The Hon Ryan Park MP

Minister for Health Minister for Regional Health Minister for the Illawarra and the South Coast



Your Ref: 2019/269131 Our Ref: COR23/2

The Hon. Michael Daley, MP Attorney General 52 Martin Place SYDNEY NSW 2000 office@daley.minister.nsw.gov.au

Coronial inquest into the death of Roy Roberts

Dear Attorney General

I write in relation to the findings and recommendations made on 3 February 2023 by Deputy State Coroner Derek Lee in relation to the death of Roy Roberts.

Michael.

Mr Roberts died on 28 August 2019 due to a prolonged epileptic seizure resulting in gastric content aspiration and cardiac arrest. He died of natural causes while in lawful custody at 33 years of age. Mr Roberts was a First Nations man. He spent various periods in custody, with his most recent period from mid-November 2018. He was administered daily doses of methadone under supervision at this period. Mr Roberts had three suspected seizures in April and May 2019, and on each occasion was transported to Bathurst Base Hospital for investigation and treatment.

On 26 August 2019 Mr Roberts was transferred to Long Bay Correctional Centre, and two days later, he was found convulsing in his cell. Medical assistance was sought and CPR commenced, however Mr Roberts was declared dead a short time later. An autopsy on 30 August 2019 recorded cause of death as gastric content aspiration due to methadone toxicity.

Magistrate Lee found that Mr Roberts' seizure on 28 August 2019 was his fourth seizure event and although opportunities existed to further investigate his previous episodes, it is not known if these opportunities had been taken whether this would have materially affected the ultimate outcome.

The Deputy State Coroner made 3 recommendations to the Justice Health and Forensic Mental Health Network (Justice Health), that are all supported.

Recommendation 1

The Deputy State Coroner recommended:

- 1. That, in consultation with Corrective Services New South Wales, appropriate steps be taken to ensure that adequate education and guidance is provided to Justice Health clinicians so that they may inform inmate patients of:
 - a. the confidentiality requirements that attach to provision of any health information by an inmate to a clinician; and
 - b. the ability to request a consultation with a clinician in the absence of a Corrective Services New South Wales officer, subject to any safety and security considerations that may attach to such a request.

Resources are available to support patients' understanding of their healthcare rights and Justice Health clinicians are provided with guidance in relation to these resources.

Justice Health note that clinical consultations without a Corrective Services Officer present occur in the correctional setting, at the request of health staff and/or patients. Justice Health clinicians work with Corrective Services Officers to identify the most appropriate and safest approach. Justice Health advise that when asked, Corrective Services Officers often agree to requests to wait outside the consultation space during a healthcare discussion.

Justice Health will amend Policy 4.030, Requesting and Disclosing Health Information and Guideline 9.036, Guidelines on use and disclosure of health information to include guidance for clinicians to strengthen clinical communication and advocacy for patients in their care. Justice Health will also include this in health reception training and orientation sessions. Internal communications will be sent to clinical staff notifying them of the amended policy and guideline.

Recommendation 2

The Deputy State Coroner recommended:

2. That consideration be given to providing ongoing education and training to all nursing and medical clinicians regarding the clinical features and identification of primary epilepsy.

Justice Health Clinical Nurse Educators will use best practice resources to facilitate refresher education over the next 4 months to clinicians on the clinical features and identification of primary epilepsy. Additionally, epilepsy training and education material has been sourced in collaboration with the Department of Neurology and Prince of Wales Hospital. The Justice Health general practitioner education day scheduled in September 2023 and Justice Health Grand Rounds, which is open to all clinical staff, will include epilepsy education. The recorded education component will be made available to all staff via targeted in-service, and on the Justice Health intranet.

Recommendation 3

The Deputy State Coroner recommended:

3. That a review be conducted to ensure that Aboriginal Health Worker positions in New South Wales correctional centres are sufficiently staffed to provide inmate patients with access to culturally appropriate healthcare.

Justice Health continue to promote and develop their Aboriginal workforce. Justice Health acknowledge a long-standing challenge in relation to First Nations health care worker roles and prioritise recruitment and retention of First Nations workforce in the Justice Health Strategic Plan and the new Workforce Enabling Plan. A Justice Health Director of Aboriginal Health position has been created and will be instrumental in informing the strategic direction including Closing the Gap initiatives, strengthening culturally appropriate services and creating a sustainable Aboriginal workforce. Justice Health has two First Nations Board members.

Justice Health has initiated discussions with TAFE NSW regarding pathways for students completing the Certificate IV in Aboriginal & Torres Strait Islander Primary Health Care Practice into full time employment with Justice Health - Aboriginal Health. The Justice Health Aboriginal Chronic Care Program is aimed at the detection and management of chronic and complex health conditions in Aboriginal and Torres Strait Islander people within the custodial environment. The program workforce includes 7 full time Aboriginal Health Workers, with recruitment efforts to fill an additional 7 positions, with support and guidance of the Director of Aboriginal Health and Director of People and Culture.

I trust that this response confirms NSW Health's commitment to a process of continuous improvement and delivering safe and high-quality care to all patients of the NSW health system.

For more information, please contact Joanne Edwards, Executive Director, System Management Branch, NSW Ministry of Health at moh-systemmanagementbranch@health.nsw.gov.au.

Yours sincerely

Ryan Park MP

Minister for Health

Minister for Regional Health

Minister for the Illawarra and the South Coast

CC: NSW Coroner's Court

Encl. Coroner's report – Inquest into the death of Roy Roberts