per minute and his oxygen saturation was 77%. His blood pressure could not be detected and he was provided oxygen. At 1.39pm the RN called for a Priority 1 ambulance dispatch.[44] Dr P attended and heard 'crackling' in his lungs. Shortly after Dr L also attended and suggested a chest x-ray. This x-ray confirmed Dr P's impression of left ventricular failure. He was administered Furosemide, a drug to treat the build-up of fluid. An ECG was performed which produced an abnormal result.

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[40] T 128 Corrections Officer

[41] Additional folio 9, Corrections Officer statement, 8 January 2024, [7-8]

[42] T 114 RN

[43] T 112 RN

[44] Although why it is documented as "Urgent? No" in the Medical Evacuation Form –Remote Health, Exhibit 1 folio 18, is unexplained

49. The ambulance arrived at 1.55pm and departed with Mr Dooley at 2.10pm. Two Corrections Officers escorted the ambulance in a separate vehicle with a 'Hospital Bag' that contained, amongst other things, restraints, but these were never applied to Mr Dooley. This decision was appropriate given the medical care that he required and his open security classification.[45]

His time in hospital

50. At 2.50pm Mr Dooley was admitted to a resuscitation unit at the Royal Darwin Hospital. He underwent an angiogram and was diagnosed with cardiogenic shock with an acute coronary syndrome. Appropriately, in my view, a General Leave Permit was authorised by Corrections and for the remainder of his life he was not directly supervised by Corrections Staff, who thereafter received updates on his condition from the hospital staff. He was placed into an induced coma and transferred by CareFlight to Flinders Hospital in Adelaide for urgent definitive management of severe triple vessel coronary artery disease.

51. He remained in a coma until 18 October 2022. Mr Robert Williri, upon hearing the news of his uncle's poor health, travelled to Adelaide to be with him during this time.[46]

52. At Flinders, Mr Dooley had stenting of his left circumflex artery and received an intra-aortic balloon pump but there was minimal cardiac recovery.[47] Mr Williri was with Mr Dooley when he was woken from his coma and told that he was unable to be saved. At the family's request he was transferred to Royal Darwin Hospital on 18 October 2022 and placed into palliative care. He passed away on 22 October 2022 surrounded by more than twenty five family members.[48]

The expert opinion

53. Cardiologist Dr Hossack provided a report and gave evidence to assist me in evaluating whether Mr Dooley's care was appropriate and his death avoidable. In his opinion, the ECG in 2019 showed evidence of a heart attack.[49] He considered that Mr Dooley should have been referred to and reviewed by a cardiologist at that time

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[45] T 260 David Thompson observed that the decision to escort Mr Dooley unrestrained was correct and appropriate given his open security classification and the level of medical intervention required; Standard Operating Procedure 4.3.15 Prisoner In-Patient is to be updated to expressly incorporate considerations of health in all risk assessments.

[46] T 27 Robert Williri

[47] Folio 9, Summary Post-Mortem Examination Report to the Coroner

[48] T 23 Sherese Dooley

[49] T 197 Kenneth Hossack

so that further investigations could be completed and interventions, including medication or procedures, commenced.

54. On 13 September 2022, the second ECG showed abnormal results, and it was different from that taken in 2019. Dr Hossack said aspirin should have been administered, a cardiologist should have been consulted, and Mr Dooley should have been immediately referred. That Mr Dooley's consent was required (noting that he was not afforded the opportunity to consent) and that there may have been some delay between referral and appointment,[50] is not to the point. In Dr Hossack's opinion, Mr Dooley had more than a 50% chance of survival if, on 13 September 2022, a cardiologist had been consulted and received the abnormal ECG readings. He said, *"a cardiologist could have prioritised when he saw the person"* and *"I would have seen that person within a week."* [51]

55. It was most likely that his heart attack started on 25 September 2022, possibly on the 24th.[52] It was Dr Hossack's opinion that Mr Dooley had a greater chance of survival if treatment had commenced on 25 September than on 26 September 2022.

56. On the 26 September 2022, when he presented with a two day history of nausea, dizziness and a blood pressure reading of 80/40, Dr Hossack considered that an ambulance should have been called immediately at 11.10am (rather than at 1.39pm) and Dr P should have considered there were possible cardiac issues given his history combined with those symptoms.[53]

57. I consider that the circumstances of Mr Dooley's death were avoidable, the more so, if his ECG had been properly understood on 13 September 2022, or his deteriorating condition had been correctly identified on 25 September 2022. I accept Dr Hossack's opinion that the care that he received was suboptimal.

[50] NT Health submission, 15 April 2024, [96](a)(iii)

[51] T 205 Kenneth Hossack

[52] T 206 Kenneth Hossack

[53] T 199-203 Kenneth Hossack

ISSUES FOR THE INQUEST

Was the care given to Mr Dooley by NT Health and NT Corrections appropriate and sufficient?

58. In its submissions NT Health frankly conceded that there were shortcomings in Mr Dooley's care on 13 and 25 September 2022[54] and:

> *There was a failure by those treating Mr Dooley on 26 September 2022 to promptly recognise him as a deteriorating patient and accordingly, there were deficiencies in the care provided to him. This was materially contributed to by a failure to take a complete set of Mr Dooley's observations by the RMP and the Registered Nurse, which in turn corresponded with a failure to follow the Central Australian Rural Practitioners Association (CARPA) Manual.*[55]

ECG Management

59. The evidence established that there were repeated, and likely systemic, failings to recognise and appropriately respond to Mr Dooley's abnormal ECGs. During the Root Cause Analysis the Co-Director of Cardiology reviewed all three of Mr Dooley's ECGs and stated:

> *All 3 ECGs are abnormal and are showing probable LVH…..A clinical assessment with an echocardiogram in 2019 or 13/9/2022 may have shown LVH and possible anterior wall motion abnormality which would have led to earlier assessment of his coronary arteries.*[56]

60. NT Health has identified that there is no standardised process for ECG management in Primary Health Care. I am advised that the Co-Director of Cardiology has recommenced a *Cardiac Working Group* to review ECG management across NT Health, with the aim of developing a standardised process. In the interim, I am advised that since January 2024 Cardiology Registrars are reviewing ECG, stress test and/or echocardiograms, comparing them to previous test results and preparing a clinical report. There is no evidence as to the time frame for these reviews. The Cardiac Working Group is still considering the best way to ensure appropriate care is provided following a clinical report.[57]

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[54] NT Health submissions ,15 April 2024, [62-64]

[55] NT Health submissions, 15 April 2024, [77]

[56] RCA, ECG Management

[57] NT Health submissions 15 April 2024, [79-81]

Recall Management

61. Mr Dooley's 'T+1' recall from 13 September 2022 was dealt with 13 days later on 26 September 2022. The failure to recall him the following day, as directed by the RMP, was a critical missed opportunity,[58] which may have cost Mr Dooley his life. The PCIS system generates a huge number of recalls automatically in addition to the human entries. In Mr Dooley's case, recalls (in effect, appointments to see a doctor) were not made due to competing demand, indeed over-demand, on Prison Health services. The recall system at the Darwin Correctional Centre is currently overwhelmed and inefficient.[59]

62. A different but related issue that concerned access to Prison Health care was considered in the *Inquest into the death of Bernard Hector.*[60] Numerous recalls were issued for Mr Hector but *"none proceeded because of lockdowns, staff shortages and medical prioritisation."*[61] The recommendation in that case, that NT Corrections and NT Health together ensure that all prison clients attend scheduled health appointments, does not address the issue in this case, because the recalls identified as required on PCIS were not scheduled or were delayed.

63. In response to recall and Prison Health access issues in the Darwin Correctional Centre (and broader recall issues arising from the PCIS recall system) I am advised that a *Recall Working Group* has been established to conduct a system wide review of recalls in NT Health. A *High Priority Recall PHC Remote Guideline* is being developed to include guidance on, for example, identifying high priority recalls and processes to be followed, including in life threatening situations, and (perhaps in response to access concerns identified in Mr Hector's inquest) processes for escalating the retrieval of patients if issues with prisoner access arise. I am presently unconvinced as to the likely efficacy of this guideline. It seems that, so far as Mr Dooley was concerned, the guideline could only have assisted his prioritisation if the seriousness of his ECG results were properly appreciated, and they were not. Indeed, concerning this *Guideline* the Root Cause Analysis cautioned that it would require *"ongoing evaluation."*

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[58] Notwithstanding that a referral to a cardiologist would require consent, there was clear evidence that Mr Dooley was interested in his health

[59] T 233 Lisa Vermeulen

[60] [2023] NTLC 3

[61] *Inquest into the Death of Bernard Hector* [2023] NTLC 3, [63]

Use of the Medical Housing Unit

64. The Root Cause Analysis identified that a procedure was required to identify persons who could be safely managed in the Medical Housing Unit. The *Medical Housing Prison Health Guideline* was approved in December 2023.[62] According to that *Guideline* the Medical Housing Unit may be used for persons receiving IV fluids but only after a full set of observations have been taken and a Remote Early Warnings Scale (REWS) score of between 0-2 is documented and there are no other concerns "*as per CARPA protocol indicated by symptoms."*

65. Although there is no evidence that Mr Dooley attempted to use the intercom, the evidence is that the intercom from the Medical Housing Unit connects to the Corrections Officers station and not the nurse's station. While it is understood that intercoms can be used for either general or medical requests, consideration should be given as to whether it is more appropriate that intercoms in the Medical Housing Unit (housing Prison Clinic clients) connect with the nurse's station (or a nurse on duty) instead of the Corrections Officers station when there are medical staff on duty.[63]

66. On the evidence it is unclear whether anyone is, or should be, responsible for monitoring CCTV of patients housed in the Unit.[64] In its submissions NT Health said that nursing coverage is maintained during lunch breaks and staff are seated within view of the of the CCTV monitors in the Correction's Officers station.[65] However, this assurance does not address the question as to whether or not the CCTV monitors in fact display the Medical Housing Unit rooms (in light of the priority given to the At-Risk rooms). Responsibility, if any, for monitoring CCTV of the Medical Housing Unit should be clarified.

67. If there were Prison Health staff seated within view of the Corrections Officers' station during the lunch break as submitted by NT Health, this begs the questions as to why Mr Dooley's cries were help were only first heard by the RN when he returned from his lunch break early.

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[62] NT Health Institutional Response, Annexure LV 7

[63] Family submissions, 8 April 2024, [39]

[64] NT Correctional Services Standard Operating Procedure Primary Health Care Centre Appendices A and B requires Correctional Officers to "monitor 'At Risk'" but there are no specific provisions for the Medical Housing Unit.

[65] NT Health submissions, 15/4/2024, [159]; T 112 contrary to the evidence of the RN

68. Consideration should be given to revisiting the *Medical Housing Prison Health Guideline* to clarify responsibilities for CCTV, intercom, and coverage of the nurse's station when health clients are housed in the Medical Housing Unit.

Communication between Health Staff and Corrections Staff and contemporaneous records

69. The 25 September 2022 communication between the Corrections Officer and the RN was of significant concern. As noted earlier in these findings, both NT Corrections and NT Health identified there were risks associated with prisoner health concerns being relayed to health staff by a Corrections Officer, as occurred on 25 September 2022.

70. In consultation with NT Health, NT Corrections advised that they are updating their Standard Operating Procedure in respect of prisoner medical complaints to ensure that direct communication via telephone occurs between a prisoner and Prison Health staff (and not through a Corrections Officer as intermediary) when a prisoner makes a medical complaint and is unable to attend the Prison Clinic. A 'Code Blue' is still to be called where an immediate medical response is required. The General Manager of the Darwin Correctional Centre explained:

> *Where an officer…initiates a phone call on behalf of a prisoner to the health centre, the health centre service practitioner is to directly speak to the prisoner. If that prisoner is unable to speak, for whatever reason, he is to be conveyed to the medical centre. No ifs or buts.* [66]

71. In September 2022 there was no requirement that the Corrections Officer make a record his involvements with Mr Dooley or the phone call to the Prison Clinic. The evidence as to the Corrections Officer's conversations with Bartholomas (on behalf of Mr Dooley) was lacking as there was no contemporaneous record. However, I am advised that on 4 January 2024 Corrections Officers were reminded by email to record notable events in accommodation sector journals, including when a prisoner reports ill-health, and any response to the report of ill-health. I am advised that there is a plan to reinforce journal recordings in recruit and refresher training courses.[67]

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[66] T 222 David Gordon

[67] NT Corrections submissions, 5 April 2024, [21]; T 222 David Gordon

72. Additionally, I am advised that there is a plan to implement *teams based rostering* at the Darwin Correctional Centre. It is hoped greater familiarity between prisoners and Corrections Officers may improve communication and Corrections Officers may be better equipped to identify any changes in prisoner well-being or behaviour. [68]

73. NT Health advised that a *Non-Clinical Triage PPHC Remote Form*[69] is now located at each workstation in the Health Centre which must be completed during prisoner health complaint phone contact. The *Form* provides a checklist for triaging symptoms and creates a contemporaneous record of the call, and the completed *Form* is to be scanned into PCIS. If a 'Yes' box is ticked I understand the client/prisoner is to be seen immediately.

74. However, I am concerned about the likely efficacy of this *Form.* Concerns that spring to mind arising from this inquest include:

- Regarding the symptom triage boxes, it is unclear whether, in order to tick the 'Yes' box, all or one or more of the symptoms listed are required to be reported. So for example, for ABDOMINAL PAIN, the symptoms listed are "severe to moderate pains, vomiting, diarrhoea, unwell". If a person reports they are vomiting and unwell (but does not report the other symptoms) is the ABDOMINAL PAIN box to be ticked? Is the person to be seen immediately?

- The *Form* does not specify that there should be direct communication between the client/prisoner and the clinical staff member receiving the call. Whether or not direct communication has occurred (and if not, why not) should be documented.

- Where a client/prisoner is not seen immediately, the *Form* does not contain any guidance in respect of 'closing the loop'. If part of the plan involves an element of 'wait and see', guidance as to it being the responsibility of the clinical staff member to 'close the loop' should be included, and when and how the 'loop has been closed' should be documented.

75. NT Health further advise that a *Nurse and Manager On-Call Prison Health Procedure*[70] was approved on 27 December 2023 with the aim of ensuring on-call nursing staff identify high priority medical concerns which require medical review. The concerns raised in relation to the *Non-Clinical Triage PPHC Remote Form,*

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[68] T 223 David Gordon

[69] NT Health Institutional Response, Annexure LV 9

[70] NT Health Institutional Response Annexure LV 8

equally apply to this *Procedure*. In light of the issues identified in this inquest, it is particularly concerning that Appendix B assumes that the health conversation will occur with Corrections Officers and not directly with the complaining prisoner.

76. It seems that the triage envisaged in the *Non-Clinical Triage PPHC Remote Form* and *Nurse and Manager On-Call Prison Health Procedure* may not be consistent with the triage documented in *Prison Health Triage Codes.*[71] If so, this should be rectified to reflect the new triage approach.

Availability of Aboriginal Employees to Support Prisoners and to Promote Cultural Safety

77. This inquest again briefly traversed the question as to whether communication and cultural safety between prisoners and staff could be improved by greater access to Aboriginal staff. The *Safer Prisons, Safer Communities, Safer People Report*[72] identified that access to dedicated and culturally safe support from an Aboriginal Welfare Officer was the single most important factor that helped Aboriginal people feel culturally safer in custody. The Darwin Correctional Centre currently employs six Prisoner Support Officers, five of whom are Aboriginal, which is clearly inadequate for the growing Aboriginal prisoner cohort. However, in an effort to support access to medical services I am advised there is a plan for a Prisoner Support Officer to be available at the Prison Clinic each morning and afternoon, to assist prisoners accessing Prison Health.[73]

78. In the *Inquest into the death of Bernard Hector*[74] I recommended that Aboriginal Mental Health First Aid Training be made available to all prisoners. As I understand it the training is directed at promoting awareness of mental health issues, increasing confidence to raise and discuss those issues, and includes information about how to respond if concerns are noticed or raised. I was very heartened to hear that the recommendation is being implemented by NT Corrections.[75] I understand that this development was raised during evidence in this inquest because there is a hope that this training may encourage and empower prisoners to better engage in health communications more generally.

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[71] Institutional Response LV 11, Health request For Management Prison Health Procedure Appendix 1

[72] Cultural Review of the Adult Custodial Corrections System, Victoria, 1/12/2022, p 501

[73] T 222 David Gordon

[74] [2023] NTLC 3, p28

[75] T 223 David Gordon

79. NT Health had two Aboriginal Health Workers but no Aboriginal Liaison Officers employed at the prison (at the time of inquest)[76] and telephone interpreters were rarely used.[77] Aboriginal health staff are recognised as invaluable to assisting communication and cultural safety. [78] The minimal Aboriginal health staff as compared to the growing Aboriginal cohort at the prison is a continuing risk factor for Aboriginal people in custody.[79] NT Health advises that they continue to actively recruit Aboriginal Health and Liaison Officers, have appointed a First Nations Executive Director, and are implementing *special measures* recruitment.[80]

80. Mr Dooley's first language was Kriol, though the evidence indicates that he was capable of communicating in English, although had difficulty reading. Even so, his family were concerned about the apparent limited use of interpreters in the prison, including in the Prison Clinic. NT Health and NT Corrections have listened to those concerns and I encourage them to review any 'Use of Interpreter' policies and training to confirm they are sufficient to ensure interpreters are used by their staff when needed. It might be expected that interpreter engagement would be growing in line with the increasing Aboriginal prison population. Assessment of usage as compared to prison population may provide a measure, albeit crude one, as to the effectiveness of the policies and training.

Inaccurate Health Information in NT Corrections Records

81. The recording of health information (and indeed other information) in a prisoner's Immediate Risks/Needs Assessment (IRNA) and Security Classification and Transfer Eligibility Assessment (SCATE) relies heavily on self-reports from prisoners. The health information recorded in Mr Dooley's various IRNAs and SCATEs (over his numerous receptions) was unreliable, inconsistent, and contained significant errors. For example, in each of his IRNAs Mr Dooley inaccurately reported no heart or other health problems and on 24 June and 13 September 2022 his SCATE assessments referred to, and seemingly (at least in part) relied on, this inaccurate information. [81] It is not known whether the information was inaccurate because Mr Dooley did not understand the questions; did not properly understand his heart and other medical conditions; or (as a reasonably seasoned prisoner) he was

[76] T 230 Lisa Vermeulen

[77] T72 RN; T249 Lisa Vermeulen; T 226 David Gordon

[78] T 216 Dr L; T 230 Lisa Vermeulen; T158 Dr P

[79] Folio 21 - Cultural review of the adult custodial corrections system final report. Aboriginal mental health training has been rolled out to prison offices as a result of earlier recommendations arising out of a death in custody; T 223 David Gordon

[80] T 229 Lisa Vermeulen; NT Health submissions 15 April 2024, [126]

[81] T 223-226 David Gordon

deliberately inaccurate with a view to increasing his chances of a favourable assessment for the more desirable low and open security classifications.[82]

82. It is concerning that important decisions within the prison, such as security and housing classifications, are being made on potentially inaccurate information. According to the Sentence Management Manual staff conducting intake assessments should "access relevant information from a wide range of sources,"[83] however, these sources do not include accessing any information held by NT Health. The General Manager of the Darwin Correctional Centre recognised this as a risk.[84] It was indicated that there may be some process instituted whereby Prison Health might "double-check" the health information recorded in SCATEs and IRNAs.[85] Improving the accuracy of the information in the IRNAs and SCATEs is a matter that NT Corrections would be wise to urgently address.

Diet

83. While a less than ideal diet over time (including a diet too high in saturated fats while in prison) is a factor that may have contributed to Mr Dooley's poor cardiac health, he also likely had a genetic predisposition to high cholesterol.[86] Dr Hossack considered that the standard prison diet was too high in saturated fats and some of the red meat and should be replaced with chicken and fish, and polyunsaturated margarine should be available.

84. NT Corrections have advised that the standard diet was reviewed by Healthy Living NT in 2022. Among other things, that review identified that on the current diet 20% of daily energy came from saturated fats which was higher than the Australian Guidelines recommended 10%.[87] NT Corrections advise that in response to that review, some servings of red meat have been replaced with chicken and fish. I understand a further diet review will be imminently finalised from 2023, this (or a further review) should consider whether the current diet now meets the Australian Guidelines and whether it is suitable for prisoners with high cholesterol or increased cardiac risks.

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[82] Immediate Risks/Needs Assessment conducted on 21 June 2022 and earlier on 8 April 2020 and 14 December 2019. None of the earlier IRNAs contained a reference to heart problems. Mr Dooley spoke English well enough but there was evidence he struggled to read. Progress notes of RMP 9.8.22 " not a great reader" Folio [18] (p 171 of PDF). Evidence of family was that they spoke to him in Kriol and English was not his first language

[83] NT Correctional Services Sentence Management Manual 2020, "Guiding Principle 1.5.1 Supporting Information"

[84] T 225 David Gordon

[85] T 225-226 David Gordon

[86] T 203 Kenneth Hossack

[87] Menu Review Darwin Correctional Centre, Darwin Dieticians, 2022

Communication with Family

85. Mr Dooley's family were concerned about how information about his health and his passing was communicated to them by NT Corrections and NT Health.

86. On reception into the prison Mr Dooley nominated a son and his mother as his next of kin. When he was taken to the hospital his son was in prison and was informed that he had been hospitalised. His mother's phone number was not answering and Corrections staff spoke to other incarcerated family members in order to obtain contact details for an Aunt. When the Aunt was notified on 27 September 2024, Mr Dooley had already been evacuated to Adelaide and the information as to his condition was scant, likely in keeping with the limited medical information available to the Corrections Officer making the call. In all the circumstances, it seems NT Corrections did their best and there is no evidence of undue delay on their part. However, it is understandable that family were upset to learn Mr Dooley was extremely ill and already in Adelaide.

87. Family suggested that perhaps NT Corrections could have contacted community agencies at Manyallaluk, such as the clinic or council office, when they experienced difficulties in contacting next of kin. NT Corrections' policy appears to address this. It provides:

> *7.2.6 Where a prisoner is from a remote community, the assistance of NT Police, Elders Visiting Program or the community clinic may be sought to advise the prisoner's emergency contact person.*
> *7.2.7 Appropriate notations are to be made on the prisoner's file of all attempts, successful or otherwise, to notify a prisoner's emergency contact person.* [88]

88. NT Health had a meeting with family members following Mr Dooley's passing, including with his mother, Lily. Lily does not speak English well and other family members, who had a good command of English, said they also struggled to fully understand the information that was provided. Where a significant family member does not speak sufficient English to properly participate in important health communications, NT Health should take appropriate steps to engage an interpreter. Additionally, Aboriginal family members should be offered the support of an Aboriginal Liaison Officer or Aboriginal Health Worker during such meetings to promote cultural safety and improve communication.

[88] Serious Incident Report, 9 March 2023, NT Correctional Services Directive 2.8.17 Notification of Prisoners Critical Illness, Palliative Care or Serious Injury, August 2020

89. It was pleasing to hear that care had been taken by NT Corrections to ensure there was an opportunity for incarcerated family members to participate in Sorry Business.[89] However, the family were concerned that perhaps not all incarcerated family members were informed of, or given the opportunity to participate in, Sorry Business. As there were no records made of who was informed or participated, it was difficult to alleviate the family's concerns. There was no NT Corrections policy or procedure concerning Sorry Business at the time of Mr Dooley's passing. This has been addressed and an NTCS Directive, 2.1.19 Sorry Business/Body Viewing and Smoking Ceremonies, was approved on 14 December 2022. Family members may now make a written request for Sorry Business to be conducted at the prison. The request requires the approval of the Deputy Superintendent and records of the request, decision and conduct of the Sorry Business are to be made and retained on IOMS. I consider the policy could be strengthened by an additional requirement that at the time of a passing, family members are informed that they may request Sorry Business/Body Viewing or Smoking Ceremonies, and a record should be kept concerning when and how the information was provided, and to whom it was provided.

Some limitations of the investigation into Mr Dooley's death

90. This was an anticipated death in custody that occurred while Mr Dooley was at the hospital. However, it seems that as it was a medical death at the hospital it was not fully appreciated that the investigation was to be conducted in accordance with NT Police Force and NT Corrections Death in Custody policies and procedures, including a full investigation of his care while in custody.[90]

91. As a result, CCTV footage from the Prison Clinic, which is preserved for 28 days and was available for a short period after Mr Dooley passed away, was not secured by either the investigating police officer, or NT Corrections.[91] When this lapse was identified, the CCTV was no longer available. In addition, all NT Corrections 'reporting requirements' were not followed.[92] In particular, neither reports nor statements were taken from all Corrections staff associated with his time at the Prison Clinic (or his ill health the previous day). A statement was not taken from the Nurse Team Leader who was involved in his care on 26 September 2022. Nor were statements taken from other prisoners who may have shed light on his health in the days before he attended the clinic on 26 September 2022. Statements from several

[89] T 265 David Thompson

[90] S26(1)(a) Coroners Act 1993

[91] Serious Incident Report 9 March 2023, NT Correctional Services Directive 2.8.2 Death in Custody, March 2021, 7.9

[92] Serious Incident Report 9 March 2023, NT Correctional Services Directive2.8.2 Death in Custody, March 2021, 7.8.3

important witness were not taken until months after his passing, and some over a year later, in the context of a heavy investigative workload at the time.

92. Contrary to directives[93] there is no evidence that the Aboriginal Legal Service were notified of Mr Dooley's passing. Additionally, the importance of identifying family members at Mr Dooley's bedside, recording their contact details, keeping them updated and supporting their inclusion in the inquest process was seemingly not well understood.

93. So far as NT Corrections is concerned, a direction has been issued to retain prison CCTV for all Category 1 ambulance transfers to hospital, including all CCTV footage leading up to a prisoner's arrival at the clinic, their treatment and departure from the clinic.[94] The NT Police Force submitted that enhanced supervision of the investigation by the designated Officer in Charge within Major, Serious and Regional Crime may have mitigated certain oversights.[95]

Findings

94. Pursuant to section 34 of the Coroners Act, I find as follows

    a. The identity of the deceased was Mr Glen Woy Woy Dooley born 23 November 1984 at Katherine in the Northern Territory.
    b. The time of passing was at 12.40 pm on 22 October 2022. The place of death was hospice,[96] Royal Darwin Hospital at Darwin in the Northern Territory.
    c. The cause of death was complications due to atherosclerotic heath disease and dyslipidaemia.
    d. The particulars required to register the death:
        1. The deceased was Glen Woy Woy Dooley
        2. The deceased was of Aboriginal descent
        3. The deceased was a prisoner
        4. The death was reported to the Coroner by Police
        5. The cause of death was confirmed by Forensic Pathologist, Doctor Althea Neblett

[93] Serious Incident Report 9 March 2023, NT Correctional Services Directive2.8.2 Death in Custody, March 2021, 7.10.7

[94] NT Corrections submissions, 5 April 2024, [32;] T 222, 183 David Gordon

[95] NT Police Force submissions, 3 April 2024, [9]

[96] This is what the occurrence of death says folio 9

6. The deceased mother was Lily Munawanga Woy Woy and his father, Dooley Nungalowi

Recommendations

NT Health

95. **I recommend** that there be clear guidelines/procedures established for appropriate ECG management, review, and referral in Prison Health.

96. **I recommend** that there be clear guidelines/procedures established for managing the PCIS recall system within the prison to ensure timely recall, including any necessary guidance for ensuring high priority recalls are identified and actioned, and the guidelines/procedures be subject to an appropriate period of review to ensure efficacy.

97. **I recommend** that the Medical Housing Prison Health Guideline be subject to further consideration to address, for example: whether, and if so, who, is responsible for monitoring CCTV in the Medical Housing Rooms and any appropriate guidance as to how and when this should occur; who is responsible for responding to the intercom from the Medical Housing Rooms; and the level of coverage that is required at the nurse's station when clients are housed in the Medical Housing Unit.

98. **I recommend** that the *Non-Clinical Triage PPHC Remote Form,* the *Nurse and Manager On-Call Prison Health Procedure,* and the *Prison Health Triage Codes* be reviewed to ensure: they are consistent in their approach and advice; the triage guidance is clear and unambiguous; and they make appropriate provision for direct communication with clients and 'closing the loop'.

99. **I recommend** that NT Health offer the assistance of interpreters, Aboriginal Health Workers and/or Aboriginal Liaison Officers to Aboriginal families engaging in NT Health communications surrounding a death in custody and that this be reflected in policy and procedure.

NT Corrections

100. **I recommend** that a policy or procedure be established to ensure there is direct telephone or video communication between prisoners and medical staff when prisoners have health complaints and cannot immediately attend the Prison Clinic.

101. **I recommend** that the process by which medical information is recorded in the SCATE and IRNA forms be reviewed to ensure its accuracy.

102. **I recommend** that the current prison diet be reviewed to ensure it conforms to Australian Dietary Guidelines and to determine whether it is suitable for prisoners with high cholesterol or cardiac risks.

103. **I recommend** that the policies and training in relation to the importance of note taking of incidents including health/medical incidents be reviewed to ensure prisoner medical complaints are contemporaneously documented.

NT Police

104. **I recommend** that the supervision and guidance provided to police officers investigating reportable deaths be improved to ensure reportable deaths are thoroughly investigated in accordance with NT Police policy and procedure and investigations are completed within an appropriate time frame.

Dated this 12th day of June 2024.

ELISABETH ARMITAGE
TERRITORY CORONER