CITATION: *Inquest into the death of Mati Tamwoy* [2025] NTLC 1

TITLE OF COURT:	Coroners Court
JURISDICTION:	Darwin
FILE NO(s):	D0263/2023
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FINDING OF:	Judge Elisabeth Armitage
CATCHWORDS:	**Death in custody, terminal illness, use of restraints, next of kin**

REPRESENTATION:

Counsel Assisting:	Chrissy McConnel
Counsel for Health:	Tom Hutton
Counsel for Corrections:	Taylah Cramp

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IN THE CORONERS COURT
AT DARWIN IN THE NORTHERN
TERRITORY OF AUSTRALIA

No. D0263/2023

In the matter of an Inquest into the death of

MATI TAMWOY also known as MICHAEL SAGIGI

ON: 17 NOVEMBER 2023
AT: ROYAL DARWIN HOSPITAL

FINDINGS

Judge Elisabeth Armitage

Introduction

1. Mati Tamwoy was born in the Mackay District Hospital on 14 May 1957. His parents were Arthur and Elsie Sagigi and he was one of five siblings. His birth certificate registers his name as Michael Sagigi and it is unclear when he changed his name to Mati Tamwoy, one of his many known aliases.[1]

2. It is not known when he first came to the Northern Territory but Northern Territory Police first record interactions with the legal system in July 1993, when Mr Tamwoy was 36 years old. He appeared in the Alice Springs Court of Summary Jurisdiction, as it was then, charged with driving unlicensed, driving under the influence of alcohol and providing a false name to Police. He was convicted and ordered to pay fines.

3. Only days later, he was back before the court for the first of many offences of violence and on 5 July 1995 he was sentenced to 18 months imprisonment for an assault on a female causing bodily harm.

[1] Additional Documents, Folio 1, Information for Courts.

4. Between February 1995 and 17 November 2023, it is calculated that Mr Tamwoy spent a total of 5718 days or 15 years, 8 months and 3 days in prison in the Northern Territory. His criminal history includes convictions for manslaughter and many aggravated assaults.

5. He was remanded in custody on 26 January 2022, which was his 12th and last period of custody. He had been arrested and charged for offences of robbery, aggravated assault and breaching a domestic violence order. He was remanded to the Darwin Correctional Centre (the prison), initially as a medium security rated prisoner, but later transitioned to a low security rating on 11 February 2022 following a Security Classification and Transfer Eligibility (SCATE) Assessment.

6. When he died in Royal Darwin Hospital (the hospital) on 17 November 2023, Mr Tamwoy had been on remand for 661 days. He had received no personal visits and had made no telephone calls. He had 36 professional legal visits and records show that he had been represented by multiple lawyers and legal services. However, he had not applied for bail. His matters were listed in the Supreme Court for trial. Supreme Court records reveal that on 5 October 2023 Mr Tamwoy advised that he wanted to represent himself but by 30 October 2023, the next court date, he was unable to attend court because he was in hospital.[2]

7. Following his non-attendance on 30 October 2023, and in light of his ill health, a Crown Prosecutor reviewed the matter. Noting the charges, alleged facts, time spent on remand and his serious medical condition, on 19 November 2023 the Crown Prosecutor contacted the Deputy Superintendent of the prison to indicate that the Crown would not oppose bail if it was applied for. Sadly, that was 2 days after Mr Tamwoy had already passed away. On reviewing the court files, it seems likely that Mr Tamwoy was actively choosing not to apply for bail, possibly because of the excellent medical

[2] Additional Documents, Folio 2.

treatment he was receiving while in custody and possibly because he seemingly had few ties to life outside the prison.

8. As he was in custody when he died, an inquest was mandatory.[3]

Diagnosis and treatment

9. In March 2022 Mr Tamwoy was sent from prison to the hospital for a coronary angiogram and he was diagnosed with ischemic heart disease with severe right coronary artery disease stenosis. He also suffered from stage 2 kidney disease, hypertension, dyslipidaemia, which is high cholesterol, latent tuberculosis, and hypercalcaemia, which is high calcium in the blood.

10. An incidental finding was the discovery of lesions in Mr Tamwoy's spine, sternum and ribs. His cardiologist immediately notified prison health of this and the need for further urgent investigation to be undertaken.

11. On 11 March 2022 Mr Tamwoy was seen for review by a doctor at the Primary Health Care Centre at the prison.[4] The findings from the angiogram were discussed with him and he reported feeling well. On 14 March 2022 he was seen by a registered nurse at the prison and complained of back pain. He was taken to the hospital and admitted. Further tests were carried out and on 15 March 2022 he was diagnosed with multiple myeloma, which is a treatable, but incurable, type of blood cancer which forms in plasma cells.

12. One form of treatment for multiple myeloma is a stem cell transplant however Mr Tamwoy was considered ineligible because of his co-morbid conditions. Instead, he was offered a place in the FRAIL-M trial, a clinical trial which considers the most appropriate treatment options for patients with newly diagnosed multiple myeloma who cannot receive a stem cell transplant.[5]

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[3] Section 15(1)(a) *Coroner's Act* (NT)
[4] Northern Territory Department of Health are the Primary Health Care Provider responsible for the provision of Health services within Northern Territory Correctional Services institutions.
[5] Affidavit, Dr Emma Palfreyman, 4 December 2024, Additional Documents, Folio 18.

13. On 25 March 2022, Mr Tamwoy commenced radiotherapy treatment for the lesions in his spine. He started chemotherapy on 7 April 2022. Although he did not achieve full remission, he responded well to chemotherapy and by February 2023 his cancer was under control. He then commenced cycles of maintenance chemotherapy and was regularly reviewed by the prison medical staff.

14. On 6 September 2023, Mr Tamwoy saw a doctor at the prison and complained about a lump in his right armpit which he had only just discovered (a week prior) which was painful and increasing in size. He was promptly taken by ambulance to the Emergency Department at the hospital and was admitted.

15. Tests were undertaken, including a biopsy on the lump, and on 10 September 2023 it was discovered that the multiple myeloma had transformed into the far more aggressive plasmablastic myeloma (PBM). PBM is very difficult to treat and the treatments available are very intensive. Without treatment, Mr Tamwoy's prognosis was weeks or months. On 19 September 2022 his treating haematologist advised him of his options, and he elected to commence chemotherapy treatment, which he started that same day. This particular chemotherapy treatment has the potential to cause heart damage and, with his pre-existing ischemic heart disease, it was well understood that his treatment would be difficult.[6]

16. During his last period of custody, Mr Tamwoy had 46 attendances at the hospital for treatment including admissions, some to the Intensive Care Unit (ICU), for infectious complications of his blood cancer and associated chemotherapy treatment. His last admission was on 13 November 2023 and he died in the ICU on 17 November 2023.

17. Forensic Pathologist, Dr Althea Neblett was of the opinion that he died from infectious complications of plasmablastic lymphoma.

[6] Affidavit, Dr Emma Palfreyman, 4 December 2024, Additional Documents, Folio 18.

Formal Findings

18. Pursuant to section 34 of the *Coroners Act*, I make the following findings:

    i. The identity of the deceased is Michael Sagigi also known as Mati Tamwoy born on 14 May 1957 in Mackay in Queensland.

    ii. The time of death was at 10.55pm on 17 November 2023. The place of death was the Intensive Care Unit at Royal Darwin Hospital, Darwin, Northern Territory.

    iii. The cause of death was infectious complications of plasmablastic lymphoma.

Issues for the Inquest

19. When a person dies in custody, I am required to investigate and report on their care and supervision and treatment while being held in custody.[7]

20. There were no issues with Mr Tamwoy's medical treatment and care which was of a high standard at both the prison and the hospital. Mr Tamwoy was well informed about his condition and treatment options, was motivated by his treatment regime, and engaged well with his treating team of health professionals.

21. However, the inquest revealed some issues with his care and treatment by correctional staff while he was in hospital and in relation to his death. The most significant issue was whether it was appropriate and necessary for him to be shackled to his bed during his various admissions to hospital, and whether decisions made concerning the use of shackles followed and applied the relevant Department of Corrections Directives and Standard Operating Procedures (SOPs). Ultimately, the General Manager of the prison acknowledged that, with his low security rating, Mr Tamwoy should not have

[7] Section 26 *Coroners Act 1993*

been shackled during his hospital admissions. Although the use of shackles did not contribute to his death, in light of that concession I consider that their use was unnecessarily restrictive, demeaning and stigmatising during Mr Tamwoy's treatment and the days before his death.

22. Other issues included apparent failures by prison staff to properly maintain the hospital journal, or to contact a next of kin or an Aboriginal Legal office following his death.

23. However, despite these issues, overall, I was impressed by the correctional officers who gave evidence. They were friendly towards and respectful of Mr Tamwoy and spent many hours listening to his thoughts and reflections. This was kind of them. I accepted that they were acting in good faith and doing their best to comply with the policy and procedures of the prison. The General Manager of the prison, David Gordon, engaged fully with the inquest proceedings, frankly acknowledged failings and provided practical suggestions and commitments for improvement.

Shackling (Leg Restraints)

24. Between 7 September 2023 and his death on 17 November 2023, Mr Tamwoy was admitted to the hospital five times. As he was in custody, for each admission he was escorted by two (2) correctional officers[8] who were to always remain with him.[9]

25. When a prisoner is taken to the hospital, correctional officers are to obtain an individually numbered hospital bag from the Prison Reception that contains items and documents necessary for the supervision of prisoner in-patients.[10] Among other things, the hospital bag contains a copy of the relevant Standard Operating Procedure to be followed (4.3.14 - Prisoner In-Patient) and a

[8] Darwin Correctional Precinct Standard Operating Procedure 4.3.10 Medical Escorts @ 5.1.4.
[9] Darwin Correctional Precinct Standard Operating Procedure 4.3.14 Prisoner In-Patient @ 5.3.
[10] Darwin Correctional Precinct Standard Operating Procedure 4.3.14 @ 5.3.

section 39 form[11] which details a prisoner's classification, removal conditions and any notes for the escorting officer. Mr Tamwoy's section 39 forms noted that had a 'Low-Restricted' security classification (an example is extracted below). The hospital bag also contains leg shackles, handcuffs and a journal in which health and welfare checks are to be recorded hourly and a record of any removal and/or return of restraints is to be maintained.[12]

NT Government
Section 39 of the Correctional Services Act

ORDER FOR REMOVAL OF AN OFFENDER

As a Delegate of the Commissioner of the NT Correctional Services for the purposes of Section 39 of the Correctional Services Act, I direct that the following Offender be removed.

For the purpose of: **Medical Exam / Treatment**

From: **Darwin Correctional Centre**

To: **Royal Darwin Hospital**

Date of Removal: **23 Oct 23**

Details of the Offenders:

Full Name:	**Mati TAMWOY**
Date of Birth:	**14 Jul 1957**
Identification Number:	**11164**
Most serious offence:	**Aggravated assault**
Longest sentenced offence:	
Period of imprisonment:	
Classification:	**Low-Restricted**
Earliest discharge date:	

Removal Conditions:

Note to escorting officer:

A/sgt
Signature and Rank of Delegated Officer

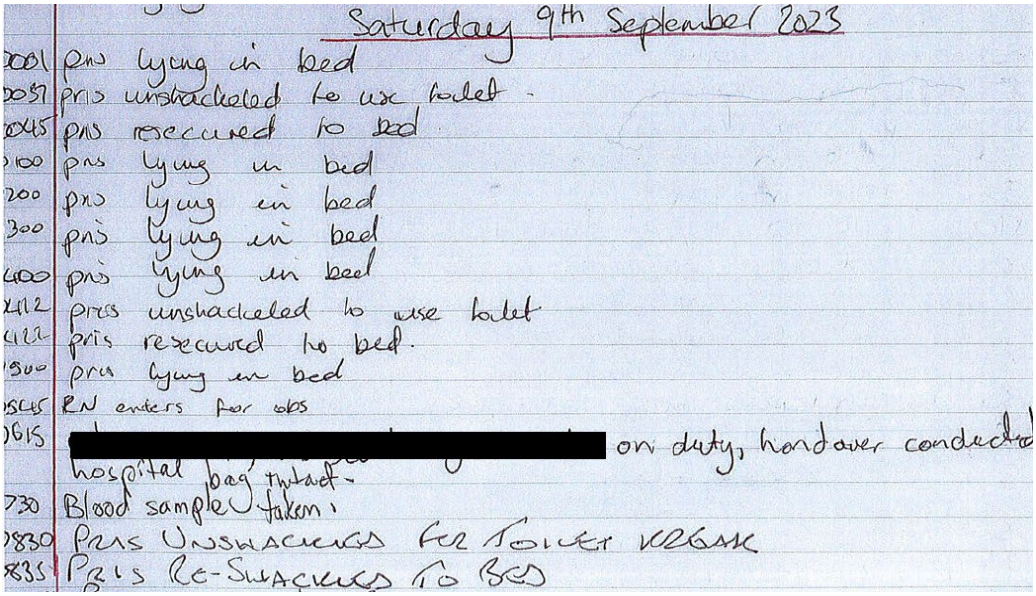
Date: 23/10/23

Section 39 from hospital admission on 23 October 2023

[11] Order for Removal of an Offender, *Correctional Services Act 2014* (NT).
[12] Darwin Correctional Precinct Standard Operating Procedure 4.3.14 @ 5.3.4.

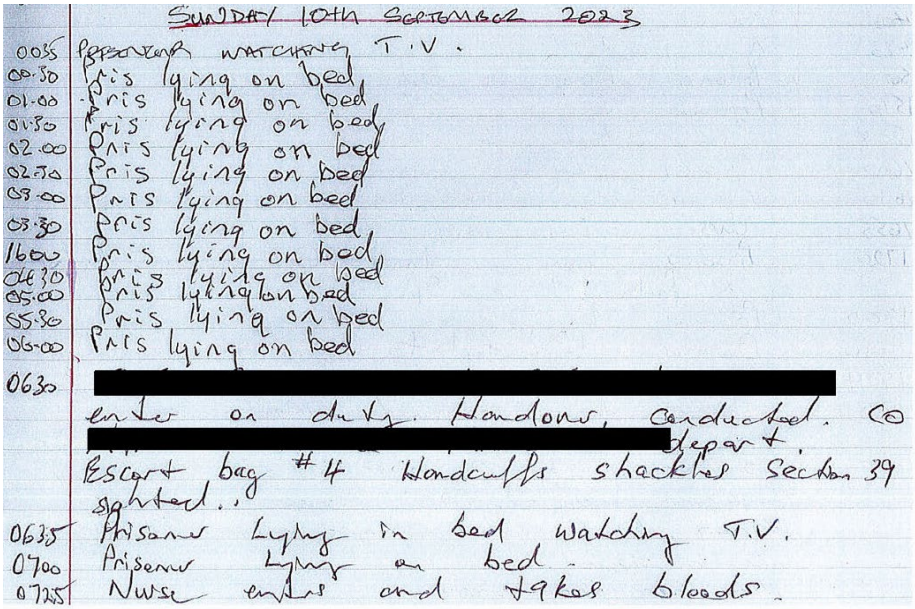
26. A copy of the journal entries relevant to Mr Tamwoy's admissions were obtained.[13] For the most part, but not always, hourly health and welfare entries were made as required. However, the level of detail in the records completed by the different correctional officers on duty was inconsistent.

27. For some dates it was clear that Mr Tamwoy was shackled to his bed. For example, see the entries below for 9 September 2023:



28. But there were many dates when it was unclear. In particular, recurrent references to the application of shackles being 'sighted' was ambiguous. When asked what 'sighted' meant, one officer explained, "It means they are seen. I'm actually seeing them. They are attached to the prisoner, or they are in the bag".[14] For example, these entries for 10 September 2023:

[13] Folio 16, Brief of evidence, Prisoner Medical Journals.
[14] T 11, Correctional Officer First Class


SUNDAY 10th SEPTEMBER 2023

00:55 Prisoner watching T.V.
00:50 Pris lying on bed
01:00 Pris lying on bed
01:50 Pris lying on bed
02:00 Pris lying on bed
02:50 Pris lying on bed
03:00 Pris lying on bed
03:30 Pris lying on bed
16:00 Pris lying on bed
04:30 Pris lying on bed
05:00 Pris lying on bed
05:30 Pris lying on bed
06:00 Pris lying on bed

0630 [redacted] enter on duty. Handover conducted. CO [redacted] depart. Escort bag #4 Handcuffs shackles Section 39 sighted.

0635 Prisoner Lying in bed watching T.V.
0700 Prisoner Lying on bed
0725 Nurse enters and takes bloods.

29. In reviewing their own and other correctional officers' journal entries, some of the correctional officers who gave evidence, could not confidently say when Mr Tamwoy was shackled and when he was not.[15] Although the journal entries were not clear, most correctional officers assumed he would be shackled if he was on the ward, but they were less certain when he was in ICU.

30. Generally, the correctional officers who escorted Mr Tamwoy were of the understanding that the normal requirement was for a prisoner of any security rating to be shackled to the bed when in hospital.[16] Indeed one officer said, " any prisoner outside the prison needs some sort of restraint…either shackle or cuffs…just everyone outside the prison needs to be shackled".[17] In

[15] See T 22-23, Correctional Officer, referring to Journal Entries 29 September 2023, "maybe he was shackled and maybe not"

[16] See T 11, Correctional Officer First Class, "the prisoner is to be restrained to the bed when they are at hospital. I can only recall one time where I had a prisoner that was not restrained to a bed and it was in my first couple of years of working"; T 20, Correctional Officer, "a common practice for the prisoner to be shackled unless we get approval from the OIC"; T 25, Correctional Officer, ""I believe that all of them are shackled unless they've been approved by the OIC"; T 31, Correctional Officer, "my concern was ensuring the prisoner… was secured to the bed, that's practise"; T 40, Correctional Officer, "from my personal experience its good practice to secure all prisoners…all the security ratings, just secure all prisoners…if they're in A&E or on a ward" and "every prisoner that I've been with in hospital, shackles are always on"; T 50, Correctional Officer, "low security…should be restrained"; T 62, Correctional Officer, "If he wasn't shackled then I would have not been happy" and T 63 "now as a rule every low security prisoner is shackled"

[17] T 21

circumstances where one of the medical staff asked for restraints to be removed for medical reasons,[18] the escorting correctional officer would seek approval (over the phone or via email) from the Deputy of Security, the General Manager or the Officer in Charge of the prison.[19] If a decision was made that shackles were not to be used, that would be written in red in the journal so that it stood out for other corrections officers.[20] In Mr Tamwoy's case, on 23 September 2023 there was in fact an entry in the journal in red which required the use of shackles, as follows, "Prisoner must remain shackled to the bed at all time as per OIC's direction. Doctor has advised prisoner does not have any condition that bars him from being shackled".[21]

31. Consistent with this general understanding and practice, one correctional officer explained that she always followed the SOP (Standard Operating Procedure) because she did not want to get into trouble and so was certain that Mr Tamwoy was shackled to the bed when she came on shift on 24 October 2023, even though it was not recorded in the journal.[22]

32. Some, but not all, of the correctional officers understood that there might be occasions when they could exercise an individual discretion to remove shackles, for example, if the prisoner was in ICU and connected to machines such as breathing apparatus or had suffered a serious head injury or was in a coma.[23] Additionally, it seems most correctional officers generally understood that they had a discretion to remove shackles for short periods of time for medical treatment, if a patient was in pain or discomfort, or to allow a prisoner to access the toilet (in which case hand cuffs should be applied).[24]

[18] T 12, Correctional Officer First Class
[19] T 12, Correctional Officer First Class; T 20-21, Correctional Officer
[20] T 12, Correctional Officer First Class
[21] Journal Entry 23 September 2023 at 12.12pm
[22] T 45, Correctional Officer
[23] T 23, Correctional Officer; T 34, Correctional Officer; T 40, Correctional Officer
[24] T 46-47,58, Correctional Officer

One officer said she would remove shackles when a prisoner was sitting on a chair eating breakfast.[25]

33. The shared understandings and practices of the correctional officers concerning the use of and removal of restraints for low security prisoners were largely consistent with the requirements of the relevant SOPs (which are discussed in greater detail later in these findings).[26]

34. David Gordon, General Manager at the Darwin Correctional Centre, provided the Institutional Response for the Department of Corrections. Unlike the correctional officers, when Mr Gordon reviewed the hospital journal entries, he was initially of the opinion that, for the most part, Mr Tamwoy was not restrained during his admissions.[27] It was his belief that references to 'shackles sighted' (or similar) were references to shackles being present with the hospital bag but not applied to Mr Tamwoy's leg. It was only after hearing the evidence of the correctional officers who appeared in the inquest, that he understood that in fact Mr Tamwoy had been shackled for most of his admissions, except for when he was in the ICU.

35. Furthermore, and again different to the correctional officers, by the time he gave evidence on 11 December 2024 his understanding of correctional policy concerning the application of restraints to low security prisoners in hospital was very different to the correctional officers understanding. In his evidence, Mr Gordon expressed his firm position that low and open security prisoner in-patients should **not** be restrained unless there is a "damn good reason", which "needs to be documented and placed and individualised on the form 39".[28] However, it is clear his understanding concerning the requirement or otherwise for restraints had only recently changed (perhaps during the course

[25] T 51, Correctional Officer
[26] Darwin Correctional Precinct Standard Operating Procedure 4.3.10 Medical Escorts @ 5.9.7, 5.9.11, 5.9.12 and Darwin Correctional Precinct Standard Operating Procedure 4.3.14 Prisoner In-Patient @ 5.5.8.6, 5.8.10, 5.8.11
[27] Institutional Response, David Gordon, 21 November 2024, [30].
[28] T 87.

of the inquest) since in his statement made on 20 November 2024 he had maintained that that the general position on the use of restraints for a prisoner admitted to hospital is handcuffs when being conveyed in public places and leg restraints within the confines of the hospital ward.[29]

36. These different understandings were not mere semantics. They directly affected whether, and in what circumstances, low security prisoners, and Mr Tamwoy in particular, are to be restrained when accessing the hospital. It was therefore necessary to understand how and why these differences of understanding arose, and what was the correct position.

Department of Corrections Directives and Standard Operating Procedures (SOPs)

37. Northern Territory Correctional Services (NTCS) issue Directives and SOPs for the management of prisoners. A Directive provides overarching guidance, and the associated SOPs are "how to" explanatory documents which are intended to provide guidance to correctional officers on their application of the relevant Directives.[30] Mr Gordon explained it this way, "where there is a conflict between an SOP and a Directive, the Directive wins out all the time".[31]

38. The Directives and SOPs applicable to Mr Tamwoy's attendances at RDH were:

- Directive 2.2.8 - Escorts
- Directive 2.8.1 - Prisoner In-Patients
- Directive 2.8.2 - Death in Custody
- Directive 2.8.17 - Notification of Prisoners Critical Illness, Palliative Care or Serious Injury
- Standard Operating Procedure 4.3.10 - Medical Escorts
- Standard Operating Procedure 4.3.14 - Prisoner In-Patients

[29] Institutional Response on behalf of the Department of Corrections, 21 November 2024, [26].
[30] Institutional Response on behalf of the Department of Corrections, 21 November 2024, [25].
[31] T 87.

Prisoner In-Patients - Directive 2.8.1 and Standard Operating Procedure 4.3.14

39. Concerning the use of restraints on prisoner in-patients, Directive 2.8.1 provides:

> 7.6.1 Escorting officers are to apply means of restraint for high and medium security rated prisoner in-patients.
>
> 7.6.2 Restraints **may** be used in other cases where the prisoner/patient's behaviour changes/deteriorates, further criminal charges are received/laid or additional intelligence is received about them that justify the use of restraints, or where no other suitable means are available to prevent the risk of escape or injury to any person or self-injury to the prisoner patient. [Emphasis added]
>
> 7.6.3 Advice on the use of instruments of restraint to be sought from the General Manager or delegate if:
>
> a. there are security concerns in relation to a low security rated prisoner;
>
> b. a prisoner patient has a significant injury whereby restraints cannot be secured;
>
> c. a Registrar specifically advises against the use on medical reasons (e.g. MRI scan);
>
> d. the prisoner patients general medical condition renders restraints inappropriate, (e.g. incapacity to walk, seriously ill etc.); or
>
> e. a prisoner is pregnant.
>
> 7.6.4 Instruments of restraint may be removed at the request of a health practitioner while the patient is undergoing consultation, examination or treatment subject to the directions of the General manager or delegate and any delegations to the senior escorting officer who may do so after assessing that their removal will not jeopardise the security of the escort.
>
> 7.6.5 Instruments of restraint will not be applied when the prisoner's general medical condition renders the use of restraints inappropriate.
>
> 7.6.6 Where restraints are utilised, officers must ensure the keys are securely fastened to their person.

40. It is clear from this Directive that for high and medium rated prisoners, restraints are to be applied with discretions to remove them in certain circumstances. For other prisoners (with a low or open security rating) the starting point is that they are not to be restrained unless restraints are justified because of certain circumstances which elevate the risk of the prisoner.[32]

41. Somewhat inexplicably, this Directive was not addressed in the Institutional Response, though it was apparently well understood by Mr Gordon and likely influenced his reading of Mr Tamwoy's hospital journal. Mr Gordon made it clear that it was the intent of the Directive not to have low security prisoner in-patients restrained. He said that Mr Tamwoy should not have been restrained because he was a low security prisoner and there was nothing which elevated his risk, he was compliant, had good rapport with the staff and there were no security concerns.[33]

42. However, it quickly became apparent that Directive 2.8.1 was not applied by any of the six correctional officers who gave evidence and who applied shackles, and sometimes other restraints such as handcuffs, to Mr Tamwoy. In doing so they were apparently applying SOP 4.3.14 which provides:

> 5.8.5 Officers are required to apply the following means of restraint for Max, High and medium security prisoners when they are in-patients.
>
> - *Handcuffs, Shackles and Restraint Belt when being conveyed in a public place or area.*
>
> - *Within the confines of the Hospital Ward – Max, High and Medium prisoners are to be secured at all times by Leg Restraints to the bed.*
>
> - *Leg Restraints are to be applied when Max, High and medium prisoners are accessing the bathroom facilities.*

[33] T 85.

5.8.6 Officers are required to apply the following means of restraint for **Low** and Open security prisoners when they are in-patients.

- *Handcuffs when being conveyed in a public place or area.*

- ***Within the confines of the Hospital Ward – Low and Open prisoners are to be secured at all times by Leg Restraints to the bed.***

- *Leg Restraints are to be applied when Low prisoners are accessing the bathroom facilities.*

[Emphasis added]

5.8.7 Officers are required to apply the following means of restraint for Open security prisoners when they are in-patients.

- *Restraints to be applied as necessary in accordance with instruction by CCO Security/OIC.*

5.8.8 Additional restraint/s may be applied in cases where the prisoner behaviour changes/deteriorates whilst an in-patient to prevent the risk of escape or injury to any person or self-injury to the prisoner.

…

5.8.10 Restraint items may be removed to facilitate treatment at the request of a health practitioner.

43. Completely inconsistent with the Directive, this SOP specified that low security prisoners in hospital wards were to be shackled.[34]

44. In addition to this significant contradiction, there was obvious confusion amongst the officers over whether Directives and SOPs had primacy, with one officer commenting frankly, that there were "too many".[35] Mr Gordon acknowledged that there are over 120 SOPs and that many of them contain inconsistencies. He further acknowledged that some of the Directives are

[34] A similar inconsistency is contained in SOP 4.3.10, Medical Escorts @ 5.1.4, and 5.9
[35] T 59.

outdated and not reflective of contemporary best practice.[36] Mr Gordon explained that use of restraints on Mr Tamwoy was "the fault of the SOP".[37]

45. In response to the identified contradiction between the Directive and the SOP Mr Gordon advised that he had tasked an Audits and Compliance Chief to review all SOPs to ensure that they are consistent with Directives but conceded that this would take time.[38] In addition, Mr Gordon said that he had received an undertaking from the Deputy Commissioner that there would be a policy review of all Directives in January 2025 to ensure they "meet current, contemporary best practice".[39] Mr Gordon has requested that 'prisoner dignity' be embedded in the revised Directives.[40]

46. Whilst the issue of shackling did not appear to have any direct negative health impacts on Mr Tamwoy and did not contribute to his death, he was shackled in circumstances and for extended and lengthy periods of time when, applying Directive 2.8.1, he should not have been.

47. This was unnecessarily restrictive, demeaning and stigmatising during Mr Tamwoy's treatment and the days before his death. It likely affected his emotional well-being and sense of dignity.[41] There was one reported incident on 6 September 2023 when Mr Tamwoy protested the use of shackles. He said, "I have cancer, I'm sick, you can't shackle me". The correctional officer

[36] T 87; as to contemporary best practice and the use of shackles on patients in hospital see, for example, Pemberton L, Panozzo S, Phillip J. Call to end shackling of hospitalised palliative prisoner patients. Ned J Aust II Published online 18 March 2024

[37] T 85.

[38] He advised that about 20 SOPs had been reviewed but given the current workload at the prison on average only 1 was being reviewed per month. By my calculation, at that rate it would take close to a decade to review the remaining SOPs which is clearly not acceptable.

[39] T 87.

[40] T 83-84.

[41] See for example, Bedi NS, Mathur N, Wang JD, Rech A, Gaden N, Annas GJ, Crosby SS. Human Rights in Hospitals: An End to Routine Shackling. J Gen Intern Med. 2024 May; American Public Health Association. A call to stop shackling incarcerated patients seeking health care. 14 November 2023. Policy No. 20233.

responded that he was "just doing his job" and shackled him to the hospital bed. [42]

48. This incident occurred in the Emergency Department which is considered a higher risk area for prisoners as compared to a ward, because of the presence of other patients and increased opportunity for escape.[43] While I accept that an assessment of risk is to be made by the correctional officers guided by the relevant Directives and SOPs, this situation provides an example of the importance of correctional officers having a clear understanding of the relevant Directives, SOPs and the discretions available.

49. Where discretions exist in the current Directives and SOPs, the discretions are not consistent across the policy documents. Focussing only on examples potentially relevant to Mr Tamwoy's situation I note the following examples.

- At 7.6.3(d), Directive 2.8.1 provides a discretion to remove restraints if the prisoner patient's general medical condition renders restraints inappropriate (e.g. incapacity to walk, seriously ill etc.).

- Then at 7.6.5 Directive 2.8.1 directs that instruments of restraint will not be applied when the prisoner's general medical condition renders the use of restraints inappropriate.

- At 7.6.1(a), Directive 2.2.8 - Escorts provides that as a general rule, prisoners are to be handcuffed while under escort, however at the discretion of the escorting correctional officer and on advice from the Officer in Charge of Security, the following may be the exception: a. where a prisoner has an injury that prevents handcuffs being secured.

- SOP 4.3.10 - Medical Escorts provides at 5.1.4 that for prisoners with a low security rating handcuffs and escort belt are to be used (which is

[42] Additional Documents, Folio 13.
[43] T 32.

a higher level of restraint than required by Directive 2.2.8). Discretions as to the application of those restraints are found at-

- 5.9.5 which provides that advice on the use of restraints is to be sought from the CCO Operations/OIC prior to departure if:

  a. The prisoner has a significant injury whereby restraints cannot be secured.

  b. …

  c. A prisoner's medical condition renders the use of restraints inappropriate (e.g. seriously ill; unable to walk).

  d. A prisoner has a significant injury and restraints should be applied.

- 5.9.11 Restraint items may be removed at the request of a health practitioner, but if this is thought to pose a security risk, 5.9.12 provides that advice is to be sought from the CCO Security/OIC.

- SOP 4.3.14 also provides discretions in the same terms as those specified in SOP 4.3.10.

- Directive 2.8.17 - Notification of Prisoner Critical Illness, Palliative Care or Serious Injury at 7.5.1 provides that instruments of restraint will not be applied if a prisoner's medical condition renders their use inappropriate and the General Manager is to be informed of restraints that are **not** removed from a terminally ill or dying prisoner for any reason.

50. In summary, across the Directives and SOPs, the discretions are expressed differently and the person from whom a correctional officer is expected to seek approval/advice also varies. In those circumstances it is not surprising

that the rules and discretions are not well understood or consistently applied by correctional officers.

51. In addition to these variations, many of the discretions require an assessment of the prisoner's health or medical condition. Correctional officers are not health practitioners and for reasons of patient privacy may know very little about a prisoner's medical condition. They are therefore ill equipped, indeed often unable, to make the kinds of assessments envisaged in the Directives and SOPs except in the most basic and crudest of forms. One of the correctional officers escorting Mr Tamwoy said, "I wasn't sure of his current medical state, I had no way of understanding that he was going to pass away".[44] Another officer said, "because we're not medically trained, we can't really tell".[45] Even though Mr Tamwoy was suffering a terminal illness one correctional officer said this created a "heightened sense of security" and he would not have taken the shackles off.[46]

52. So that I could better appreciate his medical condition and how that might relate to the discretions applicable to the use of restraints across his various hospital admissions, a statement was obtained from the Senior Staff Specialist Haematologist at the hospital. Noting that concepts such as terminally ill, dying and seriously ill are relatively subjective, the Specialist Haematologist considered that Mr Tamwoy was seriously ill when he was diagnosed with PBM in September 2023, during his ICU admissions from 29 September – 2 October and from 29 October – 7 November, and from the late hours of 16 November. He was terminally ill/dying once admitted to ICU on 17 November.

53. It is patently obvious that correctional officers are not equipped to exercise the medical assessment type discretions currently contained in the Directives and SOPs which require a sound medical understanding of the prisoner's

[44] T 15
[45] T 48
[46] T 63

condition. Whether or not this could be resolved by the provision of medical advice from treating practitioners is a matter for Department of Corrections and Department of Health to determine. However, in this case the Specialist Haematologist said, "to the best of my recollection, I was not requested to provide advice on the application of restraints to Mr Tamwoy by Corrections, and nor was I requested to provide advise in relation to any other patients during the period I worked in NT Health. …I was unaware of Corrections policy on restraints".[47]

Maintaining the Hospital Journal

54. Concerning the maintenance of a hospital journal, Directive 2.8.1 provides the following:

> 7.5.1 Hospital shift officers must maintain a record of important events. These events can be recorded on the hospital journal by the officer as appropriate.
>
> 7.5.2 Officers must ensure that entries are legible, and that the observations are informative, timed and signed.
>
> 7.5.3 Information that must be recorded includes but is not limited to:
>
> a. the names of officers on duty and time of handovers;
>
> b. details of visitors to the prisoner;
>
> c. details of the prisoner's behaviour (mood, eating habits, requests);
>
> d. details of the removal and/or re-application of restraints, including the time the restraints were removed/re-applied and the reason. Note: where restraints have been removed on the advice/instruction of a healthcare professional, that person's name and position must be recorded along with the name of the correctional centre manager authorising the removal of the restraints and the time authorisation was given;
>
> e. checks that restraints are applied properly and have not been tampered with at least once every 60 minutes;

[47] Affidavit of Dr Emma Palfreyman, 4 December 2024, [85-95]

f. visits by correctional centre management;

g. the times the escorts provide a report to the correctional centre; and

h. any other information deemed significant in support of the safety and security of the hospital shift.

55. In Mr Tamwoy's journal I could not identify any records of 60-minute checks of restraints and while there were some examples of the removal and re-application of restraints recorded, this was not commonly or consistently recorded as required. It was precisely this failure which led to confusion and uncertainty about when and if shackles were applied.

56. SOP 4.3.14 provides:

> 5.3.5 At the commencement of each shift, relieving Officer(s) must ensure all listed equipment items (in the Hospital Bag) are accounted for and in working order and appropriately notated in the Journal.
>
> …
>
> 5.3.7 The Prisoner name must be recorded when making entries in the journal, and a new page utilised at the commencement of each shift.
>
> 5.3.8 All officers are to record a minimum of hourly health and welfare checks on the prisoner and make an appropriate notation in the Journal.

57. While two of these provisions were largely complied with, a new page was not commenced at each shift.

58. SOP 2.3.5 purportedly provides guidelines for all paper-based records (registers and journals) kept for record keeping purposes within the prison. It specifically refers to several registers but not the hospital journal. It is not entirely clear to me whether this SOP applies to the hospital journal but if it does apply then the hospital journal does not comply with all the guidelines outlined in this SOP. Some of the anomalies are minor, for example the use of red pens in the hospital journal.[48] Some are more significant, for example,

[48] Contrary to Standard Operating Procedure 2.3.5 Journals and Registers @ 5.2.2

there was no evidence that Senior Correction/Industry Officers were inspecting the hospital journal daily to correct discrepancies and provide guidance and training[49] or that the Chief Correctional/Industries Officer was inspecting and signing the journal not less than once a week for compliance purposes.[50]

59. I sympathise with the correctional officers who are expected to navigate numerous Directives and SOPs, let alone grapple with inconsistencies between them, to understand their obligations in respect of what should be a simple act of maintaining the hospital journal.

60. In response to the identified shortcomings of the hospital journal, in January 2024 it was replaced with a 'Hospital Bedsit Log'.[51] Mr Gordon has indicated the pro forma log will be further improved to address the issues identified in the inquest and is considering whether pro forma examples of log entries and/or a hospital checklist would be beneficial.[52]

Failure to notify a Next of Kin or an Aboriginal Legal Service

61. Directive 2.8.17 - Notifications of Prisoner's Critical Illness, Palliative Care or Serious Injury requires prisoners to nominate emergency contact persons during their reception into the prison and receiving correctional officers are to record the information on IOMS (the Integrated Offender Management System). It is expected that next of kin will be notified in the event a prisoner is hospitalised for a serious life-threatening illness, injury or accident or to receive palliative care. Responsibility for informing the next of kin rests with the General Manager or delegate.

62. Directive 2.8.2 – Death in Custody at 7.10 provides that reception procedures are to ensure that on entering the centre each prisoner has indicated clearly

[49] Standard Operating Procedure 2.3.5 Journals and Registers @ 5.3.1
[50] Standard Operating Procedure 2.3.5 Journals and Registers @ 5.5.1
[51] Institutional Response, 21 November 2024, Annexure DG-3.
[52] T 86-87.

who is to be contacted in the event of serious illness, injury or death; that accuracy with full names, phone numbers and spelling is essential; and prisoner contact details are to be verified each time a prisoner has a SCATE or OMP (Offender Management Program) review. In the event of a death the General Manager without delay will provide the name and address of the next of kin to NT Police and NT Police will notify the next of kin of the death.

63. Following Mr Tamwoy's death, his next of kin could not be identified and no one was notified. Over 12 episodes of imprisonment between 1995 and 2023, there were only two entries for emergency contacts for Mr Tamwoy in (IOMS) which were dated 2009 and 2015. Both entries were names only, with no addresses or phone numbers recorded. Other correctional services documents from as early as June 1998 consistently recorded that Mr Tamwoy did not wish for anyone to be notified of his imprisonment[53] and he had not used his Prisoner Telephone System account (PTS) since 2017.

64. While it is unclear from the documents whether he declined to provide any emergency contacts or whether he was not asked, I accept that the former was likely because Mr Tamwoy declined to nominate a next of kin to hospital staff at 7.30am on the day of his death and said, "Do not contact my family. I do not want them to know what is going on".[54]

65. On the morning of 17 November 2023, when it was apparent that Mr Tamwoy would pass away, Corrections and Health staff nevertheless attempted to identify a next of kin. Previous legal representatives, Mackay Hospital, NAAJA and the Thursday Island Health Clinic were all contacted without success.[55]

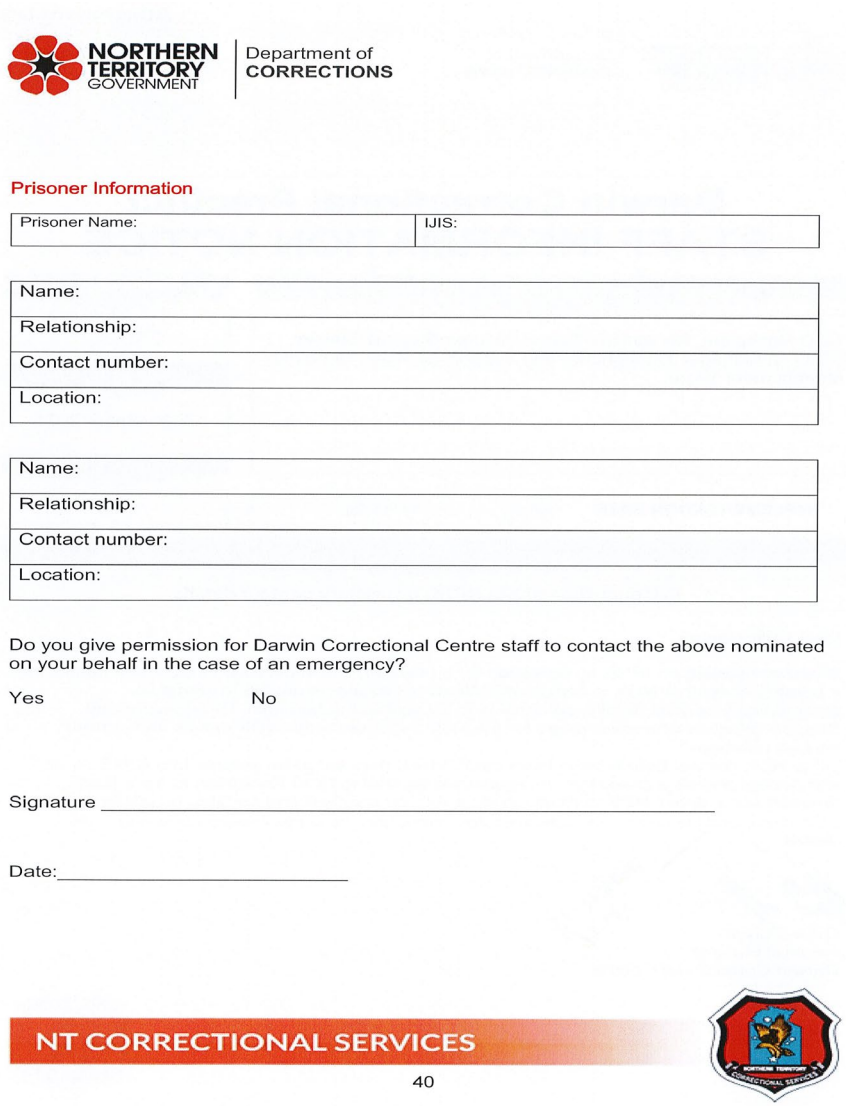
66. In circumstances where a prisoner is not able or willing to provide an emergency contact, in consultation with the Manager of Throughcare and

[53] Brief of evidence, Prison Records, Folio 18.
[54] Affidavit, Critical Care Nurse, 15 November 2024, [23]
[55] Brief of evidence, Folio 10, [7].

Support Services (Throughcare), Mr Gordon has advised that a new procedure has now been developed. On reception, if a prisoner does not nominate an emergency contact, the receiving correctional officer is to notify the Manager of Throughcare who will task a Prisoner Support Officer (PSO) to make enquiries to identify an appropriate prisoner contact person in the community. PSOs would be expected to engage with visiting Elders of the prisoner's home community or other family members to identify an appropriate person. This person will be recorded on IOMS but prisoners will be asked whether they give permission for staff to contact the identified person in an emergency. Ultimately it remains the decision of the prisoner as to whether they give permission for staff to contact an identified person.

67. On 7 November 2024, a 'Staff Information Notice' was issued to all staff at the prison advising of the new procedure, attaching a new Prisoner Information form for recording the information (see below), and which reminded staff of their duties to ensure that contact details for a primary contact or next of kin be obtained upon reception, and that those details are checked and updated in SCATE or Offender Management Program reviews.[56]

[56] Institutional Response on behalf of the Department of Corrections, 21 November 2024, Annexure DG-4.



NORTHERN TERRITORY GOVERNMENT | Department of CORRECTIONS

Prisoner Information

Prisoner Name:	IJIS:

Name:
Relationship:
Contact number:
Location:

Name:
Relationship:
Contact number:
Location:

Do you give permission for Darwin Correctional Centre staff to contact the above nominated on your behalf in the case of an emergency?

Yes No

Signature _____

Date:_____

NT CORRECTIONAL SERVICES

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68. To avoid any doubt, an indication on the 'Prisoner Information' form that a prisoner has declined to provide an emergency contact should perhaps also be included.

69. Direction 2.8.2 - Death in Custody obliges the Deputy Commissioner of Custodial Operations to notify the nearest Aboriginal Legal Office of the death of a prisoner of Aboriginal descent, unless the next of kin requests otherwise. This did not occur following Mr Tamwoy's death.

70. To ensure that such notifications occur in the future, Mr Gordon advised that a General Manager's Checklist for Deaths in Custody had been created which

will form part of a new SOP for deaths in custody which is in the process of being developed.[57]

Conclusion

71. It is highly unfortunate that Mr Tamwoy was subjected to periods of unnecessary restraint whilst he was very unwell and in hospital as a prisoner in-patient. However, there is no evidence to suggest that his shackles (or other restraints) contributed to his death, which was sadly an inevitable outcome following his diagnosis of plasmablastic myleoma in September 2023.

72. It appears that he received excellent medical care throughout his last period of custody, both at the prison and at the hospital, and the correctional officers who gave evidence at the inquest displayed compassion and care in their supervision of him.

73. The correctional officers followed the relevant SOP concerning the use of restraints. It was not their fault that the SOP did not accurately reflect the intent of the relevant Directive, namely, that low security in-patient prisoners were not to shackled, except if elevated risks were identified, and no such risks were identified for Mr Tamwoy. He should not have been shackled when he was.

74. The Department of Corrections have committed to a review of all Directives and SOPs to improve consistency and clarity, but the current resources allocated to that task are inadequate to ensure it is completed in a timely fashion. Given the issues identified in this inquest, the Directives and SOPs concerning the use of restraints on low security prisoners should be urgently addressed.

[57] Institutional Response on behalf of the Department of Corrections, 21 November 2024, [58-59] and attachment DG5.

Recommendations

75. **I recommend** that the NT Department of Corrections conduct a thorough review of all Directives and Standard Operating Procedures concerning the use of restraints on prisoners under medical escort and prisoner in-patients, to ensure consistency and clarity, and to ensure any correctional officer discretions are appropriate to their training and role. All correctional officers should receive training on any new or updated Directives and SOPs.

76. **I recommend** that any Directives and Standard Operating Procedures referable to the maintenance of the Hospital Journal or Hospital Bedsit Log, be reviewed and consolidated into one Directive or SOP. The procedure should include a requirement that the application of restraints be clearly identified in the journal/log. All correctional officers should receive training on the consolidated Directive or SOP.

77. **I recommend** that relevant Directives and Standard Operating Procedures be reviewed to ensure that up-to-date next of kin and/or emergency contact details are accurately recorded, and alternatively, that it is clearly recorded that a prisoner declines to provide such details and/or declines to consent to persons being contacted.