ATTORNEY-GENERAL

Parliament House
State Square
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Darwin NT 0801

REPORT TO THE LEGISLATIVE ASSEMBLY

Pursuant to section 46B of the *Coroners Act 1993*

In the matter of the Coroner's Findings and Recommendations regarding the death of Glen Dooley

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Pursuant to section 46B of the *Coroners Act 1993* (the Act), I provide this report on the findings and recommendations of Local Court Judge Elisabeth Armitage, Territory Coroner, dated 12 June 2024, regarding the death of Mr Glen Dooley (the Deceased) (Attachment A refers).

The report includes the responses to the recommendations of the Territory Coroner from:

- Mr Matthew Varley, Commissioner / Chief Executive Officer (CEO), Department of Corrections (DoC) (Attachment B refers);
- Mr Chris Hosking, CEO of the Department of Health (DoH) (Attachment C refers);
- Mr Michael Murphy APM, former Commissioner of Police (Attachment D refers).

The Deceased, a 37 year old Aboriginal man, died at 12.40 pm on 22 October 2022 at the Royal Darwin Hospital. The cause of death was complications due to atherosclerotic heart disease and dyslipidaemia. The Deceased was a prisoner in the custody of the Northern Territory Correctional Services, now DoC.

Recommendations of the Coroner

At paragraphs 95 to 104 of the Coronial Findings, the Coroner made the following formal recommendations in regards to the death of the Deceased:

'**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.'

Responses to coroner's recommendations

A copy of the Coronial Findings was provided to the CEO of DoH, the former Commissioner of Police and the Commissioner/CEO of DoC for a response in accordance with section 46A(1) of the Act.

A written response was received from the Commissioner/CEO of DoC, dated 11 March 2025 as required by section 46B(1) of the Act, advising that:

(a) Recommendation 100

On 8 February 2024, the Darwin Correctional Centre Standard Operating Procedure – Primary Health Care Centre1 for the Darwin Correctional Centre (DCC) was updated as follows:

7.5 – Prisoners outside the main jail (secure perimeter) liaising with medical over the phone when they are not able to attend medical. If an Officer initiates a call to medical (PHCP) in regards to a prisoner not feeling well and the prisoner is unable to attend the PHCC medical centre, the PHCP may request to talk to the prisoner over the phone so they can triage and do an assessment of their condition whilst talking to them to ascertain the best course of action. (This is not to replace in person consultation and only to occur where PHCP is unable to attend to the prisoner in person. Regardless of the phone consultation outcome, the prisoner is to attend medical centre at the next available opportunity).

This update has included that the PHCP may request to speak with the prisoner by phone to enable an assessment to occur in circumstances when a face-to-face assessment is not able to occur.

The Alice Springs Correctional Centre (ASCC), correctional officers contact the health clinic to relay health complaints, and act on advice provided. After hours the contact is made to on-call medical staff at the Alice Springs Hospital.

Work is continuing to align the practices of the Darwin and ASCC.

(b) Recommendation 101

DoC has taken steps to address the potential of inaccuracies in the IRNA through a systems update in the Integrated Offender Management System (IOMS) that determines any positive responses recorded will remain positive in all future custodial episodes. For example, if a prisoner discloses a heart issue, this positive response will be recorded permanently against their DoC identity for any future custodial episodes, and cannot be overwritten by DoC staff.

(c) Recommendation 102

In January 2024, a review of the prisoners' menu at DCC was undertaken by an Accredited Practising Dieticians) of Healthy Living NT, who provided a comprehensive report detailing where improvements could be made. Their recommendations have been accepted and the necessary improvements were implemented and are now included in the current prisoner menus.

ASCC menus are reviewed every two years to check and monitor compliance with dietary guidelines. These reviews were postponed due to COVID in 2021 and 2023, but a new review is about to be undertaken.

DoC will work to align the practices with regard to the dietary requirements and provision of menus that align with national guidelines.

(d) Recommendation 103

The Staff Learning and Development Unit (SLDU) within DoC conduct recruit training around the recording and maintaining of notes, journals and records. Current training includes that they maintain contemporaneous notebook records while conducting duties such as:

- hospital escorts and watches; and
- other types of escorts.

Following Mr Dooley's inquest, SLDU were requested to reinforce the type of information that must be recorded in journal entries, and that escorting officers should maintain a record of important events, including:

- observations of the prisoner under escort;
- details of the removal and/or application of restraints;
- details of updates provided to the correctional centre;
- details of visitors; and
- any other information significant in support of the safety and security of the officers' shift.

A written response was received from the CEO of DoH, dated 21 November 2024, as required by section 46B(1) of the Act, advising that:

(a) Recommendation 95

A review is currently being undertaken by the Top End Region Population and Primary Health Care division of NT Health with the aim of strengthening ECG management in all Primary Health Centres, including Prison Health, across the Big Rivers, East Arnhem and Top End Regions. This review will be expanded across the Barkly and Central Australia NT Health Primary Health Care services.

A program of ongoing education for improving the capacity of health staff for ECG reading and interpretation has commenced for all primary health medical staff across the Top End Region with a plan to implement training across the Territory. An improved process has been developed to enable primary health staff access to specialists when required.

A process for ECG management, including recording and reporting within the electronic medical record system, for both acute and non-acute presentations has been developed. A trial of this process is being undertaken in two smaller Top End health centres and learnings from this trial will inform a broader trial to be commenced

at DCC. The trials include auditing, continual monitoring and evaluation of compliance, patient outcomes; including the strategies for mitigating harm and risk, feedback on staff experiences with the process, and the capacity to raise concerns about the process, access to specialist services or patient outcomes. Following completion of the trials and assessment of the outcomes, the updated process will be finalised, implement across all NT Health primary health clinics, including within other correctional facilities and published on the intranet.

(b) Recommendation 96

Prison Health Senior Leadership Team have commenced a project to holistically review access to clinical services within correctional facilities, including planned episodes of care and acutely presenting conditions. In conjunction with the recently published NT Wide PPHC High Priority Recall Management Guideline, a triage tool and recall codes have been reviewed and a trial of this tool within DCC is due to be completed in October. Outcomes of this trial and review will be incorporated into the suite of access to care documents that are being developed. The Prison Health and PPHC leadership team are committed to working with Correctional Services to improve timely access to health care and pathways to escalate high priority reviews with regular inter agency meetings.

(c) Recommendation 97

The Medical Housing Prison Health Guideline, which applies to DCC, has been extensively reviewed, including the criteria for placement of clients in the Medical Housing Rooms at that facility. Under this guideline clients are to be hemodynamically stable, with a full set of vital signs recorded prior to placement in the Medical Housing. The shift team leader must allocate clinical accountability to a nurse for the duration of the client's stay in the Medical Housing. All clients require a documented treatment plan, and are to be included in the verbal handover to daily clinical staff and the on-call nurse. Correctional Services is to be notified when clients are placed in the Medical Housing. Once a client is placed in the Medical Housing they are to receive the treatment in accordance with their treatment plan.

Clients who need continuous monitoring or are at risk of deterioration are not suitable for placement in Medical Housing. CCTV is not used for clinical monitoring of clients.

CCTV is utilised by Correctional Services for observation across the entire DCC. Monitoring the CCTV and responding to the intercom in Medical Housing Rooms is the responsibility of Correctional Services.

(d) Recommendation 98

NT Health is addressing this recommendation in combination with its review of access to clinical services referred to in response to Recommendation 96 above. Correctional Services has committed to providing hand held devices across all sectors/ accommodation blocks to ensure direct communication can occur between Prison Health staff and the client. This will improve the ability for clinicians to remotely assess clients and formulate appropriate follow-up, allowing the clinician to 'close the loop'.

(e) Recommendation 99

NT Health is committed to providing culturally safe health care and has many resources and mandatory training in Cultural Awareness and culturally safe communication, including the use of interpreters and Aboriginal Liaison Officers in circumstances of a death in custody. The NT Health Clinical Incident Management Guideline includes the need for Open Disclosure in line with the Australian Commission on Safety and Quality in Health Care's Open Disclosure Framework, and prompts health staff to offer and arrange for an interpreter. PPHC has recommended inclusion of a prompt in this guideline to offer, where relevant, participation of an Aboriginal Health Worker or Aboriginal Liaison Officer.

Under section 91(2) of the Correctional Services Act 2014 where a prisoner is critically ill or injured, the Commissioner is responsible for notifying the prisoner's next of kin. In the event of a death of a prisoner, the Coroner's Office is to notify the family or next of kin. NT Health works with each of these agencies to assist with identification of the appropriate persons and to provide their contact details.

A written response was received from the former Commissioner of Police, dated 14 August 2024, as required by section 46B(1) of the Act, advising that:

(a) Recommendation 104

The General Order – Crime (Homicide and Serious) Investigation was promulgated on 24 November 2022 with only designated Detectives assigned to serious investigations involving reportable deaths, ensuring a specialised focus on these critical cases.

Since February 2024, the Northern Territory Police have introduced internal process improvements to strengthen investigator supervision, oversight and the timely resolution of file management issues, including through active engagement with supervisors by the Commander of Crime, and fortnightly meetings specifically dedicated to reviewing all deaths in custody or care.

Improved governance for non-suspicious deaths which occur in remote locations have been raised with the Command Leadership Group.

I am satisfied that the CEO of DoH, the former Commissioner of Police and the Commissioner/CEO of Department Corrections, have considered the recommendations of the Territory Coroner and that they are taking necessary steps to implement the recommendations.

DATE:

MARIE-CLARE BOOTHBY

11 APR 2025