Report by the NSW State Coroner

into deaths in

custody/police operations

for the year 2021.

A report Prepared pursuant to s23 of the *Coroners Act 2009* (NSW)
NSW Office of the State Coroner
NSW Department of Community & Justice
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The Hon. Mark Speakman SC, MP
Attorney General and Minister for Justice
Level 15, 52 Martin Place
Sydney NSW 2000

29th April 2022

Dear Attorney General,

Section 37(1) of the Coroners Act 2009 ('the Act') requires that I provide to you annually, a summary of all deaths in custody and deaths that are the result of police operations that were reported to a coroner in the previous year. Inquests are mandatory in such cases but many of the deaths that occurred last year have not yet been finalised. I have also included a summary of the deaths that were reported in previous years but only finalised last year.

I attach a hard copy and an electronic copy of the 2021 report.

Section 37(3) requires that you cause a copy of the report to be tabled in each House of Parliament within 21 days of receipt.

The deaths in question are defined in Section 23 of the Act and include deaths that occur while the deceased person is in the custody of a police officer or in other lawful custody, or while the person is attempting to escape. Also included are deaths that occur as a result of police operations, or while the person is in or temporarily absent from a juvenile detention centre or an adult correctional centre.

As you would appreciate, deaths in prisons have for centuries been recognised as sensitive matters warranting independent scrutiny. Similarly, deaths occurring as a result of police operations which include shootings by police officers, shootings of police officers and deaths occurring as a result of a police pursuit, also attract significant public and media attention.

The inquest findings referred to are available on the Coroners Court webpage at: http://www.coroners.justice.nsw.gov.au/Pages/findings.aspx. Please do not hesitate to contact me if you wish to discuss any of the matters contained in the report or would like further details of any of the matters referred to.

Yours faithfully,

Magistrate Teresa O'Sullivan
NSW State Coroner

2021 OVERALL–SECTION 23 - SUMMARY IN BRIEF

- A total of 43 deaths in custody/result of police operations (*s.23 of the Coroners Act)* were reported to the NSW State Coroner in the calendar year 2021.

- Of the 43 deaths, 16 were of First Nations people, representing 37.2% of all the s.23 deaths reported; this figure represents an increase of 12 deaths from the previous year.

- Of the 16 deaths of First Nations people, 9 occurred in custody and 7 deaths were as a result of police operations.

- The State Coroner and Deputy State Coroners completed a total of 40 inquests.

- 1 matter was suspended following advice that a person had been charged with the death.

- 1 matter reported prior to 2021 was identified as not being a S 23 reportable death and the inquest was dispensed with by the Coroner.

- The figure of 43 deaths represents a decrease of 5 deaths from the previous Annual Report for the year 2020.

- 39 of the 43 deaths were male.

- 13 of the 43 deaths occurred as a result of a police operation.

- 30 of the deaths were in custody.

- 27 of the 30 deaths in custody were in NSW Correctional facility custody.

- 1 of the 30 deaths in custody occurred in Cumberland Hospital, 1 occurred on weekend release and 1 occurred whilst in police custody.

- 1 of the deaths in custody in the Correctional facility was as a result of an alleged homicide by another inmate.

- Of the deaths in custody, 17 were serving a fulltime sentence and 13 were held on remand.

- 20 of the overall 43 deaths were as a result of natural causes.

STATUTORY APPOINTMENTS

Pursuant to Section 22(2) of the *Coroners Act 2009*, only the State Coroner or a Deputy State Coroner can preside at an inquest into a death in custody or a death in the course of police operations. The inquests detailed in this report were conducted before the following Senior Coroners:

NSW State and Deputy Coroners 2021 who undertook Section 23 Inquests

Her Honour Magistrate TERESA O'SULLIVAN NSW State Coroner

1987	Admitted as solicitor of Supreme Court of QLD
1987-89	Solicitor, Legal Aid QLD
1989-90	Solicitor, Child Protection, Haringey Borough, London
1990	Admitted as solicitor Supreme Court of NSW
1990-97	Solicitor, Marrickville Legal Centre, Children's Legal Service
1998-03	Solicitor, Central Australian Aboriginal Legal Aid Service, Alice Springs
2003-08	Solicitor, Legal Aid NSW, Children's Legal Service
2008-09	Solicitor, Legal Aid NSW, Coronial Inquest Unit
2009	Appointed Magistrate Local Court NSW
2015	Appointed NSW Deputy State Coroner
2019	Appointed NSW State Coroner

Her Honour Magistrate HARRIET GRAHAME

Deputy State Coroner

1993	Admitted as a solicitor of the Supreme Court of NSW
1993-2001	Solicitor at Redfern Legal Centre, Western Aboriginal Legal Centre & NSW Legal Aid Commission
2001-2006	Barrister
2006-2010	Lectured in Law (Various Universities)
2010	Appointed a Magistrate in NSW
2015	Appointed NSW Deputy State Coroner

His Honour Magistrate Derek Lee

Deputy State Coroner

1997:	Admitted as a solicitor of the Supreme Court of NSW
1998-2002:	Solicitor, Office of the Director of Public Prosecutions (ODPP)
2002-2005:	Senior Solicitor, ODPP Special Crime Unit
2005-2007:	Solicitor, Legal Aid (Inner City Local Courts)
2007-2012:	Barrister
2012:	Appointed NSW Local Court Magistrate
2016:	Appointed NSW Deputy State Coroner

Her Honour Magistrate Elizabeth Ryan

Deputy State Coroner

1986	Admitted as solicitor of Supreme Court of NSW
1986-1987	Solicitor, Bartier Perry & Purcell Solicitors
1988-2003	Litigation Lawyer, Commonwealth Director of Public Prosecutions
2003-2009	Managing Lawyer, Commonwealth Director of Public Prosecutions.
2009	Appointed a Magistrate, NSW Local Court
2017	Appointed a NSW Deputy State Coroner.

Her Honour Magistrate Carmel Forbes

Deputy State Coroner

1983	Admitted as Solicitor of the Supreme Court of NSW
1986-87	Solicitor for Department of Motor Transport.
1987-92	Solicitor in private practice.
1992-98	Solicitor for Legal Aid Commission.
1998-2001	Solicitor in private practice.
2001	Appointed a Magistrate.
2011	Appointed a Deputy State Coroner.

Her Honour Magistrate Elaine Truscott

Deputy State Coroner

1984-1986	Barrister & Solicitor, Grey Lynn Community Legal Centre, Auckland NZ
1986-1987	Project Officer, Civil Rehabilitation Committee, Sydney
1987-1993	Solicitor, Legal Aid Commission, NSW
1993-2000	Barrister
2000	Appointed Magistrate Local Court, NSW
2010	Deputy State Coroner whilst Local Court Magistrate Newcastle
2014	Appointed NSW Deputy State Coroner.

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Introduction by the New South Wales State Coroner

What is a death in custody?

It was agreed by all mainland State and Territory governments in their responses to recommendations of the Royal Commission into Aboriginal Deaths in Custody that a definition of a 'death in custody' should, at the least, include:

- the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the Migration *Act 1958* (Cth).

- the death, wherever occurring, of a person whose death is caused or contributed to by traumatic injuries sustained, or by lack of proper *care* whilst in such custody or detention.

- the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and

- the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.

Section 23 of the *Coroners Act 2009* (NSW) expands this definition to include circumstances where the death occurred:

- while temporarily absent from a detention centre, a prison or a lock-up; and

- while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody.

It is important to note that in relation to those cases where an inquest has yet to be heard and completed, no conclusion can be drawn that the death necessarily occurred in custody or during the course of police operations.

This is a matter for determination by the Coroner after all the evidence and submissions have been presented at the inquest hearing.

Intensive Correction Orders

Where the death of a person occurs whilst that person is serving an Intensive Correction Order, such death will be regarded as a death in custody pursuant Section 23 of the *Coroners Act 2009* (NSW).

Corrective Services NSW has a policy of releasing prisoners from custody prior to death, in certain circumstances. This generally occurs where such prisoners are hospitalised and will remain hospitalised for the rest of their lives.

Whilst that is not a matter of criticism it does result in a "technical" reduction of the actual statistics in relation to deaths in custody. In terms of Section 23, such prisoners are simply not "in custody" at the time of death.

Standing protocols provide that such cases are to be investigated as though the prisoners are still in custody.

What is a death as a result of or in the course of a police operation?

A death which occurs 'as a result of or in the course of a police operation' is not defined in the *Coroner's Act 2009*. Following the commencement of the 1993 amendments to the *Coroners Act 1980*, New South Wales *State Coroner's Circular No. 24* sought to describe potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in Section 23 of the *Coroners Act 2009*, as follows:

- **any police operation calculated to apprehend a person(s)**
- **a police siege or a police shooting**
- **a high-speed police motor vehicle pursuit**
- **an operation to contain or restrain persons**
- **an evacuation**
- **a traffic control/enforcement**
- **a road block**
- **execution of a writ/service of process**
- **any other circumstance considered applicable by the State Coroner or a Deputy State Coroner.**

After well over twenty years of operation, most of the scenarios have been the subject of inquests. The Senior Coroners have tended to interpret the subsection broadly. This is so that the adequacy and appropriateness of police response and police behaviour generally will be investigated where we believe this to be necessary. It is critical that all aspects of police conduct be reviewed notwithstanding the fact that for a particular case it is unlikely that there will be grounds for criticism of police.

It is important that the relatives of the deceased, the New South Wales Police Force and the public generally have the opportunity to be made aware, as far as possible, of the circumstances surrounding the death. In most cases where a death has occurred as a result of or in the course of a police operation, the behaviour and conduct of police is found not to warrant criticism by the Coroner's.

We will continue to remind both the NSW Police Force and the public of the high standard of investigation expected in all Coronial cases.

Why is it desirable to hold inquests into deaths of persons in custody/police operations?

In this regard, I agree with the answer given to that question by former New South Wales Coroner, Mr Kevin Waller, as follows:

> *The answer must be that society, having effected the arrest and incarceration of persons who have seriously breached its laws, owes a duty to those persons, of ensuring that their punishment is restricted to this loss of liberty, and it is not exacerbated by ill-treatment or privation while awaiting trial or serving their sentences. The rationale is that by making mandatory a full and public inquiry into deaths in prisons and police cells the government provides a positive incentive to custodians to treat their prisoners in a humane fashion and satisfies the community that deaths in such places are properly investigated.*

I also agree with Mr Waller that:

> *In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution.*
>
> *When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state.*
>
> *It is entirely proper that any death in custody, from whatever cause, must be meticulously examined.*

Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.

New South Wales coronial protocol for deaths in custody/police operations

As soon as a death in custody/police operation occurs in New South Wales, the local police are to promptly contact and inform the Duty Operations Inspector (DOI) who is situated at VKG, the police communications centre in Sydney. The DOI is required to notify immediately the State Coroner or a Deputy State Coroner, who are on call twenty-four hours a day, seven days a week.

The Coroner so informed, and with jurisdiction, will assume responsibility for the initial investigation into that death, although another Coroner may ultimately finalise the matter. The Coroner's supervisory role of the investigations is a critical part of any coronial inquiry.

Upon notification by the DOI, the State Coroner or a Deputy State Coroner will give directions for experienced detectives from the Crime Scene Unit (officers of the Physical Evidence Section), other relevant police and a coronial medical officer or a forensic pathologist to attend the scene of the death.

The Coroner will check to ensure that arrangements have been made to notify the relatives and, if necessary, the deceased's legal representatives. Where aboriginality is identified, the Aboriginal Legal Service is contacted by NSW Police.

Wherever possible the body, if already declared deceased, remains in situ until the arrival of the Crime Scene Unit and the Forensic Pathologist. The Coroner, if warranted, should inspect the death scene shortly after death has occurred, or prior to the commencement of the inquest hearing, or during the inquest.

If the State Coroner or one of the Deputy State Coroner's is unable to attend a death in custody/police operations occurring in a country area, the State Coroner may request the local Magistrate Coroner to attend the scene.

A high standard of investigation is expected in all coronial cases. All investigations into a death in custody/police operation are approached on the basis that the death may be a homicide. Suicide is never presumed.

In cases involving the NSW Police

When informed of a death involving the NSW Police, as in the case of a death in police custody or a death in the course of police operations, the State Coroner or the Deputy State Coroner's may request the Crown Solicitor of New South Wales to instruct independent Counsel to assist the Coroner with the investigation into the death.

This course of action is considered necessary to ensure that justice is done and seen to be done. In these situations Counsel (in consultation with the Coroner having jurisdiction) will give attention to the investigation being carried out, oversee the preparation of the brief of evidence, review the conduct of the investigation, confer with relatives of the deceased and witnesses and, in due course, appear at the mandatory inquest as Counsel assisting the Coroner.

Counsel will ensure that all relevant evidence is brought to the attention of the Coroner and is appropriately tested so as to enable the Coroner to make a proper finding and appropriate recommendations. Prior to the inquest hearing, conferences and direction hearings will often take place between the Coroners, Counsel assisting, legal representatives for any interested party and relatives so as to ensure that all relevant issues have been identified and addressed.

In respect of all identified Section 23 deaths, post mortem experienced Forensic Pathologists at Lidcombe or Newcastle forensic facilities conducted the examinations.

Responsibility of the Coroner

Section 81 of the *Coroners Act 2009* (NSW) provides*:*

81 Findings of Coroner or jury verdict to be recorded

(1) The coroner holding an inquest concerning the death or suspected death of a person must, at its conclusion or on its suspension, record in writing the coroner's findings or, if there is a jury, the jury's verdict, as to whether the person died and, if so:

(a) the person's identity, and

(b) the date and place of the person's death, and

(c) in the case of an inquest that is being concluded the manner and cause of the person's death.

(3) Any record made under subsection (1) or (2) must not indicate or in any way suggest that an offence has been committed by any person.

Section 78 of the *Coroners Act 2009* (NSW) provides:

78 Procedure at inquest or inquiry involving indictable offence

This section applies in relation to any of the following inquests:

(a) an inquest or inquiry held by a Coroner to whom it appears (whether before the commencement or during the course of the inquest or inquiry) that:

(i) a person has been charged with an indictable offence, and

(ii) the indictable offence raises the issue of whether the person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(b) an inquest or inquiry if, at any time during the course of the inquest or inquiry, the Coroner forms the opinion (having regard to all of the evidence given up to that time) that:

(i) evidence is capable of satisfying a jury beyond reasonable doubt that a known person has committed an indictable offence, and

(ii) there is a reasonable prospect that a jury would convict the known person of the indictable offence, and

(iii) the indictable offence would raise the issue of whether the known person caused the death, suspected death, fire or explosion with which the inquest or inquiry is concerned.

(2) If this section applies to an inquest or inquiry as provided by subsection (1) (a) the Coroner:

(a) may commence the inquest or inquiry, or continue it if it has commenced, but only for the purpose of taking evidence to establish:

(i) in the case of an inquest—the death, the identity of the deceased person and the date and place of death, or

(ii) in the case of an inquiry—the date and place of the fire or explosion, and after taking that evidence (or if that evidence has been taken), must suspend the inquest or inquiry and, if there is a jury, must discharge the jury.

(3) If this section applies to an inquest or inquiry as provided by subsection (1)(b) the Coroner may:

(a) continue the inquest or inquiry and record under section 81(1) or (2) the Coroner's findings or, if there is a jury, the verdict of the jury, or

(b) suspend the inquest or inquiry and, if there is a jury, discharge the jury.

(4) The Coroner is required to forward to the Director of Public Prosecutions:

(a) the depositions taken at an inquest or inquiry to which this section applies, and:

(b) in the case of an inquest or inquiry referred to in subsection (1) (b) - a written statement signed by the Coroner that specifies the name of the known person and the particulars of the indictable offence concerned.

Role of the Inquest

An inquest is an inquiry by a Senior Coroner into the circumstances of a particular death. Coroners are concerned not only with how the deceased died but also with why.

Deaths in custody and Police Operations are personal tragedies and continue to attract much public attention.

A Senior Coroner inquiring into a death in custody is required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions (so far as regards a possible link with the death).

The role of the coronial inquiry has undergone an expansion in recent years. At one time its main task was to investigate whether a suicide might have been caused by ill treatment or privation within the correctional centre. Now the Coroner will examine the system for improvements in management, or in physical surroundings, which may reduce the risk of suicide in the future.

Similarly, in relation to police operations and other forms of detention the Coroner will investigate the appropriateness of actions of police and officers from other agencies and review standard operating procedures. In other words, the Coroner will critically examine each case with a view to identifying whether shortcomings exist and, if so, ensure, as far as possible, that remedial action is taken.

Recommendations

The common-law practice of Coroners (and their juries) adding riders to their verdicts has been given statutory authorisation pursuant to Section 82 of the *Coroners Act 2009*. This section indicates that public health and safety in particular are matters that should be the concern of a Coroner when making recommendations.

Any statutory recommendations made following an inquest should arise from the facts of the enquiry and be designed to prevent, if possible, a recurrence of the circumstances of the death in question. The Coroner requires, in due course, a reply from the person or body to whom a recommendation is made.

Acknowledgment of receipt of the recommendations made by a Coroner is received from Ministers of the Crown and other authorities promptly.

Unavoidable delays in hearing Inquests

The Coroner supervises the investigation of any death from start to finish. Some delay in hearing cases is at times unavoidable and there are many various reasons for delay.

The view taken by the State Coroner is that deaths in custody/police operations must be fully and properly investigated. This will often involve a large number of witnesses being spoken to and statements being obtained.

It is settled coronial practice in New South Wales that the brief of evidence be as comprehensive as possible before an inquest is set down for determination. At that time a more accurate estimation can be made about the anticipated length of the case.

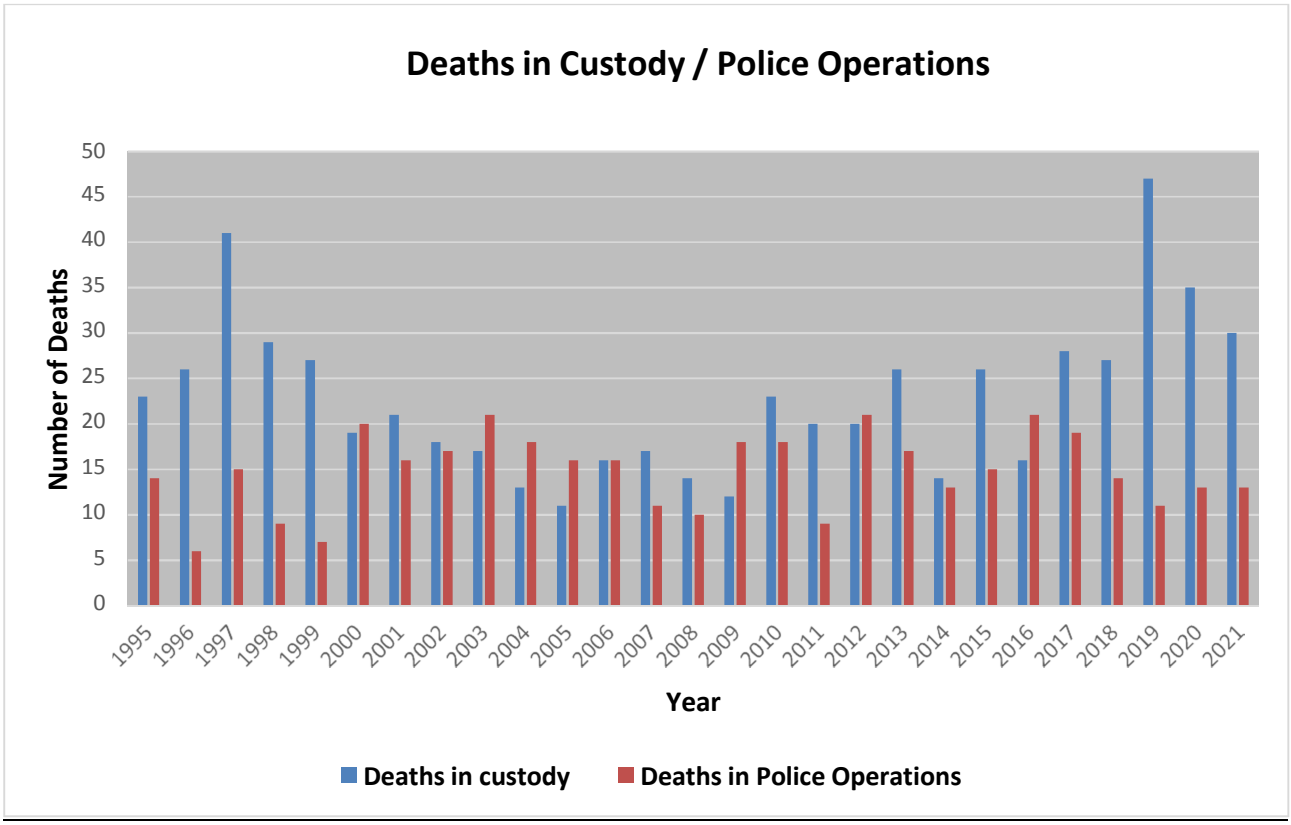
It has been found that an initially comprehensive investigation will lead to a substantial saving of court time in the conduct of the actual inquest.

In some cases, there may be concurrent investigations taking place, for example by the New South Wales Police Service Internal Affairs Unit or the Internal Investigation Unit of the Department of Corrective Services.

The results of those investigations may have to be considered by the Coroner prior to the inquest as they could raise further matters for consideration and perhaps investigation.

Table 1: Deaths in Custody/Police Operations, for the period to 2021.

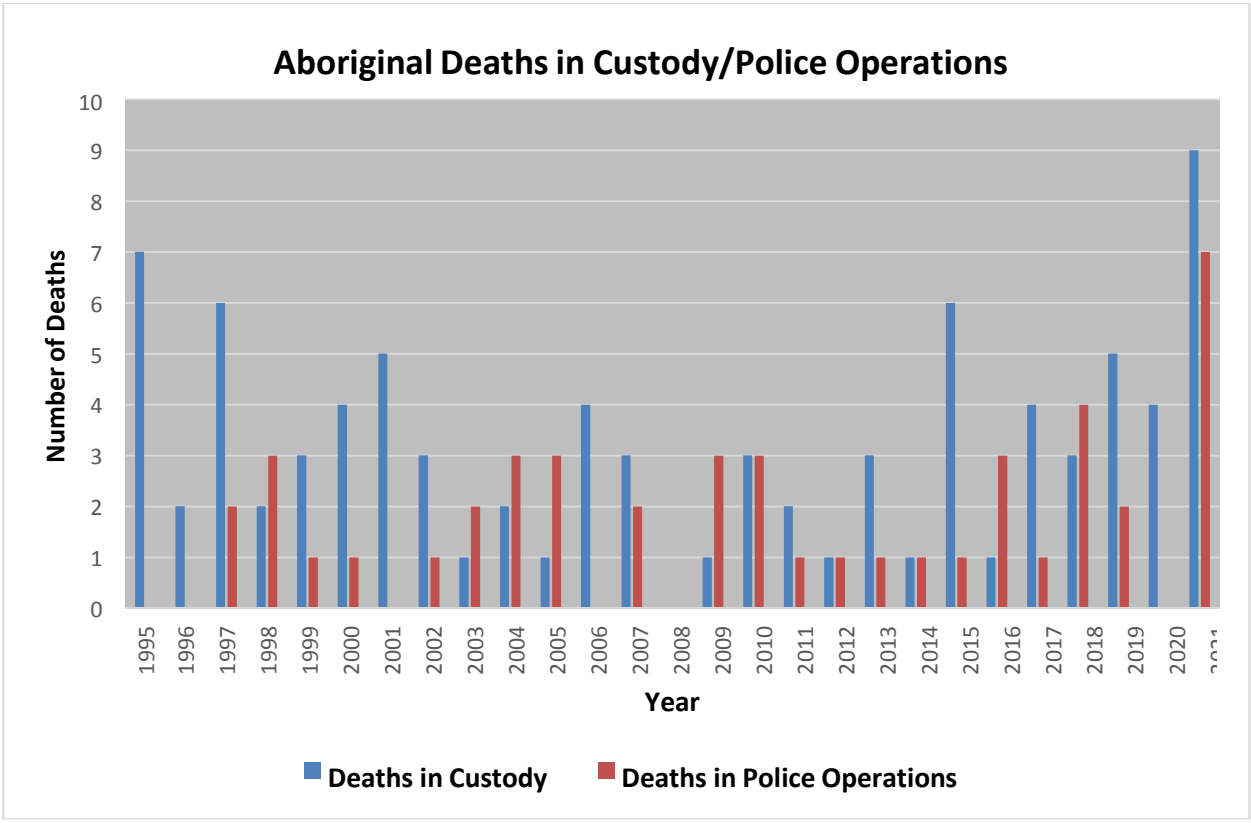
Year	Deaths in Custody	Deaths in Police Operation	Total
1995	23	14	37
1996	26	6	32
1997	41	15	56
1998	29	9	38
1999	27	7	34
2000	19	20	39
2001	21	16	37
2002	18	17	35
2003	17	21	38
2004	13	18	31
2005	11	16	27
2006	16	16	32
2007	17	11	28
2008	14	10	24
2009	12	18	30
2010	23	18	41
2011	20	9	29
2012	20	21	41
2013	26	17	43
2014	14	13	27
2015	26	15	41
2016	16	21	37
2017	28	19	47
2018	27	14	41
2019	47	11	58
2020	35	13	48
2021	30	13	43



** 27 of the 30 the deaths in custody were persons in the care of Corrective Services.

Table 2: Aboriginal deaths in custody/police operations 2021

Year	Deaths in Custody	Deaths in Police Operation	Total
1995	7	0	7
1996	2	0	2
1997	6	2	8
1998	2	3	5
1999	3	1	4
2000	4	1	5
2001	5	0	5
2002	3	1	4
2003	1	2	3
2004	2	3	5
2005	1	3	4
2006	4	0	4
2007	3	2	5
2008	0	0	0
2009	1	3	4
2010	3	3	6
2011	2	1	3
2012	1	1	2
2013	3	1	4
2014	1	1	2
2015	6	1	7
2016	1	3	4
2017	4	1	5
2018	3	4	7
2019	5	2	7
2020	4	0	4
2021	9	7	16


Aboriginal Deaths in Custody/Police Operations
Number of Deaths
0
1
2
3
4
5
6
7
8
9
10
1995
1996
1997
1998
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2020
Year
Deaths in Custody
Deaths in Police Operations

Circumstances of deaths of persons who died in Custody/Police Operations in 2021:

20- Natural Causes

3 - Fall/Jump

2 - Gunshot/Firearm

7 – Hanging

1- Drugs/Alcohol

1-Assault

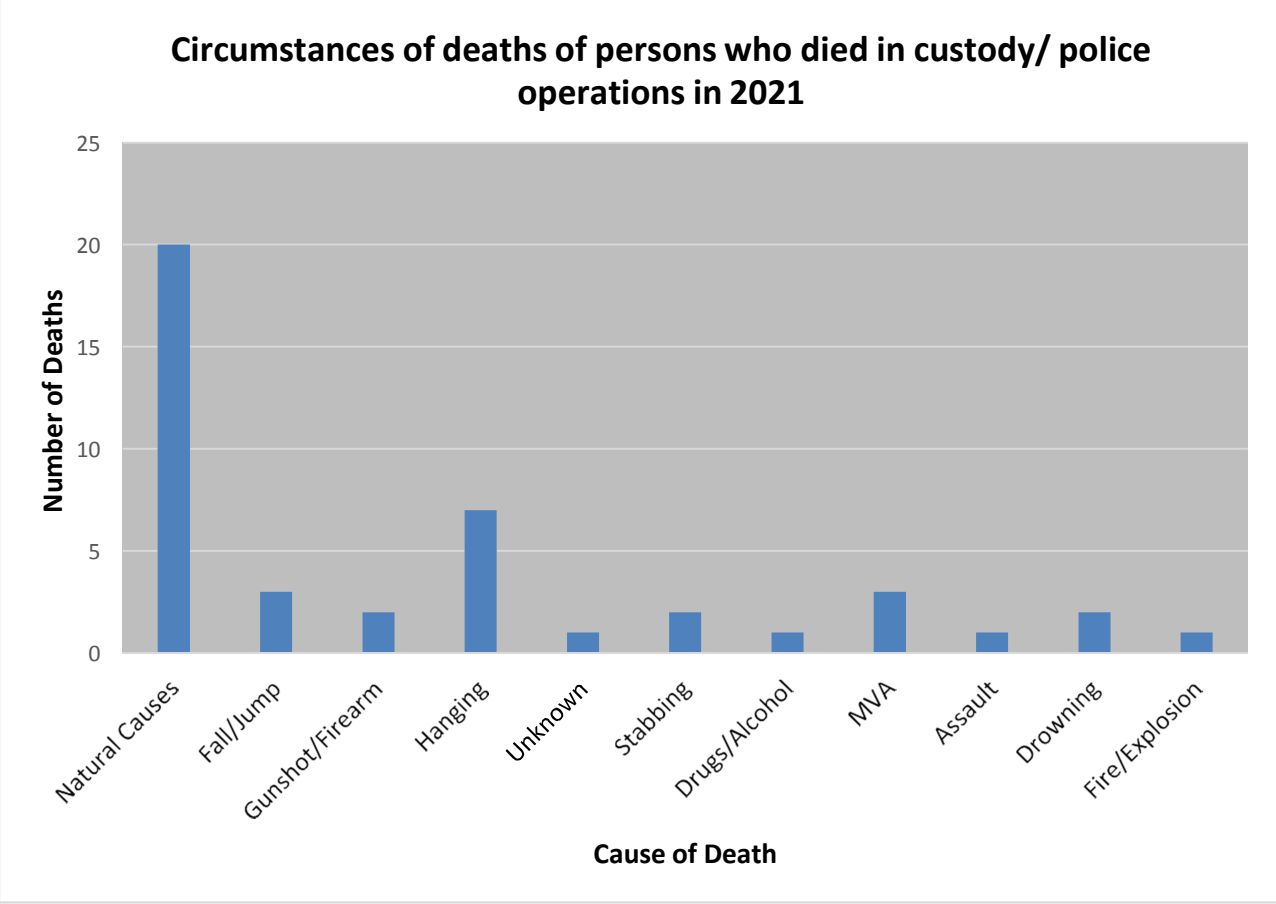
2- Drowning

1-Unknown

1 -Fire/Explosion

2 - Stabbing

3– MVA



SECTION 23 INQUESTS UNDERTAKEN IN 2021

Following are the written findings of each of the cases of deaths in custody/police operations that were heard by the NSW State Coroner or Deputy State Coroner in 2021.

These findings include a description of the circumstances surrounding the death and any recommendations that were made.

Please note: Pursuant to Section 75(1) & (5) of the *Coroner's Act 2009* the publication of the names of persons has been removed where the finding of the inquest is that their death was self-inflicted unless the Coroner has directed otherwise. ***The deceased names in those cases will be referred to as a pseudonym.***

	Case No	Year	Name	Coroner
1	329568	2015	Danny WHITTON	DSC Truscott
2	24535	2016	YW	DSC Lee
3	73098	2016	WW	DSC Forbes
4	290240	2016	MF	DSC Grahame
5	121886	2017	P	DSC Ryan
6	157550	2017	F	DSC Ryan
7	185430	2017	John LAURENSON	DSC Ryan
8	188495	2017	MH	SC O'Sullivan
9	225703	2017	Ivan GOOLAGONG	DSC Truscott
10	54392	2018	Jack KOKAUA	SC O'Sullivan
11	114791	2018	S	SC O'Sullivan
12	123983	2018	Zhing LIU	DSC Ryan
13	150097	2018	Samih ZRAIKA	DSC Forbes
14	166031	2018	Dimitrios MAVRIS	DSC Lee
15	269824	2018	Nathan REYNOLDS	DSC Ryan
16	291962	2018	LC	DSC Truscott
17	305251	2018	Nathan MACRI	DSC Truscott
18	314209	2018	James DORAN	DSC Grahame
19	392964	2018	A	DSC Ryan
20	4700	2019	AF	DSC Forbes
21	83697	2019	Tafari WALTON	SC O'Sullivan
22	117552	2019	Walter CLOUGH	DSC Ryan
23	154687	2019	Milo WILD	DSC Ryan
24	181202	2019	Robert MAXFIELD	DSC Ryan
25	308628	2019	Conway PERRIE	DSC Lee
26	323357	2019	Kingsley EAGER	DSC Forbes
27	337389	2019	Ivan MILAT	DSC Lee

28	351386	2019	Bailey MACKANDER	DSC Truscott
29	362566	2019	George MCLEOD	DSC Lee
30	388175	2019	Elias MELHEM	DSC Lee
31	388183	2019	Melvyn LYNCH	DSC Lee
32	7308	2020	Terence GRAY	DSC Truscott
33	38704	2020	Victor Madeley	DSC Truscott
34	80909	2020	Timothy MOFFATT	DSC Ryan
35	103425	2020	David JONES	DSC Truscott
36	148520	2020	Jodie ST JOHN	SC O'Sullivan
37	201875	2020	Willian BERGER	DSC Lee
38	241740	2020	Donald GREENAWAY	DSC Forbes
39	273670	2020	Jack KING	DSC Grahame
40	334150	2021	Kevin Thomas BYRNE (suspended)	DSC Shields

1. 329568 of 2015

Inquest into the death of Danny Keith Whitton. Inquest findings delivered by Deputy State Coroner Truscott at Lidcombe on the 19th November 2021.

Danny Whitton, a First Nations man of the Wanaruah People died aged 25. Danny was the son of Darren Whitton and Kylie Knight. When Danny was a baby Kylie and Darren separated and each re-partnered. Danny was the loved brother of 4 sisters and 3 step brothers. Danny was a young father. When Danny and Emma Price were teenagers they had a daughter, who was 8 years old when he died. He had a 2-year-old son as well. The Wanaruah Country is around the Hunter Valley area and Danny grew up around Maitland and Newcastle. His families have attended this inquest both in person and by remote technology.

Danny lived with each of his parents and siblings at different times during his childhood. His parents have always been supportive of Danny who unfortunately had to deal with numerous difficulties arising from serious and repeated traumatic incidents, causing him significant and ongoing mental health problems. He had significant disruption to his schooling and as a very young teenager he became involved with illicit substances, offending and the criminal justice system.

When Danny was 13 years old, he first appeared in the Children's Court and despite numerous Juvenile Justice Interventions, he was later sentenced to control orders and then once he turned 18 to sentences of imprisonment.

Danny was a talented sportsman, especially playing rugby league and was hoping to be a teenage player with the Newcastle Knights. Darren described how Danny loved his family and though a problem child was a good child and he would do anything for anybody. Danny lived with his girlfriend Emma and they had their daughter when Danny was 17 years old. Danny took much pleasure and pride being a father, but his personal problems continued, and his drug use escalated as did his offending. At times he experienced drug induced psychosis and was prescribed Seroquel to manage his mental health.

When Danny was 19, he commenced the methadone programme and remained on it until he last collected his prescribed dose on 17 March 2015. He then travelled to Queensland and inevitably started using illicit drugs. He returned to NSW and was involved in a motor vehicle pursuit resulting in his arrest on 3 June 2015. Danny was charged with a number of offences and he was refused bail by the police and then by the Local Court. He later pleaded guilty to charges and was sentenced to imprisonment with an earliest release date of 2 June 2016. In the week leading up to his death Danny became unwell after consuming diverted methadone and a mixture of pills. He presented to the medical unit on Thursday 5 November 2015 and on Saturday 7 November 2015 he was transferred to Wagga Wagga Base Hospital. On Sunday 8 November 2015 he was airlifted to Royal Prince Alfred Hospital in Sydney where he was placed on life-support. He had irrecoverable multi-organ failure. Danny died on 9 November 2015. A post mortem examination included an analysis of a blood sample taken at 5 pm on Saturday 7 November 2015 at Wagga Wagga Base Hospital. That sample indicated Paracetamol at <5mg/L, methadone <0.05 mg/L.

A urine sample taken by GEO at 3.45 pm on Friday 6 November 2015 indicated the presence of Buprenorphine and Benzodiazepines. The post mortem report prepared by Dr Bailey sets out that the cause of Danny's death was multi-organ failure. A discussion in the report sets out that the results of toxicology do not exclude Paracetamol toxicity. In this regard an expert opinion was sought from clinical and forensic toxicologist Professor Naren Gunja. He provided a report dated 15 September 2018 and a supplementary report dated 14 March 2020. Professor Gunja also gave evidence in the inquest that in his opinion the cause of Danny's organ failure was Paracetamol toxicity. Associate Professor Anna Holdgate an emergency physician who also provided a report dated 14 November 2019 concurred with Professor Gunja as to the likely cause of Danny's death. The inquest into Danny's death is required under ss23 and 27 *Coroners Act 2009* as he was in custody. The inquest was overdue for quite some time and in 2019 it was set down for hearing in March 2020, but the hearing did not proceed as it was vacated due to Covid-19 restrictions. The inquest heard evidence in February 2021 and in May 2021. That findings are delivered 6 years after Danny's death is highly regrettable.

The findings required under s81 in relation to identity, place and date and cause of Danny's death were uncontroversial. It was the manner or circumstance of Danny's death and the issues and any recommendations arising out it which were the focus of the inquest. The issues in the inquest related to the care and treatment provided to Danny whilst accommodated in the medical clinic between 5-8 November 2015 with particular regard to policy compliance, whether the symptoms with which Danny presented were appropriately recognised and investigated, the adequacy of observations and medical testing and whether Danny's deteriorating condition was appropriately responded to. Other issues included whether Danny's placement on the Opiate Substitution Treatment program ("OST") was appropriate. There was also evidence about the diversion by prisoners of their prescribed methadone at Junee Correctional Centre and the availability and stockpiling of Paracetamol by prisoners.

An issue arose in the inquest where evidence demonstrated that as a result of Danny presenting to the clinic for medical care a nurse sent an email to GEO Intelligence (Intel) that Danny should be subjected to an Intel urine test. Another issue arose in relation to the selection of material provided to the investigating police officer called the Death in Custody Briefing Package. Though the medical ward cell Danny was house in had CCTV footage for the duration of his time in the clinic only the footage showing his initial attendance at the clinic on 5 November 2015 and the paramedics transferring him from the ward on 7 November 2015 was provided. Given the poor nursing record keeping and observations made of Danny during his time in the clinic, the footage of the entirety of Danny's time in the clinic would have been useful and time saving in the inquest. For the same reasons it would have also been better to have made available the CCTV footage relevant to the time and location of Danny's prison accommodation relating to his movement and appearance. The need for this material was realised after the CCTV footage was deleted which was about 6 weeks later.

Evidence was comprised of statements, documents and CCTV footage contained in over six volumes and the testimony over eight days of numerous witnesses including the expert witnesses as well as prisoners (Messrs. A, B, C, D) who attested to seeing Danny unwell before he went to the medical clinic on 5 November 2015, a Corrections Officer ("CO") Raewyn Withers who observed Danny over the day he presented to the clinic, Registered Nurses RN Marsters who admitted Danny onto the ward, RN Duddy who attended Danny once on 5 November 2015.

RN Wall who was on duty overnight on 5 and 6 November 2015, RN McGloin a drug and alcohol nurse who saw Danny on the afternoon of 6 November 2015 and RN Bryon who was on duty on the morning of 7 November and who made arrangements for Danny's transfer to hospital, Dr D Corbett who is the General Practitioner who reviewed Danny on 6 and 7 November 2015 and spoke on the telephone with RN Bryon over the morning of 7 November 2015 and finally a prisoner Mr. E who was housed with Danny in the medical ward from 6-7 November 2015.

Other witnesses called included managerial staff at Junee including Ms. J Te Maru, manager of the Medical Unit, Mr. W Doherty who was at the time head of Junee CC Intel, and Ms. A Wood the past GEO Contract Compliance Manager who gave evidence that the medical unit has undergone a major refurbishment and that prisoners are no longer housed in the ward for medical care. There are now 8 single bed observation cells for the purpose of management of prisoners "at risk". Ms. E Halliburton, GEO Human Resources Co-Ordinator spoke to the implementation by GEO of a staff training package regarding identifying prisoners intoxicated or withdrawing from drugs arising out of a recommendation in the inquest into the death of Anthony Van Rysewyk. Mr. S Ward, the Acting Service Director of Drug and Alcohol Services for Justice and Forensic Mental Health Network ("Justice Health") gave evidence about the availability of places on the OST program and the programme that is now available and has been rolled out in NSW prisons involving depot buprenorphine called Buvidal. He also gave evidence responding to an issue which arose in the inquest relating to GEO health staff's access to NSW Health Education Training Institute. CO Denyer and CO Moisan of Corrective Services NSW ("CSNSW") gave evidence in relation to their guard duties at the Royal Prince Alfred Hospital and their understanding of providing access to Danny by his family when they visited.

After the hearing further evidence was received in chambers and submissions were received which addressed the evidence including the supplementarymaterial.

Danny's custody 4 June 2015 to 16 August 2015

Danny was received into custody at Cessnock Correctional Centre on 4 June 2015 as a remand inmate. The "reception screening" of an inmate involves a number of CSNSW forms being completed one of which is often commenced at the Local Court cells which is called an Inmate Identification and Observation Form ("IIO"). The IIO was commenced by CSNSW Officer Andrew Tulan at Maitland Court Cells. Mr. Tulan recorded that Danny:

- was Aboriginal.
- was on medications Lyrica and Seroquel, [which is Pregabalin and Quetiapine respectively].
- had last used methamphetamine [recorded as "ice"] on "Sunday" [which was 31 May 2015].
- was on the methadone program at a dosage of 150mls; and
- had not previously attempted suicide or self-harm.

As a result of the reception screening at Cessnock Correctional Centre it was recommended that Danny be accommodated in a special management area due to "fear".

The reception screening also includes a separate interview with Justice Health where a number of health documents are completed. A Reception Screening Assessment ("RSA") was completed by Ms. Amy Gibbs on 5 June 2015. The RSA recorded that Danny:

- had used benzodiazepines in the last 4 weeks.
- tended to use ice daily; however, he had last used ice one week previously.
- last used cannabis one week previously.
- was experiencing symptoms of withdrawal.
- was on an opioid substitution treatment, namely methadone, that his prescribing doctor was Dr Khan and that the date of his last dose of methadone was 17 March 2015: and
- current medications were listed as quetiapine, methadone and pregabalin.

Ms. Gibbs recorded that Danny had previously been treated for a mental health problem and that he had tried to hurt himself by "slashing up" nine years ago. It is also recorded that Danny had stopped attending Cessnock Plaza for his methadone because he had moved to Queensland for a period, where he had used street methadone instead.

The inquest heard evidence about the difficulties of accessing the NSW Health OST program in NSW prisons. A prisoner was able to continue receiving methadone in prison provided that they had been regularly picking up their dose within the last three days prior to entering custody. Danny, having been two months outside of that time was accordingly unable to access the program and was required to reapply which involved him being placed on a waitlist to see the Drug and Alcohol nurse for an assessment. At that time throughout the NSW prisons there were limited places available on the program and even once a prisoner had applied there were wait times on average of about 18 months. On that basis Danny was never going to be received onto the program as he would be released 6 months prior to the expiration of 18 months.

Danny signed a document called "Consent to Obtain Health Information from External Agencies Form" ("Consent Form") which was faxed on 6 June 2015 and responded to that day with a "Full Summary" document to Justice Health, which listed "methadone 75mg/15mls under the heading "Current Medications" and noted the last script was given on 26/2/15. On 13 June 2015 Danny signed another Consent Form addressed to the Hunter Valley Medical Centre. An Intake Screening Questionnaire completed by welfare officer Neville Bowen on 12 June 2015 recorded that Danny took daily medication for drug-induced psychosis. It further recorded that, in response to the question, "are you withdrawing/expecting to withdraw from drugs" Danny answered "no". Danny was also asked "Have you tried to take your own life or harm yourself in the past", Danny replied that he had harmed himself by cutting his arm 9 years ago; however, had no thoughts or plans of harming himself since that time.

On 16 June 2015, Danny was escorted to Maitland Hospital. A Justice Health nurse stated in a referral letter:

"Thank you for seeing this patient who sustained a king hit to R side of face approx. 6 weeks ago. Since then, has had severe headaches, has been vomiting intermittently, has an unsteady gait, has had clear fluid dripping from nose, has had blood clots in ear (infrequent). Numbness and tingly over site of injury R/eye, confusion, aggression…blurred vision in R/eye and sometimes complete black out of vision…short/long term memory loss, is photophobic and loud noises are distressing…"

Danny was reviewed by a Resident Medical Officer on 17 June 2015 at Maitland Hospital, who noted:

"Investigations: CT Brain – no obvious bleed or midline shift report pending, Diagnoses: …? Methadone Withdrawal…Discharge and Follow up: GP – to look into his methadone program and see if he requires continuation. Follow up the formal CT Brain report."

Danny was not admitted into hospital and returned to Cessnock Correctional Centre in the early hours of 17 June 2015. On 26 June 2015, Danny was subjected to a targeted strip search and a half Seroquel tablet secreted in the waistband of his track pants and an uncapped gaol made syringe was located between his buttocks. He was placed on a 14-day segregation order, the reason cited as being "for the good order" of Cessnock Correction centre. Such an order is accordingly not deemed by

CSNSW to be a punishment. Danny receive a penalty for the possession of those items which was 2 months without "buy-up" however by the time he arrived at Parklea he was able to participate in buy-ups. The inquest heard evidence that Danny would trade his buy up items to acquire drugs from other prisoners. Accordingly, withdrawal from the buy-up program would have affected his capacity to pay for drugs in the prison system. Though the find on the strip search would indicate that Danny was using illicit drugs whilst in prison it did not trigger a priority enrolment onto the OST program and Danny continued to apply for the programme whilst apparently being engaged in illicit and unsafe drug use whilst in prison.

On 7 July 2015 the segregation order was revoked. On 9 July 2015, Danny requested that he be accommodated in another unit as he was "receiving threats from other inmates in relation to drug activity and debts". It was recommended that he be managed as a Protection Requiring Limited Association ("PRLA") inmate until he could be moved to another correctional centre.

Shortly after being placed on protection, on 10 July 2015, Danny activated the intercom in his cell ("knock up") threatening to "slash up" with razor blades if correctional officers did not move him. Danny was escorted to an observation or "camera" cell and placed on a Risk Intervention Team ("RIT"). The relevant form stated that Danny had presented as:

"hearing voices, very angry threatening violence" and noted that the trigger for the incident was "not getting psych medication".

On 11 July 2015 Danny was transferred from the camera observation cell to a "2-out" cell so he was housed with another prisoner. On 14 July 2015, Danny apparently lit a fire in his cell (although he later denied this) and was taken to John Hunter Hospital after being removed from his cell unresponsive.
The Incident Details Report in relation to the fire states:

"claims his perceived needs were not met over the last 5 days and this was the result."

On 14 July 2015 Danny's placement in the Special Management Area Placement was revoked. On 15 July 2015, at about 12:40 am Danny returned to Cessnock Correctional Centre and he was again placed on a RIT and accommodated in a camera observation cell.

On 17 July 2015 a Justice Health nurse, RN Sharpe conducted a mental health assessment and the notes referred to Danny having auditory hallucinations and stated that he "would like to be on methadone". She recorded that Danny reported sexual abuse from the age of 8. Danny reported being a heavy user of "ice" and as having started smoking cannabis at the age of 11, "ice" at 13 and heroin at age 16. He reported that at the age of 15 he spent a few days in the child and adolescent psychiatric ward at John Hunter Hospital (Nexus) until he was discharged into the care of his father. He reported that there was no follow up commitment. He suffered physical chronic pain after he had been deliberately run down by someone driving a car. He was on Seroquel 50 mg each night for depression anxiety and panic attacks. He denied self-harm though had previous thoughts of self-harm.

He scored 47/50 on the Kessler scale but RN Sharpe noted that the score might not be consistent with Danny's presentation and queried whether Danny was over reporting to improve his chances of having an increase in his medication and to be enrolled on the OST program. Similarly, it is unclear whether Danny's report of his symptoms which led to the brain CT scan at Maitland hospital in June 2015 was genuinely from an injury or the result of prison drug use or was an act of drug seeking behaviour.

Danny's accommodation was subject to review from 18 July 2015. Danny requested to remain on PRLA until his transfer to another centre but on 25 July 2015, he informed CSNSW Officer Joy Gallen that he would sign off the PRLA in order to be transferred to another centre. He also informed Ms Gallen that his uncle was the then-current active president of the Bandidos, Hunter Valley. A Placement/Threat Assessment conducted on the same date found the likelihood of a threat occurring against Danny as "high".

On 27 July 2015 Danny appeared at Maitland Local Court and was sentenced and his earliest release date was 2 June 2016. On 30 July 2015 the protective custody order was extended to 8 October 2015. On 8 August 2015 Danny was transferred from Cessnock Correctional Centre to Parklea Correctional Centre. A Reception Committee Screen form indicates that Danny was offered and accepted a place in the Equips Addiction Program. A box was also checked to indicate that Danny would be referred to psychology services, with a handwritten note stating, "AOD Methadone".

On 13 August 2015, Danny was transferred to Junee Correctional Centre via three days at Bathurst Correctional Centre. On 16 August 2015, Danny was received at Junee Correctional Centre as a PRLA inmate, and was placed in Unit B1, BPod.

Junee Correctional Centre 16 August 2015 – November 2015

Junee Correctional Centre is operated by GEO Group Australia Pty Ltd ("GEO"). The medical services provided at Junee are provided by GEO rather than Justice Health.

On 18 August 2015, Danny submitted an "Inmate Medical Request" stating "I have been using needls [sic] in Parklea I wish to get back on my methadone".

On 19 August 2015 Danny attended an induction interview with an Offender Development Officer. On 25 August 2015 he was assessed as suitable for the EQUIPS program and on 12 October 2015 after attending an information session he was accepted onto the program but he only attended the morning session on 26 October 2015 because he identified that it wasn't the right program for him as he was not a violent person. On 24 August 2014 Danny was referred to another program, IDATP but was unable to attend the commencement session on 4 November 2015 due to being unwell. On 24 August 2015, Danny filled out an Inmate Request Form requesting to sign off PRLA to go to B2 A Pod as a Special Management Area Placement ("SMAP") inmate, as he wished to engage in work and programs. This request was approved and on 26 August 2015 Danny was relocated to Unit B2, A Pod.

On 22 September 2015, Danny was assessed by RN McGloin the Junee Drug and Alcohol Nurse, as he had requested to enrol in the OST program. Ms McGloin wrote a progress note:

"Requesting methadone. Has previously been (on) methadone from aged 19 yrs. to 25 yrs. Prior to methadone always in trouble. On methadone stayed out of trouble for 3 years. Came off it on the run.
17 March 2015. Was dosing in Cessnock…While on the run…mainly? heroin occasionally. Currently using but whenever he can…could be look at for methadone for pain relief but would need further investigations to prove need…referral for OST."

RN McGloin completed an "Initial Risk Assessment for Patients Requesting OST" form and she recorded that there was no evidence of opioid withdrawal, that Danny was previously on opioid substitution treatment and he was opioid dependent prior to custody and was currently using "bup" (buprenorphine prescribed to other prisoners). A box was checked indicating Mr Whitton's matter was "routine". Ms McGloin gave evidence at the inquest and she described the triage system used to assess and prioritise candidates for the OST program. She said that Danny did not meet the criteria for high priority or fast track according to the assessment method used by Justice Health (which was mandated by NSW Health). This meant Danny's application was considered "routine". The fact that Danny had previously been on the program in the community could not be used as a factor for high priority in the triage assessment, nor could Danny having a history of self-harm and suicide attempts. The inquest heard that the delay of 4-5 weeks between Danny's request on 18 August 2015 and his first assessment on 22 September 2015 was not atypical and in fact continues currently. In effect however, Danny had requested to go onto the program in his reception screening at Cessnock Corrections Centre on 5 June 2015 so the period of 5 June – 22 September 2022 was a period of nearly 4 months. In 2015, at Junee CC, the waiting time to get onto the program for patients assessed as "routine" was between 12 and 18 months but usually around 13 months.

Ms McGloin said that this was "very frustrating". The OST program is now readily available, and Ms McGloin said that had the new program been available in 2015 Danny would have been readily able to participate. RN McGloin estimated that at the time in September 2015 there were about 60 prisoners on the same waiting list as Danny. She said she was aware that most of those prisoners would have been engaged in the dangerous activity of procuring methadone or buprenorphine from other prisoners who were on the OST programme. She said that such behaviour could not be taken into consideration when assessing eligibility for the OST program.

That prisoners who were unable to access the OST program would engage in the procurement of methadone or buprenorphine from other prisoners who were on the OST program was well known at GEO. The Junee Correctional Centre operated a system to minimise the opportunity for prisoners to divert their doses to other prisoners but despite such measures the practice continued.

Given Danny's 10-year history of drug use, his traumatic childhood and his ongoing mental health issues it would seem not only unrealistic to expect that he would not participate in methadone diversion and indeed it would seem inevitable that he would engage in this and other extremely unsafe drug use. In any event, that Danny was due for release prior to the earliest date he might expect to be accepted onto the program raises questions as to the utility of any application process and waitlist. Throughout August and September 2015, Danny was charted to take Naprosyn SR 1000mg nocte ("NSAID") and Seroquel XR SR Tablet 50mg, 2 nocte. Throughout October and early November 2015, Danny was charted to take Naprosyn SR 1000mg nocte p.r.n and Seroquel XR SR 400mg nocte daily. Danny using illicit drugs continued to cause him to be in strife with other prisoners and continued to affect his mental health and wellbeing. On 13 October 2015, Danny presented to the medical clinic and threatened to cut his throat with a razor, he reported he had been sexually assaulted when he was 7-8 years old, and stated that the trigger for his self-harm threat was "problems with another prisoners [sic] feeling 'down'". He threatened to harm himself or others if he returned to B2. Danny was moved to a safe cell and placed on a RIT. The RIT plan required CSNSW officers to observe Danny every 30 minutes.

In an undated Inmate Request Form, Danny wrote that he feared certain inmates in B2A and that he feared if he was placed in B2A he would get hurt. An Offender Information and Management System ("OIMS") Association Alert Registration Details Form dated 16 October 2015 noted that Danny feared (named) inmates due to "prior conflict within the community". On 16 October 2015, following an assessment by a psychologist the RIT plan was amended so that Danny was moved out of the safe cell into Unit B3 A pod Cell 8 and CSNSW officers were to conduct observations every 60 minutes. On 17 October Danny was moved from Cell 8 to Cell 16. On 20 October 2015 Danny was again reviewed by a psychologist and Danny reported to have no thoughts of self-harm. He was removed from the RIT. On 26 October 2015 Danny was transferred from cell 16 to cell 11.

Danny becomes Unwell

On Sunday 1 November 2015 Mr C arrived in B3 A Pod and when Danny saw him, they arranged that he would move into Danny's cell as they had known each other since 2009. On Monday 2 November 2015 Mr C moved into Danny's cell.

On Tuesday 3 November 2015 Danny had a short telephone call to his mother at about 10.45 am. A recording of the telephone call was tendered in the inquest. In the call he did not complain that he was unwell, nor does he sound ill or under the influence of any substance. On Tuesday inmates have buy-up and the records indicate that Danny obtained items at buy-up.

On Wednesday 4 November 2015 Danny was reported as vomiting and his attendance at the IDATP program was cancelled. In the morning of Thursday 5 November 2015 Danny reported to correctional officers that he was vomiting and had pains in his stomach and was urinating blood and he attended the medical clinic reporting that he had kidney pain and was vomiting. He spent the day in the clinic and in the afternoon was admitted as a patient onto the medical ward. The ward was a two-observation cell unit. At about 10.00 am on Friday 6 November 2015 Danny was reviewed by Dr Corbett. Mr E, another prisoner was admitted into the ward and shared the cell with Danny. Later that day at about 3 pm GEO Intelligence (Intel) correctional officers obtained a urine sample from Danny to test for drugs use. About 1.40 pm on Saturday 7 November 2015 an ambulance was called for Danny to be taken to hospital and about 3.45 Danny was transferred *in extremis* to the Wagga Wagga Base Hospital.

The time at which Danny became ill is difficult to pinpoint. Mr C gave evidence in the inquest. In November 2015, following Danny's death Mr C was interviewed by Mr Doherty, who was then GEO's Manager of Intelligence and at the time of the inquest was GEO's Operations Manager at Junee Correctional Centre.

According to Mr Doherty's briefing note of November 2015 Mr C told Mr Doherty the following:

- 4 November 2015 Danny injected "pills" known as "Gabbas" having purchased them off "one of the boys" diverted from pill parade.

- Wednesday 5 November 2015 Danny drank regurgitated methadone, having gone halves and was "probably 180 mls".[64]

- Wednesday night Danny woke up and was pissing blood and Mr. C told him to go to medical as he believed that Danny's "kidneys were failing", however Danny refused to go.

- Inmates were spewing methadone into plastic bags and passing them under the doors in the unit.

The reference to Wednesday being 5 November is incorrect as Wednesday was 4 November 2015. On 9 November 20915 Mr C was also interviewed by Detective Inspector James, the Officer in Charge of the investigation. Mr C made a statement. Relevantly the information he gave was:

On Tuesday 3 November 2015 Danny was absolutely bombed. He had taken regurgitated methadone and a mixture of pills which included Pregabalin, Tramadol, Seroquel and Naprosyn – he was mixing it altogether on the day he had the drink of methadone. Danny had a shower and returned to the cell, had a little bit to eat for dinner and then crashed on his bed.

About midnight Danny was vomiting hard in the toilet, he had a drink of water and returned to bed. Wednesday he woke up and was still bombed out and feeling really crook. It was buy-up day. Danny bought some food and munchies, sat at the table with his head on his arms and sat there; he had a shower and went back to bed.

Danny spent Wednesday in bed and slept alright without waking Mr C.

Thursday morning Danny was vomiting hard, he showered and returned to the cell and told Mr C he was pissing blood and had a real bad pain in his stomach. He was worried and sick. He went to the medical unit.

In his evidence to the inquest Mr C said Danny received his buy-up but that Danny was still sick, and he didn't want to get up to go get it. Though he described that Danny had a tin lid of crushed up white powder in his cell, Mr C said in his evidence that he didn't actually see Danny take the drugs and that he had told Detective James what drugs Danny took because "it was obvious". He said that the lid with white powder was still in his cell when he left it before being placed on segregation on 9 November 2015 but when he returned it was gone. There is no evidence in the inquest that any such item was located from the cell in Mr C's absence.

Mr C said in his evidence that he had seen Danny inject "bup" in another prisoner's cell and that he had been in the unit a week before Danny became ill. Though the length of time Mr C says he had been in the unit is incorrect and he had not mentioned this incident to Mr Doherty or Detective James in his interviews in November 2015, it is at least consistent with the toxicology report that buprenorphine was found in the urinalysis sample taken by GEO Intel on Friday 6 November. Mr C likely did see Danny inject "bup" and given that there is a report that Danny was leaving a day between "bup" and methadone use, he likely used the "bup" on Sunday 1 November 2015 when Danny first saw Mr C.

Mr C's evidence was fairly unreliable given he denied actually seeing what Danny took and though he may have witnessed on numerous occasions prisoners using diverted methadone or stockpiling and taking pills, given the short period of time he was with Danny in Junee, much of his evidence in that regard unlikely related specifically to Danny. However, Danny's illness and his report of having had "recurrent" pain in his kidneys before taking regurgitated methadone is consistent with Danny having ingested crushed up pills with methadone and or taking crushed up pillsgenerally.

On Friday 6 November 2015 Danny told RN McGloin that he had consumed a lot of regurgitated methadone the day before he presented to the medical clinic. CO Withers reports that on Thursday 5 November 2015 she was on duty all day at the medical clinic. She said that after Danny attended the clinic, she saw him sitting in the clinic shower for long periods over the day. One prisoner, Mr B gave evidence that he had seen Danny on Wednesday 4 November 2015 spending the day sitting in one of the unit showers. Mr B said that Danny was sick, and his skin was yellow. No one in the clinic called in the inquest said that they thought Danny's skin was yellow which indicates jaundice and arouses suspicion of liver injury.

It is likely that Danny consumed the regurgitated methadone and the mixture of pills on Tuesday 3 November 2015 after he had spoken with his mother on the telephone. That the mixture contained Paracetamol is consistent with the traces identified in a blood test on 8 November 2015 as well as the trajectory of his illness and ultimate death.

Paracetamol toxicity

Professor Naren Gunja identified that "the combination of liver failure, jaundice and hepatic encephalopathy point to a hepatotoxic cause" for Danny's illness and he opined that the trajectory of Danny's illness was consistent with paracetamol use rather than an overdose of methadone and/or buprenorphine. Associate P r o f e s s o r Holdgate agreed that the likely cause of Danny's death was paracetamol toxicity and there is no issue in the inquest about this.

As to when Danny had ingested the toxic dose, Professor Gunja referred to the trajectory of Danny's illness and the analysis of an ante-mortem blood sample taken at Wagga Wagga Base Hospital at 5pm on Saturday 7 November 201. Professor Gunja noted that Danny had metabolised away the Paracetamol by the time Danny arrived in hospital. He said that was entirely consistent with the way people metabolise paracetamol from the time they ingest it several days before and succumb to it a week later. He said that the paracetamol could have been ingested as a single large dose or by a repeated ingestion over a period of many hours or days. He opined that a single dose of at least 10 gm (20 tablets of 500mg) would besufficient.

There was evidence in the inquest that prisoners at Junee Correctional Centre were able to obtain up to 6 paracetamol tablets without a script and that these would often be stockpiled and then later made into a drink or a concoction. It would be likely that Danny engaged in such practice given his complaint of pain, his drug addiction and use of diverted methadone and his report that he had experienced kidney pain previously. If it was a single dose of a large quantity of crushed up paracetamol, it may have been on a background of previous and recent such doses.

Professor Gunja described the phases of paracetamol toxicity. The first stage is called the "gastrointestinal phase" which is marked by nausea, vomiting and abdominal pain. This occurs over the first or second days. Then there is the "quiescent phase" which lasts a couple of days. The third phase which starts at about day four marks the start of having liver injury. Dr Gunja said that a person can either improve from that point or could progress to full blown liver failure. Such failure is associated with kidney failure, failure of coagulation, hepatic encephalopathy (seen as a delirium) which then leads to death.

Professor Gunja opined that Danny was in multi-organ failure or third phase on 7 and possibly 6 November 2015. He surmised that ingestion occurred 4-7 days prior. He estimated that Danny could have ingested a single dose around 1-3 November 2015. Professor Gunja referred to the elevated results of the blood test on 7 November 2015 and said that had the blood test occurred on 6 November 2015, it would have shown elevated results sufficient to have prompted Danny's hospitaladmission.

Professor Gunja told the inquest that an antidote to paracetamol poisoning is acetylcysteine which is optimally administered within 8 hours of poisoning. He noted that it was administered at Wagga Wagga Base Hospital. He was asked by Mr Rees whether it would have been beneficial to Danny had it been administered on 6 November to which Professor Gunja said it would be more beneficial than the 7 November, but it was difficult to say whether it would have changed the outcome. He said that had it been administered three days after ingestion of paracetamol it could have possibly altered the trajectory of the overdose.

Neither the buprenorphine nor the methadone contributed to the cause of Danny's death. Whether the diverted methadone contained the paracetamol, or whether Danny placed powdered paracetamol into the methadone is unclear. If Danny placed the powder into the methadone it is unclear if he did so knowing it was paracetamol because he had been told that it was or because he had made the powder himself.

Danny's attendance and admission into the Junee Correctional Centre Medical Clinic Thursday 5 November 2015

At about 7 am Thursday 5 November 2015 Danny told Corrections Officers that he needed medical help. CO Carr called the clinic reporting that Danny had complained of possible kidney pain and vomiting. Registered Nurse Alfred Marsters was on duty and he relayed a message to tell Danny to drink plenty of water and come up to sick parade. This meant Danny would not be seen until 1.30 pm. Danny notified another officer that he was worse, and he went to the clinic. He arrived at the clinic at 7.15am.

The corrections officer on duty at the clinic was CO Withers. She had made a report on 11 November 2019, but it was not included in the briefing package provided by the General Manager Brideoak to Detective James. The report was not provided to those assisting the coroner until it was attached to Mr Doherty's statement of 12 May 2021. There is no explanation as to why CO Wither's report was not included in the briefing package. It should have been as she provided valuable information as to how Danny was presenting throughout the day of 5 November 2015.

According to CO Withers, at the time Danny arrived at the clinic, RN Masters was busy "with inmates having blood tests, insulin and medications were still being processed".

CO Withers spoke with Danny and she relayed to him what RN Masters had previously said and Danny replied that he wasn't going anywhere and if he vomited on the floor it wasn't his fault. Danny lay on his stomach over some chairs and CO Withers informed RN Marsters that he was there. CO Withers said that during this time RN Marsters was given directions to urgently facilitate a urinalysis report for GEO Intel Officers and RN Marsters told her that all other tasks had to wait until the report for Intel was completed. CO Withers then told all inmates present that all the nurses were very busy and that they could choose to wait or to come back later. CO Withers said RN Marsters spoke with Danny sometime between 8.30 am and - 9.00 am.

RN Marsters asked Danny whether he had taken any medication or drugs other than what he was on and Danny said he had not and that he had had the pain before - it was his kidneys. According to CO Withers, Danny was given some medication for pain and she was instructed to place him on the ward. She said she secured him and continued to monitor him throughout the day.

She said that Danny spent much of the day sitting for long periods under the shower or vomiting in the toilet and lying in bed. He refused all food offered. He remained quiet and only responded when questioned. He told her he had vomited the medication provided to him. CO Withers informed RN Marsters of this. Danny was consequently he administered an injection to help settle Danny's stomach. RN Masters advised Danny to drink water. RN Masters kept asking Danny if he had taken anything he shouldn't have, and Danny said he hadn't. Danny was formally admitted to the clinic at 3.35 pm.

That Danny did not seek medical assistance prior to Thursday and that he did not disclose to RN Marsters the appropriate history of his complaint may have been due to being fearful that the information would not remain private between himself and the medical services provider. Danny may well have apprehended that the consequences of the information being passed onto Corrections would place him in significant trouble. Such consequences include being placed on a segregation order and receiving a punishment as he had experienced after the strip search in Cessnock Correctional Centre. Danny had already experienced difficulties within the prison community due to his drug use which caused him to go onto a RIT and asking to be housed in a separate unit so he may also have been concerned about those consequences as well.

That Danny did not tell RN Masters that he had ingested crushed up pills of some kind may have been because he was unaware of the contents of the bag of diverted methadone. On the other hand, that he told RN Masters he had pain in his kidneys before could indicate that he had experienced such when using crushed up pills as described by Mr C. Whatever the reason behind his denials that Danny maintained this position in the face of repeated questioning had the dire consequence of not receiving a more useful medical investigation and treatment. That an inmate believes that his health condition would not be kept private from the custodial services so that he could secure appropriate health care is extremely concerning, particularly where a consequence of death could, or as in this case, did ensue.

In any event, RN Marsters apparently did not believe Danny's denials of having ingested something he shouldn't have. After Danny was admitted into the clinic RN Marsters sent an email to Mr Doherty, the Correctional Manager, and Intelligence at Junee Correctional Centre at the time, to place Danny on a urinalysis list. The email was copied and sent to Ms Jan Te Maru, the Health Services Manager. It is unfortunate that RN Marsters took this course as opposed to turning his mind as to what communication and assurances he should undertake so that Danny would disclose to him what had occurred which may have resulted in earlier treatment of Danny's symptoms. However, that is not to say that RN Marsters should have considered whether Danny's symptoms were as a result of having ingested paracetamol. As Professor Gunja said, paracetamol poisoning would not have been at the top of the list of suspected causes.

RN Masters did conduct a dipstick urine sample. He said that he thinks he did this due to Danny's presentation of lethargy, headache, nausea and vomiting that prompted a concern for dehydration - the taking of a urinalysis test would provide a baseline of how his body was functioning. The result of the test was recorded by RN Marsters in a Progress Note (PN). He recorded "*protein ++*" and *"blood +++*", that is, two plus signs and three plus signs respectively, each indicating levels in the moderate range. There was some confusion about the number of plus signs in RN Marsters' progress note. Dr Corbett understood it to be four, and the handwritten note does clearly show a vertical post and another mark, consistent with a fourth plus sign. However, RN Marsters said that four plus signs would indicate a "large amount of blood" in the urine, maintaining he wrote only three plus signs.

RN Marsters' PN does not identify the time at which Danny presented to the clinic, writing "seen this morning presented lethargic, headache, nausea and vomiting. Denies any illicit drug use". RN Masters' PN does not refer to being advised at 7 am that Danny had complained of severe abdominal pain and had been urinating blood or that Danny complained about his kidneys. He did record Danny's vital signs but does not record the time at which he made those observations. He recorded that he had a discussion about Danny with Dr Corbett and that the doctor directed that Danny be given Maxalon (by injection) and to push oral fluids. There is no record of the time of this discussion.

A "Standard Adult General Observation" ("SAGO") Chart does not appear to have been established at 9.00 am when Danny was given a bed in the clinic nor at 3.30 pm on 5 November 2015 when he was formally admitted into the medical unit. RN Marsters made a second progress note at 3.30 pm indicating he had administered the Maxalon and again that he had taken Danny's observations and that Danny was given ice and water and he was housed in medical.

In his evidence RN Marsters said that he would keep notes on a piece of paper and glance in at Danny throughout the day. CO Withers said she saw that RN Marsters made notes when he periodically interacted with Danny. She said she heard Danny tell RN Marsters him that he had been vomiting blood. There is no reference to such in RN Masters' progress notes, nor is there any reference to Danny complaining of pain in his kidneys or having vomited throughout the day or being under the shower for lengthy periods.

A nursing note made by RN Duddy at 4.50 pm records that Danny complained of chest pain, pain in both clavicles and his left wrist that he had lower abdomen pain but on examination there was no guarding or tenderness. The PN indicates that Danny said he had pain in his kidneys and that it had been there for several days. The PN says "doesn't appear to be in severe pain". RN Duddy did not record Danny's vital signs and she said that she was not sure if there was a chart in use. There does not appear to be any care plan other than push oral fluids and administer Maxolon. According to the overnight shift nurse Anthony Wall, RN Duddy was responsible for Danny until she handed his care over to him at 9.00 pm. The overnight nursing shift was from 6.30 pm to 6.30 am. Mr Wall was the overnight nurse on duty on both overnights 5 and 6 November 2015. His PN for each shift was recorded at 3.00 am. The PN for the first night set out that Danny had nil issues, he was given his medication which he tolerated well and was given three glucose tablets, had a Glasgow Coma Score ("GCS") of 15 and had nil complaints. RN Wall said that he attended Danny between 8.00 pm and 9.00 pm and his progress note was a summary up until the time he made it.

He did not make any direct observations of Danny before or after his attendance. He said in his evidence that he would check on Danny on the CCTV screen but that might be only every couple of hours and if the lights were off, he would only see a silhouette. He conceded that it was possible that Danny had been vomiting during the night and that RN Wall had not noticed this due to carrying out other duties. He said that such tasks could involve reception screening of new inmates, administrative tasks, impending releases and parole reports. He said that there were big chunks of the night that he could not observe Danny on the CCTV monitor. At that time there was no log kept of any "knock up" or stenophone calls an inmate makes whilst a patient on the ward in the medical centre.

Danny's medical review and treatment in the Junee Correctional Centre Medical Clinic Friday 6 November 2015

Dr Corbett reviewed Danny at about 10.00 am on 6 November 2015, though the time is not recorded in his notes which are written in the PN form. Dr Corbett recorded that Danny complained of *recurrent upper abdominal pain Nausea. On examination: Tender all over abdomen. Worse epigastrium + RIF. No GRR. PHx Appendectomy. IMP –Gastro 2nd Naprosyn. Stop Naprosyn. Add Pariet. Bloods.*

Dr Corbett said that he had had two previous dealings with Danny prior to 6 November 2015. The first was on 17 August 2015 when he had reviewed Danny for a complaint of back pain for which he prescribed Danny Naprosyn. Dr Corbett had also spoken with Danny on 20 October 2015 in his capacity as a member of the High-Risk Assessment team when Danny was removed from the RIT [see paragraph 43 above]. Dr Corbett said that he recalled having a discussion with Danny about the use of pain medications such as Naprosyn and Lyrica. On 5 November 2015 RN Marsters telephoned Dr Corbett around 3.30 pm and spoke to him about Danny. Dr Corbett directed that Danny be admitted to the ward, given an anti-emetic and that nurses push oral fluids. He asked for Danny to be placed on the list to see Dr Corbett the following day.

Dr Corbett made a statement for the coronial investigation on 2 September 2019. He set out in his statement that he was told that Danny had tea coloured urine, and that Danny complained of pain in the abdomen, nausea and vomiting. He had normal blood pressure, blood sugars and respiration but that he had tachycardia with a heart rate of 120 BPM. He sets out that RN Marsters told him that he suspected that Danny had been using unknown illicit substances. Dr Corbett said that he considered drugs, dehydration and infection including Hepatitis C as causes for the presentation. He said that Danny was admitted for observation due to the tachycardia.

There is no indication in RN Marsters' PN the reason for admission and there was no indication as to what observations and at what frequency those observations should be made. I note that in a referral letter written by Dr Corbett to the Wagga Wagga Base Hospital on 7 November 2015 Dr Corbett wrote, inter alia, *"On examination yesterday he was lucid co-operative and was vomiting (bile). Motor function was ok. He had some epigastric tenderness. GCS 15, 126/83, pulse 120, sats 96% 36.5, BSL 6.9. Naprosyn was ceased and he was started on pariet and his pain seemed to settle. He had a settled night and was up to pee a couple of times".*

There is no record of any vitals taken by Dr Corbett or any nurse on Friday 6 November 2015 ("yesterday") at all. The observations referred to by Dr Corbett in his referral letter match the observations of RN Marsters taken in the morning of 5 November 2015 and recorded in RN Masters' PN. According to RN Marsters he conveyed those observations to Dr Corbett by telephone on 5 November 2015. RN Marsters said he also conveyed the urinalysis results to Dr Corbett. I note that Dr Corbett's referral letter does not contain any reference to such. After RN Marsters spoke to Dr Corbett on 5 November 2015 Danny was admitted onto the ward at about 3.30 pm at which time RN Marsters administered Maxolon and performed another set of observations which recorded that Danny's blood pressure was 106/69 and pulse 102, oxygen saturation was 97% or room air, GCS of 15.

In his statement Dr Corbett explained his examination of Danny on 6 November 2015:

"On 6 November 2015 Mr. Whitton denied taking any other substances when I asked him. On examination, Mr. Whitton seemed to be getting better from the night before. He was lucid, alert, and co-operative. His pulse had decreased to 100 beats per minute and the rest of his observations were normal. He still had nausea and was vomiting bile and had some generalised abdominal tenderness worse in the epigastrium and right iliac fossa. There was no guarding rebound or rigidity and normal bowel sounds were present. I made a provisional diagnosis of gastritis possibly due to the Naprosyn. I ceased the Naprosyn and prescribed Rabeprazole which is a proton pump inhibitor that reduces gastric acid production. I did consider the generalised abdominal pain was a little unusual for gastritis, so I ordered blood tests – full blood count, erythrocyte sedimentation rate, C reactive protein (CRP), electrolytes, urea, creatinine, liver function tests, calcium, magnesium, and phosphate. Although Mr. Whitton did not appear "yellow" it was not uncommon for patients in the jail suffering from hepatitis C to present with his complaints. Thus, Hepatitis C was considered a differential diagnosis".

In his notes made at review on 6 November 2015 Dr Corbett did not refer to the abnormal urinalysis results identified in RN Marsters' PN though the PN indicates that RN Marsters had discussed them with Dr Corbett in his telephone call the previous afternoon. Dr Corbett did not note that he had considered whether to conduct another urinalysis. Dr Corbett did not include in his notes any reference to Danny's kidney pain and number of days he had it as set out in RN Duddy's PN of 4.50 pm the previous day. He made no note relating to Danny's tachycardia or vomiting or that it was suspected he had taken drugs. There was no note referring to concerns of dehydration and infection including Hepatitis C. There was no note of any vital sign observations at all. There was no note of what bloods were being ordered and whether they were urgent or when they were required. There was no note or record of what observations, if any, nursing staff should make in relation to Danny's admission in the ward. There was no note on when Danny would be next reviewed. There was no note about continuing Maxolon.

After Danny was reviewed by Dr Corbett he was returned to his bed in the ward. The next contact he had with a nurse performing clinical duties appears to be after Dr Corbett left the clinic which was about 12 noon. There is recorded on the telephone order 10 mg Maxolon tablets TDS and according to that record a tablet was administered to Danny. This indicates that a nurse had to telephone Dr Corbett to script the Maxolon as he had apparently failed to note it in his review.

The next contact Danny had with a clinical nurse was sometime at about 8.30pm when RN Wall administered Danny's nightly Seroquel. He also administered the Maxolon tablet. I note that it would appear that though Dr Corbett's direction to stop Naprosyn was actioned, Danny was not administered "pariet" on 6 November 2015 that was apparently given for the first time in the morning of 7 November 2015. There is no evidence to explain this. It would appear from Dr Corbett's reference in his referral letter that "he was started on pariet and his pain settled" he was not aware that Danny in fact had not been administered the pariet on 6 November 2015. There is no record of Danny having any observations taken of his vital signs from 3.30 pm 5 November 2015 to 9.00 am 7 November 2015. There is no PN made by any clinical nurse on 6 November 2015.

The blood test ordered by Dr Corbett was not carried out and Dr Corbett was not advised of this until 7 November 2015. The inquest heard evidence that Dr Corbett had reviewed Danny at about 10 am on 6 November 2015 and ordered bloods which are collected daily by courier at 11.30 am and 4.30 pm Monday - Friday. He said that he conveyed to nursing staff the need to collect the bloods that day and after completing the pathology order would have placed it in a tray on the nurses' station. He was unable to recall whether he requested that the bloods be taken in sufficient time for the 11.30 am pick up which would require him to hand the pathology report to a nurse rather than leaving it in the tray. He said that he considered that the blood analysis was urgently required. He left the medical centre at about 12 noon.

Dr Corbett gave evidence that where a blood test result was concerning (abnormal) the pathology laboratory had a practice of directly contacting him by telephone. He did not receive such a phone call. He had not been advised by any nursing staff on 6 November 2015 that bloods were attempted but were unable to be taken that day. What had occurred with Danny after his review by Dr Corbett at 10 am Friday until he was seen by RN Byron on Saturday morning is unclear because there is no SAGO chart and no clinical PNs during the day and a scant PN written at 3.00 am. It is unclear who had the nursing responsibility for Danny on the day of Friday 6 November 2015.

Danny was visited by RN McGloin who was not carrying out any clinical duties. RN McGloin was the drug and alcohol nurse and she had assessed Danny for the OSP on 22 September 2015. RN McGloin made a statement and gave evidence. She thought it was late morning or early afternoon when she saw him. In her evidence she said that the purpose of seeing him was to see if he had taken anything that was considered illicit and whether that might be affecting his current state of health. This was a little different to her statement when she said that the purpose of seeing Danny was to undertake a review as he was on the methadone waiting list. She said in her evidence that she thought she might learn something to advance his position on the waitlist. However, later in her evidence she said that she would not cause a review of an applicant until being notified that they were off the waitlist which was at least 12 months. On balance, it would appear that the reason RN McGloin spoke to Danny was for the purpose to see what he had taken. She made a PN in his clinical records to that effect:

Drug & Alcohol: Pt seen after? Overdose. He stated he had a lot of recycled methadone the day before he presented to medical. Took the dose in the morning and woke up the next morning unwell. Stated he had been using Bup every now and then and methadone approx.. 2 x month.

Always has a day between Bup use and methadone. Stated he had kidney pain prior to presenting to medical and using methadone. He is on the waiting list to go on to methadone. In her evidence RN McGloin said that Danny wasn't really wanting to talk too much but he answered her questions, and that she had spent longer than 5 minutes with him, but it was difficult to say whether it was as long as 20 minutes.

She said that he did not appear to be jaundiced, nor did he appear to be intoxicated or suffering from an overdose. She said that she did not record in the PN that Danny presented as unwell rather than withdrawing or intoxicated because she was not performing clinical duties. She said the drug and alcohol nurse worked Monday to Friday and that her shift ended at 2.30 pm. She said that if Danny was still in the unit on Monday, she would have visited him. In relation to the issue of jaundice, she was asked how she was able to observe Danny's colour she said had sat on a beside chair close to Danny's head. She was unable to say whether there was a corrections officer in the room or at the door or whether the door had been left open. That Danny did not tell RN McGloin he had mixed crushed pills into the recycled methadone is somewhat curious. Mr C identified that Danny mixed the pills into the methadone but in his evidence he resiled from actually seeing him do so though he seemed aware that Danny engaged in such a practice. That the recycled methadone had an intoxicating effect on Danny seems likely given that Mr C reports that Danny said he was "smashed" or "bombed" to indicate his level of intoxication.

On the afternoon of 6 November 2015 GEO Intel had attended the clinic to take a urine sample from Danny following RN Marsters' email the previous day. Mr E said that he helped Danny to the toilet to do this and he noticed that the urine sample was "dark as coke". RN Wall wrote a PN at 3.00 am "nil issues overnight patient stable GCS 15". In his evidence he said that he made this assessment when he gave Danny his medication at about 8.30 – 9 pm. He said Danny was standing up in front of him in the room at this time. It is not possible to ascertain when it was after about 9 pm that Danny began to deteriorate. Certainly, by the following morning he was observed to be in need of medical help

Danny's deterioration, nursing and medical care and transfer to hospital

RN Bryon started his shift at 6.30 am on Saturday 7 November 2015. In his statement of 17 September 2019 RN Bryon wrote that at handover RN Wall told him that Danny was stable overnight. He said he read Danny's medical file and saw that a drug overdose was suspected, and that Danny had been in pain for about 4 days and that a Drug and Alcohol nurse had seen him the day before. RN Bryon wrote in his statement: *"I knew she would assess him again that day"* though RN McGloin was not engaged in a clinical role and the drug and alcohol nurse does not work outside a Monday-Friday shift. RN Bryon said he attended Danny at about 9.00 am. His evidence is that at that time he took Danny's vital signs observations and entered them on a SAGO chart. He said that he wrote observations in both the SAGO chart and also in the Progress Notes. He said that he wrote the observations that he recorded on the SAGO chart onto the Emergency Response Form. He said that there was no advice or guidance about the frequency with which the vital signs should be recorded – rather that he said that he took it upon himself, when he had a spare moment, to go in and check on Danny, and do his observations, though ideally it would be hourly.

He said he photocopied the SAGO chart, the Emergency Form and the Medication chart and sent them with Danny when he was uplifted by ambulance. RN Bryon could give no explanation as to what happened to the SAGO chart. RN Marsters, Dr Corbett and RN Wall attest that they did not at any time see a SAGO chart for Danny. There was no such chart in either hospital files. The Emergency Response Form has three sets of observations at 9.00 am, 11.30 am and 1.25 pm. The PN note has two sets of observations, at 10.30 and 12.15. According to RN Bryon the 12.15 pm observation is a recording of what was observed at 11.30 am. Over a 6-hour period from 9 am until the ambulance arrived at 3.00 pm, RN made a record of four sets of observations.

The observations at 9.00 am were: P100, BP 126/83., BSL 6.9. Resp 14, SpO2 98 GCS 11

Despite RN Bryon saying quite adamantly that he recorded the observations also in the progress note, there is no PN of his attendance and observations for 9.00 am. RN Bryon said in his statement that Danny "was ambulant around the room". He recalled asking Danny if he was going to have a shower and Danny told him that he had already showered and had been to the toilet. He said that Danny returned to sleep. In his evidence RN Bryon said that it was the cellmate rather than Danny that had said he had showered and been to the toilet. RN Bryon did not say in his statement or evidence that he returned to Danny at around 10.30 am but he must have done as there is a set of observations that he wrote in his PN:" *pt. [patient] very hard to wake, is moving around has been up and showered, according to cell mate, also has passed urine, nil vomiting today. Rolling around bed naked unable to control his fine motor skills MO (Medical Officer) made aware; to observe him and then ring MO again if concerned. Obs 97% [referring to oxygen sats] BP 114/57, P100, RR 14 T 36.5 Commence on Narcotic programme if necessary. Patient reluctant to eat or drink".*

RN Bryon said in his statement that he had no recollection of the conversation with Danny's cellmate. RN Bryon said that he was writing the 10.30 am PN when he was talking to Dr Corbett and told him of the vital signs observations. He said Dr Corbett asked him to take bloods and hang fluids (administer IV saline) as Danny might be in withdrawals. Dr Corbett's recollection is quite different in that he gave evidence that he did not suggest fluids or that bloods should be taken as there was no collection until Monday. RN Bryon says that he unsuccessfully attempted to cannulate Danny and he telephoned the doctor back to say he was unable to cannulate him. Dr Corbett told him he was on his way and would be there shortly. There is no time as to when this happened. In his evidence RN Bryon said that he spoke to Dr Corbett twice – the first was after Dr Corbett returned his call at 10.30 am in response to the 9 am voice message at and the second time was at about 12.15 pm. There may have been other calls as suggested by RN Bryon at times during his evidence.

At 11.30 am RN Bryon took another set of observations which are set out in The Emergency Response Form: P100, BP 112/55., BSL 5.1. Resp 14, SpO2 100 GCS 11

At 12.15 pm RN Bryon made a second PN: "*pt. [patient] responds to verbal commands then goes back to sleep. Obs 112/55. P98, RR 14 T36.4, 100% [referring to oxygen sats]. staggering around the room short distances when awake unable to hold conversation goes back to sleep MO called will come see patient"*

In his statement RN Bryon says the observations set out in his PN at 12.15 pm are those taken at 11.30 am but that he had recorded Danny's "pulse as 98 in the progress note but transcribed it as 100 erroneously in the Emergency Response Form" whereas in his evidence he said that he had transcribed the observations from the SAGO chart onto the Emergency Response Form. RN Bryon said in his statement that he called Dr Corbett at 12.15 pm and told him what Danny's vital signs were and that Danny was ataxic. Dr Corbett said he would be there soon.

Dr Corbett's referral letter to the hospital set out the observations recorded in the 12.15 pm PN as he did not take any observations when he examined Danny. At the time he examined Danny he assessed Danny as having a GCS of 12 which he included in his letter. Dr Corbett said he immediately identified that Danny required hospitalisation and directed RN Bryon to organise an ambulance and he wrote the referral letter and then left the prison. RN Bryon took one further set of observations but did not record them in any PN, but they are recorded on the Emergency Response Form at 1.25 pm: P102, BP 101/42., BSL 3.8. Resp 14, SpO2 99 GCS 11

The observations recorded on the ambulance Patient Care Record at 2.55 pm set out that that Danny's RR was 96, Pulse was 108, his BP 98/60 his GCS 11 and at 3.30 pm those observations were RR 96, Pulse 104, BP 100/PAL. GCS 11. RN Bryon says in his statement that Danny "moved to the ambulance stretcher by himself with some assistance". The CCTV provided by GEO shows that Danny was unable to move on his own accord and was entirely lifted by several people from the bed onto the ambulance stretcher.

In his evidence RN Bryon said Danny *"…couldn't hold a conversation, he would wonder off and say different things and which weren't to the answers to what you were saying. Sometimes later on, it became more evident that it was inappropriate words that he was using to describe how he was feeling. And the pupils of his eyes. He would shy away from the light".*

In relation to the GCS Mr Hammond asked RN Bryon *"Did you consider that to be a significant drop or change?"* to which he replied *"Yes. I did. The other person said he'd been up vomiting all night. No sleep will certainly drop your GCS down when different people check them"*. He then said that Danny had told him. *"When he said he'd been up vomiting all night and hadn't had much sleep, that sort of covered that area for the moment, for that particular period of time I can understand how tired he'd be if he was in there for drug withdrawal…so everything just sort of makes it a lot harder to assess"*. RN Bryon agreed that what he had been told impacted on how he had assessed Danny under the GSC. It is difficult to accept RN Bryon's evidence that Danny himself told him he was up all-night vomiting. His notes do not indicate that he was told this by either Danny or his cellmate Mr E. Indeed, there is no note that Danny was vomiting all night. There is a note "nil vomiting" but RN Bryon said that related to just on his shift.

I do not accept that Danny had been vomiting overnight nor that Mr E had told RN Bryon that he had been. Having heard from RN Bryon, Mr E and Dr Corbett I am of the view that RN Bryon developed this evidence to explain his inaction upon correctly identifying a GCS 11. RN Bryon knew that Danny was deteriorating and that is why he telephoned Dr Corbett at 9.00 am.

He was concerned for Danny and though he should have made more frequent vital sign observations he made as many as he could, given the workload with other tasks at the clinic. Dr Corbett was not available to take RN Bryon's call and it was not until 10.30 am that they had their first conversation about Danny. It would be another 2 ½ hours before Dr Corbett could come to the correctional centre but he did not tell RN Bryon that. He told RN Bryon to "wait and see" and to call him back if RN Bryon became concerned.

RN Bryon took another set of observations at that time and then an hour later and as a result he was concerned. He rang Dr Corbett again at 12.15 pm and Dr Corbett said he was on his way and would be at the correctional centre soon. He arrived 45 minutes later. RN Bryon did not make any note that Danny had been vomiting or that he had been told that he had been. There is no reference to it in either RN Bryon's statement or Dr Corbett's statement. RN Bryon did not tell Dr Corbett that Danny had been vomiting all night. In his referral letter to the hospital Dr Corbett wrote that Danny "had a settled night and was up to pee a couple of times". Dr Corbett said that he obtained that information from RN Bryon. Mr E was first spoken to by those assisting me on 12 May 2021 - over five years since the event- and he was unable to recollect if Danny was vomiting. In his evidence he was asked "Do you recall whether he was vomiting at all?" to which he replied "No. Actually, I do recall one thing. I – he did - I do recall him – he - he started weeing blood at one stage…. because I helped him going to the toilet". Later he was asked "Do you recall if Danny was vomiting overnight" to which he replied "Yeah, he was, yeah".

He explained his improved memory had been triggered and that he could remember because little snippets were coming to him since being spoken to a couple of weeks earlier. He was later asked "When you say he was vomiting how many times now do you say he made it across the cell on his own to vomit, seemingly neatly in the toilet bowl?" and he replied "The poor bugger could barely move okay. I probably seen him vomit once…Once or twice max. You know what I mean. He was lucky to get up off the bed". Mr E was unable to say when it was that this occurred, indeed it could have been earlier rather than later meaning it could have been on 6 November 2015.

In his submissions Mr Sergi, on behalf of Dr Corbett, misstated the evidence relating to whether Danny vomited overnight and whether that was known to Dr Corbett. Mr Sergi wrote *"Dr Corbett gave evidence that upon his arrival at the Clinic he was informed (by Danny's cellmate Mr E) that Danny had been up in the night vomiting and going to the toilet".*

The evidence of Danny getting up was in relation to him urinating not vomiting. Dr Corbett was asked by Counsel Assisting "Were you advised that Danny had been up all-night vomiting?" and he answered, "Not that I recall". Counsel Assisting said "Because your referral letter to the hospital says that you were advised that he had a settled night and had been up a couple of times to pee" to which Dr Corbett replied "Yep" and Mr Hammond asked "Do you know where you got that information from?" and Dr Corbett replied "Yeah from his roommate. He was the one that told me that he'd been to the toilet twice".

Mr Sergi again misstated evidence in his submissions when he suggested that RN Wall said that he had seen Danny vomiting (despite his PN note recording "nil issues"). Mr Sergi submissions read:

"On day 7 of the Inquest, RN Wall confirmed that he in fact observed Danny vomiting and going to the toilet overnight but had not recorded

a. *those matters".* The evidence to which he refers are questions of RN Wall by Counsel Assisting:

b. Q. Dr Corbett who saw Danny on the 7th gave evidence that hewas told by the cellmate on the morning of the 7th that Danny was up several times in the night

a. Yes

c. Q. …going to the toilet…

2. yes

a. Q -and vomiting?

3. Yes, I saw that

a. Q. Now would you agree that that appears inconsistent with the note that you've made?

b. A Yes

c. Do you know - well, the observations as reported to Dr Corbett, Danny being up, going to the toilet and vomiting, could that have happened?

d. A Yes

e. Q Do you know when the last observations you made of Danny were on that shift?

f. A It would have been – after that, I would imagine, I would have gone through the clinic. I walk - I walked through the clinic and had a look at the CCTV footage. It could have been – you know, yeah, an hour or so after that: 5.00, 4.00

g. Q Did you see Danny moving around?

h. A Not from my observations. My observation was he was in bed at all times. I never saw him wandering around, and asleep from - you know, from the – the footage that I could see, he was in bed. He wasn't out of bed.

4. RN Wall has never said he saw Danny vomiting and Dr Corbett – despite Counsel Assisting's question.

5. Transcript 25/5/21 T101.31-102.10 vomiting. The evidence came from RN Bryon when he was in the witness box to explain away Danny's condition.

The evidence from Dr Gunja is that the trajectory of a paracetamol poisoning is that there is a period of time after vomiting stops and before liver failure commences. RN Bryon said that at about 10.30 am Mr E told him that the day before Intel had taken a urine sample from Danny and it was "dark as coke". He said that he didn't take another sample from Danny but rang Dr Corbett back again and the doctor said that he was on his way. RN Bryon was asked questions about why he did not escalate Danny's care or the observations when he saw at 9.00 am a GCS of 11 – a significant deterioration from RN Wall's record of a GCS of 15.

He said that did not escalate Danny's care at 9.00 am because Danny *"was tired and he just wanted to rest. So, I just thought I would come and check on him again shortly".* The truth is he mistakenly thought he could not do anything without the doctor's approval, and he couldn't get hold of the doctor. RN Bryon said at 10.30 am: *"Yes. I rang him and told him what was happening with him that he was still vomiting. He was because he's on call. I don't know where he was, he was actually driving from…And I if I didn't contact him, I'd leave a message on his voice, his answering machine and he would ring me back as soon as he got service".*

The evidence that "he was still vomiting" was inconsistent with the 10.30 am PN "nil vomiting" and it is uncontroversial that Danny was in fact not vomiting during RN Bryon's shift. He was later asked what he said in the message to the doctor and he replied: "*That could he give me a ring at the, at the Junee Correctional Centre please as soon as he got the message".* RN Bryon was asked about his note regarding a narcotic program and he said that he presumed Dr Corbett and the drug and alcohol nurse had had a conversation about that and he thought they had to get Danny's pain under control first. He said in his evidence that he didn't know why he had included that in the PN.

Dr Corbett gave evidence that he was concerned that Danny may have taken drugs which caused his deterioration. He said that Danny's cell mate told him that Danny had been to the toilet during the night and Dr Corbett explained: *"If they're in the toilet and the curtain is pulled and it just, just the comment from the inmate just raised that, that issue for me when I saw him – just confirmed the suspicion, that you know, maybe he has taken something".* Dr Corbett said he did not record his concern that Danny may have taken something overnight to explain his deterioration. He didn't raise it in his referral letter.

That Dr Corbett considered that Danny's deterioration could have been due to Danny having consumed drugs overnight or sometime between RN Walls 3.00 am PN is not on a consideration that is well-founded on the evidence. The symptoms conveyed to him or at least recorded by RN Bryon are not consistent with an opiate intoxication and contrary to Dr Corbett's evidence of the likelihood of a prisoner in the medical ward using illicit drugs. Other witnesses testified that this was not understood to have been an issue at the medical unit ward.

RN Bryon said in his evidence that he had no recollection of Dr Corbett asking him about the blood results when they spoke at about 10.30 am. He said he was aware that no bloods had been taken as there was no cannula in Danny's arm. He said he thought there would be a cannula because Dr Corbett had written "fluids" above where he had written "bloods" in his notes. This was a misreading of the notes Dr Corbett wrote on one line "stop Nap" and the next line under that he wrote a version of "Rabe[prazole]".

Dr Corbett said that he asked for the blood test results and it was then that he learned that the bloods had not been taken the previous day. Dr Corbett said he didn't direct RN Bryon to take bloods as there would be no point as they would not be collected for testing until the Monday. He said he did not suggest to RN Bryon to administer IV fluids. Dr Corbett attended at about 12.30 pm and wrote a PN "*sig. Deterioration for t/f WWBH; see (referral letter)*". He said in his statement that he reviewed Danny as set out in the referral letter and "I ordered his urgent transfer to Wagga Wagga Base Hospital for further assessment and wrote the referral letter.

In his evidence he said that the picture he was presented by RN Bryon over the telephone was very different to what he saw when he attended. He also said in evidence that Danny was a totally different person than the person he saw the previous day. Dr Corbett left the clinic at about 1.30 pm after completing the referral letter and instructing that Danny be conveyed to hospital.

RN Bryon said in his statement that between 1.00 pm and 1.50 pm he called the shift manager to call an ambulance. The Justice Health document "Emergency Response Form" completed by RN Bryon indicates that it was 1.50 pm when an ambulance was notified. There is no explanation as to why an ambulance was not called prior to this time given that Dr Corbett had "ordered his urgent transfer". There were significant ambulance service delays and Danny was ultimately transferred to Wagga Wagga Base Hospital at 3.30 pm. By the time the ambulance had arrived Danny was unable to follow directions or move himself from the ward bed onto the stretcher and had to be lifted by several people onto the ambulance stretcher.

Review of the Medical and Nursing Care and Treatment provided in the Medical Unit up until the morning of 7 November 2015.

Associate Professor Anna Holdgate, an emergency physician, provided an expert report and gave evidence in the inquest. She had a number of criticisms about the medical care provided to Danny whilst in the care of the medical unit in the Junee Correctional Centre.

Associate Professor Holdgate concurred with Professor Gunja's opinion that Danny died of paracetamol toxicity. She noted that given the lack of history of paracetamol ingestion given by Danny, and his history of polysubstance abuse, mental health issues and chronic pain, his vague presentation did not necessarily immediately point to liver failure. However, she thought that the urinary findings from the dipstick test of 5 November 2015 were significant and warranted further investigation. She noted that Dr Corbett had not recorded in his notes that Danny had haematuria and she thought this was a significant condition to make note of as it is a concerning sign for kidney injury.

Associate Professor Holdgate noted that RN Marsters' dipstick urine test did not record leukocytes, nitrites and bilirubin levels. She said that Danny's bilirubin levels would have almost certainly been elevated. She said that every component of the test should have been recorded. She noted the protein and blood and commented that *"…in the clinical context of someone presenting with reported blood-coloured urine and abdominal pain and vomiting you'd be concerned it could be reflective of an acute injury to the kidney."*

RN Marsters said in his evidence he only recorded significant readings which suggests that he did not understand either that the bilirubin levels were significant or that they were elevated. Associate Professor Holdgate considered that a further dipstick urinalysis test would have identified a more complex issue than Dr Corbett's working diagnosis of gastritis and that it would have been at least a useful test to monitor Danny's progress. Associate Professor Holdgate noted the lack of monitoring of Danny's condition and that without a standing order Dr Corbett would be expected to set the frequency of such monitoring when he reviewed Danny on 6 November 2015. I note Dr Corbett's evidence that he advised RN Marsters on 5 November 2015 to admit Danny as he had tachycardia.

There are no admission documents or patient charts (SAGO) which set out why Danny was admitted, the frequency of observations, the plan for his care other than RN Marsters' comment in the PN "push oral fluids".

In November 2015 the applicable process for patient care in the clinic was contained in GEO's Observation Unit Care Manual ("OUCM"). It had been released in 2008, revised in 2010 and was available on the intranet for all staff to access at any time. Nurses were made aware of the manual upon their orientation into the clinic. The OUCM requires observations to be taken every 2 hours. A SAGO Chart requires observations to be taken every 8 hours. Ms Te Maru considered the OUCM as a standard and that observations might be more frequent depending on the clinical indicators.

She considered the requirements of the OUCM mandated observations to be consistent with general practice and common knowledge, and a minimum. The disparity between the OUCM and SAGO may be explained by the fact that the cells in the Junee Medical Centre were essentially for observations. RN Wall said in his evidence that if a patient requires observations every 2 hours then they should be in hospital. It is extremely concerning that it would seem that nurses who had the care of Danny were not aware either of the requirements of the OUCM or if they were so aware, had no regard to it. Further, for the most part, the means of observation seemed to range from none at all to a glance on a CCTV screen while carrying out other duties. If observations were made, such as those by RN Marsters in the morning and afternoon of 5 November 2015 they were written on a piece of paper and the information transferred to a PN.

That there was a complete absence of clinical observations of any kind conducted by any clinical nurse on 6 November 2015 demonstrates a gross lack of care. There seemed to be an acceptance of a medical unit with poor systemic compliance.

Dr Corbett, when reviewing Danny on 6 November 2015, did not consider a lack of chart as a problem. In evidence he described the practice of nursing staff using a SAGO chart as "hit and miss", which indicates that there was a lack of compliance with "standing orders". However, Dr Corbett did not apparently consider it necessary to set out his own directions. He did say that there was an expectation that observations would be taken three times a day – once on each shift. Dr Corbett should have read the nursing PN when he reviewed Danny. Doing so he would have been aware from that there was no chart and no PN regarding observations since RN Duddy's PN of 4.50 pm 5 November 2015 and no observations in the morning of 6 November 2015.

Dr Corbett should have made it clear what observations he expected. He gave evidence that at the time of Danny's deterioration reported to him by RN Bryon on 7 November 2015, he expected that RN Bryon would take observations hourly. If this was so it appears, he failed to communicate that expectation to RN Bryon though RN Bryon understood that such observations should be taken in any event. Counsel Assisting submits that inadequate nursing care was provided to Danny and that deficient record keeping not only failed to comply with policy but was a reflection of the inadequate care provided to Danny during his admission in the medical unit. The inadequacy of the care was due to systemic failures of complying with policy, understanding the purpose of Danny's admission and actually carrying out the tasks required.

Counsel for GEO submits that it was reasonable for GEO to expect that the registered nurses employed by them would carry out their duties appropriately. That should be so, but it is incumbent upon GEO to ensure that best practice, policies and standards are adhered to by a sound management and audit process. If that had been the case GEO may have learned of the apparent lack of understanding and application of the OUCM before that evidence came to light in the inquest. The GEO submissions submit that the primary health services provided at the centre were akin to a GP practice and not a public hospital (as set out in Ms Te Maru's statement). It seems that such an analogy is of little relevance where a prisoner is accommodated in the unit for medical observation and treatment. As that is outside a GP practice situation, whatever hybrid the medical centre was, it performed its function to fulfil the purpose for which the patient was there. I note that the functions of the medical unit are now changed so that prisoners are no longer accommodated for patient care.

Mr Sergi, counsel for Dr Corbett submitted that though he made no response on behalf of Dr Corbett in regard to Counsel Assisting's submission, that the context of a custodial setting must be taken into account when determining the adequacy of care. He emphasises that the OUCM identifies that the "care provided to patients in the Observation Unit is under the supervision of a Registered Nurse". He says that whereas a registered nurse is always at the correctional centre, a medical officer is not though is on call and available 24 hours a day.

In relation to the morning of 7 November 2015 Mr Sergi's submissions spoke to how busy the ward was, with reference to CO Withers' evidence about being on duty that day. That was yet another misstatement by Mr Sergi of the evidence as CO Withers was not on duty on 7 November 2015. The evidence she gave related to 5 November 2015. The only witness who gave evidence about how busy the nurse on duty on 7 November 2015 was RN Bryon. Mr Sergi's submission that the adequacy of care provided to prison patients should be viewed in the context of the fact that they are in custody is not particularly helpful. Danny was in a medical unit; he was not in a prison accommodation unit. There is no evidence that observations could not have properly been made and charted because a nurse could not access Danny or did not have the time to do so.

In relation to 7 November 2015 RN Bryon said he could have made arrangements with a corrections officer to open the cell every hour to make observations but did not do so and was unable to explain why he did not do so. Dr Corbett did not direct hourly observations before or after he attended Danny. In relation to after he said that he expected that the ambulance transfer would be 15 minutes and I note that he had left the centre well before the ambulance had been called by RN Bryon.

In relation to the blood test request, Associate Professor Holdgate held the view that it was the responsibility of the ordering doctor to ensure that the tests were actually done and that there needed to be a system in place that if the blood could not be taken or the blood was not collected that the doctor would be notified. She also noted that Danny had a long history of intravenous drug use and a month prior a nurse had made a record that he deferred a blood test in relation to another matter, commenting that taking blood was difficult. There is no evidence that Dr Corbett considered that taking blood from Danny would present with any problems. In any event, Associate Professor Holdgate considered that it was reasonable that Dr Corbett presumed that the bloods would be taken and that he would be notified of an abnormal result on the basis of there being a system for that communication at the clinic. However, the evidence clearly shows that there was no such system in place.

There was no PN that the bloods had been attempted. There is no evidence of the nature of any pathology request on Danny's file other than Dr Corbett's handwritten word "bloods". There is no record of an urgent request or when the bloods should be taken. The Manager of the Medical Unit Ms Te Maru expected that for an urgent pathology request, the doctor would hand the nurse the pathology form. For routine pathology, the doctor would put it into a pathology tray in the clinic. She said that as at this time in 2015, patients from whom blood was not possible to draw would be expected to have been sent to the hospital for this purpose on the same business day. She said that any difficulties in drawing blood should be recorded in the progress notes and the fact that there was no such progress note for Mr Whitton on 6 November 2015 after the doctor had seen him in the morning, meant that nobody sought to draw his blood on 6 November 2015.

Dr Corbett said that on Saturday 7 November 2015 he did not suggest to RN Bryon to take bloods because there was no collection service until the Monday. Ms Te Maru said urgent blood collection could have been organised at the time, including on the weekend. Counsel Assisting submits that there was no system in place to ensure that requests for blood tests were actioned during the shift the request was made, or that outstanding requests for blood tests were actioned by the next shift. Consequently, the request for bloods made by Dr Corbett was never actioned.

Mr Sergi submits that "there could be no reasonable issue that Dr Corbett did order blood tests on an urgent basis". He further submits that though there was a system in place for the collection of bloods it was susceptible to failure and since 6 November 2015 GEO has implemented a more robust electronic system. GEO submits that "the evidence of Dr Corbett as set out in the submissions served on his behalf is also consistent with the system that was in place (as identified in Ms Te Maru's evidence referred to below). I do not accept that submission because Ms Te Maru's evidence distinguished the system applicable for an urgent blood test as compared to a routine blood test and it would appear that Danny's test request fell into the latter category when it should have been directed on an urgentbasis.

Any urgency as to the blood test Dr Corbett conveyed to nursing staff is not as Mr Sergi submits. Dr Corbett gave evidence that he reviewed Danny at 10.00 am, he handwrote the pathology blood request, he put the form in the "nurses' job list for the day". At that time that was a tray in the nurses' station and in his evidence, he said he assumes that he told a nurse that bloods were to be taken.

Though there was an 11.30 am courier collection he understood that the nurses would traditionally action those forms in the afternoon, though someone might flick through the tray in the morning but take the bloods in the early afternoon. The form must have been put in the tray by noon because that is when Dr Corbett left the centre.

According to Ms Te Maru, if the bloods were considered to be urgent the doctor would hand the pathology form to the nurse rather than put it in the tray or take the blood themselves. Danny's bloods could have been taken and collected by 11.30 am on 6 November 2015 as there was ample time to do so. Dr Corbett did not recall making such a request, however, it is clear that he did not make any such request because Dr Corbett's evidence was that he did not consider that Danny was in such a serious state as to get the blood test quicker – he was content to have the results that day. Given that he was content with the form being left in the tray for the nurses to action after lunch it is unlikely that he informed any nurse that the bloods were urgent. There was no reference in his PN or his statement of 2 September 2019 in that regard.

Ms Te Maru said that unless the pathology form had a day as to when the bloods were to be taken written on it the nurses would treat the request as "routine" and know to action the forms in the tray "during that week". Dr Corbett did not give evidence about having written a day by which the bloods were to be taken on the form and again there is no such direction in his PN. Associate Professor Holdgate placed significance on the urine test of 5 November 2015 and the fact that it was not repeated the following day. She considered that it would have been useful as a monitoring test for Danny and that it could have assisted in identifying a more complex working diagnosis of gastritis. Dr Corbett's response to this was fairly dismissive and as he did not think it would have added much to his review. He said that he would have ordered blood tests regardless of what the results of another urinalysis test were, and that Danny's presentation was not such at that time that he required hospitalisation.

That approach accordingly places more weight on the need for Dr Corbett to have ensured that a blood test was carried out so that he could be informed as to what was going on for Danny. Associate Professor Holdgate opined that Danny's colour was likely yellow from 5 November 2015 indicating jaundice. Dr Corbett said that Danny did not have jaundice. That he didn't perform a urine test on 6 November 2015 suggests that he had not included in his differential diagnosis kidney or liver issues. In any event he did not record that he considered anything other than gastritis in his notes. I agree with Associate Professor Holdgate that given Danny's urinalysis dipstick results of 5 November 2015, his complaint and description of pain; a suggestion that Danny may have gastritis was inadequate.

Ms Te Maru gave evidence that the fact that there was no PN on 6 November 2015 about drawing blood meant that it was not attempted. Dr Corbett said that on the Monday or Tuesday the following week he "chased up everyone and spoke to the boss about" why the bloods weren't taken. He wasn't able to identify who told him the answer. He said "the story I got was that it got very, very busy Friday afternoon there was a lot of code whites that took nurses off, they started taking the blood at 4, couldn't find a vein and by the time the courier had gone the blood didn't-wasn't taken". Ms Te Maru as manager of the unit did not give any evidence in that regard. Ms Te Maru gave evidence that if an urgent blood test was unable to be actioned, the patient would be transferred to hospital for pathology.

That Dr Corbett was not advised on 6 November 2015 that bloods could not be taken, and that Danny was not conveyed to hospital to take the bloods if the nurses were unable to draw it. That there is no PN tends to indicate that the bloods were not taken as there was no understanding that they were urgently required and/or of the system inplace.

There is no evidence that as at November 2015 there was an adequate "urgent blood test system" in place at the medical centre let alone a system requiring the nursing staff to clear the pathology tray the same day as the request was placed in it. There was no system in place to notify the Medical Officer in the event that the request could not be carried out other than an expectation that this would be done for an urgent blood request. If the nursing staff understood that the blood test was routine and was unable to draw blood the doctor would not be notified as the doctor would be on site during the week. There was no system in which a copy of the pathology request was kept and since Danny's death no such form has been located. Such a flawed system was perpetuated by both medical and clinical practitioners. In this case, it resulted in Danny's medical condition not being properly investigated so that an accurate diagnosis could be made, and an appropriate treatment plan implemented.

GEO's response to Counsel Assisting's submissions in relation to any blood testing system in the medical centre submits that that it was "more informal, which was not surprising given the nature and size of the Clinic." It wasn't just the blood testing system which was "more informal" as the poor observations; record keeping absence of nursing attention could be described in such a way. The fact that the clinic was small in terms of admitted patients but large in terms of prisoner population is no excuse for poor practice, informal or otherwise. As a result of the circumstances surrounding Danny's death, soon after the GEO medical centre acquired an i-Stat blood testing machine so tests can be conducted on site and the results known within 15 minutes. The pathology requests are now electronic.

Review of the care and treatment provided to Danny on 7 November 2015.

RN Bryon had been on the same shift (6.30 am to6.30 pm) the day prior but though he was the only RN performing clinical work with 2 or 4 enrolled nurses he had no dealings with Danny. There is a nursing standard called ISBAR (Introduction, Situation, Background, Assessment, Recommendation) system that due to the applicable Justice Health policy was required to be followed at the GEO Junee medical centre. RN Bryon said it was common to receive a fairly cursory handover such as "nil issues" rather than the ISBAR check. This deficiency was identified after Danny's death and GEO updated its clinical handover format to comply with the policy and in-service training was implemented to ensure staff used the ISBAR. There were only two patients in the ward: Danny and Mr E. According to RN Bryon he had been informed by RN Wall that they were both stable with nil issues.

Nursing staff within Junee Correctional Centre's medical clinic are required to comply with the Justice Health policies *Recognition and Management of Patients who are Clinically Deteriorating* and *Clinical Observation Beds in Health Centres (Adults*). SAGO charts were not consistently used in Junee Correctional Centre health clinic in November 2015 No SAGO chart was being used to indicate that Danny was under appropriate clinical observation and that his vital signs were monitored and recorded. RN Bryon repeatedly said that he used a chart on 7 November 2015 and that the entry of Danny's 09.00 am vital signs followed on from the entry made on the previous shift.

As there was no SAGO chart on either 5 or 6 November 2015, I would have expected RN Bryon's evidence to have been that he discovered that there was no SAGO chart in Danny's file and that he had to establish one. He did not give that evidence and I am not satisfied, despite his repeated assertions, that there was one used on 7 November 2015. The effect of not having the chart compromised a longitudinal understanding of Danny's condition making it more difficult to not only identify when he was not "between the flags" but what his deterioration progression was. RN Bryon explained that at one-point Danny's 10.30 am blood pressure was lower than it was at 9.00 am because he had moved from a sitting position to a lying position on the bed.

I took that evidence as gratuitous as RN Bryon's memory was clearly not being exercised when he said it. RN Bryon's understanding as to why Danny was in the clinic was that it was due to drug withdrawal and associated abdominal pain. He said he had come to that understanding from reading RN McGloin's PN note (which though had not been a clinical note was in the nursing PN) and seeing that Danny had been prescribed Maxalon. The evidence in the inquest clearly demonstrates that Danny should have been hospitalised in the morning of Saturday 7 November 2015 or as indicated by Professor Gunja. Had the blood tests been conducted and reported on by 7.00 pm Friday 6 November 2015, the test results would or should have prompted Danny's hospitalisation.

Associate Professor Holdgate referred to evidence that Danny was noticeably jaundiced and that there seemed to be a failure by clinical staff to recognise this as being indicative of liver issues. RN Marsters, RN Wall, RN McGloin, RN Bryon and Dr Corbett all say that Danny did not appear to be jaundiced. Dr Corbett said he looked for it on 6 November 2015 as he was aware of the urine test conducted by RN Masters. His experience was that jaundice can be "very very hard to spot sometimes" and may not be evident even when the bilirubin levels rise above 40-50 umol/L. The medical unit witnesses said that the lighting is not very good in the cell suggesting that may have contributed not being able to recognise Danny's jaundice. Mr E said that Danny was turning yellow. I note that ambulance records do not indicate that Danny's skin was jaundiced but note that his eyes were. Dr Corbett pointed out that the registrar of Wagga Wagga Base Hospital wrote three pages of notes without a mention of jaundice until after the blood test results were in.

It is possible that Mr E said that Danny was turning yellow in front of him because he was the only person who spent a significant period of time with Danny and was able to measure that change in him. I accept in regard to the nurses that Danny's skin to them was not appreciably jaundiced, they were not looking for it and they spent minimal time with him. Observations via a CCTV monitor would not afford an adequate opportunity to identify jaundice, let alone recognise it and perhaps the same could be said for the lighting in the cell and the clinic generally. Dr Corbett did not see it on 7 November 2015 and that may have been due to the lighting and the fact that Dr Corbett spent very little time with Danny as he saw immediately that he required transfer to hospital. Dr Corbett then set out directing that that occur and wrote the referral letter. Dr Corbett left the medical unit expecting that the ambulance would arrive within 15 minutes.

Associate Professor Holdgate thought that a patient with GCS 11 warranted observations every 30 minutes. Ms Te Maru was familiar with the SAGO chart which stipulates that if a patient has a reduced consciousness, and the deterioration was not reversed within one hour of a clinical review, an urgent response would be called for. If the patient was asleep, this would mean rousing the patient to conduct the relevant tests. Ms Te Maru said that her practice would have been to rouse him every 10 minutes. It has not been her experience that anyone with a GCS of 11 would improve after sleeping an hour or two.

Counsel Assisting submits that Danny was not provided with an adequate level of observation by nursing staff during the morning shift of 7 November 2015. Appropriately detailed progress notes were not made by nursing staff, in particular RN Bryon, during the morning on 7 November 2015, and Dr Corbett was not provided with a satisfactory description of Danny's critical condition. In her second written statement, Ms Te Maru concluded that staff had complied with policies in relation to the management of a deteriorating patient. She resiled from this position in the inquest.

It would appear that rather than reviewing Danny's file and requiring written reports Ms Te Maru had relied on her expectation that staff would have complied with policies and guidelines, verbal feedback from the nursing staff and the doctor, and the fact that Danny was transferred to Wagga Wagga Base Hospital. Ms Te Maru said she was not aware of a difference between her expectations and the actual practice within the clinic before Danny's death and only became so aware following a review and creation of an action plan in 2016.

I agree that nursing staff did not make detailed progress notes on 6 November 2015 there were none but for a nonclinical record by the drug and alcohol nurse. Whilst I agree that RN Bryon failed to make appropriate detailed Progress Notes and failed to conduct an adequate level of observations it is difficult to accept that he failed to recognise and provide a satisfactory description of Danny's critical condition to Dr Corbett. I do accept that whatever communication there was between nurse and doctor, RN Bryon did not counter Dr Corbett's direction at 10.30 am to "wait and see" how Danny was until he could attend the correctional centre. That positioning no doubt caused Dr Corbett not to be alerted that Danny required immediate hospitalisation and that there was no time to wait.

Mr Sergi submits that Dr Corbett's advice to RN Bryon at 10.30 am to observe Danny and call back if concerned is "evidence consistent with the proposition that RN Bryon understood that Dr Corbett wished there to be a significantly increased level of observation of Danny". I do not accept that submission. In his evidence Dr Corbett did not say that he communicated an increased level of observation, the evidence he gave was that he assumed the observations would be hourly. According to Associate Professor Holdgate, ideally the observations would have been at least every 30 minutes and according to Ms Te Maru they could have been every 10 minutes until Danny's condition improved. Dr Corbett did not communicate any level of observations to RN Bryon. According to Dr Corbett he did not even suggest that RN Bryon cannulate Danny. I do not accept that RN Bryon is so incompetent that he honestly believed that "No sleep will certainly drop your Glasgow Coma Scale down when different people check them".

Nor do I accept his evidence and his explanation that he failed to convey urgency to Dr Corbett because *"it wasn't clinically indicated that it was an urgent call apart from the fact that he was a little bit, his Glasgow coma scale was a bit down but only because he hadn't had any sleep and he was still vomiting, he vomited all night sorry".* I do not accept RN Bryon was told that Danny had been vomiting all night so I cannot accept that he believed at the time that Danny's GCS was explained by this nor that he believed he would "sleep it off". He didn't suspect Danny had taken an intoxicant, he said he thought Danny was in the clinic for withdrawal from substances.

I have come to the conclusion that RN Bryon sought in the coronial investigation and inquest to suggest that Danny's illness was not as apparently grave as it was – probably to justify the late decision to transfer Danny as well as to demonstrate a lack of discord of opinion and action between himself and Dr Corbett as to that decision. In his written statement RN Bryon said that Danny was sufficiently well and able to move himself from the bed onto the ambulance stretcher. The CCTV footage totally contradicts this evidence and shows Danny was unable to move or follow a command at all and numerous personnel were required to move him.

Likewise, the CCTV footage does not support RN Bryon's evidence in regard to learning the colour of Danny's urine as being when the ambulance personnel were wheeling Danny out (this version given in his statement). If the CCTV footage of the entire morning had been provided to the police, the events of the day would have been far easier to have ascertained. In this inquest, identifying what is truthful, reliable or otherwise has been difficult as RN Bryon's versions of events were so various. Whether the 9.00 am call to Dr Corbett was a narrative description of Danny's presentation or a simple telephone message to call him back, whether it was urgent or not, whether the doctor returned the call 1 ½ hours later at 10.30 am, whether there was another telephone call before or after 10.30 am or advising the doctor that Danny couldn't be cannulated or about the colour of Danny's urine has all been difficult to ascertain.

There is no evidence of how many calls there really were that day nor are there notes about what was said in the telephone calls. Accordingly, it is difficult to ascertain the content of the telephone calls. Dr Corbett says he could not recall being told that Danny had vomited all night, that he had a GCS of 11, that Danny had dark urine, that he had asked Danny to be cannulated or that he was later told on another call that this couldn't be achieved. Mr Sergi submits that "RN Bryon informed Dr Corbett that Danny's urine was normal and that he was no longer vomiting".

That is an incorrect statement of the evidence and is a submission that follows from Mr Sergi saying "RN Bryon stated that he did not recall discussing the colour of Danny's urine with Dr Corbett" with a footnote to the transcript. Associate Professor Holdgate thought it was not reasonable for Dr Corbett to have advised at 10.30 am on 7 November to "wait and see" if Danny got better, "in the context of the reason he was there in the first place which was the abdominal pain, the vomiting and the other physiological abnormalities that haven't been noted". Dr Corbett sought to explain his reasoning that he thought Danny might have been intoxicated because the cellmate told him that Danny had been to the toilet.

Despite Dr Corbett's evidence that this "happened all the time" this was not supported by other witnesses. In any event, RN Bryon didn't share that concern and indeed it wasn't until he was at the prison that Dr Corbett spoke to Danny's cellmate. Associate Professor Holdgate opined that "the clinical staff at Junee did not adequately assess Danny and did not recognize that he was seriously unwell. They failed to recognize his jaundice or the significance of his urinary findings, they responded slowly when he became drowsy and confused."

I have come to the conclusion that whilst RN Bryon did not conduct observations as frequently as he should have, he did recognise that Danny was seriously unwell. His slow response was due to him thinking that he had to wait for the doctor who unbeknown to him was at 9.00 am some hours away. RN Bryon identified at 9.00 am that Dany's GCS score measured a 2-point drop in fine motor skills and verbal commands respectively. Danny was unable to hold a cup - he was shaking when he was trying to hold a cup of water. RN Bryon said that Dr Corbett advised him to take bloods, but he couldn't find a vein to do so. Dr Corbett denied giving such a direction saying that there would be no utility in doing so given that the blood would not be collected until the Monday. RN Bryon said that Dr Corbett did not indicate how often to take observations but that because he was on CCTV and "we could monitor him through that and also just go and do regular obs". CCTV screen monitoring is certainly an inadequate means of observation of a critically unwell patient, but RN Bryon had a multitude of other duties that day as well as his concern for Danny must have been very stressful for him.

Being told to "wait and see" and "I'm on my way" would have provided little support for the nursing task that befell him. Ms Haider asked RN Bryon "Did you suggest to Dr Corbett that Mr Whitton should go to hospital as soon as possible?" and he replied, "No. He said he was on his way, I said I could look after him until he gets there". RN Bryon says that he did not call an ambulance because he understood that a doctor had to authorise a medical transfer of a prisoner. This is a misunderstanding of the policy. However, there is no evidence that RN Bryon at any stage suggested to Dr Corbett that in his opinion that Danny should go to hospital. Dr Corbett said that the information RN Bryon gave him over the telephone about Danny's condition was different to how he assessed Danny's condition when he attended.

I have considered whether RN Bryon did not really understand that Danny required hospitalisation or that he mistakenly understood he had to wait for Dr Corbett to be transferred to the hospital. On balance I have come to the conclusion that RN Bryon did think Danny required immediate hospitalisation; he did not tell the doctor this because of a misperceived reliance and loyalty to the doctor's opinion and participation. He said, "We always looked after people with withdrawal; we've always looked after people with – abdominal pain until they are reviewed by the doctor".

I do not accept that RN Bryon did not appreciate that Danny's illness warranted evacuation. Though Danny's vital signs observations were "between the flags" despite a drop in blood pressure, Danny's GCS and inability to hold a conversation, falling back to sleep together with ataxia and delirium, were identified by RN Bryon. Danny's condition warranted immediate hospitalisation especially since he could not be cannulated for bloods to be taken and fluids to be given.

Indeed, RN Bryon was asked whether he considered that Danny should go to the hospital rather than wait for the doctor he said, "I did make that assumption, yes". The joint decision to wait until Dr Corbett was able to attend was a poor choice to make when Danny could have been easily transferred to the hospital without Dr Corbett's attendance. I note that Dr Corbett still works in the medical unit at Junee Correctional Centre and that there have been significant systemic changes, clarified policy and protocol and training to achieve a culture of best practice. Since giving evidence in February 2021, RN Bryon has ceased working at Junee Correctional Centre. The inquest heard evidence that on 6 November 2015 Dr Corbett had to travel to Sydney for an urgent family matter and he left Sydney in the early morning on 7 November 2015 to return to Wagga Wagga. Dr Corbett was unable to attend the prison prior to 1 pm and that should have been conveyed to RN Bryon. The four hours lost may not have altered the course of Danny's illness but it would at least give his family confidence that on that day Danny received the best health care that could have been afforded him in the circumstances of being cared for by a Registered Nurse in the absence of a visiting GP.

RN Bryon gave numerous versions as to when he learned from Mr E that Danny's urine sample taken by GEO Intel on 6 November 2015 was "dark as coke". He did not make a PN note of it, but it is included in the Emergency Response Form. He was asked by Counsel Assisting why he included in his statement (para 18) "Although I have referred to a conversation with…cellmate...in my progress note I have no recollection of this conversation. If the cellmate had described the urine to me at this stage as "dark as coke" I would have sought a sample and escalated his care immediately".

He said in his evidence "...the cellmate, that was with him and he said "Geez, that was as dark as coke" and then alarm bells went off of my head to say that usually that is a sign of kidney failure". His evidence was that occurred at 10.30 am on 7 November 2015. At another point in his statement (para 36) RN Bryon said that Mr E told him this information as the ambulance were wheeling Danny out. He said in answer to a question from Ms Haider that he rang the hospital to tell them this information because it was pivotal information. Later in his evidence as to when he was told, he said that it probably would have happened from 10.30 am to 12 noon when the cellmate spoke to me again". RN Bryon said that he didn't take another sample from Danny but rang Dr Corbett back again and the doctor said that he was on his way. Later RN Bryon said that he did not know if he ever told Dr Corbett this information but he did record it on the Emergency Response Form after Dr Corbett told him to call an ambulance so that Danny could go to hospital for "a head and abdo CT". Another time advanced by RN Bryon was "just before the ambulance turned up". He said he wasn't 100% sure when it was that Mr E told him whether it was the first time, the second time or when he called the ambulance. RN Bryon said he learned the information sometime between after his first attendance on Danny at 9.00 am and before the ambulance but he had no recollection of having told the doctor.

Mr E was asked by counsel assisting "And do you recall whether you told the nurse that morning that Danny's urine was "dark as coke" to which he replied "Yep. Yeah…I remember that now that you say that, yeah". As to when that was, he said "pretty sure it was when they done the urine on him". He was asked whether he meant medical or Intel and he said he couldn't remember. He said he remembered about the coke because "that's when I was blowing up, saying that youse need to help him you know". He said that was probably the Saturday.

On balance taking into account Mr E's poor memory due to lapse of time, he was unable to assist me in identifying the time at which he told RN Bryon about the colour of Danny's urine. However, given that RN Bryon had read Danny's progress notes, when being told he had urinated that morning it would have been a good information to have inquired into as to whether the colour was normal or not. That is something that Dr Corbett might have inquired over the telephone too when told that Danny had passed urine.

RN Bryon's evidence in regard to when he learned that Danny's urine was "as dark as coke" is entirely unsatisfactory. His evidence in his statement that he was only told this by Danny's cellmate when the ambulance was wheeling Danny out is not born out by the CCTV footage. The last observation recorded by RN Bryon is at 13.25 around the time that Dr Corbett left. The ambulance did not arrive until 3 pm and despite RN Bryon being concerned that Danny was deteriorating he did not take any further observations. He said that he looked on the CCTV and "I watched him just lay there on the bed and, and try to get some sleep".

That RN Bryon continued this narrative throughout his evidence to the inquest did not convince me that on 7 November 2015 he did not think that Danny was in *dire straits*. His evidence when questioned by his solicitor indicated he is a knowledgeable and experienced registered nurse. RN Bryon was left to complete the paper work, organise Danny's evacuation, deal with an ambulance cancellation and watch and wait until the paramedics arrived. Mr Rees on behalf of Kylie Knight, Danny's mother, submits that the treatment afforded to Danny was "incompetent", displayed a "lack of care" and "attention to detail". Mr Rees submits that in accordance with regulation 151A of the *Health Practitioner Regulation National Law* (NSW), Dr Corbett should be referred to the Medical Council. Ms Cooper on behalf of Darren Whitton likewise makes this submission.

I do not think that the evidence supports such a course, though at times Dr Corbett was somewhat flippant in the witness box, it should not be taken as an indication of medical care. For example, such as when he attended Danny on 7 November 2015 he was asked "When you got there, did you physically examine Danny?" he said "I certainly looked at him. I poked his belly, yeah" and that he didn't form a view about a possible diagnosis or speak with any clinicians because "I wanted him out". There is no evidence to suggest that had Danny been conveyed to hospital at 9.00 am that morning, his death would not have occurred. Sadly, the evidence suggests that even at that stage Danny's condition was irreversible. It should be noted that though Danny had arrived at Wagga Wagga Base Hospital it was not until blood test results were known that Danny was treated for paracetamol overdose.

Ms Cooper submits that had Danny been hospitalised on 5 November 2015 his death "would certainly have been prevented" and relies on Professor Gunja's evidence in that regard though Dr Gunja did say that acetylcysteine should commence within eight hours of ingestion. Danny presented to the clinic well outside that time period. The evidence does not support a finding that RN Marsters or Dr Corbett should have at that stage transferred Danny to hospital. Associate Professor Holdgate does not provide that opinion nor does Professor Gunja. Ms Cooper lists in her submissions the failings at the medical centre at Junee Correctional Centre. Those issues are identified throughout these findings.

Ms Cooper submits this list as indicative of the suboptimal care provided to Danny when he was a patient in the medical unit at Junee Correctional Centre and that it acted as a barrier to Danny being referred to hospital. She acknowledges the changes that have been made to the unit since that time and notes that a patient now presenting as Danny had would be transferred to hospital rather than being admitted. Mr Rees also includes a list in his submissions and for the most part they too are contained throughout the findings. Mr Rees' list includes a failure by Dr Corbett to hospitalise Danny on 6 November 2015 in light of the elevated results in the urine dipstick test of 5 November 2015. The evidence does not support a finding that Dr Corbett should have referred Danny to hospital at that time or in answer to another item on the list that Danny should have had IV fluids that day.

In relation to 7 November 2015, Mr Rees' list is contained throughout the findings, but he identifies that RN Bryon failed to call an ambulance at 9.00 am and failed to identify that Danny's GCS 11 required a rapid response. The rapid response was to conduct closer observations and record them and if there was no improvement to escalate Danny's care. Due to RN Bryon's misunderstanding of the transfer protocols and his misplaced understanding that he should wait for the doctor, his escalation of care was to call the doctor back. It is unclear due to the lack of good record keeping whether RN Bryon told Dr Corbett about the GCS 11, but one would expect that he did. There is an inference available from the evidence of RN Bryon that the GCS was the reason for the call to Dr Corbett, and that information was provided to the doctor. Mr Rees is critical that Dr Corbett did not advise the medical unit on the whiteboard that he was going to be in Sydney.

I don't think Dr Corbett knew that he was going to be in Sydney and there is no evidence that he did not convey to RN Bryon his whereabouts. It would have been ideal Dr Corbett had indicated to RN Bryon that he was unable to attend Danny until some hours after RN Bryon called shortly after 9 am. In addition to referring Dr Corbett to the Medical Council, Mr Rees submits that RNs Marsters, Wall and Bryon should be reviewed. I do not intend to do so but that does not prevent either of Danny's parents to pursue such a course. Mr Rees submits that there be a recommendation that Justice Health undertake a review of the staffing levels, training and competency of health staff at Junee Correctional Centre. I decline to do so given the passage of 6 years and the changes made at the Centre since Danny's death.

Changes made at Junee Correctional Centre

Following Danny's death GEO Health addressed the issue of recognition and management of clinically deteriorating patients by introducing in-service training around the use of SAGO charts and "between the flags" principles. Ms Te Maru thought medical and existing staff could benefit from refresher courses. The OUCM is now redundant, and in any event if it ever had been in use, it was not by the nurses who gave evidence in the inquest. RN Bryon's evidence was that in 2015 a nurse was unable to call an ambulance without the doctor's approval. RN Duddy said that such authorisation can be given over the telephone if the doctor is not in the clinic. As to the policy in 2015 for calling an ambulance, Ms Te Maru's attention was drawn to a policy that existed in 2015 called the *Transfer Protocol for Wagga Wagga Base Hospital* (the 2015 protocol) relating to the circumstances in which a patient might be transferred to the base hospital.

Ms Te Maru, said that she disagreed with RN Bryon's evidence that there was a general policy that a nurse in his position was unable to call for an ambulance without permission from a doctor, and thought RN Bryon misunderstood the policy. Ms Te Maru said the relevant policy allowed for a nurse to call an ambulance and then inform the correctional group without contacting first the health services manager or a person of higher rank than the registered nurse on duty. Given the time that Danny ingested the paracetamol and his noted deterioration on the morning of 7 November 2015, had RN Bryon called an ambulance at 9.00 am, it is unlikely that there would have been a better outcome for Danny as the damage had been done and he was in multi-organ failure. However, the evidence warrants a finding that an ambulance should have been called at least by 10.30 am.

The 2015 protocol was part of the *Junee CC Primary Health Care Manual – Emergency Clinical Guidelines* and was applicable in November 2015. The policy was referred to in oral evidence and later provided to those assisting the Coroner on 2 August 2021 and entered into evidence.

The protocol indicates the procedure following the nurse's completion of several urgent information-gathering and resuscitation steps (underliningadded):

a. [6] If the condition of the inmate warrants transfer to the base hospital, ***phone ambulance control on 000 or 131233*** *to arrange a transfer.*

b. [7] Only the Doctor or General Manager can authorise the removal of a patient from the Centre and must be notified as soon as possible of all Patients transported out.

c. [8] ***Inform Central Control****. Central Control is able to inform shift manager (Correctional Manager Operations), Front Gate Officer*

d. [9] Complete Section 24 (Removal of Prisoner from Centre). Delegate this task if necessary.

e. [10] Complete ***Consultation Emergency Room Referral*** *if time permits. Hand enveloped original to ambulance officers.*

f. [11] ***Notify Wagga Base Hospital A&E Department*** *of impending arrival of inmate through switchboard.*

g. [12] Inform Doctor of action taken.

h. [13] Inform Health Services Manager of action taken

i. [14] Complete Incident/Assault Report [15] Update Medical Record

The Nurse is then required to inform the Nurse Manager and Justice Health of the action taken. The protocol was apparently approved by the Centre Medical Officer, although there is no signature on the foot of the document confirming suchapproval.

The current policy dealing with the transfer of patients from Junee Correctional Centre to hospital was published on 21 January 2021 and is called the *Emergency Hospital Transfer and Daily Status Update* (the 2021 policy). Relevantly the policy provides:

j. "The decision to transfer a Custodial Patient to hospital is made by either medical and/or nursing staff based on clinical assessment and the determination that the acuity of the Custodial Patient warrants further assessment and/or treatment at an external hospital."

The 2021 policy provides that nursing staff are to make every effort to advise the Shift Manager or Code Co-Ordinator to what kind of escort is required and are required to complete forms to be kept on JHeHS system. In the case of the transfer of prisoners for serious incidents involving life and death situations, the Health Services Manager (HSM) must be immediately advised of the transfer or if after hours within four hours of its occurrence.

Health Related Emergency Response and Emergency Clinical Guidelines (the Guidelines) accompany the 2021 policy and provide that custodial patients are required to be given 24-hour access to emergency health care at Junee Correctional Centre, including access to nursing staff and telephone advice or personal attendance by a medical officer 7 days a week. Nursing staff are responsible for leading the coordination and management of a health-related emergency. According to the Guidelines, one registered nurse will assume the role of Health Coordinator and act as liaison with the Shift Manager or Code Coordinator regarding the attendance of an ambulance, the medical officer and advising of the patient's transfer. The guidelines reiterate that the decision to move the patient from the incident location to an external hospital will be made by the nurse or GP. The guidelines expect that all Junee Correctional Centre correctional and health staff are trained and orientated in relation to their respective responsibilities in a health- related emergency, with the HSM responsible for ensuring health staff are adequately trained and adhere to reporting requirements.

Counsel Assisting submits that the 2015 protocol was ambiguous as to whether a nurse could transfer a prisoner without the doctor's authorisation which may have given rise to different understandings and approaches by nursing staff. The 2021 policy now makes it clear that a nurse does not require a doctor's authorisation to transfer a patient. However, counsel assisting noted that at the time the nurses gave evidence in February 2021 they were likely not trained about the then recent policy and guidelines and suggests a recommendation that the GEO ensure that training occurs so that all health staff are aware that nurses can call an ambulance to transfer a prisoner without a doctor's authorisation.

Counsel Assisting also referred to a change in the use of the cells in the medical unit. The evidence is that the medical unit has undergone significant renovation so that rather than two accommodation cells there are now eight. However, unwell prisoners are no longer accommodated in the medical unit except those who require observation in CCTV monitored observation cells "for the sole purpose of monitoring patients with deteriorating mental health. Counsel Assisting noted that the 2021 policy indicates that a prisoner who is returned the correctional centre from the hospital may be placed in an observation cell or a treatment room. That policy seems to require clarification that it applies to only mental health patients as the observation cells are, according to the Junee Corrections Centre Operating Manual not for any other use.

Counsel Assisting pointed out that GEO Health were in August 2021 reviewing the local policy regarding the observation cells within the health centre and suggests a recommendation that the policy accurately reflects the importance of regular monitoring and notation, recognition of signs of deterioration inpatients and clear procedures for escalation for the particular facilities and circumstances that exist at the Junee Correctional Centre health clinic.

I have not seen the policy and would presume though that considering the purpose of the policy it would address those matters. Junee Correctional Centre health staff need to be aware of the relevant Justice Health and NSW Health policies. Whilst Justice Health staff have the benefit of training and education on the Health Education and Training Institute ("HETI") platform, GEO health staff do not. GEO Group suggest a recommendation that "Justice Health advocate on its behalf to the Ministry of Health for GEO health staff at Junee CC to have access to training on the HETI system".

However, I decline to make such a recommendation due to Mr Lynch's submission on behalf of Justice Health that provides compelling reasons why such a recommendation would not be made:

The Health Education and Training Institute (HETI) provides training and education to clinical and non-clinical staff, trainers, managers across the NSW Health system. HETI is a statutory health corporation established pursuant to the *Health Services Act* 1997 (NSW). It is therefore a distinct legal entity to Justice Health and has its own Chief Executive and Board who report to the NSW Health Secretary and NSW Health Minister. Justice Health has no involvement or authority in respect of the day- to-day business of HETI, including the determination of which agencies or parties have access to HETI training systems. Justice Health is not in a position to advocate on behalf of any private company, including GEO with respect to access to HETI. Although Justice Health does not oppose GEO having access to the HETI system, this is a commercial decision which must be made by HETI, the NSW Ministry of Health and the GEO Group.

Paracetamol

The evidence in the inquest demonstrated that prisoners have ready access to paracetamol and that some, probably a lot, stockpile it. The ready access is due to the policy that a prisoner can attend the pill dispensing counter and receive up to six tablets for a 24-hour period on a nurse-initiated administration. After three days if the prisoner continued to request same, he would be assessed by the nurse. The protocol required the prisoner to ingest two of the tablets at the counter and take four away. Dr Corbett was shown Danny's medication chart and confirmed that from 2-9 October 2015 Danny obtained paracetamol tablets every day over the course of the 8 days. According to the records this amounted to 46 tablets. This was in the addition of Danny's daily Naprosyn which he had been prescribed on 17 August 2015. On the basis that Danny had to ingest 2 tablets each of the 9 days before leaving with the remainder he could have stockpiled up to 28 tablets.

The hoarding of medications was well known at Junee Correctional Centre and Dr Corbett tried to initiate the reduction of the dispensing of paracetamol as an attempt to combat this. However, he said this proved unsuccessful due to the ongoing need for pain relief in prisoners with dental and other pain-inducing issues. Dr Corbett also knew that correctional officers would sometimes find a bag of medication and dispensing staff were asked to identify which inmate the medication corresponded to. Mr E said that prisoners would stockpile paracetamol and exchange it for "buy-ups" or other items.

Mr E described paracetamol as the "*wonder drug of the Corrective Services*" because it is given out so frequently – this made stockpiling easier. In Mr E's experience, there was no education whatsoever given to prisoners about the risk of liver failure from excessive paracetamol.

He agreed that many prisoners believed that taking paracetamol in large doses would get them 'stoned' because they did not understand it was the codeine ingredient that had the 'stoning' effect. Since 2015 there had been a policy change to reduce the amount of daily paracetamol. Since 2014, training in "*Identifying Inmates under the Influence*" has been delivered to correctional staff at Junee CC. The training notes that "paracetamol is the most common cause of intentional self-harm and acute liver failure." The training does not, however, provide guidance on recognising the signs of paracetamol toxicity and how it should be treated. Counsel Assisting suggests that there are opportunities for better education to both prisoners and those working in correctional centres about the dangers of paracetamol toxicity and the recognition and treatment of it.

Professor Gunja gave evidence that acetylcysteine, ideally administered within eight hours of a paracetamol overdose, is an effective antidote. Though he agreed that it may have had benefit for Danny on 6 November 2015, given that Danny had not presented to the medical clinic until over 36 hours after he had ingested it, even if the acetylcysteine had been administered then, its effectiveness is seriouslydiminished.

Counsel Assisting put forward recommendations dealing with paracetamol toxicity as follows:

That Justice Health, in partnership with CSNSW (including privately operated correctional centres):

- promote better education amongst the inmate population throughout NSW of the dangers of paracetamol overdose.

- Provide training to correctional staff and health staff at correctional centres throughout NSW on recognising and treating paracetamol overdose; and,

- Ensure that correctional centres are stocked with antidote acetylcysteine and medical staff are trained in the correct administration of the antidote

- That the GEO Group Health Services make available in the health clinic at Junee CC the paracetamol toxicity antidote acetylcysteine"

Mr Pickering on behalf of CSNSW opposes the recommendations and nominates that Justice Health is the appropriate organisation to address those recommendations. Ms Berberian on behalf of GEO also opposes the recommendations and adopts Mr Lynch's submissions on behalf of Justice Health. Mr Lynch on behalf of Justice Health says that paracetamol overdose is uncommon within the prison cohort despite its ready availability. Justice Health supports the education of prisoners in terms of the general advice readily available in the community which is "do not take more paracetamol you are prescribed". Mr Lynch says that the Justice Health Consumer Medicines Information (CMI) for paracetamol attached to the Adult Nurse Initiated Medication Protocol advises *"Prolonged use of paracetamol without medical supervision may be harmful. Contact the medical officer immediately if you have taken too much paracetamol".*

Justice Health would support a recommendation that it review the wording of the paracetamol CMI. The CMI should be reviewed to include in its warning the issue of misuse or overdose and set out the risk of harm and the range of possible symptoms at which a person should seek medical attention. Justice Health does not support the suggested recommendation relating to training correctional and health staff to recognise and treat paracetamol overdose. Mr Lynch points out that it is extremely difficult to diagnose paracetamol overdose based on physical signs or symptoms and that a patients reported clinical history and pathology, including testing for serum paracetamol concentration in blood is required.

Mr Lynch says that there is more benefit in providing education to corrective services and medical staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol. An information sheet prompting staff to inquire with an inmate as to the quantity of paracetamol ingested when they present would be useful. Such information would assist in determining the appropriate clinical management of a patient, particularly in circumstances where paramedics, clinical staff and/or after-hours doctors (ROAMS) become involved. Counsel Assisting's recommendation regarding acetylcysteine is also opposed by Justice Health. Aside from pointing out that there was no evidence led in the inquest about this, Mr Lynch explained in his submissions the complexities of acetylcysteine and why a paracetamol overdose requires review by an Emergency Department team to determine the appropriate treatment, and patients who are suspected of suffering from paracetamol overdoses ought be transferred directly to a hospital for immediate management.

For those reasons I decline to make recommendations as advanced by Counsel Assisting. It is necessary however to make the recommendations suggested by Mr Lynch which helpfully meet those put forward by counsel assisting.

<u>GEO Intelligence Urinalysis</u>

An issue that was not identified during the coronial investigation but came to light in the inquest was the apparent relationship between GEO Intelligence and GEO Health staff in two particular respects. The first was the provision of lists of prisoners and their medication to GEO corrections so that when a prisoner was required by GEO Intelligence officers to undergo a random urinalysis sample, the tester would know what drugs should or should not be in the sample. Without inquiring into the policy arrangements of that relationship the inquest heard evidence that Danny's medical attention was delayed on 5 November 2015 because RN Marsters was under instruction that the list was required on a prioritised basis that morning.

Though RN Marsters said that he did not understand that it was urgently required, CO Withers was under the impression it was as she had to clear the area to allow RN Marsters to undertake the task and she thought that the direction to RN Marsters "hindered him having to complete his own tasks and also seeing the other inmates that were there for sick parade as well. Mr. Doherty gave evidence that his understanding that such lists were prepared by the nurse over the night shift and were generally not urgent but there may have been some imperative attached to it that day.

Ms. Te Maru expectation is that it was not a priority for a nurse to provide a list upon request to Intel for urinalysis when a patient requires care. It would appear that RN Marsters prioritised the provision of the list to GEO corrections over his duties to provide medical care to prisoners. That he was able to rely on CO Withers to observe Danny and report to him those observations is not an adequate practice. One remark in regard to the practice generally, GEO should ensure that in adopting such a practice it is not imposing upon its medical and clinical staff a risk of breaching patient confidentiality and placing at risk prisoner patienthealth.

The second aspect relates to RN Marsters sending to Mr Doherty an email at 3.09 pm on 5 November 2015 which said:

k. Hi Wayne

l. Danny Whitton presented to the clinic this morning c/o nausea and vomiting. He denies any drug use, but his observations seem to indicate otherwise.

m. Requesting a drug urine screen please. Regards

n. Alf Marsters RN

The email was copied to Ms Te Maru. Mr Doherty sent a response email at 3.10 pm requesting an officer to add Danny to the list for 6 November 2015. Ms Te Maru was again copied into that email chain. Justice Health CSNSW and GEO Group collecting 'personal information' or 'health information' from an individual, to ensure that the information is safeguarded from unauthorised disclosure and that any dissemination of the information is in accordance with legislation and policy which governs such disclosure.

Additionally, cl.288(2) of the *Crimes (Administration of Sentences) Regulation 2014* (CAS Regs) requires that correctional centre prisoner medical records are not to be divulged to any person outside Justice Health except in accordance with guidelines established by the Chief executive of Justice Health. There were applicable "Guidelines on the Use and Disclosure of Inmate/Patient Medical Records and Other Health Information". Though Danny signed a consent for Justice Health to disclose health information "that was reasonably necessary for the functions of CSNSW…under Justice Health's duty of care" to Corrective Services NSW he did not provide such consent in relation to GEO.

Mr Doherty also said the email request made by RN Marsters was not common practice, although he could not recall whether this was the first time it had happened. He said that a report from any staff member in the health centre that would warrant that the inmate be targeted for a urinalysis test may arise because "that's the action they're trained to make sure happens". However, despite the policy requiring a written report from a medical officer that was not the practice in 2015 or currently. He said expectation of making a report was more relevant to custodial staff and there was no expectation that nursing staff report such observations to the Intelligence Group, although he understands the policy to mean requests for urinalysis tests could come from medical or correctional staff.

Mr Doherty states that there is no specific policy setting out when medical staff might request Intel to conduct urinalysis on an inmate.

RN Marsters was unable to say why he sent this email other than that he may have been confused as to the task he had engaged in earlier that day providing to Intel the list of other prisoners' medications. He accepted that neither task was for a therapeutic purpose. Despite this evidence he and Mr Doherty said it was not common practice and Ms Te Maru said that despite being copied into the email was unfamiliar with such. Counsel Assisting suggested that I might consider a censure in these findings rather than a referral of RN Marsters under s151A (2) of the Health Practitioner Regulation National Law (NSW). Alternatively Counsel Assisting suggested that I could find that "…Given that RN Marsters mistakenly thought that his duties as an employee of GEO Group required such notification to the Intel group, it may be that rather than a referral that the Coroner recommend to GEO that such a practice not be repeated andto ensure that their health service providers are not requested to engage in correctional matters".

Ms Haider supports such a course and points out that if RN Marsters breached the Regulations so did Mr Doherty and probably Ms Te Maru. However, I do not accept her submission that RN Marsters thought that his email was "a misguided but honest attempt to assist the patient". Counsel assisting also suggests a recommendation that GEO provide clear guidance and training to health service and correctional staff about the permissible collection, use and disclosure of health information. Ms Haider correctly submits that all nurses including the health service manager were aware of the practice of GEO Intel asking nursing staff to assist in the detection of offences by providing names of inmates and their medication. Ms Haider says that the information is provided without the consent of each patient and it appears to have no therapeutic purpose but that there was a possible overlap between security, patient safety and therapeutic carefunctions.

On behalf of GEO Ms Berberian says in her submissions "GEO considers the email request by RN Marsters to Mr Doherty on 5 November 2015 was an anomaly and one which was entirely inconsistent with the confidential nature of the therapeutic relationship. GEO accepts that such a disclosure is likely to perpetuate a general reluctance in inmates being forthcoming about their presenting histories and hence prohibitive to provision of appropriate health services. Whilst GEO considers that it is not necessary to educate the health staff about such fundamental matters as preservation of health information confidentiality, GEO would be more than willing to provide training to health staff about the permissible collection, use and disclosure of health information." GEO considers that the extension of that training to correctional staff as recommended by Counsel Assisting is not appropriate given this is an issue which relates specifically to health staff".

There is no evidence from GEO that they have carried out an audit and confirm that RN Marsters' email was an anomaly. Though one would hope it was the language of the email and the unquestioning response from Mr Doherty would suggest otherwise. I do not accept that the training should be restricted to health staff as the evidence in this inquest demonstrates that GEO correctional staff are engaged in health matters more than what one would expect and given that GEO employs both sectors it is important that the separation of their functions is implicitly and explicitly understood.

Further, Mr Doherty did not question the email nor did the officers who he directed to carry out the task – even though Danny was in the medical unit. The evidence in this inquest demonstrates that a prisoner might not seek medical care for fear of a punitive rather than a therapeutic response and it needs to be addressed at Junee Correctional Centre. Ms Berberian takes issue with the term "punitive" but in her submissions she overlooks the fact that a prisoner's refusal to provide a sample and the outcome of a "dirty urine" can be met by charge and penalty and placing a prisoner in segregation for the good order of the prison. I am of the view that the recommendation put forward by counsel assisting is necessary as the evidence demonstrates that both corrections and medical staff have, even unwittingly, involved in inappropriate disclosure and use of health information and tasking.

Sufficiency of information provided to police investigating Danny's death-Incident Package

An issue that arose during the inquest included the information contained in the Briefing Package provided by GEO to the police officer Detective James who was tasked with preparing a brief for the coroner. Counsel assisting submits that GEO Group should have ensured that all incident reports, log books, briefing notes and other relevant material were provided to investigating police and/or those assisting the Coroner in a timely way and not 5 ½ years after they were written. Mr Scott Brideoake, General Manager of Junee Correctional Centre at the time of Danny's death, said that the "*practice was to collate the incident reports of staff who had relevant interactions with an inmate and for a briefing note to be prepared*" and provide this to the Corrective Services Investigation Unit (**CSIU**) of NSW Police Force as part of the 'Incident Package'. He said Mr Doherty was tasked with preparing the Incident Package and briefing note. Mr Doherty gave evidence that he, at that time, had not previously engaged in such a task and sought advice from other managers about what to include in the package.

Later, it was apparent that it was Mr Brideoake who settled and provided the package to the Detective James. As part of the original internal investigation by GEO Group, Mr Doherty interviewed Mr C on 9 November 2015 and made a briefing note containing that conversation. However, the briefing note that was included in the Incident Package to Detective James had been amended from the original version thereby removing any reference to the interview with Mr C. The longer, fuller briefing note was produced for the first time to the inquest as WD-1, attached Mr Doherty's statement dated 12 May 2021.

In oral evidence, Mr Doherty had no explanation for why the briefing note he wrote on 9 November 2015 had been edited and that there were two versions. He said a number of senior staff had access to the electronic document. After giving his evidence Mr Doherty provided an explanation in a further statement that he had excised reference to Mr C's interview as he was advised to do so by other officers. I note that Detective James also interviewed Mr C on 9 November 2015, and it may be due to that fact that the version provided to Mr Doherty was considered unnecessary. If that was the case, that is unfortunate as the contents of the interviews taken together would have assisted the investigation and the inquest. More important was the list of witnesses and their incident reports. On 11 November 2015 CO Withers made an incident report relevant to 5 November 2015. Her name and copy of her report was not included in the Package.

The identity of Mr E as being a cellmate when Danny deteriorated was not known until the inquest was well on foot. In his second statement Mr Brideoake conceded that a number of correctional officers' incident reports obtained by GEO should have been included in the report but were not. He did not offer an explanation as to why they were not. The investigation also experienced the all too common problem of not having access to the names of the clinical and medical providers who dealt with Danny. Statements were not taken until over 3 years later. Given the paucity of note making in the clinic, reliance on memories affected the reliability of evidence.

Ms Berberian submits that Detective James' investigation was on a very different trajectory than that which was the focus of the inquest. Detective James determined that Danny's continued use of illicit drugs, specifically (an overdose of methadone and buprenorphine) coupled with the fact his liver was in poor condition contributed to his multi-organ failure. He found that "no policy or procedures were breached" in relation to his death in custody. He determined that there should be no recommendations as there were no issues with any care and treatment at the clinic and that Danny was sent to hospital as soon as it became apparent his condition was deteriorating. Further he commended Junee Correctional Centre's attempts to stop prisoners from diverting methadone and buprenorphine and stated that it should be best practice used in all prisons. Ms Berberian correctly identifies that the police investigation did not focus on the medical treatment at the unit and it was not until the reports of Associate Professor Holdgate and Professor Gunja in 2019 that it became an issue. The problem of determining what issues should be investigated and what evidence should be obtained in this case highlights the need for better supervision from the outset which may now be improved given the commencement on 24 September 2021 of Coronial Practice Note 3 of 2021 relating to Deaths in Custody which will also be accompanied by the First Nations People Draft Protocol.

However, the determination of what "incident" is relevant to be included in the package could have been identified by Mr Doherty as being the incident referred to by Mr C when he said that bags of regurgitated methadone are passed under the doorway to a prisoner and for Danny this occurred on buy up day. Mr C and other prisoners also told Detective James about Danny's movements until he went to the clinic. CCTV in relation to Danny from buy-up day until he left the prison on 7 November 2015 could have been kept – he was in a video recorded observation cell for about 48 hours. Its utility is particularly relevant for this case given the poor record keeping and observations and work practices inside the medical unit. This could have been identified by GEO as operators of both the correctional and health services. Detective James did not seek it, nor did GEO provide it. Danny's death was not understood to be anything other than a self-inflicted accidental drug overdose and this inquest shows that such a bias is a disservice to not only t h e coronial investigation but more importantly to Danny and his family who need answers as to what happened to him.

<u>Keeping the CCTV Footage for Coronial Investigation</u>

Mr Doherty gave evidence that CCTV footage is available for six weeks. CCTV footage was available for the entire time Danny was at the clinic, but the only footage secured and provided to the investigation was the "incident" of Danny being admitted into the clinic the afternoon of 5 November 2015 and the "incident" when he exited the clinic in the afternoon of 7 November 2015.

Mr Doherty's determination of what footage to copy and keep was guided by advice from either the Deputy Operations Manager or the Operations Manager that only these parts were "recordable incidents "and relevant to the investigation. This was despite not knowing the cause of Danny's death, there being reports of Danny vomiting, showering for long periods in the day or other movements made by Danny during this time in the clinic. Mr Doherty said he was new to the role and had not dealt with a similar matter previously so relied on advice. Though the policy relating to CCTV footage states that "all recordings of evidentiary value must be downloaded from the CCTV system", there is no guidance as to what is considered of evidentiary value. As Ms Berberian submissions addressed it may well be dependent on what the focus of the investigation is.

Though the responsibility for managing the CCTV footage fell to the Correctional Manager, Intelligence, which at the time was, ironically Mr Doherty himself, he did not hand it to the investigating police. Mr Doherty said that he understood that the process was that the police would arrive at the centre and would view it to see if it was relevant. Mr Brideoake said that Junee CC was guided by any further requests for information and assistance from the CSIU. Though the provision of information appears to be as good as the request made for it, these issues could not be progressed at the inquest as Detective James was not available. Ms Ainslie Wood, former Contracts Compliance Manager GEO Group, could not explain why CCTV might be available from 5 and 7 November 2015 and missing from 6 November 2015, as it has been "*standard practice for a long time that CCTV footage is captured in relation to the death in custody*". Ms Wood said that since Danny's death, efforts are made to capture relevant CCTV from at least 24 hours before a person's death in custody. The evidence in the inquest demonstrates that 24 hours would be the bare minimum and each case should be carefully assessed, any error should fall on the side of caution. Counsel Assisting suggests a recommendation that all CCTV footage for up to 7 days be kept until the coroner investigating the death orders otherwise.

Mr Pickering on behalf of CSNSW submits that selecting and keeping 7 days of footage would involve the need for correctional officers to look at multiple CCTV cameras throughout the correctional centre and taken Statewide that would amount to thousands of hours of time. He submits that the recommendation therefore is impracticable. Ms Berberian for GEO adopts this submission. It is unclear how "thousands of hours of time" are calculated. Most prisoners are locked in their cells or their pods for up to 16 hours a day, their movements such as going to the clinic, the yard, being in the common area, going to education or welfare or the phones are or should be generally known. In Danny's case, his whereabouts were known from the moment he left the pod and went to the clinic. He spent two days in an observation cell which unlike most cells has CCTV recording 24/7. Further, there is thankfully, not the large number of deaths in custody in NSW which would make such a task impracticable. The hours spent in copying and keeping the footage would likely save the more hours which are involved in a coronial investigation and inquest to determine what had happened. The identification and securing of relevant evidence in a correctional centre should be better achieved by the commencement of the Coronial Services PN 3 of 2021.

<u>Buvidal Depot Program</u>

The UNLOC-T Clinical Trial of the Depot Buprenorphine (Depot) in the correctional system began in November 2018. NSW Health sponsored the program and by January 2020 the Buvidal Depot program was rolled out across the correctional centres of NSW. The Depot is used in place of the methadone and involves a weekly or monthly intramuscular injection of a slow-dissolving gel. It is therefore incapable of being diverted. All inmates requiring OST are now started on the Depot as opposed to methadone. Fewer resources are required, and the old triage system is not necessary.

The Depot program is apparently very successful in preventing diversion of prescribed opioid medication. As at 18 May 2021, in Junee CC, of the 161 inmates on the OTP (formerly OST) Program, 120 were on the Depot. In Mr E's opinion, as an inmate with many years' experience in custodial settings, the introduction of the *Buvidal* injection program was "*the best thing they could have done in the gaol system*", as it prevents diversion and 'stand- overs'. RN Bryon said that prisoners will trade anything, and it still goes on. Mr A was in custody when he gave evidence and was asked about the difference between the OST program in 2015 and the recently released depot program. In his experience the depot program is much easier to access compared to the methadone and buprenorphine programs saying: "Methadone they just straight out refuse you and back then there was Bupe but they would straight out refuse you for that too. There's no way. Now, with the injection, it's only been around for maybe a year, year and a half, it's pretty easy to get onto."

I agree with Mr Rees' submission that had Danny been able to access the OST program he wouldn't have used illicit and dangerous drugs whilst in prison. Mr Rees submits that there is still a delay in prisoners accessing the program and that as at May 2021 there were at least 41 prisoners receiving liquid methadone at Junee Correctional Centre. He puts forward a recommendation that all Opiate Agonist Treatment (OAT) should be intra muscular injection, and staffing levels at Junee Correctional Centre be reviewed to ensure a reduction in the waiting time for eligible custodial patients to commence OAT. I decline to make this recommendation.

It was an issue completely outside the scope of this inquest. There is no evidence to suggest that the wait time has anything to do with staffing levels. Rather, applications for OST are submitted to Justice Health and then determined by the Pharmaceutical Regulatory Unit of NSW Health. When Danny was transferred to the Royal Prince Alfred Hospital in Sydney, CSNSW communicated with Danny's parents so they could attend hospital. Danny was on life-support and his parents were understandably extremely stressed and upset.

Despite being on life support Danny was under guard as he was in lawful custody. Ms Knight found the experience traumatising and was upset with how she was treated by the officer in charge and corrective services custodial officers. The inquest heard evidence from two of those officers.

The officers were required to comply with policy but Ms Cooper points out in her submissions that CSNSW policy that applied in November 2015, *13.2 Deaths in Custody, Corrective Services NSW Operations Manual* does not address any procedure around hospital admission under guard and how staff should communicate with family members in the event an inmate is in a serious condition in hospital.

One of the incidents involved when Danny's life support was turned off and his mother wanted to physically touch him to be with him but was told that she was unable to as it was a crime scene. CO Moisan denied using that terminology but rather said "Please ma'am, you cannot touch the body", and "I'm sorry, it's the procedure".

The police officer in charge then told Ms Knight that she could be with Danny. The Corrective Officers had received no training about dealing with family in such situations and were open to the opportunity should it be provided. Ms Cooper suggests that a recommendation be made to CSNSW that they develop best practice guidelines for communications with families, in particular for First Nations deaths in custody cases. Mr Pickering on behalf of CSNSW submits that "the Corrective Services Officers in attendance at the hospital acted in compliance with their operational guidelines and in a professional and appropriate manner in what were difficult and emotional circumstances". He does not address the suggestion of a recommendation. I accept that submission and I think the evidence was insufficient for me to conclude that specific training in relation to this is required. It is hoped that the Coronial Direction PN 3 of 2021 together with the First Nations Protocol will go some way in improving relationships between families and their loved one.

Conclusion

Identity: Danny Keith Whitton

Date of Death: 9 November 2015

Place of Death: Royal Prince Alfred Hospital, Camperdown, Sydney NSW

Manner of Death: Danny died after ingesting an overdose of paracetamol at Junee Correctional Centre operated by GEO Group Australia Pty Ltd. Danny's condition was not appropriately investigated as blood tests were not actioned and Danny's condition was not appropriately monitored, his deterioration was not appropriately actioned in a timely manner due to overall suboptimal care and a significant misunderstanding of the transfer procedure of a patient from the health clinic at Junee Correctional Centre to the Wagga Wagga Base Hospital. Danny's condition was irrecoverable despite appropriate intervention at that hospital and then his transfer to the Royal Prince Alfred Hospital. Danny died whilst he was in the custody of Corrective Services NSW**.**

The Recommendations

To GEO Group Australia Pty Ltd

- Ensure that training occurs so that all health staff is aware that nurses can call an ambulance to transfer a prisoner without a doctor'sauthorisation.

- Ensure that GEO Health Service policy accurately reflects the importance of regular monitoring and notation, recognition of signs of deteriorationinpatients and clear procedures for escalation for the particular facilities that exist at the Junee Correctional Centre health clinic.

- Provide training to health staff and corrections staff about the permissible collection, use and disclosure of health information.

To Justice Health and Mental Health Forensic Network

- Provide training to staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

- Develop an information sheet for health and correctional staff which will prompt staff to inquire with an inmate as to the quantity of paracetamol ingested when they present and provide pathways for staff to take regarding any paracetamol overdose.

- Conduct a review of the Paracetamol Consumer Medicines Information to ensure it includes a warning about the misuse or overdose of paracetamol, the risk of harm and the range of possible symptoms and an indication as to when a person should seek medical attention.

Corrective Services NSW (and on behalf of privately operated correctional centres in NSW including GEO Group Australia Pty Ltd)

- Provide training to staff which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

- Provide information to inmates which identifies and raises awareness that paracetamol overdose can occur as a result of excessive consumption of paracetamol.

- Implement policy and practice to retain a copy of CCTV footage capturing the last 7 days of movements of a person who has died in custody and only release such footage upon an indication by a senior coroner that such footage is no longer required for the coronial investigation andinquest.

2. 24535 of 2016

Inquest into the death of YW. Inquest findings delivered by Deputy State Coroner Lee at Lidcombe on the 9th December 2021.

Introduction

On the morning of 23 January 2016 YW was found suspended from a ligature, with no signs of life, inside a cell at a correctional centre. YW was only 19 years old and had entered lawful custody some six weeks earlier on 15 December 2015. Following a mental health assessment conducted on 24 December 2015, it was identified that YW required a review by a psychiatrist. However, due to an administrative error this review, which should have occurred prior to 23 January 2016, did not take place.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

In this context it should be recognised at the outset that the operation of the Act and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, although an inquest into YW's death is mandatory, by virtue of him being in lawful custody at the time of his death, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family like YW's to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum. This is an entirely uncommon, and usually foreign, experience for families who have lost a loved one. It should also be recognised that for deaths which result in an inquest being held, the coronial process is often a lengthy one. The impact that such a process has on family members who have many unanswered questions regarding the circumstances in which a loved one has died cannot be overstated.

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made to organisations and individuals in order to draw attention to systemic issues that are identified during a coronial investigation and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable. Where an inquest is able to identify issues that may potentially adversely impact upon the safety and well-being of the wider community, recommendations are made in the hope that, if implemented after careful consideration, they will reduce the likelihood of other adverse or life-threatening outcomes.

YW's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore, it is extremely important to recognise and acknowledge YW's life in a brief, but hopefully meaningful, way. YW was born in Germany in 1996 and had three sisters, SG, MG and NG. YW's mother and sisters later moved to Australia whilst his father remained living in Germany. The family lived in a number of different locations in the western suburbs of Sydney before eventually settling in Pendle Hill.

As a young boy YW used to attend church on a regular basis. He was fond of many sports and activities such as cricket, football, and dancing. YW was also a talented singer. After leaving school early, YW worked in a variety of casual roles with his last job working for a transport company. YW enjoyed this role, and both he and his family found the stability that the job brought to his life to be encouraging. One of YW's sisters describes him as being entirely selfless and someone who was always ready and willing to help a friend, or someone, in need. He was a source of advice, support and wisdom for many of his friends, and displayed a maturity beyond his years. One of YW's best friends recalls a time when she was faced with the prospect of having nowhere to live and turning to YW for help. He provided her with some clothes and welcomed her into his home. More importantly, YW provided the emotional support to his friend to ensure that she felt safe and secure. YW's friend describes him as the kindest soul she ever met.

Another one of YW's friends fondly recalls him to have been such a humble and caring person. The care that YW had for others was reciprocated by his family and many friends. The significance of YW's loss to them, and the impact that YW had on their lives, is evident from the fact that over 600 people attended YW's funeral. All of them no doubt were touched in some way by YW's infectious energy and zest for life, his compassion for others, and his cheeky attitude to life and warm smile.

YW was, and still is, deeply loved by his family and greatly missed. YW's family lovingly supported him through the challenges that he faced in his life. It is most upsetting to know that YW has been taken from them at such a young age.

YW's previous custodial and medical history

YW first became involved with the criminal justice system in 2013. He was dealt with in the Children's Court jurisdiction for a number of dishonesty and anti-social offences, with some resulting in periods of detention. In December 2014 YW had his first experience of being dealt with in the Local Court jurisdiction. He was later convicted and sentenced to a custodial sentence with a non-parole period between March and May 2015. According to available medical records YW reported experiencing psychotic symptoms, auditory hallucinations and paranoia in 2013. It was thought at the time that this may have been related to YW's use of cannabis and other illicit drugs. It appears that as a result of YW's contact with the criminal justice system in 2014 he was referred to Headspace in September 2014, a national youth mental health foundation providing early intervention mental health services for young adolescents and young adults.

According to Headspace records, by at least December 2014 YW had been diagnosed with a first episode of psychosis. This resulted in YW's involvement in Headspace's Youth Early Psychosis Program (**YEPP**). However, in early 2015 YW unfortunately failed to engage with Headspace by not attending appointments. This led to YW's referral being closed in April 2015. Further, YW continued to use illicit drugs and engage in criminal activity, ultimately leading to him being convicted and incarcerated, as noted above.

The period of custody leading up to, and at the time of, YW's death

On 15 December 2015 YW was arrested and charged in relation to an alleged offence of interpersonal violence involving the use of a weapon. He was subsequently refused bail and remanded into the custody of Corrective Services NSW (**CSNSW**).

YW was initially received at the Metropolitan Remand and Reception Centre (**MRRC**) in Silverwater. As part of the reception assessment process, a Health Problem Notification Form (**HPNF**) was created which noted that YW had a history of self-harm, depression and alcohol abuse. Accordingly, he was placed on a Risk Intervention Team (**RIT**) protocol. Instructions were given for YW to be placed in a camera assessment cell with 30-minute observations, and that he was to have nil sharps and minimal possessions until he had been cleared by a RIT review, and by a drug and alcohol nurse. A Mandatory Notification Form (**MNF**) for offenders at risk of suicide or self-harm was also completed.

On 18 December 2015 YW was reviewed by a RIT. Notes taken during the review record that YW had no "*previous or current thoughts of self-harm and suicidal ideations*". A further MNF was completed noting that YW's level of risk diminished because he had guaranteed his own safety. Accordingly, a RIT Management Plan was completed which noted that YW was suitable for two-out cell placement (sharing a cell with another inmate) but was to remain in the MRRC reception pod until he had been cleared, following review by a drug and alcohol nurse, to be transferred elsewhere.

On 20 December 2015 YW was reviewed by a drug and alcohol nurse and he was noted to be alert and indicating that he was feeling better. He was subsequently cleared from detox and remained in shared cell placement until he had been cleared by a mental health review. On 23 December 2015 a mental health assessment was completed for YW. A risk assessment noted that YW had no recent thoughts, plans, symptoms or behaviour indicating or suggesting risk. Further, the assessment noted that YW's level of risk did not appear to be highly changeable, that he was a low risk of suicide, and that a more detailed assessment of suicide risk was not required.

Psychiatric review

YW was subsequently reviewed by a psychiatrist, Dr Gordon Elliott, on 24 December 2015. The progress notes from that review record that reported that being in custody was "*a bit stressful*" and that he felt "*pretty drained emotionally*". YW also reported that his physical health generally was "*pretty good*" but that his appetite had been poor. On assessment no evidence of affective or cognitive deficits were found and it was noted that YW displayed no current psychotic symptoms. It was also noted that YW denied any thoughts of self-harm or suicide. According to the progress notes, the impression formed by Dr Elliott was that YW had a history of drug-induced psychosis and that YW's complaints of paranoia were more consistent with anxiety.

Dr Elliott also cleared YW from the Darcy Unit to a normal cell placement in the main population. Dr Elliott noted: This would allow him to move to a relatively quiet and generally more predictable pod environment than Darcy, and one in which he would find it easier to get his needs met, such as access to the phone and more regular exercise. Relevantly, Dr Elliott also indicated that YW would require a formal psychiatric review in four weeks. As to the rationale for this, Dr Elliott explained:

I did not consider [YW] represented a significant risk of self-harm although, given his history of psychosis, I did believe he warranted a further psychiatric assessment to review his treatment with risperidone, including a check for side effects, and his mental state more generally.

One-out cell placement

On 25 December 2015 YW was cited for fighting with other inmates. He was reprimanded and cautioned and confined to his cell for two days. The following day, 26 December 2015, YW was placed alone in a one-out cell as he had threatened violence against his cellmates. Following this, an alert was placed on YW's CSNSW Offender Integrated Management System record which stated:

Inmate must be placed 1-out until reviewed by Mental Health. His cell mates have reported that he constantly threatens violence towards them and makes comments like, 'I'd like to know what it's like to stab someone and kill them'. While it is impossible to verify these statements, the same comment has been made by enough inmates to make me concerned that he will engage in some kind of violent act against others.

A HPNF completed on 29 December 2015 noted that YW had been cleared by a psychiatrist and, following a mental health assessment, that he was suitable for normal cell placement. This categorisation meant that YW could be placed in either a one-out cell or in a shared cell.

Review on 3 January 2016

At around 4:00pm on 3 January 2016 YW was reviewed by Registered Nurse (**RN**) Patricia Guilfoyle. This was not a pre-booked appointment, but rather a new mental health assessment. Available records indicate that this review was related to a "*recent assault*". Case reports kept by CSNSW indicate that YW was involved in a verbal argument with another inmate on the same day, with the potential for physical interaction. As a result of the incident, YW was removed from the area and placed in different accommodation.

Transfer to Metropolitan Special Programs Centre

On 19 January 2016 YW was transferred to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex. He was moved there as a remand bed placement. This is a strategy used by CSNSW to optimise bed space and is used for inmates who have been given a future court attendance date. In YW's case he was next due to appear at court on 11 May 2016. A progress note entry recorded at 4:00pm on 19 January 2016 noted that YW denied having any medical issues and guaranteed his safety.

YW also took part in an interview with a CSNSW Service and Programs Officer on 20 January 2016. Records note that at the time YW did not have any current thoughts of self-harm and that he did not have any immediate concerns or issues. It was also noted that YW remained suitable for normal cell placement.

What happened between 20 and 22 January 2016?

Upon his arrival in the MSPC YW was housed in 9 Wing. This is an accommodation unit that houses remand bed placements and inmates in transit to regional correctional centres. At the time of YW's arrival, one of his friends, Jake Milojevic, was also housed in 9 Wing in the MSPC. Mr Milojevic occupied cell 67 with another inmate, George Tzanis, who had never previously met YW. Both Mr Milojevic and Mr Tzanis had been in custody since November 2015. Mr Tzanis described YW and Mr Milojevic as being "*excited*" when they first saw each other. He also said that he saw YW and Mr Milojevic "*in the yard a bit mucking around and talking*".

YW was placed in cell 66, adjacent to the cell occupied by Mr Milojevic and Mr Tzanis. Initially, YW shared his cell with another inmate. Mr Milojevic spoke to YW's cellmate to ask how YW was and was told that "*he was alright*". Later, Mr Milojevic had a chance to have a "*good talk*" with YW and that "*he seemed normal*". YW's cellmate was later moved from the cell on Wednesday 20 January 2016. On Wednesday, 20 January 2016 Mr Milojevic described YW as being "*very quiet and cut off from everyone*". Mr Milojevic asked YW why he was keeping to himself.

When his friend asked about him YW told his friend that he was "*just kicking back*". YW's friend believed that nothing was amiss as he understood that "*sometimes you just need to relax by yourself in gaol*". Mr Milojevic describes YW to be the same on Thursday, 21 January 2016. He said that YW was "*very quiet*" and that he did not see him talking to anyone and said that "*he just stayed by himself and kicked back*". Mr Milojevic described YW as being the same on Friday, 22 January 2016. Mr Tzanis also saw YW on Friday, 22 January 2016. He said that YW "*looked to me to be depressed because he had his head down to the ground and he was looking up every time I walked up to him and then he would put his head down again*".

Mr Tzanis said that he formed the view that YW "*seemed like a very depressed guy when I met him*" but did not know if this was how YW usually appeared. At some stage between 20 and 22 January 2016 it appears that Mr Tzanis mentioned this observation to Mr Milojevic who told him that YW "*was the kind of guy you have to look out for because he's a quiet guy, but he can just snap*".

What happened on 22 and 23 January 2016?

YW was locked in his cell at about 2:30pm on 22 January 2016. At around 7:00pm an inmate in a neighbouring cell to YW's heard what he described as "*the door banging two [sic] or three kicks of punches*". At just before 8:30pm the inmate heard what he described as "*a couple more bangs or kicks on the door*". The sounds did not cause the inmate to believe that anything was amiss.

At about 7:20am on 23 January 2016 CSNSW officers began conducting a head check in the wing where YW was housed. YW's cell door was opened at about 7:25am and he was found suspended from his CSNSW jumper which had been tied around his neck and fastened to the bars of his cell window.

The CSNSW officers immediately lowered YW to the ground and commenced cardiopulmonary resuscitation whilst also calling for assistance from Justice Health & Forensic Mental Health Network (**Justice Health**) staff and emergency services. Justice Health staff arrived on scene at about 7:27am with a defibrillator and oxygen tank and mask. Resuscitation attempts continued until the arrival of paramedics from NSW Ambulance, but YW remained unresponsive with no signs of life. YW was later pronounced life extinct at 7:42am.

Investigating police later attended the scene at around 9:30am. They found three notes written by YW in his cell. All three notes were addressed to members of YW's family. In the notes YW expressed his inability to continue with life and bade farewell to his family, expressing his love for them.

What was the cause and manner of YW's death?

YW was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Istvan Szentmariay on 28 January 2016. A faint, broad-based red ligature mark with occasional fine, horizontal abrasions present around the neck was identified. In the autopsy report dated 24 January 2017, Dr Szentmariay opined that the cause of death is hanging.

Three matters are relevant to the manner of YW's death:

- The observations made of YW by Mr. Milojevic and Mr. Tzanis between 20 and 22 January 2016, when it appeared that YW was showing signs of low mood.
- The circumstances in which YW was found on the morning of 23 January 2016; and
- The notes written by YW which contained content consistent with an intention to self-harm.

Having regard to the above, there is sufficiently clear and cogent evidence to allow for a conclusion to be reached that YW died as a result of actions taken by him with an intention of ending his life. Therefore, YW's death was intentionally self-inflicted.

What issues did the inquest examine?

Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the issues to be considered. That list identified the following issues:

- Did Justice Health comply with its policies and procedures in relation to the care and treatment of YW during his time in custody?

- What measures have Corrective Services NSW put in place to safeguard and minimise actual or potential ligature points within the Metropolitan Special Programs Centre since 23 January 2016?

- Is it necessary or desirable to make recommendations in relation to any matter connected with YW's death?

Compliance by Justice Health with relevant policies

Follow-up appointments

As at December 2015 there was both an electronic and paper-based administration system used by Justice Health relevant to the management of inmate patients.

First, Justice Health utilised the Patient Administration System (**PAS**), a centralised patient booking system used to record referrals and medical appointments for patients, and to ensure that scheduled appointments are easily identified. Relevantly, Justice Health staff within Darcy Unit used PAS to make initial and follow-up appointments for a patient with a psychiatrist.

Second, Justice Health staff also utilised the following paper-based processes:

As at December 2015, a Daily Appointment Sheet (**Daily Sheet**), which would be printed from PAS by a clinical support officer, and which provides a list of all patients booked into a clinic on a particular day. The Daily Sheet contains a number of tick boxes to identify whether a patient has attended the clinic, and whether a review or follow-up appointment is required.

If such a review or follow-up appointment is required, the date of the relevant appointment is also recorded. The relevant clinician (for example, a nurse or psychiatrist) is responsible for completing the Daily Sheet. Once completed, the Daily Sheet is provided to administrative staff so that information can be entered onto PAS.

At some time after December 2015, a Darcy Unit diary (**the Diary**) was kept in the psychiatrist's office and updated by a psychiatrist following each patient review. The Diary is used by psychiatrists to record follow-up appointments, together with essential notes regarding each patient has been seen. At the end of each day, the Diary is photocopied and sent to administrative staff so that PAS can be updated accordingly. Nursing staff use information contained within the Diary to initiate any follow-up action that is required, and also review the Diary the day after a patient is seen to ensure that nothing is missed.

The 24 December 2015 Daily Sheet

The Daily Sheet for 24 December 2015 lists a number of inmates, including YW, with appointments to see Dr Elliott on that day. Whilst the tick boxes for a number of inmates are ticked, and there are handwritten notations indicating the date by which a follow-up appointment is to be made, there are no similar notations regarding the entry for YW.

Dr Elliott explained the function and purpose of the Daily Sheet in this way:

[It] was used, in combination with the diary, to handover in a succinct format the essential recommendations for each patient seen on the day […] The [Daily Sheet] was used to indicate whether a patient had actually been seen and provide a recommended psychiatric follow-up time.

Despite the above, Dr Elliott did not complete the relevant entry for YW in the 24 December 2015 Daily Sheet. Instead, Dr Elliott recorded an entry in the progress/clinical notes for that day noting that YW was for psychiatric review in four weeks' time (using the abbreviation "*Ψ rv 4 weeks*"). However, Dr Elliott acknowledged that typically this progress notes entry "*would only be seen by nursing and medical staff subsequently assessing [YW]*, and not by administrative staff so that an appointment for the review could be booked in PAS.

Dr Elliott recognised that he should have instead both noted that YW had been reviewed and provided a follow-up appointment time on the Daily Sheet, so that a follow-up appointment could then be booked in PAS. As to these omissions, Dr Elliott explained: This was an error, and one I cannot explain, as I do not have a clear recollection of the assessment. I do not understand why I neglected to complete the boxes for [YW]. In evidence, Dr Elliott could not explain with any precision why he did not complete the relevant section of the Daily Sheet regarding the need for YW to be reviewed by a psychiatrist in four weeks' time, despite documenting the same in the progress notes. Whilst such documentation is of clinical importance to provide other clinicians with an understanding of a patient's clinical course, and the severity of a patient's condition at a particular point in time, it serves no administrative function in ensuring that the requisite booking for a follow-up appointment is made on PAS.

Instead, Dr Elliott could only surmise that he did not complete the relevant Daily Sheet entry for YW because his attention may have been diverted by an ad hoc enquiry. Dr Elliott explained that as he was reviewing patients alone on 24 December 2015, there were a number of persons eager to gain his attention throughout the course of the day, and that in the course of this daily practice he may have become distracted from completing the Daily Sheet entry for YW.

Changes since December 2015

Between January 2016 and October 2020, a number of changes have been made regarding processes within the Darcy Unit:

Further education has been provided to staff at the MRRC in relation to the use of PAS, and the particular the PAS waitlist and appointment booking function.

If, following review, a psychiatrist recommends that a patient be followed up by another clinician, this recommendation must be documented in the Diary, as well as on the electronic medical record system.

Up until October 2020, the relevant entry from the Diary is scanned and faxed to the Custodial Mental Health Administration team (**the CMHA team**) at the conclusion of each shift.

An entry is created by the CMHA team in PAS in relation to any requested follow-up appointment.

Weekly audits are provided by the PAS Quality Coordinator on overdue PAS waitlist appointments, which are provided to Unit Managers for action.

In October 2020 a further change was made by Justice Health with the introduction of the Darcy Daily Clinic Tracker Sheet (**the Tracker Sheet**). This is used to assist with the handover of both clinical information and information about the recommended timing for mental health nursing and psychiatrist reviews. The Tracker Sheet, which is to be completed by psychiatrists working within Darcy Unit at the time of patient review, has a number of relevant features:

It contains a number of prompts as to whether follow-up appointments are required with either mental health nurses and/or psychiatrists.

It provides for a timeframe (in weeks) in which a follow-up appointment is required, if at all.

It provides for notes to be made in respect of handover, together with comments for PAS.

It includes a number of yes/no responses as to whether a patient requires:

- referral to the Mental Health Screening Unit or other accommodation.
- is clear to return to the main prison population; or
- Specialist placement.

It contains prompts to record the appropriate cell placement for each patient.

Prior to the impact of the COVID-19 pandemic and associated restrictions, the Tracker Sheet was sent to the Darcy Unit Coordinator. Upon receipt, the Tracker Sheet is actioned by the administrative support team and saved in a secure electronic network storage system.

The Tracker Sheet is divided into a number of columns for each patient to be reviewed. The columns are divided to identify whether any follow-up review by a mental health nurse or psychiatrist is required, the timeframe for such a review, and for information to be included on PAS. Additional columns are also included to convey any handover information, and any additional comments to be recorded on PAS.

As at the date of the inquest, the Justice Health Custodial Mental Health Operations Manual (**the CMHO Manual**) had not been updated to reflect that the Tracker Sheet is now used within the Darcy Unit. Dr Sarah-Jane Spencer, Clinical Director, Custodial Mental Health and Co-Director (Clinical) Services and Programs for Justice Health gave evidence that the absence of such updating has been due to resourcing constraints and added pressures relating to the impact of the COVID-19 pandemic. However, Dr Spencer gave further evidence that there are plans by Justice Health to update the CMHO Manual accordingly "*in the new year*".

Since the introduction of the Tracker Sheet, quarterly audits have been conducted to cross-reference and check the accuracy of information recorded in Tracker Sheets with corresponding entries in PAS. The most recent audit, conducted in August 2021, indicated that all patients who had a recommendation for review by a mental health nurse or psychiatrist, as recorded on a Tracker Sheet, also had a PAS waiting-list entry to accurately reflect this recommendation.

Dr Elliott gave evidence that he had not been provided with any formal training regarding the use of the Tracker Sheet. However, he indicated that the Acting Nursing Unit Manager had informally introduced the Tracker Sheet and explained its use. Further, Dr Elliott explained that the Tracker Sheet is "*rather self-evident*" and is both easier to use and more prescriptive than the previous Daily Sheet. Ultimately, Dr Elliott gave evidence that he felt comfortable using the new Tracker Sheet.

CONCLUSION: Dr Elliott made the frank concession that a record-keeping error on his part resulted in no booking being made for an intended psychiatric review of YW. Had such a booking been made, it is likely it would have been made for on or about 21 January 2016, two days before YW was found unresponsive in his cell. However, it is not possible to say how YW might have presented at any such review, or whether his presentation might have resulted in any change to his cell placement, or for the need for any treatment to be provided to him.

Since January 2016, a number of changes have been introduced by Justice Health regarding the manner in which follow-up appointments are made for inmate patients. Relevantly, the introduction of the Tracker Sheet means that a more robust system now exists which ensures that such appointments are clearly documented and booked on PAS.

Although it appears that Justice Health has not provided any formal training to clinical and administrative staff regarding use of the Tracker Sheet, the evidence establishes that the Tracker Sheet is both easy to understand and use. Indeed, the results of a number of quarterly audits indicate that the Tracker Sheet has been appropriately used by both clinical and administrative Justice Health staff.

Review on 3 January 2016

PAS records confirm that YW was reviewed by RN Guilfoyle on 3 January 2016 at the MRRC Outreach Clinic. However, there is very limited information regarding the nature of this review, what information was available to RN Guilfoyle at the time of the review, and whether any further action was initiated by RN Guilfoyle. In response to a request for further information regarding the events of 3 January 2016, RN Guilfoyle provided a statement which indicates the following:

The appointment list indicates [YW] presented to the MRRC Outreach Clinic on 3 January 2016 in relation to a recent assault-paranoid [sic]. Unfortunately, I have no recollection of having seen this patient, on 3 January 2016. I also have had access to Volume 3 of his file and that hasn't triggered any memories of seeing him on this date. The above statement represents the entirety of what is known regarding RN Guilfoyle's interaction of YW on 3 January 2016. Therefore, it is not known whether RN Guilfoyle had regard to any information contained in the progress notes for YW, and in particular to Dr Elliott's entry of 24 December 2016 in which reference was made to the need for YW to be reviewed by a psychiatrist in 4 weeks.

It should be noted that in January 2019 Justice Health updated its policy and guidelines in relation to accurate and comprehensive record-keeping in relation to all inmate patients receiving healthcare. Furthermore, Justice Health published a policy document (*Implementation Guide to NSW Health PD2012_069 Health Care Records - Documentation and Management and PD209_057 Records Management - Department of Health*) to provide guidance to all staff in relation to good record-keeping practices, and in particular the implementation of the NSW Health policies referred to above.

CONCLUSION: Regrettably, in the absence of any contemporaneous record, it is not possible to reach any conclusion regarding the nature of YW's presentation on 3 January 2016, and whether it was appropriate to initiate any treatment or action in response to his presentation. More particularly, it is not clear whether RN Guilfoyle might have had regard to the progress note entry by Dr Elliott regarding the need for YW to be reviewed by a psychiatrist and recognised that a corresponding booking for such an appointment had not been made on PAS.

Since January 2016, Justice Health has published a policy document which provides guidance to its staff regarding the need for accurate and comprehensive record-keeping to ensure that reviews of inmate patients, such as the one that occurred on 3 January 2016, are properly documented.

Minimisation of potential ligature points

The inquest also examined aspects of cell architecture within correctional centres more broadly, and within the MSPC in particular. Information provided by CSNSW indicates the following: From at least February 2010, CSNSW conducted an audit of correctional centres and court cell complexes to identify cells that may be used for "a stepdown" following a period of acute suicide risk, followed by a prioritise program of capital works to eliminate obvious ligature points within accommodation areas for inmates on stepdown regimes. As at February 2019 there were 24 assessment cells and three stepdown cells utilise at the MSPC.

Whilst correctional centres constructed after 2004 have been constructed with obvious potential ligature points being removed, difficulties have been encountered with correctional centres constructed prior to 2004 due to some centres being heritage listed. Both Long Bay Correctional Complex and the MSPC fall into the latter category. Accordingly, CSNSW has been limited in making any substantial changes to reduce obvious ligature points, as this would require a major upgrade in both design and layout.

By a letter dated 26 November 2021, the Governor of the MSPC indicated that through the prison bed capacity program two wings at the MSPC have been upgraded, with the upgrade involving the installation of Perspex sheeting on windows to cover bars in each cell, with coverings placed over potential ligature points on the walls of each cell. It is noted that neither of these wings are the wing where he was found.

Further, on 26 October 2021 the Acting Commissioner approved a submission for a strategy to prioritise capital funds of $6 million allocated for cell safety works to reduce the risk of inmates self-harming using ligature points in cells. The capital works prioritisation strategy is divided into five stages:

Stage I involves the creation of a risk matrix to identify and prioritise cells from highest risk to lowest risk to inmates, together with completion of a risk assessment report to identify and prioritise cells with potential ligature points for refurbishment. Stages II to IV involve site audits to analyse and prioritise the proposed works. Stage V involves commencing recommended works based upon priority.

In addition, the Acting Commissioner has also proved the preparation of a briefing note for a business case to seek additional funding in excess of the current improved $6 million to complete the remaining identified scope of works. Terry Murrell, General Manager, State Wide Operations, CSNSW Custodial Corrections Branch, gave evidence that it is not presently known whether the MSPC will be included on the list of correctional centres that will form part of the creation of a risk matrix as set out above. However, Mr Murrell indicated that as older will buildings in correctional centres are considered to pose the most risk, he expected that a correctional centre such as the MSPC would be high on the risk matrix.

CONCLUSION: The available evidence indicates that whilst CSNSW have, over many years, previously recognised the need to modify cell architecture in correctional centres in order to eliminate obvious ligature points, there have been a number of practical difficulties associated with implementation of such modifications. Relevantly, the fact that some correctional centres are heritage-listed has limited the extent to which necessary upgrades to cell architecture design and layout can be made.
Therefore, the recent approval of a strategy to prioritise capital funds for cell safety works to reduce the risk of an inmate self-harming by using an available ligature point represents a significant improvement to inmate safety.

One additional issue which arose for consideration concerned the placement of YW in a one-out cell. Following his review on 24 December 2015, Dr Elliott cleared YW for a return to the main prison population for normal cell placement. Dr Elliott described the Darcy Unit as a "*noxious environment*" that is loud, where it is difficult to rest and sleep, and houses inmates recently admitted into custody who may be experiencing withdrawal from alcohol and other drugs.

In YW's case, Dr Elliott explained that transferring YW out of Darcy Unit into the main population would have provided a calmer environment for him. The determination of what type of cell (one-out or two-out) YW was to be housed in was not a matter for Justice Health but, rather, a matter for CSNSW. Mr Murrell gave evidence that upon receiving clearance from Justice Health that an inmate is suitable for normal cell placement, CSNSW reviews that inmate's record for any relevant alerts in order to identify whether the safety of other inmates might be affected by a particular cell placement. In YW's case, Mr Murrell noted that because YW previously had a number of disciplinary issues, and because some inmates had expressed fears for their safety regarding YW, a determination was made for YW to be placed in a one-out cell.

Dr Elliott explained that the issue of whether one-out cell placement might increase the risk of self-harm is a "*vexed question*". Relevantly, Dr Elliott referred to there being "*mixed evidence*" as to how effective two-out cell placement is in preventing self-harm. Further, Dr Elliott noted that mandatory two-out cell placement may cause disharmony amongst inmates, and that an inmate who is deemed to require a two-out cell placement may be viewed by other inmates as a burden, with associated stigma attached to such a view.

Further, Dr Elliott noted the following from his review of Yw on 24 December 2015:

With regards [YW's] risk of self-harm or suicide, his presentation was an extremely common one for the Darcy psychiatric clinic. He was a young offender with some custodial experience in Juvenile Justice Facilities, a mental health history, and an extensive substance use history commencing in early adolescence and continuing up to the point of incarceration. He expressed anxiety about his charges, and this was evident on mental state examination, but he denied a history of self-harming behaviour and he denied thoughts of self-harm or suicide around the time of the assessment. He did not appear pervasively depressed and there was no evidence of psychotic symptoms. I did not consider he represented a significant risk of self-harm […]

CONCLUSION: The available evidence indicates that the decision to place YW in a one-out cell was consistent with Dr Elliott's determination that he was suitable for normal cell placement. Further, it appears that this decision was reasonable as fears expressed by other inmates regarding YW's alleged anti-social behaviour needed to be properly considered. However, given the opinion expressed by Dr Elliott as to whether YW was at significant risk of self-harm, and the limited evidence regarding the effectiveness of two-out cell placement in preventing self-harm, it is not possible, to reach any conclusion as to whether a two-out cell placement might have had any impact on the eventual outcome.

Is it necessary or desirable to make any recommendations?

One issue which arose for particular consideration regarding the necessity or desirability of making a recommendation pursuant to section 82 of the Act concerned the Tracker Sheet. It was submitted by both the Coronial Advocate Assisting, and the solicitor for YW's family, that a recommendation should be made for the CMHO Manual to be updated to reflect that the Tracker Sheet is now to be used within the Darcy Unit.

Conversely, it was submitted on behalf of Justice Health that such a recommendation is neither necessary or desirable given that the absence of an update to the CMHO Manual is understandable having regard to the impact of the COVID-19 pandemic, that there is an intention by Justice Health to update the CMHO Manual "*in the new year*", and that a procedure has been adopted for use of the Tracker Sheet since October 2020, which has been subject to multiple audits.

CONCLUSION: It is accepted that the evidence establishes that the Tracker Sheet has already been in use since October 2020, with quarterly audits demonstrating compliance by Justice Health staff regarding its use. Further, it is also accepted that the impact of the COVID-19 pandemic has required the prioritisation of limited resources and their diversion elsewhere. Notwithstanding, 14 months have now passed since the introduction of the Tracker Sheet without the CMHO Manual being updated accordingly. Further, there is no precise evidence available as to a date by which the CMHO Manual might be the subject of a formal review, or as to when the CMHO Manual might be updated other than by a vague reference to such an update occurring sometime "*in the new year*". Therefore, it is desirable to make the following recommendation.

RECOMMENDATION: I recommend to the Chief Executive, Justice Health & Forensic Mental Health Network, that the Custodial Mental Health Operations Manual be updated to reflect the introduction and use of the Darcy Daily Clinic Tracker Sheet.

Findings:

Identity:	The person who died was YW
Date of death:	YW died on 22 or 23 January 2016.
Place of death:	YW died at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036.
Cause of death:	The cause of YW's death was hanging.
Manner of death:	YW died, whilst in lawful custody, as a result of actions taken by him with the intention of ending his life.

3. 73098 of 2016

Inquest into the death of WW. Inquest findings delivered by Deputy State Coroner Forbes at Lidcombe on the 16th April 2021.

This is an inquest into the death of Mr WW's who died on 7 March 2016, when he shot himself after shooting another man, Mr Mazam ("Michael") Bassal.

The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- the identity of the deceased.
- the date and place of the person's death.
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

The issues in this case as to identity, date, place, cause and manner are uncontroversial. The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*as a result of police operations".* (s.23(c) , s.27) . In this case, the police were contacted prior to Mr W's death and arrived at the scene as this tragic event unfolded. Police attempted to negotiate with Mr W. In those circumstances, this inquest has been a close examination of the police actions on the day. Pursuant to s.37 of the Act a summary of the details of this case will be reported to the Minister.

Background

Both the deaths of Mr Bassal and Mr W's took place at Inline National Signage ("Inline Signs") , at Ingleburn. Mr W's was 33 years old at the time of his death. The operations of Inline Signs include the manufacturing and installation of commercial grade signage. Ms Chantelle Tonna, who also used the name Chantelle Strand, was the sole director of Inline Signs. At the time of Mr W's death, she had known him for about nine years. They had been in an intimate relationship for more than eighteen months prior to the incident.

Mr W and Mr PW and Mr W'S's father, were employees of Inline Signs. At the time of these deaths, Inline Signs was doing work for members of the Bassal family, through Mr Bassal's company, 'Xpress Group'. Mr Bassal and Ms Tonna met through Ms Tonna's former husband Martin Strand. In November 2015, Mr Bassal approached Ms Tonna about a service station development project in Gundagai. Ms Tonna was to provide signage for $30,000 and to engage a subcontractor, for $35,000 in building works. According to Ms Tonna, around December 2015, the sub-contractor began increasing his prices and she passed the increases on to Mr Bassal.

According to a friend of Mr Bassal, the Bassals began paying the sub-contractor directly for his building services. The Bassals also paid Ms Tonna for her services in the form of a car and $15,000 cash. According to Ms Tonna, the Bassals also paid $5,000 directly to an engineer for their services.

In early March 2016, the sub-contractor had completed his work and there was one last sign to be fitted by Inline Signs. The service station could not trade until the sign was completed and the Bassals were frustrated because Ms Tonna would not give them a completion date.

Events of Friday 4 March 2016

On Friday 4 March 2016, at approximately 1:00pm, Mr Bassal attended the office of Ms Tonna with Mr Hassan Dib, also called "Huss". Mr Bassal asked Mr Dib to accompany him to help resolve the situation as he was a builder by trade. Mr Sean Whyte, an employee of Inline Signs was present at the meeting. An argument ensued; Mr Bassal accused Ms Tonna of "ripping them off" and apparently began threatening her. Ms Tonna agreed to install the signs on Monday 7 March 2016. According to Mr Whyte, after Mr Bassal left the premises, Ms Tonna and Mr W were sitting in a white car at the entrance to the factory. He observed Mr W walk to the rear passenger side door of the car and remove an object wrapped in a white/green coloured blanket. Mr Whyte said he believed it was a rifle based on the shape. Mr Whyte saw Mr W look at him as he walked past to use the toilet and overheard him say "*I'll fucking sort them. I'm gonna fucking kill them*". As he said this, he placed the rifle on his hip and discharged a round from the rifle into the back wall of the factory. After Mr Whyte came out of the toilet, he saw Mr W had placed the blanketed object on a bench. When Mr W and Ms Tonna were not looking, he walked over and looked under the blanket and saw the butt of a brown rifle. Mr Whyte spoke with two other employees, Gurjinder Girn and Navjot Kaur, about what they had just seen.

According to Ms Tonna, at approximately 3:00pm, Mr Bassal called her upset and said she had "*made him look like a dickhead in front of his friend*". Ms Tonna says Mr Bassal then called Mr W and had a nine-minute conversation. Ms Tonna told Mr W about the interaction with the Bassals that night. They decided Ms Tonna would go to Queensland for the weekend to "*have some time out*". She returned to work on Monday, 7 March 2016 at about 8.30am.

Events of 7 March 2016

According to Ms Tonna, Mr W attended Inline Signs between 9:00 and 9:30am to make sure she was alright following the argument on 4 March 2016. Ms Tonna says she was aware that Mr W had brought a gun with him that he concealed from staff and from his father, Mr PW. Mr W sat down on the lounge next to Ms Tonna's desk, unwrapped the gun and asked her to call Mr Bassal. Ms Tonna apparently protested but Mr W told her "*it's better we sort this out while I'm here. We don't want this escalating…while I'm not here*". Ms Tonna later admitted that she saw bullets in a banana-shaped magazine.

At approximately 10:00am Ms Tonna called Mr Bassal and asked him to attend her office so they could chat. He asked if everything was alright and she told him it was. Mr Bassal arrived five minutes later and went straight upstairs to Ms Tonna's office. According to Ms Tonna, he walked in and stood in front of the air conditioning unit. Mr W stood up and asked him if he had a problem and they argued. Mr W pointed the gun towards the ceiling and fired it. He said to Mr Bassal "*if you have a problem you need to tell me now, we have a problem, you don't wait for me to leave and then you staunch my missus. You can't staunch my missus while I'm not around…that's not how it works…you deal with me; you don't deal with her*". Mr Bassal left the premises saying "*[they] would be sorry, that he would be back and that [they] would be sorry*".

Mr Bassal contacted his brother Mark Bassal and told him what had happened. Mark asked Mr Bassal if he had called the police and Mr Bassal responded "*I'm not gonna ring the police up. Just leave it for now*". While Mark was on the phone to Mr Bassal, Ms Tonna sent a text message that said, "*are we all good…you still want us to go ahead with the job?*" Mark said to Mr Bassal, "*don't worry about it…let's get our signs and…we'll take them to court later*".

Around 10:00am, Mr Bassal's other brother Terry attended Mark's office for a meeting and was told about the events at the factory. Terry immediately drove to the factory to confront Ms Tonna. Mark spoke to Mr Bassal on the phone and told him that Terry was going to confront them. Mr Bassal asked Mark to go and make sure he was alright. Mark left and picked up his business partner Sinan Ergun on the way. They were in a silver Hilux.

Sometime shortly after 10:00am, Terry attended Inline Signs alone to confront Ms Tonna and Mr W. He was driving a black Holden Commodore. Terry stood outside the factory and asked them to come outside. They refused and invited him upstairs instead. According to Terry, Ms Tonna came downstairs to meet him and said she "*had nothing to do with this, they went too far*". Ms Tonna says she told Mr Williams to stay upstairs. Terry asked Ms Tonna "*did you just put a gun to my brother's head?*" She replied, "*No. No one put a gun to anyone's head…he shot the gun in the air but didn't put the gun to anyone's head*". According to Ms Tonna, Terry said "*you'll be sorry for this Chantelle. You should know better. You know us, you know who we hang out with*".

According to Ms Tonna, Terry then got into his car and Ms Tonna asked, "*but don't you want to even know what happened on Friday with your brother?*" He replied, "*I don't give a fuck what happened…. that's not right*". He then said he was "*going to come back for [them], that [they] have a death wish, that all she has done is cause problems for W…. hurting me will hurt him and that's how he'll make him suffer*". By 'him' she took to mean Mr W. Terry denied making threats at this time. Regardless of the differing version of that conversation, Ms Tonna agrees that she went back upstairs and told Mr W what had happened and that 'they' were planning to come back to 'hurt her'.

At approximately 10:15am, Terry left the premises and drove to meet Mr Bassal who was on the phone to Mark when he arrived. Mr Bassal told Terry that Mark was at Inline Signs, so they drove there to make sure he was okay. At approximately 10:30am, fifteen minutes after Terry left the premises, Peter Williams told Ms Tonna that three cars containing four men including Mark, Terry and Mr Bassal had just arrived at the premises. At this point Terry did not know that Mr Bassal had arrived. Sinan Ergun remained in the car while the three brothers entered the factory. Mr W was at the top of the stairs holding a gun. Terry stated that he said:

> *"Hey man I come here by myself. I'm not here to cause trouble. If I wanted to cause trouble, I wouldn't be here by myself. Just let's talk about it. This is stupid."*

After Mark and Mr Bassal got out of their cars, they came a short distance into the factory floor. Mark said that he heard Terry 'blabbering on' and that Terry had referred to Mr W as a 'Fucking idiot'.

Mark denies that any of them uttered any threats. According to Ms Tonna, she was approximately 1.5 metres away from the Bassal brothers and Mr W told her to "*move*" or "*duck*". She heard 5 or 6 shots. She turned around and saw Peter Williams at the bottom of the stairs.

Three staff members (Jay Cole, Steve Hertmanii and Seksane Phoumivong) took cover behind a guillotine. Mr Bassal and Terry had been shot. At this point, Sinan Ergun exited the car and called "000".

Mr W had in fact fired around 11 shots towards the three Bassal brothers. Terry stated that until that stage, he had not seen the rifle. Mr Bassal was located on the outside of the building near the roller door lying face down. Mark turned him over and then dragged Terry out of the factory towards where Mr Bassal was lying. He found a blanket, wrapped it around Terry and left him there screaming. He then went back to Mr Bassal, called "000" and commenced CPR. Mark told Ms Tonna to call an ambulance, but she refused. The emergency call was logged at 10.43am. Mark indicated that his brother had been shot in the arms and legs and when asked about the location of the gunman said that "he's upstairs in the office."

According to Ms Tonna, Peter Williams was standing at the bottom of the stairs and did not move at all. Ms Tonna then ran up the stairs to Mr W. He was "*whitish and a little bit cold*". He said, "*I've shot bullets*". She told him "*it's alright, we'll be alright*". She directed him to go into the office, which he did, because she didn't want him "shooting cops" and ran back down the stairs. She called "000" at 10.44am, picked up the casings from the ground, went upstairs and hid them in her desk. She told Mr W to sit down and not move. She then went down and heard sirens. During the 000 call she implied that it was the persons who had come to the factory who were armed with guns and had carried out the shooting. When asked if each of the males outside had a gun she replied, "I think so."

A number of other people in the vicinity made calls to the emergency services.

Terry was struck by three projectiles. One caused a penetrating wound and exit wound to the right arm, causing an open fracture to the humerus and damage to the radial nerve. One struck the thorax causing a penetrating wound and an exit wound to the thorax. One struck the foot causing a penetrating wound and an exit wound.

Mark was struck by a projectile that caused a penetrating wound to the lower anterior leg and an exit wound. Mr Bassal died from a gunshot wound to the chest. The post mortem found numerous penetrating injuries of differing sizes of the lower limbs. Ms Tonna also said she was hit in the leg by some collateral "splatter" as bullets ricocheted off the concrete factory floor.

Police attendance on 7 March 2016

At 10.45am, police radio transmitted the following message for police vehicles in the Macquarie Fields and Campbelltown area:

> *"Macquarie Fields car, car in the vicinity, for two Stennett Road Ingleburn, the informant's brother's been shot. Car in the vicinity."*

A number of police cars acknowledged the broadcast and proceeded to the location. Further broadcasts were made indicating that a person was *not conscious, not breathing* and *shot in the arms and legs*. Senior Constable Craig Bradshaw was the first to attend the scene at approximately 10:45am. He was in marked highway patrol vehicle with call sign South West Metro 220.

At the time the In-Car Video (ICV) fitted to the car was recording and continued to do so even after the car stopped. He saw two bodies on the ground and Mark performing CPR on one of them.

Senior Constable Bradshaw yelled "*where is the shooter, is he still here?*" and Mark answered, "*He is upstairs with an AK 47*". Senior Constable Bradshaw went into the factory area to check for other victims. In his statement he describes an open plan factory with machinery, an elevated office area and a kitchen area downstairs.

He observed Ms Tonna exit the office upstairs with Peter Williams following behind her. He called on them to "show their hands". They placed their hands over their heads but did not answer any questions being yelled at them, such as "where is the gun? How many people upstairs?" They were directed to lie on the ground. Senior Constable Bradshaw covered the exits and waited for other police to arrive. A large police presence then ensued.

Some of the officers rendered first aid to the victims and removed them from the scene. Other police evacuated people nearby or managed people who were present in the factory. At the same time, the police at the scene attempted to identify the person responsible for the shooting and their current location. Senior Constable Bradshaw asked for someone to get him a ballistics vest. Senior Constable Julianne Savage handed it to him. At that point Ms Tonna says she could see Mr W through the window. The window was in the office and looked over the factory floor. He blew her a kiss and she winked back at him. She thinks she told him that she loved him. Senior Constable Bradshaw told a male police officer to "*cover*" the witnesses while he put his vest on.

Senior Constable Bradshaw ordered Peter Williams and Ms Tonna to walk backwards out of the building. At this time, Senior Constable Esposito was assisting Terry with his injuries. Senior Constable Savage and Detective Magee dragged Mr Bassal out of the factory. Senior Constable Savage took over the CPR on Mr Bassal. Senior Constable Azzopardi observed Ms Tonna with her hands in the air, telling police that "*[she] will get [W] out*". Senior Constable Azzopardi, who had previous dealings with Ms Tonna, told her to come to him and she complied. He asked her who the shooter was to which she replied, Wayne W. Senior Constable Azzopardi relayed this information to police officers at the factory entrance. He left Ms Tonna and Peter Williams with Detective Senior Constable Perugini.

The body worn ICV audio transmitter worn by Senior Constable Bradshaw recorded an officer calling out: "W, W".

According to Detective Senior Constable Bornhorster, Detective Senior Constable Cavan was calling out:

> *"W come out with your hands up mate and let's go home. We can work this out. Talk to me mate and we will try and work everything out."*

No police who were at the factory report any response from Mr W at any stage.

Over the next few minutes Inspector Greer arrived and took command and control of the scene. A command bus arrived at the scene shortly after. A perimeter was established behind the factory and an operations log was started.

Inspector Greer spoke with the Region Operations Manager, Alf Sergio and the Region Commander, Assistant Commissioner Mennilli as well as the Tactical Operations Unit (TOU) Commander. At 10.59am an ambulance arrived at the location. A number of further ambulances followed.

The gunshot at 11.06am

At 11:06am, another gun shot was heard. The sound was captured on the ICV recording from highway patrol vehicle SWM220 at a displayed time of 11:06:36 hrs. The time of the shot is further corroborated by Detective Senior Constable Knighton who, after hearing the shot, asked Detective Bernhorster for the time and was told it was 11.06am.

Detective Senior Constable Cavan referred in his statement to hearing the shot and then said:

> "*during the course of about 40 minutes, I started yelling into the factory in an attempt to communicate with W. I was yelling for him to come out and telling him not to worry about what had occurred, but there was no response.*"

Tactical Operations Unit (TOU) response

The TOU was contacted to attend at approximately 11am. Information obtained and assessed by the TOU Commander indicated the situation was categorised as High Risk. Permission for the deployment of the TOU to the premises was granted at approximately 11.13am. At approximately 11.19am the TOU Commander provided information about the situation at the premises to the Region Commander/Assistant Commissioner Frank Mennilli and an initial plan was made to authorise the use of specialised weapons and tactics to surround and contain the situation, and to negotiate to resolve the situation. Inspector Greer says that after the shot was fired at 11.06am, he requested an estimated time of arrival for the TOU over the police radio and then received a call from the Commander shortly after who said they would be at scene within half an hour. They were at scene by approximately 11.30am.

Upon the arrival of the TOU it was necessary to gather information and develop a Deliberate Action Plan rather than take Immediate Action and potentially risk injury to those inside the factory. The TOU worked together with the Negotiators who also attended the scene. There were attempts made by the negotiators to make contact with Mr W using the landline to the business or two mobile phones it was believed he had access to. A statement by a Negotiator states that the negotiators had two areas to focus on and that was to engage the subject and have him exit the premises safely and, secondly, to communicate with the employees within the premises, identify their condition, identify where they were located and reassure them that police were working to safely resolve the situation.

Numerous calls to both the landline and mobile went unanswered. Negotiators also sent a number of text messages to the mobiles of a number of workers that were unaccounted for. They received messages back and identified that there were three workers still in the ground floor area of the premises. At approximately 4.52pm, the TOU teams made entry into the premises. Three males were located inside the warehouse area. These men were protected by the TOU until they received confirmation that there was no further threat in the premises. A TOU team proceeded upstairs where a deceased male was found. He appeared to have sustained a gunshot wound to the head consistent with being self-inflicted. It later became known that the deceased male was Mr W.

Criminal offences relating to Ms Tonna Strand

Ms Tonna was initially charged with murder and was in custody from May 2016. On 29 June 2018, Ms Tonna pleaded guilty to firearms and hinder investigation offences.

The murder charge was withdrawn.

On 9 July 2018, Ms Tonna was sentenced to 3 years and 4 months imprisonment with a non-parole period of 2 years and 2 months. She was released from custody on 9 October 2018 under the supervision of probation and parole for 2 years.

Conclusion

The single gunshot heard within the factory at 11.06am was Mr W taking his own life in the upstairs office inside the factory. He used an unlicenced semi-automatic rifle, prohibited in NSW. He had no permit for firearms. Police have been unable to trace the rifle. Police first arrived at the premises at 10.45am on 7 March 2016. Between 10.45am and 11.06am, attempts were made by police to communicate with Mr W and have him exit the office and be removed safely. Police never received a response. Subsequent to the gun shot at 11.06am, police continued to call to Mr W to come out. They did not receive a response. The TOU arrived at 11.30am and his body was discovered shortly before 5pm.

Nothing further could have been done by the officers involved in this tragedy. Each of them carried out their duty in a professional and appropriate manner.

Findings:

I find that WW died on 7 March 2016 at 1D/17 Heald Road, Ingleburn, NSW as a result of a gunshot wound to his head that was intentionally self-inflicted.

4. 290240 of 2016

Inquest into the death of MF. Inquest findings delivered by Deputy State Coroner Grahame at Lidcombe on the 23rd September 2021.

MF's death came after a struggle with depression and substance use issues. Events escalated on 27 September 2016, after police were contacted in relation to a report of violent behaviour in a domestic setting. MF was well affected by amphetamines when he left the premises at which his partner was staying in his partner's car. MF subsequently stopped by the side of a nearby road where a sympathetic member of the community, spotting a rope looped through the back windows of the vehicle, sensed he needed help and tried to calm him. On returning to his truck on the pretext of getting MF a cigar, this man made a surreptitious call to police for assistance. Tragically, a short time later it appears that on seeing a police vehicle approach, MF sped off and intentionally crashed his vehicle into a tree. Given the circumstances it is likely that he was concerned that police were arriving to arrest him. The Police found MF almost immediately and although resuscitation was commenced, MF had suffered very significant injuries and could not be saved.

The events before the collision were extremely distressing for his family, but they do not sum up his life or worth as a person. His family gave the Court some insight into his personality, his struggles and his passions.

His partner, ("JA"), told the Court that she and his children continue to feel his loss every day. She described his central position in their lives. Losing a loved one in tragic circumstances is always traumatic and difficult. In JA's case, however, that pain must have been compounded by the fact that when she first received notice of MF's death, she was at Windsor Police station making a statement in which she disclosed very serious acts of personal violence committed by MF against her earlier that day. It is appropriate to record the distress and anguish this terrible state of affairs must have caused JA. For this reason, I wish to sincerely thank her for her presence at the inquest and for the generous and gracious approach she took to these proceedings. JA experienced at first hand the results of MF's trauma and uncontrolled drug use. She nevertheless had the grace to acknowledge the love they also shared.

MF's foster family also assisted the Court in understanding the complexities of his personality. Despite some years of minimal contact, they had reconnected with MF and tried so very hard to assist him with the internal demons he faced. ("BB"), MF's foster brother, spoke of happy childhood memories and reiterated the family's unconditional support. He also undertook to communicate the essence of these proceedings to MF's biological family who could not attend. MF is greatly missed by all those who loved him. JA wrote eloquently of the profound effect MF's death continues to have on the lives of their children. I wish to express my sincere condolences to her and to MF's children for their profound pain andloss.

The role of the coroner and the scope of the inquest

The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death. A coroner may also make recommendations, arising from the evidence, in relation to matters that have the capacity to improve public health and safety in the future. In this case there was no dispute in relation to the identity of the deceased or to the date, place or medical cause of death. However, the manner or circumstances of MF's death required significant investigation.

This inquest was a mandatory inquest. MF's death occurred prior to relevant amendments to s. 23 of the current *Coroner's Act 2009.* At the time of MF's death an inquest was mandatory if the death occurred "in the course of a police operation." I am satisfied that a police operation was underway at the time of death and I note NSW Police's investigation was carried out pursuant to critical incident guidelines. A list of issues was prepared before the proceedings commenced. In addition to the statutory findings pursuant to s. 81 of the *Coroners Act* 2009, the listed issueswere:

- Whether MF's death was intentionally self-inflicted and/or precipitated by a mental health episode.

- Whether the manner of driving by NSW Police Force Officers, both to the report concerning MF in his car, and in response to MF driving away from them, was appropriate and in accordance with the applicable policies and procedures; The appropriateness of the medical treatment MF received for his depression, mental health and substance abuse issues by Nepean Hospital and Dr Tan.

The evidence

The inquest proceeded some five years after MF's death. This occurred for a number of reasons including delay caused by the determination of an interlocutory application and associated proceedings in the Supreme Court of NSW. COVID 19 meant that the hearing was conducted via audio and video link. The Court is aware that delay can cause additional stress on a family and acknowledges the difficulties inherent in conducting proceedings in a virtual courtroom.

The Court took evidence and submissions over three days. Three involved officers gave oral evidence, as well as the member of the public who tried to assist MF on the day. The Court also heard from Sergeant Hyrmak, who was formerly an Acting Sergeant in the Traffic Policy Section of the Traffic & Highway Patrol Command, and who had some expertise in relation to interpreting the NSW Police Force's Safe Driving Policy. In addition, the Court received extensive documentary material. This material included witness statements, medical records and CCTV and audio recordings. While I am unable to refer specifically to all the available material in detail in my reasons, it has been comprehensively reviewed and assessed.

Background

Counsel Assisting's opening set out a brief chronology of the undisputed facts and I rely heavily on that summary which I regard as an accurate record of events. MF was 46 years of age at the time of his death. He was an Aboriginal man who had been taken from his family at a young age. The Court is unaware of the background involved in his removal from his birth family but accepts it is likely to have caused considerable grief. While MF developed a strong and loving relationship with his foster family, the effects of early trauma can be profound and ongoing.

MF was fostered to the ("B") family when he was around two years of age. He became part of a loving and close family of nine siblings. BB told the Court that the B family loved MF unconditionally and that he fitted in well in the family, enjoying soccer, motorcycle riding and go kart racing. MF reconnected with his biological family at around 14 years of age after his mother reached out through a foster care organisation. The B's supported MF's decision to make a connection with his birth family and have remained in contact with that family. BB told the Court that as a teenager MF left their family to explore life and that at one point spent time with his birth family and with friends in Brewarrina.

The B's remained in MF's life and at crucial moments were there to give him support and assistance. MF was a skilled racer and BB assisted him at one point to get employment at the Hawkesbury indoor kart centre. It was here that MF met and formed a relationship with JA. In the early years of the relationship there were some drug problems, but the couple had three children and eventually settled into running egg farms in the Hawkesbury area. Unfortunately, at some point things deteriorated and MF commenced using amphetamines, specifically the drug ice. As time went by MF's drug use escalated and there was significant turmoil and repeated incidents of domestic violence.

It is clear from what is before me that MF loved his children greatly, even during these years when he struggled to care for them as he may have wished. There is considerable evidence to indicate that the relationship between MF and JA was, especially in the early days, close and loving. However, as his addiction to ice developed the relationship was also characterised by episodes of significant violence. I accept JA's evidence that the violence was ongoing and that many instances were never reported to NSW Police. Eventually police took out an ADVO against MF on JA's behalf. That order was in force at the time of MF's death.

At the time of his death, MF was in crisis. His General Practitioner, Dr Tan, reports that when he first saw MF (in the period between 2010-2011) he presented as a loving husband and hard worker. Dr Tan described MF as a "respectful man" who was "always courteous and friendly" and as a "responsible father". However, when Dr Tan next saw MF (in 2016, after a gap of many years), he saw a changed man. MF told Dr Tan that he was depressed and homeless and that he was addicted to ice.

Prior to seeing Dr Tan in 2016, MF had been admitted to Nepean Hospital to treat his drug dependency issues. This ultimately, does not appear to have been effective to allow MF to break his addiction to ice nor does treatment appear to have helped MF understand the underlying issues that plagued him. Substance use issues can be chronic and recurring. Many attempts are sometimes needed to understand deep seated causes and triggers. MF was again admitted as a voluntary patient to Nepean Hospital in 2016. On 1 September 2016 he was again discharged.

This, of course, was only a matter of weeks before his death. Again, it appears that this admission was not effective in breaking the cycle of problematic drug use or helping MF gain greater insight into the triggers for hisbehaviour.

Events leading up to MF's death

On the day of MF's death, Constable Goldsmith and Senior Constable Taydler had been called to the premises where JA was staying to respond to an allegation that MF had breached the ADVO made for JA's protection. They were attached to the vehicle, Hawkesbury 16. MF was not present when police attended, and no action was taken at that time. JA reports that, at a later point on that day, MF again attended the address. He seriously assaulted her during a prolonged episode of violence. MF then took JA and their daughter for a drive at which time he repeatedly said: "I'm going to run this car into a tree". He also said, "I don't want… [his daughter] in the car when I do it". He eventually let JA and their daughter out of the car at JA's mother's premises and drove off.

At this time a broadcast ("the first radio broadcast") was made over police radio for police to attend the premises where JA was staying. Hawkesbury 16 (with Senior Constable Taydler as the driver and Constable Goldsmith as the passenger) responded to that call and expedited to that job under lights and sirens. The VKG records that they were responding in a "Code Red" capacity to that job. The first radio broadcast was also acknowledged by Hawkesbury 15. Senior Constable Galea was the driver and his partner was Senior Constable Cole. They proceeded "Code Red" to the job (again, under lights and sirens).

Whilst both Hawkesbury 15 and 16 were en route to the address where JA was staying, a further radio broadcast was made over the police system (the "second radio broadcast"). The substance of that broadcast was that a man had been seen in a car with a rope attached to him at a location in Fairey Road. That location was only a couple of hundred metres from the address where JA had been staying. The southern end of Fairey Road is a partially paved and partially gravel or dirt road. It terminates in a dead end. All officers were well acquainted with the area. Perhaps unsurprisingly, responding police treated what was communicated over the second radio broadcast as a job involving a potentially suicidal person. Accordingly, both Hawkesbury 15 and Hawkesbury 16 decided to divert to that location. I accept this was the rightdecision.

There was some conflicting evidence about the exact routes each vehicle took, however it appears that Hawkesbury 16 turned on to Fairey Road and proceeded south closer towards where that road terminates in a dead end. At a different intersection further north, Hawkesbury 15 also turned onto Fairey Road and proceeded to follow behind Hawkesbury 16 which had emerged onto Fairey Road in front of them. The Court heard evidence that Hawkesbury 16 deactivated its lights and sirens because they believed that they were responding to a potentially suicidal person and were concerned, in the words of one of the involved officers, to avoid "inflaming" that situation. Hawkesbury 15 was further back from the car in question but similarly deactivated their siren, leaving the lights on to warn other potential road users of their presence.

Before the police arrived, Mr Maher, the member of the public who had made the second report to police, engaged with the man in the vehicle, a Nissan Pulsar, which was parked to the left- hand side of the road.

Upon seeing the rope dangling outside of the Pulsar, Mr Maher had adduced, correctly, that its occupant, now known to us as MF, was contemplating suicide. The Court had the opportunity to hear directly from Mr Maher. He explained that he immediately knew something was wrong and had a fair idea that the driver was suicidal. It appears that he was able to quickly assess what was happening and that he planned to establish rapport with the driver in an attempt to buy time until he could arrange for the police to come. In my view, he acted with extraordinary sensitivity, discretion and skill. He was immediately focussed on trying to prevent MF from taking his own life.

He first tried to engage MF in conversation, offering him a cigar. Under the pretext of retrieving the cigar from his vehicle, Mr Maher then surreptitiously called 000, the action which prompted the second radio broadcast. Mr Maher then re-engaged MF in conversation. Mr Maher directed the conversation to topics such as MF's family. He was able to keep MF engaged in conversation until police arrived in Fairey Road. It appears clear that, at some point, MF saw a police vehicle or vehicles on Fairey Road behind where he was parked and, after he did, he accelerated away at some considerablespeed.

Mr Maher says that, prior to this point in time, the keys to the Pulsar were not in its ignition. Upon noticing the police, MF took the keys from his pocket and went to insert them in the ignition. In an attempt to stop MF from doing so, Mr Maher covered the ignition with his thumb, but MF was able to force it away, by bending it backwards. MF then inserted the key in the ignition and the Pulsar drove off, running over Mr Maher's foot in the process (although, fortunately, not occasioning him any harm, due to the steel capped boots Mr Maher was wearing). Again, it seems appropriate to acknowledge Mr Maher's bravery at this point.

Hawkesbury 16 was the first vehicle to arrive at the location where the Pulsar was parked. There were discrepancies in the evidence as to how close this vehicle got to the Pulsar. The distances given in oral evidence ranged from around 100 metres, on the account Senior Constable Goldsmith, to around 15-30 metres, or as close as ten metres, on the account of Mr Maher. Estimating distance can be a difficult task at the best of times. Mr Maher, of course, was encountering a difficult and stressful situation. He was only peripherally focussed on police and, at relevant times, was engaged in a struggle with MF with his head through the window of that vehicle, which must have impeded his view. Further, it may be noted that, in his statement, Mr Maher placed the Pulsar between 50-100 metres south of the intersection with Berger Road, and that, in his call to Police, he placed the Pulsar about 100 metres south of that intersection.

While police may be more used to estimating distance, they too were in a stressful situation. They were moving at speed and focussed on assisting the driver of the Pulsar. The whole episode happened very quickly, and Hawkesbury 15 was well behind Hawkesbury 16 when the Pulsar took off. Counsel assisting submitted that it is not possible or indeed necessary to make a precise finding of the distance between Hawkesbury 16 and the Pulsar at its closest point before the Pulsar drove away. I accept that view. What is certain is that only the briefest period of time elapsed between Hawkesbury 16 arriving in close proximity to the Pulsar and MF driving off. At most, it is possible Hawkesbury 16 may have come to a momentary pause, although the preponderance of the evidence suggests that even this may not have occurred.

Therefore, even if Hawkesbury 16 did come to within 10-15 metres of the Pulsar, there was not enough time for either Senior Constable Taydler or Constable Goldsmith to have done anything to aid Mr Maher. They knew nothing of the rapport Mr Maher was establishing with MF nor did they have any time to form a plan to assist. It is important to note at this stage that neither police vehicle appears to have ever reached great speed, particularly after the point at which they deactivated some or all of their warning devices. Senior Constable Goldsmith who was the passenger in the lead vehicle, Hawkesbury 16, stated that when responding Code Red, they would likely have exceeded the speed limit and overtaken other vehicles. He stated that they slowed as they reached Fairey Road and that there were fewer cars in that area.

Senior Constable Galea, who was the driver of Hawkesbury 15 stated that they did not speed after the siren was deactivated and later the dirt road conditions meant they needed to slow down to some degree. Sergeant Cole, who was the passenger in that vehicle, recalled they were initially travelling around the speed limit "maybe slightly higher", but they slowed when they saw Hawkesbury 16 emerge in front of them on Fairey Road. After MF drove off, Constable Goldsmith informed police radio "this vehicle has taken off on us. We are not in pursuit. We are going to follow as the road is a deadend".

By the time Hawkesbury 15 arrived on the scene, both MF and Hawkesbury 16 had already begun to drive off, travelling further south down Fairey Road. The Court was initially concerned about the reason Hawkesbury 15 had used its siren to make a short "whelp" noise at the location where Mr Maher had been engaging with MF in the Pulsar and the effect that hearing that noise may have had on MF. However, at the conclusion of oral evidence, I was satisfied that Hawkesbury 15 had not indicated a direction to stop and had used the siren very briefly as a safety warning to Mr Maher who was still adjacent to the road. Further, I was satisfied that this took place after MF had already left the vicinity.

The Pulsar accelerated away proceeding down Fairey Road. Before Fairey Road terminates in a dead end it forks to the left. Immediately behind where the road forks is a tree with which the Pulsar collided. All the indications are that MF made no attempt to apply the brakes before impact. I note that the collision is captured on CCTV footage obtained from a sewerage treatment plant located in Fairey Road. It is clear from this footage that the police vehicles were somewhat behind the Pulsar and were driving considerably slower than it. In particular, a period of 27 seconds elapses between the point in time in which the collision is depicted and when the first of the two police vehicles comes into view. The footage shows MF's car hitting the tree without slowing.

The evidence suggests that after the collision, each of the responding officers took appropriate steps to attempt to remove MF from the wreckage and to deliver him aid. These steps included cutting the rope, which by this time was observed to, in fact, be two ropes, both of which were affixed to MF's neck. Upon the ropes being cut, MF took a faint breath. Police promptly called for an ambulance. It is appropriate to record that the circumstances confronting police must have been extremely traumatising and illustrate just how difficult the jobs that first responders are routinely asked to perform can be. Dr Haden from Care Flight then attended the scene. MF had died by this time and Dr Haden completed the life extinct form at 14:48. While these events were occurring, JA's friend arrived and took her to Windsor Police Station, where police took a statement from her, and took photographs of her injuries. As previously noted, this process was ongoing at the time of MF's death.

An autopsy was conducted on 28 September 2016. MF's injuries were significant and included multiple fractures including to his skull. A subarachnoid haemorrhage involving the brain, transection of the aorta and a large amount of blood in the left chest cavity indicated his immediate injuries were wholly incompatible with life.

Toxicological analysis detected amphetamines, cannabinoids, and the anti-depressant medication citalopram.

Was MF's death intentionally self-inflicted?

A finding that a death is intentionally self-inflicted should never be made lightly. There must be clear and cogent evidence in relation to intention. On reviewing all the evidence before me I am satisfied to the requisite standard that MF's death was intentionally self-inflicted. He had previously indicated suicidal thoughts and was being treated for depression. While he was clearly affected by amphetamines, his conversation with Mr Maher indicates that he had not lost capacity to make decisions or to reason. In fact, he told Mr Maher that he "felt like doing himself in" and that if the police arrived, he was "out of here". He had earlier in the day threatened suicide by driving and had ropes around his neck. The objective evidence provided by the CCTV footage indicates that he made no attempt to stop as he drove at high speed into the tree. Subsequent examination of the vehicle did not reveal anything to suggest there was a mechanical fault.

There is poignant evidence that MF had previously felt suicidal and had survived. On this occasion, despite the efforts of Mr Maher, he took action. Tragically there are times when decisions such as this are made impulsively or in moments of despair that could ultimately pass. Mr Maher tried his hardest to delay any action by MF and for that he has my thanks and admiration.

Did MF receive appropriate assistance for his mental health and drug and alcohol issues?

Given the connection between MF's behaviour on the day of his death and his history of intertwined depression and amphetamine use, the Court was keen to understand whether MF was provided with the assistance he needed to deal with these issues. As I have stated, Dr Tan identified his use of ice as a significant factor in his mental health decline in the last years of his life.

With respect to the treatment provided by Dr Tan he provided a statement to the Court and a copy of MF's medical record. As stated above, MF returned to Dr Tan's medical practice after an absence of some years on 27 July 2016. On that occasion, MF advised Dr Tan that he had just finished rehab and was in great despair, feeling suicidal and depressed. Dr Tan prescribed MF the anti-depressant Lexapro, and in an act of kindness provided MF with the money to obtain this medication. MF again attended Dr Tan's practice on 15 August 2016, where he expressed similar feelings to those he was experiencing at the time of the previous visit, and Dr Tan increased MF's dosage of Lexapro.

MF's last visit to Dr Tan occurred on 9 September 2016. He informed Dr Tan that he had been released from rehab a few days earlier but was still feeling very depressed. He informed Dr Tan he had ceased taking his Lexapro and Dr Tan wrote him another script for the anti-depressant. A statement was obtained from Dr Anthony Korner, the Consultant in Charge at Nepean Hospital.

Dr Korner was responsible for MF's admission to that facility in September and October 2015. Dr Korner explained that the discharge plan prepared for MF at that time involved MF being followed up by the Acute Care Team (Mental Health) and by the Drug and Alcohol team. Dr Korner states that MF was given information about the available programs to assist him to deal with his drug dependency issues and that the social worker may also have assisted him with telephoning the providers of such programs prior to his discharge.

Dr Korner notes that there was some uncertainty as to when a place in these programs might become available. He explains that, as at September 2015, MF appeared motivated to pursue admission into such a program. A statement was obtained by Dr Rajneesh Singh, who was also involved in the admission for MF in 2015 at Nepean Hospital. Dr Singh suggests that, prior to his discharge, accommodation for MF had been secured and that MF was provided with detailed psychoeducation relating to his diagnosis and with information as to the support available to him in the community. A statement was obtained from Registered Nurse Siphathisiwe Sibanda. Nurse Sibanda was also involved in MF's 2015 admission at Nepean Hospital. Nurse Sibanda states that there were plans to allow MF to be provided with a telephone to allow him to contact rehabilitation services.

The services proposed to be made available to MF in the community included community outpatient services and individual and group counselling to help him achieve abstinence. These options were ultimately declined as MF wished to pursue other drug and alcohol rehabilitation options. A list of drug and alcohol rehabilitation options was provided to MF and he was advised to make contact with those services.

In relation to MF's more recent admission to Nepean Hospital, in October 2016, the Court received a statement from Dr Fisher, who was in charge of the relevant inpatient ward at the time of MF's admission. Dr Fisher explains that MF was treated as a priority patient due to his Aboriginal heritage. The history MF gave was that he had last used 36 hours previously which meant that, at the time he presented, he was not in active or physical withdrawal. Dr Fisher explained that MF was not physiologically dependent on methamphetamine and had previously demonstrated capacity to remain abstinent. Her plan was to admit MF for a week in order to break the ritual involved in his use of methamphetamine.

Dr Fisher further explained that, by the time of his discharge, MF was given contact details for community organisations to support him with his drug dependency issues. These referrals could not be arranged to coincide with his discharge from his hospital due to a number of matters including: waiting lists; MF's ineligibility with number of providers as a result of having an upcoming court case; because he did not have a criminal record check (Dr Fisher understood that certain of those organisations would not accept persons with particular criminal histories); and, financial constraints. Accordingly, there were limited options. Dr Fisher explained that the only community drug and alcohol treatment service Nepean Hospital had the capacity to influence was an organisation called We Help Ourselves ("WHOS"). An assessment with that service was done whilst MF was in inpatient.

Dr Fisher stated that Nepean Hospital did help MF find accommodation through their Aboriginal Liaison Officer, Mr Jamie Bellwood. Whilst he was an inpatient, Mr Bellwood supplied MF brochures and information regarding his options for drug rehabilitation after discharge. Mr Bellwood attempted to get MF into the Orana Aboriginal Rehabilitation Centre and worked with the Marrin Weejalli Aboriginal Corporation to secure thisoutcome.

Mr Bellwood formed the view, however, that MF was not interested in completing rehabilitation as he was committed to returning to the farm to be with his wife and children. Mr Bellwood explains that he could not force MF to attend rehabilitation against his will and expressed the opinion that he did as much as he could to help MF. Mr Brown, the Aboriginal Mental Health Worker employed at Nepean Hospital also provided a statement. Although his recall is imperfect, Mr Brown explained that he would have assisted MF to arrange for the admission into rehabilitation facilities.

While this was more the role of a social worker he would have assisted if he could and, in particular, he would have arranged for any assessments into such facilities to be conducted if he were asked to. However, he was of the impression that MF seemed comfortable and wished to follow up on the referral process himself. A report and information in the form of Wellnet records was obtained by the Court. The only report made to the NSW Health Child Wellbeing Unit concerning MF's children occurred on 23 September 2015. Contact had been made to the unit out of concerns arising from MF's mental health following a suicide attempt. No action was taken at that time because MF was voluntarily seeking treatment and there was another carer. Ms Etter, the manager of WHOS, provided a statement and documentation setting out the eligibility requirements for participating in the drug and alcohol rehabilitation program that service provides.

WHOS did not have a policy requiring a court outcome prior to an assessment being conducted and there was no initial admission fee for entry into the program it offered. Ms Etter did not say whether MF was assessed for eligibility with thatservice. Mr Coyote, the CEO of rehabilitation service provider, the Glen, provided a statement. He noted that the Marin Weejalli Aboriginal Corporation had made an online application on MF's behalf for a referral to that service on 31 August 2016. Staff from the Glen attempted to make phone contact with MF on 22 September 2016 to complete his assessment, however, the phone rang out. While the Glen charges a fee for the program, the service never rejects a client on the grounds that they cannot afford to pay the fee; rather they accept the client and help her or him to get Centrelink benefits to cover that fee. Mr Coyte explained that there is often a waiting list. The service will admit clients who have court proceedings pending but do not accept clients who have a history of particular types of offending (malicious wounding assault, robbery, sexual or indecent assault, arson, murder or manslaughter).

Mr Bennett, the CEO of Orana Aboriginal Corporation, provided a statement. He notes that MF had been referred to that service by the Marrin Weejali Aboriginal Corporation and had completed a phone assessment on 22 September 2016. MF was accepted and placed on the waiting list pending bed availability. At that time, the waiting list was 6-8 weeks. Significantly, Mr Bennett advised that, had MF been assessed as requiring immediate assistance, he could have been given priority over the other applicants in the waiting list. However, this was not done as MF had provided only minimal information in support of his application. Mr Bennett advised that while Orana charge a fee, they do not refuse entry to anyone unable to pay on arrival.

Mr Jeffries, the CEO of the Weigelli Centre Aboriginal Corporation, advised that there is always a waiting list for the services provided by that centre. Sometimes a prospective client's admission is deferred if a court date is near to see what the outcome is. The cost of admission is 75% of a client's Centrelink and rent assistance benefits and clients are not required to pay any money up front. A person convicted of serious violence, arson, sex offence charges or who has been released from custody is not eligible for the programs provided by thatservice.

Major Gavin Watts of the Salvation Army provided a statement in relation to the services available to be provided by the Dooralong Transformation Centre. The only criterion for admission is that participants must be willing on their own volition to be an active participant in the program. Major Watts stated that the waiting list in September 2016 would likely have been around 4-6 weeks.

Ms Babineau, the CEO of Odyssey House, stated that there are some circumstances where a prospective client to that facility may not be admitted. To be eligible for admission, the person must be mentally stable, well enough to do the program and would need to want admission. Waiting lists are rarely needed. Ms Babineau said Odyssey House would not defer assessment of a potential client due to upcoming court dates but that the organisation may defer admission if court is within 6 weeks as the organisation did not have the means to transport a person to and from court. There is an admission fee, but the service is generally able to access brokerage to assist if a person is not able to pay upfront.

Significantly, it appears that the Marrin Weejali Aboriginal Corporation had been providing MF with a significant degree of support throughout 2016 and had been actively involved in assisting him with the process of securing a referral to these service providers after his discharge from Nepean Hospital in 2016.

Ms Bonham, a team leader at that Corporation notes that the support provided to MF throughout 2016 included: individual counselling; the provision of Narcotics and Alcoholics Anonymous meetings; and, the referral to other support groups and services (including Nepean Hospital detox unit, WHOS, the Glen, Odyssey House, William Booth and Orana Haven). Ms Bonham notes that there were no available beds at those facilities at the relevant time resulting in MF having to wait "indefinitely" for a bed to become available.

In summary, the evidence appears to show that appropriate steps were taken to refer MF to support for his mental health and drug and alcohol issues, both after his 2015 and his 2016 admissions. Individual service providers and indeed Dr Tan appear to have acted conscientiously and appropriately. However, once again this Court cannot help but observe that the perennial resourcing issues in this sector mean that lengthy waiting lists affect a patient's ability to get adequate treatment at the moment of crisis. Unfortunately, the lack of residential rehabilitation beds in NSW means that patients may be left unsupported at a critical time in their care.

While the Court accepts Dr Fisher's opinion that at the time of MF's discharge, he was not physically dependent on methylamphetamine, he was clearly in need of ongoing support. One worker has expressed the opinion that MF may not have been sufficiently motivated to engage in treatment at that time. However, in my view it is difficult to say this with any degree of certainty given that MF was not offered a bed forthwith. Instead, he was advised that he would be placed on a waiting list. In my view the ongoing shortage of residential places in rehabilitation for those struggling with amphetamine or ice addiction remains a very significant problem in the community.

The B family raised this issue as a particular concern, and it is one I share. This Court reviews numerous deaths each year where the lack of immediate access to drug and alcohol treatment an issue is. The problem has not been solved by successive governments. I intend to send a copy of these findings to the Minister of Health for his information and review. MF was provided with some support for his substance use issues and he was prescribed an anti-depressant medication by Dr Tan.

The Court accepts that it may not have been possible to further treat whatever underlying mental health issues MF may have had while he was using significant amounts of ice. MF needed long term support to understand and properly unpack the complex reasons behind his substance use. His suicidal feelings, his depression and his amphetamine use were interconnected and needed to be addressed in a safe and culturally appropriate environment.

Was the response of the NSW Police on 27 September 2016 appropriate and in accordance with the NSW Safe Driving Policy (SDP)?

The Court needed to consider whether the police involved were well guided, supported by, and compliant with, the NSW Police Force's Safe Driving Policy (SDP). Sergeant Hyrmak formerly of the Traffic Policy Section of the Traffic & Highway Patrol Command was called to give expert evidence and assist in this regard. Sergeant Hyrmak analysed the police actions within the context of the relevant policy framework. It is important to note that all four involved officers stated that they were never "in pursuit" of MF. In oral evidence officers from each car stated that they considered themselves to be involved in "urgent duty driving" pursuant to the SDP. This is entirely consistent with Senior Constable Goldsmith's call to VKG.

Having heard all the evidence I accept Sergeant Hrymak's analysis of events and his opinion that neither car was "in pursuit" of MF for the purposes of the SDP. While both police vehicles followed MF's vehicle down Fairey Road, there was no relevant communication by police indicating for him to stop. Sergeant Hrymak's evidence as to the type of matters that could be regarded as a direction to stop was clear and consistent and I accept that, even if the evidence as to the shortest distance between the Pulsar and Hawkesbury 16 is accepted, there was no indication that Hawkesbury 16 took action which should properly be construed as a direction to stop. Counsel assisting also submitted that Sergeant Hrymak's opinion that the police were engaged in "urgent duty driving", even after the point at which they had de-activated some or all of the warning devices ought to be accepted. I note that no submission to the contrary was made by Mr Hood.

Part 6 of the SDP which was in force at the time of MF's death deals with "urgent duty driving" which is defined as "duty which has become pressing or demanding prompt action". Urgent duty driving is governed by rules which are distinct from those governing police pursuits. Prior to engaging in urgent duty driving police should take into account the potential danger to other road users. A number of other factors required to be taken into account are set out including weather and road conditions, traffic density (including vehicles and pedestrians), the time of day (including specific factors such as school zones or road works). The distance to be covered and the driver's level of certification should also be considered. Part 8, specifically clause 8-2 makes it clear that when undertaking an urgent duty response or driving "code red" warning devices are to be activated. Sergeant Hrymak pointed out that cl. 8-2 of the SDP mandating "warning devices", required police to have sirens and lights activated at all times when "driving urgent duty". The version of the SDP presently in force contains an identical requirement. The Court understands the officers' decisions to deactivate warning devices in these unusual circumstances. The circumstances involved responding to an incident in which there was a significant potential for imminent self-harm. I accept the police evidence that heralding their arrival could have frightened or "spooked" a person in crisis.

While using these devices offers some protection to other road users, in a quiet area, faced with someone anxious to avoid the police, but also possibly suicidal, it appears to make sense to turn them off. The police were in marked police vehicles so they could hardly approach unnoticed, but there was little to be gained by using a police siren in these circumstances. I accept that the involved officers had some regard to the risks involved and took into account appropriate factors such as their speed, the road surface and the number of other vehicles in the vicinity. Counsel assisting submitted that while the deactivation of the warning devices constituted a technical breach of the SDP, it was not something which should greatly concern the Court in these particular circumstances or prompt criticism of the officers involved. I accept that view.

Counsel Assisting took the Court to policy equivalents to the SDP in the Federal and Queensland jurisdictions. Both policies provide police who are driving urgent duty with the discretion to turn off lights and sirens in particular circumstances. These policies are intended, it is presumed, to reflect particular operational exigencies which police may from time to time encounter and to provide police with some degree of operational flexibility. These exigencies could include, as Sergeant Hrymak observed, responding to an incident concerning an apparently suicidal person.

Is there a need for recommendations in this matter?

Section 82 of the *Coroners Act 2009* confers on a coroner the power to make recommendations that he or she may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

The Court carefully considered whether it is appropriate to make a recommendation in relation to the requirement to have lights and sirens activated when engaged in urgent duty driving. It may be observed that the appropriate wording of such a condition is a matter of some complexity. While it may seem sensible to allow some level of operational discretion in an appropriate case, the limits of that discretion need to be very carefully considered. Lights and sirens should ordinarily be activated whenever an officer is undertaking a course of urgent driving. The exceptions to that rule of practice should be very clear and carefully controlled. There is the potential for extreme danger if a police vehicle is permitted to undertake "urgent duty driving", and thus have the capacity to disobey certain road rules, without activating its warning devices. The situations where this may be appropriate are likely to be extremely rare. I am not confident that the limited evidence before me about the particular facts surrounding MF's death is adequate to allow me to suggest where the limits of that discretion should lie. I was heartened to hear that Sergeant Hrymak has raised the issue himself in the context of a review being undertaken by NSW Police of the SDP. Sergeant Hrymak advised that he tabled the issue of an amendment to the relevant provision and I understand that such an amendment is being given serious consideration. Given the issue is already under consideration by NSW Police it does not seem necessary for the Court to make any recommendation in this regard and I decline to do so. However, I intend to send a copy of these findings to the NSW Police Force's Traffic & Highway Patrol Command to assist in their ongoing review.

Findings

Identity: **The person who died was MF**

Date of death: **He died on 27 September 2016.**

Place of death: **He died on Fairey Road, South Windsor NSW.**

Cause of death: **He died of blunt force injuries.**

Manner of death: **He died as a result of a motor vehicle collision with a tree. His death was intentionally self- inflicted.**

5. 121886 of 2017

Inquest into the death of P. Findings delivered by Deputy State Coroner Ryan on the 21 October 2021.

Introduction

P was aged 72 years when he died at Long Bay Correctional Centre, at some time between 22 and 23 April 2017. P had been in custody since 11 October 2011. In 2012 he was sentenced to a term of imprisonment of nine years. He would be eligible to seek parole on 10 October 2017. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

P was born in Sydney on 17 July 1944. As an adult he worked as a computer technician, before retiring from paid work. He then taught computer skills on a voluntary basis. He was divorced from his second wife, and he did not have contact with his four adult children. On 11 October 2011 P was convicted of child sexual assault offences. He was taken into custody to await sentencing. On entering custody, he disclosed a history of depression and hypertension, for both of which he used prescribed medication. These medications were continued while he was in custody.

During his time in custody P's mental health was reviewed by psychiatrists and mental health nurses. A psychiatric assessment on 24 July 2012 resulted in an increase to his medication sertraline. This was changed to desvenlafaxine as a result of a psychiatric review on 31 October 2013. During this assessment P disclosed for the first time that he had attempted to overdose on his hypertension medication. His risk of suicide was assessed as medium to high, and he was assessed daily until 14 November 2013. By this time, it was considered his risk had abated, but that he would require a 'two out' cell placement to mitigate his risk, meaning that he was required to share a cell with another inmate. This arrangement continued until July 2014, when he was considered suitable for normal cell placement. In a mental health review on 9 September 2016, P disclosed that he was not tolerating his desvenlafaxine medication. He was reviewed by a psychiatrist the following week, and his medication was replaced with the antidepressant mirtazapine. P denied having any thoughts of harming himself or others.

P's dosage of mirtazapine was increased as a result of a mental health review on 3 November 2016. Registered Nurse Philomena Twomey, who conducted the assessment, spoke by phone with the on call psychiatric registrar who approved the dosage increase.

On 14 March 2017 P was charged with further offences. He was refused bail for the new charges, meaning that it was unlikely he would be released to parole later that year as he had anticipated. On 28 March 2017 P had another mental health review with RN Twomey. He told her he was feeling stressed and worried about the new charges, but that he was not having thoughts of self-harming or suicide. He rated his mood as at a level similar to that which it had been throughout most of his incarceration. However, he told RN Twomey that he didn't think his medication was as effective as it had been previously.

RN Twomey discussed with P a plan of increasing his mirtazapine and having a follow up mental health review in two to three weeks' time. Her overall impression was that his mood had deteriorated as a result of the new charges, but that he did not intend to harm himself. RN Twomey spoke by phone with the consultant psychiatrist and obtained approval for the medication increase. This dosage commenced on 29 March 2017.

On the evening of 22 April 2017 P had a physical altercation with his cellmate. During the incident P said: '*I'm going to die in here, I've got another ten years to serve … If I'm going to die in here, I'm going to kill you'*. P then struck his cellmate several times with the cellmate's walking stick. The fight came to an end when the cellmate managed to alert correctional staff. P was taken to the medical clinic and treated by RN Jessica McLoughlan for some minor cuts and abrasions. He told her he had no thoughts of self-harm, saying: '*As long as I'm not with [the cellmate] I'll be fine'.* RN McLoughlan noted P had an appointment for a mental health review the following week. She arranged for him to have a medical review the next day.

P was then returned to his cell, which he was to occupy alone to avoid any further altercations. There was no current requirement for him to be accommodated with a cellmate. The next morning at 7.17am a correctional officer opened the door to P's cell. P was hanging by his neck with a ligature made from bed sheets. This had been tied to the bars of the window. The correctional officer immediately called for help and P was cut down. Resuscitation efforts commenced straight away and were continued when Justice Health nurses arrived. However, P could not be revived, and he was pronounced deceased at 7.43am.

An autopsy performed by pathologist Dr Elsie Berger confirmed that P had died as a result of hanging. There is no evidence that anyone else was involved in P's death. The evidence supports the further finding, that the manner of P's death was self-inflicted and intentional.

In the course of this coronial investigation, inquiries were made as to the practice within the JH Network of adjusting patients' medication without a face to face review by a psychiatrist. In P's case, as can be seen from the above, his mirtazapine medication was adjusted on 3 November 2016 and again on 28 March 2017. On both occasions this occurred without P being assessed in person by a psychiatrist. Instead, the mental health nurse discussed P's case on the phone with the on-call psychiatrist. It is noted that the model of health care provided to inmates by the JH Network largely involves nursing staff '*consulting with remotely based specialty medical staff for advice'.*

An internal review into the circumstances of P's death did not find any deficiencies in his care and treatment for his mental health issues. However, the review identified two ways in which access to care could be improved for inmates like P. The first was that there be a review into the adequacy of resourcing for mental health nurse positions. The court heard that this review was conducted and that as a result, at Long Bay Correctional Centre there was an increase in such positions, from 1.6 to 2 fulltime positions. The second proposal was that clear guidelines be developed, including timeframes, for when there should be a face to face medical review of patients who have medication increases.

This proposal led to the development within the JH Network of *Guidelines for Psychotropic Medications 2020.* This document notes that '*best practice for patients on long term medications [is] to be reviewed by a clinician or mental health nurse who can discuss with the prescriber every six months'.* Medication could be adjusted without a clinical review provided that:

- the patient has been compliant with their current medication
- the change is considered clinically appropriate and safe
- the patient has been seen within the previous six months by a psychiatrist, GP, or mental health nurse and
- any required metabolic monitoring is ordered.

The practitioner must however request that the patient is booked for a face to face review of medications within the next six months. With regard to this issue, the court was assisted with a report from forensic psychiatrist Dr Danny Sullivan dated 31 December 2020. Dr Sullivan's opinion was sought as to whether the development of such guidelines for medication review would be beneficial within the custodial setting.

In Dr Sullivan's opinion the above Guidelines set appropriate standards and timeframes for review, having regard to *'community standards and the realities of medical practice in correctional settings'.* Dr Sullivan noted the potential for adverse effects and abuse of prescription medications, and added that '*a safe and effective system that was equivalent to the community standard*' would ensure that:

- at any time, an inmate could initiate a process for urgent review
- clinical staff informally reviewed the inmate at least monthly (e.g. when dispensing medication)
- the prescriber or another prescriber reviewed the inmate face to face at least every six months.

The evidence at inquest established that P's mental health care and treatment generally conformed with the *Guidelines for Psychotropic Medications 2020,* which I note were yet to be developed at the time of P's death. P's last face to face medical review for his mental health occurred on 15 September 2016. Following that he had three reviews with a mental health nurse. On the second and third of these, his medication was adjusted after the mental health nurse discussed his condition by phone with the on-call psychiatrist.

Compliance with the *Guidelines for Psychotropic Medications 2020* would however have meant that when P's medication was adjusted on 3 November 2016, he would have been booked for a face to face review with a prescriber within the following six months. The development of the *Guidelines for Psychotropic Medications 2020* is welcome. I observe however that within the document, the concern is expressed that it will not always be possible to comply with the six-month timeframe for a face to face medical review, '*due to high demand and low resources in custody'.*

The second issue for examination was the perennial one of suicide mitigation within prisons. This is, tragically, a recurrent issue in NSW inquests due to the numbers of inmates who take their own lives while in custody. Expert witnesses have repeatedly told courts that the most effective way of reducing the risk of suicide in prisons is by removing access to hanging points in cells. Recent examples include *Inquest into the death of A*, 22 October 2021, DSC Ryan; and *Inquest into the death of Tane Chatfield,* 26 August 2020, Grahame DSC. In the current inquest, information was sought from Corrective Services NSW as to what steps had been taken to reduce suicide risks in Long Bay Correctional Centre. Assistant Commissioner Leon Taylor provided a statement confirming that the cells located in P's former wing have now been refurbished to remove obvious hanging points. The work included removal of cell furniture, toilets, electrical fittings and window screens, and their replacement with safer anti ligature designs. This is welcome news and evidences a commitment on the part of Corrective Services NSW to address this serious issue. I encourage the Acting Commissioner to maintain this commitment, to ensure that all cells in prisons throughout NSW conform to similar safety standards.

Findings required by s81 (1)

Identity
The person who died is P.

Date of death:
P died between 22 and 23 April 2017.

Place of death:
P died at Long Bay Correctional Centre, Sydney.

Cause of death:
P died as a result of hanging.

Manner of death:
P's death was an intentional self-inflicted death, while he was in lawful custody.

6. 157550 of 2017

Inquest in to the death of F. Findings delivered by Deputy State Coroner Ryan on the 11th June 2021

Section 81(1) of the *Coroners Act 2009* [the Act] requires that when an inquest is held, the Coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of F. F was aged 49 years when he died by hanging in his prison cell, sometime between 24 and 25 May 2017. At the time of his death F was a sentenced inmate of Goulburn Correctional Facility. He had been in prison for almost sixteen years. An inquest into the circumstances of F's death is mandatory. This is because as an inmate, F relied on authorities to provide an adequate level of care for his health and welfare. In these circumstances an inquest is required to determine whether authorities have discharged their duty.

The focus of the inquest

There was no issue as to the medical cause of F's death. An autopsy report prepared by pathologist Dr Kendall Bailey found that F died as a result of hanging. Dr Bailey's report also noted the presence in F's post mortem blood of a high level of the antipsychotic medication olanzapine. The focus of the inquest was on the manner of F's death. The inquest sought to understand the circumstances which led him to take his own life, and whether the care and treatment he received in custody for his severe mental illness was adequate.

Throughout the many years of his incarceration, F was chronically and severely unwell with schizoaffective disorder. He had a consistently high risk for suicide. His mental illness was complex, and this was well understood by those who treated him in custody. It is fair to say that even had he been living in the community; F's illness would have presented very significant challenges for his clinicians. The central issue at the inquest was whether an inmate such as F, with severe and chronic mental illness, can receive adequate care in a prison environment. The evidence which emerged strongly at the inquest was that the existing model of custodial health services is *not* able to meet the needs of such prisoners.

In this inquest the court was assisted by expert psychiatric evidencefrom:

- Dr Kerri Eagle, consultant forensic psychiatrist and staff specialist with Sydney Local Health District (Mental Health). Dr Eagle's experience includes working as staff specialist psychiatrist at the Forensic Hospital, Malabar NSW.
- Dr Danny Sullivan, forensic psychiatrist, and Executive Director of Clinical Services at the Victorian Institute of Forensic Mental Health. Dr Sullivan has many years' clinical experience working in prisons and forensic hospitals.

In addition, the court received assistance from the evidence of:

- F's treating psychiatrist for many years, Dr Jeremy O'Dea. Dr O'Dea has provided psychiatric services to prisoners since 1993

- Dr Sarah Jane Spencer, forensic psychiatrist, and the Clinical Director of Custodial Mental Health. Custodial Mental Health [CMH] is the specialty service within the JH Network which provides mental health services to NSW prisoners.

Dr O'Dea's and Dr Spencer's many years' experience providing mental health care in NSW correctional centres lends significant weight to the evidence they gave at the inquest.

F's life

F was born on 4 April 1968 at North Sydney and he had a sister M. By the time he entered custody at the age of 33 his relationships with his family were very complicated. Nevertheless, it is apparent that his sister M cared about him and she attended each day of the inquest. In addition, F's mother maintained close contact with him throughout his life in prison, initially with prison visits and in his later years by telephone.

When he was a child of ten years, F's young life was altered tragically and forever. He and other children suffered sexual abuse at the hands of a gymnastics teacher. The offender faced trial and was convicted, with the help of F's evidence. However, F's sister said he never recovered from these terrible experiences. In his late teens F became socially isolated and began to show signs of psychiatric illness. He attempted to take his own life when he was nineteen and was admitted to hospital, where it was thought he may be suffering schizophrenia. He tried to take his own life again in 1987 and in 1992. In the opinion of forensic psychiatrist Dr Kerri Eagle, F was by this time suffering severe mental illness. She opined that in retrospect it was likely to be schizoaffective disorder with bipolar characteristics. F met his wife MC in 1993 and they had their first child, a daughter. After their marriage in 1995 they had two further children. The couple separated in 1997 and for some time they maintained a flexible parenting arrangement.

MC commenced a new relationship around July 2001. This angered F and he tried to persuade her to end it. This was the prelude to the terrible events which took place the following month. Over the weekend of 17-19 August 2001 F was to have the care of the three children, now aged 7, 5 and 4. Sometime between 18 and 19 August he killed his children, using sleeping tablets to sedate them and then drowning them in the bath. He was discovered in the home consuming a milky substance, apparently with the intention of ending his own life. F was charged with the murder of his children. The Crown did not accept his offer to plead guilty to manslaughter on the grounds of substantial mental impairment. Following a jury trial F was convicted of three counts of murder. On 13 February 2004 he was sentenced to imprisonment and would not be eligible for parole until 20 August 2028.

F's psychiatric history in custody, 2001 to 2010

F entered custody on 21 August 2001 and received an initial screening assessment. Over the years the diagnoses of his treating psychiatrists varied, but without exception they assessed that he had a very high risk of self-harm and suicide. From 2003 onwards F's treating psychiatrist in prison was Dr Jeremy O'Dea, who came to develop a good understanding of F and his complex mental condition. F told his clinicians that he wanted to die and was thinking about it constantly.

This and other behaviours led to him being periodically admitted to acute mental health units within the NSW prison system. The antipsychotic drug olanzapine was added to his medication regime in 2003.

On 1 March 2005 while in Goulburn Correctional Centre [GCC] F tried to hang himself using a bed sheet which he had tied to the window bars of his cell. He was transferred to the JH Network's Acute Crisis Management Unit in Sydney's Long Bay Prison for treatment and stabilisation. Of note, the Acute Crisis Management Unit assessed F as at high chronic risk of self-harm. They considered it likely his acute risk would fluctuate depending on circumstances, but that his long-term risk was unlikely to dissipate. On F's discharge his clinicians made recommendations for the management of his suicide risk, including being placed in a shared cell. F was then transferred back to GCC.

In 2007 it became apparent that F was not taking his olanzapine. This behaviour recurred many times throughout his incarceration, and frequently led to relapse of his schizoaffective illness. Over the next three years he had seven admissions to the Mental Health Screening Unit and Long Bay Hospital's Mental Health Unit. These were for management of relapse of his mental illness, paranoia, bizarre behaviour and risk of self-harm and suicide. He was prescribed various mood stabiliser and antipsychotic medications. On many occasions F strongly expressed to his clinicians that he wanted to be housed in a cell on his own. He was persistently anxious about interacting with fellow inmates and being asked about the nature of his offences. For the most part he wished to be left alone. In May 2007 his request for a one out cell was refused by his treating psychiatrist Dr Jeremy O'Dea.

In November 2009 F attempted suicide again. Once again, he tried to hang himself using one of his bed sheets. Of note, it was also found that he had been storing his antipsychotic medication for several weeks. F had another admission to the Mental Health Screening Unit, then returned to GCC on 4 January 2010. For the most part he remained there until his death seven years later.

F's psychiatric history in custody, 2010 to 2017

Over the following years F had further periods in which he refused to take his antipsychotic medication. These episodes were generally followed by relapse of his schizoaffective disorder. He continued to request single cell accommodation.

Of significance is an observation about F which Dr O'Dea documented on 2 March 2011, that:

> *'…longer term management in secure psychiatric hospital [is] likely to be more appropriate than prison'*.

This issue is a very significant one in the inquest and will be examined later in these findings.

In the two to three years prior to his death, F's nursing and psychiatric reviews became much less frequent. He was reviewed by Dr O'Dea in August 2015 and again in December 2015, with Dr O'Dea recording that he was showing some signs of stabilisation. At the latter review Dr O'Dea decided that F could be trialled on unsupervised medication, albeit with '*close monitoring'.*

This meant that when F received his daily medication from JH Network staff, he was no longer required to ingest it under their supervision. Despite Dr O'Dea's recommendation for close monitoring, this did not take place. Moreover, in 2016 F did not have any psychiatric reviews, and was seen just once by a JH Network nurse. The following year on 16 February 2017 F was reviewed by mental health nurse clinician Michael Harris. On his recommendation F was moved into a one out cell.
The appropriateness of this decision is discussed later in these findings.

F's final interaction with the JH Network was a telehealth review with Dr O'Dea on 26 April 2017, four weeks before his death. Dr O'Dea recorded:

'Impression: schizoaffective disorder remains under adequate if not optimum control and set to make full remission'.

He documented a plan to increase F's dosage of olanzapine and to '*continue current treatment with metabolic monitoring'.*

In fact, the last time F received metabolic monitoring was in 2012. At the inquest Dr O'Dea explained that metabolic monitoring is an important element in the care of patients with schizoaffective disorders. As a result of lifestyle factors and medication side effects they require regular monitoring for weight gain, cholesterol and insulin levels.

F's final days

During May 2017 F spoke regularly on the phone with his mother, who was unwell. At about 2.45pm on 24 May 2017 F was locked in his cell, in accordance with usual routine. The next morning at 8.30am a correctional officer opened F's cell door to find him hanging from the cell's window bars. He had again fashioned a ligature from his bed sheet. He appeared to have accessed the cell window by climbing onto the toilet seat below it. Other correctional officers responded immediately and lowered F to the ground. He was unresponsive. JH Network staff arrived and found him pulseless and unable to be revived by CPR or defibrillator. Ambulance officers pronounced him deceased at 8.47am.

I will now examine the issues at the inquest.

The nature of F's mental illness

From their review of F's medical records, Dr Eagle and Dr Sullivan were both of the opinion that F suffered from schizoaffective disorder, bipolar type, and had likely suffered this condition since early adolescence. In her report Dr Eagle noted F's tragic background of childhood sexual abuse. She thought it probable this had given rise to early difficulties with self-esteem and interpersonal relationships. Dr Eagle and Dr Sullivan agreed further that F was at chronic high risk of suicide for the entire period of his incarceration. They concurred that it was extremely challenging to manage such a patient where he or she is serving a long sentence of imprisonment.

F's treating psychiatrist Dr Jeremy O'Dea readily agreed with these conclusions. In his first statement he said:

'I considered [F] to have a severe psychiatric illness and that … he presented a significant long-term risk of suicide. I believe this was borne out in my clinical notes and was indeed a recognised problem in the context of his multiple suicide attempts, non-compliance with medication and relapsing condition'.

What was the appropriate treatment for F?

In her report Dr Eagle described schizoaffective illness as:

> *'…a severe mental illness requiring responsive and coordinated individualised mental health treatment.'*

In her opinion, given the complexity of his illness F required case management involving:

- regular clinical monitoring of his mental state and early warning signs of deterioration and relapse
- regular reviews by a psychiatrist or psychiatrist registrar
- prescription of antipsychotic medication, and psychiatric reviews to monitor for response to treatment, compliance, and side effects
- development of a plan for relapse prevention, risk management and recovery
- collaboration between different stakeholders involved in hiscare.

Dr Danny Sullivan agreed that F needed a comprehensive and coordinated approach which incorporated these elements. Significantly however, he did not consider that such a treatment plan was feasible within the custodial environment. Dr Sullivan did however agree that in the last few years of his life F did not receive adequate nursing and psychiatric reviews. These were not frequent enough to enable an assessment of the stability of his mental health. In her report Dr Eagle had described the reviews as '*of varying frequency'* and:

'… largely reactive to the stability of F's mental state and behaviour, rather than providing regular monitoring of his mental state and compliance… [They] did not appear to be determined with reference to any overall treatment or management plan or for the purpose of monitoring specific early warning signs of relapse'.

Dr Sullivan concurred, characterising F's reviews as '*of high quality and consistency of clinicians, but low frequency'*. It is notable that at the inquest, both Dr O'Dea and Dr Spencer agreed that the frequency of F's nursing and psychiatric reviews was neither adequate nor appropriate. The unanimity of expert evidence on this issue provides a strong basis for me to make this finding.

Notably, the four psychiatrist witnesses were likewise unanimous, that mental health services within the custodial setting could not provide adequate treatment for F's severe illness. I will return to this issue later in thesefindings.

Should F have been placed in a one out cell?

On the face of it, the decision to place F in a one out cell does not appear to represent good management of his high risk for suicide. JH Network policy recognises that placement with a cell mate can be a protective factor against self-harm and can facilitate an early emergency response. On previous occasions F's cell mates had notified correctional officers when he attempted self-harm. However, Dr Eagle acknowledged that there are competing factors in managing suicide risk by way of cell placement. This opinion was endorsed by Dr Sullivan, Dr O'Dea and Dr Spencer, all of whom have extensive experience treating inmates with a high risk of suicide. While placement in a two out cell can mitigate against risk for suicide, this must be balanced against the risk of harm to the inmate or his cell mate. F found the experience of sharing a cell very distressing and had on more than one occasion voiced thoughts of harming his cell mate. For his part Dr O'Dea, who knew F well, considered that F himself was at risk of harm from cell mates, due to his high levels of agitation and anxiety.

I acknowledge that in F's case a decision about cell placement cannot have been a straightforward one. The consensus of expert evidence on this issue does not provide a basis to be critical of the decision to place him in a one out cell, despite his risk for suicide.

Was the management of F's medication regime adequate?

This issue was of significance to the inquest for two reasons. First, for certain periods while in custody F was not compliant with his olanzapine. These periods often precipitated relapses of his illness. Secondly, he was known to hoard his olanzapine and had on at least one prior occasion overdosed on his supplies. The evidence supports an inference that in the weeks prior to his death F had again been stockpiling his doses of olanzapine, sufficient to produce the fatal level found in his blood post mortem. This evidence raised concerns about the appropriateness of the decision, in December 2015, that F could be trialled on unsupervised medication, and the further decision on 4 March 2017 that his medication could be dispensed to him in monthly rather than daily batches. Given F's history, the risks inherent in such decisions are evident.

According to the medical records, on 15 December 2015 Dr O'Dea determined that F could be trialled on unsupervised medications. This meant that F would be permitted to ingest his daily allotment of olanzapine in his own time. Dr O'Dea recorded that staff were to '*continue to monitor closely with regular review'.* Dr O'Dea and Dr Sullivan noted that olanzapine has a significant sedative effect. Supervised medication orders require that inmates receive and ingest their medication within dispensing hours. Providing it on an unsupervised basis permits the inmate to ingest it at a more suitable time, usually before going to bed.

At the inquest Dr O'Dea said that this decision appeared reasonable to him, as in recent times F had been compliant with his medication. However, while this may have been the case, the decision was problematical in circumstances where, despite Dr O'Dea's direction that F be monitored for compliance, this did not take place. The further plan that F could receive his olanzapine in monthly batches appears to have developed after RN Michael Harris discussed it with F on 16 February 2017. A Self-Medication Risk Assessment was performed by visiting GP Dr Scott on 4 March 2017, following which Dr Scott approved the plan. It does not appear that F's treating psychiatrist Dr O'Dea was consulted about this decision or was aware of it. At the inquest Dr Spencer expressed the view that medication decisions of this kind should be approved by the doctor who best knew the patient, and that this would ordinarily be the treating psychiatrist. This also was the view expressed by Dr Eagle and Dr Sullivan. In the present case, it is evident that this ought to have been Dr O'Dea.

Dr Sullivan added that in F's case the decision may not have been inappropriate, provided that F was monitored to ensure that he remained compliant. As we have seen, this did not happen. In circumstances where medication monitoring of F either did not or could not take place, I conclude that the decision that he receive his medication in monthly batches was not an appropriate one. Nor was it appropriate for this decision to be made by clinicians who lacked the familiarity with F that Dr O'Dea had developed. In making this finding I express no criticism of F's individual clinicians. They breached no policies or procedures in making this decision. The shortfall was a systemic one, about which I will make a recommendation at the end of these findings.

F's history of medication non-compliance and previous overdose attempt in 2009 raised the further question, whether his clinicians ought to have considered administering his olanzapine via monthly injections. This mode of delivery would have mitigated the risks of non-compliance and hoarding. The evidence at inquest showed that Dr O'Dea had given careful thought to this course of action and had made a reasonable decision against it. He explained that safe delivery of olanzapine via monthly injection is problematical within prisons, as it requires a 3-4-hour period post administration to monitor for its potential side effect of collapse. Should the patient collapse, there could not be guarantee within a prison of speedy emergency help within a prison. I note Dr Sullivan also highlighted this difficulty when asked about it in his evidence.

Dr O'Dea added that in F's case he had also considered the option of injecting alternative antipsychotics which did not carry this particular risk. However, in his opinion none were suitable for F due to their known side effects of increasing agitation. On the basis of the above evidence, I accept there could not be any criticism of the JH Network or of Dr O'Dea, in deciding that monthly medication injections were not a suitable option for F.

Was a custodial environment capable of providing adequate care for F?

I turn now to an issue which was central to the circumstances of F's death, namely whether his complex mental health needs could adequately be met within a custodial environment. At the inquest the court heard evidence about this from both the psychiatrist experts, and also from Dr O'Dea and Dr Sarah Jane Spencer. All were of the opinion that due to its severity; F's mental illness could not be adequately managed within a prison setting.

I will first outline the evidence heard at inquest about the manner in which custodial mental health care was provided at the time of F's incarceration. The court heard that there have not been any changes of substance since then. The JH Network provides health and psychiatric services to most of NSW's inmates, who according to figures from the Bureau of Crime Statistics and Research NSW, currently number more than 13,000. Visiting psychiatrists are employed to assess and diagnose inmates' mental illnesses and to prescribe medication. Nurses are also employed to review patients and dispense medication. Psychological services on the other hand are mostly provided by psychologists employed by CS (NSW).

The Custodial Mental Health Service [CMH] is the specialist service operating within the JH Network to provide the above services to NSW inmates. It applies a '*hub and spoke*' design. According to this model, specialist mental health facilities provide additional treatment to that provided within the inmate's jail of classification.
Most of these specialist services are located in Sydney.Notably, all are for short stay only.

The court heard from Dr Spencer that CMH specialist services for male inmates comprise:

- the Mental Health Screening Unit (MHSU), a 43-bed mental health unit to assess and manage inmates who are acutely ill, and those with who combine a mental illness with high suicide risk
- Darcy Places of Detention, with 110 beds for inmates at acute risk for suicide or self-harm
- Hampden Places of Detention, a 'step down' unit for up to 138 inmates who no longer need intensive care but are not sufficiently recovered to return to their jail of classification
- the Acute Crisis Management Unit at Long Bay Prison Complex. This has 8-10 beds and is for inmates being managed under a safety protocol, but who cannot be managed within their jail of classification
- The Long Bay Prison Hospital, located within the Long Bay Correctional complex, which has a 40-bed mental health unit for involuntarytreatment.

The '*spokes'* of the CMH model are located at 17 correctional centres, including GCC.

As noted, none of the specialist units is able to accommodate inmates on a long-term basis, due largely to the very high demand for their services. This raises the question, what is available for a patient like F, whose severe and enduring mental illness required long term monitoring and review? At the inquest the court heard evidence about this from the four psychiatrist witnesses. All agreed that under the current model, there did not exist any long-term option which could adequately manage F's complexcondition.

Dr O'Dea explained that a patient like F required long term hospital care, to treat his acute phases and to monitor him through his remissions. In his opinion, with which the other three witnesses agreed, services within prison could not provide this kind of care, for the following reasons:

- custodial mental health resources are very stretched. GCC was typical in that it was resourced to provide only a limited number of psychiatric and nursing clinic hours each month. Care of patients needing long term review was compromised, due to the constant need to prioritise new inmates and patients in relapse or acute phase

- prisons severely restrict the availability of health care for inmates, due to the limited hours they permit inmates to attend appointments. These hours are further disrupted by unscheduled lock downs

- a prison is essentially a punitive environment which imposes significant stress upon inmates, exacerbating the condition of those who are severely mentally ill

- a prison can provide only a very restricted range of treatment options. These are usually limited to prescribing medication and reviewing it. This leaves no room for other elements important for the treatment of schizophrenia, including medication supervision, psychosocial treatment, and social support.

In short, the degree of monitoring which F needed made him unsuitable for treatment within a custodial environment. Yet as Dr O'Dea noted, his status as a sentenced prisoner within the NSW correctional system made him ineligible for any other type of long-term placement, such as a secure psychiatric hospital.

The unanimity of expert agreement on this issue was compelling. I reproduce below a sample of the views expressed by the four psychiatrist witnesses, in their reports and oral evidence.

In his first statement Dr O'Dea commented:

'Whilst a general tenet of forensic psychiatry is that offenders with severe psychiatric illness are more appropriately and effectively treated in secure psychiatric facilities independent of Correctional Centres, this option was not practically available for [F] the long term management of suicide risk, even if high as in [F]'s case, remains a problematic endeavor in Correctional Centres'.

In a supplementary statement he added:
'*… [F] was someone who was not suitable to be managed in a correctional centre. Unfortunately, there was no alternative accommodation, such as a long stay psychiatric facility for sentenced inmates in NSW which could accommodate [F]. This remains the case today.'*

Dr Spencer was of the same view. Her opinion carries significant weight, not only because of her extensive qualifications but significantly, by reason of her role as Director of CMH services in NSW. In a supplementary statement he stated:

'The environment within which custodial patients are accommodated is counter therapeutic: patients are locked in their cells for more than 16 hours a day and their autonomy is severely limited. However, this is the environment within which [the JH Network] provides its mental health service'.

In his report Dr Sullivan expressed a similar view:

'It is noted [F] was treated in mental health settings in prison rather than being treated in mental health hospitals …mental health treatment provided in prison is unlikely to have the same therapeutic benefit as treatment in a secure and specialised non-prison healthcare setting'.

Dr Spencer contrasted this with the model of care provided in the Forensic Hospital at Malabar, which cares for persons who have been found not criminally responsible for their acts due to their mental illnesses. In her supplementary report she said:

'The Forensic Hospital is under the control of NSW Health and both security and health services are provided by [the JH Network] inside the walls of the Forensic Hospital. As a result, [the JH Network] can implement and administer a health-based model.'

In the same statement she provided this striking statistic:

'…There are approximately the same number of equivalent forensic psychiatrists to provide care for the 135 patients in the Forensic Hospital, as there are to cover the 12,000 inmates in the public run correctional centres.'

How did the limitations on mental health resources affect F's care?

The answer to this question may appear self-explanatory, but it was enlightening to hear from Dr O'Dea how resource limitations impacted on his ability to care for F, and for other patients like him.

At the time of F's death, Dr O'Dea was employed to provide only eight psychiatric clinic days over a three-month period within GCC. Dr Spencer provided an additional half day clinic each week delivered via telehealth. According to Dr O'Dea, the bulk of this time had to be given to theassessment of new patients, or of patients who had relapsed into acute illness. As he described it at the inquest:

'*Eighty to ninety percent of my patients need to be seen within the next few weeks. They are very unwell*'.

Dr O'Dea also had to work around the routines of a correctional setting. In practical terms this meant that patients could be accessed for at most four hours within the day, even without the stoppages of unscheduled lock downs. Dr Spencer's oral evidence at the inquest confirmed Dr O'Dea's assessment. As she described it, psychiatrists were restricted to '*putting out fires'*.

Dr O'Dea understood that these restrictions severely compromised his ability to care for patients like F. In his supplementary statement hesaid:

'Ideally if I was treating [F] in the community, I would see a patient in his condition on at least a one to three monthly basis. As a result of the demand on psychiatric services at Goulburn Correctional Centre, however, the frequency of reviews would be dependent on the competing needs of other inmates and it may be 6 to 12 or even more months, between each of my reviews.'

These frustrations were echoed by RN Harris in his evidence at the inquest, which described a similar scarcity of resources for mental health nurses. Dr O'Dea's comments are borne out by the evidence. As we have seen, in the two-year period before his death F received a psychiatric review on only three occasions. Furthermore, it appears that after his psychiatric review on 9 December 2015 no time frame was set for his next appointment. At the inquest Dr O'Dea said that he now tried to document a clinically appropriate timeframe for next review. However, he cautioned that given the limited resources available, there was little prospect of being able to meet such a timeframe.

Question of adequacy of resources

At the heart of this difficulty is the question whether the level of resources for mental health care in NSW is sufficient to provide an appropriate level of care for inmates such as F.

The evidence given by Dr O'Dea, Dr Spencer and Dr Sullivan regarding custodial environments within which they have worked, strongly indicates that it is not. Dr Eagle and Dr Sullivan attested to the high prevalence of mental illness in the inmate population, relative to the general population. Both noted that the incidence of chronic and severe illness in prisons is higher than in the community, in particular schizoaffective and psychotic disorders.

These witnesses attested that in their experience, the prevalence of severe mental illness within prisons had not been accompanied by an equivalence of mental health services. Dr Spencer and Dr O'Dea testified to a high degree of competition within NSW for the services of CMH's '*hub'* facilities, forcing JH Network staff to triage their services based on severity and urgency of condition. In their oral evidence Dr Eagle and Dr Sullivan agreed that given the level of psychiatric services available at GCC, it was unlikely that the needs of a patient such as F could be met.

Further evidence was available at the inquest regarding the adequacy of resourcing for custodial mental health services. Tendered at the inquest was the document about which more will be said later in these findings. This document cited figures from the Bureau of Crime Statistics and Research NSW, showing a steady increase in prison population numbers in recent years.

At the inquest Dr Spencer said that there had not been a commensurate increase in workforce levels to cope with the increased workload. I accept the evidence of the four psychiatrist witnesses regarding the challenges of providing mental health services with an insufficiency of resources. All impressed as caring and dedicated practitioners. Just as importantly, I assess them to be credible witnesses who have extensive relevant qualifications and working experience within prisons.

The conclusion one reaches on the basis of the evidence is that the nature and level of mental health services available at GCC did not and could not provide an adequate standard of care for F. Furthermore, based on the experiences described by the psychiatrist witnesses, there is a strong likelihood that funding for custodial mental health resources has not kept pace withneed.

An alternative psychiatric care model

I have noted above the absence in NSW of a long stay psychiatric facility for the care of inmates like F.

At the inquest the court heard from Dr Spencer about a proposal for an alternative model of mental health care, for patients with what she described as '*serious and enduring mental illness'.* In Dr Spencer's opinion, F's clinical need for intensive mental health support would have placed him within this category.

The proposal has been provided to the NSW Ministry of Health and is still under consideration. If implemented the project will also require coordination with CSNSW. I accept that it would not be appropriate to disseminate evidence heard at the inquest about the proposal before stakeholders including the Ministry of Health have been able to properly consider it. For this reason, I have made interim orders for non-publication in relation to it. In my published findings I refer to the proposal only as '*the renewed model of care'*, and I have redacted my discussion of the evidence in relation to it.

The evidence heard at inquest about the circumstances of F's sad death exposed a gap in mental health services for long term inmates like F. There is no reason to suppose that this shortfall is confined to the GCC. The renewed model of care, in addition to providing a more contemporary approach to mental health care, would help to fill this gap. It represents a significant and practical step in improving the care of seriously ill inmates like F. Its implementation is worthy of support. I accept the submission advanced on behalf of the JH Network, that potential funding of the renewed model of care will be a matter for the Ministry of Health, who is not a party of sufficient interest in this inquest. I will make the renewed model of care the subject of a recommendation drafted in terms which is intended to meet these concerns.

Changes within the JH Network since F's death

Since F died the JH Network has sought to address some of the systemic issues that his death exposed, within the limitations of its resources and funding. These include the following steps:

- development of a new business rule designed to provide better assurance that metabolic monitoring will take place where needed
- introduction of software (Qlikview) to better monitor patientwaitlists
- increased psychiatric and nursing coverage, through use of telehealth services throughout the JH Network

- introduction of electronic medical records to improve informationflow

- a new method of dispensing daily medication via sachets, reducing time pressures on nurses.

In addition, the JH Network has received funding as part of the NSW Government's *Towards Zero Suicides* initiative. This has been applied to create a unit within the Metropolitan Remand and Reception Centre, to house 55 inmates who have a heightened risk of suicide. The new unit, named 'O Block', is to open in the next few months. It is intended that the unit will be less punitive and more therapeutic in its approach, by comparison with the safe cells currently used in NSW's correctional centres.

The question of recommendations

Counsel Assisting the inquest provided closing submissions in which she proposed three recommendations arising out of theevidence.

Proposed recommendation 1

The first recommendation urged the implementation of the renewed model of care, and that it be separately funded and resourced '*independent of the need to reallocate resources from the existing model of care*'.

This recommendation was not supported in submissions advanced on behalf of the JH Network. This was on the basis that:

- the JH Network does not determine its own funding. It operates pursuant to a service agreement with the NSW Ministry of Health, which was not a party of sufficient interest in the inquest

- the JH Network's present funding does not extend to providing care pursuant to the renewed model of care.

I accept that these features preclude me making a recommendation in the existing terms. The JH Network is unable to implement the renewed model of care without the agreement of the Ministry of Health. Nor is the JH Network able to make decisions about the level of its own funding and resourcing. Nevertheless, I wish to provide as much support to the renewed model of care as is available within my role. It cannot be known if F's death would have been averted had he been able to be accommodated in a secure psychiatric environment. However, the evidence was overwhelming that the custodial setting was incapable of providing him with the care that he required. The renewed model of care offers an alternative, with the hope of better meeting the needs of inmates such as himself.

I therefore make the following recommendation:

> *To the CEO of the Justice Health and Forensic Mental Health Network:*
> *That the JH Network use these findings to advance the position before the Ministry of Health that the renewed model of care be implemented in consultation with CS (NSW)*

I have not recommended that the renewed model of care be separately funded and resourced. This is not in any way because the evidence suggested that additional funding for this project and for custodial mental health services generally was not greatly needed. On the contrary, the evidence was compelling that CMH services are overstretched, and that the care that can be provided to severely ill inmates suffers as a result.

I have avoided any recommendation regarding how the renewed model of care is to be funded, because I recognise that the manner in which public funds are to be allocated is appropriately left to the members of the executive government.

I will however provide a copy of these findings to the Ministry of Health for consideration of its contents.

Proposed recommendation 2

The second proposed recommendation was that the JH Network develop a guideline in relation to decisions about unsupervised medication.

The expert evidence regarding F's medication care supports the conclusion that there were gaps in its implementation which may have contributed to his death. I refer here to the decision that he be allowed to take his medication on an unsupervised basis, in circumstances where monitoring of his compliance did not take place. I refer also to the decision that he be permitted to receive his medication in monthly batches without consultation with his treating psychiatrist.

According to submissions advanced on behalf of the JH Network, new guidelines [referred to as *Medication Guidelines published in January 2021*] now mandate that a decision for self-medication be made only by the inmate's prescribing medical officer. But my reading of the extract which was provided within those submissions does not support this interpretation. Clause 6.6.1 of the new Guideline states that the decision is to be made '*by the prescribing medical officer or nurse practitioner, the NUM or delegate and Pharmacy Department staff*'.

Neither this provision, nor the proposal that *changes* to a self-medication program should be made by this group of people, is in my view sufficient to meet the concerns identified in the inquest.

I make the following recommendation:

To the CEO of the Justice Health and Forensic Mental Health Network:

That in relation to patients approved for unsupervised medication, consideration be given to developing a guideline outlining that any alteration to the patient's medication regime in relation to antipsychotic and antidepressant medication be approved by the patient's treating psychiatrist. An alteration includes any modification to the type, dosage or frequency of medication, including any shift from daily to monthly dispensing. Such guideline should be disseminated to JH Network staff and Visiting Medical Officers and incorporated in relevant induction and annual training.

Proposed recommendation 3

The third proposal was that the JH Network consider developing health care plans for patients at GCC who suffer chronic and major mental healthillness.

This recommendation arose from Dr Eagle's advocacy, in her report and oral evidence, for a case management plan for patients like F who require regular monitoring of their mental state and compliance, in addition to a plan for relapse prevention and recovery. Dr Sullivan in his report supported the requirement that there be a chronic health care plan for inmates such as F, to '*reduce the likelihood of further episodes of mental illness.'* In his oral evidence he added that such a health care plan needed element not only as to medication but also preventive measures.

However, Dr Sullivan and Dr Spencer cautioned that the kind of model contemplated by Dr Eagle was not realistic in a correctional setting without appropriate resourcing and funding. The proposed recommendation was not supported by the JH Network for those reasons. Although it appears likely that the proposal for chronic mental health care plans would benefit patients, I recognise that current levels of funding and resourcing make this recommendation unfeasible.

Findings required by s81 (1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity: The person who died is SF .

Date of death: He died between 24 and 25 May 2017.

Place of death: He died at Goulburn Correctional Centre, Goulburn NSW.

Cause of death: He died as a result of hanging.

Manner of death: The death was an intentional self-inflicted death, at a time when he was a sentenced prisoner at Goulburn Correctional Centre.

7. 185430 of 2017

Inquest into the death of John Glen Laurenson. Findings handed down by Deputy State Coroner Ryan.

On 20 June 2017 Mr Laurenson, aged 47 years, died at the Royal Prince Alfred Hospital, Camperdown Sydney. The cause of his death was a ruptured brain aneurysm. At the time of his death Mr Laurenson was a remand inmate of Bathurst Correctional Facility. He had been transferred to hospital after collapsing in his cell on the morning of 16 June 2017.

An inquest into the circumstances of Mr Laurenson's death is mandatory. This is because as an inmate, he relied on authorities to provide an adequate level of care for his health and welfare. In these circumstances an inquest is required to determine whether authorities have discharged their duty.

Mr Laurenson's family has requested that I refer to him as 'John', and this is how I name him in these findings.

The focus of the inquest

In this inquest there was no issue as to the medical cause of John's death. An autopsy report prepared by pathologist Dr Lorraine Du Toit-Prinsloo found that John died as a result of the *'sequelae of ruptured berry aneurysm'*. The radiology report noted extensive basal subarachnoid bleeding.

An aneurysm is a weakness in a blood vessel of the brain, which balloons and fills with blood. It can leak or rupture, causing life-threatening bleeding which can lead to massive brain injury and death.

The focus of the inquest was on the manner of John's death. The inquest sought to understand the circumstances which led to his ruptured brain aneurysm, and whether the care and treatment he received in custody was adequate.

John's life

John was born at Goulburn on 10 February 1970. He was the third child of his parents, and throughout his life he remained close to them. He had two brothers and a sister. He leaves behind two adult children A and B, and a stepdaughter C. John had previously worked in an abattoir but was unemployed when he entered custody on 8 November 2016.

He had a lengthy criminal history, much of it associated with his dependence on narcotics. John also struggled with overuse of alcohol, which led to liver complications. John was loved by his family, and they miss him deeply. His daughter A and son B attended each day of the inquest. At the close of the evidence A shared with the court their memories of their father, while B held up a photograph of him. Their tribute to John was deeply affectionate.

A said: *'People couldn't help but like Dad. He was always joking around and always trying to make others laugh. He loved surrounding himself around people'*. She described weekends and holidays spent with her father, who was *'so much fun to be around'*. They would swim, go fishing and exploring. He was delighted when he became a grandfather to A's two young children. With her brother B he would go rock climbing and playing laser tag. In his spare time John also loved reading non-fiction, especially history.

At the time of his death John's cell mate was T. T also wrote a warm tribute to John, recalling that while in custody John enjoyed reading books and listening to the rugby league on T's radio. John also liked to talk fondly to T about his children and his grandchildren. T described the night of John's death and ended his tribute with the words: '*I never saw John again. As I write this now, I would have been in cell 63 with John now, listening to a game of footy…. I was his last friend'.*

The morning of 16 June 2017

At the time of his collapse John was housed at Bathurst Correctional Centre where he shared a cell with T. At about 8.15am on the morning of 16 June 2017 T awoke to the sound of a loud thud. He looked down from the top bunk to see that John was lying on the cell floor. John did not answer when T called to him. Nor did he move when T shook his shoulder, although his eyes were open. T noticed a blood stain on John's pillow. He knew that John had brain aneurysms and was awaiting an operation. He pressed the cell emergency alarm button.

Correctional officers arrived almost immediately. They found John on the floor, largely not responding to stimuli. Emergency medical assistance was called, first from Justice Health staff and then an ambulance. John was taken to Bathurst Base Hospital, arriving there at 9.24am. Urgent CT scans showed that John had suffered a large intracerebral bleed from the largest of his aneurysms. He was intubated and ventilated, then transferred by air ambulance to Royal Prince Alfred Hospital in Camperdown. He arrived there in a critical condition. Despite emergency surgery at Royal Prince Alfred Hospital, John's condition continued to deteriorate as pressure built up around his brain. He did not respond to medical treatment, and on 18 June his treating team held a meeting with John's family. It was decided to remove his life support. John was given palliative care and he was pronounced deceased at 4.30pm on 20 June 2017.

John's brain aneurysm

John had ongoing medical conditions of high blood pressure, which he managed with medication, as well as depression, anxiety and liver complications as a result of Hepatitis C. Until 2015 John was unaware, he had brain aneurysms. In May that year he suffered injuries from a car crash as he was driving through Nambour in southern Queensland. Imaging of his brain revealed three intracranial aneurysms. It was established that the aneurysms pre-existed John's car accident. In August 2015 John's regular GP, Dr Himmat Moond, arranged for him to have a CT scan of his aneurysms and a follow up neurosurgical review at Canberra Hospital. John attended for the CT scan and neurosurgical review, but he did not attend two subsequent bookings at Canberra Hospital to undergo a Digital Subtractive Angiogram [DSA].

However, on 8 March 2016 John did attend for an MRI scan of his brain. This confirmed that he had:

- a 1.5cm x 2 cm right middle cerebral artery bifurcation aneurysm [a right MCA aneurysm]
- a 3.5mm x 2mm anterior communication artery aneurysm
- a 5mm pericallosal aneurysm.

John was told that he would *'likely require surgical treatment'* for his aneurysms. On 1 April 2016 he underwent a DSA at Canberra Hospital. This identified that in fact he had four brain aneurysms.

It does not appear that anyone at Canberra Hospital arranged a follow up appointment with John for neurosurgical review of the DSA results. In late April 2016 Dr Moond ascertained that this was the case and provided John with contact details to make an appointment with Canberra Hospital's neurosurgical clinic.

John did not make the appointment. The next weeks were disruptive for him and included the following events:

- from 10 April to 27 April 2017 John was an inpatient at Bega Mental Health Unit for depression and issues arising from his alcohol abuse
- on 10 May 2016 he saw a gastroenterologist in relation to his liver impairment due to Hepatitis C.

Then on 27 May 2016 John was arrested on criminal charges and commenced a four-month prison sentence. These events disrupted any orderly follow up of treatment for his brain aneurysms.

In custody: May to September 20

John's prison sentence was for the period 27 May 2016 to 26 September 2016. He served this part of this sentence at South Coast Correctional Centre, Nowra.

While he was in custody John, in common with most NSW prisoners, received his primary health treatment from the Justice Health and Forensic Mental Health Network ['Justice Health']. He had a screening assessment which recorded that he had brain aneurysms. Justice Health staff then requested and received material from Canberra Hospital which included the results of the DSA performed on 1 April 2016. They also sought and received John's medical records from Dr Moond. During this period of incarceration John received treatment for his conditions of hypertension and depression, but he did not receive any treatment for his brain aneurysms.

However, it would not be correct to say that John's aneurysms were ignored. On 1 June 2016 he was reviewed by the visiting GP, who noted that John was *'fully aware of the importance of neurosurgery follow up and is happy to wait until release in September 2016'*. The GP (who was not a witness at the inquest) may have had the impression that John was under the management of Canberra Hospital's neurosurgical clinic, and that given John's release date of 26 September little would be gained by intervening with earlier action.

If this was the GP's assumption, unfortunately it did not quite reflect the reality. John did not have any follow up appointment with Canberra Hospital. Nor does it appear that Canberra Hospital took any action to contact him for follow up after his DSA on 1 April 2016. In this sense, it would not be correct to describe his life-threatening condition as under management.

It can be seen from the above that a complex of factors underlay the failure of Justice Health, during this incarceration, to advance treatment for John's aneurysms. Nevertheless, the effect was that four months passed during which an opportunity was missed for Justice Health to initiate early treatment for John's very serious condition.

In custody: November 2016 to June 2017

Six weeks after being released to parole in September 2016 John commenced another period of custody, after being refused bail on offences allegedly committed in 2013 and 2014. It was during this incarceration that John suffered the fatal rupture of his brain aneurysm.

On 16 November 2016 a Justice Health nurse again completed a reception screening assessment. This noted '*brain aneurysms x 3'* and high blood pressure for which John used medication. The nurse recommended that John be housed in *'a low risk cell/pod where assault could be minimised as the outcome could potentially be fatal if patient sustained injury to the brain'*. In addition, she recommended that he be placed in a '*two out cell'*, meaning that he needed to share a cell with another inmate. The purpose of this was to increase John's chances for emergency help, if he should suffer an episode which incapacitated him.

Both recommendations were appropriate and wereimplemented.

The appointment with Dr Mayer

On 15 November 2016 John had an appointment with visiting GP Dr Linda Mayer. Dr Mayer has been employed with Justice Health since 2011. John was the tenth of her eleven patients listed for review that day. Dr Mayer was aware from John's file that he had a history of '*at least 4 cerebral aneurysms, 2015'*, and that he was in the process of alcohol withdrawal treatment. She was also able to review his DSA and MRI results from Canberra Hospital. In addition, John told her that his maternal grandmother had died of a brain clot.

Dr Mayer found John to be '*reasonably concerned about his health and diagnosis of the brain and neck aneurysms*'. She too was very concerned, and she prepared a referral for John to be reviewed by a specialist on an urgent basis. She also directed that his blood pressure be measured each day, and that he continue his use of blood pressure medication. As a caring doctor, Dr Mayer was also concerned about the hereditary implications of John's aneurysms. She directed that his children be contacted with a recommendation that they undergo screening. Unfortunately, when Dr Mayer prepared John's specialist referral, she erroneously selected the specialist discipline '*vascular'*, and not '*neurosurgical*'.

At the inquest Dr Mayer expressed genuine regret for her error. She explained that she was most likely rushed that day and did not give full thought to what the appropriate specialty would be. Since then, she said, she has paid extra attention to her patient referrals, and has also tried to limit interruptions to her patient consultations. John's appointment with the Vascular Clinic took place at Sydney's Prince of Wales Hospital [POWH] on 22 December 2016. The doctor who reviewed him noted the error of specialty and directed that he be referred to POWH's Neurosurgery Clinic. Unfortunately, the result was a further delay in getting treatment for the aneurysms. John was placed back on the prison wait list to see a visiting GP so as to secure a second, correct referral. The second GP appointment did not take place until 10 January 2017, on which date Dr Mica Spasojevic made a second referral on an urgent basis, this time for a neurosurgical review at POWH. The appointment was fixed for 6 March 2017.

As can be seen from the above, despite Dr Mayer's intention on 15 November 2016 that John receives an urgent specialist review for his aneurysms, he did not receive one for almost four months. One reason for this delay was Dr Mayer's incorrect referral to the Vascular Clinic. Compounding the delay was the Vascular Clinic's referral of John back to the prison GP list to secure a correct referral. Thus, almost a year passed after John's Canberra radiology established a serious neurological condition before he received a specialistreview.

The Neurosurgical Clinic consultation

On 6 March 2017 John was taken to the outpatient Neurosurgical Clinic at POWH. Here he was reviewed by Dr Kyle Sheldrick, a fourth-year neurosurgical registrar.

The court heard that the POWH outpatient Neurosurgery Clinic involves patients being reviewed by neurosurgical registrars. Their cases are then discussed with the consultant neurosurgeon supervising the clinic. On 6 March 2017 the consultant was Dr Peter Wilson. Dr Sheldrick's notes of his review of John are scant. However, on 10 March 2017 he prepared a more detailed letter of his review. This recorded that: John's largest aneurysm was 17mm in diameter (Dr Sheldrick derived this information from Dr Spasojevic's referral form) although previous brain scans existed he had not had access to them at the review, and would arrange for them to be transferred to POWH John was a non-smoker and '*does not have high blood pressure*' he had explained to John that '*these are very serious findings*' and that the large aneurysm '*would almost certainly require treatment*', the real question being what kind of treatment.

Dr Sheldrick's note that John did not have high blood pressure was surprising. At the inquest and in his coronial statement Dr Sheldrick explained that John had replied *'no'* when asked if he had high blood pressure. Yet John was aware he suffered from this condition and had disclosed it, and his medication, in his November 2016 screening assessment. At the inquest Dr Sheldrick did not agree with the suggestion that John may have interpreted his question as enquiring if he had high blood pressure *at that particular time*. Dr Sheldrick agreed he had not followed up with questions as to whether John had a history of this condition, or if he was using medication to manage it.

Dr Sheldrick decided that John's case needed to be discussed at the next Multi-Disciplinary Team [MDT] meeting, which was to take place on 14 March 2017. The purpose of the referral to the MDT was to review John's scans and determine the appropriate treatment for his condition. Dr Sheldrick discussed this proposal with Dr Wilson, who agreed it was appropriate.

The MDT meeting on 14 March

The MDT meeting is a weekly meeting of senior consultants in Vascular and Neurosurgery. The attending specialists manage patients with cerebrovascular pathology from POWH and other hospitals. At this meeting between ten to twenty patients are discussed, usually, according to Dr Wilson, within the space of an hour.

In his statement Dr Wilson described the purpose of the MDT as '*to discuss surgical management and the optimal approach'* to a patient's treatment. Typically, the patients' cases are presented to the meeting by neurosurgical registrars. As Dr Wilson noted, given the limited time available to discuss each patient, the registrar's summary needs to be very concise. Even so the expectation of the MDT members is that the registrar gather and present all available information relevant to the patient's level of risk. Unfortunately, as will be seen, the MDT members did not have before them certain information that was critical to assessing John's risk. According to Dr Wilson, at the meeting on 14 March 2017 the group viewed *'relevant imaging'* of John's aneurysms and discussed his relevant risk factors for rupture. They determined that his large aneurysm required surgical intervention, being craniotomy and clipping. They settled on a plan to bring him back to the Clinic on 23 June 2017 to explain the proposed surgery and to obtain his consent. He would then be booked in for the surgery within 90 days following that appointment.

As we know, John did not survive to make the 23 June appointment. In setting this time table, the court heard that the MDT had reference to international studies which attempt to predict risk of rupture. The MDT members assessed that John's large aneurysm had '*a very low risk of rupture within the total time frame of 6 months'*. Dr Wilson told the court that it is uncommon for vascular aneurysms to change over time, and that John was not showing any alarming symptoms such as severe headaches.

In his second statement Dr Wilson acknowledged that '*in a perfect world'* it would be preferable to treat such aneurysms immediately, but this was not possible given the number of patients to be treated and the limited resources of the public health system.

Expert evidence at the inquest was that in fact, John's risk for rupture of his large aneurysm was high and that he required urgent treatment.

At the inquest Dr Wilson was asked about the factors which the MDT had taken into account in assessing that John's risk for rupture was low. Dr Wilson was largely in agreement with Professor Besser that the most significant risk factors for a patient with an unruptured aneurysm were:

- the size of the aneurysm

- whether the aneurysm was growing
- the existence of multiple aneurysms
- the existence of other features such as hypertension and impaired coagulopathy (the ability of the blood to clot).

With reference to these, Dr Wilson agreed that John's aneurysm was a very large one. He also acknowledged the presence of multiple aneurysms, a further risk factor. He stated however that the MDT had no evidence of other risk factors such as hypertension or impaired coagulopathy. As noted, Dr Sheldrick had recorded that John denied having high blood pressure. And Dr Wilson asserted that there was no evidence that John was coagulopathic.

An important question for the inquest was whether the MDT had access to evidence that John's large aneurysm was growing, a strong risk factor for rupture. Growth can be evidenced by serial scanning. In John's case a comparison between his 2016 scans and those performed in Queensland in 2015 when his aneurysms were first discovered would have shown that the largest aneurysm was increasing in size.

It cannot be known with certainty what images were available to the MDT members when they reviewed John's case. This is because the minutes of the meeting are scant and do not disclose this information. Unsurprisingly given the lapse of time, Dr Wilson was unable to recall this detail. Nor could the hospital records assist him. Dr Wilson explained that in the case of radiology from sources external to POWH, this is uploaded onto the POWH system for review and then removed soon afterwards.

It is however unlikely that the MDT members were aware of the existence of the 2015 brain scans. At the inquest Dr Sheldrick stated that he had not been aware of them, and hence had arranged only for the 2016 scans to be transferred to POWH. He had noted these from Dr Spasojevic's referral. Her referral had not specifically noted the 2015 scans, although their existence might have been inferred from her notation: *'Intracranial aneurysms x 4. Incidental finding post MVA May 2015'.* At the inquest Dr Sheldrick said that if he had been aware of the 2015 scans, he would certainly have obtained them. He was well aware of their high clinical value in assessing John's risk for rupture.

Dr Wilson's evidence provides a further indication that the MDT members did not have the 2015 scans, and hence evidence that John's large aneurysm was growing. Dr Wilson told the court that the plan for John would have been very different if the MDT members had had evidence of growth. He would have recommended that John be immediately admitted as an inpatient to the POWH's Annex for inmates, where he would receive further scanning and, most likely, surgery on an urgent basis. John's family were understandably very distressed to hear that there were opportunities for him to have received treatment for his aneurysms at a stage which may have saved his life.

Was the care and treatment provided to John adequate?

I will now turn to assess whether John received adequate care and treatment for his aneurysms at Canberra Hospital, Prince of Wales Hospital, and while he was in custody.

The court had the assistance of two experts in addressing this question. The first expert was Professor Michael Besser AM, who has thirty years' clinical experience as a consultant neurosurgeon. He was formerly the Head of Department of Neurosurgery at Royal Prince Alfred Hospital, and continues as consultant emeritus neurosurgeon there and at the Royal Alexandra Hospital for Children. The second expert was Dr Laughlin Dawes, a subspecialist neuroradiologist.

He provided relevant evidence about the size of John's largest aneurysm. In his reports and evidence Dr Besser made certain criticisms of the health care John had received.

His overall conclusion in his first report was that '*… earlier medical intervention may have prevented [John's] fatal intracerebral haemorrhage'*, and that delay in treatment for his condition '*contributed significantly'* to his death.

Canberra Hospital

Dr Besser's criticism of Canberra Hospital's involvement in John's health care was two-fold.

First, in his view the reports arising from John's 2016 scans at Canberra Hospital were inaccurate. He considered the DSA report had understated the actual size of John's largest aneurysm and that the more accurate measurement was 2.5cm size in its largest diameter. For Dr Besser, the significance of this was that had the aneurysm's size been correctly reported it would have been classified as a '*giant aneurysm'*, which is associated with much higher rates of mortality. The correct classification would have elevated John's risk for rupture.

Dr Dawes concluded that the maximal external dimension of the large aneurysm was in fact 2.3cm. At the inquest Dr Besser conceded that Dr Dawes had arrived at the more accurate measurement, as he had used a more sophisticated measuring method.

Dr Besser maintained the view that an aneurysm having a 2.3cm diameter required urgent medical review. There was however no real dispute asto this, as Dr Wilson agreed that John's aneurysm was very large and that this increased his risk for rupture.

Secondly, Dr Besser was critical of Canberra Hospital for taking no action to contact John for neurosurgical assessment, after having performed imaging in March and April 2016 which revealed a very serious condition.

It appears this was the case. Dr Himmat Moond's patient notes record that on 22 April 2016 he rang Canberra Hospital's Neurosurgery Clinic and learnt that John had no forthcoming appointments there. When Dr Moond saw John the next week, he reminded him of the need to call the Neurosurgical Clinic for this purpose. However, soon afterwards John was arrested and incarcerated at South Coast Correctional Centre. It is of course important that individuals accept responsibility for their own health care, and that this be encouraged by health clinicians. It is also acknowledged that John had previously missed appointments booked for him at Canberra Hospital.

However, given the seriousness of John's health situation as disclosed by the Canberra Hospital radiology, and the disruptive circumstances of his life due to his mental health and substance dependencies, there may be a case for health organisations to take a more proactive approach in cases like his. Had this happened in John's case, it is likely he would have received a neurosurgical review during the period he was at South Coast Correctional Centre, several months before his appointment at POWH in March 2017.

NSW Coroners have no jurisdiction to make recommendations to persons or organisations outside NSW. However, in submissions advanced on behalf of Canberra Hospital, Ms Gerace of Counsel told the court that Canberra Hospital would review the findings made in this inquest, with a view to considering whether any changes to its procedures in this area would be appropriate and feasible. I welcome this invitation and will forward these findings to the Director- General of Canberra Hospital.

Justice Health

I have noted that during John's incarceration from May to September 2016, Justice Health did not take any steps to arrange specialist review of his aneurysms, of which its staff were aware. During this period John did receive appropriate treatment for his other medical and psychological conditions, in particular his hepatitis. Furthermore, Justice Health clinicians may have been under the impression that John was under the active management of Canberra Hospital for his aneurysms. These circumstances provide some explanation for their lack of action. Even so, John's incarceration presented an opportunity for him to receive a timely specialist neurosurgical review of his life-threatening condition. It is for this reason that Counsel Assisting has proposed a specific recommendation which is discussed later in these findings.

As regards John's care and treatment during his incarceration commencing in November 2016, this has been described above in some detail. During this period Justice Health staff took active steps to advance the treatment of John's aneurysms. Unfortunately, as noted, Dr Mayer's error in making an incorrect specialist referral resulted in a delay of many weeks before this could happen. Dr Mayer's error provides a further basis for the recommendation proposed by Counsel Assisting. The purpose is to provide clear guidance to visiting GPs that in the rare cases where they are presented with an inmate with aneurysms, neurosurgery is the correct discipline to which that inmate should be referred.

Prince of Wales Hospital

In his reports and evidence Dr Besser was critical of certain treatment decisions made in John's case within POWH. His principal criticism was the failure of the MDT members to place John in a higher risk category for rupture. While Dr Besser fully approved Dr Sheldrick's decision to refer John's case to the MDT meeting, he asserted that there was no evidence that the MDT members had taken into account John's additional risk factors of hypertension and coagulopathy, nor the evidence of growth which would have been evident from a comparison between the 2015 and 2016 scans. Had they done so; his condition would have been treated with the urgency it required.

At the inquest Dr Wilson agreed that hypertension was a risk factor for rupture of an aneurysm but maintained there was no evidence before the MDT that John suffered this condition. This is correct. As noted, Dr Sheldrick had incorrectly recorded that John did not have hypertension. There is no reason to disbelieve Dr Sheldrick's evidence that when he reviewed John, John had denied having high blood pressure. However, it would have been preferable if Dr Sheldrick had followed up his question with further ones which would likely have clarified that John did indeed suffer from hypertension, albeit medicated.

This was a missed opportunity to obtain accurate and relevant information for the benefit of the MDT. I note Dr Wilson's evidence, that even had John's hypertension been known to him this would not have altered the MDT's treatment plan or the time table for it. The likely response would have been to direct that John's blood pressure be monitored on a daily basis.

Regarding coagulopathy, it is correct that the material presented to the MDT did not record any such impairment. However, both Dr Wilson and Dr Sheldrick asserted that this correctly presented the situation. John's last recorded measurement of his INR (a measure of clotting ability) was taken in February 2017. Although the notation on the report interpreted John's measure as outside the normal range, Dr Wilson and Dr Sheldrick disagreed with this. As a result, the evidence remains unclear on this point, and does not enable me to find that the additional risk factor of coagulopathy was present in John's case.

Among the medical witnesses however there was no disagreement that progressive enlargement was a strong risk factor for rupture and was a determinant for urgent intervention. The evidence establishes that this feature was present in John's case. Dr Besser and Dr Dawes had each examined John's scans performed in 2015 and 2016 and confirmed that his large aneurysm was increasing in size.

At the review on 6 March 2017 Dr Sheldrick did not elicit from John that relevant radiology had been performed in 2015. Dr Sheldrick was therefore unaware of its existence. It followed that the MDT members were likewise unaware of the critical information which this material would have provided. I have referred to Dr Wilson's evidence, that had he had access to the 2015 scans his treatment plan would have been a much more urgentone.

At the inquest Dr Besser declined to be critical of any of the individual doctors for the absence of the 2015 imaging. He acknowledged that developing a proper treatment plan in the absence of sufficient imaging is a difficult task. He regarded the incomplete nature of the material before the MDT as the result of systemic shortfalls which will unfortunately occur from time to time in a public health system that has limited resources. Having carefully reviewed the evidence, I accept that on the basis of the material before the MDT members on 14 March 2017, it cannot be said their treatment decision was an unreasonable one. But it is very unfortunate that a series of missed opportunities led to the absence, at this critical meeting, of material that was highly relevant to John's level of risk. The result was that treatment for John's aneurysms, already delayed, was delayed still further. Dr Besser's remaining criticisms were directed at the systems in place at POWH.

In his opinion, John's case demonstrated that POWH did not provide the registrars of its Neurosurgical Clinic with sufficient clinical support and supervision. In his view it would have been better for a patient with John's complex presentation to have been reviewed by a senior specialist.

Dr Martin Mackertich, who is the Director of Clinical Services at POWH, gave evidence at the inquest in rebuttal of this criticism. He described the outpatient Neurosurgical Clinic as a '*consultant supervised'* clinic, where registrars have 'in person' access to a consultant at all times. In his view this arrangement represented the most appropriate use of the resources available.

Furthermore, as a fourth-year neurosurgery registrar Dr Sheldrick was expected to have the expertise and experience to competently review a patient such as John and prepare his case for presentation to the MDT. Dr Wilson concurred with this opinion and agreed with Dr Mackertich that a review performed by a consultant rather than an experienced registrar would have made little or no difference to the outcome.

Secondly, Dr Besser described as '*poor*' the minuting system used by the MDT members to record their decisions. It did not permit identification of the neuroradiological images discussed for each patient. Nor did it require the members to document their reasons for the treatment decision at which they had arrived.

POWH has acknowledged the need for improvements to the quality of the MDT documentation. Dr Mackertich told the inquest that a new template document was being developed at POWH for use at the MDT meetings. The new template will now identify the medical officer who will be responsible for arranging and actioning follow up and assessments. The new template will also require that the imaging which has been reviewed is identified. Discussions are underway as to how the template will also document detail as to the clinical reasons for the treatment plan.

These are positive developments and obviate the need for me to make any recommendations regarding the form of MDT minutes.

Conclusion re care and treatment

I accept the submission of Counsel Assisting, that the evidence does not provide a basis for overt criticism of any of the individuals involved in John's care. There were however opportunities for John to have received more timely treatment for his condition of aneurysms, which may have prevented his death.

These were, first, the absence while he was in custody of referral to a specialist, followed by referral, during his second incarceration, to an incorrect specialty. John was then subject to a treatment plan which, for the reasons set out above, did not take account of information that was highly relevant to his level of risk and failed to provide him with the urgent response he required. The question then is whether there is a basis for making recommendations that are necessary or desirable, arising out of John's untimelydeath.

Question of recommendations

At the close of the evidence Counsel Assisting proposed a single recommendation. Three further recommendations were proposed in submissions on behalf of John's family.

Recommendation proposed by Counsel Assisting It was proposed by Counsel Assisting that Justice Health consider introducing a policy that, in cases where an inmate has a known brain aneurysm or where such an aneurysm is discovered during a period in custody, the inmate be referred to the visiting GP as soon as possible, and then be referred for urgent review by a specialist neurosurgeon.

The rationale for this recommendation can be found in the evidence. First, as an experienced and caring GP Dr Mayer recognised that John's condition needed urgent referral to a specialist. Unfortunately, she selected the wrong type of specialist. The proposed recommendation would provide clear guidance to Justice Health staff as to the appropriate specialty in such cases.

Secondly, for reasons which have been described, the South Coast Correctional Centre did not take action to ensure that John's life-threatening aneurysms received the early treatment they required. The proposed recommendation would provide clear guidance to Justice Health staff that early specialist referral for this condition is important.

Dr Besser and Dr Wilson agreed that visiting GPs could not be expected to make the risk assessment required in such cases, and that it was therefore important for inmates with this condition to be sent for specialist neurosurgical review. Dr Wilson stated further that the incidence of aneurysms within the inmate population is likely very low, and that therefore implementing this policy would not involve a significant increase in resources.

This recommendation was supported by John's family. It was not supported by Justice Health, on two grounds. The first was that the proposed recommendation contravened the principle that patients have the right of autonomy over their own health needs, a right that, it was submitted, was not removed when a person entered custody. The question of specialist referral for John had been considered at South Coast Correctional Centre, but John was, on the submission of Mr Bradley, under active management in the community and was content to wait until his release in September 2016.

However, the evidence does not support that John was under active management at Canberra Hospital while he was an inmate at South Coast Correctional Centre. Even if he was, that will not necessarily be the case with other inmates who live with this life-threatening condition.

The second basis was that the prosed recommendation was inconsistent with Justice Health policy that treatment pathways for inmates generally be reserved for those conditions where the custodial environment elevates the risk profile for adverse events. On this basis Justice Health has developed treatment protocols for conditions such as asthma and heart disease. Where this was not the case, there was no basis to develop treatment protocols that were applicable only to GPs working in the prison setting.

Contrary to this submission however, the inquest heard evidence that the custodial environment *does* increase the risk profile for inmates with brain aneurysms. Head injury from assault was clearly recognised as a risk factor for rupture when Justice Health staff recommended for John a 'two out' cell placement in a low risk environment. In my view the need for this recommendation is supported by the evidence, including that of the two neurosurgeon witnesses Dr Besser and Dr Wilson. It is appropriate and desirable, and I intend to make it.

The family's recommendations

Three further recommendations were advanced on behalf of John'sfamily.

The first was that Justice Health ensure that recommendations are made to Corrective Services NSW to detain prisoners with known life-threatening conditions at a metropolitan correctional centre. Underpinning this recommendation is the distress John's family must have felt, knowing that when he suffered his fatal rupture, he was at Bathurst Correctional Centre and had to be air-lifted to an appropriate treating hospital in Sydney. The family's distress is very understandable, but I do not consider this recommendation can feasibly be made in this inquest. I did not hear evidence of how many NSW inmates suffer a life-threatening condition, by comparison with the number of placements available in metropolitan prisons. In addition, there are no doubt many other factors to be taken into account when deciding inmate placement, including proximity to family. The evidence was not sufficient for me to be able to find this recommendation to be appropriate.

The second proposal was that the Minister for Health review funding for Justice Health GP clinics to ensure they can provide the highest standard of general care. At the inquest Dr Mayer told the court that while working at the Main Clinic at South Coast Correctional Centre she was often rushed, sometimes had to borrow equipment from other consulting rooms at the Clinic, and usually could not access the midday peer support teleconference because she was reviewing patients.

Despite this, I did not hear sufficient evidence to be in a position to find that the Clinic was not sufficiently resourced. Thirdly, it is proposed that the Minister for Health advocate for discussion of improved medical record sharing at the national level. This proposal was prompted by the absence of the 2015 scans when the MDT members formed their risk assessment of John's condition. The family's submission was that there did not appear to be any system for the POWH staff to search for and obtain John's medical images from Queensland. The consequences of the absent 2015 scans were indeed very significant. It appears to me however that improved medical record sharing was the purpose of the My Health Record scheme, implemented nationally in 2016. The scheme provides for a centralised database of personal health records and allows a healthcare provider such as POWH to access online a patient's records from elsewhere in Australia.

It is possible that in 2017 there was not yet sufficient capacity for this scheme to be used by POWH staff to identify and access John's 2015 scans. I did not hear evidence on this point, or on the related one of whether this course would now be possible and would remedy the problem exposed in this inquest. Given the uncertainty, I am not able to adopt this proposal.

Finally, there were two other matters that did not go to the manner of John's death but were important to his family. The first was Dr Mayer's request in 2016 that John's children be made aware of his aneurysms and consider being screened for it. For reasons which are unclear, Dr Mayer's request was not put into action. Certainly, John's daughter and son were unaware of it. This was an unsatisfactory failure of communication.

Secondly, John's daughter A and his son B experienced additional distress during John's last days and hours, by behaviour of the attending Corrective Services officers which they found discourteous and insensitive. A wrote that while she and B were with John, the officers in the hospital room were watching videos on their mobile phones with the volume turned up. At times they were laughing. This was hurtful and distressing to A and B as they attended their father in his last hours. Mr Terrence Murrell, General Manager of Corrective Services' Statewide Operations, provided evidence of policies which mandate courteous and respectful behaviour on the part of officers who are supervising an inmate patient. He advised that in response to the concerns raised by A, the current policies have been referred for review. This will involve consideration of whether further training of officers is required. The family welcomed this response, as do I.

Findings required by s81 (1)

Identity
The person who died is John Laurenson.

Date of death:
John Laurenson died on 20 June 2017.

Place of death:
John Laurenson died at Royal Prince Alfred Hospital, Camperdown Sydney.

Cause of death:
John Laurenson died as a result of the sequelae of a ruptured brain aneurysm.

Manner of death:
John Laurenson died of natural causes, at a time when he was a prisoner on remand at Bathurst Correctional Centre.

Recommendation pursuant to section 82 of the Act

To the CEO, Justice Health and Forensic Mental Health Network:

That consideration be given to introducing a policy requiring that where an inmate has a known brain aneurysm, or where a brain aneurysm is identified during an inmate's period of custody, the inmate is referred to a GP Clinic as soon as possible and then referred for urgent review by a specialist neurosurgeon.

8. 188495 of 2017

Inquest into the death of MH. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 15th July 2021.

Introduction

These are the findings of inquest into the death of whom I shall refer to in these findings as "MH".

MH was only 22 years old when he died by hanging in his cell at Goulburn Correctional Centre ("Goulburn CC") on 23 June 2017. He was being held on remand, having been refused bail at Goulburn Local Court on 21 May 2017 and was due to next face court on 1 August 2017. Immediately prior to his incarceration at Goulburn Correctional Centre, MH had been an inpatient at the Chisholm Ross Centre, a hospital based mental health facility. MH had struggled with mental health issues since his teenage years. His diagnosis, at the time of his death, was severe chronic schizophrenia with substance use disorder resistant to treatment.

In the preparation of these findings, I have been assisted by the written submissions of counsel assisting and the submissions of the legal representatives of the interested parties. MH's mother, "RH", attended each day of the inquest and her love for her son was evident. It was also evident that she went to extraordinary lengths to obtain care for her son and was a tireless and skilled advocate on his behalf. Also, in attendance in Court were other members of MH's family, including his aunt's "B" and "L", who alongside RH, tried so hard to help MH as he struggled throughout his tragically short life to deal with the impact of his illness. I extend my sincere condolences to RH and to the other members of MH's family.

The nature of an inquest

An inquest was required to be held because it appeared MH died whilst in lawful custody (s. 27(1) (b) and 23(1) (a) of the *Coroners Act 2009*). The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to: The identity of the deceased person; The manner and cause of death. A secondary purpose of an inquest is to consider whether it is "necessary or desirable" (s. 82) to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The Proceedings

The hearing of the inquest into MH's death was held at the Coroners Court of NSW in Lidcombe on 8 – 11 March 2021. An issues list was distributed to parties identified as having a sufficient interest in the proceedings.

The issues, in addition to the findings required by s. 81 of the *Coroners Act 2009*, were as follows:

- Whether MH's death was intentionally self-inflicted and/or was precipitated by a mental illness episode.
- The adequacy of the intake process at Goulburn Correctional Centre in May 2017, including as to the assessment of MH's risk of self-harm and steps to minimise that risk.
- Whether the monitoring and clinical management of MH was appropriate and otherwise in accordance with best practice in the context of MH's history of self-harm and diagnosis of chronic schizophrenia.
- The adequacy and appropriateness of communications between MH and CSNSW staff, in particular, communications conveying to MH on 21 June 2017 that his mother declined further contact.
- The effect, if any, on MH on the level of Zuclopethixol detected in his blood post mortem.
- Whether MH was appropriately housed at Goulburn Correctional Centre.
- Whether all appropriate measures were taken to remove self-harm implements and hanging points from the cell occupied by MH.
- Whether it was clinically appropriate that MH was discharged as an involuntary patient from the Chisholm Ross Centre.
- Any recommendations necessary or desirable pursuant to s. 82 of the *Coroners Act 2009*.

Background of MH

Family Background

MH was born on 6 July 1995, to parents RH. MH's biological father was not involved in his upbringing. In raising MH, RH was greatly assisted by her mother and sisters. RH described her sister B as a "second mother" to MH and he lived with B during his teenage years. It was during his teenage years that the symptoms of MH's illness began to emerge. This was a confusing and challenging time for MH and his family. MH was diagnosed with schizophrenia and was medicated for his illness. He then spent time as a resident in a number of mental health facilities. RH told of how, over the remaining years of MH's life, she would continue to seek out various treatment programs for MH.

Directly related to his mental health issue, MH struggled with drug addiction, and from time to time relapsed into drug use, which in turn adversely impacted on his mental health.

Criminal and Mental Health History

In March 2016, MH entered the custody of CSNSW for the first time in relation to breaching an apprehended violence order. He was released later the same day. Between 16 March 2016 and 21 May 2017, MH had six short periods of custody.

MH was held at the Queanbeyan Court Cells on two occasions and the remainder of the time at Goulburn CC, Parklea Correctional Centre and the Metropolitan Remand and Reception Centre ("MRRC").

On four of those occasions a Reception Screening Assessment ("RSA") was conducted by Justice Health nursing staff. MH's medical record discloses problematic substance use, a history of self-harm, behavioural issues, and medication non-compliance. The majority of his offences related to domestic violence and breach of apprehended violence orders.

MH was again detained in Queanbeyan Court Cells on 2 – 3 August 2016. A self- harm incident was recorded on 2 August 2016; however, the nature of that incident is unclear.

4 June 2016 – First admission to Goulburn Correctional Centre

On 4 June 2016, MH was taken to Queanbeyan Court Cells and later detained at Goulburn CC for about three weeks. Correctional Officer David Hall recorded that during the intake interview:

"I asked him if he would self-harm in our custody and he replied, 'how can I, I got nothing to cut myself with.'"

MH was seen by Dr Jeremy O'Dea on 14 June 2016. Dr O'Dea is an experienced forensic psychiatrist. He has worked the custodial setting since 1996. Since 2006, he has been contracted to provide approximately three psychiatric clinics each month to the Goulburn CC.

Dr O'Dea recorded the following in MH's medical record:

"He presented with a blunted affect, disorganised thinking, limited rapport, and limited insight. He has been remanded to custody charged with breach of AVO and has been threatened by cellmates who claim he has been talking to them about the devil. He has also been observed by nursing staff to be responding to auditoryhallucinations."

Dr O'Dea considered MH's diagnosis to be "severe chronic treatment resistant schizophrenia with evident negative syndrome complicated by substance use disorder." Dr O'Dea considered MH's symptoms to not be under adequate control and began the process to have him transferred to a secure psychiatric facility under the *Mental Health Act 2007*. However, before this could occur MH was released from custody and the referral lapsed.

November 2016 – Second admission to Goulburn Correctional Centre

MH was again admitted to Goulburn CC on 26 November 2016. He was charged with contravene apprehended domestic violence order ("ADVO"), destroy or damage property, and common assault.

On 27 November 2016, MH was served with a final domestic violence order in relation to his aunt L and was prohibited from going within 50 metres of her home. MH reported "I had a binge before being locked up". He reported recent use of alcohol, heroin, speed, ice, and cannabis. MH was medicated with Zuclopethixol (Clopixol) an antipsychotic. He was released on 6 December 2016.

December 2016 – Third admission to Goulburn Correctional Centre

On 30 December 2016, MH was convicted of a number of offences. He was sentenced to bonds for common assault and destroying property and to a fixed term of seven months imprisonment for contravene ADVO.

MH was detained in Goulburn CC from 30 December 2016 to 27 March 2017.

On 3 March 2017, MH was found slumped inside a plastic tub, holding a pair of snips, having cut his own calf, forearm, and side of the throat. An incident report suggested that MH kept changing his story, from doing it to himself to alleging someone else had harmed him. CSNSW staff concluded that the wounds were self-inflicted. MH was treated in the clinic and then placed in an observation cell. On 5 March 2017, MH was seen by the Risk Assessment Intervention Team ("RAIT") where he presented as settled and denied suicidal or self-harm ideation. He was discharged into a normal routine and normal cell placement.

On 20 March 2017, psychiatrist Dr Gordan Elliot provided a report to the Local Court, in preparation for a hearing on 27 March 2017. For the purposes of preparing his report Dr Elliot was provided with a statutory declaration from B who expressed her "despair about his persistent ill health and chaotic lifestyle". Relevantly Dr Elliot opined: MH presented with ongoing auditory hallucinations and persistent delusional beliefs and mild formal thought disorder, consistent with a diagnosis of chronic schizophrenia; it would be unlikely he would currently be considered for admission to an inpatient unit.

There were no reasonable grounds to believe MH was a mentally ill person within the meaning of the *Mental Health Act 2007*; and,

MH fulfilled the criterial for a diversionary order under s. 32 of the *Mental Health (Forensic Provisions) Act 1990*. That order should include, amongst other conditions, that MH attend an initial psychiatric assessment … and dutifully attend all subsequentappointments".

Upon MH's release from custody, RH arranged to rent him a flat and equipped it with furniture and other essentials. Shortly thereafter, MH contacted Police and told them his neighbours were trying to kill him. Police took MH to hospital, however, he absconded from the emergency department because he believed the radio waves would kill him. RH met MH the next morning for breakfast andit was evident to RH that he was experiencing hallucinations and hearing voices. RH then contacted the Police.

Admission into Chisholm Ross Centre – 11 April 2017

On 11 April 2017, MH was brought by Police to the Chisholm Ross Centre, a mental health unit located at Goulburn Base Hospital. MH presented with an acute psychotic episode. His diagnosis was schizophrenia complicated by substance abuse and medication non-adherence. MH was admitted and scheduled as an involuntary patient under the *Mental Health Act 2007.*

MH was admitted under the care of Dr Shweta Sharma. At that time Dr Sharma worked only one day a week at Chisholm Ross, Fridays, and would personally interview MH each week.

Dr Sharma gave evidence that when she first saw MH on 13 April 2017, she considered him to be mentally ill for the purposes of the *Mental Health Act 2007*. Dr Sharma described MH's presentation as very guarded, very suspicious, and not very engaging in terms of verbal engagement.

He looked very unwell, as if he were responding to internal stimuli and was very scared. Dr Sharma received reports from nurses of bizarre behaviour in the form of looking suspiciously at the CCTV and talking about radiations from a microwave.

She concluded that MH had ongoing psychosis in the form of persecution and bizarre delusions involving the CCTV, microwave radiations. He remained a risk to himself and others. Dr Sharma commenced antipsychotic treatment in the form of Zuclopethixol (Clopixol) and his dosage was increased from 300mg to 400mg administered weekly.

On 2 May 2017, MH was brought before the Mental Health Review Tribunal ("MHRT"). The MHRT determined MH was to be detained for five weeks with a further review on 30 May 2017. It was noted that he was to be assessed for rehabilitation for drugs and alcohol. Dr Sharma gave evidence that 30 May 2017 was the maximum period for which they were permitted to detain MH and the MHRT did not prescribe a minimum period of detention. It took roughly a month to get MH's symptoms under control. In her statement, Dr Sharma said that MH's treating team had noted consistent improvement to his psychotic symptoms in the days (roughly a week) prior to hisdischarge.

A progress note made by Dr Sharma, on 19 May 2017, records:

"MH was seen with Dr Chan, RMO … Had interview with Dooralong rehab services yesterday and he was positive that he will be accepted … He is on a CTO and has a high risk of relapse and non-compliance. A stable accommodation will assist in assertive long-term management post discharge.

Awaiting D & A rehab placement and stable accommodation.

No leave, has ongoing tendencies to break the ward rules … He may be discharged on a depot once a suitable accommodation is found."

In Dr Sharma's view, MH's problem behaviours persisted despite minimal overt psychotic symptoms. The problem behaviours included rule breaking such as keeping mobile phone in the unit without permission and using illicit drugs in the unit. In Dr Sharma's opinion "this pattern is typically observed in patients with personality disorder which then contributes towards behavioural issues, regardless of mental illness."

In relation to the presence of negative symptoms, Dr Sharma told the court that "that is a symptom that can last almost forever which such level of illness that he had, and that doesn't actually contribute to the risk, so we do not use those negative symptoms as a reason to detain someone as mentally ill."

Dr Sharma accepted that MH's continuing use of illicit drugs was linked to his mental illness "indirectly." Dr Sharma told the Court: "*It was getting more and more difficult as his psychotic symptoms were improving, because with improvement in his mental state he was entitled to have less restrictions, which means a little bit more time out of the hospital.*

He was quite young to have had that freedom, and when we tried that it ended up him bringing drugs into the unit and also managing to get drugs from other patients who were on leave when he was not granted leave. So, it was getting harder and harder for us to put the restraints on him without having seen the direct delusions or hallucinations."

Dr Sharma said that she attributed MH's history of self-harm to direct psychotic symptoms that that he was very distressed with and that he would self-harm to avoid those symptoms. On 20 May 2017, MH was charged with 'assault with an act of indecency' and 'common assault'. The allegation was that he assaulted a female patient by grabbing her and putting his whole right hand between her legs, pushing her against a wall. Following the alleged incident, Chisholm Ross staff contacted Police.

Dr Mohy-Ud-Din was the registrar on duty at Chisholm Ross on that date. He reviewed MH recorded and noted in MH's records: "No indication or evidence of psychotic illness the factor for last night incident & this seems to be behavioural (treating Psychiatrist also believes the same).

NOTE: Dr Shweta Sharma (Psychiatrist) does not have any problem with police charging MH for last night's incident. Dr Sharma reports that MH has been getting away (*sic*) for a long time due to his Dx of Schizophrenia, but there is no current evidence of acute psychosis. MH is currently in CRC only because treating team was awaiting stable accommodation for him.

Plan

D/W Dr Shweta Sharma (Staff Specialist):

Can be discharged to police custody as no evidence of acute psychosis at this stage

If police decides to release MH over the weekend, then to bring him back to CRC

If goes to prison or police custody, CTO will continue."

Dr Sharma explained that the reference to a CTO was in fact a reference to the mental health plan made on 2 May 2017.

Dr Sharma told the Court that the decision to charge MH was made by Police and not her. She agreed that it was possible that if Police had been informed that MH was mentally ill at the time of the incident that it may have made it less likely he would have been charged. However, because his symptoms were improving and staff had been noticing improvement in the preceding few days, they did not believe MH's mental state had any direct connection to the incident.

Ms. Lewer put to Dr Sharma that as soon as it is thought that a person is no longer mentally ill there is an obligation to cease their involuntary detention. Dr Sharma answered:

"You can use the Mental Health Act in so many different ways. He could not be let out in the community homeless just because he was no longer mentally ill for that legal definition. I had to keep him in the unit until I could discharge himsafely."

Dr Sharma agreed that she considered that she could discharge MH safely on 20 May 2017 because she believed he was going to be held in prison and would continue to receive treatment.

Dr Sharma told the Court that she was aware that the treating team at Chisholm Ross had contacted RH about MH's pending discharge and that she had made sure the family were aware. Asked by Ms. Lewer whether she consulted with RH before determining to discharge MH, Dr Sharma said that this was "not a planned discharge with full usual obligations", there had been an assault on a patient in the unit and she did not wish to hinder the Police process.

MH was refused bail and entered the custody of CSNSW at Goulburn CC on 21 May 2017. He remained on remand until his death. The reasons noted by Police for refusing bail include that MH's treating doctor told Police that MH was not mentally ill at the time of the alleged offending and that he was only a resident at the Chisholm Ross Centre as he had no stable accommodation. Counsel Assisting submits that there is no proper basis to criticise Police for the bail decision. Police were alerted to a potentially serious sexual offence by staff at the Chisholm Ross Centre.

MH had allegedly committed an offence whilst on parole and whilst subject to a good behaviour bond. Although a breach of parole report was not created, there was a proper basis for Police and the Magistrate to refuse bail. I accept that submission. It is not the role of this Court to go behind that decision making. Dr Sharma's role in the discharge of MH from the Chisholm Ross Centre is considered below.

Issue (h) - Whether it was clinically appropriate that MH was discharged as an involuntary patient from Chisholm Ross Centre

Counsel Assisting submits that whilst it appears that MH's psychotic symptoms did improve whilst he resided at the Chisholm Ross Centre, there were signs in the medical notes that some delusions persisted, and that his mood was labile. This was understandable in circumstances where MH continued to use illicit drugs. However, Counsel Assisting does not invite me to criticise the doctors involved in MH's care as they are required to make difficult decisions in an environment that is less than perfect, and to balance freedoms for a young person with an effort to treat patients.

Ms. Lewer makes three broad submissions. First, that I should find that MH should not have been discharged from the Chisholm Ross Centre because this was not in accordance with the *Mental Health Act 2007* or best clinical practice and that the decision to discharge MH contributed to his death. Ms. Lewer submits there was no plan to discharge MH before he committed the alleged assault and that if MH were not mentally ill for the purposes of the *Mental Health Act 2007,* he was being unlawfully held as an involuntary patient before discharge. Ms. Lewer submits that the more compelling explanation is that MH remained a "mentally ill person" and that is why Dr Sharma instructed Police that if MH were to be released from custody he was to be returned to Chisholm Ross. Secondly, Ms. Lewer submits that Dr Sharma breached s. 79 of the *Mental Health Act 2007* in failing to consult with RH before MH's discharge from the Chisholm Ross Centre. Thirdly, Ms. Lewer submits that Dr Sharma failed to take any proper measures to endure MH would receive ongoing treatment of follow up. Mr. Jackson endorsed the submissions of Counsel Assisting and submitted that Ms. Lewer's submissions fail to sufficiently acknowledge the challenges that complex patients like MH present.

Ms Lower's first submission

I accept that the decision to discharge MH into the custody of Police, and subsequently to CSNSW, caused RH considerable pain and distress and that it continues to do so. MH was young and vulnerable due the nature of his illness. In circumstances where, it seems clear, MH's symptoms, to some degree, remained throughout his time at Chisholm Ross, it is, on one view, difficult to understand how it could have been appropriate for MH to be discharged from a treatment facility where he resided as involuntary patient, and taken to into custody, in circumstances where it was not known where and for how long he would be detained.

However, I accept the submission of Counsel Assisting that there is no basis to criticise the doctors involved in MH's care at Chisholm Ross. In doing so I give significant weight to the evidence of Dr Nielssen and Dr Sullivan who are well placed to provide an opinion on the way in which the *Mental Health Act 2007* is applied in practice.

Ms. Lewer's submission that MH's discharge was contrary to the *Mental Health Act 2007* proceeds by the following logic. The *Mental Health Act 2007* requires that upon a clinician forming the view that a patient is no longer "mentally ill", that patient must immediately be released from involuntary detention. Accordingly, because MH remained detained as an inpatient at Chisholm Ross, it follows that I would find he was "mentally ill" and, accordingly, his discharge to Police custody was not in accordance with the *Mental Health Act 2007* or best clinical practice.

I do not accept Ms. Lewer's submission since I do not consider the first plank of Ms. Lewer's argument to be made out. The determination that a person is "mentally ill" for the purposes of the *Mental Health Act 2007* is a risk assessment. I accept that that risk assessment may be informed by the environment it was proposed that the patient was to be discharged to. This view is in accordance with the evidence of the experts that practitioners apply the relevant provisions of the *Mental Health Act 2007* with a degree of flexibility.

Counsel Assisting asked Dr Nielssen and Dr Sullivan whether they had experience with the *Mental Health Act 2007* being applied somewhat flexibly to ensure a person is not discharged from a ward into unsafe circumstances. Dr Sullivan told the Court:

"All clinicians are faced with the same conflict, the conflict to ensure that they follow the letter of the law and the tension between doing that and ensuring that they do the right thing for patients, so in a situation where a person has a chronic relapsing mental illness, even when they appear well on a cross-sectional interview, I think most clinicians would be satisfied that, longitudinally, and in the short term, that person would be likely to show evidence sufficient to satisfy the Mental Health Act, and I think they would in good faith maintain a person there rather than immediately discharge them because they saw the criteria were not satisfied. So, for a clinician, although bound by the law, the clinician is also bound by their clinical perspectives on the patient at a particular time."

Dr Nielssen agreed with Dr Sullivan and added: "There is an obligation not to discharge a person without having made proper arrangements, for example, or without having some concern about what will happen after they are discharged. So again, those decisions were perfectly within the meaning and spirit of the law."

Dr Nielssen and Dr Sullivan both accept, contrary to Ms. Lewer's submission, that continuing to hold a patient in involuntary detention in circumstances where they may appear well, as Dr Sharma indicated she did, may be justified when consideration is given to the harm that might arise from discharge to a particular environment such as discharge to homelessness. I do not accept MH was being held unlawfully, and accordingly, do not accept that because unlawful detention would be unlikely it must follow that MH was mentally unwell when discharged rendering his discharge contrary to the *Mental Health Act 2007*.

Further, I am not persuaded that there was no plan to discharge MH prior to the incident on 20 May 2017. Review of MH's medical record reveals repeated references to attempts to obtain accommodation for MH. The note made by Dr Sharma on 19 May 2017, extracted earlier in these findings, expressly states that MH was awaiting a drug and alcohol rehabilitation placement and stable accommodation, and that MH could be discharged on a depot once suitable accommodation was found.

In circumstances where I have not found that MH should not have been discharged from the Chisholm Ross Centre, I do not consider it necessary to deal in detail with the submission that MH's discharge contributed to his death. In any event, I do not consider that, given the passage of time between MH's discharge and his death, and the complexities of MH's condition generally, such a finding is open.

Ms Lower's second submission

I do not accept that any failure to consult with a person's designated carer prior to discharge constitutes a breach of the *Mental Health Act 2007*.

Section 79(1) requires the taking of "all reasonably practicable steps" to ensure a patient's designated carer is "consulted in relation to planning the patient's or person's discharge".

Dr Sharma's evidence was that MH's discharge from Chisholm Ross Centre was not planned. Significantly, in my view, the catalyst for his discharge was the report received by staff that MH has assaulted a fellow patient. That allegation was serious and had a sexual component. I have great sympathy for MH and his vulnerability, but I am not critical of the decision to reportthe allegation to Police in the context of the duty of care owed by the Chisholm Ross Centre to its patients, some of whom reside in that facility involuntarily, and some, if not many, would be regarded as vulnerable persons. Once the allegation was reported to police it set in train a process which was, to some extent, outside of Dr Sharma's control. Dr Sharma's evidence was that she did take steps to ensure RH was notified of the pending discharge. While I appreciate the circumstances in which MH was discharged from the Chisholm Ross Centre were well short of ideal, and that this quite understandably caused MH's family distress, I am unable to accept that, in the circumstances, any failure by Dr Sharma to consult with RH in advance of the discharge constituted a breach of the *Mental Health Act 2007*.

Ms Lower's third submission

With respect to whether there were sufficient plans in place for MH's ongoing care this must, in my view, be considered in the context of the events leading to MH's discharge, being the allegation made against him. Dr Sharma told the Court that she expected MH to be held in custody and that, accordingly, he would continue to receive treatment. Dr Sharma also gave evidence that Police were instructed to return MH to the Chisholm Ross Centre in the event he was released from custody. This evidence is supported by notes made in MH's medical record. Dr Sharma's evidence was that in circumstances where MH would be on the street, homeless, and with access to drugs, she would have considered that MH could have been detained under the *Mental Health Act 2007* because of the risks associated with that environment. In the context of the unplanned nature of MH's discharge and the circumstances surrounding it, I do not consider that Dr Sharma failed to take any proper measures to ensure MH would receive appropriate ongoing treatment or follow up.

Admission into Goulburn Correctional Centre

May 2017 – Reception and Justice Health Screening

On 21 May 2017, MH was received into CSNSW custody at Goulburn CC. When screened at reception MH was asked whether he had previously attempted suicide or self-harm to which MH answered "Four years ago. Hanging".

MH was also asked if he had received psychological or psychiatric treatment to which he replied "Arrested while in Chisholm Ross Centre. Schizophrenia Injection Clybixec". MH was not recorded as being at risk of self-harm or suicide.

On 21 May 2017, MH was seen by Registered Nurse Narelle McLaren, a primary care nurse employed by Justice Health. RN McLaren recorded the following note in MH's medical record:

"New reception from Goulburn Court this PM. Previous gaol history; stated released from Chisholm Ross Centre yesterday and is on IM depot and meds for history of schizophrenia. Release of Information signed. Denies suicidal ideation or intent. HPNF completed. Placed on mental health waitlist. Denies any medical history. Nil issues or complaints voiced."

RN McLaren completed a Reception Screening Assessment. This assessment is undertaken for every inmate when they enter Goulburn CC and takes about 20 minutes to one hour to complete. MH reported no medical issues and denied drug or alcohol use in the preceding four weeks. MH stated that he had been discharged the day before from the Chisholm Ross Centre and indicated he had schizophrenia. RN McLaren assessed MH using the Kessler Psychological Distress Scale which measures psychological distress. MH scored 13 out of 50 giving a result of "likely to be well". RN McLaren recorded that MH presented with "blunted affect, normal behaviour during interview, good insight into current custody. Denies suicidal ideation or intent."

MH denied having ever tried to hurt himself and denied that there was anything causing him concern. RN McLaren determined MH was not at immediate risk of self-harm or suicide. RN McLaren did not have access to any records which showed that, contrary to what MH told her, he had previously tried to self-harm.

However, RN McLaren told the Court that even if she had been aware of this information it would not have changed her assessment or recommendation for placement, which was based on his presentation at the time of assessment. RN McLaren had MH sign a release of information to obtain his records from the Chisholm Ross Centre. Those records arrived on 23 May 2017.

RN McLaren placed MH on the waitlist to be seen by the mental health team and allocated him a priority of '2' which she understood required him to be seen within 24 hours. At that time, however, a priority of '2' required a patient to be seen within 3 – 7 days. RN McLaren allocated him that category as:

"he had been just discharged the day before from Chisholm Ross and then he had a history of schizophrenia and I wanted him seen because he was on depots and everything and I wanted the medication ordered and everything, so that's why I would have done that."

RN McLaren then completed a Health Problem Notification Form ("HPNF"). Under the heading "Signs/symptoms to look for in the inmate", she noted "Mental health history; observe for inappropriate laughing, isolation, mood, swings, agitation or aggression". These were matters RN McLaren considered indicative of a schizophrenic episode. If CSNSW Officers noticed any of these signs they were to contact the clinic or mental health immediately. It was further noted that MH denied any suicidal ideation or intent and that he "must be placed 2 out cell placement until reviewed by Mental Health." This meant that MH was to be housed with another inmate. It was a matter for CSNSW to determine which inmate MH was to be housed with.

RN McLaren explained that the rationale behind the "two out" policy was so that the cellmate could use the cell intercom (known as the "knock up" button) to call for assistance if required.

RN McLaren did not have access to the CSNSW Offender Integrated Management System ("OIMS"). That system contains a series of alerts for inmates, including an alert for self-harm or suicide. RN McLaren thought that it would be useful for Justice Health nurses to have access to this system. However, I accept Counsel Assisting's submission that access to OIMS would not have made a difference to RN McLaren's assessment in this case as the focus of the assessment was on the identification of acute risk.

May 2017 – Intake Screener Questionnaire

On 22 May 2017, an Intake Screen Questionnaire was completed with MH at Goulburn CC. The following matters were noted:

- States diagnosis of schizophrenia and is medicated.
- States he has just spent over a month in Chisholm Ross Centre.
- States nil health issues, nil self-harm, or suicide issues.
- States under influence of ice and heroin at time of offence.
- Has support of his mother.

Referral to psychology, AOD support and education.

Issue (b) The adequacy of the intake process at Goulburn Correctional Centre

In relation to the intake and assessment process, Counsel Assisting submits that it appears to have been done adequately and notes that it is limited to identifying acute risk and that that was not apparent. No expert was critical of the intake and assessment process and I accept it was performed adequately.

May 2017 – Medication continued by Dr O'Dea

On 23 May 2017, Dr O'Dea, at the request of Justice Health nursing staff, ordered the continuation of MH's medication in accordance with his medication regime at the Chisholm Ross Centre, being 400mg of Clopixol weekly.

Dr O'Dea did not see MH on that day and said it was common to receive a request to continue medication in that manner.

23 May 2017 – MH seen by Bronwyn Ford, CSNSW Psychologist

On 23 May 2017, MH was seen by psychologist Bronwyn Ford. Ms. Ford is employed by CSNSW. Being a CSNSW employee she does not have access to Justice Health records. At the time of seeing MH, Ms. Ford was working four days a week and was one of two psychologists employed at Goulburn CC. There are now three psychologists, and Ms. Ford told the Court this had not eased the workload for her team. In relation to her role, Ms. Ford gave evidence that: "*We don't generally get an opportunity to provide treatment because of staffing issues and our focus on risk assessment and – yeah, the risk and assessment and the needs and responsivity to rehabilitation. We generally only have the resources and capacity to provide brief interventions."*

Ms. Ford's immediate concern is to keep a prisoner safe whilst in custody.

Ms. Ford had previously seen MH when he was an inmate at Goulburn CC earlier in 2017. When she saw MH on 23 May 2017, Ms. Ford found him difficult to engage. MH sat with his eyes closed and was mumbling to himself. He gave contradictory answers and was difficult to talk to. He denied any history or current thoughts of self-harm.

Ms. Ford recorded on OIMS:

"Inmate reported very poor sleep and stated he is really tired. Inmate stated he is stable on antipsychotic medication. Inmate stated that he wants to deal with all the issues in his past. Advised him that as psychology is short-staffed we are unable to provide that type of service at this centre or provide a safe environment to deal with those sorts of issues."

Ms. Ford clarified that by "those sort of issues" she meant any childhood trauma or issues he may have been talking about. Ms. Ford noted on OIMS that there was no further contact arranged at this time.

Ms. Ford explained that that was because MH said that he didn't want engagement with psychology other than to talk about the issues they were not equipped to address. At the time of Ms. Ford's interaction with MH, the senior psychologist was on extended leave. As a result, Ms. Ford and one other registered psychologist provided the psychology services for the entire gaol. At that time the prison population was around 600. Upon reflection, Ms. Ford said that if a prisoner presented similarly in the future, she would try to engage them a little bit more and try to get more information about how they were coping.

25 May 2017 – MH seen by Michael Harris, Justice Health Nurse

On 25 May 2017, MH was seen in the Justice Health Clinic by RN Michael Harris RN Harris was a very experienced mental health nurse, who had been employed at Goulburn CC since 1991. Prior to seeing MH on 25 May 2017, RN Harris had treated or reviewed MH on a number of occasions when MH had previously been detained at Goulburn CC, including as a member of the Risk Intervention Team ("RIT") that reviewed MH in June 2016. RN Harris was not one of the nurses involved in treating MH when he self-harmed in March 2017.

MH was paged to attend the clinic for administration of his depot medication and review. He arrived around 11:30am. During that appointment, MH voiced to RN Harris an objection to the frequency with which his medication was being administered. MH reported that it was making him too drowsy and that was "the last thing he wanted or needed whilst being in custody". MH presented to RN Harris as quite reasonable and rational and did not become agitated or aggressive. As compared with previous interactions, RN Harris observed nothing of concern in MH's presentation.

RN Harris checked MH's discharge summary from the Chisholm Ross Centre to confirm the dosage of 400mg weekly. In his experience this seemed a fairly high dose at this frequency. RN Harris then discussed this matter with Dr Sarah-Jane Spencer, the psychiatrist on duty in the clinic.

He relayed to her MH's concerns. Dr Spencer did not see MH but agreed to reduce his medication. Dr Spencer's decision is discussed further below.

RN Harris recorded in the notes:

"Seen in clinic from waitlist and for depot intramuscular injection of Clopixol. Patient known to me from previous sentences. Most recent discharge summary from Chisholm Ross indicates 400 milligrams Clopixol weekly which patient objects to. He was open to discussion on this point. See Dr Spencer's notation above. Placed on psychiatrist's waitlist for review of dose and frequency. Patient states he's copying okay and no reported problems with others, cellmate okay, nil obvious acute or active psychoses evidence. Minimal insight into his substance use and exacerbation of his mental illness. Agreed to accept 400 milligrams of Clopixol every fortnight until psychiatrist'sreview."

RN Harris was responsible for allocating the level of priority for MH's review by a psychiatrist. RN Harris prioritised MH '4' or 'routine' on the Justice Health Patient Administration System ("PAS"). This meant that MH had to be seen within 12 months. It is these PAS waitlists that are reviewed by the mental health nurses to determine the list of patients to be seen in the psychiatrist's clinics when held.

When wait listing MH, RN Harris recorded in the comments section on PAS: *"History of schizophrenia requires review of Clopixol dose and frequency. Recent return to custody, next court date late June 2017."*

Dr Nielssen, a forensic psychiatrist providing expert evidence to the Court, gave evidence that a 12 month wait for an assessment was "absurd" and that a patient in MH's position really should be seen at the first clinic if their medication has been changed. RH Harris' evidence was that just because a patient was prioritised as 'routine' this did not mean they would have to wait for 12 months to be followed up. The comments entered onto the PAS system would be reviewed by mental health nurses, who could then adjust the waitlist as required.

RN Harris said that it was the "usual objective" for someone in MH's position with chronic schizophrenia and acute episodes at different frequencies to see a psychiatrist within a relatively short period after having entered into custody. He explained that this is why those matters were noted in the comments. RN Harris said that he now thought that MH should have been allocated a '2' or a '3' and could not recall why he listed him as '4'. RH Harris said it might have been an error of judgement or an error with the actual process of the computer on the day.

Ms. Doust submits that the categorisation of MH as a priority 4 was either an error in entering the priority number in PAS or an error due to not having enough time, rather than an error of judgment on the part of RN Harris. However, in circumstances where RN Harris' evidence is that he cannot recall why he prioritised MH as a 4, that submission cannot be accepted.

In my view, RN Harris' concession that MH should have been allocated ahigher priority on the waitlist was appropriate. I acknowledge, however, that the numerical priority category assigned to a patient was not the only mechanism available to Justice Health nurses to organise the psychiatrists' waitlist. Those mechanisms included consideration of the comments entered against the entries on the waitlist and the time that had elapsed since the patient was last seen. I accept also that the presentation of patients for their depot injection provided a further opportunity for patients to be, as least superficially, reviewed and monitored by the mental health team.

25 May 2017 – Medication reduced by Dr Spencer

Dr Sarah-Jane Spencer is a forensic psychiatrist. She is presently employed by Justice Health as the Clinical Director, Custodial Mental Health. In May 2017, Dr Spencer was the Deputy Director, Custodial Mental Health.

On 25 May 2017, Dr Spencer was conducting a clinic at Goulburn CC. At around 2:00pm, near the end of her clinic, she was approached by RN Harris who informed her that MH was did not want to take his medication. Dr Spencer said that this occurred during lock in and there was no opportunity to see MH. RN Harris told Dr Spencer that he felt MH was at baseline as compared to how he had presented on previous occasions and that MH reported he was experiencing side effects. RN had MH's medication chart which showed his current medication to be 400mg IMI Clopixol weekly. Dr Spencer gave evidence that this was not a recommended dose in MIMS and that normally the maximum is 400mg every fortnight.

Dr Spencer recorded in the notes:

"Asked to review medication because patient refusing 400 mg Clopixol IMI weekly, it is a large dose. Patient agreeing to take 400 mg IMI every two weeks. Previously on 200 mg every two weeks, from ROI [release of information] in 2016 No time to review now. Plan: 400mg clopixol IMI every 2 weeks, due 31/5/17. For psychiatric review when possible."

As indicated by the above note, Dr Spencer reviewed MH's previous medical notes and noted that in the past he had received a dose of 200mg IMI Clopixol every two weeks. Dr Spencer reduced MH's dose from 400mg IMI Clopixol weekly, to 400mg every two weeks.

Counsel Assisting submits that I would not be critical of the decision to alter the interval for medication as requested by MH. I accept that submission. Neither Dr Sullivan nor Dr Nielssen were critical of the decision of Dr Spencer to reduce the frequency of MH's medication, although both noted that it is preferable to see and assess a patient before adjusting their medication.

During his final period of detention at Goulburn CC, MH, despite the severe and chronic nature of his illness, was not reviewed by a psychiatrist. Counsel Assisting asked Dr Spencer if she agreed that the fact that MH did not see a psychiatrist indicated he did not receive adequate care.

Dr Spencer said that it would have been good if he had seen someone. Dr Spencer explained why she had not recorded, in her note, a particular priority for MH's review in the following way:

"So, there are lots of patients who come into custody not on any medication and not agreeing to take any medication and they do tend to be the priority from a psychiatrist's point of view, because we're the only ones who can prescribe. He had also had a period of inpatient treatment, whereas lots of patients have come in off the street and haven't had that opportunity, and I think that the team in Chisholm Ross had determined he was well enough to be remanded into custody, and Dr Sharma is someone who works in custody and so has knowledge of the resource constraints, what is available in custody and the limitations, and the team made that decision. So, based on that and the large proportion of patients who are in Goulburn unwell and not taking treatment at that time, he wasn't a priority to be seen forme."

***Issue (c) Was the monitoring and clinical management of MH* appropriate and otherwise in accordance with best practice**

This issue is one of significance. As the inquest progressed, its focus began to shift from consideration of whether the monitoring and clinical management of MH was appropriate, to consideration of whether prisoners like MH, who suffer from a severe chronic mental illness, are even capable of being appropriately cared for in NSW prisons.

In considering the appropriateness of MH's clinical management, and the reasons for any identified failings, I was greatly assisted by the evidence of the experienced health professionals, some in their capacity as experts, who gave evidence at the inquest. I give significant weight to theirevidence.

Forensic Psychiatrists – Dr Olav Nielssen and Dr Danny Sullivan

The Court received expert evidence from Dr Olav Nielssen and Dr Danny Sullivan. As previously stated, Dr Nielssen is a consultant forensic psychiatrist who holds appointments at St Vincent's Hospital in Sydney. Dr Nielssen has previously held appointments at the MHRT and Justice Health. Dr Sullivan is a consultant forensic psychiatrist who is Executive Director of Clinical Services at Forensicare, the state-wide public forensic mental health service in Victoria. Dr Sullivan has been a consultant at inpatient units and has worked at most of the prisons in Victoria in outpatient clinics. Both experts agreed with Dr O'Dea's diagnosis of severe chronic schizophrenia with substance use disorder resistant to treatment, with Dr Sullivan observing that "every word in that diagnosis is relevant." Dr Nielssen and Dr Sullivan both agreed there was no basis to criticise any individuals involved in MH's care and that there were no acute signs of psychosis during his last period in custody that had been missed. In his expert report, Dr Nielssen stated, in answer to the question, did MH receive adequate and appropriate care and treatment during his incarceration at Goulburn CC from 21 May 2017 – 23 June 2017:

"The answer is obviously no, not because the staff who attended to him provided inadequate care, more because prison is such an inefficient place to treat people with severe forms of mental illness.

We know that between 5% and 7% of NSW prisoners have schizophrenia, a condition that affects about 0.5% of the population, which means there are as many as 800 people with schizophrenia in NSW prisons at any one time. There are a total of around 1600 psychiatric beds in New South Wales, so that in effect prisons are our new asylums."

Dr Sullivan agreed with Dr Nielssen. Dr Sullivan told the Court: *"I certainly have a strong personal belief that people with a health disorder should be treated in a health facility and people with a mental health disorder should be treated in a mental health facility, and that although there are numbers of people who remain in the prison system with a psychotic illness, that they can't get the most effective holistic multidisciplinary care that they would get in a hospital setting. Now you need to select which of the patients with a chronic mental illness in a prison system need to prioritised for that treatment, so in an ideal world, he would have been transferred, but of course, in the real world he would require active symptoms, non-adherence to medication or a significant risk to others to meet the threshold for transfer."*

Psychologist - Patrick Sheehan

Patrick Sheehan is a highly experienced psychologist who has relevant experience in treating and assessing prisoners in the custodial environment. He gave expert evidence at the inquest. Mr. Sheehan opined that the level of support and supervision MH received in custody:

"fell well short of that offered in the Chisholm Ross Centre" and that this was "not a criticism but an inevitable difference between a correctional setting and a hospital setting". Mr. Sheehan considered that MH's risk markers for self-harm were chronic rather than acute. MH's "guarded presentation gave correctional staff little reason to suspect that he was floridly psychotic or at immediate risk of serious self-harm".

Mr. Sheehan agreed with the opinion of the expert psychiatrists that the custodial environment is not an appropriate place to treat prisoners with an illness like MH and that, therefore, MH could not receive adequate care at Goulburn CC.

Forensic psychiatrists at Goulburn CC – Dr O'Dea and Dr Spencer

Dr O'Dea gave the following answer to a question from Counsel Assisting about the role of a psychiatrist providing treatment to prisoners:

"The usual situation in the prison system, because of the extent of psychiatric morbidity, particularly upon the severe end of the psychiatric spectrum, with psychosis, the usual thing is that we would do assessments of patients and instigate treatment, but of course, the treatment we would instigate, because of the practicalities of the situation, would usually be the medication. The idea of doing ongoing follow up with psychotherapy – which is something, of course that psychiatrists do all the time, but in prisons there's just not the opportunity from the workload, to do those kinds of interventions. So essentially we would be assessing people and commencing the medication, which I might hasten to add is the single most effective intervention for these people in the context of also abstinence from substance use and being in a supportive environment which of course they're not necessarily in when they're in prison".

Dr O'Dea told the Court:

"Prison is not a place to be treating people with severe chronic schizophrenia. They need to be treated in a hospital setting and prison is actually very adverse for their condition. You know, the problem is we don't – we aren't provided with the resources to do that and there's been frequent directives to governments – not just in New South Wales, across Australia and across the world – but governments haven't been able or prepared to do that. But you're quite right, it's very inappropriate to be treating people with severe mental illness in prisons. … [P]risons are the new asylums, and the level of psychiatric morbidity within prisons is enormous, and you know, unfortunately in closing psychiatric beds, severe mental illness hasn't gone away, it's just been relocated. And I think we've seen in this case somebody being transferred from a hospital to a prison, albeit because, as I understand it from reading the material, … they've been alleged to have committed an offence in hospital – but of course that, from my point of view would point very significantly to the fact that they have some major mental illness going on at the time and they could be managed with the hospital in a secure setting, as we do in other hospitals, but of course, the resources are just not there."

Dr Spencer gave evidence that in the prison environment the priority is given to people in the acute phase of their illness or at immediate risk of suicide or self- harm.

Accordingly, in circumstances where MH was not manifesting positive signs of his illness to CSNSW and Justice Health staff he was not accorded priority despite the severe and chronic nature of his illness. Dr Spencer agreed that prison is not a therapeutic environment to treat somebody with a mental illness and that there is a significant shortage of beds to appropriately care for those patients suffering from a chronic mental illness.

Resolution

Counsel Assisting submitted that while the monitoring of MH would ideally have been more frequent, the failure to arrange for more frequent review by a mental health team was not the fault of any individual, but a reflection of how inadequate and inappropriate NSW prisons are for dealing with prisoners with chronic severe schizophrenia like MH.

I accept that submission. Prisoners who suffer from a chronic mental illness, like schizophrenia, in a severe form, require, at a minimum, closer monitoring and assessment than is capable of being provided under the present model ofcare. The evidence in this inquest amply demonstrates that the needs of prisoners in NSW with a severe chronic mental illness such as schizophrenia cannot be adequately met. The existing model of care provision is incapable of meeting the complex needs of such prisoners. This was the view of each of the four experienced forensic psychiatrists, and one experienced psychologist, who gave evidence.

Dr Spencer gave evidence that Justice Health have developed a proposal for an alternative, more therapeutic model of care ("the renewed model"). In addition to the oral evidence given by Dr Spencer, the Court received a copy of a document outlining the renewed model. As that document is the subject of a non-publication order I will not detail its contents further. Suffice to say, having reviewed the document, and heard the evidence of the witnesses in this inquest, the case for its implementation is compelling.

29 May 2017 – Self-tattooing

On 29 May 2017, MH was brought to the Health Centre for review of laceration to his right thumb due to self-tattooing. The wound was cleansed, sterile strips and a simple dressing applied. His wound was reviewed on 31 May 2017 and was clean and dry requiring no further dressings.

Contact with Services and Programs Officer, Frances Crown

RH told the Court how challenging it was to support MH during this period of incarceration. RH said that she asked MH what he had done on the day of the incident and that upon hearing MH's answer, she formed the view that he had sexually assaulted someone which, understandably, she found particularly distressing.

RH said that this affected the way she was able to communicate with, and relate to, MH in the weeks that followed. MH and RH did continue to communicate over the phone, and, at MH's request, RH put money in his account on the condition it was not for drugs.

On 13 June 2017, RH contacted an Offender Services and Programs Officer, Frances Crown, and informed her that she wanted to cease contact with MH. Ms. Crown recorded the following note of her conversation with RH in the Offender Integrated Management System ("OIMS"):

"Phone call received from mother of offender RH who wants no more contact with MH due to phone call over weekend "being the last straw" and which was manipulative. She would not disclose further details.

She will be sending in birth certificate and other ID documents for his valuables bag at the gaol. She will be changing her address and phone number. When this is done she will pass this onto the gaol, but this information is not to be disclosed to theoffender."

RH described her emotional state at this time as "hurt, confused, angry, under stress."

RH sent a letter to Ms. Crown dated 13 June 2017, confirming her conversation, and enclosing some of MH's property. She sent the letter to Ms. Crown so that someone would convey the information to him.

RH gave evidence that she had a further conversation with Ms. Crown within about a week of the first conversation and that during that conversation Ms. Crown said to RH words to the effect "You can block MH's calls". RH said that by this time she was growing reluctant to cease contact with MH because she still enjoyed spending moments with him over the phone.

RH said that she then asked Ms. Crown not to provide MH with the letter until after MH's court hearing on 21 June 2017, and that she would see what happened after Court. RH said that she asked Ms. Crown to call her after the Court appearance, so that they could discuss the letter.

Ms. Crown gave evidence that she could recall the conversation with RH on 13 June 2017, but no subsequent call. There is no OIMS note record of such a call. Ms. Crown did not think that a second conversation occurred.

The conflict in the evidence between RH and Ms. Crown will be discussed further below.

Despite RH's misgivings, there were further calls between RH and MH on 14, 15, 16, and 19 June 2017.

June 2017 – Court attendance and notification about R's calls

On 21 June 2017, James Apps, a CSNSW Officer, escorted MH to the AVL booth for his court appearance. Mr. Apps sat in a separate booth and did not hear what occurred during the appearance. Mr. Apps noticed nothing unusual in MH's appearance or demeanour, noting that he only interacted with him for a short time. Mr. Apps recorded in OIMS:

"Inmate attended video link today for Goulburn Local Court. Nil issues. Inmate was assisted by intellectual disability services."

RH sat beside MH's solicitor during his court appearance so that MH could see her. They were in Court for about five minutes and MH gave her a shy smile which RH said was typical of him.

That same day, after the Court appearance MH was seen by Ms. Crown who informed him that RH wanted to cease contact. The conversation occurred in Ms. Crown's office and lasted for around 15 minutes. Ms. Crown recorded the following note of the conversation in OIMS:

"Offender seen to pass on news that his mother RH does not want to have further interaction with him due to a phone call where she felt manipulated, I suggested it might have had something to do with asking for drugs or money. He did not disagree or agree. The information explained further to offender that property had been sent to the gaol and placed in his property.

Offender appeared to understand but did not react. Said I would see him again on Friday as officers called him away. Further information needs to be given." Ms. Crown said that MH appeared calm when given the information and thatshe was aware he might be distressed to hear his mother wanted to cease contact. She had tried to deliver the information gently. Ms. Crown explained that the "further information" referred to in the OIMS note concerned aspects of the letter she had not had the opportunity to inform him of including information regarding Dooralong and money that he believed he had been owed.

Issue (d) - The adequacy and appropriateness of communications between MH and CSNSW staff

As set out above, Ms. Crown and RH have differing recollections of the number of conversations they had during MH's last admission to Goulburn Correctional Centre and of the content of those conversations.

Counsel Assisting submits that it is unfortunate that there was a communication breakdown between RH and Ms. Crown and that it is difficult to resolve the factual dispute that arises, but also not possible to determine that it had any impact on MH's death. Ms. Lewer submits that, with respect to the issue of whether a second conversation occurred, I would prefer the evidence of RH, first, on the basisthat RH is recalling evidence about a highly significant matter which she is likely to remember and, secondly, that the timing of the meeting between Ms. Crown and MH corroborates RH's version.

Both Mr. Broad and Mr. Russell submit that it is not necessary for me to determine whether the second conversation occurred. I accept that it is not necessary for me to determine whether the second conversation occurred as I do not consider there is sufficient evidence for me to find Ms. Crown's conversation with MH had any impact on MH's death.

Ms. Lewer submits that, with respect to Ms. Crown's meeting with MH, Ms. Crown failed to properly discharge her obligations to MH to complete any real risk assessment about a risk of self-harm after she delivered the news to MH about RH's proposed cessation of contact with him. Ms. Lewer submits that failure may have arisen because the meeting was cut short, however, given that fact and the contents of the news Ms. Crown had given, she ought to have taken steps to ensure some other person conducted a risk assessment or that MH was monitored for signs of self-harm upon his return to the wing. Ms. Lewer submits these failures contributed to MH's death.

Mr. Broad submits that: Ms. Crown met with MH in the privacy of her office so that she could provide him support; that she tried to deliver the message gently; and, that she monitored MH for any adverse reaction. Ms. Crown's evidence was MH had not appeared distressed and, accordingly, she did not alert others to the possibility that MH might self-harm. Mr. Broad further submits that it is highly speculative to suggest that had MH been closely monitored upon his return to the wing his risk of suicide would have been detected. Mr. Russell submits that MH was not presenting or behaving in a manner that would support a contention that he was at risk of self-harm and therefore Ms. Crown was not required to raise a mandatory notification or refer him for a risk assessment. As previously indicated, I do not consider there is sufficient evidence for a finding that Ms. Crown's interaction with MH impacted upon his death. I accept, as Counsel Assisting submits, that an inference can be drawn that receiving news that his mother wished to cease contact with him would have been upsetting.

However, Ms. Crown, who accepted that it forms part of her role to look out for signs and symptoms of risk, gave evidence that MH appeared calm when he received the news.

In circumstances where Ms. Crown monitored MH for an adverse reaction to the news she delivered and he displayed no such reaction, I do not accept the submission that Mr. Crown ought to have taken steps to ensure some other person conducted a risk assessment or otherwise monitored MH for signs of self-harm. In making this finding I give weight to the evidence of Mr. Sheehan who told the Court that it was not realistic to expect additional supports to be put in place around the delivery of information such as that delivered to MH. Mr. Sheehan pointed out the delivery of information that might be upsetting to inmates is not uncommon as it is often the case that, for prisoners, their relationships andlives are *"in chaos"*.

June 2017 – Entire Centre Search

On 22 June 2017, Goulburn CC was locked down for the duration of the day for the purposes of conducting an "Entire Centre Search". The razor blades MH would later use to harm himself appear not to have beenlocated.

22 June 2017 – Last known contact between MH and a Correctional Officer

On 22 June 2017, at around 2:00pm, First Class Correctional Officer Michelle Lynch opened Cell-66, where MH was housed with his cellmate to deliver their evening meals.

Office Lynch sighted MH standing towards the rear of the cell. At around 5:05am the following morning, Senior Correctional Officer Darren Wake was called by Correctional Officer Conway Bogg in the Control Room to say that he had just received a "knock up" call from MH's cellmate that MH was hanging himself. A number of CSNSW Officers then attended the cell. They discovered MH hanging. One end of a bedsheet had been tied to a bar of the cell window and the other was tied to MH's neck.

Correctional Officers entered the cell and removed securing him to railing outside the cell. Officers lifted MH to cut the bedsheet from his neck using the 911 tool. MH was then lowered to the ground where CPR was commenced. Efforts to resuscitate MH continued until the arrival of NSW Ambulance Officers at about 5:20am. The efforts to resuscitate MH were recorded by CSNSW Officers.

Ambulance Officers conducted a medical assessment and informed CSNSW staff there was nothing further that could be done as there were no signs of life. At 6:05am, Justice Health Registered Nurse Susan Miller and Roy McNair, Manager of Security, attended Cell 66. Nurse Miller assessed MH and completed a 'Life Extinct' form. At around 8:00am, Detectives from Goulburn Police Station and Crime Scene Officers attended the scene. Detectives from the Corrective Services Investigation Unit and Investigators from the Investigation Branch CSNSW later attended.

The scene was processed by Senior Constable Brenton Day. It was identified that MH had injured himself by making cuts to his neck area and forearm with a broken gaol issue razor blade prior to hanging himself. Blood was located on the wall (below the rear window of the cell) and floor below the window. The pillow and sheeting on the top bunk, where MH had slept, also had an amount of blood on it. A razor blade was located on the top bunk.

A number of letters and poems were collected. The Officer in Charge in this inquest, Detective Joseph Coorey, was one of the officers who interviewed Detective Coorey gave evidence that he kept an open mind as to the circumstances of MH's death. Detective Coorey told the Court that therewas no inconsistency between the forensic evidence and version of events. There was no evidentiary basis toconsider that had any involvement in MH's death.

MH's cellmate of one month also suffered from schizophrenia and was treated with fortnightly injections. He told Police that on 21 June 2017, he and MH had exercised together in the yard and lay in the sun, laughing and joking around. During the lockdownon 22 June 2017, noticed MH was wearing rosary beads and reading aloud from his prayer book. He said that MH had not done this before and that he was being secretive. Later that evening and MH listed to the radio through the television.

He told Police that around 4:00am on 23 June 2017, he got up to get a drink of water and noticed MH underneath the window. He buzzed the cell intercom to alert CSNSW Officers. He told Police he had no idea that MH was planning to take his own life.

Cause of death

An autopsy was performed by Dr Rebecca Irvine on 28 July 2017. Dr Irvine determined the cause of death to be hanging. She noted a superficial incised wound on the anterior neck and two vertical incised wounds on the right forearm.

The forearm wounds sat atop a rectangular area of concentrated linear scarring.

Toxicological examination showed a nontoxic range of blood concentration of mirtazapine (an anti-depressant) which had not been prescribed to MH. Also detected was a low toxic range of blood concentration of Zuclopethixol (Clopixol), the antipsychotic medication MH was prescribed. No other drugs or alcohol were detected.

There was evidence that MH had used buprenorphine whilst in custody, buying it from fellow inmates. However, the toxicology results demonstrate that any use by MH of buprenorphine was not directly related to the cause ofdeath.

Issue (a) Was the death self-inflicted and/or precipitated by a mental illness episode?

Counsel Assisting submits there is ample evidence to be satisfied, on the balance of probabilities, that MH's death was intentionally self-inflicted. I accept that submission. The forensic evidence is consistent with the account of MH's death given to Police by his cellmate and there are no suspicious circumstances.

I am satisfied that MH intended to take his own life, by hanging, having shortly before cut himself with a razor blade later located in his cell. With respect to the issue of whether MH's death was precipitated by a mental illness episode, Counsel Assisting submits that it is likely the MH's death was precipitated by the reappearance of some intrusive psychotic thoughts, given the evidence of his cellmate. I accept that submission.

The evidence in relation to MH's illness was that his symptoms fluctuated over time and, as Counsel Assisting submits, theevidence of MH's cellmate supports the view that MH was experiencing intrusive psychotic thoughts.

Issue (e) The effect, if any, on MH of the level of Zuclopethixol detected in MH's blood post mortem

Counsel Assisting submits that the level of Zuclopethixol detected post mortem is not likely to have made any difference to the behaviour of MH or the tragic outcome.

Mr. Jackson submits that 400mg weekly was an appropriate dose to prescribe within the context of MH's acute presentation in the context of a severe, treatment resistant, chronic schizophrenia. Further, no side effects were recorded during MH's stay at the Chisholm Ross Centre, and no side effects are particularised in the Justice Health records.

Both Dr Nielssen and Dr Sullivan addressed this issue in their expertreports.

Dr Nielssen stated that Zuclopethixol is very tissue bound and that blood levels are not closely correlated with either clinical effects or side effects. In relation to any effect on suicidal ideation, Dr Nielssen observed:

"The main problem would appear to be the lack of an effect on acute symptoms, based on the various observations and the content of MH's writings. There were no reports of akathisia, or motor restlessness, which is a particularly distressing neurological side effects of potent antipsychotic medication especially in confined quarters, and I did not find any entries in the CRC or prison records commenting on the neurological side effects of a potent form of antipsychotic medication. However, the untidy form of MH's handwriting suggests the presence of neurological side effects from a high dose of Zuclopethixol."

Dr Sullivan, in his report stated:

"Post mortem toxicology indicated toxic concentrations of antipsychotic medication. However, there was no evidence of movement side-effects, sedation, or other clinical suggestions of toxic levels of medication while MH was alive. In the absence of other evidence, this may reflect post mortem redistribution of medication in body tissues rather than preceding toxic levels."

In her oral evidence, Dr Spencer said that when RN Harris asked her to review MH's medication, he reported to her that MH had asked for his medication to be reduced because he was experiencing side effects. Dr Spencer could not recall what those side effects were and did not document them in MH's medical record. Dr Spencer reduced MH's medication on 25 May 2017. Other than Dr Nielssen's observations of MH's handwriting, there is no documentary or oral evidence to suggest MH was suffering from any further ill effects relating to hismedication.

In my view, on balance, the evidence establishes that that the toxic level of Zuclopethixol detected in MH's blood post mortem had no impact upon the circumstances of MH's death.

Issues relating to CSNSW

Issue (f) - Whether MH was appropriately housed at Goulburn Correctional Centre

As stated above, MH was housed two-out in a cell. .

Whilst the "buddy system" has limitations it was, in my view, appropriate, in the circumstances, to house MH with a cellmate. The "buddy system" provides an opportunity for an inmate to raise the alarm should he or she have concerns about their cellmate which is what MH's cellmate did after becoming aware that MH had self-harmed.

With respect to the choice of cellmate for MH, was himself diagnosed with schizophrenia and was receiving sedating medication. He does not appear to have woken up when MH was preparing to hang himself. Rather he awoke around 4am to get a glass of water and discovered MH hanging beneath the cell window. Mr. Taylor gave evidence that CSNSW are not normally informed of the medication an inmate is receiving with the effect that this was not ordinarily a matter that could be taken into account in determining which inmates were housed together in the same cell.

Dr Nielssen, who had treated MH's cellmate some years before, described him as a "calm older guy" and observed that "a very high proportion of prisoners are on psychotropic medication that's sedating, so you would have trouble finding one almost, you know, in that sort of clinical area." In light of this evidence, I accept Counsel Assisting's submission that there is no basis for criticism with respect to the housing of MH.

Issue (g) Whether all appropriate measures were taken to remove self-harm implements and hanging points from the cell occupied by MH

Access to razors

As previously stated, MH was discovered in his cell with cuts to his neck and forearms. A broken gaol issued razor blade was found in his cell. Mr. Taylor gave evidence that certain inmates can have their access to razors restricted and are supervised when shaving. Those restrictions are, however, limited to inmates on a RIT or where there is an acute risk of self-harm. In circumstances like MH's, however, where a previous suicide attempt and an incident of self-harm in the custodial setting had occurred some time ago, those restrictions would not apply.

Mr. Taylor gave the following evidence about the reasons for thisapproach:

"Because self-dignity, self-advocation, is what we're aiming for in this business and even when someone's had an episode and they're moving forward and they've presented and they've met all the pre-requisites, and they're moving forward, then they should be given the opportunity to move forward. Yes, it's a difficult road to tread; yes, we need to take into consideration especially mental health, you wouldn't get someone actively psychotic to be starting making guarantees about their own safety, but the professionals would gauge that and but it's about moving forward with people and personal hygiene is one of the big things we're aiming for to get people back on track.

So again, it's one of those issues – and I'll just make note that we do supply razors on their buy up, so they buy a different, better one on their buy up. Within the organisation we work on risk. Where the risk is high, then we act. Where the risk is low, then the person gets their benefits and civil liberties that you are entitled to whilst you're in prison." This approach is a thoughtful and considered one, which appropriately balances the safety and security of inmates with the liberties and dignity to which they remain entitled. I accept the submission made by Counsel Assisting that CSNSW Officers did not have any immediate concerns that MH might potentially self-harm and, on that basis, restricting his access to a razor would not have been warranted.

Hanging Points

Photographs taken of Cell 66 shortly after MH's death reveal that the bed sheet with which MH constructed the ligature was attached to a bar across the window at the rear of the cell. Mr. Taylor accepted that this was a hanging point that would have been obvious to MH. Fresh photographs of Cell 66 were received into evidence. Mr. Taylor gave evidence that all cells in Goulburn Correctional Center has had the effect of preventing access to the bars thereby removing the hanging point.

Findings required by s. 81(1)

As a result of considering all the documentary and oral evidence given at the inquest, I confirm that the death occurred, and I make the followingfindings.

The identity of the deceased: The person who died was MH

Date of death: 23 June 2017

Place of death: Goulburn Correctional Centre

Cause of death: Hanging

Manner of death: Intentional self-inflicted death and was likely precipitated by a mental illness episode.

Recommendations

First recommendation proposed by Counsel Assisting

Counsel Assisting has proposed the following recommendation directed to the CEO of Justice Health: That Justice Health implement the ("renewed model") and that such model be separately funded and resourced independent of the need to reallocate resources from the existing model of care.

This recommendation is supported by Ms. Lewer.

Mr. Harris submits that this recommendation is neither necessary nor desirable because, first, the Ministry of Health is already considering the renewed model.

Secondly, the nature and funding of Justice Health services is a matter for NSW Health and Justice Health would not support a recommendation being made to the Ministry of Health to fund the renewed model in circumstances where the Ministry is not a party of sufficient interest. Mr. Harris proposes a recommendation that those assisting the Court provide a copy of its findings to the Ministry of Health for consideration together with the Renewed Model.

The Commissioner of CSNSW generally supports the implementation of the Renewed Model in consultation of CSNSW. Mr. Broad draws attention to a recommendation in identical terms to that posed by Counsel Assisting that was considered by Deputy State Coroner Ryan in the *Inquest into the death F.* Her Honour delivered findings on 11 June 2021. Her Honour declined to make the recommendation in the terms suggested by Counsel Assisting as her Honour accepted the submission of Justice Health that it was unable to implement the model without the agreement and funding of the Ministry of Health which was not a party of sufficient interest.

I accept that for reasons of fairness, and because I have not had the benefit of their submissions, it would not be appropriate to make a recommendation directed to a party who did not have a sufficient interest in the proceedings.

However, as stated above I consider the case for the implementation of the renewed model to be compelling.

I accept that the course proposed by Mr. Harris is appropriate. Accordingly, I will request that those assisting me provide a copy of these findings to the Ministry of Health for consideration together with the Renewed Model.

Second Recommendation proposed by Counsel Assisting Counsel Assisting proposed a further recommendation:

That consideration be given to developing health care plans for patients at Goulburn Correctional Centre who suffer from chronic and major mental health illness with such a health care plan being updated as necessary by the care coordinator/case manager and including, amongst other relevant matters:

Diagnosis.

Medication.

Cell placement.

Target frequency of review.

Early warning signs of deterioration or relapse.

Target interventions including metabolic monitoring, psychology, employment, other psychosocial supports.

Risk management and recovery plan; and, the wishes of the patient and family.

This recommendation is supported by Ms. Lewer.

Mr. Harris submits that the inquest did not hear any evidence in relation to the consequences of implementing health care plans, including their utility, benefits or disadvantages, cost or resource consequences, or barriers to implementation within a custodial setting.

Mr. Harris submits that given the lack of exploration of the topic of health care plans it would not be necessary or desirable to make this recommendation. I accept that the issue of health care plans was not explored in detail in the inquest. However, the recommendation is carefully framed so as to invite Justice Health to "give consideration to" the proposal.

I note that Justice Health is currently considering ways in which its systems could be updated to provide a live case management plan for chronically ill patients and observe that I consider it to be a very worthwhile endeavour.

Recommendations proposed by RH

Ms. Lewer has proposed 26 recommendations for my consideration. Seven of these recommendations are addressed to either NSW Health or NSW Police, at least in part. For the reasons stated above I do not consider it appropriate to make a recommendation to a party who has not been put on notice or been granted leave to appear as a sufficiently interested party in the Inquest. Accordingly, I decline to make proposed recommendations (c) (h), (i), (v), (w), (y) and (z). Both Mr. Broad and Mr. Harris draw attention to the terms of s. 82 of the *Coroners Act 2009* which relevantly provides that a recommendation may be made "in relation to any matter connected with the death".

I accept that where I am not satisfied that a recommendation is sufficiently related to MH's death, I am unable to make that recommendation.

Recommendations (a) and (b)

Ms. Lewer proposes that:

Consideration be given to amending s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* to either:

mandate a time period in which an inmate must be seen by a second medical practitioner once the first medical practitioner has issued a certificate in relation to the transfer of an inmate to a mental health facility or require an inmate must be seen by a second medical practitioner once the first medical practitioner has issued a certificate in relation to the transfer of an inmate to a mental health facility as soon as practicable. And,

Consideration be given to amending the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* so that obligations similar to those owed to principal care providers and designated carers under the Mental Health Act 2007 also apply in circumstances where a Schedule 1 under the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* has been completed or an order for transfer has been made by the Secretary pursuant to s. 86(1) of that Act, irrespective of whether the patient has actually been transferred to a mental health facility.

Mr. Harris submits that recommendations (a) and (b) are not matters connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017.

Further, in relation to recommendation (a) Mr. Harris submits given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case.

I accept these submissions and decline to make the recommendation proposed.

Recommendation (d)

Ms. Lewer proposes that where Corrective Services does not have sufficient or appropriate inpatient facilities for an acutely mentally ill inmate within the forensic environment, Justice Health is to implement s. 86 of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020* on every occasion it is so required and arrange for the immediate transfer of the inmate to the nearest available mental health facility.

Mr. Harris submits that this recommendation is not a matter connected with the death as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017.

I accept this submission and decline to make the recommendationproposed.

Recommendation (e)

Ms. Lewer proposes that consideration be given to conducting research into the feasibility and clinical benefits of treating all acutely mentally ill inmates in NSW in a secure facility rather than in the general prison population. Mr. Harris submits that this recommendation is not necessary or desirable on the basis that there has been significant research conducted internationally into these issues. The inquest heard no evidence on the desirability or resource implications of conducting further research. I accept this submission and decline to make the recommendationproposed.

Recommendation (f)

Ms. Lewer proposes that Justice Health undertake a review of the level of psychiatric care provided to inmates in correctional centres in NSW, with the aim of comparing that level of care to what the person would have received if they had been in the community setting and to identify the resourcing and other actions that would be required to provide a similar level of care in a custodial setting.

Mr. Harris submits that the work undertaken in preparing the Renewed Model has considered these issues.

I accept this submission and decline to make the recommendationproposed.

Recommendation (g)

Ms. Lewer proposes that Justice Health undertake a review of the level of psychiatric care provided to inmates in correctional centres in NSW in light of the size, and projected size, of the prison population and to identify the resourcing and other actions that would be required to provide an appropriate level of care to a prison population of that size.

Mr. Harris submits that the work undertaken in preparing the Renewed Model has considered these issues.

I accept this submission and decline to make the recommendationproposed.

Recommendation (j)

Ms. Lewer proposes that Justice Health implement a policy requiring that once a certificate has been issued under s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020,* the inmate must be seen by an appropriate medical practitioner for the purposes of consideration of the second certificate within 72 hours.

Mr. Harris submits that recommendation (j) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case.

Mr. Harris further submits that imposing a requirement that a second practitioner review a patient within 72 hours raises significant resource implications, in particular, in non-metropolitan areas, which were not explored during the inquest.

I accept these submissions and decline to make the recommendation proposed.

Recommendation (k)

Ms Lewer proposes that Justice Health implement a policy that once a certificate has been issued under s. 86(2) of the *Mental Health and Cognitive Impairment Forensic Provisions Act 2020,* the inmate must be reviewed again by the psychiatrist within seven days.

Mr. Harris submits that recommendation (j) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Given Dr O'Dea completed the Schedule 12 months prior to MH's death, the desirability of a particular time period for review by a second practitioner does not arise on the facts of the case.

I accept this submission and decline to make the recommendationproposed.

Recommendation (l)

Ms. Lewer proposes that Justice Health implement a policy requiring an inmate who is prescribed antipsychotic medication for a major mental illness be admitted under the care of a primary clinician who is responsible for their care. Mr. Harris submits that within Long Bay Hospital, the Mental Health Screening Unit or Hamden POS, a patient is admitted under the care of a primary clinician. However, in other locations the model of care is not "psychiatrist-led", in circumstances where a psychiatrist is available only intermittently at most correctional centres.

I accept this submission and decline to make the recommendationproposed.

Recommendation (m)

Ms. Lewer proposes that Justice Health implement a policy requiring any inmate who is prescribed antipsychotic medication for a major mental illness to be reviewed within seven days by the primary clinician who has prescribed their medication

Mr. Harris submits that while it would be ideal for patients to be reviewed within 7 days, this is not always practicable, where psychiatrists are available only intermittently. I accept this submission and decline to make the recommendationproposed.

Recommendation (n)

Ms. Lewer proposes that Justice Health implement a policy requiring any inmate who is prescribed antipsychotic medication for a major mental illness to be reviewed be a psychiatrist regularly and at least every 12 weeks unless and until a psychiatrist determines that such reviews can take place less frequently.

Mr. Harris submits that this recommendation is not necessary or desirable where, in certain locations the model of care is not "psychiatrist-led", and a psychiatrist is available only intermittently at most correctional centres.

I accept this submission and decline to make the recommendationproposed.

Recommendation (o)

Ms. Lewer proposes that Justice Health implement a policy requiring any inmate who has entered custody within 48 hours of being detained as a mentally ill person under the *Mental Health Act 2007* be reviewed by a psychiatrist within 7 days.

Mr. Harris submits that that recommendation (o) is not a matter connected with the death, as the evidence does not establish that MH was acutely mentally unwell at the time of his admission into custody on 21 May 2017. Mr. Harris further submits that whilst this proposal is desirable it is not alwayspracticable.

I accept this submission and decline to make the recommendationproposed.

Recommendation (p)

Ms. Lewer submits that Corrective Services should implement a policy that at the time of reception into each correctional centre, inmates automatically be provided consent forms that permit Justice Health and Corrective Services to share medical information relating to the inmate. Such a form shall include an area whereby the inmate can specify whether it is all information or whether some specified information is or is not to be disclosed. Mr. Harris submits that recommendation (p) is not connected with the death as the evidence does not establish that this was an issue at the time of reception. Further the evidence did not explore the consequences of a proposal to share all or some of a patient's health information with CSNSW. Mr. Broad submits that the Commissioner of CSNSW does not support the implementation of this proposal as the lawful disclosure of health information in accordance with any consent obtained from an inmate is squarely and appropriately within the remit of Justice Health and not CSNSW. I accept these submissions and decline to make the recommendation proposed.

Recommendation (q)

Ms. Lewer proposes that CSNSW implement a policy that at the time of reception into each correctional centre, inmates be automatically provided consent forms that permit Justice Health and/or Corrective Services to share information relating to the inmate with family member(s) or friend(s) of the inmate. Mr. Harris submits that recommendation (q) is not connected with the death as the evidence does not establish that this was an issue at the time of reception. Further the evidence did not explore the consequences of a proposal to share all or some of a patient's health information with CSNSW. Mr. Broad submits that the Commissioner of CSNSW does not support the implementation of this proposal as the lawful disclosure of health information in accordance with any consent obtained from an inmate is squarely and appropriately within the remit of Justice Health and not CSNSW. I accept these submissions and decline to make the recommendation proposed.

Recommendation (r)

Ms. Lewer proposes that CSNSW staff be required to undertake ongoing training and development in relation to identifying prisoners who are experiencing symptoms of a mental illness and risks of self-harm. Mr. Broad does not support the recommendation. He submits that MH did not manifest any signs or markers indicating he was at risk of suicide during the period of his incarceration leading up to his death. Further, the current CSNSW policy in relation to the management of inmates at risk of self-harm or suicide provides an appropriate level of guidance to CSNSW staff about the identification and assessment of risk factors for suicide and self-harm. I accept that submission and decline to make the recommendationproposed.

Recommendation (s)

Ms. Lewer proposes that successful applicants to become a staff member of NSW Justice are required to complete basic training, and that this basic training should include a core compulsory subject in relation to identifying prisoners who are experiencing symptoms of mental illness and self-harm.

Mr. Broad does not support the recommendation. He submits that MH did not manifest any signs or markers indicating he was at risk of suicide during the period of his incarceration leading up to his death. Further, the current CSNSW policy in relation to the management of inmates at risk of self-harm or suicide provides an appropriate level of guidance to CSNSW staff about the identification and assessment of risk factors for suicide and self-harm. I accept that submission and decline to make the recommendationproposed.

Recommendation (t)

Ms. Lewer proposes CSNSW implement ongoing training and development for all staff employed in support and welfare roles in relation to delivery of all difficult news to inmates. Such training is to include methods and strategies that might be able to be utilised to deliver such news, observations about the inmate's response that should be considered, the supports that are available for the inmate when such news is delivered and arranging follow up for the inmate. Mr. Broad does not support the recommendation. Mr. Broad submits that it is unclear what type of further training welfare officers could realistically undertake. Mr. Broad submits that Mr. Sheehan expressed the view that Ms. Crown's approach was reasonable in the circumstances. Apart from the sensitive use of interpersonal skills to convey bad news Mr. Sheehan was unable to identify any other skills or assurances that could be usefully deployed by a welfare officer. I accept that submission and decline to make the recommendationproposed.

(2) ***Recommendation (u)***

Ms. Lewer proposes that CSNSW conduct a review into the implementation of the "companion inmate" aspect of section 7.17 of its Operation Procedure Manual policy and provide reminders and training to its staff about the implementation of that policy. Mr. Broad does not support the recommendation. He submits that 7.17 of the Operation Procedure Manual has been replaced with COPP 5.2 which was last reviewed on 27 May 2020 and a cell placement guide added to the procedure. I accept that submission and decline to make the recommendationproposed.

Recommendation (x)

Ms. Lewer proposes that CSNSW and Justice Health work towards developing a consistent computer alert system in relation to self-harm, to ensure that both entities are aware of the risks that exist for a particular inmate. Mr. Harris submits that this recommendation is not necessary or desirable and that the HPNF already provides a system for alerting CSNSW staff to a patient's health problems. Mr. Broad submits that the need for development of a new computer alert system is not demonstrated and that CSNSW and Justice Health currently collaborate in identifying and managing an inmate's risk of self-harm. I accept these submissions and decline to make the recommendation proposed.

9. 225703 of 2017

Inquest into the death of Ivan Leo Goolagong. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 22 October 2021

Ivan Leo Goolagong was a proud Wiradjuri man born in Condobolin, NSW in 1949. His two eldest children, Priscilla, and Ivan (Jnr), attended each day of this inquest. Through Counsel Assisting they generously shared with the court some details about Ivan Leo Goolagong's early life.

Ivan Leo Goolagong grew up on Country in and around Condobolin. He commenced his working life at the age of 13 after leaving school aged 12 with rudimentary literacy and numeracy skills. His main work was labouring and stock work. He married young and had nine children. By his late teens, he had become a talented rugby league player. The Goolagong family moved to various towns (such as Albury in the south) and later settled on the Central Coast as their father pursued his football career. Later Ivan Leo Goolagong developed an art practice and became a clothing print designer. The family frequently travelled back to Country and to visit their large extended family, who remained in and around Condobolin.

By his mid to late 30's, Ivan Leo Goolagong had developed diabetes type II. He had been struggling with alcohol for some time and, to preserve his health, he stopped drinking. He entered custody in 2011 at the age of 61 years, by which time he had additional health problems including ischaemic heart disease, asthma, anaemia and chronic pancreatitis. While in prison, he had numerous ongoing health issues requiring review by various health services. In December 2016, Ivan Leo Goolagong was diagnosed with pancreatic cancer. On 31 January 2017 Ivan Leo Goolagong underwent a Whipple's Procedure, which is a significant surgery to remove the bulk of the pancreas.

On 20 February 2017 he was admitted into the Long Bay Prison Hospital Medical Subacute Unit ("MSU"). Apart from two occasions when he was transferred to Prince of Wales Hospital ("POWH") for treatment relating to his cancer, he remained there until his death on 23 July 2017. Upon his admission to the MSU, Ivan Leo Goolagong should have been referred to the Cancer Care Nurse Coordinator ("CCNC"). The CCNC is employed by Justice Health at Long Bay to coordinate care for prisoners diagnosed with cancer.

Ivan Leo Goolagong did not receive any such care or support. On two or three occasions, at his request, Ivan Leo Goolagong saw a psychologist employed by Corrective Services NSW ("CSNSW"), which is a separate organisation and which is siloed from Justice Health. Within a couple of days of his admission into the MSU (in February 2017), the family of Ivan Leo Goolagong sought assistance to apply for his early release on parole pursuant to s. 160 of the *Crimes (Administration of Sentences) Act 1999* ("CAS Act") so that he could return to Country for end of life care and to be with his family.

They sought the assistance of CSNSW program officers who were employed to assist Aboriginal prisoners. After their request was not progressed, approximately a further month passed, at which time the family sought assistance again. The family were incorrectly advised that they needed to instruct a lawyer to make this application, notwithstanding that Justice Health was under a statutory obligation to advise CSNSW that because of illness, Ivan Leo Goolagong would not survive his sentence. Justice Health failed to properly notify CSNSW regarding same.

Ivan Leo Goolagong's family instructed Legal Aid to submit his early release application to the State Parole Authority. Unfortunately, to obtain the information about his medical condition to provide to the State Parole Authority, Ivan Leo Goolagong's solicitor was required to submit a Freedom of Information Application to CSNSW and Justice Health, and to seek a letter from his oncologist regarding his life expectancy and trajectory of his illness. All of this could and should have been provided to the family without the need for such a time-consuming and costly process.

As a result of the Whipple's procedure, Ivan Leo Goolagong had significant difficulties consuming food and maintaining his weight. This was also compounded by the progression of his disease. Those difficulties were marked by a lack of appetite, difficulty swallowing, and aversion to certain foods he received in custody. Ivan Leo Goolagong lost a significant amount of weight as a result of his disease, and by July 2017, when he was scheduled to have palliative chemotherapy, he was deemed too frail for it to proceed.

Ivan Leo Goolagong's application for early release on parole was submitted to the State Parole Authority in late June 2017, and while CSNSW input was being sought, Priscilla was making the necessary arrangements to facilitate Ivan Leo Goolagong's release from the MSU. Initially, it was hoped that Ivan Leo Goolagong could be cared for at home by his family, however these plans were abandoned, as it became apparent that his health had gravely deteriorated. Arrangements were being facilitated to have Ivan Leo Goolagong admitted into Condobolin Hospital. Unfortunately, Ivan Leo Goolagong passed away before the State Parole Authority hearing regarding his early release had been heard (which had been listed for 1 August 2017).

On the night of 22 July 2017, he requested to speak with Priscilla on the telephone, but this was declined by CSNSW, who apparently told him that the call could wait until morning. Unfortunately, Ivan Leo Goolagong passed before then. The inquest is required pursuant to ss. 27(1) and s. 23 of the *Coroners Act 2009* (the "Act") as Ivan Leo Goolagong was in lawful custody at the time of his death.

Given the constraints of the provisions of the Act, an inquest is confined to the manner and cause of a person's death and cannot be too far removed from the events that led to a person's ultimate passing. As Ivan Leo Goolagong had suffered from a variety of health issues whilst in custody prior to his diagnosis with pancreatic cancer, his family were concerned about the overall healthcare treatment that their father received during that entire time, not just during the final months of his life.

Their invaluable First Nations perspective on the challenges that First Nations inmates face in receiving culturally appropriate healthcare is acknowledged and greatly appreciated. However, the Act requires consideration only of matters sufficiently connected to a person's death. It was therefore not appropriate that this inquest inquired into matters removed from Ivan Leo Goolagong's cancer diagnosis.

Accordingly, the inquest explored the palliative care and treatment provided to Ivan Leo Goolagong, with a focus on the scope for improvements that might assist towards providing inmates in custody with a standard of care similar to that afforded to persons diagnosed with a terminal illness in the general community.

I acknowledge and regret that this limitation will undoubtedly sadden and cause despair to Ivan Leo Goolagong's loved ones. I extend my sincere condolences to the Goolagong family and especially acknowledge their sadness at knowing that their father, Ivan Leo Goolagong, a proud Wiradjuri man, died in custody, alone, rather than being given an opportunity for early parole to travel back to Country and be with his family engaging in appropriate Aboriginal Ceremony. This fact has been traumatic, particularly for Priscilla, who feels strongly that her father's spirit is yet to go back to Country and be at rest. An inquest itself is often difficult and traumatic for family and loved ones, and I accept that this inquest has been no exception. I hope however that in some way, the inquest and these findings provide some relief and peace to Priscilla, Ivan Jnr and the extended Goolagong family.

Issues at the inquest

The issues identified in the coronial investigation to be explored in the inquest were as follows:

- Did Ivan Leo Goolagong receive adequate and appropriate treatment from the time of his transfer to the MSU on 20 February 2017 until his death on 23 July 2017?
- In particular were the palliative care, dietary and psychosocial needs of Ivan Leo Goolagong adequately met during this period when he was at the MSU?
- Following his discharge from Prince of Wales Hospital on 29 June 2017, should Ivan Leo Goolagong have been transferred back there at some stage prior to his death on 23 July2017?
- Was Ivan Leo Goolagong's application for early release based on his terminal illness being appropriately acted upon by Corrective Services NSW and Justice Health?
- To what extent, if any, are services specific to the needs of First Nations inmates in custody with terminal illnesses, available to inmates such as Ivan Leo Goolagong?

Cancer diagnosis and treatment

In August 2016, Ivan Leo Goolagong was an inmate at Junee Correctional Centre when he developed jaundice. A CT scan taken on 1 September 2016 reported *"[l]arge likely intra-ductal calcification at the head of the pancreas causing moderate to marked pancreatic and bile duct dilation, on a background of scattered calcification in the pancreas consistent with chronic pancreatitis* He was transferred to the MSU and then to POWH where stents were placed in the common bile duct. On 8 September 2016, he was transferred back to the MSU, however he was then readmitted to POWH on 8 October 2016 with cholangitis, septicemia with atrial flutter. The biliary stents were blocked.

They were replaced, and Ivan Leo Goolagong was transferred back to the MSU until 26 November 2016, when he was transferred back to Junee Correctional Centre (with four days at Bathurst Correctional Centre in the interim).

On 7 December 2016 Ivan Leo Goolagong had another CT scan at Wagga Wagga Base Hospital which indicated an enlarged pancreatic mass with lymphadenopathy and hypodensities in the liver. On 13 December 2016, Ivan Leo Goolagong was transferred to Royal Prince Alfred Hospital ("RPAH") for a Whipple's Procedure and investigation of the suspected cancer. The procedure was delayed as Ivan Leo Goolagong had hyperkaliemia (excessive potassium levels) which required treatment prior to the procedure being able to be undertaken. On 10 January 2017, he was transferred to and remained in the MSU until his transfer back to RPAH on 31 January 2017 for his Whipple's procedure. He underwent surgery, and after a period of recovery he returned to the MSU on 20 February 2017. A histopathology report dated 7 February 2017 indicated the following:

A 70mm pancreatic adenocarcinoma withmargins; Metastatic adenocarcinoma in 6/18 lymph nodes with extra nodal spread and tumor deposits; and Metastatic adenocarcinoma in liver.

Professor David Goldstein, Ivan Leo Goolagong's treating oncologist, noted in correspondence dated 9 March 2017:

"Given his pathology, Ivan has T3 N1 M1 stage IV pancreatic adenocarcinoma. We explained that he is at high risk of recurrence at 80% given the high-risk features on his pathology and foci of metastatic disease in his liver. There are 2 possible options of management for Mr Goolagong. The first being whether we would view his case as a subgroup of pancreatic cancer patients who are potentially rendered with no evidence of disease after surgery despite his focus of liver metastasis and subsequently treat with "adjuvant chemotherapy comprising of ESPAC-4 protocol. The second management option would embrace a palliative approach with surveillance and then institute palliative chemotherapy at the time of recurrence. We will discuss his case at our next gastrointestinal multidisciplinary team meeting. In the meantime, I have advised Mr Goolagong to continue to improve his fitness and nutrition. We will follow him up in 2 weeks' time and will keep you informed of his progress." On 19 April 2017, Ivan Leo Goolagong underwent a CT scan, which was reviewed by Professor Goldstein on 27 April 2017.

He noted:

"CT scan shows no evidence of disease progression at this point in time although it was a non-contrast because of difficult venous access. The plan is to continue with surveillance at present and not initiate palliative chemotherapy until there is good evidence of disease progression.

Accordingly, he will be seen again in a month's time".

On 23 May 2017, Professor Goldstein reviewed Ivan Leo Goolagong again and noted:

"He remains asymptomatic but somewhat depressed because of the knowledge that he does have metastatic disease. There is nothing new to find on physical examination. His liver function tests are stable though his albumin is somewhat low and his CA19-9 continues to slowly elevate.

Given the absence of any physical symptoms and the normal CT previously, further surveillance is reasonable, and he will be seen again in one month's time." On 23 June 2017 a contrast CT scan report indicated "*multiple new hypodense liver lesions…highly suspicious for progressive metastatic disease*".

Ivan Leo Goolagong's understanding of his diagnosis and wish to seek early release on parole

It was not until the histopathology report was received following the Whipple's surgery that it was confirmed that Ivan Leo Goolagong's cancer had metastasised, although the results of a December PET scan conducted at Wagga Wagga Base Hospital were highly suggestive of this eventual diagnosis. At that time, it appears that Ivan Leo Goolagong was expecting that the Whipple's Procedure would mean that all of the cancer had been removed, and that he would therefore be cancer free. It is unclear whether Ivan Leo Goolagong had been informed that it was known, or at least suspected, that the cancer had metastasised to his liver, and was aware of the seriousness of his disease. Professor Goldstein's reference to the recurrence of cancer in his letter of 9 March 2017 tends to support that Ivan Leo Goolagong was under the impression that the surgery had removed all of the cancer. In reality, it had only removed the cancer from the pancreas; it had metastasised to his liver as well. The fact that Ivan Leo Goolagong did not understand this is perhaps unsurprising given the terminology used.

Whether Ivan Leo Goolagong had been advised of the histopathology results (which confirmed his terminal condition) is unclear. It was recorded in Ivan Leo Goolagong's medical notes on 24 February 2017 that he remarked that he was "*cancer free now*". The writer of that note had placed in brackets *"(? told in RPAH)"*. Again, this entry is supportive of the fact that Ivan Leo Goolagong did not fully appreciate the nature of his diagnosis.

This notwithstanding, on 22 February 2017, Ivan Leo Goolagong had a telephone conversation with the CSNSW Manager of Security ("MoS"), Cheryl Wood, together with his daughter Priscilla, in which they discussed a possible early release to parole due to his terminal condition. The following day (23 February 2017), CSNSW Aboriginal case workers Catherine Ryan and Kristy Ohlsen also visited Ivan Leo Goolagong in relation to his desire to seek early release on parole. On 24 February 2017, Ivan Leo Goolagong saw MSU doctor, Dr Mica Spasojevic. She queried Ivan Leo Goolagong's understanding about being "*cancer free*". As a result of that meeting, Dr Spasojevic reviewed the February 2017 histopathology report and the December 2016 PET scan. She then spoke with Ivan Leo Goolagong again on 28 February 2017 and discussed the results of the histopathology report with him. Ivan Leo Goolagong asked to see a psychologist, which occurred the following day on 1 March 2017. The psychologist's notes indicate that Ivan Leo Goolagong had been informed that his cancerremained.

On 30 March 2017, Ivan Leo Goolagong attended Professor Goldstein and on his return to the MSU he remarked that his "*cancer ha[d] returned"* to his liver. His medical notes record that Ivan Leo Goolagong was frustrated at being told that he still had cancer in his liver, having previously been told that it was in remission. It would appear that when Ivan Leo Goolagong returned to the MSU on 20 February 2017, his understanding as to the nature of his disease may have been limited.

He had been advised that at that stage there was no cancer to treat but that there was a high chance that in the future there would be. This is consistent with Professor Goldstein's letter of 9 March 2017. From a medical perspective however, having no signs or evidence of cancer that requires immediate treatment is different to not having cancer at all. A lay person may have difficulty understanding this distinction. The fact that this distinction had apparently not been successfully communicated to Ivan Leo Goolagong meant that he may not have had an adequate understanding of his disease and its likely progression, which is most regrettable. This miscommunication was no doubt compounded by the fact that such a misunderstanding occurred with the context of Ivan Leo Goolagong holding an understandable mistrust towards medical providers in regard to the information and treatment that they provided. As such, it appears that he felt cheated by his medical providers and his treatment remained an ongoing cause of understandable, yet preventable, distress to Ivan Leo Goolagong.

As early as February 2017, Ivan Leo Goolagong understood that his medical condition was serious because at that time, he had discussions about the prospects of an early release due to his diagnosis. He reiterated this desire again on 30 March 2017 when he said he "*would like assistance from welfare because he wants to appeal his sentence on medical grounds*". Ms. Ohlsen, Aboriginal Services and Programs Officer again saw Ivan Leo Goolagong on 3 April 2017. He told her his cancer had returned and he wanted to action an appeal against his sentence. This was confirmed in a telephone call between Ms. Ohlsen and Priscilla on 6 April 2017. On or around 27 April 2017, Ivan Leo Goolagong was presumably informed of the results of the CT scan of 19 April 2017. He was presumably told that medical providers would continue to monitor his condition rather than commence treatment. Again, on 3 May 2017, Ivan Leo Goolagong told a CSNW psychologist that he wanted assistance regarding an early release from prison application. These repeated requests indicate that Ivan Leo Goolagong understood thathis condition was terminal.

There does not appear to have been a scan in May 2017 and Ivan Leo Goolagong was apparently asymptomatic at this time. He had a contrast scan on 23 June 2017 which showed progressive disease. He arranged to see a lawyer to arrange his financial affairs, power of attorney and last will and testament. Although Ivan Leo Goolagong wanted to have chemotherapy treatment and he was conveyed to POWH on 7 and 13 July 2017, on each occasion chemotherapy did not proceed as he had become so frail that he felt unable to cope with chemotherapy and its side effects.

The Medical Subacute Unit, Long Bay Prison Hospital

Counsel Assisting made the followingsubmission:

"The evidence suggests that the clinical staff in the MSU have little if any specific training in the psycho-social aspects of Palliative Care. The evidence also suggests that they had little or no interaction with Ivan Snr aimed at establishing an understanding of his social or cultural background. In short, they do not appear to have been well equipped to attempt to develop rapport and empathy with a First Nations man with a terminal illness. By contrast, some of the more specialist staff at POWH (for example the psychiatry medical officer) exhibited an understanding of how this might be done, however their opportunity to interact with Ivan Snr was limited in the circumstances".

The Goolagong family adopted this submission and remain highly upset that Ivan Leo Goolagong died in such circumstances. Justice Health did not take issue with Counsel Assisting's submission, preferring to focus their submissions on the medical care that Ivan Leo Goolagong received after 30 June 2017 and the changes that had been made more recently in regard to the palliative care services provided by Justice Health in the MSU.

Likewise, CSNSW did not take issue with Counsel Assisting's analysis. Rather their closing submissions focused on the routines in the MSU, Ivan Leo Goolagong's application for early release on parole, the refusal of Ivan Leo Goolagong's request for a telephone call to his daughter on the night prior to his death and the recommendations put forward by Counsel Assisting.

The MSU has 29 beds in one and two bed cells. The numbering system commences at number 16 (cells 1 – 15 are part of the Aged Care and Rehabilitation unit at Long Bay Hospital). The MSU accommodates prisoners who have been discharged from hospital and require ongoing medical care. The current Governor of Long Bay Hospital (which supervises the MSU) is Mr. Jason Hodges (in 2017 he was working in the prison at Broken Hill). He provided two statements which were included in the coronial brief of evidence, and he gave oral evidence at the inquest. He identified that CSNSW officers working in the MSU have a number of functions, including facilitating health providers' access to inmates, facilitating inmates to exercise outside of their rooms, interacting with prisoners and reporting and recording matters as they arise on shift. The MSU is subject to a routine similar to any hospital. This includes meal service throughout the day: 7:30am breakfast, a 10am morning tea, a 12pm lunch, a 2pm afternoon tea, and a 5.30 pm dinner.

However, as the MSU patients are prisoners, their cells are locked from 2:30pm to 8am each day as well as 11.30am - 12.30pm to allow CSNSW to have lunch breaks. From time to time, lockdowns may be imposed due to reduced staff levels, for example, when officers are redeployed to escort prisoners during unplanned transfers to an (outside) hospital or where there is a serious incident in a relevant corrections facility. Prisoners have access to the dialysis unit in the MSU until 7pm. Medical staff, who are employed by Justice Health, require a CSNSW staff member to accompany them if they are attending a patient in their cell. When a patient has an appointment to see a medical practitioner, a CSNSW staff member is required to escort them to and from the cell. The CSNSW staff member is also required to be present during the appointment. Although Mr. Hodges said that locking the cells does not hamper medical staff accessing a patient, the evidence from medical staff was that their access to prisoners is very limited given the hours that prisoners are regularly locked in their cells and additional lockdowns that would occur from time to time, and that generally, prisoners are unavailable when the cells are locked.

Mr. Hodges also stated that the locked cell system does not interfere with food service. That is because food service is either via a door hatch or the door being opened or closed in any event. Mr. Hodges stated that when a prisoner is in end of life care, the CSNSW MSU staff facilitate family members to visit regardless of lock-in times. He also stated that when requested by nursing staff, a MoS can authorise a patient's cell door to remain unlocked to enable nursing staff direct access to a patient, which allows them to provide *"comfort and care"* to a patient whose health is precarious and/or deteriorating. CSNSW staff provide corrections services for a secure facility at POWH known as the "Annex". This is a seven-bed unit for inmates requiring hospitalisation outside of the relevant medical unit of a correctional facility.

The hospital visiting regime applies to the Annex and CSNSW are able to accommodate a degree of flexibility so that visitors can attend the Annex outside of regular visiting hours. More recently, due to the COVID-19 restrictions affecting visitation to correctional facilities, CSNSW has arranged for computer tablets to be located at its hospitals to facilitate video-call visits between prisoners and their family and friends. Dr Spasojevic is a senior career medical officer at Justice Health. She has worked at the MSU as its full-time medical officer since 2008. She explained that care of MSU patients is provided under the guidance of appropriate specialists from POWH or other referring hospitals. She provided a statement as part of the coronial investigation, in which she described the MSU's rolethus:

… *"providing care to patients with chronic and subacute medical conditions, post- surgical care, spinal patients care, infectious disease, oncology patient care, palliative care and end of life care.*

For patients with a terminal illness, medical care is provided under oncology and palliative care specialists, their guidance and follow ups".

Ivan Leo Goolagong's Health Management Plan

On 20 February 2017, when Ivan Leo Goolagong was received into the MSU from RPAH following his Whipple's procedure, a form called a Health Management Plan ("HMP") was commenced and kept on his file. It is a two-page document with each side expressing a statement that *"this is a multi-disciplinary plan with an expectation that all professionals involved in care contribute".* The HMP's design identifies a patient's needs, the strategies, and interventions for each of those needs, the person or service responsible for addressing those needs and the target and review dates, as applicable. The HMP should have provided for a comprehensive palliative care plan for Ivan Leo Goolagong. The progression of the cancer, and whether palliative chemotherapy treatment was required, necessitated close monitoring and good communication amongst the MSU medical staff. Importantly, the HMP should have focused on Ivan Leo Goolagong's nutrition, in particular the requirement to be on a pancreatic enzyme replacement (Creon), which arose from his Whipple's procedure. Every time Ivan Leo Goolagong ate, he was required to take Creon. He was required to eat a diabetic diet, which the inquest learned was no different to a normal CSNSW-mandated diet. Due to his poor appetite, Ivan Leo Goolagong was also provided with the meal replacement "Ensure Plus" for supplemental nutrition.

Due to his diabetes, his blood sugar levels required especially close monitoring and were often deranged. Ivan Leo Goolagong experienced significant difficulty with his appetite and receiving palatable food. This required ongoing monitoring and communication. The HMP was completely inadequate, both in its content and use as a multi- disciplinary communication device to ensure that Ivan Leo Goolagong was appropriately managed. Dr Spasojevic said it was not a form that she dealt with, identifying it as one which the nurses were required to complete. Registered Nurse ("RN") Christine Maher said that she commenced the HMP, entering the words *"weight loss"*.

She gave evidence that she otherwise did not complete the form, as it was not a form with which she was familiar. The HMP provides for the identification of a patient as Aboriginal or Torres Strait Islander.

RN Maher stated that she did not think that Ivan Leo Goolagong identifying as Aboriginal held any relevance (regarding patient care) beyond that the HMP required that information to be completed.

The inquest heard evidence from Paul Grimmond, who is the Director of Nursing and Midwifery Services at Justice Health. In his statement, he said that all patients who have a life limiting illness are referred to the CCNC. This is required to occur if the patient identifies that they have cancer when they are received into the custody of CSNSW or if they are diagnosed at any time during their incarceration. The CCNC position is full-time and located at Long Bay Hospital. The CCNC also provides services to other CSNSW facilities. The position was occupied at the time when Ivan Leo Goolagong was a prisoner. According to Mr. Grimmond's statement, Ivan Leo Goolagong was not referred to or seen by the CCNC at any time. He should have been. According to Mr. Grimmond's statement that was because Ivan Leo Goolagong required input from the palliative care team. That team was based at POWH.

Given that the referral to the CCNC was supposed to have occurred at the time of Ivan Leo Goolagong's diagnosis and there was a five month gap before the community palliative care team attended upon him (on 18 July 2017), this evidence does not provide an adequate explanation as to why Ivan Leo Goolagong was not referred to the CCNC, in circumstances where as at the end of February 2017, it was known that Ivan Leo Goolagong had pancreatic cancer that had metastasised to his liver. Mr. Grimmond said that the explanation as to why Ivan Leo Goolagong was not referred to the CCNC was provided to him by the After-Hours Nurse Manager who, like Mr. Grimmond, worked in the Integrated Care Service at Long Bay Hospital. On the last day of the inquest Mr. Grimmond gave further evidence that he had recently spoken to the CCNC about Ivan Leo Goolagong and the CCNC told him that she had seen Ivan Leo Goolagong at one point but that he had declined her services. Mr. Grimmond was unable to say when this interaction occurred and agreed that there is no reference to such a conversation between Ivan Leo Goolagong and the CCNC in any of the Justice Health records or in any other location that he was aware of.

Further, in Ivan Leo Goolagong's Justice Health medical and nursing records there is not a single reference to the CCNC at any point. Nor did any of the staff who made statements or gave evidence to the inquest at any time mention the position or role of the CCNC at the MSU. This evidence establishes that not only did the CCNC play no role in Ivan Leo Goolagong's care or coordination of care, the staff at the MSU did not contemplate this as a possibility. The lack of coordinated cancer care resulted in a poor delivery of the already meagre palliative care services that were available to Ivan Leo Goolagong, which negatively impacted on his and his family's involvement in his end of life care.

The Cancer Care Nurse Coordinator

A document dated May 2020 and titled "Business Rules" was produced to the inquest during Mr. Grimmond's evidence.

It was not possible to discern during the inquest, whether the rules relating to the CCNC's role existed in that form since 2016 (when the role was commenced), or whether they were more recently created. In any event, the role descriptor does give an indication of what care Justice Health expects a prisoner with a cancer diagnosis to receive from its staff. The key aspects of the role are as follows:

- Guiding the patient to information and services that foster independence.
- Awareness of consultation, treatment plans and treatment outcome.

- Coordination of the implementation of care plans including the provision of information and referral to appropriate services; and
- Single point of contact for cancer services development and education of staff regarding appropriate referral pathways and documentation; and release planning.

Ivan Leo Goolagong's HMP being barely completed could be explained by the fact that it was likely to have been an appropriate task to be carried out by the CCNC. This, of course, did not occur as no appropriate referral had been made. Mr. Grimmond said that the CCNC had taken leave in January, February, March, and July 2017 but that she had known Ivan Leo Goolagong when he was in another prison as she used to give him insulin. She apparently told Mr. Grimmond that, at some stage in 2017 when she was in a meeting, she heard that Ivan Leo Goolagong was in the MSU. She subsequently went to the MSU to see him and introduce herself and talk about the service. She told Mr. Grimmond that she knew him well and he responded to her with *"[u]s Black Fellas, we do our own things our own way".*

If that is accurate, it would seem that the CCNC took that comment as dismissive (to the extent she didn't even write a note), rather than considering there might be a person other than herself, who could have a conversation with Ivan Leo Goolagong about what his cultural needs (which he raised) were. The CCNC was unable to tell Mr. Grimmond when this conversation occurred, and she said she was surprised that she hadn't made a note of it.

Palliative care

The coronial investigation included the obtaining of expert review of the c u s t o d i a l Palliative Care Services provided to Ivan Leo Goolagong. A report prepared by Associate Professor Ghauri Aggarwal was served, and Justice Health obtained a report prepared by Dr David Gorman. Both Associate Professor Agarwal and Dr Gorman are palliative medicine and pain specialists. Associate Professor Aggarwal is currently the Head of Department at the Concord Centre of Palliative Care. Associate Professor Aggarwal and Dr Gorman gave their evidence in conclave. They concurred that the following definitions provided by Palliative Care Australia relevantly explain what Palliative Care and End of Life Care is and what such care seeks to provide:

***"Palliative Care** is person and family-centred care provided for a person with an active, progressive and advanced disease, who has little or no prospect of cure and who is expected to die, and for whom the primary goal is to optimise the quality of life.*

- *…. is care that helps people live their life as fully and as comfortably as possible when living with a life-limiting or terminal illness*.
- *…. identifies and treats symptoms which may be physical, emotional, spiritual, or social. Because palliative care is based on individual needs, the services offered will differ but may include:*
- *Relief of pain and other symptoms e.g. vomiting, shortness ofbreath.*
- *Resources such as equipment needed to aid care athome.*

- *Assistance for families to come together to talk about sensitive issues.*
- *Links to other services such as home help and financial support.*

- *Support for people to meet cultural obligations.*
- *Support for emotional, social, and spiritual concerns.*

- *Counselling and grief support; and*

- *Referrals to respite care services*.

- ***…****is a family-centred model of care, meaning that family and carers can receive practical and emotional support*.

End-of-life care *is the last few weeks of life in which a patient with a life-limiting illness is rapidly approaching death. The needs of patients and their carers is higher at this time. This phase of palliative care is recognised as one in which increased services and support are essential to ensure quality, coordinated care from the health care team is being delivered. This takes into account the terminal phase or when the patient is recognised as imminently dying, death and extends to bereavement care*".

First Nations palliative care needs

Associate Professor Megan Williams is a Wiradjuri woman but from Country distant to that of Ivan Leo Goolagong's Country. As far as she is aware, they are not related. In any event, when she gave her evidence in the inquest, her expertise and independence was not subject to any challenge. Amongst other appointments and responsibilities, she is a member of the Commonwealth funded 'National Palliative Care in Prisons Project' and chairs its Aboriginal and Torres Strait Islander ("ATSI") Community Engagement Strategy Working Group. Associate Professor William's assertion that a prisoner had a right to equivalent health care in prison as a person in the community was likewise not contentious.

Associate Professor Williams adopted the Nelson Mandela Rules for prison management. She noted that prisons throughout the world have engaged Indigenous Elders and professionals to guide appropriate cultural protocols and programs of support and engagement with Indigenous prisoners. She explained that palliative care, like any health care for a First Nations person, requires a holistic understanding and practice considering matters ranging from contextual societal factors to spiritual factors.

Specifically, for palliative care she addressed the following:

- Cultural connection
- Cultural identity and identification
- Aboriginal and Torres Strait Islander cultural knowledges respected

- Cultural rights
- Aboriginal definition of health
- Respecting the context of health, wellbeing, and healing
- Addressing multiple needs
- Earlier engagement with end-of-life care
- Cultural safety
- Social support
- Cultural support
- Personal support and gendered business
- Right to equivalent care in the community
- Effective and timely access to support and palliative care
- Access to information
- Death and dying
- Intergenerational responsibilities and family care.

From material contained in the brief of evidence, Associate Professor Williams noted that although Ivan Leo Goolagong was recorded as being from Condobolin and that he was an Aboriginal man, the records did not identify him to be Wiradjuri. There was reference to Ivan Leo Goolagong having been impacted by the Stolen Generation, however, there was a complete absence of any detail about this to inform care planning. She noted that it appeared that at no time was information about Ivan Leo Goolagong's cultural identity and community probed for, named, or recorded by any of the care providers who saw him in the MSU. Without such information, any care planning results in a lack of engagement by care providers with the patient regarding their cultural needs. Given that there are over 300 Aboriginal nations in Australia, had there been some information about Ivan Leo Goolagong's cultural identity and community, it would have allowed for engagement with Local Traditional Owners and Elders, who could provide guidance (relevant to care planning), that appropriately acknowledged Ivan Leo Goolagong's Country and community.

Associate Professor Williams noted that most CSNSW and Justice Health forms had an option to select Aboriginal and/or Torres Strait Islander Identity. She identified the time when such forms are completed by CSNSW and Justice Health staff as an opportunity to prompt a First Nations prisoner for meaningful details, as well as establishing or improving trust and rapport. Associate Professor Williams made it clear that despite the First Nations peoples' experience of colonisation, the removal of land, separation of their families and communities and the consequent loss of cultural knowledge, it should not be assumed that all knowledge, such as knowledge relating to *"end-of-life"*, has been lost or destroyed. Indeed, the Goolagong family's submissions refer to their Mortuary Lore and their distress that such Lore was not respected when Ivan Leo Goolagong was dying, as well as after his death.

Associate Professor Williams asserted that it is well known that disrespect for First Nations peoples' knowledge, processes, rights, and needs, prevails in health workplaces. She observed that in prisons, a skilled and respectful prison workforce is required to ensure that First Nations cultural knowledge is respected. She indicated that this workforce should include both corrections staff and health service staff. Associate Professor Williams identified poor adherence to the United Nations Declaration on the Rights of Indigenous People occurring in the context of provision of palliative care in prison. In particular, she identified poor adherence to the need for non-discrimination based on Indigeneity and identity, the right of Indigenous people to be actively involved in developing and determining health and social programmers affecting them and the need for Indigenous people to, as far as possible, administer such programmes through their owninstitutions.

Associate Professor Williams report puts forward an Aboriginal definition of health as one that is:

"not just the physical wellbeing of an individual but refers to the social, emotional and cultural wellbeing of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total wellbeing of their Community. It is a whole of life view and includes the cyclical concept of life-death-life. (National Aboriginal Community Controlled Health Organisation (NACCHO), 2011, pp. 5-6)."

The report points to the difficulty (if not impossibility) of achieving holistic health when health and other services and systems are each siloed. The Goolagong family submissions speak to a lack of ongoing psychological care for Ivan Leo Goolagong, noting that there was no apparent communication between the prison psychologist and the POWH psychiatrist, Dr Bautovich. Dr Bautovich spoke with Ivan Leo Goolagong during his June admission at POWH. Additionally, the prison psychologists are employed by CSNSW rather than Justice Health. Accordingly, their files do not form part of the Justice Health file. This siloing of services prevents good continuity of care, effective communication, and effective delivery of health services.

Associate Professor Williams conveyed the importance of understanding First Nations holistic health and healing and explained that "*health extends to wellbeing as well as healing rather than [just] treatment and recovery of physical equilibrium. Healing in a range of domains of life can occur even if a return to physical health is not possible*". Palliative Care service providers need to be capable of cross-cultural work and contribute to (and engage with) culturally responsive systems.

In doing so, there needs to be an understanding of the numerous socio-cultural factors which adversely impact workplace practices and that these, together with other subjective factors, impact on patient and family capacity to engage with palliative care. Associate Professor Williams reminds us that rolling out palliative care funding staff and programs without a workforce that has understanding, respect and engagement with First Nations people's holistic health needs, will be both ineffective and unsustainable.

She pointed out the many reasons behind First Nations people's lack of engagement with formal health care. These range from individual and community experience, ineffective assessment and services, lack of availability of services, mainstream services not changing their model of care and not engaging staff skilled to provide culturally safe care to meet the needs of Aboriginal people and the lack of investment of funds from government.

In order for a prisoner to have their needs and beliefs respected, not only the person working for the service provider, but also the system in which they work, needs to know what those needs, and beliefs are and act appropriately in relation to them. I suspect that at this point in time, this will not be achieved in the context of a non-First Nations workforce and probably not until it is incorporated in a real sense by the government institutions involved in the imprisonment of First Nations persons. The severe over-representation of First Nations persons in custody is problematic in and of itself. It is also accepted that First Nations people have poorer health outcomes in the community than non-First Nations people.

The fact that First Nations people in custody do not have equivalence of care to those First Nations people in the community, presents as a triple disadvantage. Not only are First Nations people more likely to go to prison, but once they are there, they tend to have poorer health outcomes when compared to other First Nations people in the community (who are already disadvantaged when compared to non-First Nation community members). In relation to Ivan Leo Goolagong, it is readily apparent that, even though by December 2016 (or the latest February 2017) CSNSW and Justice Health knew that his illness was terminal with a short prognosis, there was no consideration given to his palliative care needs at all, except for his direct medical needs. Aside from Dr Sze's attendance on the one occasion on 18 July 2017, there was no proper palliative care assessment and no timely palliative care provided to Ivan Leo Goolagong.

No one sought to engage First Nations Health care providers, and no one sought to broker his engagement with a culturally appropriate person or organisation external to the MSU. There is no evidence that any person who was involved with Ivan Leo Goolagong's care, either from CSNSW and Justice Health, sought cultural guidance locally or elsewhere, so as to afford Ivan Leo Goolagong the opportunity to engage with cultural end of life protocols. That this time was an especially significant time for Ivan Leo Goolagong, his family and community seems to have gone unnoticed by those involved with his care in prison. Ivan Leo Goolagong's family needs did not receive due regard or support. This lack of regard has unfortunately, and unnecessarily, proved to be traumatic for Ivan Leo Goolagong's children Priscilla and Ivan Goolagong Jnr. It has no doubt been traumatic for other family and community members as well.

The evidence in the brief of evidence suggests that Ivan Leo Goolagong had social, financial, emotional, mental, physical, and spiritual needs and that these needs were not appropriately met. If those who failed to engage with Ivan Leo Goolagong failed to do so because they had no understanding of his needs, or they felt it was culturally inappropriate for them to personally do so, then they should have sought guidance in order to secure a person or persons with whom Ivan Leo Goolagong could engage with in a culturally appropriately manner. This did not occur. Associate Professor Williams and Aunty Glendra Stubbs gave evidence about the need for First Nations people's spirits to be respected so that they can continue their perpetual life-death-life cycle. They gave evidence as to the consequences when this does not occur, to both the passed spirit, as well as to the family. Families experience the long-term effects of sadness and worry. This then perpetuates the ongoing trauma of First Nations peoples. Cancer Australia's document *"The optimal care pathway for Aboriginal and Torres Strait Islander People with cancer"* (2018) lists key considerations which Associate Professor Williams outlines in her report:

- *"The health care provider must understand the patient, including their cultural identity.*
- *Care coordination is required for each person, informed by their culture, gender, socio-economic status and family connections*
- *An expert in Aboriginal and Torres Strait Islander health care must be included in provision of services and support such as an Aboriginal Hospital Liaison Officer or Aboriginal and Torres Strait Islander health worker*
- *Plain English must be used with guidance on using Aboriginal cultural languages and expressions.*
- *Take time to build rapport.*
- *Involve family in care planning andappointments*
- *Appropriate engagement including touching".*

Cancer Australia include what they call 'evidence-based' principles related to tumor- specific pathways but do not detail what evidence they have drawn on from an Aboriginal and/or Torres Strait Islander perspective. Their principles a r e :

- patient-centred care
- safe and quality care
- multidisciplinary care
- supportive care
- care coordination
- communication
- research and clinical trials

Prevention and early detection are also identified as necessary and relevant to end of life care, as is screening, immunisation, risk reduction for other illnesses and investigation of co-morbidities. Step seven of the Optimal Care Pathway relates to end of life care. This recommends:

- *A return to Country*
- *Multidisciplinary palliative*
- *Pain management*
- *Cultural practices for death and dying discussed with local Aboriginal and Torres Strait Islander personnel and communities.*

I recommend the reading of Associate Professor's Williams report and to facilitate her recommendations, I attach it to these findings. Aunty Glendra Stubbs is a Wiradjuri woman. She is an Aboriginal Elder with the Youth Koori Court and has been supporting the healing and recovery of members of the Stolen Generation and their families and communities for over 40 years. This work has included occupying roles with numerous State and Federal organisations. She is currently the CEO of Link-Up, an organisation for the support of members of the Stolen Generation.

She worked for nearly a decade as an advisor for Knowmore Legal Centre, working with the Royal Commission into Institutional Responses to Child Sexual Abuse. This involved extensive engagement with prisoners over a long period of time. The Commissioner sought to ensure that everybody in prison had the opportunity to say if they were a victim of childhood institutional abuse. Many of the prisoners, both men and women, were Aboriginal people.

Aunty Glendra explained that the forced separation of First Nations people has caused a deep fear, anxiety, or reluctance to seek medical treatment. This is because First Nations people were sometimes removed in a hospital or when attending a medical appointment. She said that trauma and distrust of anybody in a position of power flows down through the generations. Accordingly, the experience of many would be to not attend any medical services and/or have very limited engagement when they did attend.

Aunty Glendra spoke about being involved in interviewing many hundreds of prisoners for the "*Bringing them Home*" Report. She identified that the biggest fear for a First Nations person who has had their family removed is the fear of dying in an institution. She said that their *"memories of the institution were embedded in their psyche about bad behaviours and so they thought they would be having the same treatment in their old age that they had in their youth. Places such as Chinchilla Boys and Cootamundra Girls (Homes) were not places that anyone would want to live".*

In relation to prisons in particular, she said that prisons were obviously not *"homely places where people (visitors) feel welcomed...it's a cold institution and its punitive…there's nothing therapeutical, healing…is missing because kindness goes a long way….You've got to book, you've got to travel…it's expensive to get to places…people aren't put in prisons where their family is, they are usually put in other places…only days you (can) choose from (to visit)…like there's lockdowns all the time and people will travel and then get there and they can't see their loved ones".*

In relation to First Nations people's end of life preparation and burial rights, she wrote that it is important for an Aboriginal person to spend the end of their life on Country because it gives their family assurance that their loved one's spirit will be calm. The importance of peace and being surrounded by loved ones is as important for the person passing as it is for their family and community. She wrote of the importance of the spirit entering the right place and she said in her evidence, *"you want to hope that your family go back to their family… there'll be people there that they know and be welcomed and that the spirit leaves the body and doesn't get caught up with bad stuff…that's why we do smoking ceremonies and spend a lot of time… not rushing ceremony at the end of life… you'll say your respects and two days later you're back at work… well we can't do it that way we have to take a long time to make sure that everybody's needs are being met...we spend as much time as we need with eachother".*

Additionally, going to back to Country is important for passing on knowledge to the community. Aunty Glendra said that Ivan Leo Goolagong was an elder and elders can pass a lot of knowledge and stories on their death bed and there needs to be those opportunities to tell the stories to their community. Aunty Glendra reminded us that we all want to have somebody that cares about us there at the time we're leaving and it is really important in palliative care: "*as a community we need to look after our most vulnerable and that's at your most vulnerable stage, when you're leaving this earth".* She was saddened that Ivan Leo Goolagong did not have his request for a telephone call with Priscilla granted.

She also pointed out that just because a worker finishes at 5pm, the family's worry and care does not. She suggested that there be a 24-hour call centre facility available for prisoners whose families could not be with them at these critical times. Associate Professor Aggarwal's report emphasised the psychosocial needs of patients receiving palliative care. She expressed concern about the level of care provided to Ivan Leo Goolagong regarding his psychological care needs. She was also concerned about MSU not enabling adequate family engagement. She queried whether Ivan Leo Goolagong's spiritual, cultural, and psychological care was adequately considered during the last days of his life. Associate Professor Aggarwal said in her evidence:

"I think the principle of not dying alone is a really important one, as a society, we need to value and as the delivery of palliative care I think it's part of the concept and so really having Ivan Senior's ability to contact his family…his worries and concerns may have been assisted with having some contact with family members and I think that's implicit in the delivery of good palliative care in any setting."

Both Associate Professor Aggarwal and Dr Gorman were of the view that palliative care should have been introduced to Ivan Leo Goolagong earlier than it occurred. As palliative care involves both medical and psychosocial care, a review of Ivan Leo Goolagong's medical care as part of his palliative care treatment needed to be examined.

Medical palliative care provided to Ivan Leo Goolagong

Dr Gorman was of the view that, given the histopathology report of February 2017, a referral to the palliative community team (which attended the MSU) could have appropriately been made when Ivan Leo Goolagong was received into the MSU in February 2017.Referring to Professor Goldstein's letter of 9 March 2017, Dr Gorman said it was evident that the intended approach for Ivan Leo Goolagong was to embrace a palliative approach with surveillance and chemotherapy at time of recurrence. Dr Gorman agreed it was clear that Ivan Leo Goolagong's cancer was considered to be terminal at that point. He said in his evidence that the oncology team could have referred Ivan Leo Goolagong to the palliative team in March so that he could receive emotional, social, and spiritual support. Dr Aggarwal pointed out that there are differing pathways from different services and perhaps the fact that Ivan Leo Goolagong was in custody rather than in the community made the referral pathway more complex.

It seems that the MSU was responsible for a referral and that it was done at a time when the Community palliative care team did not have a consultant to attend the MSU and by the time Dr Sze did attend, Ivan Leo Goolagong was leaving the palliative care period and entering end of life care. Ivan Leo Goolagong had rapid weight loss due to the surgery and the cancer. His food intake was poor, and he had pain. He had episodes of hypoglycemia and so regular insulin therapy ceased on 28 February 2017. He attended POWH for oncology review with Professor Goldstein and also attended the Diabetes Centre there. His oral intake and hydration remained problematic and on 15 May 2017 he was transferred to POWH for an overnight stay for hypokalemia treatment.

On 6 June 2017 he was readmitted to POWH as he had developed an extensive deep venous thrombosis of his right leg and commenced Clexane therapy.

On 8 June 2017 at the MSU, Dr Spasojevic noted that he was *"frail, weak, unable to mobilise"* and when asked how he felt he said *"good"*. He was receiving OxyContin for pain and he told Dr Spasojevic that he wanted active CPR measures performed. Dr Spasojevic identified that Ivan Leo Goolagong should be reviewed by a Palliative Care Service. She said in evidence that she considered that a review was necessary as Ivan Leo Goolagong's health was declining and he had complex issues. She telephoned Ms. Cindy Grundy, the Sacred Heart Hospital's Clinical Nurse Consultant ("CNC") to request that someone from the service attend Ivan Leo Goolagong. As a result of that telephone call Dr Spasojevic made a file note that *"Palliative team will kindly review"*. In her evidence Dr Spasojevic said that she did not complete any paper referral and was not advised to do so. She expected that somebody would attend the MSU in the following one to two weeks to review Ivan Leo Goolagong.

Identifying the need for palliative review appears to have also triggered a welfare referral, because Ivan Leo Goolagong was attended to on the same date by both Ms. Ryan and Ms. Ohlsen. Both made a file note that they had been advised that Ivan Leo Goolagong's health had deteriorated, that he required assistance with daily living and that this information had been passed on to a family member (Dorothy Towney, as she was listed as next of kin). Dr Spasojevic went on leave from the MSU from 9 to 21 June 2017. On her return she again attended Ivan Leo Goolagong and learned that the palliative care referral had not resulted in Ivan Leo Goolagong being visited by community palliative care. She noted that Ivan Leo Goolagong's health had further declined in that he was *"very frail; complained of epigastric pain on swallowing food; minimal oral intake; weight loss; decreased mobility."* Dr Spasojevic then sent a written referral by facsimile to Ms. Grundy and she arranged for Ivan Leo Goolagong to be transferred to POWH for management of his weight loss, diabetes, and cancer.

Ivan Leo Goolagong remained at POWH from 22 to 29 June 2017. On 23 June he had a dietician review which noted *"Mr. Goolagong is well known to the dietician from previous admissions for poor oral intake and malnutrition on the background of metastatic pancreatic cancer. He has excellent appetite in hospital however very poor compliance in gaol due to dislike of food which is a long-standing issue. Mr. Goolagong has had extensive involvement with the food service manager and doctors at Long Bay to organise appropriate meals but reports ongoing issues with delivery".* The dietician determined that a nasogastric tube was not required whilst in hospital because *"currently able to meet over 100% of nutritional requirements".*

Dr Bautovich from the POWH mental health team undertook a psychiatric review and noted that Ivan Leo Goolagong had developmental vulnerabilities citing that he *"was raised in rural NSW and had witnessed repercussions of stolen generation…remains in contact with his children, continues to be connected to culture – speaks indigenous language…played rugby league at a high level and had loss of consciousness on several occasions during games…he was able to eat food at the hospital but is frustrated at the limited choice in gaol…denies thoughts of wanting to hasten death".* Dr Bautovich determined that *"there was no evidence of pervasive mood disorder that would account for his poor oral intake"*.

On 23 June Ivan Leo Goolagong had a contrast CT scan (the first contrast CT, as the earlier CT in April was non-contrast) and he saw the POWH palliative care team. The review identified that he had no specialist palliative care needs but stated that the hospital team would link with community (palliative care) to follow his progress.

There is no reference in the palliative care team's notes of that day to suggest that they had reviewed the CT scan. However, the notes indicate that members of the palliative care team spoke with Ivan Leo Goolagong about his understanding of metastatic cancer because he told them that he *"feels like people just want him to die"*. There were notes about his frustration with his diet. When Ivan Leo Goolagong was informed that he would be transferred back to Long Bay Hospital, it seems that he may not have understood that he would be going directly back to the MSU because, according to Priscilla, when she spoke to him by telephone he was very defeated. On her account, he said words similar to *"may as well dig me a hole because I'll be dead by the time I get back to the MSU".*

The notes made upon Ivan Leo Goolagong's transfer back to the MSU on 30 June 2017 indicated that he reported that he *"feels fine"*. The notes also record that Ivan Leo Goolagong met with Dr Grimsdale and the catering manager. The latter said that he could have a "finger food diet" and that he would have Creon directly before meals, as per the POWH discharge summary. Ivan Leo Goolagong continued to deteriorate, he became less mobile, was eating very little and was given nightly Endone for abdominal pain management. He experienced episodes of shortness of breath. Ivan Leo Goolagong had been taken from the MSU to POWH on 5 and 7 July 2017 for chemotherapy but declined to proceed with it.

Despite Dr Spasojevic's telephone call on 8 June 2017, a further referral on 21 June 2017 and the POWH referral on 23 June 2017, the community palliative care team did not see Ivan Leo Goolagong until 18 July 2017. The reason for this is that Dr Sze was a newly appointed member of the team commencing on 19 June 2017. He did not become aware of the referral till considerably later and only had approval to commence visits to Long Bay from 11 July 2017. His appointment was such that he was only able to attend the correctional centre one day a week. I community team. By the time Dr Sze saw Ivan Leo Goolagong, the planned palliative chemotherapy had not proceeded because Ivan Leo Goolagong was too weak from the progression of the disease and his poor nutritional intake. The palliative care provided was limited to pain management. It did not encompass other aspects such as psychosocial and cultural matters.

Dr Aggarwal commented that she thought it would have been preferable that Dr Sze prescribed Ivan Leo Goolagong with slow release OxyContin twice a day rather than 10 mg per day. She also thought that an anti-neuropathic agent might have been prescribed. Dr Sze said that he discussed the medication with Ivan Leo Goolagong and Ivan Leo Goolagong was content with the approach taken. However, it is difficult to measure Ivan Leo Goolagong's understanding and agreeability given his apparent despondency and belief that no-one particularly cared about what was happening with him. Though he was able to articulate that he had been made aware at POWH that without chemotherapy treatment he only had a few months to live, he did not seem able to articulate to Dr Sze that he felt his time of death was much closer.

Dr Sze appeared to have appreciated that Ivan Leo Goolagong was at the end of life stage as he also prescribed morphine in the event Ivan Leo Goolagong would be unable to swallow the OxyContin tablet and/or needed assistance with breathing Associate Professor Aggarwal and Dr Gorman were both of the view that there were an inadequate number of medical reviews by MSU doctors during June and July 2017. Some of this time coincided with Dr Spasojevic's period of leave from the MSU. It also coincided with Ivan Leo Goolagong's admission to POWH and transfers for treatment.

Prior to this, Dr Spasojevic had reviewed Ivan Leo Goolagong regularly and made notes approximately everyone to three days. After Ivan Leo Goolagong's return from POWH to the MSU on 30 June 2017, he was reviewed by Dr Joanne Grimsdale. He was again reviewed by Dr Grimsdale on 21 July 2017, after the palliative specialist review of 18 July 2017. Dr Grimsdale was not on duty from 6 to 21 July 2017. In relation to the last three weeks, Dr Gorman said that he did not think that Ivan Leo Goolagong's care was compromised by the lack of medical input *"although in a sub-acute unit medical input and notes every few days would be ideal."* Dr Gorman commented in his report that *"many patients who die in the community for the last weeks of life have no medical input – the family and the palliative care nursing staff manage the "comfort" care".*

This is no criticism of Dr Grimsdale. Mr. Beckett correctly pointed out that she had limited rostered shifts during this period and on the occasions she did attend Ivan Leo Goolagong she made detailed notes about each attendance. I agree with Mr. Beckett's submissions that any lack of note-making is not a comment applicable to Dr Grimsdale. Indeed, her evidence at the inquest helpfully clarified both the treatment of Ivan Leo Goolagong and the practices and procedures of the MSU. There is no evidence to suggest that Ivan Leo Goolagong's pain management was not appropriately prescribed or that it should have been reviewed more regularly. I note that Associate Professor Aggarwal would have prescribed slow release OxyContin twice daily and considered an anti-neuropathic agent. However, it appears that the medication prescribed and administered to Ivan Leo Goolagong was adequate to manage his pain and symptoms.

That Ivan Leo Goolagong passed away much sooner than the few months that had been suggested is particularly sad because Ivan Leo Goolagong's family had insufficient time to secure his early release or spend time with him. Ivan Leo Goolagong's rapid decline in July 2017 was not due to any lack of care and treatment but rather a consequence of his illness.

Services provided to Ivan Leo Goolagong in the MSU

Dr Gorman, whilst agreeing with Associate Professor Aggarwal, remarked that psychological and spiritual support are essential components of comprehensive Palliative care. Dr Gorman said that such care is not always available in the community, particularly in regional areas. Dr Gorman said he was unable to determine the degree of Ivan Leo Goolagong's contact with family and other support services (such as Aboriginal liaison services) from the material provided to him. However, he said that he hoped that these were available. He was of the opinion that there were no major deficiencies in his care, nor did he believe that Ivan Leo Goolagong suffered because of a lack of expertise or resources. With respect, in that regard, I disagree with Dr Gorman's position. Ivan Leo Goolagong did not have a case worker who coordinated his care. He did not receive culturally appropriate psychological or emotional and spiritual support.

He was denied a phone call to his daughter despite it being evident he was dying. Ivan Leo Goolagong was very much on his own, although he was obviously not well enough to deal with his situation on his own. Had there been some coordination, someone might have considered asking whether a family or community member could attend his monthly reviews with Professor Goldstein at POWH. Given that the purpose of the review was to monitor and discuss Ivan Leo Goolagong's disease progression, it would have been supportive and helpful for him to have someone with him.

This would have enabled him to be supported in asking any questions about his scans, his prognosis, and any treatment options. Despite the lack of a coordinated care approach (by, for example, the CCNC who could have overseen his HMP), Ivan Leo Goolagong did seek the assistance of psychologists and Aboriginal welfare officers. This was an attempt to obtain some level of support for progressing his application for early release. Ultimately, they were of little assistance to him. The fact that Ivan Leo Goolagong did not share or discuss any personal concerns or share his knowledge with Aboriginal welfare officers may be attributable to him presuming or realising that they were not able to provide the type of support he required.

The assistance provided to Ivan Leo Goolagong was disappointing in its lack of communication, delivery and follow up. It is unclear to what extent, if any, the situation would have changed had there been a coordinated care approach. Service program officers or Aboriginal welfare officers are not trained in palliative care or providing social/cultural support to people who are in or near their end of life. There was no such person available to Ivan Leo Goolagong. Of the documented issues, aside from metastatic cancer, it was Ivan Leo Goolagong's diet and nutritional needs which caused him (from a medical perspective) the greatest difficulty. While there were some attempts to provide him with food which he could manage better, he lost a very significant amount of weight over the five months at the MSU. Had Ivan Leo Goolagong been able to arrange other food options, his weight loss may not have been so profound and thus he may have been able to have the planned chemotherapy.

In relation to Ivan Leo Goolagong's medical needs, I note that Dr Gorman questioned the benefit of palliative chemotherapy at that stage of his treatment. Though, again from a medical perspective, I agree with that position, given the (cultural) need for Ivan Leo Goolagong to return to Country, the treatment may have afforded him additional time to do so. Ms. Ryan gave evidence at the inquest and Ms. Ohlsen was excused from doing so. In 2017, Ms. Ryan had been working for CSNSW for over 20 years. At that time, she said that (as the regional Aboriginal welfare officer) she was responsible for Aboriginal prisoners in the Metropolitan East (the other regional Aboriginal welfare officer is responsible for Metropolitan West). As such, the correctional centres she was responsible for, include the Long Bay complex, Dawn de Loas, and the Silverwater complex. She said *"[s]o basically my role is to support and provide advice and cultural support for Aboriginal offenders and also to corrective services management and other staff with regards to Aboriginal inmates…I assist them if they are placed on segregation…advocate on their behalf…".* She said that if there is a death in Aboriginal death in custody she would assist and work in with the Aboriginal Support and Planning Unit. Other duties include working with Aboriginal inmates and the program pathways to reduce their risk of re-offending, engage in therapeutic programs and other programs to help Aboriginal inmates stay connected to their culture whilst in prison.

She is involved in the organisation of numerous NAIDOC events and activities at each correctional centre. This involves an engagement with internal/external stakeholders, engaging with elders, writing submissions for funding, working with state-wide disability services for inmates, and with the prisoner's case management unit in relation to programs for prisoners. She also provided assistance to the Acute Crisis Management Unit at Long Bay giving advice to psychologists and psychiatrists.

Ms. Ryan indicated that, in 2017, she was giving assistance to two to four hundred prisoners, just in the Long Bay Prison Complex. In 2017 Ms. Ohlsen was the sole welfare officer for Aboriginal prisoners in the Long Bay complex.

Ms. Ryan was not Ms. Ohlsen's supervisor, although she was aware of what this role entailed: "…*they assist with a lot of crisis intervention. They assist with fundamental support. They assist with programs. They run EQUIPS programs…they provide the day-to-day services…like with their reintegration or...contacting family...welfare type stuff…they would assist with any death in families with providing an application to apply to attend a funeral…if …something's not going to plan, that's where...they would come to me and …then I would meet with management and advocate further*".

Ms. Ohlsen reported to a senior welfare officer who, in turn, reported to the Manager of Offender Service Programs. Each day she would assess the referrals she had received and prioritise her day's work accordingly. A referral can be created by either a custodial or non-custodial staff member (other than Justice Health) and is placed on the Offender Information and Management System ("OIMS"). This, in turn, generates a support service line which is accessible to all staff. The comment section of the referral will indicate the nature of the prisoner's requests, including whether he wants to see the Aboriginal SAPO.

If a Justice Health staff member working in the hospital, such as a nurse, wanted to assist a prisoner by communicating their request to see welfare, they would do so by asking a CSNSW officer to place a referral on OIMS. It appears from Ms. Ohlsen's statement that she had limited contact with Ivan Leo Goolagong and most of it was in relation to his application for early release. She first saw him on 3 and 6 April 2017, but his application did not progress as a consequence. She appears to have had no contact with him after that, until 8 June 2017. At this time, she had received information that Ivan Leo Goolagong had deteriorated and wanted to know what was happening with his lawyer and early release application. It does not appear that either saw him after that date though Ms. Ohlsen was fielding inquiries between Priscilla and the parole State Parole Authority. On 19 May 2017, at the request of Ms. Ryan, Ms. Ohlsen obtained from Priscilla Ivan Leo Goolagong's lawyer's contact details so that the lawyer could visit Ivan Leo Goolagong in the MSU.

Ms. Ohlsen was then on leave. On 8 June 2017, she and Ms. Ryan attended Ivan Leo Goolagong as they had received information that he had deteriorated. Ivan Leo Goolagong said that although he had seen his solicitor, he did not know what was happening with the application for early release and he had not heard from the solicitor. He also had not had any contact with his next of kin or Priscilla. On 9 June 2017, Ms. Ohlsen and Priscilla spoke about Priscilla organising visits and legal bookings. On 16 June 2017, Ivan Leo Goolagong was given a message that his solicitor would see him on 22 June 2017 so that Priscilla could hold a power of attorney.

Ms. Ohlsen provided her own details to Ivan Leo Goolagong's solicitor as a message had been left for her to do so. On 13 July 2017 Ms. Ohlsen spoke with the solicitor and made arrangements for him to call Ivan Leo Goolagong on 14 July 2017. Ivan Leo Goolagong spoke with his solicitor on 14 July 2017.

The involvement of Aboriginal Special Program Officer Ohlsen with the s 160 application for early release.

On 22 February 2017 Ms. Woods and Priscilla had a telephone conversation in which they discussed whether Ivan Leo Goolagong should or could apply for early release due to his prognosis. Priscila spoke to Ivan Leo Goolagong on the telephone about this.

File notes identify that Ivan Leo Goolagong was visited on 23 February 2017 by Ms. Ryan and Ms. Ohlsen. In her evidence, Ms. Ryan was taken to an OIMS entry dated 22 February 2017 referring Ivan Leo Goolagong to see Aboriginal welfare for an early release application. The entry also indicated that Ms. Ryan saw Ivan Leo Goolagong (with Ms. Ohlsen) on that day in relation to an early release application. Although Ms. Ryan agreed that she did see Ivan Leo Goolagong, she made no note of it and had no recollection of meeting with him. She was taken to a note setting out his complaint about the food he was being provided.

Ms. Ryan then recollected that Ivan Leo Goolagong had told her: "*[t]they're not giving me the right diet*" so she spoke with the doctor who told her the diet was correct, but he was finding it hard to eat due to having surgery. Ms. Ohlsen likewise had not included in her statement to the inquest that she and Ms. Ryan had met with Ivan Leo Goolagong on 22 February 2017. She says in her statement that Ivan Leo Goolagong first spoke to her about such an application on 3 April 2017.

On 6 April 2017 Ms. Ohlsen again saw Ivan Leo Goolagong and spoke with Priscilla over the telephone about the early release application. Ms. Ohlsen advised Priscilla that Ivan Leo Goolagong would need to instruct a solicitor. In her statement Ms. Ohlsen said her role "*did not include assisting with compassionate early release*". In her evidence at the inquest, Ms. Ryan confirmed that the welfare officers' roles did not include being involved in a prisoner's early release applications. It would appear that Ivan Leo Goolagong did not appreciate that Ms. Ohlsen was not assisting him with the application because on 3 May 2017 Ivan Leo Goolagong told the CSNSW psychologist again that he wanted to see Aboriginal Welfare in relation to his early release application.

From reading the file notes and correspondence, it would also appear that Priscilla was not aware that Ms. Ohlsen was not assisting with the application because on 19 May 2017, Ms. Ryan sent an email to Ms. Ohlsen asking that she contact Priscilla in relation to the application…as "*from your previous conversation you are assisting Ivan with this*". The content of that email shows that Ms. Ryan did not question Ms. Ohlsen's involvement with the application, but her evidence was that they advised the family to obtain a solicitor. In her evidence, Ms. Ryan said that she was aware that both sentence administration and Justice Health would be involved in such an application.

Of the welfare officer role, Ms. Ryan said that they "*can facilitate phone calls or follow things up or send an email but just not the actual lodging of an application. We can, you know, like advocate for them...like Parole you need to go and see this particular inmate…in regards to their...early release or an email – a phone call can be made, assisted to be made, with the inmate…to see if they've got ground to apply*".

Ms. Ohlsen attended Ivan Leo Goolagong on 9 June 2017. This was to follow up a telephone call from Ms. Wood, MoS, to Ms. Towney (next of kin) on 8 June 2017. Ms. Wood was advising Ms. Towney that his health was deteriorating and that he had been admitted into POWH (it is CSNSW policy to advise the next of kin when a prisoner is admitted to a hospital outside the prison complex). On 27 June 2017 the Legal Aid Commission received a letter from Professor Goldstein supporting Ivan Leo Goolagong's application for early release. This was sent with the application on 28 June 2017 to the State Parole Authority. It was emailed on 28 June 2017 to Mr. Neil McNamara and on 29 June 2017 he sent an email to Justice Health Clinical Operations seeking information as to Ivan Leo Goolagong's mobility, whether he would have better access to more medical services outside the prison, what his post release treatment would involve and whether he would live with family or be in hospital.

He asked for a response within two weeks. On 5 July 2017 Ms. Katherine McCullock, who was the Senior Community Corrections Officer at the Long Bay Parole Unit, was tasked with completing a pre-release report in relation to Ivan Leo Goolagong's application for early release. The report was required by 1 August 2017. In preparation of the report, Ms. McCullock was required to organise a home visit to carry out an assessment of the proposed accommodation and inform the State Parole Authority of any risks Ivan Leo Goolagong presented, how those risks would be addressed and how he would be managed on parole.

Priscilla was arranging Ivan Leo Goolagong to live with family, with the palliative care unit at Condobolin Hospital as back up. Ms. McCullock needed to identify where Ivan Leo Goolagong would be living and an assessment of what would need to be carried out by another parole officer. On 5 July 2017 she emailed Ms. Ohlsen to contact Ivan Leo Goolagong's family to ascertain the accommodation. She also sent an email to the Serious Offenders Board to provide their input into his application. On 12 July 2017, Ms. Ohlsen sent an email to Ms. McCullock saying that Priscilla had been calling to obtain an update about what was happening with parole. Ms. McCullock advised her by email that a home visit would need to be arranged, so asked her to contact the family in relation to Ivan Leo Goolagong's proposed accommodation. Ms. Ohlsen provided Ms. McCullock with Priscilla's contact details though Ms. McCullock did not contact Priscilla as it appears she thought that Ms. Ohlsen was doing so.

On 17 July 2017, Priscilla called Ms. Ohlsen to advise that the Condobolin Hospital required Ivan Leo Goolagong's medical information. Ms. McCullock also needed to know what Ivan Leo Goolagong's diagnosis and prognosis was. Ms. Ohlsen then contacted the MSU Nursing Manager who apparently advised Ms. Ohlsen that Justice Health did not deal with these issues because they related to parole. On 19 July 2017 Ms. Ohlsen emailed Ms. McCullock telling her that Justice Health would not be involved in the application, and she asked "*Do you know what happens from here? I have no clue*!" Priscilla was contacted and it was clarified that the plan was for Ivan Leo Goolagong to go to Condobolin Hospital. After becoming aware of this, Justice Health then indicated that there would be no difficulty with Justice Health providing information to the hospital.

Section 160: "The Early Release Scheme"

Section 160 of the CAS Act provides that:

- *The Parole Authority may make an order directing the release of an offender on parole who (but for this section) is not otherwise eligible for release on parole if the offender is dying or if the Parole Authority is satisfied that it is necessary to release the offender on parole because of exceptional extenuating circumstances.*

- *The Parole Authority is not required to consider an application for a parole order under this section, or to conduct a hearing, if it decides not to grant such an application.*

- *Divisions 2 and 3 do not apply to a parole order under this section.*

- *This section does not apply in respect of an offender serving a sentence for life*

Part 18 cl. 285 (c) of the *Crimes (Administration of Sentences) Regulation* 2014 ("CAS Regulation") places an obligation upon a "prescribed health officer" to report to a "prescribed CSNSW officer" that, because of illness, an inmate will not survive sentence or is totally and permanently unfit for correctional centre discipline (*emphasis added).*

"Prescribed health officer" and "prescribed CSNSW officer" are defined in cl. 3 of the CAS Regulation as follows:

"A prescribed health officer, in relation to a provision of this Regulation, means—

- *the Chief Executive, Justice Health and Forensic Mental Health Network,or*
- *a medical officer or other member of staff of Justice Health and Forensic Mental Health Network authorised by the Chief Executive, Justice Health and Forensic Mental Health Network, to exercise the functions of a prescribed health officer for the purposes of the provision.*

A prescribed CSNSW officer means –

- *the Commissioner, or*
- *a correctional officer or departmental officer authorised by the Commissioner to exercise the functions of a prescribed CSNSW officer for the purposes of the provision."*
- Both CSNSW and Justice Health concede that the CAS Regulation was not complied with in relation to Ivan Leo Goolagong.

Justice Health policy number 1.170 "*Early Release for Health-related Reasons*" dated 4 April 2016 was in operation in 2017. That policy relevantly states under the heading "Mandatory Requirements**"**:

"Senior staff of Justice Health & Forensic Mental Health Network (JH&FMHN) may identify patients for whom it is considered appropriate to apply for early release. For this purpose, senior staff are Nurse Managers, Nursing Unit Managers (NUM), Health Managers, Executive Directors, treating Medical Officer(s) and Clinical Directors. …… Conditions that would meet the criteria for consideration for early release include, but are not limited to terminally ill patients, patients whose health is deteriorating rapidly or a person whose condition is such that he or she should be cared for in a setting other than a correctional centre or detention centre, for example, a hospice or long-term rehabilitation unit.

In addition to the above policy requirements, the Crimes (Administration of Sentences) Regulation 2014, clauses 285 (a), (b) and (c) create a mandatory requirement when a JH&FMHN health officer has formed an opinion that:

- *the mental or physical condition of a patient constitutes a risk to life of the patient or to the life, the health or welfare of any other person.*
- *the life of a patient will be at risk if the patient continues to be detained in a correctional centre; or*
- *because of illness, a patient will not survive sentence or is totally and permanently unfit for correctional centre discipline, that the JH&FMHN prescribed health officer must report their opinion and the reasons for the opinion to a prescribed CSNSW Officer. The requirements of clause 285 apply to both sentenced and unsentenced patients".*

Justice Heath indicated in submissions that it accepted that the policy was not complied with but submitted that "*no individuals involved in the care of Mr. Goolagong should be criticised in these proceedings*". The evidence establishes that those who gave evidence in the inquest did not know of Justice Health policy 1.170 or the mandatory requirement under cl. 285 CAS Regulation. Given the numerous individuals in the MSU who fell within the category identified in Justice Health policy 1.170, namely "Nurse Managers, Nursing Unit Managers ("NUM"), Health Managers, Executive Directors, treating Medical Officer(s) and Clinical Directors".

I extend my criticism to those persons who occupied those positions during the time Ivan Leo Goolagong was in the MSU from 20 February to 23 July 2017, for failing to discharge their obligations pursuant to cl. 285 of the CAS Regulation. The MSU is involved in palliative care and the fact that its personnel do not know about the obligation and policy is, frankly, astounding. I similarly extend my criticism to those in Justice Health who failed to ensure that a prescribed health officer is aware of such an obligation, although it should be noted that Justice Health conceded it needs to train its staff in relation to the cl. 285 CAS Regulation obligations. CSNSW conceded in their submissions that their pathway to making a s. 160 early release application is vague. Further, they conceded it was not necessary for Ivan Leo Goolagong's family to engage a legal representative or make a Freedom of Information application to obtain information relevant to the application.

CSNSW also conceded that neither Ms. Ryan nor Ms. Ohlsen appears to have understood that such an application could be made directly to the CSNSW Senior Programs Officer. The CSNSW Senior Programs Officer would then prepare and provide the relevant information and a submission to the Commissioner to obtain a recommendation from the Commissioner to be submitted to the State Parole Authority. Ms. Ryan was unable to indicate where the idea that the family needed to instruct a lawyer came from. Given the positions they occupy and the ease of obtaining the necessary information, the fact that neither Ms. Ryan nor Ms. Ohlsen made such inquiries (so that they could at least give correct information about the early release application process) to assist Ivan Leo Goolagong and his family in early 2017 is highlyregrettable. Mr. McNamara provided a statement and gave oral evidence at the inquest. In his statement he said that s. 160 applications can be made by a prisoner or anyone else on their behalf. In his evidence he said an application was usually made by the prisoner or by a family. He said that once the application is received, the process of getting the information to the State Parole Authority is "*pretty good"*.

Ivan Leo Goolagong's application was received on 5 July 2017 and provided to Ms. McCulloch that day. A hearing date of 1 August 2017 was listed for less than a month after the application. Had Justice Health policy 1.170 and cl. 285 CAS Regulation been complied with, and had the Goolagong family been advised correctly, it is likely that a hearing date would have occurred much more proximate to 22 February 2017, when the family first raised their desire to make a s.160 application. Had the application been successful, Ivan Leo Goolagong would have returned to Country and would no doubt have passed in accordance with his Culture and Lore, surrounded by those who loved him.

The inquest received evidence that very few s. 160 applications are received by the State Parole Authority and of these a little under a third are granted (which amounts to about three applications granted per annum). Counsel Assisting suggested in submissions that those figures are unsurprising given the lack of adherence to policy, lack of knowledge of pathways and the giving of uninformed, and incorrect, advice that results in significant and unnecessary delays.

Often, time simply runs out prior to an application being processed. Although CSNSW sought to argue against such submission, it really is not surprising at all that disenfranchised prisoners and their families do not obtain timely access to the early release scheme. It is highly evident that both CSNSW staff and Justice Health Staff need training about this scheme and need to be compelled to discharge their duties accordingly. Mr. McNamara's email of 29 June 2017 seeking information from the Clinical Director of Primary Care at Justice Health ("Clinical Director") was a task delegated to Dr Grimsdale.

Dr Grimsdale was a rostered medical officer working in the MSU on 30 June 2017. The first time she had met Ivan Leo Goolagong was upon his return from POWH. Dr Grimsdale appropriately telephoned the POWH and spoke with a registrar to obtain information additional to her own observations. The Clinical Director relied on this information and prepared a markedly brief letter for the consideration and signature of the CEO of Justice Health. The letter contained a conclusion that "*Mr. Goolagong is receiving adequate care and management while in custody and his condition can continue to be managed whilst in custody, in a manner comparable to the care he would receive in the community".* That position is somewhat contradicted by the evidence in this inquest.

Mr. McNamara confirmed that there was no formal arrangement in place with Justice Health as to notifications regarding inmates who were seriously medically ill. He said that Justice Health would notify him of such a prisoner so that he could ask for a medical report or contact their family or a legal representative.

This would be to notify them of the s. 160 provisions so they could consider making an application. He said that the submission to the Commissioner included information relating to the following:

- *The inmate's condition and likelyprognosis.*
- *The offence and the circumstances surroundings itscommission.*
- *Time remaining to beserved.*
- *Conduct whilst incustody.*
- *Governor or General Manager comments ifprovided.*
- *Relevant Judge's Remarks on Sentencing (which are obtained when a prisoner comes into custody).*
- *Parole Officer's report in relation to post release arrangements.*
- *Other relevant information (e.g. supporting documents fromrelatives etc.)*

Mr. McNamara had indicated in his email of 29 June 2017 that the application did not seem *"super urgent"* but that a response was required within two weeks (the application had included Professor Goldstein's letter indicating that Ivan Leo Goolagong may have 4-5 months to live or up to 12 months, with treatment). On 18 July 2017, Mr. McNamara sent a second email to Justice Health asking if there was any progress with his request. Consistent with Ms. Ohlsen's involvement, the palliative care arrangements that Priscilla was making at that time were aimed at placing Ivan Leo Goolagong at Condobolin Hospital. However, that had yet to be confirmed, as the hospital was also waiting for Justice Health to provide it with information.

According to Ms. Ohlsen they were unwilling to provide this information at the request of the family rather than at the request through the parole system. The lack of published policy and information for CSNSW staff and prisoners and their families about s. 160 applications and Justice Health's failure to comply with cl. 285 CAS Regulation, caused Ivan Leo Goolagong to lose an opportunity to have his application considered by the State Parole Authority. Whether or not the application would have been granted is unknown, but I would hope that from this inquest it has been learned that when an application is made to the State Parole Authority, as part of *"other relevant information",* an application for early release should specifically include information regarding a prisoner's cultural identity and beliefs and end of life protocols, especially for First Nations persons.

This is critical information that should be taken into account by the State Parole Authority and may require separate criteria to be developed. Associate Professor Williams' report would be a useful document for such prisoners to refer to in any such application.

Ivan Leo Goolagong's request to telephone his daughter Priscilla

Registered Nurse ("RN") Christine Maher gave evidence that she worked at the MSU from 7pm on 22 July to 7 am on 23 July 2017. RN Maher's notes indicate that at about 8.45 pm on 22 July 2017 Ivan Leo Goolagong complained of severe pain. As Ivan Leo Goolagong had already had his regular pain relief, RN Maher decided to commence the subcutaneous morphine that had been charted by Dr Grimsdale in accordance with Dr Sze's notes.

Ivan Leo Goolagong wanted to sit in a chair rather than be in bed and RN Maher and the enrolled nurse who was on duty assisted him out of bed and he sat in the bedside chair. He remained there for 30 minutes and they then assisted him back to bed and he complained of breathlessness, so RN Maher placed him on nasal prong oxygen. In her evidence RN Maher said that she was aware that Ivan Leo Goolagong was deteriorating and that a decision had been made to leave his cell door unlocked and open. She thought that had occurred prior to her coming on shift that night but was not sure. Ivan Leo Goolagong's cell was door was only a meter from the nursing station, so she had ready access to him without having to ask a CSNSW officer to open it.

In her statement Nurse Maher stated that Ivan Leo Goolagong had:

"requested on the night of the 22nd of July 2017 to speak with his daughter and this was relayed to DCS. The Senior in Charge said that she would contact the daughter on the morning of 23 July 2017 regarding his request and that contact with the family for a visit/phone call for Mr Ivan Goolagong would be organised as soon as possible". It is unclear at what time this request was made by Ivan Leo Goolagong or when RN Maher conveyed his request to the senior CSNSW officer, as the note made by RN Maher in the Justice Health file does not indicate the time nor who the senior CSNSW officer was. In her evidence, she said she thought it was at about 2 or 3 o'clock in the morning (23 July 2017) that Ivan Leo Goolagong said that he wanted to speak with his daughter.

RN Maher gave evidence that she did not have access to any next of kin phone numbers even though the Justice Health admission form required that information to be completed. In any event she said she had no *"jurisdiction about contacting family. I am not allowed to"*. She said she contacted the senior CSNSW officer on duty. It is unclear what she actually said to the senior CSNSW officer.

During the inquest, RN Maher was asked by counsel assisting the parameters of what she was able to do to facilitate this call, to which RN Maher replied, *"inform [the senior CSNSW officer] and have them – and then it was up to them to follow up from there".* When asked whether she could have taken some initiative to explain to the senior CSNSW officer the urgency of the request, RN Maher replied: "*I did. I said it needed to be done as soon as possible and I had been informed by the senior it would be done first thing in the morning. And there was nothing more I could do…. I probably indicated to the officer that there wasn't a lot of time, and that it needed to be – that's why I said them it needed to be done as soon as possible and I was assured that it would be done in the morning*".

RN Maher accepted in evidence that it was evident that his death was imminent. She stated that she told her supervisor that it was imperative that they contact Ivan Leo Goolagong's daughter as soon as possible as he was particularly unwell. She said she probably said that there wasn't much time. Despite this information she said that the supervisor indicated that Ivan Leo Goolagong's daughter would be contacted in the morning and was not prepared to do any more.

The senior CSNSW officer RN Maher spoke to has not been further identified by her or by CSNSW. Ms. Melis did in her examination of RN Maher suggest that the senior CSNSW officer on duty that night was a man and not a woman. RN Maher replied that her note referring to *"she" was* probably correct. There is no record of the request made by Ivan Leo Goolagong or of the discussion's RN Maher had with any other person anywhere within CSNSW records that have been produced to the Court.

Mr. Hodges in his evidence agreed that, in the circumstances, permission should have been granted so that Ivan Leo Goolagong was able to speak with his daughter at the time he requested to do so. He indicated that procedures available at the MSU were flexible enough to enable such a call to be made outside of normal hours. In such circumstances, however, they would require nursing staff to relay the request to a CSNSW Senior Corrective Services Officer so that arrangements could be made via the MoS or relevant senior officer. Whilst it is not clear why a decision was made to not allow Ivan Leo Goolagong to have immediate contact with Priscilla, an arrangement should be in place whereby such calls can be facilitated as a matter of course. The emotional distress caused to Priscilla, knowing that her father wanted to speak to her in his final hours, but was not permitted to, was completely unnecessary andavoidable.

Counsel assisting submits that this raises questions asto:

- The extent to which relevant staff have a proper appreciation of the end of life psychosocial needs of inmates; and
- The effectiveness of a system that requires permission for a phone call between a patient (at such an end stage of their lives as Ivan Leo Goolagong was) and a family member to go through a formal decision- making process involving both Justice Health and CSNSW, and whether there should instead be greater flexibility and discretion for such calls to be facilitated by Justice Health staff when an inmate's death appears imminent.

CSNSW submitted that *"wherever possible, CSNSW is, to use RN Maher's words, "usually very accommodating", in the MSU"*. Further, it was submitted that CSNSW will set up extra family visits so that the family can say their goodbyes to an inmate who may be dying.

Even though the MSU still forms part of the Long Bay Correctional Centre, "*there are adjustments made to correctional routine to accommodate the inmates it houses, namely, inmates who may be stepping down from a hospital and recovering or ill patients."* Those submissions may be correct but RN Maher's evidence ultimately resiled from them. She refrained from stating that she knew what formal arrangements were made for family members. RN Maher noted that in her experience, which was considerable given RN Maher has worked at Long Bay Hospital since 2008, the only familiarity she had with extra family visits is that sometimes when she came on shift she was told that a patient had been visited by a family member.

It is important that prisoners and their families are aware of any visiting entitlements and arrangements available at the MSU rather than stumbling upon such latitude or learning of it when it is too late. If CSNSW is prepared to make such changes so that families can say their goodbyes then it is essential that there are published policies and good communication between Justice Health and CSNSW. This also requires appropriate training to relevant staff and standardised application, to ensure that visiting arrangements and entitlements are permitted systematically rather than haphazardly.

Current arrangements at the MSU

Justice Health do not contest that in order to meet First Nations prisoners' palliative care needs, there needs to be upskilling of medical, nursing, and other staff. Despite conceding that the palliative care needs of First Nations prisoners are not being met.

Justice Health point to Dr Gorman's evidence to note that he did not find any major deficiencies with the care provided to Ivan Leo Goolagong and that he believed that Ivan Leo Goolagong did not suffer because of any lack of expertise or resources. I accept that overall, Ivan Leo Goolagong's pain management was adequate, notwithstanding Associate Professor Aggarwal's comment that slow release Oxycontin twice daily with an anti-neuropathic agent would have been preferable. However, this assessment does not accurately assess the holistic care that was provided to Ivan Leo Goolagong.

Between July 2019 and August 2020, there was apparently no Palliative Care Specialist employed at Justice Health, as there was no funding for that position (which had been occupied by Dr Sze in 2017). From August 2020, a Specialist Palliative Care Service has been funded which allows POWH to service those prisoners not only in the MSU, but throughout the entire Long Bay Correctional Centre. Dr Gorman remarks in his report that this should enable earlier involvement in the care of terminally ill prisoners. Whether or not a Palliative Care Consultant Clinic of 1 day per fortnight adequately meets the needs of those prisoners was not a matter that the inquest inquired into. However, I note that there are significant challenges in attending to a certain number of prisoners on any given day when taking into account planned and unplanned lockdown periods. There appears to be difficulty in maintaining that position as the first occupant resigned after four months and at the time of the inquest the position remained vacant.

However, Justice Health now has a Palliative Care Team at Long Bay Correctional Centre. The team has a full-time position of a "Palliative Care Transitional Nurse Practitioner" who is the clinical lead of the Network Palliative Care multi-disciplinary team which includes the POWH Palliative Care Consultant Physician.

The team also has a full-time Palliative Care Aboriginal Health worker position. That position seems to be responsible for State-wide correctional centres. The extent to which the occupant of that position has direct clinical involvement with MSU patients must be limited because they are based in Wellington in regional NSW. As at the date of the inquest, though experienced in Aged Care, the occupant of this role still required palliative care training and support. I note Associate Professor Williams' evidence regarding cultural protocols involving *"gendered business"* and the strain placed on First Nations Health Workers to cater to the needs of First Nations prisoners, particularly where they are working without the support of proportionate representation.

Whether one First Nations worker will be able to adequately cater to the needs of all First Nations prisoners, irrespective of location and gender, is questionable and may place an undue level of pressure on such a worker. The team also has a Palliative Care Occupational Therapist (0.6 position) and a Palliative Care Social Worker (0.4 position).

Mr. Grimmond, the Director of Nursing and Midwifery Services at Justice Health, gave evidence about the development of Business Rules identifying the role or of the Cancer Nurse specialist at Long Bay Hospital, which will include:

- Guiding the patient to information and services that fosterindependence.
- Awareness of consultation, treatment plans and treatmentoutcomes.
- Coordination of the implementation of care plans including the provision of information and referral to appropriate services.
- Single point of contact for cancer services.
- Development and education of staff regarding appropriate referral pathways and documentation; and release planning.

Mr. Grimmond gave evidence that Justice Health is an active partner in the National Palliative Care in Prisons Project led by the Centre for Improving Palliative, Aged and Chronic Care through Clinical Research and Translation ('IMPACCT"). Mr. Grimmond said that the project aims to co-design a new national framework of palliative care for Australian prisoners, inclusive of national policies, workforce capacity, building strategies, clinical service models of care and a toolkit of resources, for ongoing use. Mr. Grimmond indicated that Justice Health representatives participate as partners and investigators across the National Consortia Project Advisory Group, Correctional/Justice Health Services Working Group, and the Aboriginal and Torres Strait Islander Community Engagement Strategy Working Group. Mr. Grimmond gave evidence that Justice Health was, at the time of the inquest, drafting a Model of Palliative Care, which (as referred to in the Justice Health submissions) aims to provide:

- A centralized referral pathway including an electronic health record alert for 'Palliative Care' to clearly identify patients receiving palliative care.
- Regular multi-disciplinary palliative care team meetings to discuss patient care.
- Palliative care information for staff being developed and which is accessible on the intranet.
- Palliative care staff engaging with staff across the Justice Health network to raise the profile of the team, provide education on palliative care, and how their team can support patients and staff.

- A Justice Health network palliative care education forum;and
- For the development of a cross-organisational partnership between the palliative care team and CSNSW Chaplaincy services to ensure pastoral care is offered to all palliative care patients.

At the conclusion of the evidence at the inquest, it was recommended that the scheduled meeting of the Steering Committee responsible for the development of the Model of Palliative Care should involve consultation with palliative care and cultural experts including Associate Professor Aggarwal, Associate Professor Williams, and Aunty Glendra Stubbs. Given their respective evidence at the inquest, Justice Health were very supportive of this course. The Steering Committee was apparently adjourned for a month to enable such consultation. At the time of writing its submissions, Justice Health notedthat:

"On 28 April 2021 the Palliative Care Model of Care was supported by the Steering Committee to begin piloting through PDSA (Plan Do Study Act) cycles in the coming weeks. PDSA cycles enable testing with patients and staff to ensure the Model of Care meets their needs. The cycles create a feedback loop to identify gaps, and make any changes or improvements as required. The Network are still awaiting comment from the palliative care and cultural experts, once received these will be reviewed and embedded into the Palliative Care Model of Care".

In relation to the issues identified at the outset of the inquest, those questions have been answered in these findings for the reasons alreadyarticulated:

- Although Ivan Leo Goolagong received adequate and appropriate medical treatment, he did not receive timely or adequate non-medical, psychosocial, palliative care, from the time of his transfer to MSU on 20 February 2017 until his death on 23 July 2017.His dietary care could have been improved earlier.
- There was no evidence received that consideration should have been given to transferring Ivan Leo Goolagong back to the Annex at POWH at any stage between his discharge on 30 June 2017 prior to his death on 23 July2017.

It could not have been foreseen that Ivan Leo Goolagong would be denied the opportunity to speak with his daughter in the early hours of the morning of 23 July 2017. Information about Ivan Leo Goolagong's deteriorating health was provided to his family but, due to the lateness of the s. 160 application, the family's attention was on arranging palliative care at Condobolin Hospital in furtherance of the s. 160 application rather than arranging family members to visit Ivan Leo Goolagong.

Ivan Leo Goolagong's opportunity to apply to the State Parole Authority for early release was not appropriately acted upon by CSNSW and Justice Health. The family were given incorrect information by CSNSW personnel about the application process and Ivan Leo Goolagong's lawyers were required to engage in unnecessary applications to obtain information to support the application. Justice Health failed to discharge its cl. 285 CAS Regulation obligations in February/March 2017. This failure was ongoing. Despite Ivan Leo Goolagong's continued and apparent deterioration and the progression of his terminal illness, no Justice Health member of the MSU gave consideration to cl. 285 CAS Regulation.

There were no services specific to the needs of First Nations prisoners with a terminal illness and accordingly no such services were available to Ivan Leo Goolagong. That situation has now changed since the development of a Model of Care and the employment of specialized First Nations personnel. It is hoped that such a programme successfully overcomes the deficiencies of care, and proper regard is given to the experience of Ivan Leo Goolagong, and his family, at the end of his life.

Importantly, it is hoped that Associate Professor Williams' comments regarding the pressures faced by First Nations workers are properly considered and adequate supports implemented for such First Nations workers to ensure their success and the success of the Model of Care.

The Goolagong family have, in their submissions, supported the submissions of Counsel Assisting. They have also raised additional matters outside the statutory scope of this inquest, including a desire to relocate Ivan Leo Goolagong's body to Country, which would involve an application under the Act for exhumation (they are of course, at liberty to make such an application). The family, particularly Priscilla, is understandably highly traumatised by the circumstances surrounding the death of their father.

As mentioned earlier, Pricilla's belief that Ivan Leo Goolagong died distressed and isolated, coupled with the denial of his opportunity to speak with her before his passing, has been particularly damaging and continues to be a source of continuing hurt and upset. The family is also angry that it was not until in the afternoon of 23 July 2017 that they learned of their father's passing rather than in the morning when he died (which was around 7:30am). Priscilla has found the coronial process exceptionally challenging. The difficulties in effectively engaging with CSNSW and Justice Health regarding her father's care and his possible early release, have understandably heightened the family's distrust of the coronial process.

Despite extensive efforts and assurances by this Court, this profound distrust has resulted in the family, particularly Priscilla, remaining to be convinced in relation to certain matters that were properly addressed throughout the coronial process, including:

- that the mortuary photographs shown to the family on numerous occasions are those of Ivan Leo Goolagong.
- that the CCTV footage from the MSU accurately captures the events on the morning of Ivan Leo Goolagong's death.
- that certain documentary errors in the police brief of evidence, for example, regarding the title of a document and Ivan Leo Goolagong's weight, were in fact errors as opposed to relating to a different person altogether; and
- that the smoking ceremony organised for Ivan Leo Goolagong at the MSU was not held in the correct cell.

This is most regrettable, and it is a reminder to all of us, about the effect of generational, deeply entrenched institutional distrust and trauma that has often been experienced by First Nations families. The family seek that I make recommendations in relation to matters that fall within the ambit of civil proceedings, and which relate to duty of care and compensation. A Coroner's statutory role is confined to matters set out in s. 81 of the Act. As such I am unable to make recommendations, including in relation to civil matters that fall outside of my statutory powers.

Counsel Assisting has put forward a number of recommendations to the Commissioner of Corrective Services and the CEO of Justice Health. The agencies' response to these suggestions has in large part been met with agreeance. Indeed, many of the recommendations have been addressed or are currently on foot.

I note that Associate Professor Williams submitted lengthy recommendations at my request, and they have greatly assisted in advancing the introduction of improvements. For the sake of completeness, those recommendations are attached to her report annexed to these findings. However, I note that Justice Health submissions indicated that *"the challenge in facilitating 'closeness to family and closeness to Country ' is that the MSU at Long Bay Hospital is the only appropriate environment to provide the level of care required by patients with complex palliative care needs and whom areend of life"*.

I make the following recommendations on the basis that many of the recommendations are currently already on foot.

Early release under s. 160 *Crimes (Administration of Sentences) Act 1999*

To the NSW Commissioner of Corrective Services

That CSNSW develops a policy to give guidance to Services and Programs Officers, Regional Aboriginal Programs Officers, psychologists and any other relevant staff, in relation to the advice and assistance that such staff should provide inmates who express a desire to seek early release on medical grounds, and that such policy be aimed at helping to facilitate and expedite such applications without the need for inmates engaging legal assistance. That, in the interim, CSNSW takes action to ensure that relevant staff (including Services and Programs Officers, Regional Aboriginal Programs Officers and psychologists) who are asked by inmates for assistance in connection with early release applications on medical grounds:

- Are aware of the potential need for such matters to be expedited.
- Are aware that they can and should contact relevant CSNSW project officers for further potential advice and assistance as to how the matter might best be progressed; and
- Are aware that it is not the case that such applications can only proceed by means of the inmate engaging legal assistance.

To the Commissioner of Corrective Services and the CEO of the Justice Health Forensic and Mental Health Network

That CSNSW and Justice Health formalise a policy, as soon as possible, with the aim of helping inmates suffering from a terminal illness who wish to apply for early release, or their families, to do so in a manner that minimises delay and does not require applicants to seek recourse to external legal representation to obtain medical reports from Justice Health or to advance their application.

To the CEO of the Justice Health Forensic and Mental Health Network

That Justice Health take action to ensure that any relevant staff with reporting obligations under cl. 285 CAS Regulation are aware of their obligations under that clause.

Telephone access for inmates during end of life care

To the Commissioner of Corrective Services and the CEO of the Justice Health Forensic and Mental Health Network

That a CSNSW and Justice Health working party in relation to the operation of the MSU is established to develop practices, so as to:

- Ensure that terminally ill inmates receiving end of life care in the MSU are permitted phone access to contact family members at any hour of the day and that requests for phone access by such prisoners are allowed and not delayed.
- Make phone access for terminally ill inmates more streamlined so that clinical staff are permitted to provide relevant phone access to patients without the need for permission to be obtained from CSNSW; and
- Consider any other measures that might be implemented to make the environment in the MSU for terminally ill inmates less restrictive.

Palliative Care Needs of First Nations prisoners

To the Commissioner of Corrective Services and the CEO of the Justice Health Forensic and Mental Health Network

That relevant senior officers of CSNSW and Justice Health review the report prepared for the court by Associate Professor Williams with a view to determining how some of the policy suggestions outlined at pages 28 to 31 might be implemented in their organisations.

That a CSNSW and Justice Health working party consult with Associate Professor Williams to consider the feasibility of:

- Introducing peer support programs for terminally ill First Nations prisoners inthe MSU; and enabling access to Long Bay Hospital by "in-reach" services offered by of appropriate community based First Nations Health organisations.

To the NSW Commissioner of Corrective Services

That CSNSW takes action to provide greater support for, and numbers of, Regional Aboriginal Programs Officers, and Aboriginal Support and Programs Officers, so they at least reflect the proportion of NSW inmates who are First Nations.

To the CEO of the Justice Health Forensic and Mental Health Network

That Justice Health employs at least two First Nations health care workers, nurses or medical officers as part of the complement of clinical staff at the MSU, and looks to employ greater numbers of First Nations staff generally, and that in doing so Justice Health ensures that such additional staff are provided with adequate support to perform their work effectively.

That MSU clinical staff receive immersive training in provision of health care to First Nations patients within a First Nations' community health organisation setting.

Provision of palliative care to terminally ill inmates at the MSU more generally

To the CEO of the Justice Health Forensic and Mental Health Network

That Justice Health develops a care planning protocol for all patients in the MSU who are diagnosed with a terminal illness, so that a clear multi- disciplinary plan is devised, followed up and regularly re-evaluated, commencing as soon as an inmate is identified as having a terminal diagnosis.

- That the positions responsible for devising, overseeing, and evaluating such care plans are clearly identified and known by clinical staff at theMSU.
- That the role and responsibilities of the Cancer Care Nurse Coordinator so far as it relates to MSU patients is clearly delineated, made known to clinical staff in the MSU and audited for its effectiveness.
- That Justice Health urgently prioritise providing immersive forms of training of MSU clinical staff involving placements over a number of days with outside Palliative Care providers such as the Program of Excellence in the Palliative Approach ("PEPA").
- That further training of MSU staff in Palliative Care emphasises the importance of early identification of the psychosocial needs of inmates and skills in rapport development.

Identity: **Ivan Leo Goolagong Date of**

Death: **23 July 2017**

Place of Death: **Long Bay Hospital Medical Subacute Unit**

Cause of Death: **Metastatic Pancreatic Adenocarcinoma**

Manner of death: **Ivan Leo Goolagong was a Wiradjuri man died of natural causes whilst in the custody of Corrective Services NSW.**

10. 54392 of 2018

Inquest into the death of Jack Kokaua. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 12th May 2021.

Jack Kokaua died on 18 February 2018 at the Royal Prince Alfred Hospital (**"the RPA"**) from a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors superimposed upon Jack's underlying but occult coronary heart disease, following a police operation. At the time of his death, Jack was on parole.

In the preparation of these findings, I have been assisted by the written submissions of Counsel Assisting, Kristina Stern SC and Surya Palaniappan. I have also been assisted by the submissions of counsel for the interested parties. In making these findings, I extend my sincere condolences to Jack's family, in particular to Queenie who travelled from New Zealand during the COVID-19 pandemic to attend each day of the inquest in person. At all times during the inquest, the family carried themselves with dignity and grace. I particularly wish to acknowledge the family's moving tribute to Jack on the final day of the hearing, which included the performance of a haka for Jack by Jack's family members and an evocative song of farewell to Jack, led by Queenie. Jack was clearly very much loved. He will continue to be missed and mourned by those who loved him.

The role of the Coroner

The inquest is a public examination of the circumstances of Jack's death. Unlike some other proceedings, the purpose of an inquest is not to blame or punish anyone for the death. The holding of an inquest does not itself suggest that any party is guilty of wrongdoing. Rather, the primary function of an inquest is to identify the circumstances in which a death has occurred. The role of a Coroner, as set out in s. 81 of the *Coroners Act 2009* (NSW) ("**the Act**"), is to make findings as to the:

- identity of the deceased.
- date and place of the person's death.
- physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

Pursuant to s. 27 of the Act, a Coroner is required to hold an inquest in circumstances where, as set out in s. 23(1) (c) of the Act, it appears that a person has died (or there is reasonable cause to suspect that a person has died) as a result of a police operation. In this case, Jack died as a result of a police operation conducted on Carillion Avenue, Camperdown, near St Andrews College, University of Sydney. Pursuant to s. 82 of the Act, a secondary purpose of an inquest is for the Coroner to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the person's death. This involves asking whether anything should or could be done to prevent a death in similar circumstances in the future.

These recommendations are made, usually to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest.

The purpose of an inquest

Counsel for the individual police officers relied on the following decisions of the New South Wales Court of Appeal in submitting that it was not the role of this Court to review and comment on actions and decisions of police officers made in the context of a "dynamic situation".

First, counsel referred to *Woodley v Boyd* [2001] NSWCA 35 at [37]:

… The same duties and considerations apply where a police officer is deciding how to effect an arrest. And, in evaluating the police conduct, the matter must be judged by reference to the pressure of events and the agony of the moment, not by reference to hindsight. In *McIntosh v Webster* (1980) 43 FLR 112 at 123, Connor J said:

"[Arrests] are frequently made in circumstances of excitement, turmoil and panic [and it is] altogether unfair to the police force as a whole to sit back in the comparatively calm and leisurely atmosphere of the courtroom and there make minute retrospective criticisms of what an arresting constable might or might not have done or believed in the circumstances."

Secondly, counsel referred to *State of NSW (NSW Police) v Nominal Defendant* [2009] NSWCA 225 at [46]:

Whilst the reasonableness of the performance of a police officer's duties does not escape judicial scrutiny if damage results, reasonableness has to be considered in context. The primary context is the law enforcement role of the police officer. The surrounding circumstances have to be considered, including the nature of the possible offence involved, the need to make quick decisions as to whether to take action and if so, what action to take. Indeed, many such decisions, of their nature, will be almost spontaneously reactive to the circumstances presenting themselves to the police officer.

The police officer is also required, in the same short period of time, to weigh up whether, in making a decision to take action, the safety of the public outweighs the need to take action. So far as a decision to engage in a pursuit is concerned, the context will also include the instructions, directions and guiding concepts contained in the Police Service's Pursuit Guidelines. I do not accept this submission. Each of the above cases are appeals from civil claims for damages alleging tortious conduct by police. The jurisdiction of this Court is very different. As described in *Waller's Coronial Law & Practice in NSW* (4th ed) at [23.7]:

The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances.

In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82. [emphasis added]

In giving effect to the purposes of s. 23 inquest, any finding that this Court makes must in this case be informed by, as Counsel Assisting put in their submissions: *the undoubted facts that this was a chaotic and stressful interaction, that Jack was undoubtedly aggressive towards police at times during the incident, and that Jack was a large and strong individual that the officers knew, from the incident in the morning, required considerable force to restrain. Moreover, the evidence of some of the officers was that this was a very difficult encounter, and that it went well beyond the extent of their previous policing experience.*

In reviewing the actions of the involved police officers, however, I must also consider, as Counsel Assisting put it, "the importance of safeguarding the welfare of persons such as Jack who are involved in such encounters". In doing this, I must make full use of the benefit of hindsight to work out what could have been done differently, if anything, and to ascertain whether any lessons can be learned from Jack's untimely death.

The proceedings

The hearing of the inquest into Jack's death was held at the NSW State Coroner's Court in Lidcombe in three tranches on the following dates: 17-20 September 2019, 24-28 August 2020, 2-5 November 2020. An issues list was distributed to parties identified as having a sufficient interest in the proceedings, which included the following:

- cause of death, including the impact of medication and / or tasers and / or method of restraint on cause of death.
- the adequacy and appropriateness of the police officers' response to the second
- the appropriateness of the restraint of Jack during the second incident and the position and actions of involved police officers.
- methods of restraint that the involved police officers used, all methods of restraint that were available to be utilised and training provided to the involved police officers regarding the use of those methods of restraint.
- NSW Police mental health training policies and procedures and the training that was provided to those officers involved regarding the same.
- the adequacy of mental health and other support provided to Jack whilst on parole up to the date of his death.
- how and why Jack was able to leave RPA; and
- whether any recommendations are necessary or desirable, including for the purpose of public health and safety.

Factual background

Following careful review and consideration of the brief of evidence tendered at the hearing, as well as the oral evidence of the witnesses who appeared at the hearing, I make the following findings in relation to the factual background of the inquest.

Jack's personal circumstances

Jack was born on 14 March 1987 in Bankstown, New South Wales, to Queenie Kohu Kokaua and Joseph William Kokaua. Both parents were born in New Zealand. Jack's birth certificate also recorded that at the time of his birth he had two older siblings, Adam and Pania.

Jack's parents separated when he was young, with his care being split between his parents, which required him to spend time in New Zealand whilst he was in his mother's care.

Jack left high school prior to completing Year 10, as a result of being expelled for setting fire to a classroom. Jack later attempted to complete his Year 10 school certificate at TAFE but was ultimately unsuccessful. Jack was then employed for two weeks as an apprentice fitter and machinist and was not employed following this. He completed certificates in TAFE in dogman and welding.

Jack has a daughter, who was born in 2005. Jack was not in contact with his daughter at the time of his death.

Jack's mental health history

Jack had a long history of mental health issues. These were summarised by Dr Gordon Elliott of Justice Health and Forensic Mental Health Network (**"Justice Health"**) in a report to the State Parole Authority dated 18 December 2017.

Jack's mental illness dated from his late adolescence, from around 17 or 18 years of age. His illness required repeated psychiatric inpatient admissions to Concord Hospital, and periods of non-compliance with medication also necessitated his treatment in the community under the conditions of a Community Treatment Order and utilising a long-acting injectable antipsychotic.

When unwell, Jack's illness was characterised by auditory hallucinations, passivity phenomena (or a sense that his feelings and volition were being controlled by some external power), and referential ideas from television and radio.

Jack's illness was exacerbated by co-morbid substance use disorders, in particular the use of cannabis and methamphetamines. Dr Elliot's report identifies that Jack had a history of aggression when unwell and that his offending behaviour was attributed to substance-induced exacerbation of his underlying illness. Jack was also noted to have given Dr Elliot a convincing account of experiencing psychotic symptoms.

Jack's medical history

Jack had a number of electrocardiograms (or "**ECGs**") leading up to his death. On the following dates, Jack was the subject of an ECG which indicated the following results:

- 27 November 2014: "normal" and overall cardiovascular risk recorded as "low".
- 14 April 2016: "abnormal ECG".
- 3 and 23 November 2017: "Borderline ECG"; and
- 18 February 2018: "Abnormal Rhythm ECG".

Jack's criminal and parole history

Jack had extensive contact with NSW Police, dating back to 2002. There are 154 events linked to Jack on the NSW Police COPS system, with Jack being charged with criminal offences on 13 occasions. Relevantly, on 11 November 2015, Jack was sentenced to four years' imprisonment for robbery in company, with a two-year non-parole period. Further, whilst in custody, in January 2016, he was convicted of assaulting a correctional officer. For the latter offence, on 27 February 2017, Jack was sentenced to three months' imprisonment, commencing 30 January 2017. In a pre-release report dated 6 September 2017, it was noted that if Jack was to be released to parole, he would be:

… subject to new parolee supervision level during the first eight weeks of release, which will include a field contact visit each four weeks and then as per the approved case plan …

Community Corrections in that same report, however, recommended against Jack being released to parole, noting that Jack's suitability for offender- targeted programs was unknown and his mental stability and post-release accommodation were yet to be confirmed. In a pre-release supplementary report dated 3 January 2018, Community Corrections recommended that Jack be released to parole, noting the following:

- Jack had an assessed risk rating on release of "T3/Medium-High".
- Jack "presents as an isolated individual with limited family support".
- "It is positive that he is compliant with his medications and this continued compliance with be imperative to his stability in the community".
- "following a review of notes from the Mental Health Nurse Practitioner, there is no intention to apply for a Community Treatment Order to manage [Jack's] compliance with medication prior to his release on parole".
- a referral had been submitted to the Campbelltown Integration Support Centre, given Jack was unable to provide any options for post-release accommodation.
- Jack would be required to accept the supervision of a Community Corrections Officer in accordance with CSNSW policy and guidelines.
- "[g]iven [Jack's] issues relating to mental health and drug use, his case management in the community will focus on engaging him with services to help manage these concerns … Contact with Campbelltown Community Corrections confirmed the availability of services from the Campbelltown Community Mental Health Team …"; and

- Jack would require "ongoing support regarding reintegration into the community, including focus on his associates".

On 8 January 2018, Justice Heath Mental Health Nurse Min Jiang authored a letter noting that Jack's next depot injection was due on 16 January 2018. On 11 January 2018, the State Parole Authority made a Parole Order that Jack was to be released from custody not later than 18 January 2018. Jack was subject to 18 conditions, which included, amongst others, that he:

- must, until the order ceases to have effect or for a period of three years from the date of release, submit to the supervision and guidance of the Community Corrections Officer assigned the supervision of Jack for the time being and obey all reasonable directions of that officer.
- not be in possession of a prohibited drug or substance and must, at the direction of the officer, undertake alcohol and drug testing.
- participate in mental health intervention, if so directed; and
- must comply with directions of the mental health team, including treatment and medication.

On 16 January 2018, Justice Health Nurse Practitioner Chris Muller faxed "Campbelltown COMET" (namely, the Campbelltown Community Mental Health Team, also known, and will be referred to here on in as **"Macarthur COMHET"**) to advise that she was concerned that without assertive follow up Jack "may well become non-adherent with treatment and exacerbate". She also noted that his next depot injection was due on 30 January 2018.

Registration with Macarthur Community Mental Health Team

On 16 Jan 2018, a Macarthur COMHET nurse completed a Mental Health Triage form noting the referral from Justice Health to Macarthur COMHET. The Mental Health Triage form noted that Jack's current medications were:

- Zuclopethixol 300mg IMI "every 2/52. Next LAI due 30/01/18"; and
- Quetiapine 200mg nocte, "Jack will be released with a 1/52 supply of oral medication".

Jack on parole – 17 January 2018 to 18 February 2018 at 2.40am

On 17 January 2018, Jack was released on conditional parole to reside at Campbelltown Integration Support Centre (**"ISC"**). A CSNSW Community Corrections Officer ("**the Community Corrections Officer**") was allocated to supervise Jack while on parole. At that time, the Community Corrections Officer was a Trainee Community Corrections Officer based at Campbelltown Community Corrections office.

On the same day, the Community Corrections Officer met with Jack. The Community Corrections Officer's notes on the Offender Management Integration System (**"OIMS"**) record that the following took place during that meeting: The parolee was given documentation from Justice Health to take to his GP regarding his MH medication, Seroquel XR 300mg, and also that he has been referred to Campbelltown Community Mental Health for his next depot injection due on 30/1/18.

Action – follow up on engagement with MH service provider/GP, medication and commence OIDF.

On 18 January 2018 at 8.00am, Jack signed out of the ISC and failed to return at his allocated return time.

On 19 January 2018 at 12.19am, an ISC staff member telephoned Jack to ascertain his whereabouts, noting that Jack had not returned to the ISC the previous night. During that telephone call, Jack became "agitated, argumentative and offered a myriad of excuses" upon being questioned about his failure to return on time.

At around 6.55am on the same day, Jack returned to the ISC. He advised ISC staff that he had not taken his medication the previous day and that he had been up all night. Jack also participated in a drug test which returned a negative result. It was later noted during a meeting between ISC staff and Jack at 2.00pm on the same day that Jack's speech was slow, and he was blinking profusely.

On 19 January 2018, the Macarthur COMHET also assessed Jack. In a MH Discharge/Transfer Summary form that the Macarthur COMHET completed on 28 January 2018, it was noted that Jack had indicated at the assessment that he was "wanting case management", that he was "[w]worried about running out of medication" and that he was "[w]worried about getting his depot; reassured that this is not due until Tuesday 30/01/2018".

Jack took his medication on 19 January 2018.

On 20 January 2018, Jack was observed to be singing at the ISC during the residents' hour (around 12.25am), then walking around talking loudly on his phone. Later, he left the ISC without signing out and then returned in the evening and was observed again to be yelling and singing loudly.

On 21 January 2018, Jack assaulted an ISC staff member. According to the attending police officers, the CCTV footage of the ISC showed Jack attempting to start fights with other residents at the Centre. Jack was informed that afternoon that he could no longer be a resident at the ISC, and the Campbelltown Police were later contacted at 4.30pm following Jack's refusal to leave the Centre. Upon the police arriving at 6.30pm, Jack agreed to leave, complied with verbal directions from police officers, and was transported to his aunt's home.

On the same date, Jack participated in a Drug Wipe test at the ISC. The test returned a positive result for amphetamines/methamphetamines. However, Jack denied using drugs. According to Jack's aunt, this failed drug test also contributed to the ISC's decision to remove Jack as a resident.

On 22 January 2018, Jack's aunt telephoned the Community Corrections Officer and advised that she was uncomfortable with Jack's behaviour in her home as she had young children residing there. On the same day, Jack met with the Community Corrections Officer at the Campbelltown Community Corrections office. His aunt also attended. OIMS notes in respect of that meeting record that Jack was directed to make contact with Linked2Home, a service that provides temporary accommodation.

To assist Jack's referral to Linked2Home, the Community Corrections Officer gave Jack a copy of his mental health and parole documents. Jack's aunt indicated during the meeting that Jack was not able to reside with family due to his behaviour and safety concerns for the family's children.

On the same date, a Macarthur COMHET staff member also telephoned the Community Corrections Officer and recommended that Jack be instructed to report to the COMHET. The staff member also advised that Jack's aunt had been informed that the COMHET would not be able to conduct a home visit on Jack until 24 January 2018 and that, given Jack's temporary accommodation was due to end on that date, the home visit was unlikely it would go ahead. The staff member further advised that Jack was to be referred for case management to the Macarthur Community Mental Health team and that "it will be hard to attain a residential MH facility as Jack's situation is more related to accommodation issues".

The Macarthur COMHET also discussed Jack's case on the same date, noting that Jack needed medication, that he would be provided with a script for Quetiapine and that he was due for his depot injection. Dr Karthik Modem made an entry in the clinical records that the script was prepared for Quetiapine with five repeats.

On 22 January 2018, Jack's aunt also contacted Macarthur COMHET as she was concerned about Jack's mental state and his unstable accommodation. Notes in relation to the phone call record the following plan: Aunty to pick up script [for Seroquel] MDT on 23/01/2018. Organise depot – due on 30/1/18

In accordance with the plan, Jack's aunt picked up Jack's script for Seroquel.

Following Jack's aunt contacting Macarthur COMHET, the COMHET telephoned the Community Corrections Officer. In a clinical record created in respect of that telephone conversation, it was noted that the Community Corrections Officer had indicated that he "would like CoMHET to review [Jack] due to concerns expressed by aunty". The plan was listed as:

- [Discuss with team] on 23/01/17? the need for face to face review at
- Minto office or his temporary accommodation at 28 Angle Rd Leumeah
- Organise depot chart
- Refer to CC.

Jack was then accommodated for one night through Housing NSW at Dignity House, Leumeah. He was subsequently requested to attend the Campbelltown FACS Housing office on 23 January 2018 and advised that Dignity House would no longer accommodate him due to behavioural concerns, including threatening other guests, stealing a mobile phone and exhibiting paranoid and aggressive behaviour consistent with drug use. On 23 January 2018, Jack failed to report to the Community Corrections Officer. At a team meeting at Macarthur COMHET on the same day it was noted that the Jack's plan was "PLAN: Assessment completed by CoMHET. Chronic issues with D&A use and non-compliance to medication. To discuss at Intake Meeting for CC/MATT follow up".

On the same date, a Macarthur COMHET clinical psychologist made an entry in the clinical records in relation to a multidisciplinary team meeting.

It was noted that, amongst other things, "COMHET to ascertain client's whereabouts and short-term accommodation/location" and "MATT to follow up if consumer is in area long term".

Late that afternoon, Jack self-admitted to the mental health ward at Cumberland Hospital, accompanied by his sister-in-law. Following Jack's admission, a Registered Nurse drew a mental health progress note recording a telephone call that had been received from Jack's aunty. She reported that Jack was known to "Macquarie mental health" and that his contact person was Rachel. A number for Macarthur Mental Health was noted. the Community Corrections Officer's contact number was also recorded.

On 24 January 2018 at 10.33am, Drs Graeme Sampson and Manoj Narayanan saw Jack at Cumberland Hospital. Dr Narayanan noted in a mental health progress note of the same date that "[a]s per patient he is on Seroquel, and Zuclopenthixol injection before. Last injection 300 mg last week". It was also noted that Jack "was upset and wanted to leave because he was not allowed to smoke" and the plan was to "[c]continue Clopixol and Seroquel".

On 24 January 2018 at 11.45am, mental health progress notes record that Drs Sampson and Narayanan had a telephone conversation with the Community Corrections Officer. According to the progress note, the Community Corrections Officer confirmed that Jack had received his depot injection from the Macarthur Community Mental Health Centre. The same telephone conversation is recorded in OIMS. According to the Community Corrections Officer, "the service provider is aware of [J]ack's parole order, writer requested to be contacted if day leave is granted and prior to discharge. Discussed Jack's medication and previous engagement with Macarthur Community MH".

As a result of Jack's conduct from 17 to 24 January 2018, the Community Corrections Officer submitted a breach report to the State Parole Authority on 25 January 2018. This report was noted by the Authority on 7 February 2018. The breach report stated that Jack appeared to be in breach of his parole order due to failure to comply with condition (3), namely "[t]he offender must, while on release on parole, adapt to normal lawful community life". Given Jack had been admitted to Cumberland Hospital, the Community Corrections Officer recommended that Jack's matter be stood over for a period of two weeks pending the outcome of mental health observation.

Between 25 and 27 January 2018, progress notes record that Jack was continuing to appear psychotic.

On 28 January 2018, RN Lawrence Zimbudzana authored a "MH discharge/Transfer summary" on behalf of the Macarthur COMHET. RN Zimbudzana noted in the "Summary of Care" that the COMHET plan had been to "administer depot due on 30/01/18". It was noted, however, that: COMHET received phone call from P & P Officer on 24/01/18 advising that client was admitted at Cumberland Hospital, Paringa Ward. COMHET MDT resolved to discharge client from service as client was admitted to hospital.

RN Zimbudzana noted that Jack's discharge medications were Quetiapine 300mg nocte and Clopixol 300mg IMI 2/52, and that the discharge plan was "[a]admitted in Cumberland Hospital". Following from this "MH discharge/Transfer summary", there are no further records from the Macarthur COMHET that evidence any contact between the service and Jack.

Dr Modem gave evidence in the inquest that:

… the policy is that even if he is admitted to the Campbelltown Hospital which is still in our area we still discharge them because he can't have two active running notes – two, when's not part of the service so we can't keep him as an open patient when he's part of a different service so that's procedural – that's a policy that we stick to, yes. On 29 January 2018, Registered Nurse Bahaa Al Yawafi recorded in Cumberland Hospital progress notes that Jack had "express[ed] bizarre thoughts of a religious nature and was identified as being delusional and at high risk of aggression".

There is no record of Jack receiving his scheduled depot medication on 30 January 2018.

On 1 February 2018, Jack was discharged from Cumberland Hospital. On the same day, OIMS records that Dr Sampson telephoned the Community Corrections Officer. The OIMS notes of that telephone call indicate that the following was discussed: Dr Samson [sic] diagnosed Jack with a personality disorder which affects his conduct. He feels that Jack's condition is not a treatable illness that requires ongoing observations or admission with his acute service at the hospital. He recommended ongoing case management with a community MH service provider. It is noted that Jack was referred to Macarthur MH for case management prior to his admission.

Dr Samson [sic] disclosed that Jack was not given a depot injection during his stay as it was not due, his medication is of some benefit, however believes that his behaviour will not improve and that he may get into trouble in the community and suggested that gaol may be a better place for him due to community safety concerns.

Dr Sampson's "MH Discharge / Transfer Summary" of the same date notes that Jack "was treated with Seroquel 300mg nocte, & Clopixol IMI, which was given [to] him prior to his arrival here. He has been seen in the community at McCarthur [sic] Area Health Centre". Dr Sampson also noted that Jack's diagnosis was "? Schizophrenia, Personality Disorder, & Substance Abuse".

In respect of the telephone conversation described at paragraph 66 above, Dr Sampson denied having stated to the Community Corrections Officer that Jack's depot was not due, as he said that he did not know when it was due. He also gave evidence that he did not think that Jack needed the depot medication because Jack had a personality disorder and not schizophrenia, and that, even if Macarthur COMHET had decided on a specific treatment plan, the Hospital could do otherwise. Despite this evidence, Dr Sampson ultimately accepted that Jack's depot medication was important but stated it was up to the consultant to find out, and that it was not necessarily due on 30 January because Macarthur COMHET said it was due on that date.

Dr Sampson accepted that the plan for Jack as recorded in the "MH Discharge / Transfer Summary" was to continue the depot injections and Seroquel. He also accepted that it was a problem that someone receiving the discharge summary would not know when the next dose of Zuclopenthixol was due. Contrary to his evidence, there is no evidence to support Dr Sampson's suggestion of any clinical decision to discontinue Zuclopenthixol. He ultimately accepted that, if it had been his view that Zuclopenthixol was no longer needed, he would have stated as much in the discharge summary, and it follows that he did not decide that Jack should not receive Zuclopenthixol.

Jack was re-admitted to Cumberland Hospital as a voluntary patient, however, the same day, in the company of his sister. It was noted in the "MH Review" form that: Seroquel and clopidol charted as regulation medications Depot dose and next due to be clarified by the team.

On 5 February 2018, Jack was discharged from Cumberland Hospital for the second time.

On the same day, OIMS records that someone called "Wayne" from Cumberland Hospital telephoned the Community Corrections Officer and informed him that Jack was being discharged and that he would be referred to Parramatta Housing for accommodation.

The "MH Discharge / Transfer Summary" noted that Jack presented to Cumberland Hospital with a "reported history of schizophrenia and want of accommodation". It was also noted that "[o]n the day of discharge, he did not have any psychotic or mood symptoms/ suicidal intent or plans" and his discharge medication was recorded as "[m]education information has not been updated for this patient, during this visit". There is no record of Jack receiving depot medication during his second admission at Cumberland Hospital.

Upon being discharged from the Cumberland Hospital on 5 February 2018, Jack was provided temporary accommodation through Bankstown Housing at the Banksia Motel in Bass Hill. Jack's temporary accommodation at the motel was extended until 14 February 2018.

It appears that the Western Sydney Local Health District Community Mental Health team attempted to contact Jack following his discharge from the Cumberland Hospital. On 6 February 2018, a progress note records that Sue Boyd of the Western Sydney Community Mental Health team "tried to contact patient for seven-day post discharge follow up. Patient has no fixed address or phone. There is a number for his father which is not answering". On 9 February 2018, a further progress note records that Ms Boyd had "made numerous attempts to contact [patient's] relatives, as patient doesn't have a phone. File now closed".

There is no further evidence of any contact made between Jack and a community mental health team after Jack's release from Cumberland Hospital. On 8 February 2018, the Community Corrections Officer telephoned Cumberland Hospital and was advised that Jack had been discharged from hospital on 5 February 2018. the Community Corrections Officer requested a copy of the discharge summary. There is no evidence to suggest that the Community Corrections Officer ever received the requested document.

On the same date, the Community Corrections Officer made four telephone calls – to Banksia Motel, Jack's sister, Jack's brother and Banksia Motel – and requested assistance from Housing and Jack's sister in making contact with Jack. On 9 February 2018, the Community Corrections Officer telephoned Community Corrections officer Peter Fitzgerald (**"CCO Fitzgerald"**) at the Bankstown Community Corrections office. During that telephone call, the Community Corrections Officer advised that the Campbelltown Community Corrections office had had minimal contact with Jack and that Jack had not been in contact with CSNSW since his discharge from Cumberland Hospital. On the same day, Bankstown FACS Housing telephoned the Community Corrections Officer and advised that Jack had been compliant with his obligations with Housing during his stay at the Banksia Hotel.

Jack had therefore been allocated an appointment by Housing for a mental health assessment on 13 February 2018 to determine if he was able to live independently and his eligibility for the disability support pension.

Following the telephone call from Bankstown FACS Housing, the Community Corrections Officer directed Jack to report to the Bankstown Community Corrections office. Jack complied with the direction and was seen by CCO Fitzgerald. CCO Fitzgerald's notes of the meeting record Jack's medication as "said he is prescribed Seroquel only and takes it faithfully". During the meeting, Jack also "acknowledged that he needs to be connected with MH services".

On 12 February 2018, Jack visited a brothel in Bankstown. The manager remembers that Jack's tongue was very white and that "he kept sticking it in and out of his mouth like a dog". Jack's behaviour led the manager to believe that Jack was "very high on something".

Jack failed to report to CCO Fitzgerald on 13 February 2018 and did not attend his mental health assessment. On 14 February 2018, the Community Corrections Officer telephoned Jack's sister, who advised that she had not seen Jack for a few days. She indicated that she was unsure as to whether Jack was still residing at the Banksia Motel and advised that she would go to the motel to see Jack that night or the following evening.

On the same date, Jack visited a pawn shop and sold a gold necklace that he had been wearing for $90. To complete the transaction, he was required to provide proof of address. He visited the Centrelink office next door to the pawn shop and returned with a payment summary which listed his address as a Punchbowl address. It is not clear from the material contained in the brief of evidence who in fact resided at this Punchbowl address.

On 15 February 2018, police officers were called to attend the Marrickville Tavern in response to a job relating to "a large islander male, who is possibly intellectually impaired, failing to leave the pokie area upon request". One of the attending officers, Constable Peter Treacy, now believes the relevant male to be Jack. Constable Treacy stated that Jack appeared angry because he felt that he had won a game on a slot machine, but it had not been paid out. Constable Treacy did not form the view, however, that Jack was adversely affected by drugs or alcohol, but rather "it was apparent that he may have an intellectual disability". Whilst Jack did not initially comprehend what was communicated to him, he ultimately complied with the police officers' directions.

On 16 February 2018, police officers were called to attend a 7/11 store in Marrickville due to a "Male POI inside store refusing to leave and harassing customer". The attending police officers – Leading Constable Sarah Jessup and Constable Cameron Edwards – now believe the relevant male to be Jack. Upon arrival, Constable Edwards completed checks via the police radio using Jack's ID and, at that time, Leading Senior Constable Jessup heard on the police radio that Jack had previous reports for mental health. That night both police officers formed the view that Jack was not, however, displaying signs of mental health issues. Jack was provided with a banning notice and moved along. The police officers inadvertently retained Jack's ID and they later located him while on patrol on 17 February 2018, at which time it appeared to them that Jack seemed in good spirits and did not appear to be under the influence of any drugs or alcohol.

Constable Edwards indicated that Jack advised them that he was staying at a boarding house in Marrickville. Whilst there is no evidence that this was the case, Jack had previously stayed in a boarding house in Marrickville in 2017. On 18 February 2018, between the hours of 1.30am and 3.00am, Jack buzzed the door at the Song Hotel in Chippendale. The night auditor opened the door and Jack pushed past him.

He noticed that Jack's "eyes were very red, and he smelt like alcohol". Jack appeared to be angry, and the night auditor thought Jack "was drunk or on some type of drugs". He asked Jack to leave but Jack refused and used the bathroom. The night auditor then called Redfern Police but, as he did so, Jack left. At 2:40am on the same day, police officers were called to a licensed venue in Chippendale where Jack was reported as loitering in the vicinity of the premises after he was refused entry. When approached by police officers, Jack agreed that he had been drinking and had attempted to gain access to the venue by avoiding security. Jack ultimately complied with the move on direction.

First incident

On the morning of 18 February 2018, a witness observed Jack on Bridge Road, Glebe, "babbling about the fact that he owned this land". He also saw Jack arguing with a friend about giving sunglasses to "Johnny" that Jack had sold to him. During the argument, Jack appeared to be interchangeably crying and then becoming aggressive. Another witness heard Jack call out, "Hey boss," and saw Jack pick up a hire bike and attempt to ride it, even with its back wheel locked. (It appears that the bicycle that Jack was using the morning of 18 February 2018 was a rental bike. When a rental bike has been rented, a mechanism releases the back wheel of the bike so that it can be ridden. As it appears that Jack had not paid to rent the bike, its back wheel remained locked.)

Further witnesses observed Jack riding a bicycle in the middle of the road near Allum Place, Glebe. One witness stated that Jack appeared to be sweating a lot, which seemed to that witness to be unusual as it was not a hot day and it was still early in the morning. Other witnesses described Jack as unsteady on the rental bike, having trouble peddling and falling off multiple times in the path of oncoming traffic. Jack did not appear to the witnesses to be trying to stop himself from falling off the bicycle, and he yelled at passers- by in what was perceived as an aggressive tone. A number of the witnesses called the police expressing concern for Jack's safety.

Arrival of police

Following police being contacted about Jack, Constables Jessica Guthrie and Sam Marshall responded urgently under lights and sirens. Constable Marshall was wearing a taser that day, which he had booked out and appeared to be in working order. Constables Guthrie and Marshall spotted Jack at 9.40am "at the cross of Allum St". Constable Marshall noted on the radio that Jack appeared "quite intoxicated".

Upon arrival, Constable Guthrie noted that Jack was a large Islander male, who was extremely sweaty and unsteady on his feet. She formed the view that "he clearly wasn't sober", and "was either drunk or on some other type of drug or something". She recalls that she "[p]possibly" had concerns as to Jack's mental health. Constable Guthrie was the first to approach Jack. He was on the footpath and she "kind of pushed him" further onto the footpath to get him out of the way of oncoming traffic. Jack then "kind of stood there for a little bit" and Constable Guthrie introduced herself to him. Jack was compliant during the initial conversation but then started to walk away, still straddling the bike.

Jack attempted to ride away from the police officers but "started kind of wobbling around and … stumbling over the bike as if to fall or try and run away with it between his legs". As a result of Jack's movements, Constables Guthrie and Marshall tried to hold Jack's arms to steady him on the bike. Constable Guthrie stated that both officers lost their grip on him as he was "extremely sweaty". She viewed this as an "indicator" that Jack was "on something other than alcohol". Constable Marshall also observed Jack to be "a little unbalanced, a bit dazed" and talking in incoherent sentences.

Constable Guthrie recalled that Constable Marshall then said he would call Jack an ambulance. Constable Guthrie thought it was appropriate to call an ambulance because she was concerned about Jack's state of intoxication and the potential risks arising from that. Constable Guthrie noted that it was after Constable Marshall referred to calling an ambulance that Jack began tensing his arms and saying, "Let me go".

Constable Marshall recalls Constable Guthrie then "gripped [Jack's] shoulder... put her hands on him," and said, "Look, mate, you've got to, got to stop". It was at this point that Constable Marshall believed Jack's behaviour escalated and that Jack started to "sort of thrash his arms around".

Constable Guthrie reported that she took the bike about five to ten metres away from Jack, as she was concerned that Jack, who had a "very solid build" and weighed at least 130 kilograms, might use the bike as a weapon and possibly try to get away. Constable Guthrie recalls that Constable Marshall then used the police radio to call for an ambulance. Constables Guthrie and Marshall each took one of Jack's wrists to keep him on the footpath until the ambulance came, but Jack started to become quite aggressive, trying to break free and was displaying aggressive body language, which included tensing his body and balling his fists. Jack then broke Constable Guthrie's grip and took a swing at her, connecting with her right thigh. She then stepped back in to assist Constable Marshall and fell to the ground together with Jack, trying to hold onto him as tight as she could, "bear-hugging him from the back … holding on to his … chest".

As a result, Constable Guthrie and Jack were "rolling around on the ground", with Jack "continuously try[ing] to … shake [Constable Guthrie] off his back". According to Constable Guthrie, it was at this time that Constable Marshall made an urgent radio call. Recordings of the police radio indicate that at 9:42am a radio call was made stating, "Leichardt one seven urgent". This was the first "urgent" radio call that Constable Marshall had ever made. He recalls however that the call was made before Constable Guthrie pulled Jack down. Sergeant Jacqueline Buchanan recalls hearing Constable Guthrie on the radio "very distressed … she was screaming".

Constable Guthrie gave evidence that Jack then relaxed "a bit" and she let go, leaving both herself and Jack sitting on the ground. While Constable Guthrie was moving to stand up, she felt like Jack was going to punch her, at which stage Constable Marshall grabbed hold of Jack's arm. After a further struggle, Constable Marshall sprayed Jack in the face with OC spray for a one second burst.

When Jack continued to resist, Constable Guthrie also sprayed Jack with OC spray in a short, one second burst but this had little to no effect on him. Constable Guthrie managed to restrain his legs but felt that Jack was "still extremely strong" and that it was unlikely they would get the cuffs on him. When Jack tried to push his body away from the ground in a push up position, she used her whole-body weight to pin his hip to the ground. Constable Guthrie recalls striking Jack five or six times on his thigh with a baton while directing him to "get your arm out". The VKG recorded at 9:43am a repeated "Leichardt one seven urgent" call and a further call stating, "POI's resisting".

Constable Guthrie reported being fearful at this time that Jack would assault her or Constable Marshall and that "he just wanted to walk away from us at all times". Constable Guthrie believed Jack could potentially overpower the officers and "knock me unconscious". When asked what she believed would happen if Jack was left unrestrained, Constable Guthrie stated that she feared he would continue to run into traffic, possibly be hit by a passing car or potentially lash out and hurt the officers. Sometime after 9:44am, Detective Sergeant Stephen Sutherland, who was an Inspector at the time, and Constable Patrick Pike arrived on the scene. Detective Sergeant Sutherland was also the Acting Duty Officer on this day. Sergeant Buchanan, who was an Acting Sergeant at the time, also arrived on the scene around the same time.

Constable Guthrie recalls that, once Constable Pike arrived, he assisted in pinning Jack onto his stomach and getting the cuffs on him. She also recalled that Detective Sergeant Sutherland did not get involved in the scuffle. This is inconsistent with Constable Marshall and Detective Sergeant Sutherland's evidence. They indicated that it was Detective Sergeant Sutherland who became physically involved and it was his handcuffs that were used to secure Jack. After Jack had been handcuffed, Constables Guthrie and Marshall's car (a caged truck) was moved and Jack was placed in the back. At 9:45am, a police radio call was made noting that Jack was "restrained, he's in cuffs". Detective Sergeant Sutherland radioed at 9:46am for an ambulance for decontamination as Jack was affected by OC spray. Jack then showed signs of settling down. Sergeant Buchanan and Constable Pike opened the door to the truck in order to pour some water on Jack's eyes but, when he tried to get up, they pushed him back into the truck and closed the door. They decided to wait for the ambulance to arrive before releasing Jack from the truck. Whilst Jack was in the truck, he kicked the back of the cage door.

Arrival of the ambulance

The ambulance received the call for assistance at 9.51am, it was dispatched at 10:06am, and reached the scene at 10:12am. Following the arrival of the ambulance, police officers opened the door to the cage on the truck and explained to Jack that the ambulance was there to help. Detective Sergeant Sutherland describes that Jack "virtually threw himself out of the truck onto the ground". NSW Ambulance Officer Alexander Brooks also saw Jack attempting to jump out of the caged truck.

When he saw Jack's behaviour, NSW Ambulance Officer Brooks became concerned that Jack might have been mentally disturbed or suffering from excited delirium. He tried asking Jack some questions, but Jack's responses were nonsensical. With Jack lying on his right side on the ground, one police officer was crouched down and trying to hold down his legs. Jack was calm for short periods and then would unexpectedly kick out with one of his legs and try and roll onto his back and move around. Jack told police that he loved them. While ambulance officers were assisting Jack, he appeared to speak incoherently and often in the third person, saying, "I am the God, I am the best…Jack is the boss". Jack also made a number of sexual comments to Sergeant Buchanan, including telling her he loved her and asking her to "touch my dick".

Constable Guthrie recalls the paramedics lying Jack on his side and squirting a sedative up his nose, whereas Constable Marshall, Detective Sergeant Sutherland and Sergeant Buchanan recall it being injected into his upper arm. NSW Ambulance Officer Brooks' statement confirmed that he administered Droperidol, a sedative, by injection for Jack's safety and the safety of others in attendance. NSW Ambulance Paramedic Tristan Mercer, who was at the time a paramedic intern, noted that, after Jack received the Droperidol, the police officers present continued to restrain Jack by holding his arms and legs and "[s]several minutes later it was apparent that the Droperidol had been effective and [Jack] was much calmer". Sergeant Buchanan described the effect that the Droperidol had on Jack as "it was just like an instant sort of change in his whole demeanour". She said between the administration of the injection and Jack getting into the ambulance, "I don't think there was anything more in terms of aggression there".

Constable Guthrie said Jack was "quite calm and compliant with the … paramedics. So, whether the sedative was involved with that then, yeah, possibly". Detective Sergeant Sutherland recalled that the sedative caused Jack to calm down "within maybe a matter of minutes". Detective Sergeant Sutherland also recalled that, whilst the ambulance officers were engaging with Jack, they were reassuring him. He stated further: *… I think there were police officers there too who were also speaking to Jack, and he, he seemed to calm with having that reassurance with that conversation. Even though Jack wasn't saying anything directly to us that I could comprehend, I think he calmed considerably when, when the ambulance officers and police were talking to him when he was basically laying on the stretcher.*

Jack was able to walk to the stretcher when asked. An ambulance officer placed restraints on his arms and legs. Jack was observed to be compliant. The handcuffs were removed from Jack when the ambulance restraints were secured. Jack was loaded into the ambulance at 10:28am.

While he was being loaded into the ambulance, Sergeant Buchanan asked Jack what drugs he had taken. Initially Jack responded: "oh no miss, I don't do drugs". However, when pushed, Jack claimed to have had "some weed" (or "some pot"), "some coke" and "some ice". Sergeant Buchanan says she had believed Jack to be drug affected as he was aggressive, sweating, manic, agitated, nonsensical, frothing and drooling. Constable Guthrie also believed that Jack was drug affected because of his excessive sweating and bloodshot eyes. Paramedic Mercer stated that, "[f]rom my experience, [Jack] appeared to be drug affected and later he admitted that he had recently used 'heaps of ICE and marijuana'". Ambulance officers noted that during post-decontamination Jack denied all other pain, had "no difficulty breathing, was speaking in full sentences, chest sounds were clear and equal bilaterally, nil obvious head, neck, thoracic or long bone trauma, nil neck pain on palpitation". Jack's Glasgow Coma Scale remained at 14 during transport to the hospital and there were nil changes in his sinus rhythm.

It was discussed between Constable Guthrie and Detective Sergeant Sutherland at the scene that while there may be future charges laid against Jack, he should go to the hospital for a mental health assessment under the *Mental Health Act 2007* (NSW).

Admission to and absconding from RPA

Arrival at the RPA

The ambulance left the scene at 10:28am and arrived at the RPA at 10:36am. Jack was transferred from the ambulance stretcher to a hospital bed at 11:12am.

Constables Guthrie, Marshall and Pike and Sergeant Buchanan followed the ambulance to the RPA. Upon arrival, Constable Guthrie washed the abrasions on her arms out of fear of contamination from Jack. During triage, Jack's prior medical history was listed as schizophrenia, depression and polysubstance abuse. Sergeant Buchanan recalled Jack continuing to make sexual comments during triage. Sergeant Buchanan also recalled a security guard from the hospital who was present during triage. She says that the paramedic with Jack commented to the security guard that Jack would need care. The security guard allegedly said, "I don't give a fuck," and walked out the door. The last that Constable Guthrie saw of Jack was him sleeping on the stretcher. She believed that he had been given more sedatives as he slowly became "more and more drowsy". Sergeant Buchanan recalls Jack asking for "more ice" from the doctors at the hospital. There is no evidence that security was notified of Jack's admission by any nursing or medical staff upon his entry into the hospital.

Constable Marshall recalls completing s. 22 paperwork to schedule Jack, namely a "Request by a member of NSW Police Force for assessment of a detained person" form. The form that Constable Marshall completed identified the following information:

- Jack's current behaviour was "Intoxication (Drugs/Alcohol)" and "Attempted self-harm".
- "Any other relevant information" pertaining to Jack was "Significant criminal history including numerous serious offences".

- police intervention included “Appointments” and “Weaponless control”; and
- the description of the circumstances that led to apprehension of Jack was:

About 10:30am police responded to Bridge Rd, Camperdown, following numerous reports from the public regarding a male attempting to run into traffic moving at approx. 60kmph.

On arrival police located the above-named person who appeared heavily affected by drugs and/or alcohol. Whilst police were speaking with the person his behaviour became aggressive and erratic. This person attempted to leave the scene prompting police to detain him. Due to his highly aggressive state, police were required to deploy OC spray, batons and strikes in order to subdue him.

Due to his behaviour police believe that he posed a significant risk to both himself and members of the public.

Once the s. 22 paperwork was completed, all four police officers present left the hospital.

Jack was first seen by Registered Nurse Joceli (Joy) Cabides (“**RN Cabides**”) in the Resuscitation Bay, which is a three bedded area in the Emergency Department where one nurse is allocated to each of the three beds. As Jack was a scheduled patient and in the Resuscitation Bay, he was automatically allocated 1:1 nursing.

Jack was already physically restrained to the hospital bed when RN Cabides saw him. She received a verbal handover from the ambulance officers, who advised that Jack was a scheduled patient. She was also advised that Jack had been running through traffic, had been “capsicum sprayed” by police officers and had been administered Droperidol. As part of taking on Jack’s care, RN Cabides recalls having a “brief look at” the s. 22 form that Constable Marshall prepared in respect of Jack. At the time of giving evidence at the inquest, she was unable to remember what was recorded on that form.

Dr Dawn Cutler, an Emergency Department Consultant, was also asked to review Jack in the Resuscitation Bay around about the time that Jack was being transferred from the ambulance stretcher to the Resuscitation Bay bed. Dr Cutler obtained Jack’s history from the two police officers and two ambulance officers present. She recalled that they advised her that there was concern for Jack as he had been found walking on the road, became aggressive when police officers arrived, and it had taken a number of police officers to restrain him. The ambulance officers advised that Jack had been sedated with 10mg of Droperidol. Dr Cutler understood at the time that Jack had apparently taken ice and cocaine within the 24 hours prior to presentation. Dr Cutler also accessed Jack’s power chart, which indicated that he had had previous admissions for drug-induced psychosis and a forensic history and arranged for a request for Jack’s Cumberland Hospital records.

Dr Cutler then conducted an examination of Jack. He had abrasions to his feet and “it looked as though he had been walking around without shoes for a while”. He advised he was not in pain and was unable to provide any further information or medical history. Dr Cutler described Jack’s presentation as “[o]overall, … quiet and drowsy, but cooperative”.

Given he was drowsy and still affected by the sedative, Dr Cutler did not consider that Jack could properly be assessed (that is, a mental health assessment) at that time. Finally, Dr Cutler arranged for an ECG to take place as she considered it necessary given Droperidol can affect a person's heart rate.

"Emergency Department Request for Nurse Special" form

At around 10:45am, Nurse Unit Manager Jessica Francis ("**NUM Francis**") completed an "Emergency Department Request for Nurse Special" form. NUM Francis identified the following information on the form she completed:

- Jack was scheduled.
- the "Nurse Patient Ratio" was 1:1;
- the reason given for "special" was "sedated aggressive".
- Jack's diagnosis was "MH" (mental health).
- Jack's behaviour was "violent".
- "yes" was circled next to the words "Attempting/Wanting to Leave"; and
- a male nurse was requested.

In her statement, NUM Francis explained that she had completed the above form "in case [Jack] was transferred from the Resuscitation Bay" to another ward. The nursing care provided in the Resuscitation Bay, as noted above, was 1:1, regardless of whether a patient was scheduled or not.

In giving evidence, NUM Francis explained that she had requested a male nurse because often assistants in nursing are "young 18-year-old female, 19-year-old female nursing students". As Jack "was quite a large man", she thought that those female nurses may "feel intimidated by him". She also explained that "often the boys [i.e. the male nurses] seem to have a better rapport" with male patients. In respect of NUM Francis having circled "yes" next to "Attempting/Wanting to Leave", she gave evidence at the inquest that the basis for this answer was that she believed Jack had "said at some stage that he wanted to go". She also agreed that she circled this answer as she thought there was a risk that Jack would attempt to abscond from the hospital.

The "Specialling Patients in the Emergency Care Setting" policy sets out the systematic approach that should be provided to "at risk patients who require a higher level of supervision in the ED". The role of the Emergency Department NUM is to liaise closely with members of the Emergency Department team to ensure the individual assessment and needs of the patient are met. The policy identifies that patients, staff and the general public are entitled to be protected from harm or injury and that patients may pose a risk to themselves and to others. If a patient is at risk of absconding the medical team must review the patient as soon as practical or allocate a senior medical officer or Mental Health Nurse practitioner who has the necessary skill set to provide such a review.

Despite the fact that NUM Francis identified Jack as at risk of absconding, it does not appear that NUM Francis took any action consistent with the abovementioned policy.

Use of restraints

At 11.00am, RN Cabides completed the "Patient safety physical restraint order and observation chart" form. She noted on the form that a restraint order had been made on 18 February 2018, and that Jack was being checked every 15 minutes, that his temperature was warm, that his pulse was present and his skin condition "normal". The form was not signed by a medical officer, nor did it identify the "Duration and reason required" for the restraint.

When asked who had made the restraint order, RN Cabides initially responded that:

[t]he medical officer and the ambulance … it's a collaborative team decision. This gets filled out with the signature by the medical officer. We, the special nurse or the resus nurse fills up the, the restraint, the time, the type and the area that, all of that observations.
She later clarified that she was unable to recall who specifically authorised the restraint.

In respect of the information missing from the form, the following exchange took place between Counsel Assisting and RN Cabides:

Q. Surely when you were completing this form, you should have spoken to the medical officer in order to ask how long should this patient be restrained and what is your reason for restraining him?
A. I did ask the medical officer about this. I said, 'You have to sign the order' and I did remind her, and she knows about it. I'm not sure what happened in between that and she told me 'We will just keep him under restraint until we properly assess him' and I said 'Okay' and yep that's it.

Q. So now you say that, is that Dr Cutler?
A. Yes

Q. Is your evidence that you recall Dr Cutler saying to you "Keep him restrained until he's been properly assessed'?
A. Just Dr Cutler just told me just to keep him as it is. Sorry wordings are not proper. Because I've asked her 'What's the plan?' And she asked me, 'Is he vitally stable?' I said 'Yes, but still uncooperative with the questioning and all that and won't even let me do some bloods on him.'
And she didn't give me a direct order to keep him on restraint. She said, 'We'll just wait until we get the medical records and so we can properly assess him.'

The restraints used on Jack were "posey" restraints. The Sydney Local Health District Policy Directive, "Restraint Policy" (**"2014 Restraint Policy"**), which was in place at the time, provided that restraints could be used to protect the safety of a patient and staff from immediate risk. Restraints were to be used for the shortest period necessary.

The 2014 Restraint Policy relevantly provided:

- the clinical team will determine the need to include restraint in a patient's management plan.
- the decision to restrain a patient must always be a team decision.

- the authorisation of restraint must be by the person who made the decision to use the intervention, often the senior nurse who leads the response team.
- the use of restraint must also be authorised by the medical officer; and
- a coordinator, usually the nurse in charge or other qualified health professional must accept the responsibility for initiating and coordinating the restraint.

It is not immediately apparent who formally authorised the use of the restraints on Jack.

The hospital copy of the Ambulance Electronic Medical Record noted that restraints were applied at 10:35am for the following reasons: "mental health, drug affected, [violent], in police custody". Paramedic Mercer recalls that the soft restraints that the ambulance officers used "were removed from [Jack] and he was transferred from our stretcher onto a Resus bed. Hospital soft restraints were then immediately applied to [Jack] by nurses with the assistance of security staff". It is likely that the nurse involved in this process was Registered Nurse James Churchland ("**RN Churchland**").
In his statement, RN Churchland recalled:

A short time after [Jack] arrived in the Resuscitation Bay, the Ambulance restraints were removed from him and he was transferred to Resuscitation Bay Bed 1 and restrained to the bed with Hospital restraints. I was involved in this restraint process by attaching the Hospital restraints to the Resuscitation Bay bed. The Paramedics then moved Mr Kokaua from the Ambulance stretcher to the Hospital bed and applied the Hospital restraints.

In his evidence at Court, RN Churchland advised that he could not recall who authorised the use of the hospital restraints. He noted however that: *So, I think in practice … if somebody comes in, in restraints then it's normal practice to keep them restrained. Until they've had a proper medical evaluation, we can decide whether the restraints are appropriate to come off or not. If someone doesn't come in restrained and we decide to restrain them once they're in the department, that's a medical decision.*

RN Churchland's comments referred to immediately above appear to be consistent with Dr Cutler's evidence. In contrast, NUM Francis stated that she "believed" it was Dr Cutler who had authorised the restraint because she remembered Dr Cutler "talking about restraints being on" and Dr Cutler was the medical officer looking after Jack on the relevant day. She stated however that she was not aware of any discussion amongst the clinical team about the use of restraints on Jack. Whilst Dr Cutler initially commented that Jack "came in with ambulance restraints on, so the decision was made prior to him coming to hospital", she went on to state:

I asked that the restraints were left on and that was [in] discussion with the team that were looking after [Jack] so there would've been a nurse there, which I think was [RN Churchland], possibly more nurses. I seem to remember there was [RN Churchland], two paramedics and two police officers.

Dr Cutler also agreed that she had spoken to RN Jecky Soni about the restraints.

In her statement, Dr Cutler said that her plan in respect of the use of restraints on Jack was that "once the effects of the Droperidol had worn off and [Jack] was able to be assessed by a Mental Health clinician, a decision could be made as to the removal of the restraints". Dr Cutler conceded in her evidence that her plan was not articulated in the restraint order form, but that she had advised the nursing staff that Jack should remain restrained until he was awake. She also said that her usual practice was to complete the form when conducting a comprehensive review of the patient, which she was intending to complete when the effects of the Droperidol on Jack had started to wear off. As Jack had absconded, this review was unable to take place.

Observations of Jack

Between 11:00am and 12:30pm, RN Cabides filled in information on an "Emergency Department Mental health and delirium risk assessment" form on four occasions at roughly 30-minute intervals. The risk assessment form indicated that Jack's total mental health and delirium risk assessment score was 9 or 10 on each occasion. There was no notation made against the criteria "NUM/In-charge notified if risk assessment score>8", as required. RN Cabides clarified in her evidence that she had verbally advised Dr Cutler and RN Churchland of the risk assessment scores, and that she must have forgotten to make a notation on the form regarding the same. According to the "Specialling Patients in the Emergency Care Setting" Policy Directive, a score of nine to 15 on the risk assessment form indicated a "medium risk". This required that the following was to take place:

- the patient be assessed every 15 minutes.
- that the patient be placed in the department for easier observation.
- that the patient be considered "special".
- the NUM or a more senior officer be referred to; and
- the medical and nursing staff needed to consider escalation of treatment such as oral medication.

At 11:59am, Dr Cutler reviewed the results of Jack's ECG. The results indicated that Jack had an abnormal rhythm, suggestive of sinus tachycardia. Otherwise, his vital signs were within normal range, although his heartrate was slightly elevated. According to Dr Cutler, this was consistent with Jack having taken illicit drugs.

At 12:01pm, Dr Cutler completed an entry in Jack's electronic medical record. It noted, amongst other things, the following:

- Jack "[b]became aggressive and rambling on arrival of police".
- he "[r]enquired manual restraint and 10mg IM droperidol";
- Jack's medications included "Depot" and "? Quetiapine"; and
- Dr Cutler's plan was that a psychiatric review would be conducted on Jack.

At 12:30pm, RN Cabides made a note that Jack was taking off his monitoring leads every now and then and was unable to keep still so as to allow RN Cabides to safely take bloods. She also included in the note that the medical officer (or "MO") was aware, presumably, of these observations.

Removal of Jack's restraints

At approximately 12:40 pm, Jack asked to use the toilet. RN Cabides advised Jack that, as he had been scheduled, he would have to use a bottle and was unable to go anywhere without an escort. RN Cabides then gave Jack a bottle and he asked for privacy. He then indicated that he could not use the bottle because he was restrained. RN Cabides loosened Jack's left hand restraint and undid his ankle restraints, so that he could use the bottle. In her statement, RN Cabides indicates that she had some concerns about loosening Jack's restraints as he "was a big man and it would have been difficult to re-restrain him; however, he had been compliant and cooperative up to that point". RN Cabides had not been advised that it had taken seven police officers to restrain Jack. While she agreed that increased the likelihood of his absconding, she gave evidence that if he did abscond, all they could do was to ask him to come back. She accepted that the information from the ambulance service ("mental health, drug affected, violent, in police custody") suggested that Jack may be unpredictable when the Droperidol wore off.

However, she maintained that even if she knew that due to Jack's highly aggressive state, police were required to deploy OC spray, batons and strikes in order to subdue him, this would not have made any difference to her decision to release Jack's restraints to enable him to go to the toilet. She explained, "I'm rendering care to him and according to our policy, if we are rendering care to our patient and it, the initial risk that he came in and has gone off, we can take off the restraint". She later accepted, however, that when she loosened Jack's wrist restraint, she did have a concern that she may have to re-restrain him. The 2014 Restraint Policy in place at the time provided no allowance for a restraint to be removed because a patient currently restrained requested to use the toilet. RN Churchland gave evidence that it was the practice in the Resuscitation Bay to remove restraints to allow for a patient to use the toilet and if there was a high risk of aggression then security might be called to assist.

Consistently, RN Cabides indicated that she would call security to supervise a patient's use of a bottle for urination if there was risk of danger were the patient to be unrestrained. RN Churchland and RN Cabides each gave evidence however that the risk of a patient absconding or becoming aggressive would not have changed their decision to remove restraints so that a patient could use the toilet.

NUM Francis stated that if a patient was calm and compliant, there would be no reason to not let them go to the bathroom. She would, however, tell a colleague that she was going to be releasing restraints so that "they could give you a hand". She said if Jack had become non-compliant, the plan was always to call security. Security could not have performed a controlled take- down of Jack however he should have tried to leave the hospital. The 2014 Restraint Policy provides that a "mechanical restraint can be ceased by the senior nurse or MO at any time if the reason for the intervention has ended".

When asked about the above aspect of the 2014 Restraint Policy, RN Cabides said that she was a "senior nurse" for the purpose of that policy and that it allowed her to temporarily release (rather than cease altogether) Jack's restraints so that he could go to the toilet. Dr Cutler stated that it was a "nursing decision" regarding a person who was restrained needing to use the toilet, and she would not normally expect the nursing staff to involve her in that decision. She said later, however, that she discussed with RN Jecky Soni the policy that the restraints needed to be removed as soon as they could but that she never made a decision to take them off.

RN Jecky Soni, CNC, accepted that if it was possible, it would be a good idea for him to be consulted as to the decision whether to release restraints. Each of NUM Francis, RN Cabides, and Dr Cutler gave evidence that the plan was to follow the "Absconded Patient Policy" and to press the duress alarm if Jack's behaviour escalated.

Jack absconds

Following the loosening and removal of Jack's restraints, RN Cabides then left Jack alone behind the curtains. She later "peeked" around the corner of the curtains, at which time she saw Jack remove his other hand restraint and so she pressed the duress alarm. RN Cabides said that she used de-escalation techniques once it became apparent that Jack had loosened his restraints. She said that she had developed a rapport with Jack and that when he began loosening his restraints "she offered him if he wants to go to the toilet, [she] can walk him to the toilet … And [she] even led him …"

In response to the duress alarm, a male nurse spoke to Jack behind the curtain. A short time later, security, NUM Francis and other nurses arrived in the Resuscitation Bay. According to RN Cabides, Jack then became angry. A staff member told Jack that he could use the toilet in an isolation room, but he said he did not want to. Jack then moved into the emergency department corridor, where he was followed by staff. He was directed to a "quiet room". Jack came out of the "quiet room" by which point there were three security officers present. He then walked through the ambulance bay, jumped over a stretcher with another patient in it and exited the hospital. The RPA "Absconded Patient Policy" identifies that there are a number of factors that may indicate that there is an increased likelihood that a patient will abscond and that those factors should be taken into account to implement appropriate strategies to minimise the risk of absconding. The factors which are said to increase the risk of absconding include a history of mental illness, delirium, agitation, being held involuntarily under the *Mental Health Act* and a history of drug and/or alcohol misuse/intoxication. It is apparent that Jack had a number of risk factors that may have indicated an increased likelihood of absconding.

The strategies to minimise the risk of absconding, as set out in the "Absconded Patient Policy", include identification and de-escalation of potential stressors, inclusion of details in clinical notes, location in an area of the ward where direct observation is easier, specialling of the patient and timely communication with security about the patient.

The "Specialling Patients in the Emergency Care Setting" policy also states that "[s]security should receive a verbal report regarding any patient who is at risk of absconding and a plan of escalation is discussed including any potential risks for patient or staff". As a scheduled patient, Jack was at high risk of absconding. As noted above, there is no evidence to support that security were advised that Jack, a scheduled patient, had been admitted to the RPA. On the evidence it appears that the first time that security was notified about Jack was after the duress alarm was pressed. Further, no plan was ever discussed or put in place as to how to respond if Jack were to become confrontational or violent.

A Registered Nurse also in attendance on the day indicated that usually when a patient comes in with police, the nurse triaging the patient or the nurse receiving the patient in the Emergency Department would contact security. In contrast, RN Churchland gave evidence that, while it would have been best practice for security to attend when a scheduled patient arrived, there were only four security officers available to the whole hospital and it was not feasible for security to be contacted to attend the Emergency Department every time a scheduled patient arrived. Further, the 2014 Restraint Policy provides that, if restraint has been used repeatedly, a patient's medical records must include a management plan for recurring disturbed behaviour. There is no evidence that any management plan was specifically created for Jack.

The "Absconded Patient Policy" also includes a post-absconding protocol. This requires that staff must never place themselves at risk of harm in order to return a patient to the ward, although security can "encourage the patient to return voluntarily". According to the policy, security officers do not have the authority to force a patient to return to the ward. Instead, they are to contact police for assistance. When asked whether she had given any thought to what she would do if Jack attempted to abscond, RN Cabides stated that "it came to my mind" and that she had the duress alarm at hand and was confident security would be there to stop Jack from leaving. I accept that RN Cabides should have given more careful consideration, including consulting with someone else or more senior, as to the release of Jack's restraints. Although she did so for the purpose of allowing him to urinate, there was practically no difference to the restraints being temporarily or permanently removed.

Where there remained a risk that Jack would be non-compliant, I find that RN Cabides should have considered having security present. The "Absconded Patient Policy" also requires that any scheduled patient be identified as "high" risk once absconded and that certain processes be followed when a high-risk patient absconds.

At 12:50pm, following Jack absconding, RN Cabides prepared an "Absconded Patient Report to Police". The report identified that Jack's risk level of absconding was "high", and that the action taken by the ward to locate the patient was "[p]police called".

RN Cabides explained in her evidence that she had assessed Jack's risk post-absconding as "high" because: *… at the time when he absconded, we still didn't have his bloods, only the ECG as an assessment or is observations, blood pressure, heart rate. We haven't fully had a conversation to him with regards to his medical history. Why is he running the streets? So, we don't have that assessment still, that's why it's on high.*

RN Cabides then clarified:

He, because of, because we haven't really completely assessed him. The time that he was, that he did abscond he, his – we, the risk of him injuring himself or others might, is still in there, because he absconded. If he didn't abscond then you would assume that he is still cooperative and still wants to stay in the hospital and be assessed. But because he did run away, he did abscond, then that changes.

Notifying NSW Police that Jack had absconded

Following Jack absconding, NUM Francis spoke to security staff and advised them that Jack was a scheduled patient. The security staff indicated they did not feel it would be safe to attempt to get Jack back into the Resuscitation Bay physically. Security officer Danilo Sotelo noted that Jack was very aggressive, and security did not have enough "man power" to deal with him. It is consistent with the policy at the RPA, to which I have already referred, for security not to seek to detain a patient. NUM Francis called the police and advised that Jack had absconded from the hospital. Constable Pike recalled receiving a phone call to this effect. Sergeant Buchanan and Constables Guthrie and Marshall later advised over police radio that they were looking for Jack.

St Andrew's College, University of Sydney

Shortly after absconding, CCTV footage shows Jack scaling a wall into the St Andrew's campus. At approximately 1:30 pm, Jack walked into one of the seminars at the College and said: "I am an angel". He walked around the classroom saying, "bless you, bless you," to a number of students. Jack's voice was observed to be at a normal level, but some witnesses perceived that he had some form of mental health illness. Jack had also gone into another seminar room and it was observed that he was mumbling strange, incoherent sentences. When the lecturer tried to remove him, Jack grabbed the lecturer around his chest. Jack then attempted to remove the lecturer's shoes. He later left the seminar. Prior to entering one of the classrooms, Jack told a student, Alexander Wright, that he was hungry and needed water and shoes. Mr Wright described Jack as looking disorientated and his speech as being slightly slurred. Mr Wright observed Jack to be quite subdued and passive, but uncooperative.

Mr Wright then called campus security. Greg Charlesworth, a security guard, attended the College and found Jack in the laundry room, wearing some small white square stickers, indicative of those used at a hospital. Jack told Mr Charlesworth that he was washing his clothes and asked whether it was time to go. The security guard recalled Jack leaving without incident and stated that he was not threatening, aggressive or intimidating at any time. Mr Charlesworth described Jack's demeanour as calm, polite and respectful, with Jack speaking clearly and coherently in a calm tone. Mr Charlesworth did not believe Jack to be mentally ill, but more like a recently homeless person looking for somewhere to wash his clothes.

Jack then exited the College onto Carillion Avenue.

The second incident

At 13:21:07, Sergeant Buchanan located Jack and parked vehicle LE14 near the entrance to St Andrews College on Carillon Avenue, Camperdown. Ten seconds later she exited the car, and 20 seconds after that, Sergeant Buchanan crossed the street and started speaking with Jack. At no point during the process of her arrival did Sergeant Buchanan make a call for an ambulance. In her evidence, she explained that generally you need to have control of the situation before calling for an ambulance. Further, she considered that, at that stage, she did not have sufficient information to call an ambulance and there was no time to call the ambulance in any event. Sergeant Buchanan's plan was to locate Jack, detain him and then call an ambulance. She was hopeful that Jack would cooperate, having regard to his earlier demeanour after sedation. In evidence on 3 November 2020, she elaborated and explained that her plan was that Jack would be returned to RPA, preferably in an ambulance, but if there was violence then in a police car.

Sergeant Buchanan was hopeful that Jack would cooperate, having regard to his earlier demeanour during the first incident after sedation. However, in evidence on 3 November 2020, she said she knew something was going to happen "and it's not likely to be good". In evidence, Sergeant Buchanan did not describe any plan as to how she would respond in the event that Jack did not cooperate as she hoped to save that, on 3 November, she identified that she would use the options available as per the tactical options model.

At 13:21:35, Constables Guthrie and Marshall arrived and stopped vehicle LE17 opposite the driveway to St Andrews College. Constable Marshall said that prior to their arrival he and Constable Guthrie had reached a "[g]general consensus, he's absconded, we'd like to stop him and get him back to hospital". Constable Guthrie's evidence on 4 November 2020 was that the plan was that Jack should be located and returned to hospital.

Constable Marshall also gave evidence that he had a general discussion with Constable Guthrie before they arrived about different tactical options and "what might most be suitable, given the circumstances". He said he discussed the use of the taser "because of the ineffectiveness of OC spray. He's a very large gentleman, stronger than both of us, it would be very difficult to deal with him hands on, if he became aggressive". He also said, "If we were engaged in a violent confrontation, they're very useful in helping to protect yourself and control people". Constable Guthrie gave evidence on 4 November 2020 that there was no time to call an ambulance when she and Constable Marshall arrived.

At 13:21:42, Constable Marshall alighted from the vehicle and Constable Guthrie walked around the car shortly thereafter. Constables Guthrie and Marshall joined Sergeant Buchanan and crossed the road in an attempt to stop Jack from walking away. Sergeant Buchanan described Jack on approach as being agitated, shouting and repetitively saying, "do you wanna fight me". She said that she advised Jack, "no, we don't want to fight you", and that, in response, "he was saying things and doing things, which I guess are responses, but he was not responding to what I was saying". When asked what view she formed as to Jack's mental health at that particular point in time, she said "he was obviously unwell, which is why we put him in the hospital".

When Jack first saw the police approach, Constable Marshall described Jack's demeanour as, "he appeared to get a bit agitated". Constable Guthrie said that Jack was saying things like, "Fuck off. Leave me alone. I'm not going anywhere," and rambling things. She said, "[h]e was looking away from us a fair bit so in my experience that usually means people are trying to look for a space to get away. Like maybe, generally people do that before maybe foot pursuits start… Then, he started kind of clenching his fists a little bit and just he had a bag in his hand… he was just kind of essentially arguing with us to leave him alone".

Constable Sam Marshall said the officers "were trying to stop him walking away". At approximately 13:22:16, Constable Guthrie put her left hand out towards Jack and touched Jack's chest, applying some force. She said, "Jack, stop, please. You need to go back to hospital". Constable Guthrie described Jack as quite agitated, he seemed a bit annoyed but not violent. Her evidence is that Jack was verbally resisting.

At 13.22.41, Constable Marshall activated, or armed, the taser and the taser video footage with audio commenced. Constable Marshall said he activated the taser as a precaution, so it was ready. He believed that there might be a violent confrontation.

At 13.22.47, Sergeant Buchanan discharged OC spray in Jack's face as she felt there was a threat of violence from Jack, namely, "he'd gone to run from me, he'd gone to shape up, he was frothing at the mouth, he's sweating, he's saying he wants to fight". She did not verbally warn him that she was going to use the spray but had told him to "stop". Constable Guthrie's evidence was that after the OC spray Jack became physically aggressive and violent.

The OC spray also affected Sergeant Buchanan as she had to run through it. She said she had difficulty seeing, "and breathing, talking and everything else". Constable Marshall gave evidence that, prior to Sergeant Buchanan discharging the OC spray, Jack "shaped up a bit towards us".

At 13:23:00, Constable Marshall is seen on CCTV to kick at Jack's thigh area. As a result of the kick, Jack slipped but regained his balance. Constable Marshall said his reasons for the kick were "Two-fold, I didn't want him to have his bag with him and I wanted to push him off balance. I was hoping he would fall onto his back". He said, "He was already down low. We could safely restrain him at that point, potentially".

At 13:23:02, Jack is seen to run towards Constable Marshall.

At 13:23:04, Constable Marshall fired his taser for the first time. Constable Marshall said "[h]e was charging towards me, at a fraction of a second, I was concerned for my safety, that and [Sergeant] Buchanan who was standing next to me. I deemed it was appropriate to use the taser". Constable Marshall gave no warnings to Jack before firing the taser. He said, "[i]t happened quite suddenly".

Following the deployment of the taser, Jack fell to the ground immediately.

Constable Guthrie gave evidence that after the taser was deployed and Jack was on the ground, she ran towards him and applied pressure to his back. He was face down but possibly trying to bring his hands up under him. She said, "[m]y intention was to place my body weight onto his trunk or arm or…, to restrain him on the ground and prevent him from getting back up again to possibly further assault me or Jacqui or Sam".

In the period 13:26:09 to 13:23:22, Constable Guthrie remained straddling part of the left side of Jack's upper body. She said, "I believe possibly my, my left hand may have been on his left shoulder or possibly on his left arm as he was trying to pull them in, thrash around a little bit".

At 13:23:14, Sergeant Buchanan reported to police radio, "Fourteen, need further cars urgently".

At 13:23:19, Constable Guthrie used a number of elbows strikes to Jack's upper back. She said she was yelling, "get your arms out. Release your arms". She said she was striking "the areas of his lat [sic] to have a response for him to bring his arm down".

That is, she was striking just under his shoulder. At around the same time, Constable Guthrie says Jack was starting to grab her ankle and leg.

At 13:23:50, the taser log records the second depression of the trigger. Constable Marshall had fired the taser for the second time. At that time, Jack was on the ground and three officers were behind him. Constable Marshall said, "[h]e was violently resisting us, and there was a danger, we could have been overpowered".

At 13:24:03, Constable Guthrie said she had her right arm around Jack's chest area. She does not recall whether her arm was around his neck. Her intention was not to be around his neck at any time. In the period 13:24:05 to 13:27:15, Constable Guthrie remained in the same position.

At 13:24:25, Jack is seen rolling onto his back.

At 13:25:10, the taser log records the third depression of the trigger. Constable Marshall fired the taser for the third time and Jack fell to the ground. After this, Constable Marshall kept the taser on standby.

At 13:25:17, Jack stood up with Sergeant Buchanan on his back.

At 13:25:22, Jack fell over again.

I find that the evidence establishes that all three applications of the taser resulted in charge being applied to Jack, even if, as outlined in the statement of Senior Armourer Halbmeier, that charge was erratic at times.

Arrival of Senior Constable Oscuro, and Constables Macsok and Harris

At 13:25:32, Senior Constable Susan Oscuro, and Constables Cameron Macsok and Jodi Harris arrived in vehicle IW18. Around this time, Constable Guthrie said she was taking control of Jack's legs and lower portion of his body: "[s]o I believe I'd actually wrapped my legs around his legs". She said she was also reaching above his head to hold the second cuff of thehandcuff.

By 13:27:39, Constable Harris agreed in evidence her position was over Jack's hip and lower back area. She said her mid-section was on his hips. She was "trying to plank and keep him down." She had weight on his hips to try to restrain him. In Constable Harris' notebook, she stated, "I was reaching holding down the male at his back". In evidence, she said, "[w]ell, I was over his hips and his lower back, like his hips". She also said she didn't apply pressure the whole time, "I was applying pressure when I felt him resisting… So, it was when he was trying to get up, we'd apply pressure and then alleviate that pressure with the mount of force that he was trying to resist and get up". She said Constable Macsok was to her right, towards Jack's upper body and head. She could not remember Constable Macsok lying across Jack's upper body. She was aware of him being close but could not recall the position he was in. Constable Harris remained in position over Jack's hip area, with intermittent pressure in a planking position, until Jack's breathing was checked. In evidence, she agreed that Jack was in the prone position.

Constable Macsok wrote in his notebook, "I ran over and put my body weight onto the males upper body. The male was violently resisting". In evidence, he described this as "[s]o as I ran over, I was trying to secure his right arm, he was in the process of pushing himself up…. He's laying across the footpath, I've run over and the sort of left side of my chest is sort of on his shoulders. So, he has pushed himself up, I've sort of side straddled". He said it would have been on the back of his right shoulder. He was pushing himself up.

Once on top of him, with Jack facing the ground, he said it pushed Jack down "slightly". Constable Macsok's evidence was that from the time he put weight on the back of Jack's right shoulder until he was rolled over, Jack remained in a position facing the ground. He said in his notebook, "I put my left forearm on the males upper hand and moved his head away from the male officer." In evidence, he describes this as, "at that stage Jack was looking towards Constable Marshall on his left, so I put my hands on the side of Jack's head, so it would have been on the left side of his head to control it, to keep it in a position where he couldn't keep turning and spitting". He confirmed he turned Jack's head away from the officer. Constable Macsok described his position on Jack as, "[s]o I wasn't lying across the upper, his upper body. I was… sort of side straddle, so the left side of my chest would have been on his right shoulder, and again my left forearm was, was near his, the left side of his head".

Constable Marshall agreed that the weight of several police officers was used to subdue Jack. He could not recall how many. He also recalled a point after Jack was handcuffed, where "I do recall seeing some officers on top of him, yes".

As noted earlier, Sergeant Buchanan's vision was affected by OC spray as she had run through the spray. She was unable to say whether the police officers present were using their weight to restrain Jack. She stated, "I don't know, … I can't say whether officers were using their weight. I don't know that". She also said:

I'm certain that, obviously, because it was a physical confrontation, we would have been using our weight in the same ways he was using his weight. So, yep, weight would have been involved. It's important to know and I was aware of it, but I couldn't tell you to the degree with which each officer was using weight at any given time in that wrestle through the entire period.

Constable Harris in evidence agreed that Jack in this period was in the prone position. Constable Macsok gave evidence that, from the time he put weight on the back of Jack's right shoulder until Jack was rolled over, Jack remained in a position facing the ground. He was trying to roll Jack over onto his right side. He agreed he didn't succeed in rolling Jack over.

In the period 13:26:31 to 13:26:57, Constable Guthrie says she believes her left shoulder was pinned underneath Jack's bottom portion. She was bear hugging his legs and her legs can be seen in the air. Senior Constable Oscuro sought to pull Constable Guthrie to free her from under Jack's legs.

Following this, Constable Guthrie returned to applying pressure with one or two hands to Jack's lower body, his hip or side of the thigh area.

At 13:26:09, CCTV footage shows Constable Macsok on top of Jack's torso area, Constable Guthrie and Sergeant Buchanan on his legs, and Constable Marshall holding Jack's head.

At 13:26:11, Senior Constable Oscuro said in evidence that there were two or more officers lying across Jack's upper body.

At 13:26:21, Constable Macsok confirmed from taser frame "Image Y" from the taser footage that he had his hand on one side of Jack's head with his ear between his fingers and at that point Jack had both shoulders on theground.

About 10 seconds later, at 13:26:41, Constable Macsok confirmed in evidence that at that time, from taser frame "Image EE", he had his left arm underneath Jack's chin. He had his left forearm on the side of Jack's head. Jack was pushing himself up. He said "he again spat. So, the first thing I did, reacted and put my hands around his chin so I could pull him back away from Constable Marshall".

Senior Constable Oscuro assisted with handcuffing Jack. After he was handcuffed, she said that Jack was on his side and waiting for the caged truck. She accepted after seeing the taser footage however that he was not lying on his side at that time and was face down resting on his elbows. It is clear that Jack had been handcuffed by 13.26.42 on the VKG timings, as both handcuffs applied to his wrists can be seen on the taser footage at thattime.

Based on the available evidence, the time period between the handcuffs clearly being on (and it is possible that they were on a little earlier) and the officers starting to get up is 3 minutes and 10 seconds.

Various officers report Jack spitting after being handcuffed.

Sergeant Buchanan's evidence was that she didn't know he was ever handcuffed.

Constable Macsok confirmed in his notebook and evidence that Jack's arms were extended in front of his head and he was cuffed towards the front. In evidence, he said:

… whenever he was trying to push himself up, obviously I had concerns that he was going to get up and overpower us and possibly hurt others and the public there, so that was the sort of safest position. So, whenever there is resistance, I would obviously put a bit of weight there.

His evidence was he was side on, with his upper body weight resting on Jack's right shoulder and his legs/the lower half of his body on the ground.

Constable Macsok agreed he effectively remained in that position throughout, until he was notified that Jack seemed to have stoppedmoving.

At 13:28:45, Senior Constable Oscuro tasked other police officers to go and get the caged truck.

In evidence, Senior Constable Oscuro confirmed she observed officers lying on Jack. In respect of the number of officers lying on Jack, she said, "I wrote in three or four on my notebook but, but ... I can't say where, how … they were restraining him…" The evidence given regarding the officers restraining Jack, includes: *Constable Marshall recalled having one hand on Jack's shoulder and, after he holstered the taser, two hands. At one point, he was crouched down in front of Jack with both hands on his head to stop him spitting on other officers: "I was trying to stop him turning it to spit at the officers". His head was facing the ground. He agreed that, at that time, no one would have been able to see Jack's face, his nose, or mouth, in that position.*

Constable Marshall agreed that in the period 13:27:18 to 13:27:38 he remained in position with his arm extended down onto Jack's body. He agreed he would have been putting some weight through his arm on Jack's upper body but, "I can't recall how much. He agreed he was seeking to keep Jack pinned down to the ground, as "he was still struggling". He said he "would have had to" use some force with his arm against Jack's shoulder. At 13:30:49, Constable Marshall stood up. He said at 13:31:01 he spoke with Sergeant Buchanan who was "holding onto his lower legs, or his legs somewhere". He believed her position was "[o]n top of him". At around 13:31:42, he returned to holding Jack's shoulder, he used both hands and he believed he was using some force. He remained for some period with both hands-on Jack's upper body somewhere, applying some force. Constable Marshall described at this point "There were several officers there, there were some that were on, on top of him, yes". By this, he meant their bodies were at least partially across his. He agreed it was across his back. When asked whether it was one or more than one officer lying with their bodies across his back, he said "[i]t was more than one. I'm not sure how many".

Senior Constable Oscuro in evidence said there were maybe three of four officers restraining Jack in the period between handcuffing him and the administration of CPR.

She described the positions of the officers as Constable Marshall at his upper body, Constable Macsok at the upper body, Constable Harris on his body somewhere and the two female Leichhardt officers on his legs. It difficult to reach precise findings as to the exact location of each of the officers who were restraining Jack. However, the evidence does appear to establish that each of Constable Macsok, Harris and Marshall applied weight to the Jack's torso, and Constable Macsok and Marshall to his upper torso for periods of time during the operation, including in the period leading up to when Jack was identified as not breathing.

Arrival of Senior Constable Johnson and other police officers

At 13.28.10, Senior Constable Brendan Johnson arrived with Constables Burke and Oxley in vehicle IW17.

Senior Constable Johnson recalls that when he arrived on the scene Jack was being held down on his stomach. He observed three police officers on Jack's legs, three on his torso and one at his head. The officers were lying across Jack with the top part of their bodies pushing down on Jack with their bodyweight; it was like "a bit of a stacks on". He later confirmed that he could not see Jack's body "because there were cops all over him" and that he was "effectively covered by police", but that he could tell that Jack was exhausted. Another officer asked Senior Constable Johnson to hold Jack's head as he had been apparently spitting on other officers present. At 13.28.17, Senior Constable Johnson is seen in CCTV footage crouched near Jack's head, holding Jack's head.

Jack was resisting and trying to move his head and Senior Constable Johnson could hear him making spitting sounds. Approximately 15-30 seconds later, Senior Constable Johnson recalled that there was no resistance from Jack's head, and he asked if he was still breathing. His evidence was also that there was not a great deal of resistance when he was holding Jack's head. Upon Senior Constable Johnson querying whether Jack was breathing, the other officers released their grip and rolled Jack over.

Senior Constable Johnson accepted in evidence that he was asked to hold Jack's head and remained in that position from the time he got there until he noticed that there was no resistance from Jack's head. He then asked if Jack was still breathing. That period on the CCTV from Senior Constable Johnson arriving to officers standing up is 13:31:34 to 13:33:15. Therefore, approximately 1 minute and 41 seconds passed from the time that Senior Constable Johnson arrived until the other officers present began standing up. Senior Constable Johnson observed Jack's lips change colour and instructed an officer to check whether he was breathing. At this point, he stated an officer commenced CPR.

Senior Constable Johnson gave evidence that Jack was on his stomach from his arrival to when Jack was turned over after he asked if Jack was still breathing. Senior Constable Johnson gave evidence that at least when he was present, Jack's spitting was more likely an attempt to clear his mouth of saliva. He also said that it was his impression that Jack was not getting much air but that he did not turn his mind to why that was so. He also said that Jack was not really moving much for the entirety of the time that he was holding his head.

His evidence was that he did not try sitting Jack up as he was not the officer in charge, and he did not know what had gone on previously. His concern was to get Jack in the back of the truck and off the ground as quickly as possible. Moreover, his background was in highway patrol.

Arrival of other police officers

At 13.29.15, Senior Constable George Raffoul, Constable Lachlan Dally and Probationary Constable Kristian Bodell on LE36 also responded. Upon his arrival, Senior Constable Raffoul observed three officers lying on Jack in a prone style position, spread out across him. It appeared that they were each controlling a different area. Senior Constable Raffoul noted that the "positioning of the deceased meant that his head was raised off the ground slightly and no one was putting any pressure on his head or neck" that he could see.

At 13.30.09, Detective Sergeant Sutherland and Constable Pike arrived.

Police officers recall saying, or hearing someone say, "[w]atch his breathing," on at least one occasion before Jack was rolled over and his breathing checked. When Jack's breathing was checked, Senior Constable Oscuro "saw the froth in his mouth". Constable Bodell noted in evidence that about 15 seconds after he arrived Jack had stopped resisting and that his body wasn't moving when he had arrived (it was 30 seconds from when he arrived before officers stood up). Constable Dally said when he arrived (he arrived with Bodell) he could see Jack moving, but not violently, maybe a shuffle.

The officers notice that Jack has stopped breathing

At 13.29.33, NSW Ambulance was contacted for decontamination. That call was made by LE14, which was Sergeant Buchanan'svehicle

At 13:29:53, officers appear to begin standing up. Three seconds later, Jack looks to be partially rolled over and then, six seconds after that, fully rolled over. At 13:30:10, VKG records IW17: "can I get an ambulance to my location. Male is um, not conscious."

Sergeant Buchanan's evidence was that one of the officer's said "is he breathing", that that was "such a sobering comment" that she said they should check, and at that point someone checked a pulse and checked if he was breathing and Jack was not breathing. Constable Marshall recalled Sergeant Buchanan asking that they check if he was okay. The officers "climbed off, he was rolled over and I remember seeing his lips were blue". Constable Guthrie said that it was when Jack stopped moving and resisting as strongly that she walked up towards his head. Jack was rolled over and she saw officers checking his breathing.

In evidence, Constable Harris said the time between her noticing Jack resisting less and her realising he was unconscious was a "split second… it was a really quick turnover". At the point where Jack stopped resisting, Constable Harris confirmed that she was still lying across his hips and lower back, that Constable Macsok remained to her right and at least one other officer was to her left.

She stated, “because at that time, up until that point he was violently really resisting us”.

Administration of CPR and the arrival of ambulance

At 13:30:30, CCTV footage shows that Constable Guthrie began conducting chest compressions on Jack.

At 13:30:40, IWI7 advises the police radio, “I need an ambulance to my location immediately. The male is unconscious and not breathing at this stage”. At 13.30.57, the NSW Ambulance log records “NSWPF< AMBOS REQ MALE IS UNCONSCIOUS AND NOT BREATHING”. This is the first time that Jack’s consciousness and breathing is noted in the NSW Ambulance log.

At 13.31.11, the NSW Ambulance log records “NSWPF< POLICE HAVE COMMENCED CPR”.

Dr Sophie Unell, an off-duty medical officer, came upon the scene whilst Jack was receiving CPR. Dr Unell identified herself as a doctor to police and supervised the police officers during resuscitation and encouraged the pads of the defibrillator to come on.

Dr Unell noted that Jack appeared to be frothing at the mouth, and that as a result she advised the police officers to continue administering CPR without doing breaths.

At 13.37.49, an ambulance arrived, and Jack was transported to the RPA. He arrived at the RPA at 13.57. He was triaged as Category 1 and directed to the Resuscitation Bay.CPR was discontinued at 14.28, and Jack was pronounced deceased. Dr Cutler completed a “Report of death to the Coroner” form at 15.30 and the “Apparent Cause of Death” was recorded as “Critical incident – Taser discharge and OC spray. Apparent cardiac arrest on scene and transported to hospital”.

Autopsy and expert opinions regarding the cause of Jack’s death

On 12 and 20 February 2018, Dr Jennifer Pokorny completed an autopsy of Jack. Her report was completed on 11 May 2018. The autopsy r e p o r t concluded that the direct cause of Jack’s death was “unascertained”, but that there were several possibilities suggested by the findings, including:

- sudden death, given that Jack’s coronary arteries were severely narrowed (noting that there was no evidence of myocardial infarction).
- the possibility of neck compression or mechanical asphyxia contributing to the cause of death could not be excluded.
- it appeared unlikely that the use of the taser or OC spray contributed significantly to the cause of death.
- the use of antipsychotics such as Zuclopethixol may be associated with QT prolongation and may cause sudden death by triggering lethal arrhythmia; and
- schizophrenia may be associated with sudden death due to “excited delirium”, typically in the setting of police restraint.

Dr Mark Dooris, a Senior Staff Cardiologist at the Mater Hospital in Brisbane, Queensland, provided expert opinion on the cause of Jack's death. He opined that Jack died from a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors superimposed upon Jack's underlying but occult coronary heart disease. The relevant factors he identified were:

- sympathetic activation from exertion/agitation in relation to the physical struggle during the second incident.
- possible positional asphyxia, having regard to the video and still images and that the autopsy did not exclude this, noting that, in circumstances of an underlying cardiac disease and the increased myocardial demand of the struggle, a lower degree of hypoxia may have been sufficient to precipitate a malignant arrhythmia; and
- the application of the taser three times prior to the cardiac arrest, noting that electronic control devices such as tasers may lead to electric cardiac capture and may cause precipitate malignant arrhythmias, and that the time of onset of malignant arrhythmia to the time of diagnosis of cardiac arrest is not necessarily instantaneous or a matter of seconds.

Dr Dooris labelled the above factors as a "perfect storm". In his view, the most likely factors were the sympathetic activation and agitation, but the role of positional asphyxia and the administration of the taser were not excluded. He indicated, however, that it was inappropriate to attribute Jack's death solely to his underlying coronary heart disease.

In evidence, Dr Dooris confirmed that "it's very uncommon for coronary heart disease in a person [Jack's] age" to be sudden cardiac death, but that rather, it was a "complex interaction of factors", including the vulnerability Jack's mental health placed him in. Two factors Dr Dooris also considered in his report but ultimately excluded as factors of relevance as regards causation of Jack's death were:

- the presence of drugs that may precipitate malignant arrythmia; and
- excited delirium, noting that Jack had features consistent with this syndrome including active psychiatric illness, agitated behavioural, tachycardia and he was observed to be sweaty.

Dr Pokorny agreed in evidence that mental illness is one of the factors that makes it a higher likelihood that a person will be vulnerable to sudden cardiac arrest or sudden death, and agreed with Dr Dooris as to the multifactorial aspects of Jack's death, preferring however, the term "mechanical asphyxia" to "positional asphyxia". In respect of the role that the taser had in Jack's cause of death, Dr Pokorny stated that her opinion in her report may have differed from Dr Dooris because she did not have the taser timings, and "that regardless of whether the use of the taser precipitated a lethal arrythmia it would certainly have contributed to the sympathomimetic excitatory effects that were going on with the deceased and put … him at increased risk". Both Drs Pokorny and Dooris stated that the prior administration of Droperidol and possible impact it had on QT prolongation was "unlikely" or "far less likely" to be a contributing cause.

Dr Pokorny was asked about the bruising on Jack's neck. She stated that bruising is an indication of a blunt force applied to the region, but that she could not be certain as to what the force was caused by. She noted that the bruising to Jack's neck would have been "recent" and could have been minutes or up to a few hours before his death. Dr Dooris was also asked about the bruising to Jack's neck and, whilst he deferred to Dr Pokorny's expertise, he opined that he could not be sure if the bruising occurred prior to resuscitation or as a result of resuscitation. In that regard, he departed somewhat from the finding in his second report that "post- mortem bruising around the neck seems inconsistent with the subsequent CPR resuscitation attempt" on the basis that there was a lot more uncertainty than he had acknowledged in the second report, even though it would be unusual for the neck to be involved in CPR. In addition to the above evidence and given that Jack's failure to take his prescribed medication appeared to be a critical factor in Jack's mental health decline, a forensic toxicologist report was obtained from Dr Michael Robertson.

Dr Robertson confirmed that, when it is assumed that Jack's last dose of Zuclopenthixol was possibly four or more weeks prior to his death, it is likely that the concentration of Zuclopenthixol had fallen to the extent that it would have been less effective and possibly not effective at managing his condition.

Identity: The deceased is Jack Kokaua.

Date of death: Jack died on 18 February 2018 at 14:28pm.

Place of death: Jack was pronounced deceased at the RPA.

Cause of death: I accept Drs Dooris and Pokorny's evidence that Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease.

The manner of death: I accept Counsel Assisting's submissions in respect of the manner of Jack's death. Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease

Further, I find that if those factors had been ameliorated at some point prior to when the involved police officers identified that Jack had stopped moving and breathing, then it is probable that Jack's prognosis may have improved.

Reliability of the police officers' accounts

Before I make any findings as to the adequacy and appropriateness of the police officers' responses to the second incident, it is appropriate to deal first with the reliability of the evidence of the involved police officers.

In written closing submissions, Counsel Assisting submitted that an overarching difficulty with the nature of the evidence of the involved officers was that none of Sergeant Buchanan, Senior Constable Oscuro and Constables Marshall, Guthrie, Harris or Macsok gave any directed interview in relation to the second incident nor did they give a witness statement outlining their recollection of the same. This was because each of these officers invoked their common law right to avail themselves of the privilege against self-incrimination and to therefore participate (or not) in aspects of their respective directed interviews. Of the directly involved officers, only Senior Constable Johnson gave a directed interview in relation to the circumstances leading to Jack's death and he was present for only part of the incident. Senior Constable Oscuro and Constables Guthrie and Macsok made entries in their police notebooks but these were very much in summary form.

As a result, it was not until the first tranche of the hearing of this inquest in September 2019, some 19 months after Jack's passing, that six of the involved officers gave their first accounts of the second incident. Counsel Assisting submitted that the passage of time would have inevitably impacted on the police officers' memories. In these circumstances, I have accepted Counsel Assisting's submission that I give the greatest weight to the most contemporaneous accounts of the second incident, and to those that were corroborated by others.

Further to the issue of contemporaneity, the Court also heard evidence regarding the role of perceptual distortion in accurately recalling events experienced under stress.

In his evidence, Sergeant William Watt opined that those under stress may suffer from perceptual distortions. These distortions include tunnel vision, time dilation or compression, inattentional blindness and looming. By way of example, Senior Constable Johnson's evidence that Jack was not moving much whilst he was holding Jack's head differs significantly from the evidence of other officers that Jack was violently resisting throughout the incident.

Professor Geoffrey Alpert gave evidence, consistent with Sergeant Watt, that:

Our research has shown that people react differently and … a lot of these issues vary among officers and between them as well. Someone may see something that another didn't see. Or someone may perceive something another didn't see even though they're … looking at the same incident. To support that, we've done a lot of research where we've looked at the officer's statement, interviewed the officer and then looked at the body worn video and… it's incredible to see some of the differences that the body worn video might show that the officer's didn't see and didn't remember. Professor Alpert went on to describe an experiment he had conducted in Queensland, which was then replicated in the United States of America. According to Professor Alpert, the results of that experiment indicated that "it is better to interview officers immediately after the incident rather than wait two sleep cycles that some people suggest … So, my … opinion would be that, yes, it is better to interview them sooner than later". In light of this evidence, Counsel Assisting submitted that, whilst the involved officers' actions in declining to give a contemporaneous account by reason of a claim of privilege against self-incrimination was readily understandable, it was highly undesirable that there be no means of giving a certificate to offer protection in the circumstances.

Counsel Assisting therefore proposed that I recommend that:

- Consideration be given, through legislative amendment if appropriate, to abrogating the right of involved officers from claiming the privilege against self-incrimination for the purposes of a critical incident or coronial investigation or, alternatively, providing for the availability of a certificate to involved officers who seek to claim such privilege for the purposes of a critical incident or coronial investigation, such certificate not precluding the evidence being available for use in any coronial investigation.

- Ms. Bourke took issue with Counsel Assisting's submissions. Ms. Bourke further submitted that it was "unrecognised particularly in these court proceedings, that the jobs those police officers undertook was dangerous". I find these submissions unhelpful. They do not address the substance of the proposed recommendation nor do they accurately reflect the tenor of Counsel Assisting's submissions (see for example paragraph 13 above) or the views of this Court.

Mr Haverfield submitted that I should not make the proposed recommendation. He submitted that the delay in giving evidence was not the fault of the involved police officers and that it would be unfair to make the recommendation given the circumstances of this matter. He noted that s. 61 of the Act presently allows this Court to compel a witness to give evidence in circumstances where a witness objects to giving evidence as a result of a claim against self-incrimination. Mr Glissan QC for the NSW Police Association submitted that the proposed recommendation set out paragraph 296 above was "defective" for two reasons. First, "it places and creates a serious risk of injustice to the police officers involved". Secondly, "it is not needful because the power to obtain the evidence in a timely way already exists".

In support of the first proposition, Mr Glissan QC referred to principle enunciated by the High Court in *Lee v The Queen* (2014) 253 CLR 455; [2014] HCA 20 at [32]-[33]:

The companion rule to the fundamental principle is that an accused person cannot be required to testify. The prosecution cannot compel a person charged with a crime to assist the discharge of its onus of proof. Recognising this, statute provides that an accused person is not competent to give evidence as a witness for the prosecution, a protection which cannot be waived. [citations omitted]

He submitted that the proposed recommendation was directly offensive to the principle in *Lee*. Mr Glissan QC then directed the Court's attention to existing mechanisms available in the Act to compel police officers to give evidence, whilst noting that the Act also preserves the principles of self-incrimination. Messrs Haverfield and Glissan QC's submissions, in my view, go beyond the premise of Counsel Assisting's proposed recommendation. As Counsel Assisting noted in reply, I have not been asked to further abrogate the rights of police officers to avail themselves of the privilege against self-incrimination. Rather, I am being asked to make a recommendation that consideration be given through legislative amendment, if appropriate, to either the abrogation of the right of involved officers to claim privilege or to provide for the availability of a certificate.

There is significant public interest in there being effective and prompt information taken from involved police officers, particularly in circumstances where a person has died as a result of a police operation. It is concerning that it took 19 months for the involved police officers' accounts of the second incident to be taken – such a large gap has impacted on the memories of the involved police officers and, as a result, somewhat diminished the ability of this Court to examine in depth the events that took place in the lead up to Jack's death.

I am however not minded making the recommendation at this stage without further consideration of how other statutory mechanisms might be able assist, and what if any reform is proposed including the review of the Coroners Act (NSW) 2009.

Police officers' response to the second incident

I refer to my summary of the events that transpired during the second incident at paragraphs 194 to 268 above, which set out this Court's findings regarding police involvement in the second incident.

Information as to Jack's presentation and symptoms

First, Counsel Assisting submitted that there was no dispute that the involved police officers made no attempt to seek information as to Jack's mental health presentation as at the time he absconded, or the circumstances of his absconding from the RPA.

The NSW Police Force Handbook provides:

Upon receiving notification that a person has absconded from a Mental Health Facility, speak with the Hospital Manager and ascertain as much detail as possible. Create a missing persons event where appropriate. Manage the missing person as per existing SOP's and the level of risk communicated by the reportee …

In his expert report, Professor Alpert opined that, in light of the NSW Police Force Handbook, it would have been appropriate for the police to call the hospital and attempt to contact NUM Francis. Consistently, Sergeant Buchanan agreed in evidence that, in hindsight, it could have been useful if she had tried to get as much detail as possible about Jack's mental state before approaching Jack. She stated however that the attending police officers had already been exposed to Jack that morning and so they "had some awareness of the range of [Jack's] mental scope just hours before". In his report, Professor Alpert said, "While this was a technical policy violation, a call made by [Sergeant Buchanan] may or may not have reached the appropriate person". Professor Alpert ultimately made a similar qualification in his evidence, stating that he was "not sure what difference it would have made" if the NSW Police Handbook was complied with. Sergeant Watt gave evidence that the "more information that [police officers] have is always the better", and that the information that police officers have about an abscondee will impact their level of response.

For example, if someone who was a voluntary patient had left the hospital, the level of resources to be allocated to locating that person would be different to someone who had absconded from the hospital and was a high suicide risk or currently experiencing a psychotic episode. He nevertheless qualified his evidence similarly to Professor Alpert, stating:

Generally, I would prefer to rely on what information I am seeing directly in front of me to make a determination as to police tactics. And one could equally argue that based on his behaviour prior to sedation that may have an effect on how I'd approach and both of them should. But I would be more, more willing to rely on my own judgement as I approached the individual 40 than rely on information that with a completely different organisation in a completely different circumstance, he behaved in a completely different fashion.

Mr Dunne also agreed that "it's important to have that background knowledge of a subject, particularly a mental health patient if you're going to search for them." Again, he qualified his evidence, noting, like Sergeant Buchanan, that in this case the attending police officers had previous experience with Jack during the first incident, that calling the hospital may have delayed the police officers' response and would not necessarily have provided the police officers with any insight into Jack's movements in the period between absconding from the RPA and his appearance on Carillion Avenue.

Consistent with Mr Dunne's opinion that calling the hospital would have delayed the police response, Constable Marshall's evidence on 4 November 2020 was that getting information from the hospital may have taken some time. Sergeant Buchanan also gave evidence that in any event it was the role of the station constable at the relevant station to find out more information about abscondees. Her role was to "keep a lookout for, for this patient, so it's an entirely different process".

Given the expert opinion and the police officers' evidence, Counsel Assisting submitted that attempts should have been made to acquire more information about Jack's mental health presentation and symptoms at the time of his absconding through the police radio controller, rather than by direct attempts to contact the hospital. Mr Haverfield, with Mr Madden adopting his submissions, submitted that, in this case, the police officers had done all that they could to acquire information about Jack's mental state at the time of his absconding. Namely, the hospital had made a report to the station constable and information from that report had been forwarded to the attending police officers. In any event, Mr Haverfield said, the police officers were already aware of Jack's mental state given their interactions with him that morning. I accept that while attempts should have been made to acquire more information about Jack's mental health presentation, I consider that such information may well not have changed the outcome of the secondincident.

At the same time, if a call had been made to the hospital, it might have been the case that police officers were advised that Jack was largely compliant with hospital staff and that at the time of his absconding he was not violent. Knowing this information, attending police officers might have been in a better position to plan how they would approach Jack if they found him.

Counsel Assisting's proposed recommendation overcomes any limitations on time faced by attending police officers by proposing that the radio controller make the call to the hospital. I find that, in the present case, if the radio controller had made the recommended call to ascertain more information about Jack's mental health presentation, then Sergeant Buchanan and Constables Guthrie and Marshall could have continued their search for Jack without being hampered by making telephone calls to the hospital.

Calling for an ambulance

There is no dispute that the involved police officers made no attempt to call an ambulance either at the point that Sergeant Buchanan and Constables Guthrie and Marshall arrived at Carillion Avenue and after OC spray was deployed and Jack was tapered.

Arrival at Carillion Avenue:

Each of the involved officers gave evidence that they did not call an ambulance to attend the second incident when they first attended the scene because they either did not have time to make such a call or it did not cross their mind to do so (see paragraphs 195 and 199 above). Each of Sergeant Buchanan and Constables Guthrie and Marshall gave evidence that their respective plans upon arriving at Carillion Avenue were to locate and detain Jack, and then facilitate his transport to hospital (see paragraphs 195 to 196 and 198 to 199). Given this evidence, Counsel Assisting submitted that if an ambulance were to be required in any event to enable transportation of Jack back to hospital, there was good reason to seek to have an ambulance available as soon as possible.

- First, ambulance officers have specific training in dealing with mental health patients and, as Paramedic Mercer indicated, "it would normally be a constructive part of [an ambulance officer's] role to deal with some rapport with a patient in an incident like this, to at least start the process of de- escalation and at least initiating that clinical relationship which is the, the main focus of [their] role. This is recognised in the Memorandum of Understanding between NSW Health, Ambulance Service of NSW, and NSW Police Force, "Mental Health Emergency Response" (July 2007; **the Mental Health Emergency Response MOU**). The MOU provides that the role of the ambulance service can include clinical stabilisation and behavioural management.

- Secondly, each of the officers gave evidence that ambulances can take some time to arrive at an incident.

- Thirdly, during the first incident, the evidence disclosed that Jack's sedation by an ambulance officer had a good and prompt effect. That meant that sedation, rather than ongoing physical restraint, potentially after Jack was physically restrained by police to enable safe administration, was one possible way of securing a safe return of Jack to hospital through the use of less force.

Further, Counsel Assisting drew the Court's attention to the following policies, which they submitted were consistent with the calling an ambulance at the earliest opportunity:

- The Mental Health Emergency Response MOU, which provides that the use of police vehicles to transfer individuals with mental illness should only occur in extreme situations. In addition, where police suspect that an individual is mentally ill they are to contact mental health services, and the ambulance service is to stand by "for transport and medical assistance".

- The Memorandum of Understanding, "Incorporating provisions of the Mental Health Act 2007 (NSW) No 8 and the Mental Health (Forensic Patients) Act 1990 (NSW)" (March 2018; **the Mental Health Legislation MOU**) provides that when agencies attend a mental health related incident they should have a discussion regarding the resources that are currently available and those that could become available, and the harm that could arise in the absence of another agencyattending.

Mr Haverfield submitted that ambulance officers could not be called to attend until such time as the police officers had control of the situation. He further submitted that during the second incident no control was attained. In support of his submissions, Mr Haverfield referred to Constable Marshall's evidence that he did not have time to call an ambulance. Constable Marshall stated that calling an ambulance required a conversation that he did not have time to participate in and which would have necessarily required Constable Marshall to have information that could only be obtained after locating and detaining Jack. Mr Haverfield also referred to the expert evidence of Sergeant Watt. When asked whether Sergeant Buchanan should have called an ambulance once Jack was located on Carillion Avenue, Sergeant Watt answered:

No, I do not. And that's based on operational experience. How Jack was going to react at that stage wasn't known. The ambulance will require certain information in order to prioritise the dispatch of an ambulance. So, the typical information we need to provide is sex, age, age of the individual, whether they're conscious and breathing, and a brief overview of the circumstances so they can - they can appropriately task an ambulance to the location. So, if I have an unconscious not breathing patient then that's going to be a higher priority than something else. Based on a review of [Sergeant] Buchanan's transcript, she indicated that she was more concerned about getting to Jack and stopping him before she concerned an ambulance - contacted an ambulance.

Sergeant Watt then went on to opine that:

I don't know that the, the arrival of an ambulance would have resulted in less use of force. It may have shortened the amount of time but essentially before they can sedate or provide any medication to anyone that subject is going to need to be controlled and [to] some extent the level of control is going to need to be higher because now I have non-police officers involved, I'm responsible for their safety as well. And we have sharps … out. Having them available, would it have been an option? Yes, it is. Is it necessarily - the decision as to when to call the ambulance is always going to be at the discretion of the officer there? It, it unfortunately, it has to be.

Similarly, Sergeant Buchanan gave evidence that generally a police officer has to have control of the situation before calling for an ambulance. She also gave evidence on 3 November 2020 that there was not enough time to radio for an ambulance when she first arrived at Jack's location, and that she would not have been able to give the necessary information to the ambulance operators as she needed to assess the situation. Similarly, Constable Guthrie gave evidence on 4 November 2020 that there was no time to make such a call.

Having regard to the evidence and policies, and in particular that the police officers' experience with Jack earlier that day should have informed their assessment of Jack during the second incident, I am of the view it would have been at least beneficial for the police officers to contact, or request that contact be made with, the NSW Ambulance service at the earliest opportunity. Though Sergeant Buchanan and the other officers' evidence was that they considered that Jack needed to brought under control before an ambulance could be called, Counsel Assisting suggested that a recommendation be made that, in situations where it is known a mental health patient has absconded, an ambulance be called at the earliest available opportunity.

Chief Inspector Matthew Hanlon, the Manager of the NSW Police Force Mental Health Intervention Team (**MHIT**), said he saw no downside in a recommendation that officers be required to give early consideration to the calling of an ambulance.

As noted, calls were made over the police radio for assistance throughout the second incident. There is no good reason why such calls could not have included a request to secure the attendance of an ambulance to assist with returning Jack as a mental health abscondee. As NSW Ambulance officer Mercer made clear, this was a call that the NSW Ambulance service receives on a regular basis. Further, the involved police officers' experience earlier that day during the first incident should have informed their assessment of Jack.

<u>After deployment of OC spray and taser:</u> As noted above, at 13:22:47, Sergeant Buchanan deployed OC spray, and, at 13:23:04, Constable Marshall fired the taser for the first time.

According to the CCTV footage, from the arrival of the first officer on the scene until OC spray was used, one and a half minutes had passed, and from the time that OC spray was used to the first taser deployment a further 17 seconds had passed.

The taser was then deployed a further two times.

Despite the above, no police officer made a call for an ambulance until 13:28:58, when Sergeant Buchanan radioed for an ambulance for sedation and decontamination.

In her evidence on 3 November 2020, Sergeant Buchanan said that she was not in a position to call an ambulance prior to this point because she was "pinned down under a 140kg man. I feared for my life. I didn't have a chance. I was terrified when I realised that back up was far away. In that moment, it just couldn't happen. And even if it could, nothing would have changed".

Constable Marshall gave evidence that he did not arrange an ambulance after using the taser because he did not think he had time to ask someone to radio for an ambulance. Constable Guthrie stated that she did not contact an ambulance because:

It all happened quite fast and it - Jack certainly wasn't as calm as the beginning of the first incident. So, it certainly started off quite intense. So, my focus was on working as a team with [Sergeant Buchanan] and [Constable Marshall] to try and get, get the situation to a level where we could assess properly and have the chance to get an ambulance to arrive, yeah.

Part 10 of the NSW Police Force "Use of Conducted Electrical Weapons (Taser)" policy provides that "Ambulance personnel are to be called on ALL occasions when a subject has been Tasered. Failure to do so may be considered a breach of the SOPs". It was inconsistent with this policy for the police officers to have failed to call for an ambulance until 13:28:58. Further, consistent with Counsel Assisting's submissions, I am of the view that that from the point when Jack was on the ground and restrained by the three police officers a call for an ambulance could have been made.

In particular, at 13:24, when Sergeant Buchanan made a radio call for assistance as the taser "was not working", equally a request could have been made for an ambulance to attend the incident for decontamination. Had an ambulance attended before Jack stopped breathing, it is possible that the outcome for Jack would have been different, but it would be highly unlikely that an ambulance could have been available within that short time frame. I accept the submission of Counsel Assisting that this underscores the importance of early calls for the attendance of an ambulance, and of taking all available precautions to maintain the safety of a person of interest being restrained in a prone position.

Conclusion: It is accepted that on the available evidence, the involved police officers did not seek (whether themselves or by tasking others to call) the prompt attendance of an ambulance. This was in spite of Jack's mental health presentation, his having been sedated with good and prompt effect during the first incident and at least some of the involved police officers knowing that Jack had been the subject of OC spray, had been tasered, and an ambulance was the preferable mode of transportation back to hospital for a mental health patient. In light of the above evidence, Counsel Assisting proposes that I make a recommendation that consideration be given to modifying the police and ambulance operating procedures and MOU such that:

- police radio operators are tasked with calling an ambulance if it is identified to the radio operator that a taser has been discharged; and
- police radio operators are tasked with calling an ambulance if it is identified to the radio operator that police are attending an incident involving a person with a known mental health illness or involving a person who has absconded from compulsory mental health detention.
- police are required, if it is considered that any use of force may be required to effect arrest or to return to detention, to consider calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention; and

- police are required, if it is considered that an individual is at risk of harming himself or at risk of harming others at the relevant time, to consider calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention.

In response, NSW Ambulance submit that requiring NSWPF radio operators to call an ambulance in circumstances proposed by Counsel Assisting's above recommendation would result in an increased strain on NSW ambulance resources and/or the inappropriate use of NSW ambulance resources.

It is accepted that implementing a blanket requirement that NSW Ambulance paramedics attend all incidents involving persons with a mental health issue or those who have absconded from a mental health detention facility would likely place an undue strain on the resources of NSW Ambulance. It is further accepted that the primary role of NSW Ambulance paramedics is to respond to medical emergencies, albeit, that this may well on occasion include mental health emergencies.

The closing submissions on behalf of NSW Ambulance refer to the Police, Ambulance, Clinical, Early, Response ("PACER") program, which is designed to provide a specialist mental health early response to people experiencing a mental health crisis by placing mental health clinicians in police area commands. NSW Ambulance submit that it would be more appropriate to for mental health clinicians engaged under the PACER program to attend situations involving persons with a mental health issue or those who have absconded from a mental health detention facility. This submission is not without merit. However, it is noted that the PACER program is still in a pilot phase, having only been rolled out in 12 police area commands across NSW. The PACER program is addressed further at para 458 of these findings.

For the above reasons, I am not minded making the recommendation set out at paragraph 345a and 345b. In response to the recommendations proposed at paragraph 345c and 345d, NSW Ambulance submit that NSW Ambulance paramedics are not required to enter a scene until it is safe to do so, and as such, will not attend to a patient in circumstances where the use of force is required or the individual is at risk of harming themselves or others. In these circumstances, NSW Ambulance submit that it is the responsibility of NSWPF to subdue the individual prior to paramedics attending the scene.

With respect, the recommendation proposed by Counsel Assisting would simply require a police officer to give active consideration to calling an ambulance at the earliest available opportunity when seeking to arrest or return an individual with a known mental illness or who has absconded from compulsory mental health detention in circumstances where it is considered that the use of force may be required to or where the individual is at risk of harming themselves or harming others. The requirement, in my view, is not burdensome, but would ensure police officers actively turn their mind to the need to a paramedic in potentially violent situations involving an individual with a mental health issue.

For the above reason, I am minded to make the recommendation that consideration be given by NSWPF and NSW ambulance to modifying the police and ambulance operating procedures and MOU such that police are required, to give active consideration to calling an ambulance at the earliest available opportunity when seeking to arrest or return to detention an individual with a known mental health illness or who has absconded from compulsory mental health detention if it is considered that the use of force may be required or it is considered that the individual is at risk of harming himself or at risk of harming others at the relevant time.

The lack of any plan as to how Jack should be returned to the RPA

Each of the plans formulated by the police officers in respect of locating and detaining Jack, and then transporting him to the RPA, are summarised at paragraphs 195 to 196 and 198 to 199 above. Mr Haverfield submitted that Sergeant Buchanan's and Constable Guthrie and Marshall's plans were appropriately detailed in the circumstances. According to Mr Haverfield, force is fluid and is not a factor that can be planned for. Rather, reliance must be placed on the tactical operation model in circumstances where force is required.

Whilst the situation was necessarily fluid and plans may have needed to be adapted, Sergeant Buchanan and Constables Guthrie and Marshall should have had a detailed plan in place before approaching Jack. Such a plan should have accounted for the following:

- how Jack would be returned to the RPA in the event that he was not compliant.
- when they would call an ambulance, as that would be the preferable mode of returning Jack to hospital (noting Sergeant Buchanan's evidence referred to above at paragraph 195 above and the Mental Health Emergency Response MOU referred to at paragraphs 323 and 326 above);
- in addition to, or in the alternative to b., when they would call a police truck so that it could provide a means of containment of Jack pending the arrival of an ambulance; and
- if physical restraint was necessary, then whether an officer should, if possible, be responsible for monitoring Jack's breathing, and to evaluate if and when restraint should be ended.

Counsel Assisting submitted that no plan was made in respect of any of the factors listed immediately above. Whilst planning for these factors would have led to challenges in circumstances where only three police officers were present, once more officers attended the location, those officers could be allocated with any of the above planned roles so as to ensure that Jack's safety was protected and so to minimise the period for which Jack was subject to restraint.

A plan may also have obviated the problems occasioned by each officer during the struggle that eventuated focussing upon their own particular role rather than evaluating the situation as a whole, and forming an informed view as to whether or not it would be safe to seek to roll Jack over or otherwise to seek to move him to minimise the risk of positional asphyxia. It would have given some protection to Jack's safety and welfare, in a situation where in fact the focus of officers was on control of the situation rather than on Jack's welfare.

As noted above, Sergeant Buchanan and Constables Marshall and Guthrie should have developed some plan to cater for the real possibility that Jack may not return in a compliant fashion to RPA that afternoon. Such a plan could have been developed on arrival or by communication as the incident unfolded.

Informed evaluation and consideration of risk and safety, including monitoring of Jack's breathing

Sergeant Watt gave evidence that police officers should make a "continuous series of evaluations during any use of force, considering the possibility of the technique causing injury versus the need to obtain and then maintain control". Counsel Assisting submitted that I might find that the involved police officers did not continuously evaluate whether force was necessary during Jack's restraint and, in particular that they did not adequately turn their minds to:

- the risks to Jack of positional asphyxia; and
- Jack's breathing.

Rather, Counsel Assisting say that the focus was on gaining control of Jack and maintaining Jack in what was considered to be a safe position for the police officers and not Jack.

The risks to Jack of positional asphyxia:

According to the NSW Police Force Handcuffing Manual (2014), NSW Police policies require that police officers should be mindful of the risks associated with positional asphyxia when dealing with subjects and must ensure a subject is not restrained or conveyed in any manner that may induce positional asphyxia. Sergeant Watt confirmed the current police training treats positional asphyxia as a significant risk and that prone restraint with weight on a subject's back poses a risk of sudden death. He also stated however that the NSW Police's position on positional asphyxia is under review.

Whilst most involved police officers gave evidence that they knew about the risks of positional asphyxia, none of the officers appeared to specifically turn their minds to those risks during the second incident or sought to change their actions so as to reduce those risks, save for possibly Sergeant Buchanan who gave evidence on 3 November 2020 that she said, "Watch his chest, get him on his side". Sergeant Buchanan said that she was aware of the risks of positional asphyxia and accepted that Jack had most if not all the risk factors (see above). Sergeant Buchanan said that:

… so, we are trained in something called positional asphyxia or learning to be wary of that as a risk. Having said that it's not always completely avoidable, to completely avoid those areas when detaining someone … I remember saying out loud to "make sure that he's breathing" and to try and get him on his side because I was conscious of when there was - because, you know, when more police come you always think everyone just wants to come in and get involved and that's when the risk, I suppose, heightens in terms of stuff like positional asphyxia, and that's when I was just blindly kind of calling out, you know, make sure, "make sure that he's breathing, make sure he's on his side".

Constable Guthrie could not recall participating in any specific courses relating to positional asphyxia but agreed that Jack exhibited all of the risk factors. On 4 November 2020, Constable Guthrie clarified that although the risk factors were "certainly there" at the time, she was thinking of the situation at hand and not those risks. She agreed that "potentially, yes" she should have considered the risk factors of positional asphyxia. Constable Marshall gave evidence that he was trained in the risks of positional asphyxia and agreed that all of the risk factors were present in respect of Jack during the second incident. When he gave his first account of the second incident, Constable Marshall said that positional asphyxia was something in the back of his mind, but that he could not recall any actions taken to avoid positional asphyxia. On 4 November 2020, Constable Marshall gave evidence that it was only once the subject was under control that steps could be taken to reduce the risk of positional asphyxia.

He accepted, however, that with the benefit of hindsight he should have considered the risk factors associated with positional asphyxia. Senior Constable Johnson was trained in positional asphyxia and was aware of the risks associated with an individual being restrained in the prone position. He noted however that he did not turn his mind to the risks of positional asphyxia at all during the second incident. On 5 November 2020, he clarified this evidence, saying that he did consider that Jack was at risk in the prone position because he was more likely to suffer from breathing difficulties. Senior Constable Johnson gave evidence that this was why he asked for the caged vehicle to be brought closer so that Jake could be moved out of the prone position. In hindsight, he accepted that he should have communicated this awareness of the risks of positional asphyxia to the other officers who were present.

Constable Harris also stated that the risks of positional asphyxia were in the back of her mind and that, although she was always making an assessment, she had to balance this against being in a wrestle with a violent person in the middle of the street. When she was asked why she did not try to minimise the risk factors, she said, "In that situation – couldn't have happened". Constable Macsok stated that he did not turn his mind to the risk factors for positional asphyxia, and when asked, "Do you think you should have?" He replied "No, it was constant, it was dynamic".

It appears that the involved police officers undertook no evaluation of the methods of restraint used and the risks that those methods posed to Jack in respect of positional asphyxia. Whilst the situation was certainly dynamic and Jack appeared to the police officers to be resisting (discussed further below), there was a real need for Jack, as a restrained person, to be protected. Instead, the involved police officers focused on gaining control of Jack, rather than considering the risks of positional asphyxia and seeking to obviate that risk.

Jack's breathing: NSW Police policies provides warnings that breathing should be monitored when force is used to restrain an individual: Sergeant Buchanan says that she made at least three calls to the police officers present during the second incident to check Jack's breathing and to make sure Jack was on his side. She said she was relying upon feedback from others as to his breathing and accepted that no one was tasked with monitoring Jack's breathing. Sergeant Buchanan also indicated that she was not aware of where other officers were during the period of restraint.

In support of Sergeant Buchanan's evidence, Senior Constable Oscuro gave evidence on 20 September 2019 that she heard someone say to watch Jack's breathing, but she couldn't say if it was more than once. Senior Constable Oscuro's contemporaneous notebook entry recorded that someone said, "Be careful about sitting on Jack's chest". Constable Harris recalled hearing a female voice at one stage say, "check whether he's breathing," but that she only heard that on one occasion.

It appears therefore that on at least one occasion Sergeant Buchanan called for someone to check whether Jack was breathing. It is not clear how often this call was made, or when. It also appears that on one occasion a call went out to be careful about sitting on Jack's chest. Beyond this, there does not appear to have been any instruction to monitor Jack's breathing during the incident nor was anyone tasked with undertaking that role. Sergeant Buchanan said in evidence on 5 November 2020 that "in hindsight, [she] probably should have. But [she] was monitoring his breathing, and at the time that's why [she] didn't say anything".

Moreover, the evidence indicates that Senior Constable Johnson who was in a position to monitor Jack's breathing and who listened for Jack's breathing did not communicate to others that he observed that Jack did not seem to be getting much air and sounded like he had lots of saliva in his mouth and could not swallow. Senior Constable Oscuro, albeit not physically involved in the restraint beyond handcuffing Jack and releasing Constable Guthrie's leg but who was standing back and observing, also did not herself monitor Jack's breathing but instead assumed others were doing so.

Professor Alpert opined that although multiple officers were present during the second incident, it is not clear from the CCTV footage who was watching Jack's breathing and communicating it to the other officers. Each of Professor Alpert and Sergeant Watt, however, gave evidence that Jack's breathing need only have been monitored once Jack was "under control".

In his expert report, Professor Alpert stated that:

A contested policy violation is the speed at which officers recognised Jack's compromised breathing and turned him over to remove pressure from his abdomen (to prevent positional asphyxia). This manoeuvre is not required, however, until the subject is under control. [emphasis added]

He also indicated that:

The officers had the duty and responsibility to provide Jack appropriate care and turn him to his side as soon as he was under control and quit resisting. Being handcuffed in front does not equate to being controlled … [emphasis added]

When asked whether the officers should have sought to have freed Jack from their weight at the first opportunity, Sergeant Watt answered, "Yes, and that would be once they have gained control of Jack". Further when asked whether there should be a time limit on the use of prone restraint, Sergeant Watt opined:

I would prefer that rather than have a time limit the police focus on the need for the restraint to continue. Unfortunately, in the - in a hospital environment, they have methodologies that are not available to police in the field. They can use chemical restraint. We, we don't have that capability. It's a different - it is a different environment and there are different risks and different considerations. Would consistently monitoring, tasking somebody to continually monitor the individual while we are restraining him. If possible, yes, we should be doing that. But again, it's difficult to maintain. Yep, I want you to stand there and at the one-minute mark, I want you to check. At the two-minute mark, I want you to check. At the three-minute mark, I want you to check.

I would rather they examine the need for the restraint and whether or not it's successful.

Mr Dunne also agreed that mandating a time for the use of the prone restraint position was "not possible".

In his expert report, Mr Dunne concluded that the guideline to closely monitor and assess breathing was only followed after Sergeant Buchanan gave the instruction for this to occur, although it could be assumed that if Jack was resisting then he was breathing and had a pulse. The assumption/connection that Mr Dunne made between Jack's supposed resisting and his breathing was shared by some of the involved police officers. On 4 November 2020, Constable Harris gave evidence that she assumed Jack could breathe because he was moving, and that, by reason of his conduct when she was trying to handcuff him, he was violently resisting.

Constable Macsok was unwilling in oral evidence to even consider the possibility that Jack may have been moving by reason of pain or difficulty breathing, or that he was spitting because he was trying to clear his mouth of saliva. In my view, Mr Dunne's assumption referred to immediately above and in the evidence of Constables Harris and Macsok is merely that, an assumption. It likely reflects misunderstanding as to whether Jack was in fact moving because he was struggling to breathe as opposed to "resisting". I accept the evidence of Senior Constable Johnson. He indicated that, at least when he was present, Jack's spitting was more likely an attempt to clear his mouth of saliva than a sign of resistance. Senior Constable Johnson also gave evidence that there was not a great deal of resistance when he was holding Jack's head, and that he had the impression that Jack was not getting much air but that he did not turn his mind to why this was so. His evidence was that he did not try sitting Jack up as he was not the officer in charge and did not know what had occurred previously during the second incident. His concern was to get Jack into the back of the truck and off the ground as quickly as possible.

Conclusion: Finding: I accept Counsel Assisting's submission, given the above evidence, that none of the officers, other than Senior Constable Johnson, turned their minds to the fact that Jack's spitting was on account of anything other than aggression. In those circumstances, the Court is unable to place any real weight on their evaluation that his spitting was necessarily motivated by aggression throughout. It may be, as Counsel Assisting suggested, that the officers involved were experiencing perceptual distortions (see paragraphs 291 to 293 above) such that they were not in fact looking beyond the circumstances of their own actions, nor able to evaluate whether Jack continued to be out of control or at risk of escaping if they tried to turn him over or move his position so as to lessen risk.

In any event, Sergeant Buchanan, Senior Constable Oscuro, and Constables Guthrie, Marshall, Harris and Macsok did not engage in any evaluation of whether continuing force was necessary during Jack's restraint, given the risks of positional asphyxia and the impact of force on Jack's ability to breathe. Rather, Jack remained restrained in the prone position pending a police truck being moved to a position close to Jack, in circumstances where it may have been possible for Jack to be rolled over into a safer position. Sergeant Watt's proposed continuous assessment and evaluation did not take place.

Moreover, no police officer undertook responsibility to monitor Jack's breathing or focused upon Jack's safety or wellbeing during the period of prone restraint, until Senior Constable Johnson arrived at which time he focused on Jack's breath. Rather, the focus was upon gaining control of Jack and maintaining Jack in what was considered to be a safe position for the police officers involved. In respect of Senior Constable Oscuro, given her evidence on 5 November 2020 that she saw that the police officers had control of Jack after handcuffs were applied and she was not involved in the struggle, she was in a position to evaluate the risks to Jack and the benefits of trying to move him out of the prone position. Whilst Senior Constable Oscuro indicated that she considered Jack was in a safe position, she did not herself monitor his breathing nor was she aware of anyone else in fact undertaking that task. Further, she ultimately accepted by reference to the taser footage that at the point when Jack had had handcuffs applied, he was face down resting on his elbows and therefore in the prone position.

In the light of his evidence, Senior Constable Johnson was ideally placed to perform the necessary evaluations referred to above. No-one tasked him however to do anything more than hold Jack's head and when he arrived there were six police officers, including two senior constables, involved in the incident.

Supervision

Professor Alpert, in his evidence, stated that "command and control is so important". He elaborated, "That someone is keeping an eye on what's going on if possible and, and that's why I mentioned the, the requirement to intervene if another officer sees something then, then he or she must do something". Sergeant Watt gave evidence however that it was difficult to mandate "command and control" in "specific actions at specific times".

Sergeant Buchanan, who as noted above was in an Acting Sergeant role on 18 February 2018, was the most senior officer in attendance during the second incident. There is limited evidence from the involved police officers however that Sergeant Buchanan acted in the role of supervising officer, including giving instructions to other officers as to their roles or steps they should take, during the second incident. Constable Marshall gave evidence that he understood that Sergeant Buchanan was in charge on the afternoon of the second incident but that she gave no "specific instructions" to him. Similarly, Constable Guthrie said that Sergeant Buchanan was the "sergeant, external sergeant at that stage so I believe she would be the most senior officer in charge of this".

She indicated however that Sergeant Buchanan did not communicate any plan to Constables Guthrie and Marshall. She stated: *Yeah, so, but there was no specific instructions between me, [Sergeant Buchanan] and [Constable Marshall], okay, like as to the plan. There was no, I guess, plan. We were just, our sole focus was just to locate Jack and make sure he was okay and, as requested, return him back to the emergency department, the mental health ward.*

Constable Bodell indicated that when he arrived at the second incident, he was aware that Sergeant Buchanan was the supervisor on the day. He stated however "But being a dynamic incident, sometimes it might be necessary for a lower and ranking officer to make an observation or take a certain action, but I recognised that she had the highest rank at that time". He then elaboratedthat "if [Sergeant Buchanan] was to make – to direct me to something, then I would be required to do it, but it was a very dynamic situation". When asked however whether he had turned his mind to who was in charge when he turned up at the second incident, he answered, "probably didn't if I'm actually turning my mind back to that situation and being only eight weeks policing experience. It probably wasn't something I turned my mind to. My mind was on the situation at hand".

Senior Constable Johnson and Constables Harris and Macsok gave evidence that they could not recall who was in charge when they arrived at the second incident. Senior Constable Johnson and Constable Macsok indicated that they could not recall receiving any instructions from Sergeant Buchanan during the second incident, and Constable Harris recalled being given instructions on four occasions but was unable to identify who it was that she received instruction from.

As noted at paragraph 206 above, Sergeant Buchanan also gave evidence that during the second incident she was affected by the OC spray as she had to run through it. She said she had difficulty seeing, "and breathing, talking and everything else". On 3 November 2020, when asked whether she would accept that she was in no position to exercise the role of supervisor given she was exhausted, in pain and experiencing difficulties with her vision, s h e answered that she did not accept that. She also indicated that she was unsure as to whether she could have tasked someone to take over.

She stated:

But I think that the danger in assigning any one person to do any task is that if they – if that one person is the only one doing the task and they miss it then, you know, it's kind of ineffective tasking. Whereas if everyone is putting in that collective input to collectively work out when the situation's safe or, you know, if there is an issue with anything …

In my view, whilst placed in a very difficult situation in which she was at times pinned under Jack's body, Sergeant Buchanan failed to exercise her supervisory role and did not take up opportunities to delegate the role to others in circumstances where there were six police officers present during the second incident. Senior Constable Oscuro, for example, could have been delegated a supervisory role, particularly in circumstances where for much of the time that she attended the second incident she can be seen on the CCTV footage standing back and observing the melee. Sergeant Buchanan was in a position where she was unable to properly monitor the actions of the involved police officers – she was unaware that the taser had been deployed or that Jack had been handcuffed.

If Sergeant Buchanan had delegated supervisory capacity to Senior Constable Oscuro or had Senior Constable Oscuro stepped up and taken on that role, this may have allowed the supervisory officer to monitor the safety of the police officers and Jack. This view is consistent with Mr Dunne's expert evidence. In his expert report, he identified that, given the number of officers that later arrived at the scene, it would have been preferable if Sergeant Buchanan had directed one of them to replace her as this would have enabled her to deal with the overall management of the incident. Ms Bourke submitted that there was no requirement for a supervisor to assume a supervisory role in the course of the circumstances that occurred in respect of Jack.

During the inquest, Sergeant Watt gave evidence that those under stress may suffer from perceptual distortions. His evidence was that such perceptual distortions can include tunnel vision, time dilation or compression, inattentional blindness and looming. It is plain from the differing accounts of the six primarily involved officers as to Jack's condition and movements on 18 February 2018, and as to timing during the incident, that their own perceptions were likely impacted by these factors.

I accept the submission of Counsel Assisting that this underscores the importance of planning, supervision, and allocating an officer to monitor, evaluate, de-escalate through communication and give instructions, if that is reasonably practicable. The consequence of this not occurring is that matters set out in policies, and about which officers are dutifully trained, offer little or no protection in times of stress and apparent chaos, as, on the basis of the available evidence, and was the case in the incident involving Jack on 18 February 2018.

Communication

> The NSW Police Force "Weapons & Tactics, Policy & Review, Close Quarter Control" policy provides a clear mandate for communication between police officers involved in a physical confrontation, in particular to "

Further, in the chapter "Mentally Ill People" in the NSW Police Handbook, it is noted that: *Further, expert evidence at the inquest emphasised that, where possible, communication between police officers and persons of interest is important and should be undertaken. The experts also supported the importance of communication as between officers, for example as to whether the person of interest was having breathing difficulties or had been handcuffed.*

Counsel Assisting submitted that there were deficiencies both in respect of both communication between the involved police officers and communication between the involved police officers and Jack.

Communication between the involved police officers: The evidence establishes that the involved police officers were not aware of key matters during the second incident, including:

- whether Jack was handcuffed.

- the positions of police officers relative to Jack whilst the police officers were struggling to get Jack "under control".
- who had control over what part of Jack's body?
- the level and nature of Jack's resistance.
- Jack's mental health issues and mental health presentation.
- whether any attending officers had completed the four-day mental health training course (see paragraphs 433 to 452 below);
- Senior Constable Johnson's evidence as to Jack's shallow breathing, the minimal amount of effort it took to hold Jack's head and that Jack was not moving much at the time; and
- whether it might be safe to roll Jack over or move him to his side.

The police officers' lack of awareness as to these key matters, in my view, is to be attributed to their lack of communication. This lack of communication was inconsistent with NSW Police policy. Moreover, their failure to communicate with each other impacted on their ability to properly assess the incident as it unfolded, likely impacted on their sense of safety and wellbeing and, in turn, prevented them from properly evaluating and assessing Jack's safety and wellbeing.

I note Professor Alpert's view in this regard that "[a]s communication among the officers was lacking and violated policy, it is a question as to whether this lack of communication created a gap in time between Jack being controlled and turning him onto his side to avoid positional asphyxia".

Mr Haverfield submitted that, from the moment containment of Jack did not work the involved police officers were hands on. He referred to the evidence of Sergeant Watt that, "part of the purpose of training is so that everyone knows what everyone else's job is and they move through and do that," and submitted that consistency in training of police officers means that they can work together as a unit even if the police officers are not actively communicating with one another:

I do not accept Mr Haverfield's submission. The involved police officers' failure to communicate was inconsistent with NSW Police policy and was contrary to their training.

Communication between the police officers and Jack: There is no evidence to suggest that, even after their arrival, Jack was speaking to the involved police officers.

Constable Macsok recalled that Jack "didn't speak, so he didn't say words. It was more making noises and, and grunting". He described the noises as, "He was sort of yelling and making, I can't really explain. So, he was grunting, just yelling out noises".

Constable Harris on 4 November 2020 said that, whilst she has no recollection of doing so, she would have said to Jack words to the effect of, "stop pulling your arm away" and "please stop resisting". She also indicated that she "wasn't getting any response in regard to my communications with him" but went on to say that she had no actual recollection of this. She also answered in response to the question, "Did you ask if he was ok?", "No – it [was] hard when he [was] spitting".

In her evidence on 5 November 2020, Senior Constable Oscuro stated that she directed Jack to "stop resisting". She said that this direction would have been "reassuring to [Jack] to listen to police to follow instructions". She said that there was no attempt to communicate with Jack regarding his welfare because there was no opportunity for the police officers present to make those enquiries.

The evidence establishes however that no attempt was made to meaningfully communicate with Jack in order to build a rapport, save for Constable Macsok's limited attempt during the struggle where he "asked what's his name. I said Jack just relax we are trying to help you stop resisting. He was non-verbal – he didn't respond". Rather, police officers appear to have only given Jack directions. Further, no attempt was made to reassure Jack, or to determine whether he was in pain, having difficulty breathing or moving for any reason other than violent resistance to a police arrest. Regarding this, Senior Constable Johnson said that despite the fact that he had been trained in relation to communicating with people with mental health conditions, including building a rapport and offering communication, he did not inform Jack what was happening and that in hindsight he should have. Chief Inspector Hanlon gave evidence that once the use of force commences, although communication and de-escalation remain an option, it is unlikely to be successful as any rapport that the person of interest has developed with police officers is tarnished.

Further, police officers will become increasingly adrenalized and will focus on the techniques related to and the physicality and effectiveness of the use of force. In this case, as both the police and Jack had converged in a fight, this meant that the focus was no longer on de-escalation. He stated however that communication should be used continuously where possible, and that, absent violence (even after there is violent resistance), there would be an opportunity to de-escalate. Messrs Haverfield and Madden's submitted that because of both who Jack was, this presumably being a reference to his mental health presentation, and his failure to appropriately respond to the limited efforts made to communicate with him, the police officers did all that they could to communicate with Jack and to try to de-escalate the situation.

I do not accept the above submissions. Sergeant Buchanan, Senior Constable Oscuro and Constables Guthrie, Marshall, Harris and Macsok's failure to communicate with Jack for the purposes of reassurance and de- escalation was inconsistent with NSW Police policy and Chief Inspector Hanlon's evidence as to best practice. Given Jack's mental health presentation, which was known to at least Sergeant Buchanan, and Constables Guthrie and Marshall, such communication should have been attempted notwithstanding the struggle in which they wereengaged.

In light of the above evidence, I am minded making the recommendation proposed by Counsel Assisting, namely, that consideration be given to requiring:

- one officer to be officially and verbally designated supervisor in any interaction involving 3 or more police officers and the use of force, with that officer required to undertake overall responsibility for significant events during the course of the interaction, to ensure compliance with the matters set out below and to ensure that an ambulance is called at the earliest available opportunity if the POI has a mental health history and force is at risk of being, or is being, used;

- that officers communicate and verbalise significant events in the arrest and detention of a POI such as any mechanical restraints applied or the availability of any vehicles for use.
- that officers communicate and verbalise reports as to the status of the POI and the extent of their resistance, including to ensure the designated supervisor is aware.
- that an officer to maintain a time log as to when a POI is placed in the prone position to ensure awareness of the period for which the POI is so placed, requiring an attempt that the POI be moved at a certain defined time interval.
- that an officer be tasked to monitor the breathing of any POI placed in the prone position, and to verbalise the status of the POI's breathing, including to ensure the designated supervisor is aware; and
- that all officers are trained as to these matters.

As already noted above, in reviewing the actions of the involved police officers, I am to consider the particular circumstances of Jack's death but also the importance of safeguarding the welfare of persons involved in similar encounters. In doing this, I make no apology for making full use of the benefit of hindsight to work out what could have been done differently, if anything, to prevent Jack's death, and to ascertain whether any lessons can be learned from the circumstances examined in this particular inquest.

It is through learning lessons from the past that we can hope to meet one of the fundamental purposes of this jurisdiction, namely, the prevention of tragic deaths occurring in similar circumstances.

It was initially proposed by Counsel Assisting that I make a recommendation that NSWPF consider implementing a "lessons learned" unit to review critical incidents and to identify what, if any changes could be made to avoid such incidents occurring in the future. However, counsel for NSWPF has informed the Court that NSWPF already has such a unit – the Research and Policing Practice Unit – which is responsible for the development of research that informs the principles and practice of policing in NSW. On the basis that this reach includes reviewing critical incidents to identify what, if any, changes can be made to avoid similar incidents occurring, I am not minded making the recommendation proposed by Counsel Assisting.

Methods of restraint that the involved police officers used

The issue of restraint and the involved police officers' evaluation of the methods of restraint used on Jack are referred to at paragraphs 203 to 262 above.

It is clear from the evidence referred to above that up until Senior Constable Johnson arrived at the second incident:

- at least five police officers placed significant weight on Jack over the course of the second incident, for varying durations, in varying positions, and all whist Jack was held in the prone position.

- those police officers did not communicate with each other about the positions that they were in relative to Jack's body and what they were experiencing (e.g. whether Jack was resisting and the manner of his resistance) or whether Jack was breathing; and
- there was no police officer who took on a supervisory role, and nor was there any police officer who was monitoring Jack's breathing.

In light of the above, Counsel Assisting submitted that the police officers should have at least tried to sit Jack up once he was handcuffed.

Counsel Assisting's submission is consistent with the expert evidence. In his report, Mr Dunne opined, "In the period after the other police arrived and as the activity between them and Jack reduced, there may have been an opportunity to consider reducing the weight applied to him". Sergeant Sutherland gave similar evidence in relation to the first incident, where he regarded it as likely that once he had got handcuffs on Jack that enabled him to exercise necessary control. I accept Counsel Assisting's submissions that the involved police officers should have made an assessment as to the method of control used and given consideration to other methods of restraint and whether Jack's breathing was monitored, particularly when six officers were involved. This was not done here.

There is currently no training in relation to a police officer being assigned to monitoring a persons' breathing when that person is in the prone position. The Court heard evidence however that it would not be a significant issue to add something like that to training. Indeed, evidence heard from Dr Cutler in relation to practice in a hospital setting is that she has never restrained anyone prone, and that she would almost err on not restraining a person if she had to place them in the prone position.

To accept the tactical experts' evidence that the subject has to be under "control" before any assessment as to the safety of the chosen method of control/restraint is unsatisfactory. I also accept Counsel Assisting's submission that, in particular once handcuffs were on Jack, there should have been clear supervision, command and control, and communication and careful monitoring of breathing. Moreover, an ambulance should have been engaged, at least as early as when Constable Marshall's taser was deployed for the first time. As Professor Alpert stated, in relation to the United States, the police force there has moved to a requirement for officers to intervene if they see something that should not be happening, based on the concept of active bystandership, whereby everyone is tasked with the duty to intervene.

NSW Police mental health training

NSW Police mental health training is currently developed and implemented by the MHIT. According to Chief Inspector Hanlon, the Manager of MHIT, the aims of MHIT are to:

- reduce the risk of injury to police and mental health consumers when dealing with mental health related incidents.
- improve awareness amongst frontline police of the risks involved in interaction between police and mental health consumers.

- improve collaboration with other agencies and non-government agencies in the response to, and management of, mental health crisis incidents; and reduce the time taken by police in handover of mental health consumers into the health care system.

MHIT has developed and implemented an intensive four-day training course for frontline police officers. The course involves 21 lectures on different facets of mental health and suicide awareness with a focus on communication and de-escalation techniques. Amongst other things, the course covers role plays where participants are assessed on their ability to communicate to resolve set scenarios, including a suicide intervention, a domestic situation where an involved person is experiencing mental illness and a mental health consumer who is in crisis in a busy community setting.

Between 4 February 2014 and December 2015, MHIT implemented a One Day Mental Health Workshop Program. This involved providing a one-day mental health awareness training package to all sworn police officers who had not completed the four-day program. It was effectively an abridged version of the four-day training course referred to immediately above. Following the initial rollout, the One Day Mental Health Awareness Program was integrated into the core curriculum for recruits at the NSW Police Academy in Goulburn.

The following involved officers completed mental health training on the following dates:

- Senior Constable Oscuro: four-day training commencing on 11 July 2011.
- Constable Harris: one day on 25 June 2014.
- Constable Guthrie: one day on 9 November 2014.
- Detective Sergeant Sutherland: one day on 11 September 2015.
- Senior Constable Johnson: one day on 2 April 2015.
- Constable Marshall: one day on 2 April 2016.
- Constable Macsok: one day on 23 July 2016.
- Sergeant Buchanan: four-day training commencing on 9 March 2018 (after the events the subject of this inquest).

The involved police officers had the following recollection of their mental health training. Constable Marshall could not recall having completed any courses that covered mental health specifically and surmised that it had been covered in the academy. Constable Guthrie remembered attending a one-day lecture, during which she was told that when encountering a situation where a person of interest appears to be both drug affected and potentially suffering from some sort of mental health problem, keep the situation as calm and neutral as possible until medical help in the form of an ambulance has arrived. She said there was no requirement to have someone with four-day training attend thescene. Detective Sergeant Sutherland confirmed in evidence that whether someone is: having a mental health episode or in a drug-induced psychosis, the methods [to] restrain an offender, a person, a member of the public or whoever they may be, don't particularly differ. If, if a person is violent and they need to be restrained, they'll be restrained.

Detective Sergeant Sutherland stated that the one-day mental health training was: "*more focussed on the problems that, or the issues that arise when dealing with people who are having mental ill, mental illness episodes, and perhaps they're more so their perspective and how, how these sort of things affect them rather than how the police deal with them holistically".* Senior Constable Johnson stated that he had never had any training regarding detention or restraint to people with mental health issues, nor any training in respect of communication with individuals with mental health issues.

Gaps in mental health training: Chief Inspector Hanlon's evidence on 5 November 2020 was that that the mental health training described above does not deal with situations in which force has been applied. Counsel Assisting submitted that this is a significant and undesirable gap in the NSW Police training and policies. In light of the above, Counsel Assisting proposed that the importance of communication and attempting de-escalation if possible, even after force has been used in an incident involving a person of interest with known or suspected mental health issues be included in relevant NSW Police training and policies.

As noted by Ms Bourke in submissions, Chief Inspector Hanlon stated that he could see the benefit of such a recommendation being considered by this Court. I accept Counsel Assisting's submission that in the present case where there were police officers such as Senior Constable Oscuro and Senior Constable Johnson who were present during the second incident but who were not physically involved in the restraint or likely adrenalized, it would be highly desirable for them to attempt communicate with Jack. I note the expert evidence summarised at paragraphs 407, 410 and 419 above regarding the importance of communication.

Benefits of mental health training: At the time of the second incident, Senior Constable Oscuro was the only involved police officer who had attended the four-day mental health training course. She did not however announce her training status on arrival, and, in evidence, she said that she did not know Jack's mental health history, that he had any mental health presentation or that he had absconded from the RPA. Further, at no time during the mental health incident did she become aware that Jack was believed to have mental health issues.

Senior Constable Oscuro's evidence was not unique. Constables Harris and Macsok similarly gave evidence that they were not aware of Jack's mental health presentation.

Although Sergeant Buchanan agreed that she didn't take any steps to ensure an officer with four-day mental health training could attend to Jack, she said that she was certain, having now done the course, that there was nothing that could have been done differently. Her evidence was that the four-day mental health training course was "more beneficial for junior constables to give them some perspective. For me, who's worked thousands of mental health jobs, there was nothing on the course that having known that then would have changed anything". When asked however, "do you accept that you should have got someone to attend who had done the four-day MH training?" Sergeant Buchanan answered, "Sure, why not".

Counsel Assisting submitted that NSW Police offers mental health training for a reason, and accordingly proposed that a recommendation be made that consideration be given to implementing a system whereby certain MHIT accredited officers who attend cases which meet criteria indicating a possible mental health crisis identify themselves on arrival as having undertaken the relevant training. I also do not accept Sergeant Buchanan's evidence that it would have made no difference for a police officer who had completed the four-day mental health training to attend nor that it would have made no difference if Senior Constable Oscuro had been told and intervened with the benefit of that training. Rather, that is a matter which is simply unknown. In light of the above evidence, I am minded to make the recommendations proposed by Counsel Assisting in relation to mental health training for police officers. Accordingly, I recommend that consideration be given to:

- making mandatory the four-day accredited MHIT training package for all police officers; or.
- in the alternative, developing and implementing a system requiring the dispatch where possible and early identification of four-day MHIT accredited officers as first responders in cases which meet criteria indicating possible mental health crisis; and
- initiating training and policy provision for the use of communication and de-escalation even after there has been a use of force in a situation involving a person of interest with known or suspected mental health problems to be delivered either in conjunction with or in addition to the STOPAR training for all police officers.

Further, I recommend that consideration be given to:

- developing and implementing a system to ensure any four-day MHIT accredited officers attending in cases which meet criteria indicating a possible mental health crisis identify themselves on arrival as having undertaken the four-day training.
- NSW Police Weapons and Tactics Policy and Review to develop and implement training through the use of roleplay where, in cases where there are multiple officers, one is tasked with the role of supervisor.
- MHIT and WTPR establishing and documenting a joint review of STOPAR and de-escalation training including after a use of force, and for that training to be integrated in defensive tactics training where mental health is likely to be a relevant factor.

The "Guardian versus Warrior" training module

Chief Inspector Hanlon gave evidence that NSWPF currently provide a training module referred to as "Guardian versus Warrior". Chief Inspector Hanlon explained that the training module is conducted under the Vulnerable Communities Portfolio and is specifically aimed officers dealing with vulnerable individuals, specifically those with autism. The Court understands that the training module is not currently provided to all general duties policemen as part of their basic training. Chief Inspector Hanlon explained that the training is aimed at assisting officers to transition from a warrior mentality, where the use of force or a restraint might be necessary, to a guardian approach, where the vulnerability of the person is prioritised.

It was put to Chief Inspector Hanlon that the Guardian versus Warrior module would appear to be highly relevant and beneficial as regards the de-escalation of violent interactions between police and those with a mental illness. Chief Inspector Hanlon accepted in evidence that, in principle it would be valuable, and that consideration could be given to introducing the Guardian versus Warrior module into NSWPF's mental health training program. In light of the above, I am minded making the recommendation proposed by Counsel Assisting, namely that consideration be given by NSWPF to MHIT further developing and implementing for all NSWPF officers the "Guardian v Warrior" training currently in the Vulnerable Communities Portfolio.

The PACER Program

The Court heard evidence regarding the NSWPF's PACER program, which is designed to provide a specialist mental health early response to people experiencing a mental health crisis by placing mental health clinicians in police area commands. Chief Inspector Hanlon gave evidence that the program is still in a pilot phase and that at the time of giving evidence, 36 clinicians had been recruited to work in 12 chosen high-risk area commands across New South Wales. Chief Inspector Hanlon gave evidence that under the PACER program, a mental health clinician could attend a situation where an individual was experiencing a mental health episode. Chief Inspector Hanlon explained that that, once police had rendered the situation safe, the mental health clinical would be encouraged to engage with the individual to conduct an assessment of that individual's mental health condition to determine how best to assist the individual.

Chief Inspector Hanlon accepted in evidence that, once police had rendered a situation safe, whether that be through verbal communication or physical restraint, mental health clinicians may also have a role in de- escalating the situation. In light of the above evidence, I am minded making the recommendation proposed by Counsel Assisting, namely, that consideration be given by the NSW Health and NSWPF to expanding the funding for and roll-out of the PACER program.

***The adequacy of mental health and other support provided to Jack whilst on* parole**

I accept Counsel Assisting's submission that, from an examination of the medical and parole records, it appears that for the period of time between Jack's release to parole and his death Jack:

- had no stable housing and there was some uncertainty as to his accommodation in the future.
- for considerable periods, including the days leading up to his death, the Community Corrections Officer, amongst others, did not seem to know where Jack was staying.
- had observed psychiatric symptoms of varying degrees, and yet appears to have missed his two scheduled doses of fortnightly depot medication such that he had not had depot medication since 16 January 2018.
- had a positive drug test.
- had no known contact with any community mental health service after his discharge from Cumberland Hospital, and

- had failed to report to the Community Corrections Officer on 13 February 2018.

Before I deal with the adequacy of the steps taken CSNSW and the Community Corrections Officer as regards Jack while he was on parole, it is necessary to first deal with counsel for CSNSW's submissions that neither CSNW nor the Community Corrections Officer were afforded procedural fairness in these proceedings.

Procedural fairness as regards CSNSW

In written closing submissions, counsel for CSNSW submitted that CSNSW was not afforded procedural fairness in these proceedings as "CSNSW was not informed of the content of either the proposed adverse findings or the draft recommendations prior to the close of evidence before the Court concerning." In a letter dated 28 August 2020, CSNSW were notified of a sufficient interest in these proceedings. The letter specified that:

"While the Coroner has not formed any concluded views in relation to the various issues raised in the subject matter of this inquest, it is likely that Corrective Services' conduct will be a subject of the inquiry and, possibly, of adverse comment."

On 28 August 2020, an application was made by CSNSW seeking that the evidence of Mr Phouisangiem be held over until the third tranche of the hearing in order to allow CSNSW time to review and adequately consider the brief of evidence. This application was granted.

On 5 November 2020, CSNSW was provided with a copy of Counsel Assisting's closing submissions, which included proposed adverse findings and draft recommendations. The purpose of circulating those adverse findings and draft recommendation was to assist parties in preparing closing submissions. The following day, 6 November 2020, the Court heard oral closing submissions on behalf of the remaining interested parties.

On 6 November 2020, following an application by CSNSW, the Court granted CSNSW the opportunity to provide written closing submissions in response to the adverse findings and draft recommendations proposed by Counsel Assisting.

On 20 November 2020, CSNSW provided written closing submissions.

In this jurisdiction, there is no requirement that Counsel Assisting must notify parties of proposed adverse findings or draft recommendations prior to the closing of evidence. What is important is that parties have the opportunity to respond to any adverse findings or recommendations proposed by Counsel Assisting as part of closing submissions. I am satisfied that CSNSW has been afforded such an opportunity in these proceedings and for that reason I do not accept counsel for CSNSW's submission that CSNSW was not afforded procedural fairness in these proceedings.

Procedural fairness as regards the Community Corrections Officer

In written closing submissions, counsel for CSNSW and counsel for the Community Corrections Officer each submitted that the Community Corrections Officer was not afforded procedural fairness in these proceedings. The basis for the submission appears to be twofold, namely:

- that the Community Corrections Officer was not notified prior to giving evidence that he may be the subject of adverse comment; and
- that the Community Corrections Officer was not represented during the course of his evidence, and as such, did not have the opportunity to cross-examine or otherwise test the evidence of witnesses in the proceedings.

As noted at paragraph 82 of these findings, in a letter dated 28 August 2020, CSNSW was notified of a sufficient interest in these proceedings.

The letter also referred to the fact that the Community Corrections Officer was Jack's parole officer at the time of his death, and as such had been subpoenaed to give evidence in these proceedings.

On 2 November 2020, the Community Corrections Officer gave evidence. the Community Corrections Officer was asked questions as part of examination in chief by Counsel Assisting, and was subsequently cross-examined by counsel for the family, and counsel for CSNSW.

On 4 November 2020, prior to the conclusion of evidence in the proceedings, the Community Corrections Officer was notified of a sufficient interest in the proceedings, including that his conduct may be the subject of adverse comment.

On 5 November 2020, the Community Corrections Officer obtained separate legal representation.

On 6 November 2020, counsel for the Community Corrections Officer was in attendance to hear the submission of the various parties.

On 27 November 2020, counsel for the Community Corrections Officer provided written closing submissions.

I want to make it clear at this point that any adverse comment directed to the Community Corrections Officer is a comment against CSNSW as opposed to him personally. With that in mind, I am satisfied that procedural fairness has been afforded.

Commissioner of Corrective Services NSW (CSNSW)

At the hearing of the inquest, the Community Corrections Officer accepted that the purpose of parole was as set out in chapter "D5 Supervision" of the "Community Corrections Police and Procedures Manual" namely, "to reduce the impact of crime on the community, primarily through the reduction of reoffending and provision of cost effective and efficient alternatives to custody".

Although he stated he sought to act consistently with that purpose in his dealings with Jack, Counsel Assisting submitted that there were aspects of his evidence, as set out below, that leave room for improvement. First, a difficulty that the Community Corrections Officer encountered as Jack's probation and parole officer was that he could breach report Jack, but, short of doing that, he only had available to him making referrals for Jack to Housing and encouraging Jack to engage in mental health services, without necessarily "holding his hand".

Secondly, the Community Corrections Officer said he was limited in what assistance he could provide when Jack was living in a different area to that covered by the Community Corrections Officer's office. For example, he said that to have visited Jack at the Banksia Motel would have been beyond the scope of his duties (as Jack was outside the purview of the Community Corrections Officer's office), but he could have visited Jack if he had remained at the Campbelltown ISC.

The Community Corrections Officer also indicated that he could not have arranged for another officer the Bankstown area to visit Jack because Jack had not been officially transferred to that area. When asked if he could have affected an urgent transfer, he said yes but Jack had no rapport with any other office so it would have been inappropriate. Notwithstanding this evidence, however, as noted above, Jack did attend an appointment at the Bankstown office and appears to have had some discussion with the CCO Fitzgerald there.

Thirdly, he clearly suffered from the fact that he was also supervising a number of other parolees and had responsibilities to them in addition to Jack.

Fourthly, the Community Corrections Officer agreed that he was not in a position to know whether Jack was complying with his parole conditions following Jack's discharge from Cumberland Hospital on 5 February 2018 as he could no longer get in contact with him. In light of the above I am minded to make the recommendation proposed by Counsel Assisting, namely that consideration be given to some mechanism or procedure to be put in place by CSNSW when a parolee is not contactable for 7 days. Counsel Assisting submitted the effect of the four factors identified above was that Jack was effectively left in a situation where he had one officer who had rapport with him but could not get in touch with him and felt it outside of his scope to go see him. And yet, that same officer did not transfer Jack's supervision to another office. Further, whilst Jack was in contact with the Bankstown office, it appears that they did not undertake any overarching supervisory role. This meant, they say, that it was easier for Jack to then fall through the cracks and not receive the mental health care and treatment that he required.

Ms Douglas-Baker, counsel for CSNSW, submitted that: *On a fair reading of the factual timeline, the relevant period to be examined in this inquest is not 5 February 2018 to 18 February 2018, but 13 February 2018 (the day of Jack's second appointment with community corrections and the day Jack failed to report) to 18 February 2018 (the date of Jack's death). The relevant time period is further reduced from 13 February 2018 (the day Jack failed to report) to Friday 16 February 2018 (being the last weekday of the week prior to Jack's death on Sunday 18 February 2018). The period during which Jack was not apparently engaged with community corrections was 13 February 2018 to 16 February 2018 – a mere four days.*

The evidence revealed, according to Ms Douglas-Baker that during the totality of the time Jack was released to parole:

- Jack was released to parole for a period of 33 days.
- Jack's accommodation was unstable "due to Jack's non-compliance with the rules of the house".
- Jack was twice admitted to Cumberland Hospital, which represented a total of 13 of his 33 days released to parole: and
- notwithstanding Jack's admissions to Cumberland Hospital, the Community Corrections Officer met Jack twice and spoke with him once in the period 17 January to 23 January 2018, then CCO Fitzgerald met with Jack once but Jack missed his following appointment.

Ms Douglas-Baker then referred to the following terms of the "D5 Supervision" chapter of the "Community Corrections Police and Procedures Manual":

The authority for a CCO's involvement in an offender rests in the legal document offering supervision. The extent to which a CCO can become involved in an offender's life is limited by the conditions of the legal document, legislation governing breach procedures, and the nature of the offence …

It was submitted that this, along with relevant legislative provisions, indicates that the role of a CCO "is to supervise a parolee (by encouraging, engaging, monitoring, and referring) the parolee, not to intervene generally in the parolee's life". Given this role, Ms. Douglas-Baker submitted that the CCO "stands as neither nanny nor gaoler in relation to the parolee".

Ms Douglas-Baker then proceeded to respond to Counsel Assisting's submissions as follows.

- The Community Corrections Officer's evidence was consistent with parole condition 3: "The offender must, while on release on parole, adapt to normal community life".
- In respect of Counsel Assisting's submissions summarised at paragraph 482 above, the Community Corrections Officer's evidence was that his role was an overseeing role which involved encouraging Jack to take positions steps in self-care and referring Jack to services such as Housing from whom Jack would then receive assistance with accommodation. It was not the Community Corrections Officer's role to appropriate day-to-day responsibility for Jack but to supervise, encourage and refer Jack to services that would facilitate his independence and reintegration into the community.
- Only if such measures failed, or Jack was non-compliant, would the Community Corrections Officer breach Jack. Further, if Jack posed a risk to himself or others, and that because known to the Community Corrections Officer, he would "have the obligation to inform the relevant authorities to prevent that from happening".
- In respect of Counsel Assisting's submissions summarised at paragraph 484 above, the Court's attention was drawn more fully to the Community Corrections Officer's evidence regarding whether Jack could be transferred to the Bankstown office:

- It could have been done but Jack had no contact with them, so they had no rapport with them [sic] and the accommodation itself was temporary so he could have been relocated to a different location and then again transferred to another office. So, because I've had that initial carriage and had that initial contact with him and also tried to contact family and so forth, I've already had that, I guess some rapport. It would have been difficult for the office to again start from scratch, so it's be going back to square one, then transfer him to someone else. So that's why because he wasn't formally transferred, he wasn't – yeah – things just weren't ready.

It was submitted that the above evidence should be interpreted as meaning that, in circumstances where Jack's accommodation remained temporary, it was by no means certain that Jack would remain resident outside of the Campbelltown office area and a relationship had been commenced with the Community Corrections Officer at that office, so it was inappropriate – practically or otherwise – to transfer Jack to another CCO office.

In respect of Counsel Assisting's submissions summarised at paragraph 485 above, it was noted that, whilst the Community Corrections Officer's evidence was that his office had a high workload (being allocated responsibility for 30-40 parolees), it was also his evidence that he and his colleagues worked the hours necessary to get the work done over the course of a five-day working week. The Community Corrections Officer also gave evidence that, although parolees are prescribed a specific number of hours of supervision depending upon their level of risk, in practice "basically whatever needs to be done we just do it as part of the supervision". It was submitted that Counsel Assisting's submission was not consistent with the Community Corrections Officer's evidence and that had another CCO been supervising Jack there would not have been a differentoutcome.

In respect of Counsel Assisting's submissions summarised at paragraph 488 above, it was noted that the Community Corrections Officer directed Jack to report to CCO Fitzgerald and that Jack met with CCO Fitzgerald directed. Whilst the Community Corrections Officer might not have known "personally" whether Jack was complying with his parole conditions, there were appropriate supports in place that were in effect standing in for the Community Corrections Officer and monitoring Jack's compliance with parole conditions. Counsel Assisting also submitted that, on discharge from Cumberland Hospital, those responsible, including the Community Corrections Officer, were well aware of when the next depot injection was due and that it had not been administered during his stay at Cumberland Hospital.

In response, Ms Douglas-Baker submitted that, in circumstances where the Community Corrections Officer is not a medical practitioner, and in circumstances where he received advice from Dr Sampson that the depot injection was not due (see paragraphs 57 to 69 above) and was, in Dr Sampson's expert opinion, not connected with his behaviour, "it is manifestly unfair and inappropriate to suggest that the Community Corrections Officer had any responsibility to ensure that a parolee was receiving his or her medication from treating medical practitioners". This was particularly the case in circumstances where the Community Corrections Officer did not have access to Cumberland Hospital's medical records (see paragraph 520 below) and where it was Jack who bore the responsibility of complying with the treatment regime prescribed.

I am mindful of the very relevant points raised in submissions of counsel for CSNSW and counsel for the Community Corrections Officer, namely that:

- at the time, the Community Corrections Officer was a trainee officer with a high workload.
- The Community Corrections Officer acted within the nature and scope of his powers as per CSNSW policies.
- The role of a Community Corrections Officer to engage with parolees, supervise them, encourage them, and monitor them to facilitate their adjustment to life in the community after release from prison,
- A Community Corrections Officer is not able to compel parolees to attend appointments or comply with medication.
- Jack was difficult to contact and was at times reticent to engage with services, including failing to attend meetings that the Community Corrections Officer had arranged.
- CSNSW, like any other organisation, has limited resources.

However, the facts in this matter suggest that the Community Corrections Officer was in a unique position, in that he was aware of Jack's mental health and medication needs. He knew that Jack's compliance with medication was a critical factor in maintaining his mental health. He knew that Jack needed a depot medication at the end of the month. And he knew, following his conversation with Dr Sampson on 1 February 2018, that Jack had not received a depot injection at Cumberland Hospital.

Although he tried to re-engage Jack by contacting Jack's family and the Banksia motel, more needed to be done to ensure that Jack was referred to a community mental health care team. the Community Corrections Officer conceded in evidence, properly in my view, when asked whether it was part of his responsibility to engage with Community Mental Health, that is, whether he should have checked with the hospital "are you going to refer him or should I?", that he could have asked that.

Although the Community Corrections Officer stated that "even if there were another officer supervising Jack, there wouldn't have been different outcome. Little we can do if there is no engagement", I find that he could have done more to support Jack, including engaging with COMHET.

<u>South Western Sydney LHD and Western Sydney LHD</u>

Continuity of mental health care for Jack on parole

Dr Modem gave evidence that Jack had been approved through the Macarthur COMHET for the Macarthur "MAT" (or, "Macarthur Assertive Team"), where he would be given assertive follow up including home visits. When Jack was admitted to Cumberland Hospital, however, he was discharged from Macarthur COMHET including the MAT referral because he could not have two active services.

Dr Modem said that the onus was on Cumberland Hospital to call the appropriate intake line when Jack was being released, and that the Hospital would have known that the reference to "MAT" in the Macarthur COMHET discharge summary was a reference to the Macarthur Assertive Team.

As this is a well-recognised term and not all geographical areas have an assertive team, including those within the same local health district. Mr Parker, Director of Community Mental Health Partnerships for the South Western Sydney Local Health District, confirmed Dr Modem's evidence. Dr Modem could not answer Counsel Assisting's question as to how continuity of care could be ensured in circumstances where a person was staying in temporary accommodation, as he said it was outside scope. Mr Parker, however, stated that within the same local health district there are instances where persons can stay with their existing treating team even in circumstances where, for example, a person moved from Liverpool to Campbelltown, as opposed to moving from Liverpool to Bowral where that would not be possible. He said they would need to be able to practically provide a service in the latter example. In respect of continuity of care, Dr Sampson of Cumberland Hospital said variously that it was not his responsibility to facilitate continuity of care for Jack because it was the treating team's responsibility.

He also indicated that there were limits as regards Jack's ongoing management because he had no accommodation and so Dr Sampson would not have known where to send the Cumberland Hospital discharge summary. Mr Parker stated that instability of accommodation was something that was common to people managed by their service. He said the COMHET could identify housing issues and work with housing to assist in finding accommodation. Had Jack been referred back to Macarthur COMHET by Cumberland or the Community Corrections Officer, on Mr Parker's evidence he would not have to have been triaged again and the referral to the MAT would have remained in place. Macarthur COMHET may then have assisted in finding Jack accommodation in area.

In circumstances where Cumberland Hospital was aware of Jack's prior referral to the Macarthur COMHET, including a referral to the MAT, I consider that attempts could have been made to engage with Macarthur COMHET prior to Jack's discharge from Cumberland Hospital in order to seek their involvement in arranging temporary housing within their area to seek to ensure continuing of community mental health care. Further, I consider that Cumberland Hospital could have taken steps to ensure that there was continuity of mental health care for Jack by either raising this with the Community Corrections Officer or by liaising directly with housing to seek to arrange emergency housing prior to discharge so that a community mental health team could be available from the point of discharge.

In order to address this issue of continuity of care, Counsel Assisting proposed the following recommendation directed at Western Sydney LHD: In closing submissions, counsel for the Western Sydney LHD informed the Court of Western Sydney LHD's Mental Health Discharge Liaison 7-day follow up process, and the role of the Discharge Liaison Clinician, who is responsible for conducting the 7-day follow up.

Relevantly, progress notes from Cumberland Hospital record that a Nurse Boyd made two attempts to contact Jack following his discharge. In exhibit 5, there are two notes, one on 6 Feb and one on 9 Feb. The first states "I tried to contact patient for seven days post discharge follow up. Patient has no fixed address or phone. There is a number for his father which is not answering." The second states "as per the seven-day post discharge follow up, I have made numerous attempts to contact patient's relatives, as patient doesn't have a phone. File now closed".

Nurse Boyd does not appear to have contacted Jack's parole officer. In closing submissions, counsel for the Western Sydney LHD submitted that the Discharge Liaison Clinician is reliant on the contact information provided by the treating team. In Jack's case, counsel submitted that Jack's father was the only listed contact on patient management. Counsel for the Western Sydney LHD submitted that the Discharge Liaison Clinician would have had to have conducted a search of the progress notes in order to locate the Community Correction Officer's contact details.

Accordingly, in closing submissions, counsel for Western Sydney LHD proposed amending Counsel Assisting proposed recommendation as follows: *On discharge from an inpatient mental health unit where follow up is provided by the Discharge Liaison clinician, consideration be given to introducing a policy, procedure or clinical pathway to ensure that concerns post discharge (including persons who are unable to be located) is communicated both to the inpatient facility to which the person was discharged from, to Corrective Services if the person is subject to a parole order or community supervision, and that steps are taken to ensure that that be communicated to any subsequent community mental health team or other healthcare provider to which the person had been referred to (or receiving care from) at that time."*

With respect, it appears that the recommendation proposed by counsel for the Western Sydney LHD may be broader than what is proposed by Counsel Assisting in that it would require any concerns post discharge to be communicated to CSNSW and any future community mental health team or healthcare provided. In light of the above, I am minded to make the recommendation as proposed by Counsel Assisting, namely that, where an assertive team recommendation has been accepted in a community mental health setting, consideration be given to introducing a policy or procedure to ensure that that is communicated both to any inpatient facility to which the person is admitted, and to CSNSW if the person is subject to a parole order or community supervision, and that steps are taken to ensure that that be communicated to any subsequent community mental health team to which the person is admitted.

Jack's Depot Injection on 30 January 2018

In respect of the administration of Jack's depot injection, I refer to the evidence of Dr Sampson summarised at paragraphs 57 to 69 above. Jack's failure to receive the scheduled depot injection on 30 January 2018 was seemingly a critical factor in his decline. A forensic toxicologist report obtained from Mr Michael Robertson has confirmed that when it is assumed that Jack's last dose of Clopixol was possibly 4+ weeks prior to his death (i.e. 16 January 2018), under these circumstances, it is likely that the concentration of Zuclopethixol had fallen to the extent that it would have been less effective and possibly not effective at managing his medical condition.

It was clearly noted in the Macarthur discharge that Jack should receive clopixol and Jack himself expressed a concern about getting it, and yet he was not given it at Cumberland Hospital – despite the fact that his medication was not changed by that facility. I find that this was a failure on the part of Cumberland Hospital and that steps should have been taken to ensure that Jack's clopixol was administered as due.

Follow-up about Jack's Depot Injection

Dr Sampson also gave somewhat confused evidence as to whether the Community Corrections Officer had "available" to him Jack's discharge summary from Cumberland Hospital, which clearly noted that Jack should receive a depot injection. In the end, it was clarified that it could have been provided to the Community Corrections Officer had he requested it (which he had). It appears on the available evidence however that the Community Corrections Officer never received that the discharge summary. Dr Sampson could and should have done more to ensure that the Community Corrections Officer received the discharge summary. In light of the above, I am minded to make the recommendation proposed by Counsel Assisting and directed to Western Sydney LHD that consideration be given to implementing handover procedures which specifically address the continuation of necessary medication. I am further minded to recommend that CSNSW and the Department of Health liaise to develop a means to dealing with those with mental health needs linked to re-offending, in particular, to ensure that discharges from inpatient facilities are coordinated so as to ensure ongoing mental health care, including medication, in the community upon discharge, even for those who have access only to temporary accommodation.

How and why Jack was able to leave the RPA

I refer to paragraphs 124 to 188 of the findings above regarding the factual background to how and why Jack was able to abscond from RPA. In Counsel Assisting's closing submissions, Counsel Assisting proposed two recommendations aimed at addressing how and why Jack was able to leave RPA. The first proposed recommendation is that consideration be given by RPA to requiring, including documenting this by way of written procedure and training all ED staff, that: two or more persons, with the second person being a physician, clinical nurse consultant, nurse unit manager or supervising Registered Nurse, jointly determine, and provide a signed authority, that it is appropriate for mechanical restraints to be removed even temporarily as regards mental health patients.

- a form be developed to record this.

- this procedure be expressly required as regards temporary relaxation of one or more hand or leg restraints to allow toileting or for any other purpose.

The second recommendation proposed by Counsel Assisting is that consideration be given by RPA to potential options available as to how toileting can be affected for a patient who is mechanically restrained, including the availability of security to assist or that another option may be to ensure the attendance of another member of clinical staff to provide additional protection. In closing submissions, counsel for the Sydney Local Health District did not indicate any objection to the above proposed recommendations, save to indicate that the RPA has already developed a patient safety physical restraint order and observation chart, and suggest that rather than "developing" a form, the existing physical restraint order and observation chart could be "amended" to address the matters in the first recommendation.

Accordingly, I recommend that consideration be given by RPA to requiring, including documenting this by way of written procedure and training all ED staff, that:

- two or more persons, with the second person being a physician, clinical nurse consultant, nurse unit manager or supervising Registered Nurse, jointly determine, and provide a signed authority, that it is appropriate for mechanical restraints to be removed even temporarily as regards mental health patients.

- the existing patient safety physical restraint order and observation chart amended to record this.

- this procedure be expressly required as regards temporary relaxation of one or more hand or leg restraints to allow toileting or for any other purpose.

Further, I recommend that consideration be given by RPA to exploring potential alternative options as to how toileting can be effected for a patient who is mechanically restrained, including the availability of security to assist or that another option may be to ensure the attendance of another member of clinical staff to provide additional protection.

Identity: The deceased is Jack Kokaua.

Date of death: Jack died on 18 February 2018 at 14:28pm.

Place of death: Jack was pronounced deceased at the RPA.

Cause of death: I accept Drs Dooris and Pokorny's evidence that Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease.

The manner of death: I accept Counsel Assisting's submissions in respect of the manner of Jack's death. Jack died by reason of a malignant ventricular arrhythmia without myocardial infarction, precipitated by multiple factors including positional asphyxia, exertion and use of taser, superimposed upon Jack's underlying occult coronary heart disease

11. 114791 of 2018

Inquest into the death of S. Findings handed down by State Coroner O'Sullivan at Ballina Local Court on the 7th May 2021.

These are the findings of inquest into the death of "S".

S died on 11 April 2018 from a self-inflicted gunshot wound to the head. He was 42 years old and a Sergeant of the NSW Police Force. At the time of his death, S was alone on active duty as a Highway Patrol officer. He was positioned near the Berry Jerry rest area, on the Sturt Highway, about 30 kilometres from Wagga Wagga. A week prior to his death, on 4 April 2018, S had been made aware that he was the subject of an investigation by the Professional Standards Command, including allegations of serious criminal conduct. That investigation was ongoing at the time of his death.

The nature of an inquest

An inquest was required to be held into this death because it appeared S died as a result of police operations (s. 27(1) (b) and 23(1) (c) of the *Coroners Act 2009*).

The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible asto:

- The identity of the deceased person.
- The date and place of the person's death; and
- The manner and cause of death.

A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

Background

S was born on 15 November 1975 and was therefore 42 years old at the time of his death. He grew up in the Lismore area with parents, sister and two brothers. S was in partnership in a business with one of his brothers, Ian. Together, they owned property and a cattle stud. Their niece, Sarah, lived with her grandparents from when she was 14. She viewed S as a father figure, and he viewed her as a daughter. She was named as the sole beneficiary in his Will. S joined the police and attested as a Probationary Constable in 1998. In 2016, he moved from Ballina to Wagga Wagga, to take up a promotion as Sergeant within the Traffic and Highway Patrol Command.

He was described by colleagues as an intelligent, professional, highly motivated and committed officer. He was considered to be borderline workaholic and something of a perfectionist.

He was also a compassionate supervisor; he was selfless, and colleagues went to him for advice and support. As one colleague put it, "*everyone loved him*". He was also decorated, having achieved Police Medal, National Medal and National Police Service Medal.

S formed an intimate relationship with his partner, Leon, in 2006. They lived together between 2012 and 2016 in Ballina. When S relocated to Wagga Wagga in 2016, Leon remained in Ballina. Nonetheless, they remained in a long-distance relationship at the time of his death. S intended to serve out his tenure of 3 years and then return to the Lismore area.

S appears to have been reserved or guarded about his private life; some colleagues knew or suspected he was gay, but none of them knew about his relationship with Leon.

2013 investigation

As I have mentioned, at the time of his death, S was subject of an investigation in relation to allegations of misconduct. S's death occurred before any findings were made about these allegations. It is beyond the scope of this inquest to reach a conclusion about the correctness of the allegations, but a short explanation is necessary to inform the events that led to S's death.

In March 2013, an acquaintance of S's, whom I shall refer to as "MR", was arrested at Ballina in relation to serious criminal conduct. In the course of investigating MR, his phone was seized and was found to contain text messages with S. Those messages suggested S knew about MR's alleged criminal activity. They also implicated S in the supply of cannabis to MR.

As a result, police commenced an investigation. The investigation identified further non-criminal misconduct, namely that S had accessed a COPS event involving MR and had also allowed MR to drive a highway patrol vehicle. Those non-criminal allegations were referred to the Traffic and Highway Patrol Command for investigation and were sustained, following S's admissions in interview.

S received a Commander's Warning Notice and was placed on a conduct management plan for six months. That disciplinary action had consequences for S's career. He was not eligible for promotion until May 2015. S was in dispute with his employer regarding this. However, no further action was taken in relation to the criminal allegations against S at that time. There seems to have been due to a misunderstanding as to which police command was to investigate these matters. While regrettable, there is no basis to conclude that this had any contribution to the circumstances of S's death.

2018 investigation

Some 4 ½ years later, on 4 December 2017, MR attended the police station at Ballina and asked to speak with police. MR alleged that, in 2013, S had been involved in serious criminal conduct. MR identified an alleged victim, who was interviewed about the allegations. On 12 January 2018, a meeting of the Complaints Management Team ("CMT") was convened. That is a team of senior officers within a command that d i r e c t s investigations into complaints against police. A decision was made that the Professional Standards Command would investigate S's conduct.

There was also a discussion during that meeting about "interim risk management strategies". That refers to action that can be taken to mitigate risk, for example a risk of self-harm, including by causing an officer to work in a different location, or on different duties, or restricting access to firearms.

A decision was made that S should continue his current duties with discreet monitoring by Traffic and Highway Patrol management. S at that stage was believed to be unaware of the investigation, and the CMT was concerned not to jeopardise any investigative strategies.

Following the meeting, S's manager at that time, Ch Insp Gregory Lynch, was informed of the investigation and its general nature, but not any of the details. It was Ch Insp Lynch's role to monitor S's welfare. Ch Insp Lynch asked whether S would be subject to a "suspension questionnaire", which is a process for determining whether an officer will remain in his or her role. He states that Ch Insp Adam Powderly, the Professional Standards Manager at Traffic and Highway Patrol, advised that S was to be managed in his current work location, as had been discussed in the meeting. They also discussed the need to "discreetly monitor" S's welfare.

On 25 January 2018, Professional Standards Command formally accepted the investigation and identified 10 issues or allegations. The record of that decision again refers to the need to implement risk management only after further discussion, to ensure any investigative strategies were not compromised.

On 6 February 2018, Strike Force Kurbnesh was established under Det Sgt Michael Lee. The terms of reference included both criminal allegations and non-criminal allegations against S. Det Sgt Lee commenced investigating, taking statements from witnesses. Neither Ch Insp Powderly nor Ch Insp Lynch were updated about the progress of Det Sgt Lee's investigation until earlyApril.

In early March 2018, S travelled to Ballina to visit Leon for about 3 weeks. On 8 March 2018, while S was visiting his family's farm, Det Sgt Lee contacted Leon and asked him to attend Ballina police station, which he did.

Det Sgt Lee informed Leon that a witness had come forward in relation to S's involvement in drug supply five years ago. Det Sgt Lee did not reveal other, more serious allegations. Leon declined to give a statement about what he knew. At the end of this discussion, Det Sgt Lee told Leon that S was not aware of the allegation and asked him not to discuss the matter with S. Leon was also asked whether he had any concerns about S, which he denied.

On or about 3 April 2018, Det Sgt Lee made a decision to inform S about the allegations, in order to ask him to participate in an interview. He made contact with S's Command, to advise them of his intentions, and was advised to make contact with S's supervising officer, who was at that time Sgt Hood.

On 4 April 2018, Det Sgt Lee contacted Sgt Hood to advise he was going to inform S about the complaint. He then phoned S and told him about the investigation and the nature of the allegations. Det Sgt Lee formed the view that S already knew about a complaint but was surprised about the specific allegations. During the conversation, Det Sgt Lee advised S of the support that was available to him. Det Sgt Lee subsequently sent S a copy of the complaint regarding his conduct, together with information about support packages that were available.

The complaint letter asked S to participate in an interview. It also advised S of his right to silence, and that if he exercised his common law privilege against self-incrimination, the interview would not proceed. Following this call, Det Sgt Lee made a second call, wherein he informed S of a direction not to discuss the investigation with possible witnesses, including his partner, Leon. This reflects a written direction contained in the complaint, in the following terms:

Not to interfere or compromise the integrity of this investigation in anyway, which includes disclosing information about this correspondence or the matter generally to any person that you know or have reasonable cause to suspect is a witness or otherwise involved in the investigation without my authority. This includes but is not limited to … [Leon].

This is a matter of some significance. Pursuant to cl. 8(1) of the *Police Regulation 2015,* S was obliged to promptly comply with all lawful orders from those in authority over him. The complaint contained a number of other directions, including: to attend an interview, to provide any answers in strict honesty and truthfulness, and to produce and not destroy anything under his control which may relate to the matter. These directions were given formally in the complaint, which was signed by a senior officer, Det Insp Glen Browne, and were therefore made by a person in authority over S.

According to Det Sgt Lee, S was angry and upset by the direction, saying that no one knew he was gay at the command, and so he felt he had no one he could talk to. Det Sgt Lee told S that he knew Leon was S's partner, and that S could still talk to Leon, but not about the investigation. Det Sgt Lee said that he did not consider S's demeanour during that phone call to beconcerning.

Those two calls were the only occasions when Det Sgt Lee had contact with S.

Ch Insp Lynch became aware that S had been told about the allegations. He discussed the matter with Ch Insp Powderly, who was also unaware there had been progress in the investigation. They discussed the need to monitor S's welfare. Ch Insp Powderly duly contacted Det Sgt Lee and asked to be kept informed of developments in the investigation in the future.

Ch Insp Lynch spoke to S at 11.20am on 5 April 2018 by phone. He made a note of that conversation. According to Ch Insp Lynch, S said he was okay and awaiting legal advice. He became upset about not being able to speak to Leon. While he wasn't crying, his voice was "*cracking".* But S was "*adamant that he was happy to remain at work and be supported by* [Ch Insp Lynch]". S also stated that he had "*done nothing wrong.*" Ch Insp Lynch recalls speaking to S on other occasions during the following days, although he did not make a note of these conversations.

The following day, S sought advice regarding participation in an interview from a solicitor, Mr. Ken Madden. Mr. Madden later told police that he did recall speaking to S about the complaint, but he did not recall anything of concern about S's presentation.

On 9 April 2018, S emailed Det Sgt Lee, invoking his privilege against self- incrimination and declining to be interviewed. Ch Insp Powderly was informed of this development, and he emailed Ch Insp Lynch, again advising of the need to monitor S's welfare. Ch Insp Lynch spoke with S again that day, again by phone. S informed him that he was okay to remain at work, and very much wanted to do so. They discussed the Employee Assistance Program ('EAP") and contacting his own doctor for assistance, which he declined. Ch Insp Lynch told S that he was available to talk at any time if needed.

That was the final time he spoke to S prior to his death.

2015 motor vehicle fatality

On 18 December 2015, S attended the scene of a traumatic motor vehicle accident in Lismore area which involved the death of a four-year-old girl and the serious injury of her 2-year-old sister. The vehicle in which they were travelling had been severed in two.
She was the daughter of a police officer.

S was affected significantly by this accident, and by the criminal proceeding that followed. The statement he prepared for those proceedings was within the brief, and it speaks to his level of shock at the time. Leon also described how S was "*not coping too well*" with the accident, and that S had said "*it will be good when* [the proceedings] *are over with*." They remained ongoing at the time of his death and were concluded in April 2019.

Following the incident, the local area command arranged for a trauma team to attend the police station. It does not appear that S took up this support. However, S was critical of the response by management and the lack of support he was subsequently given.

Financial position

At the time of his death, S was in a loan dispute with the National Australia Bank and in debt to a builder, Wayne Carter Homes, whom he had contracted to build a new house on a site in near Wagga Wagga.

S applied for a loan approval in early 2017, and subsequently signed a contract to purchase the land and build the house. However, it transpired that NAB had only approved a loan for around $100,000, whereas the total cost was about $470,000. Subsequent requests for review were declined, because of S's commitments on the farm properties.

On 7 November 2017, S made a complaint to the Financial Ombudsman Service. A conciliation meeting was held in January 2018 but NAB declined to change its position and the Ombudsman proceeded with a determination. This process was still outstanding at the time of S's death.

Construction of the home commenced in July 2017 and had progressed to the point where it was almost at lock up stage and there was nearly $150,000 outstanding to Wayne Carter Homes for construction costs. While NAB's loan refusal appears to have caused S stress, there is a basis to conclude that it was not of high concern. For example, S's niece Sarah believed that he was not too distressed about the dispute. He had arranged for an alternative plan for financing the home through Leon. Leon thought S was "*more pissed off about the process he was put through with the bank as opposed to being financially stretched*."

Ineligibility for promotion

S was, as I have noted, a committed police officer and was ambitious to rise through the ranks. The background difficulties in relation to his career have been described.

On 7 August 2017, a Senior Sergeant role, Cluster Senior Supervisor, was advertised within Traffic and Highway Patrol Command. However, S was ineligible for this role because it required that the applicant serve two years as a Sergeant first, and S had commenced his role in May 2016.

After it had been advertised, the role was put on hold for a period, due to a restructure. Nonetheless, S was given an opportunity to act in the role by his supervising officer, Ch Insp Lynch. S performed the role very well. He was committed and diligent, and he assisted with implementing changes in the Command brought about by the restructure. In total, he worked as the C l u s t e r Senior Supervisor for about 18 weeks, mainly during the period from 24 September 2017 to 27 January 2018.

In late 2017, the recruitment for the role was reactivated. However, Human Resources advised Ch Insp Lynch that the previous recruitment had not been finalised, and so the role should be filled without further re-advertisement, with the effect that only existing applicants would be considered. S was upset with this decision, and he informed several of his colleagues about his concern. However, given the timing of the recruitment, S was still not eligible to apply, even when re-advertised; he would not have attained 2 years' service as a Sergeant until May 2018.

On 6 April 2018, one of S's colleagues, Sgt Darryl Thomas, was informed he was the preferred candidate for the Senior Sergeant role, with an official announcement taking place after S's death. It appears that S came to be aware that Sgt Thomas had won the role prior to his death.

S's presentation

During the period prior to his death, none of S's family, or his partner, or colleagues recall anything which would have indicated that he was considering self-harm. This is consistent with S being guarded and reserved about his private life.

There was one conversation that, in retrospect, has significance. On about 3 March 2018, one of S's colleagues, Sen Cst Michael Hoogvelt, asked him how he was going. He was aware that there had been some stressors in S's life. S said, "*everything's fucked. I may as well shoot myself in the head*". Although Sen Cst Hoogvelt thought this was odd, he did not form the view that S was in need of support at that time. I note that this occurred at a time when S was apparently unaware of the complaint made against him.

Events prior to the death

On Monday 9 April 2018, S reported that he had been unwell. He had been due to attend an Internal Investigation Training course at Goulburn that day. As I have noted, Ch Insp Lynch phoned S, having been made aware that he had declined an interview. They discussed why S did not attend the course, and also welfare support. S remained adamant that he wanted to remain at work. He left the office that afternoon.

On Tuesday 10 April 2018, S sent instructions to his solicitor, regarding the distribution of his life insurance, which he and his brother Ian had taken out to meet any liabilities in relation to their joint business venture. He instructed his solicitor to distribute the payout between Ian, Sarah, and Leon, and to purchase livestock with the balance.

At 4.54pm that day, S sent a Leon a package containing: a letter, details about his superannuation policy, a ring, a photo of their cat (Kimba) and S's medals. S also sent letters to his family, including Sarah.

That letter reminded her that he considered her to be his daughter.

The letters each acknowledged that "*this is going to be hard for you".* The letters do not give any insight as to why he had made the decision to end his life.

S last spoke with Leon at 6.00pm on 10 April. According to Leon, S sounded chirpy and happy, and Leon did not detect that anything waswrong.

Events of 11 April 2018

On the day of his death, Wednesday 11 April 2018, S's behaviour at work was initially unremarkable. He attended Wagga Wagga police station at 5:51am, which was earlier than originally rostered. At 6.22am, he collected his appointments belt including his gun. He spoke with some of his colleagues and appeared to be cleaning out some paperwork.

At 8.12am, while at the station, he called his mother. There was nothing of significance in the phone call, although he usually called her on Fridays. He asked her to open some of his mail and read the contents.

At 8.39am, he left the police station in a fully marked highway patrol car, South 278. Later investigations show that he turned off the Police CAD system, which would normally display messages from the police dispatcher, and would also track the location of the vehicle. He also turned off the vehicle's Automatic Number Plate Recognition device.

During the late morning, a neighbour recalls seeing S leaving his driveway in a marked police car. The house, when later searched, was noted to be very clean and tidy, with electrical items unplugged and the fridge cleaned out and defrosted. Investigations also show that S backed up some files on his computer at home during this time, and sent an email to his accountant. S returned to the police station at 11:22am. He left again at 11:48am in the same vehicle, South 278. The CAD system shows that he travelled to the Sturt Highway, towards the Berry Jerry rest stop, stopping in a road siding near that rest stop at 12.18pm.

At 12:39pm, S pressed a "vehicle stop" button on the Mobile Data Terminal in his car. That information was reported back via the police CADsystem.

The Call Sign log shows that a welfare check prompt was displayed on the police radio dispatcher's screen at 12:54pm.

The CAD system records show that South 278 remained stationary between 12:18pm and 2:43pm. The Call Sign log shows that at 2.06pm, S logged out of the system, and then logged back in again. At 2.43pm, S pressed a button to indicate he was "back on available".

There is no evidence that the relevant police radio dispatcher, Nick Jones, performed any welfare check during this time.

Significantly, S wrote a note in his notebook, which he timed at 2.30pm, stating:

Re CAD. I have had CAD on and seen status of vehicle stop since 12.45pm. No welfare checks were conducted. Please check to see this is working in this vehicle please. During this time, it appears that S also wrote a "goodbye" note to colleagues in his police notebook, which was discovered after his death. In part, that message reads as follows:

The staff at Wagga Wagg HWP. Thanks for the support you have all shown me. Can't believe it is nearly 2 years. As we all know this job can be stressful and it takes our toll on us. All I can ask is that if you need help, please speak to someone don't bottle it up inside. Mr Lynch sir, thank you for letting me relieve in the CSS position. I totally enjoyed it.

Each of these notes show that S was mindful of his colleagues' welfare, even at a time when he appears to have arrived at a decision to end his own life. This speaks cogently to that aspect of his character.

The death

At 2.43pm, the CAD system shows that S drove the vehicle to an area near the Berry Jerry rest stop. The vehicle then slowed, appeared to perform a U-Turn, and returned to its previous location.

Sometime between 3.00pm and 3:30pm, a civilian witness, Troy Derrick, was at a property nearby. He observed a police car, facing west, towards Narrandera. As he and a colleague finished their work, he heard a sound similar to a gunshot. As they drove out onto the highway, he observed a male police officer, who is likely to have been S, picking up some small objects from the ground. The police officer got into the police vehicle and drove west along Sturt Highway. About 30 minutes later, Mr. Derrick was driving past the same spot, and he observed a police car at the same location but facing east towards Wagga Wagga.

At 2.57pm, the police CAD system shows that S again pressed the vehicle stop button. At 3:12pm a welfare check prompt was again displayed top the Radio dispatcher. At 3:28pm, the dispatcher Nick Jones conducted a welfare check, asking S for an update over police radio. There was no response. Mr. Jones did not record the fact that he had performed a welfare check at the time.

Upon hearing the welfare check broadcast, one of S's colleagues, Sen Cst Lawson, also phoned S's mobile, with no answer.

S made a final notebook entry, which he timed at 3.34pm:

Re welfare check. Radio does first check since 12.45pm when on vehicle stop. That is nearly 3 hours since I have been here.

At about 4.15pm, traffic workers who were travelling along the highway noticed S lying motionless next to his police car on the side of the Sturt Highway.

They stopped to check he was alright and saw that he had blood coming from his head. They called '000' at about 4.17pm. NSW Ambulance paramedics arrived on the scene at 4:41pm. They noted a gunshot wound to the right temple and no signs of life.

Police then attended and established a crime scene. Three spent cartridges were found at the scene. S's firearm was examined, and it was discovered that three cartridges were missing, with 12 remaining. DNA linked S to the firearm and to one of the spent cartridges.

Autopsy

Dr Hannah Elstub performed an autopsy on 16 April 2018. Her report confirms that the cause of death was a gunshot wound of the head.

There were no premorbid medical conditions nor other remarkable features noted. Toxicology was negative.

Issues

Was the death self-inflicted?

The investigation has carefully pieced together the events that occurred on 11 April 2018, including what is known about S's final movements. There are only two issues arising from those events. The first is the reason why S remained at the location near the Berry Jerry rest stop for a period of over 3 ½ hours. While he wrote some short notes during that time, it is unclear what else he did. He pressed the vehicle stop button, twice, and it appears from his note that he expected it would generate a welfare check. That did not occur until 3.28pm. This was only shortly prior to his death. The second is the fact that S appears to have fired two other shots from his firearm. Police later searched the surrounding area but were unable to locate the projectiles using metal detectors and a line search.

It would appear probable, from Mr. Derrick's evidence and the records of the police CAD system, that S fired two shots, then left the scene, possibly having been disturbed by Mr. Derrick and his colleague. Whether he did in fact pick up the spent cartridges as Mr. Derrick suggests is unclear, given that they were later found at approximately the same location. He then drove off, and then performed a U-turn and returned to the same location, facing back towards Wagga Wagga. This was the location where he fired the fatal shot.

One might speculate that he fired those two shots to confirm that his firearm was in working order. Det Insp Attwood notes that, upon reviewing CCTV from the police station, it does not appear that S checked the function of his firearm when he collected it that morning. Nonetheless, the evidence supporting a conclusion that S caused his own death, and that he intended to do so, is compelling. Five matters can be noted:

- *Firstly,* the investigation revealed no evidence of the involvement of any other person. Neither Mr. Derrick and his colleague, nor the traffic workers, nor any witnesses on the highway saw any other person present at the location near to the time of S's death.

- *Second*, the firearms evidence shows that only S and his firearm were involved. The firearm belonged to S and had his DNA on it, and his DNA was detected on a spent cartridge. Three cartridges were missing from the magazine, and there were 3 spent cartridges at the scene. Ballistics evidence linked the spent cartridges to thefirearm.

- *Third*, the nature of the injury, being a gunshot wound to the right temple, supports a conclusion that S intended to end his life. The autopsy demonstrates a contact entrance wound, caused by being fired from very close range.

- *Fourth,* the letters S had sent the previous day to his family. There is a clear inference that S had decided by 10 April 2018 to end his life, and intended do so imminently, prior to the time when those letters would be expected to be delivered.

- *Fifth,* the note S wrote to his colleagues while he was in the vehicle shows he maintained that intention shortly prior to the time of hisdeath.

I find that the death was self-inflicted, and that S had an intention to end hislife.

S's state of mind at the time of his death

It is unnecessary, in reaching findings pursuant to s. 81 of the *Coroners Act 2009,* for me to determine the reasons that led S to end his life. However, those circumstances broadly come within the enquiry into the manner of death. In the circumstances of this case, it is not possible for me to make a finding about why S did so, in particular in the absence of any suicide note in which he stated a reason.

Nonetheless, I have described above the different stressors that existed in S's life. The traumatic vehicle accident, the dispute about the loan, and perhaps his disappointment regarding the promotion, were all matters that are likely to have been operating on S's mind in the period prior to his death to someextent.

The complaint about serious criminal allegations would no doubt have been stressful for S. In light of the proximity of the notification of the complaint to S's death, there is an available inference that it was a significant stressor for S, and that it was the dominant stressor operating on his mind at the time of hisdeath.

The steps taken to assess and monitor S's welfare

The NSW Police Force's Interim Risk Management Guidelines provide a process to assist commanders effectively manage staff when a risk is identified. Taking steps to manage risk does not presume misconduct or impose a form of discipline but is employed to manage an identified risk. Interim risk management is commonly used during complaints investigations and is also explicitly referred to in the relevant policy, the Complaint Handling Guidelines. A range of possible risks are identified in the policy, including the risk of self- harm. The process described is to consider a broad range of circumstances when assessing risk, including the seriousness of the allegations, possible impacts on the subject officer, any complainants and witnesses, and the wider community expectations. The first consideration is whether the officer can be adequately managed in the workplace.

One issue to be considered is any risk associated with the subject officer's access to a firearm.

A range of strategies can be developed, as part of an interim risk management plan. This could include working in a different location, with different duties, or with restrictions on access to weapons and appointments.

In some circumstances, risk management may comprise suspending an officer from duty. In that event, the Suspension Procedures are engaged. These commence with a suspension review and a questionnaire, and ultimately a decision whether or not to suspend is made by the Commander. The circumstances in which a Commander must give consideration to suspending an officer include where there is reasonable cause to believe the officer's conduct is such as to justify the institution of criminal proceedings.

However, the NSW Police Force's Policy Statement on Suspension of a Police Officer notes that it is an "*extreme measure and should only be exercised when no viable alternative is available*", which include those canvassed above. At the time the complaint was first being considered, in January 2018, the CMT made a deliberate decision to hold off taking risk management strategies and instead decided to manage S in the workplace, with "discreet monitoring" of his welfare.

The rationale was so that S was not alerted to the investigation, so that witnesses could be approached, and investigative strategies employed without being compromised.

Det Sgt Lee endorsed this approach and commenced his investigation without S being advised. Det Insp Attwood, who I note is an experienced investigator, considered this to be an appropriate approach to take.

Ch Insp Lynch and Ch Insp Powderly discussed the need for suspension to be considered, and the strategy going forward, consistent with the policy I have described. In light of the strategy adopted by the CMT, they understood the plan was to monitor S in the workplace. It was Ch Insp Lynch who was to perform the role of monitoring S's welfare, although both Ch Insp Powderly and Det Sgt Lee stated that, if they had become aware of anything concerning, they would have done something.

Ch Insp Lynch worked in Wollongong, while S was in Wagga Wagga. Although during January 2018 he was in regular contact with S by phone, he did not see him face-to-face. After that point, he did not have as regular contact. He relied to some extent on the lack of adverse reports from the command by way of monitoring.

However, I note also that it was unlikely that S could have become aware of the investigation at that early stage, and as he was physically distant from the informant and alleged victim, the risk was minimal. Accordingly, risk management strategies did not need to be employed. The situation with regard to risk potentially changed when S became aware of the investigation. Two points in time need to be considered.

The first is 8 March 2018, when Det Sgt Lee met with Leon and advised him of a complaint against S. Despite his request that Leon not to tell S about the complaint, there was some risk that S would learn about it. Det Sgt Lee did not inform Ch Insp Lee or Ch Insp Powderly that he had contacted Leon.

He told the Court he would not usually do so and was not aware of any of his colleagues within Professional Standard Command updating other commands about an investigation. Some were performed covertly.

Det Sgt Lee accepted, in hindsight, that it would have been appropriate to have updated Ch Insp Lynch or Ch Insp Powderly about the fact that he had told Leon about a complaint. I agree that it would have been desirable for him to do so. However, the following matters are relevant:

- Det Sgt Lee only told Leon about the less serious aspect of the investigation, which carried with it a lesser risk.
- There is no evidence that S became aware of the investigation at that stage, although he may have learned about it prior to 4 April 2018; Leon denied he told S at any stage.
- Ch Insp Lynch was, in any event, discreetly monitoring S's welfare at this stage, and received no reports of anything of concern.

The second point in time was 4 April 2018, when Det Sgt Lee informed S of the detail of the allegations. At that point there was clear a need to reassess risk. Although he attempted to contact the command on the day prior, Ch Insp Lynch and Ch Insp Powderly only learned about it after S had been informed. It would have been desirable for them to receive more notice, so that they could consider what action to take to support S.

Ch Insp Powderly and Ch Insp Lynch each gave evidence. They both impressed as thoughtful, concerned officers who addressed their mind to the need to monitor S's welfare. The obligation to consider S's welfare primarily rested on Ch Insp Lynch.

While no formal process was undertaken to re-assess risk at this point, none is in fact required by the policy. What was required was consideration of all the circumstances to identify any risk, and where risk is identified to develop a plan to meet that risk.

Ch Insp Lynch made contact promptly with S, speaking to him by phone on 5 April 2018. He frankly admitted that it was less than ideal to have a conversation by phone, and that face-to-face would have been preferable. Nonetheless, he had a basis to assess S's welfare. He had a good working relationship with S, if not a close personal one, and thought S would raise any concerns with him. To some extent, this is supported by the message S wrote to Ch Insp Lynch shortly prior to his death, thanking him for the opportunity to take on the Cluster Senior Supervisor role, which at the least show's gratitude and a lack of animosity. He believed S was being frank with him.

S did become upset about the issue of the direction not to discuss the matter with Leon. However, Ch Insp Lynch had experienced S becoming upset about his inability to apply for the promotion a few months prior. He used that as a "yardstick" against which to assess S's emotional state and concluded that S was no more upset about the complaint. He said in evidence that S did not raise the issue of the direction regarding Leon with him again. Ch Insp Lynch continued to monitor S's welfare over the coming days. He made further calls to S, during which he did not detect any change.

He drew comfort from the fact that there were no reports from officers at Wagga Wagga raising concern about S. He noted that at least 2 officers at Wagga Wagga, the Commander, and the Crime Manager, were also aware of the complaint, and therefore would be expected to identify any concerning behaviour in that context.

The fact that Ch Insp Lynch was relying on the lack reports from others, rather than actively seeking feedback, was not a robust manner to monitor S's welfare. However, his own contact with S did not detect concern. All of this needs to be considered in context.

Importantly, S was guarded and private about his life generally, and there is no evidence that he displayed any open signs of distress to anyone during this time. Neither Leon, nor Sarah, nor any of S's colleagues at Wagga Wagga who have provided statements to this inquest, detected any adverse change in S's behaviour at any stage. He maintained the pretence of outward normality right up until the time of his death. Mr. Cameron submitted that a risk assessment ought to have been conducted not only on the basis of outward signs of distress, but on the simple fact that S faced serious allegations, the implication being that these brought a risk of self- harm that needed to be managed regardless of a person'spresentation.

The seriousness of the allegations was one factor to be considered; it is explicitly identified in the policy, and was a matter clearly known to both Ch Insp Lynch and Ch Insp Powderly, albeit neither knew the details of theallegations.

Ch Insp Lynch did address his mind to risk management at the time. He stated that, had he known about the comments made by S to Sen Cst Hoogvelt, about "shooting himself in the head", he would have taken action. Mr. Cameron also submits that I should make a recommendation, requiring such comments to be reported.

While I understand the reason behind that submission, in my view there may be undesirable consequences of any policy that would require compulsory reporting in the manner suggested. It would alert subject officers to the consequences of doing so, and it may inhibit people from disclosing fears of self-harm. In my view, such a recommendation is not desirable.

Ch Insp Lynch also told the Court that the stage of the investigation was significant. If the case had come back from the DPP and criminal proceedings were to be commenced, he would have performed a suspension review. But the investigation was not at that stage.

If interim risk management strategies had been undertaken, these also brought risks. Almost any action would have alerted S's colleagues to the fact that he was facing a complaint investigation. Suspension, removal from the workplace or removal of a firearm would have had that effect. This may have caused S greater stress and isolation. Ch Insp Lynch endorsed the proposition that removing a person from the workplace can bring a greater risk than managing them within the workplace. In particular, it takes away a protective factor, namely a person's work colleagues and routine.

Ch Insp Lynch was evidently focused on S's welfare during this time. He told the Court he genuinely did not believe there was a risk to manage, in light of the way S presented. He also stated that, had he identified a need, he would not have hesitated to remove S's firearm.

In all the circumstances, I accept that the steps taken to assess, and monitor S's welfare were appropriate.

Support offered to S

Det Sgt Lee informed S that he should seek advice and support, and he provided details of support packages to S at the time he emailed the complaint. These are standard support packages provided to police officers facing a complaint, and copies are within the brief. They include the EAP and Police Association guidance, and a guide which describes the support and the process of a complaint investigation. S did not avail himself of support services at any stage.

In addition, Ch Insp Lynch reminded S that he could access support during their discussions on 5 and 9 April 2018. On 9 April, he asked S if there was anything he needed for support, and they discussed the EAP or contacting his doctor, which S declined. He also suggested S take some annual leave. S was adamant that he wanted to stay in work. It is clear to me that, even apart from this contact, S would have known about support he could obtain. He may well have felt isolated by his predicament, but he knew services existed to help. Ch Insp Lynch described how S had been instrumental in setting up a program of support for the command, during his period as the Cluster Senior Supervisor.

S also referred obliquely to the need to access support in the message he wrote to staff on 11 April 2018, when he said, "*All I can ask is that if you need help, please speak to someone don't bottle it up inside*."

Since the time of S's death, Ch Insp Lynch told the Court that the support available within the regional Traffic and Highway Patrol command has been improved. Psychologists attend the region three times per year to be available to staff who want to discuss issues, whether work-related or not. Ch Insp Lynch considers that the ready availability of this service has meant that officers now take it up, whereas before they would often decline assistance when it was offered.

The program is intended to continue. This is a positive legacy.

The direction not to disclose information to S's partner

There was a need to protect the integrity of the investigation and to ensure than any potential witness would not be influenced. Leon had already stated that he did not want to give a statement, although the possibility that he might do so in the future was still in Det Sgt Lee's contemplation.

It was not in fact Det Sgt Lee who made a decision to give this direction, although he delivered it. The direction was one of a number that are given to police officers who face a complaint, as I have set out above. It is part of a "standard form" and Det Sgt Lee understood that it is (or was in 2018) provided to all police officers who are the subject of a complaint. He had been investigating complaints for about 2 years at the time of these events. He told the Court that he was aware of, but had not in fact read, the Complaint Handling Guidelines. He has since moved to a different role.

Det Insp Attwood formed the opinion that this was not a lawful direction, though he acknowledged it was his personal view.

His rationale was that police officers facing a criminal investigation should be placed in the same position as a member of the public facing a criminal investigation. A direction could not be given to a member of the public not to talk to a potential witness, at least not prior to the point of charge and when bail is determined. Det Sgt Lee endorsed this view. Each of them are experienced investigators.

The direction was given by an appropriately senior officer (Insp Browne) and on its face S was required to comply with it (cl. 8 of the *Police Regulation 2015*). Whether it was appropriate in the case of a criminal investigation is unclear. The lawfulness of the direction is not strictly a matter within the scope of this inquest.

I note that there are provisions which restrict information that may be disclosed by a police officer about a complaint, including a complaint about criminal conduct, but these relate to specific information, such as the identity of the complainant (see cl. 54(3) *Police Regulation 2015*). There are no provisions preventing disclosure of other information about an investigation. I acknowledge, as Ms. Melis has reminded me, that police officers are in some respects held to a higher standard than members of the public. There is a community expectation that this should be so. This is supported by the Code of Ethics and the unique framework for investigating complaints, under Part 8A of the *Police Act 1990.* There are also other instances where police are required not to disclose information.

For example, in the case of critical incident investigations, involved officers are directed not to discuss an incident, a direction that would not (and could not) be given to witnesses in other incidents. Such incidents might later become criminal investigations. The guidance relevant to this issue is the Complaint Handling Guidelines. The only relevant reference is at [9.3.3], which relates to a direction to be given "*at the conclusion of a departmental interview*", i.e. a non-criminal interview, which is in similar terms to the direction given to S, namely:

You are directed not to disclose any information in respect of this interview to any person including any person you have reasonable cause to believe could be a subject officer or witness or otherwise involved in t h i s investigation without my authority or the authority of a member of the CMT. Do you understand that?

Similarly, the "*Support package for police officers interviewed in relation to a complaint",* which was provided to S, contains the same direction as above, but only under the heading "*Non-criminal investigations".* It would appear the guidance available to the inquest does not advise such a direction be given in criminal investigations, or what to do in the situation where an investigation has both criminal and non-criminal elements.

The direction given to S might have contributed his feeling of isolation. It did not prevent him talking to Leon, but it meant he was not able to talk about the details of what was probably a very stressful event. As I have noted, S did have other support he could have accessed.

While the direction appears to be given as standard, I consider it to be unsupported by, if not at odds with, the guidance available to this inquest. I consider it desirable that the Commissioner clarify relevant guidance, to make clear whether a direction such as the one at issue should be given in the case of a criminal investigation. I will make a recommendation to that effect, below.

The adequacy of welfare checks performed on 11 April 2018

Sen Sgt Bernard Sloane, the State Co-Ordinator of the Radio Operations Group, provided a statement regarding system for conducting welfare checks.

Relevantly, the CAD system automatically prompts the police radio dispatcher to conduct a welfare check, where a particular call sign or vehicle has been at a vehicle stop for a period of 15 minutes (although this period can be varied manually). The need to conduct a check is displayed in a red prompt box, and it remains there until it is actioned, or until further action is taken by the call sign or vehicle.

A radio check is to be conducted when this prompt is displayed. If there is no response after making repeated enquiries, the dispatch assist would be asked to make enquiries with the police station. If there is still no response, the dispatcher would request a second unit to attend to check onwelfare.

Dispatchers are trained in this process, to actively monitor the welfare prompt box and to be aware of the situation where officers are located. It is best practice to note when a welfare check has been conducted, either in the CAD log relating to a job the unit is attending, or in the Call Sign log. The dispatcher, Nick Jones, gave evidence that he was aware of this process as at 2018. He was on duty from 7.30am to 7pm that day. He was working for the relevant radio channel where S was located.He would have taken breaks at different times, and would have spent some of the day dispatching, and some assisting. The evidence supports a finding that the dispatcher was prompted to make a welfare check at 12.54pm, and that no welfare check was performed, in particular prior to 2.06pm, when S logged out of the system.

Mr. Jones was unable to explain why. He may not have been working as dispatcher at that time, although the message would also have been displayed to the dispatch assist. He suggested that a message may have been broadcast, but did not get through to S. However, the note S wrote about the lack of a welfare check suggests one was not broadcast. In any event, there was evidently no follow-up. When the later welfare check prompt was displayed at 3.12pm, Mr. Jones says he did make a broadcast, at 3.28pm. There was no response to this. S died shortly afterwards, with the 000 call being made at 4.17pm.

While Mr. Jones did not record the fact that he performed this check at the time, this is because he was unaware he could do so, by making a note on the Call Sign log. He did make a retrospective entry in the CAD log relating to S's death, at 5.08pm. Mr. Jones, to his credit, has learned from the experience. He has been guided about his conduct. He now makes a point of recording welfare checks he performs on the Call Sign log, to ensure there is a record. Since S's death, an education package has been prepared regarding the importance of welfare checks, and best practice when conducting these. It was required to be completed by all communications officers.

In the circumstances of this case, while it was regrettable that the earlier welfare check was not performed, it is unlikely to have had any impact on the circumstances of S's death. His death occurred soon after he knew the second check had been performed. As I have already noted, prior to that time, he had clearly made a decision to end his life.

Findings:

The identity of the deceased: The person who died was S

Date of death 11 April 2018

Place of death Collingullie, NSW

Cause of death: Gunshot wound to the head

Manner of death: Self-inflicted, with an intention to end his life

Recommendations

1. I make the following recommendation pursuant to s. 82 of the *Coroners Act 2009*.

To the NSW Commissioner of Police:

Review any relevant policies and procedures to clarify whether a police officer subject to a criminal complaint investigation should be given a direction that a subject officer should not disclose information about an investigation to a witness or involved person.

Conclusion

This inquest concerned the tragic death of a valued and dedicated police officer. I acknowledge that the inquest has dwelled on aspects of his life which those who knew him would prefer not to recall. The material shows he was a compassionate person who often placed the interests of others above his own. He was meticulous in his life, and also in the steps he took preceding hisdeath.

S's partner Leon, Leon's mother Jenny, and S's niece Sarah were present throughout the inquest. I thank them for their attendance, and for Leon's insightful words about S at the conclusion of proceedings. I hope that the inquest has been of benefit to them, and to the rest of the family, and that some of their questions about the circumstances surrounding the death have now been answered. I again express my condolences for their loss.

12. 123983 of 2018

Inquest into the death of Zhong Liu. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 8th June 2021.

Zhong (Peter) Liu was aged 54 years when he died in hospital on 18 April 2018. He had been taken by ambulance to St George Hospital, Kogarah that evening, after collapsing outside his apartment.

Earlier that night police had been called to Mr. Liu's home, which was on the third story of an apartment block in Rockdale. Mr. Liu suffered from a schizophrenic illness and he had become acutely unwell. In an act that was very uncharacteristic of him, he had tried to choke his elderly mother with whom he lived. Mr. Liu's mother ran to neighbours for help and they immediately contacted police.

When police officers arrived minutes later they saw that Mr. Liu was in the throes of an acute mental health episode. He was highly agitated and had blood on his face and hands. The top part of one of his fingers had been severed. Shortly after the arrival of the police officers he appeared to fall forward down a number of stairs, to the second-floor landing where they stood. His agitation continued and he was restrained and handcuffed. Ambulance officers arrived and he went into cardiac arrest. Despite a short return to spontaneous circulation, he could not be revived. He was pronounced deceased at St George Hospital.

Issues at the inquest

- the involvement of the St George Community Mental Health Service [the CMHS] in Mr. Liu's care and in particular, whether involuntary admission and detention under the *Mental Health Act 2007* [the MH Act] would have been appropriate
- the appropriateness of the response of NSW Police
- whether the cause of Mr. Liu's death could be ascertained
- Mr. Liu's access to prescription medicines.

The third issue, regarding cause of death, required examination due to the fact that an autopsy examination was unable to identify the cause of Mr. Liu's death. This was because a number of contributing factors were identified, whose respective contributions could not be quantified. At the inquest the court sought the assistance of medical experts on this issue.

At autopsy, forensic pathologist Dr Rebecca Irvine had found evidence of a condition known as arrhythmogenic cardiomyopathy [ACM]. This is an inherited heart condition which can lead to ventricular arrhythmias and sudden cardiac death, especially during periods of intense physical exertion or stress. However, Dr Irvine's examination also found evidence of multiple drug toxicity, specifically a combination of the medication's venlafaxine and doxepin. Further, she noted the possible contribution of physiological stress, arising both from Mr. Liu's psychotic state and the periods of physical restraint he had experienced. For these reasons she had found the cause of Mr. Liu's death to be unascertained.

The first and second issues arise from the evidence of interactions Mr. Liu had on the day of his death, firstly with psychologist Ms. Xiaoyun (Loy) Lai and secondly, with officers of NSW Police who were called to assist when he became acutely unwell. The fourth issue is one which arises all too frequently in coronial inquests. Misuse of prescription medication is a pressing public health issue and is the cause of great harm and heartache. The inquest examined what measures exist to assist doctors to prescribe medications safely, where they believe patients are at risk of this behaviour.

Mr. Liu's life

Mr. Liu was born in Beijing, China on 9 November 1963. He was the son of mother Ling Su and Father Yi Liu and he had an older brother, Henry. According to Henry Liu, Mr. Liu's childhood was a happy one. In 1987 Henry, an engineer, emigrated to Australia and sponsored his parents and brother to move here as well.

After he arrived in Australia Zhong Liu lived with his parents and worked in traditional Chinese massage therapy. Then in the late 1990s Henry Liu started to notice that his brother was unwell. He showed signs of paranoia and believed he was being watched. He was diagnosed with schizophrenia and continued to live with his parents, until his father had to move into a nursing home due to his dementia. Mr. Liu and his mother visited him regularly. Mr. Liu's family was of Russian and Chinese descent, and Mr. Liu and his mother were fluent in both languages. However, at the time of his death Mr. Liu spoke only limited English. Mr. Liu's social world was very limited. He did not marry or have children, and at the time of his death he had not worked for several years. He loved his parents and spent much time with them and with his brother Henry. Otherwise he was socially very isolated and rarely left his home. As his parents grew older he became increasingly distressed at the thought of being left alone once they had died.

Mr. Liu's history of mental illness

In 2004 Mr. Liu came under the care of psychiatrist Dr Richard Wu. Dr Wu developed a sound understanding of Mr. Liu's conditions of schizophrenia, depression, and anxiety, and how they affected his life and those around him. In 2016 Dr Wu determined it would be in Mr. Liu's interests to transfer hiscare to the CMHS. He provided the CMHS with a transfer letter in which he identified principal treatment issues as follows:

- that Mr. Liu was at risk of developing benzodiazepine dependence, and therefore required consistent supervision and treatment. Dr Wu noted that Mr. Liu had a store of the benzodiazepine alprazolam which he had obtained from China and was visiting more than one General Practitioner [GP] to obtain further prescriptions of this and other medications. He needed to remain under the care of a single GP and a psychologist, preferably Mandarin speaking
- that Mr. Liu was becoming increasingly reclusive. Apart from interactions with his immediate family Mr. Liu had no social contacts. Dr Wu wrote that *'this predisposes him to further recurrence of depression, psychosis and indeed, raises questions of his ability for independent living when his mother passes on'*.

- He could benefit from the services offered by a community- based health service.

Dr Wu wrote a similar letter to Dr Chinh Le, a GP whom Mr. Liu frequently attended.

At around this time Mr. Liu's mental health began to deteriorate, with intrusive thoughts of harming his mother. In May 2016 he was admitted to St George Hospital Mental Health Unit as a voluntary inpatient. It was poignant to read the conclusion of his treating team that Mr. Liu was seeing the possibility of his mother's death as a way to precipitate his own suicide, and that he was in fact most distressed at the thought of harming her.

When Mr. Liu was discharged on 3 June 2016, the CMHS allocated psychologist Ms. Lai as his mental health clinician and case manager. Ms. Lai maintained this role until Mr. Liu's death and frequently attended him at his home, usually when his mother Ms. Ling was also present. She conducted her meetings with Mr. Liu and his mother in Mandarin.

In April 2017 Ms. Lai noted that Mr. Liu's mental state was '*relatively stable'*. She noted further that he was not interested in accepting the help which the CMHS offered for his psycho-social issues. Her impression was that Mr. Liu used the service mainly to seek adjustments to his medication.

Mr. Liu's medications

Mr. Liu's anxieties about his medication were a consistent feature of his mental health history. The evidence establishes that he frequently made his own decisions to increase his dosages. It is also clear from the evidence that he did not confine himself to a single GP when seeking prescriptions.

In the six months preceding his death Mr. Liu had been prescribed the following medications for his mental health:

- risperidone, an antipsychotic
- quetiapine, another antipsychotic
- venlafaxine, a serotonin-norepinephrine reuptake inhibitor antidepressant
- doxepin, a tricyclic antidepressant sometimes used to treat insomnia
- diazepam, an anti-anxiety medication.

In addition, there is evidence that Mr. Liu was using the medications alprazolam, nitrazepam and diazepam (all benzodiazepines) which he said he had obtained from China. Some of Mr. Liu's clinicians were not aware that he was obtaining extra prescriptions of medication from other GPs.

Those who were aware counselled him to restrict his dosage to that prescribed by his doctors, and further to confine his usage to medications prescribed for him in Australia. There were occasions when clinicians, including his allocated psychiatrist at the CMHS, refused his requests for further prescriptions. It is likely for this reason, that in early 2017 Mr. Liu told Ms. Lai that he wanted to transfer his care to a psychiatrist in private practice. Dr Le, the GP whom he most consistently attended, had already sent a letter of referral on his behalf to psychiatrist Dr Monir Younan.

Why did Mr. Liu overuse his medications?

The evidence indicates that Mr. Liu's overuse of medication stemmed in large part from his sleeping difficulties. This was why, on 26 February 2018, Dr Younan prescribed him the drug doxepin to be used as a sedative.

There is no doubt that in the days leading up to his death Mr. Liu took large amounts of this medication, well in excess of what Dr Younan had prescribed. This coincided with Mr. Liu reporting to Ms. Lai that his troubles with sleep had increased. Unfortunately, in the past he had showed little interest in pursuing non-pharmaceutical ways of addressing this problem.

Another reason why Mr. Liu often increased his dosages of medication was because of his concern that he might harm his mother. In September 2017 Mr. Liu told Ms. Lai that he had been feeling more agitated and irritable with his mother, and therefore had increased his medication to reduce his agitation. In his last two years, what he called his '*bad thoughts'* about his mother were a recurring feature. Distressing thoughts about harming her had prompted his voluntary admission to hospital in May 2016. In October 2017 Mr. Liu told Ms. Lai that these thoughts had resurfaced. In an effort to banish them he had taken more diazepam and risperidone.

It is important to note that until 17 and 18 April 2018 there is no evidence Mr. Liu ever acted on these thoughts of harming his mother. Indeed, he was very distressed about such thoughts, as he loved her. Ms. Lai's case note of 15 November 2017 recorded that he was feeling '*terrible, self-blaming, thinking he's not a good person after re-experiencing vague thoughts of harming mum in October'.*

There is some evidence that Mr. Liu's medication overdosing around the time of his death may also have resulted from a misunderstanding with his new psychiatrist, Dr Younan, as described below.

Mr. Liu's consultations with Dr Younan

Mr. Liu had two 'in person' consultations with his new psychiatrist, Dr Younan, in the two months leading up to his death. The first took place on 26 February 2018. Because of Mr. Liu's limited English, a telephone interpreter was used to assist, but Dr Younan did not think this was very satisfactory and took care to arrange an interpreter to attend in person at the next appointment.

At the first meeting with Dr Younan, Mr. Liu described delusions of Russian spies following him and fears that people would '*damage*' him. In order to help Mr. Liu's sleep Dr Younan added to his medications the medication doxepin 25mg, one tablet to be taken at night. The addition of this medication is significant, as it together with the medication venlafaxine were identified in high quantities in Mr. Liu's post mortem blood. As will be seen, expert evidence at the inquest identified that these two medications in combination were likely to have contributed to Mr. Liu's death.

At the second meeting on 19 March 2018 Mr. Liu told Dr Younan he had ceased using doxepin as it made him dizzy.

As a replacement sedative Dr Younan prescribed quetiapine 100mg, one tablet at night. On 13 April 2018 Mr. Liu rang Dr Younan and had an unscheduled phone discussion with him, again about his struggles with sleep. Due to this being an unscheduled call, an interpreter was not present to assist.

In fact, Dr Younan stated that the conversation probably took place while he was seeing another patient. It is very likely that genuine concern for Mr. Liu's welfare prompted Dr Younan to speak to Mr. Liu without an interpreter that day.

According to Dr Younan's patient notes, Mr. Liu told him he had increased his use of quetiapine to 200mg per day, and doxepin to 50mg per day. At the inquest Dr Younan said that although he was concerned Mr. Liu had increased his medication without consulting him, the increased amounts were not problematical as they were not out of range for him.

Dr Younan's notes record that he told Mr. Liu that he could increase his quetiapine up to 300mg daily. However as described below, Mr. Liu may have misunderstood Dr Younan, believing that he told him he could increase his dosage of d*oxepin* to 300mg daily.

The phone calls of Dr Le and Ms. Lai to Dr Younan

In the following days Mr. Liu had separate conversations with his main GP Dr Le and with psychologist Ms. Lai. Mr. Liu told each of them that Dr Younan had approved him to take large amounts of doxepin.

Firstly, in a consultation with Dr Le on 16 April 2018, Mr. Liu said he had taken up to 12 tablets of doxepin 25mg for his insomnia, on Dr Younan's advice. This would amount to 300mg of doxepin daily, the precise amount Dr Younan had told him he could take of quetiapine.

Dr Le was worried when he heard this. During the consultation he decided to ring Dr Younan to clarify Mr. Liu's prescribed dosage of doxepin. Dr Younan had no independent recollection of this phone call from Dr Le. Nor did he make a written record of it.

However, Dr Le did make a contemporaneous note of the conversation. He recorded that he [Dr Le] '*called Dr Younan and being advised to be able to take up to 300mg…'* From this Dr Le concluded that in the opinion of Mr. Liu's specialist psychiatrist, Mr. Liu *was* able to take up to 300mg of doxepin daily. Despite this Dr Le counselled Mr. Liu to reduce his nightly dosage of doxepin to the equivalent of 200mg.

At the inquest Dr Younan denied that he would have given such advice to Dr Le. He could only assume, he said, that he had thought Dr Le was asking him about the dosage of q*uetiapine* he had prescribed for Mr. Liu.

Two days later on 18 April 2018, Ms. Lai was making a home visit to Mr. Liu. Mr. Liu told her too that he had increased his doxepin medication, having taken 8 tablets on 13 April 2018, 10 tablets on 14 April 2018, and 12 tablets on 15 April 2018 (a total of 750mg over those three days). He told her further, that Dr Younan had said he could take '*plenty*' doxepin.

Like Dr Le, Ms. Lai was worried to hear this. She rang Dr Younan and told him Mr. Liu had taken up to 12 tablets of doxepin on 15 April 2018. Dr Younan informed her that Mr. Liu's correct dose of doxepin was a maximum of *2 tablets* daily, equivalent to 50mg. In Mandarin, Ms. Lai passed this information on to Mr. Liu.

As with his conversation with Dr Le, Dr Younan did not document this conversation with Ms. Lai. Ms. Lai told the court that Dr Younan had not expressed to her any concern about the very large amounts of doxepin Mr. Liu had reportedly taken, or its potential interactions with his other medications.

At the inquest Dr Younan expressed confidence that in his phone conversation with Mr. Liu on 13 April 2018, Mr. Liu had understood that his advice about '*up to 300mg daily'* referred to the medication quetiapine, and not doxepin. However, the evidence described above does not bear out this assumption. I accept that Dr Younan did not *intend* to convey either to Mr. Liu or Dr Le, that Mr. Liu was able to take up to 300mg daily of doxepin. It does appear however that language difficulties resulted in a significant miscommunication taking place, certainly between Dr Younan and Dr Le, and possibly between Dr Younan and Mr. Liu.

I say '*possibly*' in the latter case because I accept it cannot be excluded that Mr. Liu did understand what Dr Younan was saying but chose for his own reasons to exceed his dosage of doxepin.

These aspects of Dr Younan's involvement in Mr. Liu's care warranted further examination and resulted in a further supplementary statement from Dr Younan regarding certain changes he had made in his practice. This is discussed later in these findings at [98]–[100].

Ms. Lai's home visit on 18 April 2018

In the days leading up to his death Mr. Liu's mental state deteriorated very significantly, in particular on 17 and 18 April 2018.

For this reason, the inquest examined whether it would have been appropriate for him to have been involuntarily admitted and detained under the MH Act. There was an opportunity for this to have happened. On the afternoon of 18 April 2018, Mr. Liu's case manager Ms. Lai came to his home to assess him.

The reason for Ms. Lai's visit was that on the morning of 18 April 2018, Mr. Liu's mother Ms. Ling had rung her with concerns about her own safety. Ms. Ling told Ms. Lai that the previous day Mr. Liu had rung his brother Henry and frantically asked him to '*come and save us'*. He believed cameras were monitoring him. He thought his father was God and that he himself was Jesus. He had trashed a book which he believed came from Satan and had thoughts of hitting the rubbish bin with a hammer but had decided not to. He was restless, agitated, and had been crying and distressed at the thought of being left alone.

Significantly, Mr. Liu had also been irritated with his mother and had poured water over her head to punish her for not listening to '*his instruction'*. In addition, he had threatened to hit her on the head with a phone handset but had resisted that urge. Instead he had sprayed her with some perfume. Poignantly, this gesture was intended to express his remorse for having poured water over her.

In response to Ms. Ling's call Ms. Lai attended on the afternoon of 18 April 2018 and spent almost three hours with Mr. Liu and his mother. She observed that Mr. Liu was less well-groomed than usual. She heard Mr. Liu and his mother describe the bizarre and unusual behaviour outlined above. She heard further from Mr. Liu that he had '*a big mission to stop the war and save the world'.* He repeated his fears that when his parents died he would be alone and unable to cope.

Ms. Lai had to decide what action to take. She was concerned that Mr. Liu's symptoms had escalated and that he had behaved in a bizarre and aggressive way the previous day. She realised that some symptoms of psychosis were persisting on 18 April 2018.

However, she took comfort from the fact that Mr. Liu was not currently displaying agitation, was expressing remorse for his previous aggressive impulses towards his mother and had acted upon them in a very limited way. She also felt reassured when Mr. Liu said he had no thoughts of harming himself or his mother, and that he would comply with his medication dosages. Ms. Lai concluded that Mr. Liu did not pose a risk to his own or his mother's safety. She decided that the grounds did not exist for him to be psychiatrically assessed against his will. Ms. Lai did however offer to take Mr. Liu straight away to the emergency department for a psychiatric assessment. But Mr. Liu did not want to go to hospital. He agreed to have an early appointment the following week with the psychiatric registrar at the CMHS, which she would attend with him.

They arranged that Ms. Lai would call him the following day to check on his condition. The question whether it would have been more appropriate for Ms. Lai to have sought involuntary admission for Mr. Liu that day is discussed later in these findings.

The police response

Ms. Lai left Mr. Liu's apartment at about 4.00pm that afternoon. In the following hours Mr. Liu became increasingly unwell. Ms. Ling said he was very tired, but he would not go to bed. Around 9.00pm she encouraged him once again to get some sleep, but he became angry and threw a cup of water at her. He then put his hands around her throat and started to choke her while, as she described it, '*staring directly into my eyes'*. Scared that he would kill her, she pushed him away and ran to a neighbour's apartment on the level below.

Mr. Timothy Wu and his parents lived in this apartment. Mr. Wu described Ms. Ling running in and saying, '*My son has gone crazy'*. Mr. Wu rang '000'. In the meantime, he could hear Mr. Liu upstairs, yelling in another language and banging on apartment doors. Neighbours described him pacing back and forth along the corridor, throwing his arms around, and trying to pull off the screen door to unit number 34, the apartment next door to his own. They had never seen Mr. Liu behave like this before.

The occupant of number 34 also rang police, and her '000' call was played in court. Loud banging noises can be heard in the background and her voice is clearly frightened as she speaks to the operator. When scene photos were taken shortly afterwards, they showed a large amount of blood on her screen door and on the wall nearby. The door handle was broken off, later to be found on the floor. Also found on the floor was the tip of Mr. Liu's right index finger. It appears that during this episode part of his finger had become severed – an indication of how extremely unwell he was.

Police officers arrived at the scene very shortly after 9.00pm. Leading the police response was Sergeant Mark Paulo. After obtaining some information from Ms. Ling, Sergeant Paulo and his fellow officers went out to the landing of level two. They could see Mr. Liu pacing in the hallway above, mumbling words, speaking fast in another language, and making praying signals. Sergeant Paulo called out to Mr. Liu, asking him '*Are you alright? What's wrong*?' Mr. Liu did not answer.

In their directed interviews Sergeant Paulo and Constable Brittany Lotter described Mr. Liu as '*zombie-like'* in his appearance. He seemed to be oblivious to their presence. They saw that he had blood over his face, hands, and shirt. Another of the police officers said he seemed '*very dazed and out of it and was muttering incoherently'.*

While Sergeant Paulo was calling out to him Mr. Liu started to come down the stairs. When he was only a few stairs from the bottom he suddenly fell onto the landing where the police officers stood. Almost all the witnesses perceived this as the result of a trip or a faint, rather than a deliberate action. After falling, Mr. Liu was described by police and neighbours as still shouting and throwing his arms about. He was placed on the floor and handcuffed with his arms behind his back. Noting his wounded index finger and the blood on his hands and face, police officers called an ambulance.

Thereafter Mr. Liu's agitation levels fluctuated between episodes of shouting and trying to get up and lying in a calmer state. This is attested to by the evidence of the neighbours as well as that of the involved police officers.

At the times when Mr. Liu was highly agitated Sergeant Paulo put him face down into the prone position, returning him to his side once he had calmed. Sergeant Paulo was aware of the dangers of positional asphyxia, having received training in this area. In his statement he said he wished to minimise the risk by keeping Mr. Liu on his side whenever possible. On the occasions when Mr. Liu was placed in the prone position Sergeant Paulo checked that he was breathing and that his mouth was not pressed into the ground.

When ambulance paramedics arrived, they found Mr. Liu lying prone and handcuffed, with police officers standing around him. They were not physically restraining him. Mr. Liu was described as '*agitated'*, moving around, and making incomprehensible sounds.

About three minutes after the arrival of the paramedics Mr. Liu went into cardiac arrest. His handcuffs were immediately removed, he was placed on his back, and cardiopulmonary resuscitation began. Paramedics were able to get his heart beating; however, while he was being moved into the ambulance he went into cardiac arrest once again.

Resuscitation efforts continued on the trip to St George Hospital. However, on arrival there Mr. Liu was still in a state of cardiac arrest, with pulseless electrical activity. Shortly afterwards he was pronounced deceased.

I turn now to examine the issues of the inquest.

Would involuntary admission have been appropriate on 18 April 2018?

Specialist forensic psychiatrist Dr Kerri Eagle was asked to provide her expert opinion as to whether on 18 April 2018 Mr. Liu would have met the definition of a person who was mentally ill for the purposes of the MH Act; and if so whether any other and less intrusive manner of meeting his treatment needs was available or appropriate. Dr Eagle acknowledged that as Mr. Liu's long-term case manager Ms. Lai was in a difficult position, when faced with his refusal to voluntarily attend hospital. She also acknowledged that it is nearly always easier in hindsight to assess the risks of such a situation – an acknowledgement which I fully endorse.

Having reviewed the evidence Dr Eagle concluded that on 18 April 2018 Mr. Liu did meet the definition of a person who was mentally ill under the MH Act. In her opinion, the risk he posed to himself and to his mother that day strongly indicated that he needed *immediate* assessment by a psychiatrist or psychiatric registrar. It was not appropriate to wait a further week for the next available date.

Dr Eagle based her opinion on the following factors:

- Mr. Liu's unauthorised overdosing of his medication and its potential effect on his mental and physical condition
- the deterioration of his mental state over a short period of time
- that he was suffering delusions which had caused him to act in an aggressive way
- that his mother felt afraid for her safety.

In reaching this conclusion Dr Eagle placed less weight on a factor which had reassured Ms. Lai: namely that on 18 April 2018 Mr. Liu was not displaying the bizarre and aggressive behaviour of the previous day. Dr Eagle commented that the behaviour of a person who is severely mentally ill can fluctuate over a period of hours and days. Minor precipitants could escalate their condition, making them feel unsafe and causing them to act on their delusions. In her view, the behaviour Mr. Liu had exhibited the previous day ought to have been seen as a warning sign that he was severely ill.

I accept Dr Eagle's opinion that Ms. Lai's judgement erred in reaching the conclusion she did. Her treatment plan was not an appropriate one given the risk which Mr. Liu's deteriorating mental health presented to himself and to others. At the least, and as Ms. Lai herself acknowledged, this was a difficult assessment which warranted discussion with her supervising manager. This was also acknowledged in submissions on behalf of the relevant Local Health District, which noted that in the case of complex or unusual clinical situations there was an expectation that Ms. Lai would escalate issues to her team leader or Senior Clinician.

However, it would not be appropriate to be critical of Ms. Lai. There is no doubt that the decision whether to escalate a person into an involuntary assessment can be a finely balanced one. In addition, there were, as Ms. Lai stated, previous occasions where Mr. Liu had expressed thoughts of harming others but had not acted on them. It can be accepted that on 18 April 2018 Ms. Lai made the decision that she believed was the appropriate one in the circumstances.

At the inquest Ms. Lai made two appropriate concessions. First, she said she wished that at the time, she had discussed with a more senior team leader whether her proposed management plan was the appropriate one. Secondly she said that she wished she had spoken to Ms. Ling alone about whether she felt the proposed plan was sufficient to protect herself and her son.

It cannot be known if Mr. Liu's death would have been averted had Ms. Lai taken these steps. It is also important to note that Ms. Lai impressed as a caring mental health clinician and case manager who genuinely wanted to help Mr. Liu. She had been his case manager for almost two years. He was not an easy client to help. There must have many times when she felt discouraged at her inability to influence him to make changes which would have made him healthier and happier.

Was the police response appropriate?

The second issue was whether the police response to Mr. Liu's situation, in particular the decision to physically restrain him, was appropriate. This issue arose as a result of Dr Irvine's evidence (and as will be seen, that of other medical experts at the inquest) that the physiological effect of being restrained was likely to have been one of the contributors to his death.

In determining whether a person needs to be restrained, a police officer is required to assess the level of resistance given and use the level of force that in his or her assessment is necessary to control the situation.

Mr. Liu had acted violently toward his mother, had apparently tried to break into another apartment, was shouting and behaving erratically, and had harmed himself. I accept that the circumstances required that he be restrained, in the interests of his own safety and that of others.

There is no evidence that the actions used to restrain Mr. Liu were unjustified, or that they breached any NSW Police Force policies or guidelines which applied.

Can the cause of Mr. Liu's death be established?

In determining whether the cause of Mr. Liu's death could be ascertained, the inquest was assisted with the evidence of:

- Professor Alison Jones, clinical toxicologist, Director of Medical Education at Fiona Stanley and Fremantle Hospitals Group, Western Australia.
- Associate Professor Mark Adams, cardiologist, Head of Department of Cardiology at Royal Prince Alfred Hospital Sydney.

In her report dated 27 August 2019 Professor Jones opined that a significant factor in Mr. Liu's death was the effect of his combined doses of venlafaxine and doxepin:

'*In combination venlafaxine and doxepin were much more likely to cause death than either drug alone at the concentrations found in Mr Liu's post mortem blood sample'.*

The concentrations to which Professor Jones referred were those of doxepin found in the toxic but not fatal range, and of venlafaxine at the lower end of the toxic level. Professor Jones was confident that in order to produce these levels at the time of the autopsy (some 34 hours after his death); Mr. Liu must have taken *additional* doses of each medication after Ms. Lai left at around 4.00pm on 18 April 2018.

The court heard that there is a known risk that these two medications when taken in combination can produce fatal cardiac arrhythmias. This is due to their potential effect of causing abnormal heart rhythms, greatly increasing the risk of developing fatal arrhythmias. A/Professor Adams agreed with Professor Jones that that this was a known risk associated with the combination of doxepin and venlafaxine, and further that the risk increased with higher doses of doxepin.

Both experts agreed that the risk for Mr. Liu of fatal cardiac arrhythmia was increased when coupled with the high levels of agitation which he experienced that night. A/Professor Adams added that those who suffer schizophrenia are also at higher risk of adverse cardiac events at times of high physical or emotional stress.

The expert medical evidence identified an additional but related mechanism by which Mr. Liu may have suffered a fatal arrythmia, namely the condition of ACM. This condition increases a person's risk for fatal arrhythmia and cardiac death. A/Professor Adams explained that ACM causes loss of cardiac muscle cells and infiltration of the heart muscle with fatty and fibrous tissue.

These features were noted at Mr. Liu's autopsy examination. The condition is usually asymptomatic and only diagnosed in the event of heart failure and/or sudden cardiac death. For this reason, A/Professor Adams did not consider that the condition, if present in Mr. Liu, could reasonably have been detected by his treating doctors. I accept his evidence on this point.

As to arriving at a cause for Mr. Liu's death, both experts agreed that it was not possible to unravel the relative contribution of each of the above causal factors.

I conclude on the basis of the evidence that the cause of death remains unascertained, as recorded by pathologist Dr Irvine.

Was it appropriate for Mr. Liu's doctors to have prescribed doxepin in combination with venlafaxine?

The toxicological evidence raises the question whether it was appropriate for Dr Le and Dr Younan to have prescribed doxepin in circumstances where Mr. Liu would be taking it in combination with venlafaxine.

On this issue the court heard evidence from Dr Eagle and from Professor Matthew Large, who provided a report to the inquest at the request of Dr Younan. Professor Large is a Conjoint Professor in the School of Psychiatry at UNSW, and Clinical Director of Mental Health in the Eastern Suburbs Mental Health Service. It is important to note that a combination of doxepin and venlafaxine is not contraindicated either on the MIMS database or in the 'Best Practice' software which was used by Mr. Liu's GP, Dr Le. However, in her report Dr Eagle expressed the view that use of these drugs in combination would generally be avoided by psychiatrists. This was due to their known association with cardiac complications and serotonin syndrome.

However, in the opinion of Professor Large, '*when done cautiously and in lower doses [it] can be safe and effective'* (at page 26 of his report). Professor Large noted that Dr Younan had correctly identified Mr. Liu's reliance on benzodiazepines.

Therefore, in order to treat his insomnia Mr. Liu required a sedative that did not come from this class of drugs. One of the few choices available was the sedating antidepressant doxepin. In Professor Large'sview:

'… there was nothing particularly unusual about prescribing Doxepin at a dose of 50mg a night to a patient such as Mr Liu with insomnia, benzodiazepine use and concurrent prescribing of a non-sedating antidepressant [venlafaxine]'.

In Professor Large's opinion however, given the language barrier Dr Younan ought not to have given pharmacological advice to Mr. Liu in their phone conversation on 13 April 2018. He noted the possibility that Mr. Liu had received the impression that he was able to take up to 300mg daily of doxepin. Professor Large observed further, that if on 18 April 2018 Dr Younan had been told by Ms. Lai that Mr. Liu had taken large amounts of doxepin, Dr Younan ought to have taken steps to ensure Mr. Liu went to hospital to have an ECG and be monitored for cardiac toxicity. The evidence does not enable me to find that it was inappropriate for Dr Le or Dr Younan to have prescribed doxepin for Mr. Liu in combination with venlafaxine. However, the above concerns expressed by Professor Large warranted a response by Dr Younan as to whether his practices in these areas had changed.

Response from Dr Younan

Dr Younan provided a supplementary statement responding to the concerns expressed by Professor Large. In his statement Dr Younan said that he was aware that the combination of doxepin at a daily dose of 300mg and venlafaxine at a daily dose of 300mg had the potential to cause serotonin syndrome and cardiac toxicity. He stated that if a patient advised him that they had been taking these medications in these doses, he would:

- tell the patient to attend the emergency department for physical examination, ECG, and monitoring
- verify the patient had understood this by asking them to repeat back to him those instructions. If the patient could not clearly repeat the instructions due to language difficulties he would arrange an urgent telephone interpreter
- ring the emergency department to advise them to expect the patient and to confirm that the patient had attended
- ring the community mental health team (if involved) to make them aware of this development
- arrange an urgent appointment to review the patient after the hospital attendance
- document these conversations and actions.

The contents of Dr Younan's supplementary statement indicate an appropriate consideration of the matters raised by Professor Large in his report. It can be concluded that Dr Younan has recognised the importance of ensuring that a patient in Mr. Liu's situation clearly understands advice regarding medication, in particular when it is given over the phone. Similarly, it can be accepted that Dr Younan understands the need for action in the event that a patient appears to have taken excessive amounts of doxepin in combination with venlafaxine.

The issue of medication overuse

The final issue for consideration was whether there was a basis for any recommendations arising out of Mr. Liu's access to prescription medication. In his last 16 months Mr. Liu filled large numbers of prescriptions for risperidone, quetiapine, doxepin, and various benzodiazepines.

None of the clinicians whom Mr. Liu attended were aware of the full picture regarding his access to prescription medication. Those like Dr Wu who had some awareness of it were concerned and tried with limited success to ensure he was monitored within a stable treating team. Mr. Liu's ability to access harmful amounts of medication raised the question whether there are measures to assist doctors to make safe prescribing decisions, in particular where they are concerned that a patient may be misusing prescription drugs. The issue of medication overuse is one of pressing public health importance. The associated harm and loss of life is illustrated in a Consultation Paper recently issued by the NSW Department of Health:

'In 2018 there were 1556 unintentional (and therefore avoidable) drug-induced deaths in Australia. 457 (29%) of unintentional drug-induced deaths involved pharmaceutical opioids; and 648 (42%) involved benzodiazepines.'

Coroners receive heartbreaking letters from parents, partners, and friends of people whose deaths are associated with the overuse of prescription drugs. Those left behind cannot understand why there appears to be no system to alert prescribing doctors to their relative's plight. They implore coroners to do what can be done to help keep their loved ones safe. In a succession of inquests, coroners have urged the implementation of a real time prescription monitoring system, to reduce the harm associated with misuse of medications. In NSW, examples include the 2018 *Inquest into the death of Alissa Campbell*, Deputy State Coroner H Grahame: and the 2014 *Inquest into the deaths of Christopher Salib, Nathan Attard and Shamsad Aktar,* Deputy State Coroner C Forbes.

At the time of Mr. Liu's death, the Commonwealth's Prescription Shopping Information Service [the PSIS] was in operation. This is a phone service which prescribers can use to check on a patient's prescribing history. It is important to note however that in the six months prior to his death, Mr. Liu did not meet the criteria to be flagged as a 'Prescription Shopper' under this scheme, a fact noted by his GP Dr Le. The criteria are strictly limited and during this period the number of Mr. Liu's visits to different doctors, while significant, did not meet them. The PSIS is also restricted by its operation as a phone-in service, limiting its capacity to provide timely information to busy practitioners.

The NSW Real Time Prescription Monitoring scheme

After many years however it appears that a real time prescription monitoring system will finally become available in NSW. In this inquest the court sought advice from the NSW Ministry of Health about the implementation of this scheme. Real Time Prescription Monitoring [RTPM] is a national digital health system established by the Commonwealth Government. Its national database captures information about the prescribing and supply of controlled medications to individual patients. NSW has now built its own RTPM database to connect with the national one. According to the Consultation Paper referred to above at [104], the NSW RTPM database will capture information at the point at which a patient is prescribed or supplied with monitored medicines. It will record the patient's name, address, the name and quantity of the medication, and details of the prescriber and pharmacy. Prescribers and pharmacists will be able to view this history, without the patient's express permission. Nor is a patient able to 'opt out' of this system. The specific medications to be monitored under the NSW RTPM scheme will likely include all Schedule 8 substances (including opioids and psychostimulants), all benzodiazepines when included in either Schedule 8 or Schedule 4, and certain other medications including quetiapine.

There will be scope for further medications to be added as needed. As for when the RTPM scheme will begin operating in NSW, the advice given to the inquest was that a 'staged roll out' is expected to commence in July 2021. In evidence was a letter dated 11 February 2021 from the Ministry's Legal and Regulatory Services, providing this advice. It is most welcome to hear that, after many years of expressed commitment, the NSW Department of Health is close to implementing this sensible scheme. The issue of medication overuse is undoubtedly a complex one, but the scheme has an important part to play in reducing the harms of a very significant problem.

This welcome news obviates the need for me to make a recommendation urging the implementation of the RTPM scheme.

Findings required by s. 81(1)

As a result of considering all of the documentary evidence and the oral evidence heard at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

Identity

The person who died is Zhong Liu.

Date of death:

Zhong Liu died on 18 April 2018.

Place of death:

Zhong Liu died at St George Hospital, Kogarah NSW.

Cause of death:

The cause of Zhong Liu's death is unable to be ascertained. A number of contributing factors were identified, whose respective contributions could not be quantified.

Manner of death:

Zhong Liu died in the course of a police operation, while he was suffering a mental health episode.

13. 150097 of 2018

Inquest into the death of Samih Zraika. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 4th August 2021.

This is an inquest into the very sad death of Mr Samih Zraika who died on 11 May 2018 while in NSW Police Force (NSWPF) custody at Mt Druitt Police Station. He was only 29 years of age.

- The role of a Coroner as set out in s.81 of the *Coroners Act 2009* (NSW) (the Act) is to make findings as to:

- the identity of the deceased.
- the date and place of the person's death.
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

The Act also requires a Senior Coroner to conduct an inquest where the death appears to have occurred "*while in the custody of a police officer*" (s.23(1)(a), s.27(1)(b)).

"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."

This Inquest has been an independent judicial inquiry into how Mr Zraika's death came about. It has been a close examination of the police actions on the morning of his death and in accordance with s.37 of the Act a summary of the details of this case will be reported to Parliament.

Samih Zraika

Mr Zraika was one of seven brothers. One of his brothers, Ali, sadly passed away in 2007 from leukaemia. His parents were too emotionally fragile to attend this inquest as they are bereft at the loss of yet another son.

The presence throughout the inquest of all five of Mr Zraika's surviving brothers and their close attention to the evidence is testament both to the regard in which they held their brother and their desire to see whether something can be learned from his death.

Mr Zraika was described by his family as being a tender, loving, funny, gentle giant. He was clearly a much-loved member of a large extended family who all miss his affection and his sense of fun; they miss his contagious laugh and the care he gave to each of them.

I offer my sincere condolences to all of Mr Zraika's family.

Medical Background

Mr Zraika had an extensive medical history. He was being treated for:

Drug induced Myocarditis (an inflammation of the heart muscle that reduces the heart's ability to pump and can cause rapid or abnormal heart rhythms),

Dilated Cardiomyopathy (an enlargement of the heart that reduces its ability to pump blood efficiently),

- Inflammatory Bowel Disease (IBD),
- Anxiety,
- Lactose intolerance, and
- High blood cholesterol.
- He was prescribed the following medications:
- Bisoprolol (a beta-blocker known to prolong the life of patients with cardiomyopathy),
- Coversyl (used in the treatment of hypertension and heart failure),
- Magmin,
- Mesalazine (for IBD),
- Nexium,
- Lipitor (to lower cholesterol), and
- Lovan (an anti-depressant).

In the six months prior to his death Mr Zraika had multiple admissions to hospital and reviews by doctors, including: On 10 December 2017 he was admitted to Blacktown Hospital under the care of the toxicology team due to MDMA and cocaine use.

On 13 December 2017 he was again admitted to Blacktown Hospital and diagnosed with urosepsis, dilated cardiomyopathy, haematuria and acute kidney injury. He was commenced on bisoprolol (Bicor) and perindopril (coversyl), referred to a cardiologist, and discharged on 18 December 2017.

On 21 December 2017 he was reviewed by Dr Fred Nasser, cardiologist. Dr Nasser formed the impression that Mr Zraika had probable drug induced myocarditis from exposure to both cocaine and amphetamines. His bisoprolol medication was doubled from 2.5mg to 5mg daily.

On 21 February 2018 he was reviewed by Dr Nasser and assessed as clinically stable from a cardiovascular perspective. There was a plan for further review in 3 months.

On 29 March 2018 he presented to Blacktown Hospital. He left shortly afterwards and was located outside Blacktown Police Station approximately an hour later in an agitated state. He remained in and around the station for a period of over an hour during which time he was managed by a number of police officers and an ambulance crew before transfer back to Blacktown Hospital. At the Hospital he tested positive for cocaine use and he remained under care at the hospital for his heart condition until discharge on 3 April 2018. The discharge document shows a diagnosis of drug induced myocarditis and a plan for review by a cardiologist in four weeks.

Events of 11 May 2018

On 10 May 2018 Mr Zraika was at his home watching a football game on television. His partner, Ms Mercedi Cooper, arrived home at 11.50pm after finishing work. Ms Cooper gave evidence that they drank some alcohol and that Mr Zraika also took cocaine. During the course of the night an argument erupted, and Ms Cooper left the house at around 5.00am on 11 May 2018 due to concerns about his physical conduct towards her. It is probable that Mr Zraika continued to consume further cocaine between 5.00am and prior to his arrest at 11.50am given the high level of cocaine in his system found at autopsy.

Ms Cooper states that she returned to the house at about 8.00am to collect her car keys and mobile phone. At this point she says Mr Zraika was "barricading" himself inside the house by putting objects in front of the doorway. She was unable to retrieve her property and contacted the police for assistance. Ms Cooper made three calls to "000". On the third call to "000", at around 11.40am, she sounded distressed. She stated that Mr Zraika had chased her down the road. Available CCTV evidence supports that Mr Zraika had ran after her down the street. She said she sought refuge by hiding behind some garbage bins at a nearby property.

At 11.50am Acting Sergeant David Tazzyman and Probationary Constable Bradley Jackson attended and detained Mr Zraika. At about 12 noon he was placed in a caged police van and taken to Mt Druitt Police Station Constable Bianca Peacock also attended and she remained at the scene and obtained a Domestic Violence Evidence in Chief (DVEC) statement from Ms Cooper.

Events following Mr Zraika's arrest

Mr Zraika exited from the police van at Mt Druitt Police Station at 12.09pm. He was placed into one of the docks in the charge room where he remained for the following 26 minutes. The CCTV footage shows that while he was in the dock, he was given a cup of water on three occasions. He can also be observed wiping his face with his shirt and hands. Police gave evidence that he was sweating.

At about 12.10pm, while Mr Zraika was still sitting in the dock, Acting Sergeant Tazzyman can be seen on the CCTV footage jotting down details on a post it note while he spoke to Mr Zraika. Acting Sergeant Tazzyman gave evidence that Mr Zraika told him that he:

"...was on a number of medications for various conditions that he had. One of them was a medicine called Baycol (sic) or something similar to that. I asked him what that was for, he said it was for a heart condition. He named the heart condition, but I can't remember what he said. He gave it a medical term and then told me that his heart could stop beating and that medication was to stop that. I asked him how many times he took that medication and he's told me daily. And I said, is it morning or at night? He told me that he takes it in the morning. I asked him if he'd taken it this morning and he said that he hadn't."

At about 12.15pm the door of the dock was left open for Mr Zraika as he informed Constable Jackson that he was claustrophobic or anxious with the door closed.

At 12.22pm Acting Sergeant Tazzyman sent a text to Constable Peacock:
"Can you get some of old mate's medication? It's called Bicor or similar. It's to stop his heart from stopping. Give us a ring before you leave the house please".

Constable Jackson gave evidence that he heard Acting Sergeant Tazzyman tell Sergeant Kim Duncombe, the custody manager:

"He's prone to heart attacks … I guess random heart attacks … heart attacks with no … indication."

At 12.23pm, Constable Peacock rang Acting Sergeant Tazzyman and informed him she could not gain access to the house to obtain the medication as it was locked and that the keys were with Mr Zraika's possessions at Mt Druitt Police Station. Acting Sergeant Tazzyman discussed this situation with Sergeant Duncombe and it was decided that they would see if Mr Zraika would get bail before further arrangements were made to obtain his medication. At around 12.30pm, Sergeant Duncombe spoke with Mr Zraika about his medication. She gave evidence that she asked him how he was feeling and to let her know if he needed the medication. She gave evidence that he said he was okay. She then went on her lunch break and Leading Senior Constable Matthew Glynn relieved her as custody manager.

At 12.35pm Leading Senior Constable Glynn released Mr Zraika from the dock to the custody desk so that he could formally process his reception into custody. Leading Senior Constable Glynn gave evidence that, on noticing that Mr Zraika was fidgety, he asked Mr Zraika if he was feeling "alright" to which Mr Zraika replied by saying "yes". Leading Senior Constable Glynn gave evidence that he asked Mr Zraika a second time if he was feeling ok and that Mr Zraika let him know if he is not feeling ok, to which Mr Zraika replied by saying "Yes, I'm fine". Leading Senior Constable Glynn also said to Mr Zraika that he knew he had medical conditions and that it was important to let him know if he was not feeling ok. Leading Senior Constable Glynn let Mr Zraika know that he could arrange medical treatment right away. Mr Zraika said again that he was fine.

Leading Senior Constable Glynn checked with Mr Zraika yet another time to see if he was sure that he was ok. Mr Zraika then said that he didn't feel good and that "everything is rocking". Leading Senior Constable Glynn immediately requested for "000" to be called. Leading Senior Constable Glynn then opened a holding cell that had a mattress in it where Mr Zraika could potentially lie down. Upon entry into the holding cell just after 12.38pm, Mr Zraika's condition rapidly deteriorated.

Leading Senior Constable Glynn assisted Mr Zraika to lie down and placed him in the recovery position a number of times. During this period Mr Zraika stated that he had consumed a large quantity of cocaine. Over the following few minutes Mr Zraika had three seizures lasting between 15 and 5 seconds. This made providing assistance to him challenging, although after the third seizure, officers were able to place Mr Zraika onto the floor of the cell and commence CPR at 12.45pm. A defibrillator was obtained and utilised at 12.47pm. Ambulance officers arrived at 12.50pm and worked on Mr Zraika while police officers-maintained CPR until such time as Mr Zraika was pronounced dead.

Cause of death

The forensic pathologist's report found that Mr Zraika had died from Acute Cocaine Toxicity, with other significant contributing causes being Chronic Coronary Artery Disease and cardiomegaly, a large heart.

Associate Professor Mark Adams, Cardiologist and head of Cardiology at Royal Prince Alfred Hospital, provided an independent expert review of the cause and circumstances of Mr Zraika's death. He reviewed Mr Zraika's medical history and concluded that Mr Zraika had cardiomyopathy, likely due to chronic cocaine use, and confirmed that Mr Zraika was receiving the appropriate treatment with the medication called Bicor. He concluded that the omission of a dose of Bicor on the day of the arrest would not have had any deleterious effect for Mr Zraika and that its administration would not likely to have changed the clinical outcome. He agreed with the forensic pathologist that the cause of Mr Zraika's death was cocaine toxicity.

Circumstances of death

All of the officers involved in Mr Zraika's arrest observed that he was sweating. This was evident at the time of his arrest, at the time of his entry to the police station, and during the period that he was in the dock. A viewing of the CCTV footage reveals a number of occasions, when it is apparent that Mr Zraika is using his shirt or hands to wipe his head or face. Mr Zraika gave no verbal indication that he required medical assistance. There was no indication that Mr Zraika was unable to talk or walk coherently. Police gave evidence that in their opinion the sweating was readily explained by Mr Zraika having just been arrested in the course of chasing Ms Cooper, his weight, and the stress of being arrested. Further, Probationary Constable Jackson gave evidence that the sweating did not worsen in the time he interacted with Mr Zraika and that he was not sweating profusely. Associate Professor Adams viewed the CCTV footage of Mr Zraika entering the police station and sitting in the dock.

He did not observe anything that he thought was out of the ordinary or of concern. He gave the following evidence: "To my eye, he looked perfectly ok, certainly maybe a little agitated, I think I'd be more agitated if I was in that position". Clearly Mr Zraika's condition deteriorated rapidly once he exited the dock to go to the custody desk. Prior to this he had provided details of his medications and he was responsive to police conversation. While it may have been that Mr Zraika's physical condition was deteriorating I am satisfied that the police at Mt Druitt Police Station could not have known with the information they had that Mr Zraika was about to collapse from a cocaine overdose.

Had the police at Mt Druitt Police Station known that Mr Zraika had six weeks earlier been taken to Hospital by ambulance from Blacktown Police Station, that prior to his arrest he had consumed a large quantity of cocaine and that he had a serious heart condition that was made worse by cocaine ingestion, they may been in a better position to assess his need for medical attention.

At page 3 of his report Associate Professor Adams observed that:

"*Knowledge that he had known cardiomyopathy likely due to chronic cocaine and amphetamine use might have led to a suspicion that an adverse cardiac event might occur in the setting of having taken a large dose of cocaine."* The NSWPF Code of Practice for CRIME (Custody, Rights, Investigation, Management and Evidence) (now incorporated into the NSWPF Handbook) sets out the obligations of officers who are responsible for persons taken into police custody. It states:
"You have a duty of care to use the supportive resources provided by … medical health professionals to deter and prevent … an escalation of medical problems". *"The custody manager is to assess those in custody in a comprehensive manner and to consider whether there are any medical problems that need immediate attention"*. *"If a detained person has or claims to need medication for a heart condition … get a doctor's advice"*. *"Someone needing or addicted to drugs might experience harmful effects within a short time. Always call a doctor when in doubt."*; and *"If the person admits to having been treated for an illness or if you have any doubts about required medication or their health, seek medical advice as soon as possible. Maintain maximum observation of people who … have a history of heart disease …"*.

The more significant and relevant information about a detainee's history that the custody manager has at their disposal to make the important assessments they are required to make, the better. The custody manager at Mt Druitt Police Station could have had the following information. Six weeks prior to Mr Zraika's collapse at Mt Druitt Police Station he had been taken by ambulance from the foyer of Blacktown Police Station to Blacktown Hospital. He was accompanied in the ambulance by Constable Campbell Battye-Smith. He was treated for excessive cocaine use and his heart condition. This information was in Mr Zraika's COPS records.

Mr Zraika had a significant heart condition exacerbated by cocaine use that could result in his heart unpredictably stopping. Mr Zraika had ingested a large quantity of cocaine before he was taken into custody. (Constable Peacock had been informed of this by Ms Cooper while she was obtaining the DVEC statement but all of the officers at Mt Druitt Police Station said that they were not made aware.

While Constable Peacock gave evidence that she passed this information onto Acting Sergeant Tazzyman, he gave evidence that he did not recall that happening. In any event, it is not in dispute that the custody manager was not informed.

I note that having the above information may not have made a difference for Mr Zraika. Associate Professor Adams gave evidence that the only really useful intervention that could have occurred would have been cardiac assessment and monitoring. He said that in practical terms the best intervention was to call for an ambulance that might have been able to provide assessment of blood pressure and temperature as well as monitor for cardiac arrhythmias and provide transport to hospital. He concluded that even if the police had called an ambulance earlier it would have only increased Mr Zraika's chances of survival from around 0 to 12%.

While this is the case in Mr Zraika's circumstances, it is important to consider whether any lessons can be learnt from his death. In future, this extra information might have an impact on the outcome. This is particularly so bearing in mind that the factual matrix in other instances may encompass a range of circumstances where prospects of survivability might be much greater.

When the relevant parts of the Code of Practice for CRIME above at [38] were shown to both Acting Sergeant Tazzyman and Sergeant Duncombe, both indicated that they were not aware of those provisions. Both accepted that it would have been a good idea to seek medical advice in relation to Mr Zraika's heart condition given the uncertain circumstances in relation to his medication.

Sergeant Duncombe was asked how she might go about seeking such advice but was unclear as to how she might do this. The Code of Practice for CRIME twice refers to the police "Clinical Forensic Medicine Unit" as a place to contact. Sergeant Stuart Edgell, the Lead Educator for Safe Custody for NSWPF gave evidence that as of August 2020 this unit does not exist. He suggested that a local hospital would be the best place to call. The "Safe Custody: Medical Risks" poster developed by NSWPF in 2017 (Exhibit 4) advises that places to call in relation to medication are a local hospital, the NSW Poisons Information Centre, or the person's prescribing doctor. None of the officers at Mt Druitt Police Station asked Mr Zraika the name of his treating doctor nor made any attempt to obtain medical advice.

Both Sergeant Duncombe and Acting Sergeant Tazzyman were asked whether they had seen the NSWPF "Safe Custody: Medical Risks" poster. Initially neither officer indicated an awareness of such a poster, nor that there was such a poster displayed at Mt Druitt Police Station. When shown a copy of the poster, Sergeant Duncombe indicated that she thought she may have seen such a poster at the station at some point, though was unclear as to when and where, and indicated that she was not aware of its contents. The poster clearly reinforces, in concise form, relevant information for custody officers concerning medical conditions and drug issues in custody. It reminds officers of their duty of care and that this requires officers to continually assess the level of risk and to reasonably foresee what might happen if certain signs or symptoms exist. It states that any officer has the authority to call an ambulance at any time if they have concerns.

Further, it advises officers to be aware of a range of matters in relation to drugs and alcohol, including that a person might initially appear fit for custody, but later need urgent medical attention when the drugs and/or alcohol take full effect.

In the context of the management of a person in custody the information Constable Peacock had obtained was important and it was the sort of information that officers must be encouraged to be alert to and to pass on to custody managers. Officers Tazzyman, Jackson and Duncombe all agreed that this would have been important information for them to have in relation making assessments of Mr Zraika's health and management while in custody and would have been added reason to potentially seek medical advice or assistance. Further, Sergeant Edgell, the Safe Custody Educator, agreed that this was potentially important information that should have been passed on for evaluation by the custody manager.

Conclusion

It is not in dispute that the police had the power to arrest and detain Mr Zraika.

Mr Zraika was arrested at 11.50am. The CCTV footage at Mount Druitt Police Station shows him walking into the charge room from the police truck and engaging in conversation with the officers at the station. Despite the fact that he was sweating, the officers could not have known that he was about to collapse. He collapsed within three quarters of an hour of being arrested and within 40 minutes of arriving at the police station. Associate Professor Adams confirmed that a collapse from a cocaine overdose is random and sudden. The circumstances of Mr Zraika's death do, however, raise the possibility for changes to be made that may save lives in a similar situation in the future.

The police at Mount Druitt Police Station should have had access to medical advice as to whether it was necessary to obtain Mr Zraika's medication. While the relevant policy requires police to obtain for detainees their medication or get medical advice, there is no clarity on where they are to obtain the medical advice from. I have not heard detailed evidence in this inquest as to how this might best be addressed. The NSW Commissioner of Police (Commissioner) should consider resolving this issue. It seems unlikely that police would be able to ring the local hospital and be put through to a doctor for advice without some sort of standing arrangement. Clearly there are not always treating doctors or if one does exist, they may not be available at the time their advice is required. One possible solution may be the establishment of an on-call medical advice service for custody managers and other officers to contact. I propose to make a recommendation that the Commissioner clarify this matter.

The more relevant information the police have about a detainee the better position they are in to exercise their duty of care. It would have been useful information for the custody manager to know that Mr Zraika had been taken to hospital by ambulance from Blacktown Police Station only six weeks earlier for a similar collapse to the one he died of in custody at Mt Druitt Police Station. That was in his COPS records. The officers at Mt Druitt Police Station didn't read that entry. The Commissioner could consider whether a serious and acute collapse of this nature should be entered as an alert on the COPS system so that future custody managers are made aware of the very relevant history.

It is not in dispute that Constable Peacock had been informed Mr Zraika had taken large amounts of cocaine prior to his arrest and that this information should have been relayed to the custody manager. I propose to make a recommendation in that regard.

While I am satisfied that it is unlikely that Mr Zraika's death could have been prevented, even if the actions of the officers involved in his arrest and subsequent period of custody had been different; I am also satisfied that his death highlights possible areas for improvement in police policy and practice for consideration by the Commissioner.

Findings: s 81 *Coroners Act 2009*

I find that Samih Zraika died on 11 May 2018 at Mount Druitt Police Station, NSW. The cause of his death was acute cocaine toxicity, with another significant cause being dilated cardiomyopathy. He died while in a police holding cell as a result of his ingestion of cocaine prior to his arrest.

Recommendations: s. 82 *Coroners Act 2009*

To the NSW Commissioner of Police:

I recommend that relevant police guidelines including the NSWPF Handbook be amended to require that police officers who receive information suggesting that a person who they know to be in the custody of police has recently taken an illicit drug and is likely to be affected by that drug must ensure that they promptly relay that information to the responsible custody manager.

I recommend that the NSWPF Handbook and the NSWPF "Safe Custody: Medical risks" poster set out clearly where officers responsible for the custody of detainees are to obtain the medical advice they are required to seek.

14. 166031 of 2018

Inquest into the death of Dimitrios Mavris. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 19th February 2021.

On 23 May 2018 Mr Dimitrios Mavris was arrested by Australian Federal Police agents at Sydney International airport. He was subsequently charged with a drug importation offence and transferred to the Sydney Police Centre at Surry Hills. After being denied bail Mr Mavris was then transferred into the custody of Corrective Services New South Wales and held in a cell within the Surry Hills Cells Complex from the early hours of the morning on 24 May 2018. Mr Mavris remained in his cell for the remainder of 24 May 2018.

At around midday on 25 May 2018 Mr Mavris engaged in behaviour within his cell that was directed towards intentionally causing his own death. This behaviour involved fashioning a ligature from his clothing and a blanket and attempting to affix the ligature to potential anchor points within his cell.

At around 6:30pm on 25 May 2018 Mr Mavris placed the ligature around his neck and affixed it to the door frame of his cell. He became unresponsive several minutes later. At 6:37pm an alarm was raised with Corrective Services New South Wales officers. An emergency medical response was initiated but despite resuscitation attempts Mr Mavris could not be revived and was later pronounced life extinct. At the time of his death Mr Mavris had been in lawful custody for approximately 40 hours.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. When a person is charged with an alleged criminal offence or is sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be investigated in an objective manner. This is because a coronial investigation and an inquest seek to examine the circumstances surrounding that person's death in order to ensure, through an independent and transparent inquiry, that the State appropriately and adequately discharges its responsibility.

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

Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

Recognition of Mr. Mavris' life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore, it is extremely important to recognise and acknowledge Mr Mavris' life in a brief, but hopefully meaningful, way. Mr Mavris was born in Cyprus on 27 December 1969. He was married to his wife, DM, and together they had three children: AM, NM and CM. Mr Mavris previously worked as a mechanic for many years. However, he later operated a scaffolding business, and became involved in property development and other entrepreneurial activities.

Mr Mavris was known for his selfless qualities, always choosing to see the good in people, being extraordinarily generous with his time, and making himself available to anyone in need regardless of whether he knew them or not. DM describes her husband as being the type of man who would give the shirt off his back to anyone that needed it. Mr Mavris had a remarkable and caring attitude towards children. DM fondly recalls that children were drawn to Mr Mavris because of his down-to-earth nature and the wonderment they found in the magic tricks that he would perform for them. However, it is abundantly clear that, apart from his wife, the most loving and special relationships that Mr Mavris enjoyed was with his own children. At the conclusion of the evidence in the inquest Mr Mavris' children honoured those present in court by sharing some private and treasured memories of their father. Their words were truly heartbreaking to hear. Each of Mr Mavris' children spoke of their adoration for their father, his kindness, his generosity, his gentle and non-judgemental nature and his inherent ability to make others laugh and feel at ease. Each of Mr Mavris' children also spoke of the milestones in life that they will now forever be denied from sharing with their father: learning how to drive, graduating from university, getting married, buying their first home and introducing their children to their grandfather.

Whilst it is not possible to quantify how much Mr Mavris is missed by his family, the many people that attended his funeral to mourn his passing is indicative of the high regard in which he was held by those closest to him. There can be no doubt that Mr Mavris' passing has been devastating for his wife, children and loved ones. It is equally distressing to know that Mr Mavris' family have been made to endure enormous grief and trauma amidst the media scrutiny associated with his passing.

Background to the events of May 2018

On 23 March 2018 two shipping containers of frozen fish were imported from Peru, via Columbia, to Australia. The containers were consigned to Mazzo Investments Pty Ltd, a company which did not exist. However, a company by the name of Mazzco Investments Pty Ltd was, at the time, registered with the Australian Securities Investment Commission, with Mr Mavris listed as the sole director, secretary and shareholder of the company. Upon arrival in Australia, the shipping containers were inspected by the Australian Border Force. When the shipping containers were subjected to x-ray examination a number of anomalies were identified. The containers were subsequently searched and found to contain 30 blocks of cocaine in one container, and 29 blocks of cocaine in the other. Each block of cocaine weighed approximately one kilogram, meaning that a total of approximately 59 kilograms of cocaine was located in the two shipping containers.

The cocaine was subsequently removed from the shipping containers and the Australian Federal Police (**AFP**) arranged for a controlled delivery of the containers, under both physical and electronic surveillance. This surveillance indicated that Mr Mavris inspected the containers several times, observing that the cocaine had not been secreted in the containers as anticipated. On 13 May 2018 Mr Mavris travelled to Bogota, Colombia. The AFP considered this trip to be for the purpose of Mr Mavris meeting with unidentified members of a drug syndicate in order to discuss the importation of the cocaine.

What happened on 23 May 2018?

At 5:50pm on 23 May 2018 Mr Mavris returned to Australia, arriving at Sydney International Airport on an overseas flight from Columbia. At around 7:00pm Mr Mavris was arrested by Federal Agents Dunbar and Blunden for an offence of importing a commercial quantity of cocaine. He was searched and then taken to the Sydney office of the AFP. At 8:20pm Federal Agents commenced an electronically recorded interview with Mr Mavris, during which he denied having any knowledge of the cocaine that had earlier been found in, and removed from, the two shipping containers. Instead, Mr Mavris maintained that he had arranged for the importation of two containers of frozen fish to sell for bait as part of a profitable venture. However, Mr Mavris acknowledged that he was in financial difficulties. Further, when asked about the purpose of his trip to Columbia, Mr Mavris indicated that he had been experiencing a significant amount of stress and needed to "*get away*". The interview concluded at 11:56pm. Following this, Mr Mavris agreed to take part in a forensic procedure which involved the taking of a buccal swab.

Mr Mavris was subsequently charged with importing a commercial quantity of a border-controlled drug, namely cocaine, contrary to section 307.1 of the *Criminal Code* (Cth). Federal Agent Nathan Robertson had a conversation with Mr Mavris regarding the charging process and the seriousness of the offence, explaining that the maximum penalty is life imprisonment. Federal Agent Robertson observed that Mr Mavris appeared weary, which he attributed to the effects of a long-haul flight from Chile.

What happened on 24 May 2018?

At about 1:15am on 24 May 2018 Mr Mavris was taken from the Sydney office of the AFP to the NSW Police Force (**NSWPF**) Sydney Police Centre (**SPC**) at Surry Hills. Located within the SPC is the Surry Hills Cells Complex (**Surry Hills Cells**) which is frequently used to house inmates on remand prior to their transfer to a correctional centre.

Upon admission, Mr Mavris was refused bail by Leading Senior Constable Charles Cook on the basis that he had been charged with a Show Cause offence. Mr Mavris was subsequently remanded to appear at Central Local Court. At about 2:20am Leading Senior Constable Cook completed a NSWPF Custody Management Record which relevantly recorded that Mr Mavris showed no signs of mental illness or self-harm, no agitation or aggressiveness, no scars or injuries that would suggest any previous attempt at self-harm, and that no threat of self-injury in custody had been made by Mr Mavris. The Custody Management Record also noted that Mr Mavris denied ever trying to kill himself, and that Mr Mavris indicated that this was not the first time he had been arrested and placed in police custody.

Mr Mavris was subsequently taken into custody by Corrective Services New South Wales (**CSNSW**) officers. At about 2:35am Correctional Officer Adrian Dowell completed a *New Inmate Lodgement & Special Instruction Sheet* which recorded that Mr Mavris indicated that he had no immediate medical issues, no mental issues for which he had been receiving treatment, that he had never tried to hurt himself, never tried to end his life, and that he was "*feeling fine*". Officer Dowell formed the impression that Mr Mavris showed no signs of suicide, self-harm, agitation, aggression, depression or withdrawal.

At 2:43am Mr Mavris entered Cell 1 of the Surry Hills Cells. He was wearing his own clothes, namely a blue button up collared shirt over a black T-shirt, trousers, and boxer shorts. Mr Mavris remained in these clothes throughout his time in custody. At 9:30am Mr Mavris' matter was listed at Central Local Court in relation to the question of bail. A solicitor appeared for Mr Mavris and it appears that bail was not applied for. Accordingly, Mr Mavris' matter was adjourned to 30 May 2018 for a bail application, and Mr Mavris was remanded into custody, bail refused. At 3:44pm Mr Mavris was transferred from Cell 1 to Cell 20. At the time, this latter cell housed two other inmates, Mr NR and Mr ND.

What happened on 25 May 2018?

At 6:37am on 25 May 2018 Mr Mavris was provided with breakfast, with his meal including a plastic knife. Later that morning at 9:38am Mr Mavris was escorted from his cell in order to meet with his solicitor. He later returned to his cell at 11:15am and appeared to take a nap. At 11:26am one of Mr Mavris' cellmates, Mr NR, was transferred out of Cell 20 and did not return. Mr Mavris remained in Cell 20, together with Mr ND. In the period between 11:50am and 1:40pm on 25 May 2018 Mr Mavris was captured on CCTV engaging in behaviour consistent with attempted self-harm. During this period Mr Mavris created a ligature using his shirt and a blanket. He appeared to affix this ligature to several potential anchor points within his cell and then test their efficacy. Mr Mavris also used the plastic knife obtained from his breakfast meal to alter the ligature in order to make it easier to attach to an anchor point. Mr Mavris then appeared to make several self-harm attempts, including the following:

At 12:10pm Mr Mavris attempted to tie the sleeve of his shirt around his neck.

At 12:45pm Mr Mavris placed the shirt around his neck whilst lying on his mattress and pulling at the shirt.
At 1:40pm Mr Mavris stood next to his mattress with his shirt around his neck and pulled on the shirt.

At 2:00pm there was a change in shift between the CSNSW officers who were rostered to work at the Surry Hills Cells on that day. The officers in the A Watch ended their shift and were replaced by officers in the C Watch.

There is no evidence that any of the A Watch officers had observed Mr Mavris' self-harm attempts between 11:50am and 1:40pm earlier that day. Equally, there is no evidence that during any handover between each Watch any aspect of Mr Mavris' behaviour earlier that day was discussed. Between 1:41pm and 5:21pm Mr Mavris remained in his cell, spending much of his time resting and showing no behaviour out of the ordinary.

At 5:21pm Mr Mavris and Mr ND were both provided with dinner in their cell by Officer Neil Bissett. Following this, Officer Bissett returned to Cell 20 at 5:39pm in the company of Registered Nurse (**RN**) Miriam Doggett, the Justice Health & Forensic Mental Health (**Justice Health**) nurse on duty, in order to perform a head check, and check on the inmates' medical welfare. Mr Mavris approached the cell door and said that he did not need anything. At 6:00pm the lights in the individual cells were turned off after the inmates had been provided with their evening meal, in accordance with usual practice at the time. CCTV footage of Cell 20 shows that at 6:10pm Mr Mavris tied his shirt around his neck and spoke to Mr ND. Mr Mavris reportedly told Mr ND, "*I want to kill myself, come help me kill myself*". In response, Mr ND told Mr Mavris, "*I'm not dumb, I'm not gonna do it. I'm not going to do life for you*". Notwithstanding, Mr Mavris lay down on the mattress with his shirt wrapped around his neck and asked Mr ND to pull the shirt.
Mr ND complied and began pulling on the shirt for less than one or two minutes before suddenly letting go, telling Mr Mavris, "*No I can't do it*", and "*I don't want to do it, there is a camera here*". Mr Mavris pleaded with Mr ND to continue, but Mr ND responded, "*I can't help you*".

At 6:13pm Mr ND returned to his own bed, lay down and faced the wall. He reportedly then went to sleep for a short time.

At 6:14pm, CSNSW Officer David Walker was in the reception area of the Surry Hills Cells. This area contains four screens which show CCTV footage from individual cells. Officer Walker used a remote control to change one of the four screens displaying CCTV footage of individual cells to, instead, free to air television. The CCTV screen that was changed by Officer Walker did not show CCTV footage from Cell 20. That footage remained visible on one of the three other CCTV screens.

At 6:15pm, Mr Mavris continued to pull on the shirt by himself, attempting to tighten the ligature around his neck.

Approximately two minutes later Mr Mavris affixed the ligature he had created using a blanket and his shirt between the cell door frame and a wall. At 6:28pm Mr Mavris placed his shirt back around his neck. Approximately two minutes later at 6:30pm Mr Mavris sat down, with the ligature positioned around his neck. At 6:33pm Mr Mavris can be seen on the CCTV footage to no longer be moving. At 6:37pm Mr ND got out of his bed, walked over to where Mr Mavris was located and touched Mr Mavris' head. Mr ND subsequently used the cell intercom to call CSNSW officers located at the reception area telling them that Mr Mavris had "*hanged himself*" and that "*someone hanged themselves*". At the time of Mr ND's cell call alarm (known colloquially within the corrections environment as a "knock up") Officer Neil Bissett and Officer Walker were facing the screens, apparently watching television, whilst Officer Sawhney was seated at the workstation in the reception area eating his evening meal.

At 6:38pm CSNSW officers left the reception area, arriving at Cell 20 a minute later. Officer Bissett found Mr Mavris sitting with his back to the cell wall, with the ligature tied around his neck and with no signs of life. Officer Bissett instructed Officer Searle to retrieve what is commonly known as the 911, a tool used to cut a ligature in the event that an inmate is involved in a self-harm hanging incident. Meanwhile Officers Bissett and Walker attempted to lift Mr Mavris in order to remove the strain from his neck, but they were unsuccessful. Officer Walker then attempted to loosen the ligature by inserting his hand between the ligature and Mr Mavris' neck.

Officer Searle returned to the reception area at 6:39pm and retrieved the 911 tool, whilst also instructing Officer Sawhney to call for a Justice Health nurse. After returning to Cell 20, Officer Searle unsuccessfully attempted to cut the ligature free using the 911 tool, before Officer Bissett took over and was able to cut the ligature. Mr Mavris was placed on his side on the ground. He was noted to be unresponsive and not breathing, with his eyes open. RN Doggett arrived at Cell 20 at 6:40pm. She checked for a pulse, also observed that Mr Mavris was not breathing, and then commenced cardiopulmonary resuscitation (**CPR**) using a bag valve mask. Later RN Doggett switched to a laerdal mask as she was unsatisfied with the seal of the bag valve mask. RN Doggett also applied a defibrillator to Mr Mavris at 6:44pm which detected no shockable rhythm. CPR continued. After moving Mr ND to a different cell, Officer Walker returned to the reception area at 6:41pm and switched the monitor displaying television to its usual display of CCTV footage from individual cells.

NSW Ambulance paramedics were despatched at 6:42pm and arrived at Cell 20 at 6:50pm. They took over CPR from RN Doggett and continued until further paramedics arrived at 6:53pm. By this stage Mr Mavris was noted to be in asystole, pulseless and peripherally cyanosed but still warm to the touch. Cycles of CPR continued, and Mr Mavris was cannulated and intubated. His heart rate subsequently changed from asystole to pulseless electrical activity.

At 7:11pm Mr Mavris was removed from Cell 20 by attending paramedics and loaded into an ambulance at 7:22pm. He was transferred to St Vincent's Hospital, arriving at 7:28pm and then triaged a short time later. Despite continued resuscitation efforts Mr Mavris could not be revived and was pronounced life extinct at 8:00pm.

What was the cause and manner of Mr. Mavris' death?

Mr Mavris was subsequently taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 29 May 2018. Dr Szentmariay noted that there was a broad-based pale ligature mark over the anterior aspect of the neck, but that the cervical spine and laryngeal hyoid bone were intact. In the autopsy report dated 31 May 2019 Dr Szentmariay opined that the cause of Mr Mavris' death was hanging. In a supplementary report dated 3 November 2020, Dr Szentmariay noted that every minute after hanging can decrease the chance of successful resuscitation. Further, whilst resuscitation may result in the return of spontaneous circulation after an extended period of time (20 to 40 minutes), irreversible brain damage is typically caused after a relatively short period of time (5 to 10 minutes). Given the gravity of a finding that a person has intentionally inflicted their own death it is well-established that such a finding cannot be assumed but must be proved on the available evidence.

Mr Mavris' actions during the period between 11:50am and 1:40pm on 25 May 2018, his interactions and conversation with Mr ND in the brief period after the cell lights were turned off at 6:00pm, and Mr Mavris' own actions at 6:30pm in placing the ligature around his neck and affixing it to the cell door frame all demonstrate an intention by Mr Mavris to inflict his own death.

Conclusions: Having regard to the above, there is sufficiently clear and cogent evidence to establish that Mr Mavris died as a result of actions taken by him on the evening of 25 May 2018 with the intention of ending his life. The cause of Mr Mavris' death was hanging.

What issues did the inquest examine?

Prior to the commencement of the inquest a list of issues was circulated amongst the sufficiently interested parties, identifying the scope of the inquest and the matters to be considered. That list identified the following issues:

- Whether CSNSW adequately managed Mr. Mavris' risk of suicide while he was in custody
- the adequacy of the information provided by the AFP to CSNSW as to Mr. Mavris' mental health upon his transfer to the Surry Hills Cells.
- the adequacy of the assessment conducted by CSNSW of Mr. Mavris' mental health upon his admission to custody.
- the adequacy of monitoring of Mr. Mavris by CSNSW whilst in custody.
- whether CSNSW has mechanisms in place to adequately monitor inmates.
- the appropriateness or otherwise of cell architecture, in relation to hanging points.
- consideration of any materials available to inmates to create ligatures (including the practice of permitting inmates to remain in their own clothes); and
- the practice of keeping inmates at the Surry Hills Cells for up to 72 hours before transfer to a correctional centre.
- Whether the matter ought to be referred to CSNSW for review in relation to possible disciplinary action against involved officers.

Operational features of the Surry Hills Cells Complex as at May 2018

Before going on to consider a number of specific issues that the inquest was concerned with, it is convenient to describe some operational features of the Surry Hills Cells relevant to these issues.

Physical layout

In order to enter the actual cells within the Surry Hills Cells it is first necessary to pass through an area where inmates are received and processed (**the Reception Area**) by CSNSW officers.

Located within the Reception Area is a workstation, where CSNSW officers perform certain duties including answering knock ups made by inmates from their cells and communicating with vehicle entry points at the SPC that were used for the transfer of inmates. A small office used by the CSNSW Officer-in-Charge (**OIC**) for each Watch and an office used by the Justice Health nurse on duty are also located with the Reception Area.

CCTV footage

As at May 2018 each individual cell within the Surry Hills Cells contained a CCTV camera which streamed real-time footage to a bank of four display screens (**the CCTV screens**) in the Reception Area. The CCTV screens are located on a wall perpendicular to the workstation and are able to be viewed from most points within the Reception Area, except from within the offices referred to above. Relevantly, it is possible for a CSNSW officer to be performing duties at or near the workstation and be able to see the CCTV screens. Each CCTV screen is divided into nine images, in a three by three grid, with each image showing CCTV footage from the cells and exit/egress points in the complex. As at May 2018 it was possible for the CCTV screens to be manually switched from displaying CCTV footage from individual cells to displaying free-to-air television.

There is also a CCTV camera in the Reception Area itself which records activity within it and captures both the workstation and CCTV screens. Division of CSNSW officer duties into Watches CSNSW officers on duty at the Surry Hills Cells were rostered on to shifts, described as Watches, during the day and night. CSNSW officers were rostered on the A Watch, B Watch or C Watch. Relevantly for 25 May 2018 the C Watch was between 2:00pm and 10:00pm.

On 25 May 2018 the following CSNSW officers were rostered on the C Watch:

Assistant Superintendent (**AS**) Warren Searle who was the OIC.

Senior Corrections Officer Jasdeep Sawhney who was the Second in Charge (**2IC**).

First Class Correctional Officer David Walker, who was initially rostered on the Control role.

First Class Correctional Officer Neil Bissett, who was initially rostered on the Cells role.

First Class Correctional Officer Bryan Denyer, who was initially rostered on the Monitor role.

The officers rostered on the Control, Cells and Monitor roles would rotate through each role at regular intervals during the course of a Watch. For example, an officer on the C Watch who commenced duties at 2:00pm in the Control role would rotate to the Cells role at 4:30pm, and then rotate again to the Monitor role at 7:00pm, before ceasing duty at 10:00pm.

Roles and duties of the CSNSW officers

As noted above CSNSW officers who performed duties at the Surry Hills Cells rotated between the Monitor, Cells and Control roles each shift. These roles were common across all three Watches. Each role had a specific set of duties and responsibilities. However, it was the role of the Monitor that was closely examined at the inquest. The Monitor role was created in January 2018 (and later filled by February/March 2018) to meet obligations arising under the CSNSW Custodial Operations Policies and Procedures (**COPP**). Section 3.7 of the COPP provides for the management of inmates at risk of self-harm or suicide. It specifically requires that "*immediate action must be taken following identification of risk of suicide or self-harm*", and that "*[o]one of these actions is to make a mandatory notification about an inmate at risk of suicide or self-harm*".

Section 3.7 also provides that "*[t]he primary purpose of mandatory notification is to ensure that all relevant staff are aware of inmates who require additional management strategies to prevent suicide or self-harm, and to ensure that appropriate care is provided for the inmate's health and safety*". all inmates who are the subject of a mandatory notification must have an Immediate Support Plan (**ISP**) developed.

An ISP is "*a plan to manage an inmate immediately after they have been identified as being at risk of suicide or self-harm*".

Section 3.7 of the COPP also provides that following a management identification and development of an ISP a Risk Intervention Team (**RIT**) must convene. The RIT is then responsible for a number of matters, including ongoing assessments of an inmate's risk of suicide of self-harm, and developing and reviewing a RIT Management Plan to manage an inmate's risk.

At the time that the Monitor role was introduced a set of post duties was created which described the duties and responsibilities of the officer performing the role. Similar post duties were also created for both the Cells and Control roles. According to the post duties the role of the Monitor on the C Watch was to: "*Take up monitor room duties… (1.2) Perform duty as per Departmental regulations, rules and procedures… (1.5) Maintain a vigilant watch on all ISP inmates and record all alarms on inmate monitoring system*". The Post Duties for the C Watch (when there were less than 41 inmates in the Surry Hills Complex) in 2018 provided the following duties for the officer performing the Monitor role between 2:00pm and 7:00pm: "*Monitor Room, Answer Knock Up's [sic], (Answer Phone When Truck's [sic] in*". Additionally, from 7:00pm to 10:00pm the Monitor is to perform the following duty: "*Morseman & Head Check at 9:30pm*".

Morseman Tour Guard Wand

The Morseman Tour Guard Wand (**Morseman Wand**) is a device which is pressed to a docking ring outside individual cells which records the time and date that a cell inspection is performed. The CSNSW *Standard Operating Procedures – SWTC, Section 30: Moseman [sic] Wand* (drafted on 9 February 2009) (**Morseman SOP**) provides at clause 4.3.2 that the Morseman Wand is to be used generally every hour by a first-class correctional officer during each Watch and that all docking ports will be activated at least once. Further, clause 4.3.3 provides that when a mandatory notification is put in place the Morseman Wand will be used as per the management plan, generally being every 10 to 30 minutes. In addition, a document authored by AS Yarnton and titled "*Head Check and Morseman Check*" (**the Head Check document**) was displayed on a board in the Reception Area.

The Head Check document was on display on 25 May 2018, and provided that a head check was to be performed three times each day using the Morseman Wand: at 6:00am during the A Watch, at 9:30pm during the C Watch, and at 5:30am during the B Watch.

Was adequate information provided by the Australian Federal Police to Corrective Services New South Wales?

Following Mr Mavris' interview at the Sydney office of the AFP, Federal Agent Nathan Robertson engaged in a brief conversation with Mr Mavris during which he explained a number of matters related to the charging process. Federal Agent Robertson explained the charge to Mr Mavris, the applicable maximum penalty and matters relevant to the question of bail. Federal Agent Robertson gave evidence that during this interaction Mr Mavris displayed little emotion, and only asked questions in relation to the likelihood of bail. In response, Federal Agent Robertson explained that whilst the AFP would request that bail be refused that issue was initially not a matter for the AFP to determine. Federal Agent Robertson indicated that whilst Mr Mavris appeared weary, he did not ask Mr Mavris about his apparent weariness or any mental health issues.

Federal Agent Robertson explained that if Mr Mavris had said or done anything which indicated the possibility of suicidal ideation that he would have sought advice from the AFP and that this information would have been conveyed to the custody manager at the SPC.

Federal Agent John Turner assisted in escorting Mr Mavris from the Sydney office of the AFP to the Surry Hills Cells. During this process Mr Mavris indicated that he was tired and asked about an opportunity to sleep. Federal Agent Turner gave evidence confirming that Mr Mavris appeared tired, but that he was otherwise polite and quiet, and compliant in relation to all of his interactions with AFP Agents. Federal Agent Turner also gave evidence that if he had observed from Mr Mavris' state any matter which suggested a mental health issue he would have communicated this to the charging officer or custody manager at the SPC.

> **Conclusions:** There is no evidence to suggest that, during his interactions with AFP Agents prior to his transfer to the SPC, Mr Mavris displayed any signs of suicidal ideation or any indication that he planned to self-harm. It is clear from the evidence of Federal Agents Robertson and Turner that if any such signs had been identified, appropriate steps would have been taken to convey this information to NSWPF officers upon Mr Mavris' admission to the SPC and, eventually, the Surry Hills Cells. Therefore, the AFP provided adequate information to the NSWPF upon the transfer of custody of Mr Mavris.

Was an adequate assessment conducted by Corrective Services NSW of Mr. Mavris' mental health upon his admission to custody?

The NSWPF Custody Management Record for Mr Mavris disclosed no history of mental illness, self-harm, or any threat of self-injury whilst in custody. Similarly, the *CSNSW New Inmate Lodgement & Special Instruction Sheet* (**the Lodgement Sheet**) identified that Mr Mavris had no immediate medical concerns. Further, the Lodgement Sheet specifically identified that Mr Mavris had nil medical issues requiring Justice Health review on reception, and that Mr Mavris had never previously tried to hurt himself or end his life. When asked a specific question as to how he felt at the time that the Lodgement Sheet was completed, Mr Mavris indicated that he was "*feeling fine*".

Each of the CSNSW officers on duty during the C Watch on 25 May 2018 gave evidence that they had previously attended an ISP workshop as part of their overall training. Each of the officers also gave evidence that, as part of the training, they were aware that for some offenders the front end of the correctional chain is a high-risk time, that the first few hours in police or correctional custody is known to be a very high risk period, and that the risk of suicide is dynamic and can change within seconds and hours. Each of the officers also agreed that, based upon this training, the assessment of risk factors for attempted suicide begins from the moment that an inmate is received into the care of CSNSW staff. Section 1.1 of the COPP deals with reception procedures. Clause 6.1 of Section 1.1 deals specifically with the risk of self-harm and provides that an ISP and a mandatory notification form must be completed if an inmate is identified as being at risk of self-harm.

> **Conclusions:** Based upon the available information that could be gleaned from Mr Mavris' interactions with Federal Agents and NSWPF officers up to the point that he was received into custody by CSNSW officers at the Surry Hills Cells, together with the contents of the Custody Management Record, there was nothing to suggest that Mr Mavris warranted being placed on an ISP. As already noted above, there was nothing to suggest that Mr Mavris had expressed suicidal ideation or that he was contemplating self-harm. To this extent, the initial assessment conducted by CSNSW officers at the point of Mr Mavris' admission was adequate.

However, for reasons which are explored in more detail below the adequacy of the assessment conducted by CSNSW officers ought not to be limited to the initial intake period.

Was Mr. Mavris appropriately monitored by Corrective Services NSW whilst in custody, and does CSNSW have appropriate mechanisms in place to adequately monitor inmates?

It is convenient to consider these two issues together. Examination of the appropriateness of the monitoring of Mr Mavris by CSNSW officers, and the adequacy of mechanisms to monitor inmates in general, requires consideration of a number of discrete issues. These will be dealt with in turn below.

Effectiveness of the Monitor role

It became clear during the course of the inquest that whilst the duties and responsibilities of the officer performing the Monitor role are explicitly stated and understood when there is an inmate on an ISP, the situation is quite different when there is no such inmate on an ISP. Craig Osland, the General Manager of the Court Escort Security Unit (**CESU**), was asked about his expectation of the role and responsibilities of the Monitor in circumstances where there was no inmate on an ISP in the Surry Hills Cells. Mr Osland gave evidence that, "*[s]hould there be nobody in the cell location under mandatory notification either by immediate support plan or any other observation regime, that that [sic] Officer whilst within the proximity of the monitoring room area, answering telephones, accessing or assisting to access control for staff; perhaps assisting in the clinic, which is adjacent to the monitoring room area; make notations on the whiteboard in relation to cell population, the names and details of officers who are arriving or are being discharged. I have those types of duties [sic] could very well be delegated onto that person should there be nobody under observation*". Mr Osland also gave evidence that around the time that the Monitor role was introduced he had a conversation with AS Yarnton in which he communicated his expectation as set out above.

Mr Osland also gave evidence that he had an expectation, in circumstances where there was no inmate on an ISP at the Surry Hills Cells, that the CCTV screens in the Reception Area would be used by the Monitor to perform "*general observations*". However, whether the responsibility to perform general observations using the CCTV screens was the sole responsibility of the Monitor is unclear from Mr Osland's own evidence.

Mr Osland was asked in evidence to identify any provision within the post duties for the Monitor that indicates that a Monitor is to maintain general observation of the CCTV screens. In answer, Mr Osland referred to clause 1.4 of the post duties which provides that the Monitor is to "*[e]nsure strict security and control of inmates at all times*". However, this clause appears in identical terms in the post duties for officers performing the Cells and Control roles, suggesting that the expectation to perform general observations of the CCTV screens (when there was no inmate on an ISP) was not limited solely to the Monitor.

The evidence established that AS Yarnton had a very different understanding to that of Mr Osland as to the role of the Monitor when there was no inmate on an ISP. AS Yarnton gave evidence that shortly after the Monitor role was introduced at Surry Hills, he considered it to be "*pure overkill*", variously describing it as a "*free post*" and an "*extra post*", and that he fought against the position. AS Yarnton explained in evidence: "*I believe we didn't need it because we had a regime that when we had an ISP we got an extra officer…The monitor officer was just pure overkill as far as I was concerned. It was just another post to sit there and, you know, cause had the [sic] RIT officers there to monitor RITs*". AS Yarnton also gave evidence of a conversation with Mr Osland in which the latter expressed no issue with the Monitor being used for other roles throughout the complex (such as assisting with the unloading of inmates from a truck, feeding inmates, and taking inmates to see a Justice Health nurse) provided that there were no inmates on an ISP. According to AS Yarnton the only limitation that was placed on him so far as the role and responsibilities of the Monitor was that he "*wasn't to strip the [Monitor] post*".

Notwithstanding the divergent views of AS Yarnton and Mr Osland regarding the role of the Monitor, it is clear that the Monitor role was utilised in the way that AS Yarnton intended, namely, to perform duties both in the Reception Area and elsewhere throughout the Surry Hills Cells. Indeed, none of the CSNSW officers on the C Watch on 25 May 2018 had a clear understanding of the duties of that role. Only Officers Sawhney and Denyer considered that part of the role involved periodically checking the CCTV screens in the Reception Area in order to monitor inmates in their cells. The other officers who gave evidence, in particular Officer Bissett who was assigned the Monitor role at 6:00pm on 25 May 2018, did not consider this to be part of their duties, unless an inmate was on an ISP. Officer Bissett gave evidence that he had no recollection of how often (if at all) the Monitor was required to observe the CCTV screens. Indeed, Officer Bissett explained, "*I don't think [the screens] were ever really meant to be a [sic] monitoring, a person monitoring what was going on inside the cell. I think they were more about the recording of what was in the cell*". To put this evidence into stark perspective, Mr Osland gave evidence that he would be surprised to learn that as at May 2018, where no inmate was on an ISP, a number of officers working at the Surry Hills Complex had no understanding the need to make general observations of inmates by using the CCTV screens in the Reception Area.

Mr Osland agreed that this absence of understanding was clearly contrary to what he had sought to convey regarding the responsibilities of the Monitor when this role was introduced.

Conclusions: It is clear that Mr Osland's expectations of the duties and responsibilities of the Monitor, when there was no inmate on an ISP, were not put into effect on 25 May 2018. Most of the officers on the C Watch did not consider that the duties of the Monitor were limited to the Reception Area, and also did not consider that there was any requirement for the Monitor to perform general observations of inmates in their cells by periodically checking the CCTV screens in the Reception Area. Relevantly, Officer Bissett, who was performing the Monitor role at the time of Mr Mavris' death, had an entirely contrary belief as to the intended use of the CCTV screens in this regard.

Therefore, whilst appropriate mechanisms were in place for Mr Mavris to have been effectively monitored on 25 May 2018, these mechanisms were not appropriately utilised due to a misapprehension as to the role of the Monitor. If any of the CSNSW officers on the A Watch had observed Mr Mavris actions in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, it is most likely that a mandatory notification would have been made in accordance with Section 3.7 of the COPP. This would have in turn resulted in Mr Mavris being placed on an ISP and being subjected to close observations at regular intervals. Counsel for the Commissioner of CSNSW submitted that whether Ms Osland's expectations as to the Monitor role were sufficiently communicated or explicitly stated is a "*moot point*". This is because, it is submitted, all CSNSW officers knew (or ought to have known) that they were under a duty to be vigilant (see further at [13.26] below). However, the general duty of a CSNSW officer to be vigilant cannot be said to entirely address an officer's precise role and responsibilities in a particular correctional setting. Clearly, there is a need for the role of the Monitor, in circumstances where there is no inmate on an ISP at the Surry Hills Cells, to be explicitly stated and, in turn, clearly understood by the relevant CSNSW officer performing that role. The existing post duties and Local Operating Procedures contain no such explicit instructions. Therefore, the following recommendation is necessary.

Recommendation 1: I recommend to the Commissioner of Corrective Services New South Wales that the post duties of the Monitor role at the Surry Hills Cells Complex, and the Local Operating Procedure 2019/04 *Generic duties and responsibilities of the Monitor Room Officer*, be amended to explicitly state that one of the responsibilities of the Monitor role is to regularly observe the CCTV footage of inmates in their cells for the purpose of identifying any behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm.

One final matter regarding this issue should be noted. Counsel for the various CSNSW officers on duty during the C Watch made certain submissions regarding Mr ND's conduct on 25 May 2018 and the veracity of his evidence. To the extent that such submissions suggest that Mr ND is, or ought to be, exposed to some jeopardy pursuant to section 79 of the Act,
the following should be made clear. That section does not provide the basis for a sufficiently interested party to make submissions regarding the possibility of referral pursuant to 78(4) of the Act.

Rather, section 78(1)(b) provides the basis for certain procedural steps to be taken in relation to the conduct of an inquest if a coroner forms an opinion as to the likelihood of a known person being convicted of an indictable offence that is causally related to the death of the person who the inquest is concerned with. Its purpose in doing so is to preserve the rights of any such person of interest and the integrity of any consequent criminal proceedings, and to separate the role and functions of the coronial and criminal jurisdictions.

If an issue had arisen during the course of the inquest as to the possible enlivenment of section 78(1) (b) then, as a matter of procedural fairness, the opportunity to make submissions regarding this issue would only have been extended to any individual in potential jeopardy, and to Counsel Assisting. The opportunity for submissions to be made would not have been extended to any other party with sufficient interest in the inquest but that was not in jeopardy. This is on the basis that any party's right to be afforded procedural fairness could in no way be affected by whether section 78(1)(b) was enlivened or not. However, given that the available evidence does not enliven consideration of section 78(1) (b) the issue, and any submissions made regarding it, are immaterial.

For completeness, if the submissions made in this regard suggest that Mr ND had some moral obligation to respond to Mr Mavris' actions, then the following should be noted. It is accepted, as submitted by counsel for the Commissioner of CSNSW, that it is standard practice for an inmate considered to be at risk to be placed in "two-out" cell with another inmate, who may report matters of concern regarding an inmate's welfare to CSNSW officers. However, there is no evidence that any of the CSNSW officers on duty during the C Watch gave any consideration to Mr ND having some role in this regard. Further, any submission which might suggest that the presence of Mr ND in Mr Mavris' cell in some way abrogated the duty of care of all CSNSW officers in relation to inmates, and their duty to remain vigilant at all times, ought to be rejected.

Quality of the CCTV footage

Related to the role of the Monitor is the issue of whether the quality of the footage that could be viewed (or not) on the CCTV screens allowed a CSNSW officer to perform effective observations of inmates in their cells. In this regard there was conflicting evidence as to the quality of such footage:

AS Yarnton gave evidence that the quality of the CCTV footage was variable, and that inmates had a tendency to impair the functionality of the CCTV cameras (by, for example, throwing toilet paper or water over the cameras) which in turn adversely affected the quality of the footage. Officer Sellman gave evidence that following lights out at 6:00pm "nothing" could be seen on the CCTV screens. Officer Bissett gave evidence that because the CCTV screens were divided into nine smaller images it was difficult to discern what was occurring in an individual cell, and that after lights out it was difficult to discern anything "*on some cameras*". Officer Walker gave evidence that generally speaking movement could be seen within a "*majority of the cells*" whilst *"[s]ome cells were very tough to see*" after lights out, and that the use of night vision cameras would be of assistance in this regard.

Officer Sawhney gave evidence that, depending on whether a CCTV camera had been tampered with, the CCTV, "*some of the cells are really good with the cameras, some of them are not really good*". AS Searle also gave evidence of variable quality in CCTV footage with "good vision" in some cells, some cells not being ideal but with vision possible, and some cells (including Cell 20) being "*terrible when the lights are off*". It is clear that caution needs to be exercised when considering the extent to which self-serving statements by some of the CSNSW officers who gave evidence can be used in order to reach any conclusion as to the quality of footage that was viewable on the CCTV screens on 25 May 2018.

Further, the evidence given by each of the officers is of little weight given that none were looking at the footage on the relevant CCTV screen at the time that Mr Mavris made preparatory acts to commit, and then committed, self-harm. Regrettably, there is limited objective evidence available to allow for a definitive conclusion to be reached. It should be noted that as part of the CSNSW investigation, Graham Kemp, a CSNSW investigator conducted a "re-enactment" test in the early hours of the morning on 26 May 2018. This test involved Mr Kemp standing inside Cell 20 whilst a colleague took a photo using a mobile phone of the relevant CCTV screen in the Reception Area. However, it should be noted that there are certain limitations with the test performed by Mr Kemp, namely the quality of the mobile phone camera used to take the photo, the fact that the photo was digitally magnified and the fact that Mr Kemp was not standing in the exact location where Mr Mavris was found following the knock up call. It is acknowledged that Mr Kemp's colleague told him that she was unable to see him inside Cell 20 when she herself looked (without using a mobile phone) at the relevant CCTV screen. However, this is contrasted against a still image of the interior of Cell 20 which appears to show the location where Mr Mavris was found unresponsive to be illuminated and visible.

Conclusions: The evidence given by the various CSNSW officers indicates that apparent poor-quality CCTV footage was most often associated with the period after when lights in the cells were turned off. This tends to suggest that Mr Mavris' actions in the period between 11:50am and 1:40pm on 25 May 2018 was most likely visible if observations had been made of the relevant CCTV screen. Counsel for the various CSNSW officers on duty during the C Watch submitted that it would be reasonable for an officer to expect that an inmate who had requested that the lights in their cell be turned off would go to sleep, and not be likely to embark upon a course of action with intention to self-harm. However, no support for such a submission can be found in the CESU Standard Operating Procedures (**CESU SOP**) which contains no such qualifying provision. Further, such a submission is entirely consistent with a CSNSW officer's duty to be vigilant at all times (see [13.26] below). Finally, if a CSNSW officer were to unreservedly base the performance of their duties upon such an assumption, it would detract from the need to for that officer to critically assess any self-report made by an inmate as to their mental wellbeing. Whilst the issue of whether Mr Mavris' subsequent actions in the period between 6:10pm and 6:30pm is not without doubt, it is most likely that enough of Mr Mavris' actions would have been visible to any officer performing a proper observation of the CCTV screens in order to trigger a mandatory notification. This is because the objective evidence of the still images from Cell 20, even accepting the associated limitations, suggests that the location in the cell where Mr Mavris was found unresponsive was illuminated so as to make his actions at least partially visible. Notwithstanding, the variable evidence given by the CSNSW officers as to the quality of the CCTV footage of the cells indicates that the following recommendation is necessary.

Recommendation 2: I recommend to the Commissioner of Corrective Services New South Wales that consideration be given to an urgent review of the CCTV cameras in the cells and the display screens in the reception area within the Surry Hills Cells Complex in order to determine (a) whether the CCTV footage is of sufficient quality to allow a correctional officer to identify any inmate behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm at all times; and (b) whether there is a need to implement a Local Operating Procedure in relation to the timing and circumstances in which cell lights are turned off, and the extent to which the absence of lighting in cells adversely impacts on the quality of CCTV footage.

Watching of television by CSNSW officers whilst on duty

Part 1 of the CESU SOP sets out a mission statement and the legal duty of care of all CSNSW officers in relation to inmates held in lawful custody. Further, Part 1 reproduces in part clause 252 of the *Crimes (Administration of Sentences) Regulation 2014* (**the Regulation**) which relevantly provides:

Vigilance

A correctional officer on duty must at all times devote the whole of his or her attention to the performance of his or her duties.

A correctional officer must not do anything that is calculated to distract another correctional officer from the performance of the officer's duties.

Part 1 goes on to provide the following:

"*Supervising officers are to ensure that the vigilance of correctional officers is not distracted by watching television or any activity that would compromise their ability to maintain optimum vigilance and security awareness. Control room monitors are not to be used for any activity other than security surveillance. Television units for staff are allowable in the staff amenities and areas of correctional centres/court cells for out of hour's [sic] access only. Whilst on duty (including crib breaks) Correctional Officers are not [sic] access television units in the staff amenities areas or other areas of a correctional centres [sic]/court cells [sic]*".

CCTV footage of the Reception Area between 6:07pm and 6:30pm shows Officers Bissett and Walker seated and watching television on one of the CCTV screens. Officer Walker watched the TV while eating his evening meal. Officer Bissett also sat watching TV with his feet up on a chair. It is evident from any fair and reasonable viewing of the CCTV footage of the Reception Area that the gaze of each officer remained on the television throughout this period. AS Yarnton was asked in evidence, as one of the OICs of the Surry Hills Cells, whether he had raised the permissibility of watching television during a shift with other CSNSW officers. He explained: "*Look, TVs are being watched I think as long as Corrective Services has been operating. Obviously there's certain points and certain times that if you were going to flick the TV on that you shouldn't and there's other times when you think, well, there's nothing happening, we have no inmates, we have no prisoners, yeah, we can turn it on*". AS Yarnton agreed that, having regard to his supervisory position, he set expectations for other CSNSW officers throughout each watch.

However, as to the question of watching television, AS Yarnton said: "*We, we, we all know what's right and what's wrong, at the end of the day. We all know what's right and what's wrong. I can't be there 24 hours a day. If they choose to turn the TV on when I'm not there, yeah, I can't do much about it, but if I'm on and I turn the TV on, well, then, obviously then I turned the TV on*". AS Yarnton agreed that if he made a decision to turn the television on during a shift then he "*owned*" that decision.

Notwithstanding AS Yarnton's awareness of the relevant provisions of clause 252 and Part 1 of the CESU SOP, he did not consider that the watching of television diminished the vigilance of CSNSW officers. Indeed, AS Yarnton considered that (apart from a television located in a staff kitchen area) it was acceptable for CSNSW officers to watch television on one of the four CCTV screens if they considered that it was safe to do so. AS Yarnton also frankly conceded that he took an approach that it was contrary to the CESU SOP, and that he did not raise this approach with any person in a position of greater seniority.

None of the CSNSW officers on the C Watch on 25 May 2018 were aware that the CESU SOP expressly prohibited the watching of television. However, each of the officers was well aware of the provisions of clause 252 of the Regulation. Notwithstanding, the officers gave differing evidence as to the permissibility of watching television in the Reception Area whilst on duty, and whether this has the potential to distract another officer from the performance of their duties: Officer Bissett gave evidence that he had previously discussed the watching of television whilst on duty with both AS Yarnton and AS Searle, both of whom indicated that doing so was permissible. Officer Bissett was asked whether he had ever sought guidance as to when during a shift the watching of television was permissible. He gave evidence that "*[u]sually it would be when officers, it's around when they're having their meal break and instead of sitting out in the meal room where they're isolated, they will sit in the reception room to assist other officers that are working, while they have their meal break, to watch the news or something like that*".

Although Officer Bissett understood that watching television whilst on duty was contrary to CSNSW policy he did not consider that doing so distracted from the performance of his duties. When asked why this was the case, he explained: "*Because I wasn't concerned about watching TV, I was actually sitting where the monitor and the phone was answering phone calls, answering knock-ups and also still looking at the monitors and no way did I, no way was I distracted from doing my duties at all*".

Officer Walker similarly understood that the watching of television during a shift was contrary to CSNSW policy. He said that he had never had a discussion with either AS Yarnton or AS Searle regarding the watching of television in the Reception Area. Officer Walker indicated that he changed the screen over to television on 25 May 2018 so that he could "*catch up on the local news*" while eating his evening meal, which he usually ate in the Reception Area.

Initially Officer Walker gave evidence that he did not consider that having the television on distracted Officer Bissett or any other officer in the Reception Area. He said: "*I don't think I would've been distracting any officer; it was just myself was watching at the time I believe. I'd have to ask Neil if he, I don't know, but I don't believe I would've, as I said that was just a thing that I did while I was eating, and I don't know. It wouldn't have stopped anybody doing their duties I don't believe*". However later in his evidence, officer Walker agreed (after being shown the CCTV footage of the Reception Area depicting Officer Bissett reclining in a chair, with his feet up on the chair, and appearing to be watching television) that Officer Bissett was not performing his duties with the vigilance that was required.

Officer Searle gave evidence that the practice of watching television in the Reception Area began when the CCTV screens were first installed, which he believed was sometime in about 2017. Notwithstanding the views of AS Yarnton and Officers Bissett and Walker, Officer Sawhney indicated that whilst he was aware of the impermissibility of watching television whilst on duty, he considered this to be common sense. He explained: "*[Y]ou are in an environment where you shouldn't be watching TV. It is not allowed, there is a protocol in place to say this, but it is common sense too that you don't turn it on. You don't turn a monitor on to a TV*".

Mr Osland acknowledged that historically there had been issues with CSNSW officers watching television whilst on shift. It is for precisely this reason that this issue was addressed at the forefront of the CESU SOP. Indeed, this issue had also been addressed in previous versions of the SOP which also provided that the watching of television by CSNSW officers whilst on shift was impermissible.

Given AS Yarnton's attitude to the watching of television whilst on duty, and his practice of allowing it to occur, it is unsurprising that other CSNSW officers did not give consideration to whether such a practice adversely impacted upon their duty of vigilance, or whether such a practice ought to cease. Mr Osland gave evidence that it was the obligation of all CSNSW officers to report (anonymously) any concerns with such a practice to personnel within the CSNSW professional branch. Whilst Mr Osland expressed a hope that such reporting would occur, he also acknowledged the "*complexities and challenges*" surrounding the issue in circumstances where there had effectively been passive endorsement of the practice by senior officers such as AS Yarnton.

The challenges and complexity is described by Mr Osland is perhaps best illustrated by the fact that even though Officer Sawhney held a supervisory role as 2IC during the C Watch shift on 25 May 2018, he did not consider that he had an obligation to challenge the practice of watching television whilst on shift. Indeed, Officer Sawhney described in this way: "*[T]here is an OIC who is above me on the shift. And I feel that it is insubordination on my part to - if the OIC is there it is insubordination on my part to tell [other CSNSW officers] what to do*".

Since Mr Mavris' death the ability to change the CCTV screens from displaying CCTV footage from the cells to television has been removed. This was done by removing an aerial cable that had been connected to one of the four CCTV screens. However, Officer Bissett gave evidence that within the Reception Area, on the wall opposite to where the four CCTV screens are located, is another screen that is used to monitor trucks delivering inmates to the Surry Hills Cells (**the Truck screen**). As Searle gave evidence that when the aerial cable from one of the four CCTV screens was removed it was simply reconnected to the Truck screen.

Officer Bissett gave evidence that since the death of Mr Mavris the Truck screen was still occasionally used to watch television. Indeed, AS Searle gave evidence that the aerial cable to the Truck screen was only disconnected one to two weeks before the commencement of the inquest on 2 November 2020, and that the Truck screen had been used to watch television from May 2018 up until the time of this disconnection.

Conclusions: On 25 May 2018 the conversion of one of the CCTV screens in the Reception Area to television by Officer Walker, and the subsequent watching of television by Officers Walker and Bissett was clearly contrary to the CESU SOP. Indeed, such a practice also arguably defied common sense, particularly when regard is had to the provisions of clause 252 of the Regulation. However, the evidence established that this occurrence was not an uncommon one within the Reception Area. Indeed, it was a practice that was, if not endorsed by AS Yarnton, at least countenanced by him. This appears to have been due to a prevailing culture within the Surry Hills Cells (and indeed, possibly, within CSNSW more broadly) that the watching of television whilst on duty, especially during periods of inactivity over the course of a shift, was permissible and a matter for an individual officer to exercise their own judgement.

Counsel for AS Yarnton submitted that regard should be had to Part 1 of the CESU SOP which prohibits CSNSW officers from watching TV even whilst on crib breaks, and even in a staff amenities area such as a staff kitchen. Such a prohibition, it is submitted, is unreasonable and prone to encourage the watching of television whilst on duty in the Reception Area. To the extent that such a submission touches upon occupational health and safety, and employment conditions, that is a matter which falls outside the scope of an inquest. Notwithstanding, the evidence establishes that the practice of watching television in the Reception Area whilst on duty was one borne of convenience and a (mistaken) belief that doing so would not be a distraction, rather than from any prohibition of watching television in the staff kitchen.

Counsel for AS Yarnton also submitted that as CSNSW officers are prohibited from having mobile phones in the workplace, "*often their only communication with the outside world is by reference to news reports on television*". If such a submission is intended in some way to justify the watching of television by a CSNSW officer whilst on duty then it cannot be accepted. An observation that a CSNSW officer is not employed to watch television whilst on duty, and that having no "*communication with the outside world*" over the course of an 8-hour shift could hardly be said to be onerous, is so self-evident as to be almost superfluous.

Some of the CSNSW officers who gave evidence expressed either reluctance or ambivalence in accepting that the watching of television whilst on duty was at odds with the need for vigilance in the performance of their duties, or that such a practice had the potential for distraction. However, the CCTV footage of the Reception Area on 25 May 2018 shows Officers Bissett and Walker watching television from 6:14pm until 6:37pm. This is clearly a significant period of time and not a situation, for example, where the television might simply have been on in the background whilst the officers continued performing their duties.

Indeed, it should be remembered that the watching of television only ceased because of the knock up call made by Mr ND regarding Mr Mavris' emergency situation. In such circumstances, it is difficult to accept that the watching of television did not detract from the officers' duty of vigilance. This is so, even in circumstances where it was considered that no officer (and in particular Officer Bissett, who was performing the Monitor role) was required to use the CCTV screens to make observations of the inmates in the cells.

It is concerning that despite the events of 25 May 2018, and the removal of the ability to watch television on the four CCTV screens in the Reception Area, the ability to still watch television on the Truck screen remained up until shortly before the inquest commenced on 2 November 2020 when the aerial cable to the Truck screen was disconnected. Precisely what prompted this disconnection remains unclear on the available evidence,

but it is perhaps not entirely coincidental that a pre-hearing scene view took place at the Surry Hills Cells on 30 October 2020. During the period of some 29 months that the Truck screen remained connected to the aerial it was used by CSNSW officers to watch television whilst on duty. This demonstrates either that there has been no appropriate consideration given to the circumstances surrounding Mr Mavris' death, or that CSNSW officers working at the Surry Hills Cells have not been provide with appropriate training as to the impermissibility of watching television whilst on duty, or both. Therefore, the following recommendation is necessary.

Recommendation 3: I recommend to the Commissioner of Corrective Services New South Wales that (a) CSNSW officers rostered on duty at the Surry Hills Cells Complex be provided with appropriate training regarding Part 1 of the Court Escort Security Unit Standard Operating Procedures relevant to the impermissibility of watching television whilst on duty; and (b) periodic audits be conducted by the General Manager, Court Escort Security Unit to ensure compliance with the provisions of Part 1 of the Court Escort Security Unit Standard Operating Procedures. The evidence given during the inquest has raised concerns regarding the conduct of AS Yarnton in two respects. Firstly, the watching of television was countenanced by AS Yarnton in a supervisory role, both as part of own practice and by leaving the matter to an individual officer's discretion rather than applying the policy set out in the CESU SOP. Secondly, the intended duties and responsibilities of the Monitor role were not performed as intended due to AS Yarnton's personal attitudes regarding the utility and purpose of the role. For these reasons, the following recommendation is necessary.

Recommendation 4: I recommend to the Commissioner of Corrective Services New South Wales that the conduct of Assistant Superintendent Dean Yarnton be reviewed for possible disciplinary action in relation to (a) countenancing a practice of subordinate officers watching television whilst on duty at the Surry Hills Cells Complex, including after 25 May 2018; and (b) not utilising the Monitor role for its intended purpose.

Counsel for AS Yarnton submitted that such a recommendation ought not to be made because the watching of television by other CSNSW officers on 25 May 2018 "*did not result in a failure of any Officer to view events occurring around that time in the [sic] Cell 20*", due to the fact that whilst CCTV footage of Cell 20 remained on display it contained limited or no visibility, and Mr Mavris was not subject to an ISP which required close monitoring. However, it remains the case that the watching of television between 6:14 and 6:37pm on 25 May 2018 significantly detracted from any opportunity by a CSNSW officer to observe the actions that Mr Mavris was engaged in to commit self-harm.

Further, it was submitted by counsel for AS Yarnton that there was an established practice of CSNSW officers watching television whilst on duty, and that such a practice occurred even when AS Yarnton was not on duty. Whilst there is no factual dispute as to this submission, part of AS Yarnton's role as a supervisor was to reduce the likelihood of such a practice occurring. Instead, AS Yarnton's passive endorsement of the practice facilitated its occurrence.

Use of the Morseman Wand

As at May 2018 AS Yarnton was aware of the Morseman SOP. However, he gave evidence of having no expectation that the terms of the Morseman SOP would be complied with by any officers under his supervision. As to the Head Check document which he authored, AS Yarnton described it as a "*local document*" and explained: "*I've put out a document that says how, how often I want it done and obviously [the Morseman SOP] tells you another thing, doesn't it?*". AS Yarnton was asked whether he turned his mind to the fact that the Head Check document was providing instructions to officers that were contrary to the Morseman SOP. AS Yarnton described the Surry Hills as a "*complex place*" where CSNSW officers were "*in and out of those cells all day long*" attending to a variety of duties such as feeding inmates, taking inmates to showers, facilitating the attendance of Justice Health nurses for medication rounds, and taking inmates to legal and welfare appointments.

Despite AS Yarnton's views regarding the utility of the Morseman SOP, documentary records indicate that the Morseman Wand was activated at the docking port outside Cell 20 at 6:45am and 6:46am on 25 May 2018, and not again at any point up to when Mr Mavris was found unresponsive in his cell. Indeed, the records also demonstrate that the Morseman Wand was not activated at any docking port at the Surry Hills Cells at any stage between 1:01pm on 24 May 2018 and 11:59pm on 26 May 2018. None of the CSNSW officers on the C Watch on 25 May 2018 who gave evidence were aware of the Morseman SOP. Further the CESU SOP makes no reference to the use of the Morseman Wand. Mr Osland gave evidence that the Morseman Wand was only used in two correctional settings (at the Surry Hills Cells and at Amber Laurel Correctional Centre in Emu Plains), and that the use of the Morseman Wand at the Surry Hills Cells dated back to 2009, before he became General Manager of the CESU. Mr Osland was also unfamiliar with the Head Check document or the practice of using the Morseman Wand when conducting head checks once during each A, B and C Watch. Clause 4.6 of Section 3.7 of the COPP deals with observations that are to be made of inmates who are on an ISP. It provides that "*[a]ll inmates who are assessed as requiring physical with or without a Morseman Tool [sic] or electronic observations must be identified for each watch*". Clause 4.6 goes on to provide that all physical and electronic observations, whether with the use of Morseman Wand or not, are to be recorded and detailed in a "*meaningful way*". Therefore, these provisions in the COPP suggest that the use of the Morseman Wand is a discretionary matter when CSNSW officers are performing observations of inmates on an ISP. Mr Osland gave evidence that he did not "*necessarily link the use of a Morseman tool to the role and responsibilities of monitoring a person who was at risk*" and that the use of the tool is "*akin to more [sic] perimeter security corridors and security checkpoints*". Mr Osland explained it in this way: "*If the Morseman tool is used on the perimeter to indicate that the roving officers have been active during the evening I support that process. It fits with the ethos of the Morseman tool*".

Conclusions: The Morseman SOP contemplated more frequent and regular use of the Morseman Wand within the Surry Hills Cells than was actually occurring as at May 2018. Indeed, the terms of the Head Check document only provided for the use of the Morseman Wand three times every 24 hours, with two such uses occurring only 30 minutes apart (between 5:30am on the A Watch and 6:00am on the B Watch). Notwithstanding the significantly less frequent use of the Morseman Wand as stipulated by the Head Check document, actual records demonstrate that even these requirements were not being complied with; the Morseman Wand was not used at all in a 35-hour period from 1:01pm on 24 May 2018.

Whilst use of the Morseman Wand appears to be discretionary according to the COPP, it clearly contemplates the use of the Morseman Wand when CSNSW officers are performing observations of at-risk inmates who are on an ISP. There does not appear to be any basis for the Morseman Wand not being use simply because, according to AS Yarnton, CSNSW officers are performing other routine duties in the vicinity of cells during the course of a shift. The COPP clearly contemplates that observations of at-risk inmates are to be recorded and detailed in a meaningful way. A CSNSW officer merely performing an incidental observation whilst in the vicinity of a cell would appear to be inconsistent with inmate welfare in general, and contrary to the provisions of the COPP for inmates identified to be at risk in particular. Therefore, the following recommendation is necessary.

Recommendation 5: I recommend to the Commissioner of Corrective Services New South Wales that consideration be given to the implementation of a Local Operating Procedure for the Surry Hills Cells Complex which provides for (a) correctional officers to physically attend the cell of an inmate with sufficient frequency (for example, at least twice during each Watch) to ensure the safety and well-being of an inmate; and (b) that the Morseman Tour Guard Wand be used to confirm such attendances.

Was the cell architecture at Surry Hills, particularly in relation to hanging points?

As the Surry Hills Cells is located within the SPC aspects of cell architecture are the responsibility of the NSWPF. Prior to May 2018 there had been no review of the cell architecture at the Surry Hills Cells. On 5 March 2019 a risk assessment team consisting of NSWPF and CSNSW staff conducted a health and safety risk assessment of the Surry Hills Cells. This assessment identified a number of risks, including hanging points, and methods to mitigate such risks. A completed health and safety risk assessment form was subsequently provided to the NSWPF Police Property Group so that works could be undertaken to rectify any areas that were deemed to pose a risk to an inmate's safety. Relevantly, the assessment identified that in individual cells (and shower areas) there were exposed bolts and gaps, together with poor welding on cell doors and frames. It was identified that such gaps could be used as potential hanging points. Accordingly, as part of the remedial works undertaken, it was identified that the gaps in doors and frames needed to be filled with filler material that would not pose any further risk to inmates.

Conclusions: It is obvious that as at 25 May 2018 the cell architecture of individual cells at the Surry Hills Cells provided opportunities for inmates to self-harm. However, since that date appropriate steps have been taken by both NSWPF and CSNSW to investigate deficiencies in cell architecture. Further, appropriate remedial action has been conducted by the NSWPF to eliminate aspects of cell architecture that could contribute to an inmate committing self-harm in the same circumstances as Mr Mavris.

Materials available to inmates to create ligature

Clause 5.7 of the CESU Standard Operating Procedure for *Inmate Bedding/Clothing Control* provides that "*[i]inmates held in 24hr cell complexes for an extended period of time will be issued a set of inmate clothing at the discretion of the OIC*". No guidance is provided as to what constitutes an extended period of time, or what factors may be relevant to any exercise of discretion by an OIC. AS Yarnton gave evidence that if Mr Mavris had been observed engaging in the type of behaviour that was recorded on the CCTV footage in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, then action would have been taken to limit his access to materials which could be used to self-harm. Specifically, this would have likely included providing Mr Mavris with only cardboard cutlery and dinnerware and providing safe cell blankets which are manufactured in a way which prevents them being fashioned into a ligature.

Conclusions: If Mr Mavris had been adequately monitored in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, it is evident that a mandatory application would have been made, which in turn would have resulted in him being placed on an ISP. To further mitigate the risk of self-harm, it is most likely that any materials capable of being used to fashion a ligature would have been removed from him.

Keeping inmates at Surry Hills Cells for up to 72 hours before transfer to a correctional centre

Part 3 of the CESU SOP provides that "*[w]here possible all fresh custody inmates are to be moved to a correctional centre within 72hrs of reception from Court. No inmate sentenced or otherwise is to be held in excess of 72hrs without the express permission of the Assistant Commissioner, Security & Intelligence*". It is evident that Mr Mavris was in custody for approximately 40 hours prior to his death. After being refused bail, it is unclear whether any immediate steps have been taken to transfer Mr Mavris to a correctional centre ahead of his next court appearance.

Conclusions: At the time of his death there was no procedural or policy requirement for Mr Mavris to have been transferred from the Surry Hills Cells to a correctional centre prior to 6:30pm on 25 May 2018. More relevantly, and as noted above, if Mr Mavris had been adequately monitored in the periods between 11:50am and 1:40pm, and 6:10pm and 6:30pm on 25 May 2018, then it is most likely that he would have been placed in an ISP. This would have significantly mitigated any risk of self-harm and decreased the possibility that the period of time that Mr Mavris spent in custody contributed to his death.

Findings pursuant to section 81 of the *Coroners Act 2009*

Identity

The person who died was Dimitrios Mavris.

Date of death

Mr Mavris died on 25 May 2018.

Place of death

Mr Mavris died at the Surry Hills Cells Complex, Sydney Police Centre, Surry Hills NSW 2010.

Cause of death

The cause of Mr Mavris' death was hanging.

Manner of death

Mr Mavris died whilst in lawful custody, after having been refused bail, as a result of actions taken by him with the intention of ending his life.

To the Commissioner of Corrective Services New South Wales:

1. I recommend that the post duties of the Monitor role at the Surry Hills Cells Complex, and the Local Operating Procedure 2019/04 *Generic duties and responsibilities of the Monitor Room Officer*, be amended to explicitly state that one of the responsibilities of the Monitor role is to regularly observe the CCTV footage of inmates in their cells for the purpose of identifying any behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm.

2. I recommend that consideration be given to an urgent review of the CCTV cameras in the cells and the display screens in the reception area within the Surry Hills Cells Complex in order to determine (a) whether the CCTV footage is of sufficient quality to allow a correctional officer to identify any inmate behaviour that would give rise to a concern that an inmate is at risk of suicide or self-harm at all times; and (b) whether there is a need to implement a Local Operating Procedure in relation to the timing and circumstances in which cell lights are turned off, and the extent to which the absence of lighting in cells adversely impacts on the quality of CCTV footage.

3. I recommend that (a) Corrective Services New South Wales officers rostered on duty at the Surry Hills Cells Complex be provided with appropriate training regarding Part 1 of the Court Escort Security Unit Standard Operating Procedures relevant to the impermissibility of watching television whilst on duty; and (b) periodic audits be conducted by the General Manager, Court Escort Security Unit to ensure compliance with the provisions of Part 1 of the Court Escort Security Unit Standard Operating Procedures.

4. I recommend that the conduct of Assistant Superintendent Dean Yarnton be reviewed for possible disciplinary action in relation to (a) countenancing a practice of subordinate officers watching television whilst on duty at the Surry Hills Cells Complex, including after 25 May 2018: and (b) not utilising the Monitor role for its intended purpose.

5. I recommend that consideration be given to the implementation of a Local Operating Procedure for the Surry Hills Cells Complex which provides for (a) correctional officers to physically attend the cell of an inmate with sufficient frequency (for example, at least twice during each Watch) to ensure the safety and well-being of an inmate; and (b) that the Morseman Tour Guard Wand be used to confirm such attendances.

15. 269824 of 2018

Inquest into the death of Nathan Reynolds. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 11th March 2021.

Nathan was 36 years old at the time of his death in prison on 1 September 2018.

Nathan was a First Nations man of Anaiwan and Dunghutti heritage, and a beloved member of a large family. He had a history of severe asthma and he suffered an acute asthma attack on the night of 31 August 2018. By the time Corrective Services officers attended Nathan, his condition had rapidly deteriorated. Tragically, ambulance paramedics could not save him, and he was pronounced deceased.

Nathan's medical crisis on the night of 31 August required an emergency response. But the response he received fell well short of this. It was confused, uncoordinated and unreasonably delayed. The delay deprived Nathan of at least some chance of surviving his acute asthma attack. These failures were due both to numerous system deficiencies, and to individual errors of judgement.

But the failures in Nathan's care went beyond what happened that night. In critical ways, the health care he had received since entering custody was inadequate. It failed to reduce his risk for a fatal asthma attack. It did not comply with established treatment for the management of severe asthma. It did not even comply with NSW Health's own policies to prevent chronically ill prisoners from deterioration and death. These failings significantly increased Nathan's risk for the fatal attack which took his life on the night of 31 August.

Two questions lay at the heart of this inquest. What prevented correctional officers from responding promptly to Nathan's medical emergency that night? And in the months before he died, what went wrong with the management of his chronic illness? These questions go to the central issue of whether Nathan's death could have been prevented. Nathan's death exposed the need for changes to be made in the care given to people with severe asthma in NSW's prisons. This is why I have made a number of recommendations in this inquest. These recommendations are not focused on attributing blame. Rather, they are made in the hope that people like Nathan who enter custody with conditions of severe asthma will have a better chance of avoiding a life-threatening attack, and of surviving one should it happen.

A further issue was examined in this inquest. It arose from Nathan's identity as a First Nations man. First Nations people are grossly over represented in custody, a fact officially recognised thirty years ago in the 1991 Royal Commission of Inquiry into Aboriginal Deaths in Custody. As noted by the Commissioners, this over representation '*provides the immediate explanation for the disturbing number of Aboriginal deaths in custody*'. Thirty years later we have no reason to suppose those numbers will fall. In the findings made into the death of First Nations man Tane Chatfield, Deputy State Coroner Grahame said that *'…until we do something about over representation, we will certainly continue to record a disproportionate level of Indigenous deaths in custody'.*

The focus of this inquest into Nathan's tragic death was the health care and treatment which he received, both on the fatal night and in the preceding four months he had spent in custody. Thirty years ago, the Royal Commission recommended that custodial health and safety practices:

'demonstrate cultural awareness and be implemented in consultation with Aboriginal Health Services, [Aboriginal Legal Services], and the broader community'.

The Royal Commission recognised that First Nations people in prison have specific health and emotional needs. Models of care which improve their health outcomes need to be carefully considered. Can anything be learned from prison settings where First Nations health care is delivered by different models? The inquest received some limited evidence about this. Much more however can and must be done to understand and meet the specific health and wellbeing needs of First Nations people in custody. Nathan's family grieve his loss and miss him deeply. They attended each day of the inquest and participated with dignity and courage. It was profoundly distressing for them to hear that Nathan did not receive the care he needed. I want to express to Nathan's family and friends my deep appreciation for their participation, which they did for Nathan's sake and in the hope of changes which will mean that others do not suffer as they have.

The issues at the inquest

Witnesses who gave evidence at the inquest included a number of involved correctional officers and some of Nathan's fellow inmates. In addition, respiratory physician Dr Greg King assisted the court with expert reports and oral evidence. Dr King is well qualified to provide this assistance, as staff specialist and Medical Director at the Royal North Shore Hospital's Respiratory Investigation Unit. He has 27 years' experience in the management of asthma and as a researcher into asthma and airways disease.

Nathan's life

When Nathan died he left behind a grieving mother, sisters and brothers, aunts and grandmother. He also left a partner who is the mother of his 12-year-old daughter Summer, and his partner's two children. Nathan was born on 1 December 1981, the eldest child of parents Jodie Reynolds and Steven Hampton. The couple had three other children including Taleah and Shannon, who were both close to Nathan. Jodie Reynolds had other children Makayla, Brodie and Labreh Reynolds and they too had a close connection with him. During Nathan's childhood the family lived mainly in Sydney's Rooty Hill area. When Nathan left school, he undertook a gyprocking apprenticeship, and he worked as a gyprocker both for himself and for companies. He was a hard worker and as his sister Taleah described it, most times they saw him he was covered in a layer of plaster dust. Nathan and Karen Pochodyla had known each other since their primary school days, and they commenced living together soon after 2006. Ms Pochodyla had two children from her former marriage, Briley and Brock, who continued to live with herself and Nathan. In 2008 the couple had a daughter Summer who was Nathan's pride and joy. Taleah told the court he usually referred to Summer as '*Darling*', and he told people she was '*his best achievement in life'*.

At the close of the evidence the court heard loving and affectionate tributes to Nathan from many family members. Ms Pochodyla, supported by her son Brock, shared with the court a letter Nathan had sent to herself and the three children. At times both reflective and funny, it made clear his genuine love for them all. Briley and Summer made videos in which they spoke of their feelings of loss and sadness. The close and affectionate bonds they shared with Nathan were clear, with Summer describing her father as '*creative and fun and the best Aussie ever'*. On behalf of the Reynolds family Nathan's sister Taleah, supported by her sister Makayla, spoke very movingly about Nathan. She described his central position in their family's life, how dearly loved he was, and the gap he has left behind. Taleah showed great strength and courage in taking on the role of family spokesperson and fulfilling it so well. She gave a generous and loving tribute, highlighting the deep connections Nathan had with his family and their profound sadness that he is no longer with them.

The cause of Nathan's death

There was no controversy as to the direct cause of Nathan's death. The autopsy report of pathologist Dr Lorraine Du Toit-Prinsloo recorded this as bronchial asthma.

Dr Prinsloo described asthma as *'an inflammatory disease process of the bronchioles with obstruction of airflow and narrowing of the airways.*' The features she observed in Nathan's lungs were in her opinion characteristic of asthma. She found no evidence of injuries to Nathan's body, or of other disease apart from asthma. Dr King concurred. In his expert opinion Dr Prinsloo's post mortem findings, and the evidence about Nathan's deterioration and death that night, were entirely consistent with death from asthma. In the first of his two reports he commented that the descriptions given by those present with Nathan that night were: *'…consistent with a life-threatening asthma event, then a respiratory arrest … with consequent loss of consciousness, an hypoxic (lack of oxygen) seizure, cessation of breathing and then cardiac arrest….'*

General information about asthma

Asthma is one of the top five chronic conditions among prison inmates, according to NSW Health's Justice Health's Strategic Plan 2018-2022.
At the inquest it was useful to hear some basic information about asthma and its proper management. Dr King provided the following information:

- asthma is a condition suffered by 5-10% of the general population
- about 5% of asthma sufferers have *severe* asthma
- approximately 400 Australians die of asthma each year.

Dr King also provided evidence about the types of medications commonly used for treatment of asthma. He explained that the frequency with which a person uses their medication is highly relevant in assessing whether their asthma condition is well managed.

Asthmatics are recommended to do as Nathan did, and always carry an asthma reliever puffer for quick relief of their immediate symptoms. These are fast-acting medications which reduce asthma symptoms by relaxing the muscles around the airways. Salbutamol (brand name Ventolin) is a commonly used reliever, delivered from a blue puffer.

However, reliever puffers do not treat the underlying cause of asthma, namely airway inflammation, and hence do not provide protection from the risk of a severe asthma attack. According to National Asthma Council Australia, use of a reliever puffer more than twice per week is a sign of poorly controlled asthma. As will be seen, there is evidence that while in prison Nathan was using his reliever puffer on a very frequent basis.

Asthma preventer medications are regarded as critical to good asthma treatment because they treat the underlying cause of its symptoms. They are taken daily to reduce the risk of asthma attack. Symbicort and Seretide are commonly used examples.

Oral corticosteroids such as Prednisone are also sometimes prescribed to regain control during an attack. These are anti-inflammatory medicines which quickly reduce lung inflammation.

Key to the effective treatment of asthma is an asthma action plan which has been developed between the patient and an asthma clinician. This reduces the risk of a sudden and severe attack and guides the response if such an attack occurs.

Nathan's history of asthma

Nathan was well aware of his asthma condition, and he understood the need to manage it with medication and seek help when necessary. This he did. However, he may also be described as typical of most asthma sufferers, in that he had what Dr King described as a '*high tolerance ..for having frequent attacks'*. This can lead to asthma sufferers '*normalising*' their condition and underestimating their risk for life threatening episodes.

Nathan's sister Taleah said that the Reynolds family had a history of asthma. Although Nathan had a Ventolin puffer and preventive medicine, she recalled he often ran out of Ventolin. Taleah reported that when she spoke to him on the phone while he was in custody he often sounded wheezy, as though he was struggling to breathe.

According to Ms Pochodyla, Nathan had experienced breathing difficulties since 2015. He regularly attended the Rooty Hill Medical Centre for asthma treatment, where his preferred doctor was Dr Khaled Etri. On 21 February 2016 Nathan spent two days in Mount Druitt Hospitalwith acute respiratory distress, after being unwell for two days with flu-like symptoms.

Nathan commenced a sentence of nine months' imprisonment on 3 February 2017 for domestic violence related offences. While in custody on 3 May 2017 he had an episode of shortness of breath, and he was prescribed a Ventolin inhaler and a Seretide preventor inhaler. The next day he suffered an acute episode of respiratory distress and was admitted to Bathurst Hospital. The hospital records documented the following: Nathan had reported two days of worsening wheeze and difficulty breathing, despite hourly use of twelve puffs of Ventolin his lung function had fallen to 10% due to his asthma attack, objective evidence which demonstrated very severe asthma.

Another asthma attack followed on 7 May 2017, for which he was treated in the prison health centre with oxygen therapy. Thereafter he was reviewed on various occasions until his release to parole on 2 June 2017.

In January 2018 Ms Pochodyla took Nathan to Mt Druitt Hospital as he was experiencing a breathing emergency. She reported he was '*blue in the face and couldn't breathe*'. Between February and May 2018, on at least two occasions Nathan was unable to undertake his community service obligations due to asthma attacks. According to a medical certificate, on one of these occasions he was hospitalised.

In his report dated 12 March 2020 Dr King stated that Nathan's symptoms as described by his family were *'absolutely typical'* of severe asthma. Furthermore, Nathan's *'frequent ED attendances and ICU admission … are also typical of severe, uncontrolled asthma*'.

On 10 May 2018 Nathan commenced a second period of imprisonment. This was to be served at the Outer Metropolitan Multi-Purpose Correctional Centre [the OMMPCC], in southwestern Sydney.

Nathan's severe asthma attack and the response to it

I will firstly consider the evidence about Nathan's fatal asthma attack on the night of 31 August 2018, the response to it, and whether deficiencies in the response contributed to Nathan's death. Some preliminary information is important to understand the night's events, and how correctional officers responded.

The Outer Metropolitan Multi-Purpose Correctional Centre

At the time of Nathan's incarceration, the Outer Metropolitan Multi-Purpose Correctional Centre [the OMMPCC] was part of a complex of three correctional centres. The other two facilities were John Moroney Correctional Centre and Dillwynia Correctional Centre. At that time, inmates for all three centres totalled approximately 1,000.

The OMMPCC was a minimum-security centre, and Nathan was accommodated in its H wing which housed 25 male inmates. H wing provided what is known as '*open wing'* accommodation. Its inmates were let out at 8.00-8.30am and returned to the wing at 3.30pm.

They were not locked in their individual cells and were able to move around the communal room and in other inmates' cells if they chose. Each cell in H wing had at least one alarm, which connected the inmate to the duty office via a radio communication system. Activating the cell alarm was known as a 'knock up'. At the OMMPCC in common with most NSW correctional centres, the inmates received health services from the integrated Justice Health and Forensic Mental Health Network [the JH Network].

The night shift on 31 August 2018

The correctional officers on B watch night shift on 31 August 2018 were officers Matthew Fawzy, Nirvair Singh and John Fifita. Also, on duty was an officer stationed at the OMMPCC's front gate, Mr Sham Dhanju. All four were under the supervision of Mr John Phali, who occupied the role known as the 'night senior' or senior CO and had overall command for the OMMPCC during the night shift.

During the afterhours of 7pm to 7.30am, a sole registered nurse was rostered to provide nursing assistance to the inmates of all three facilities. On the night of 31 August that nurse was Registered Nurse Kasey Wright. She was stationed at the Dillwynnia Health Clinic, meaning that if her help was needed at one of the other two facilities she had to make her way there from Dillwynnia. RN Wright had been registered for two years and employed with Justice Health for twelve months. Her induction training was of a general nature and did not include training specific to performing the role of afterhours nurse. Since Nathan's death RN Wright has left Justice Health and has completed Advanced Life Support training, but at the time she was trained in basic life support only.

CSNSW policies regarding knock up call responses

Two key practices were cited in response to questions about the timeliness of the response made by correctional officers. These were local practices which, the involved officers believed, required the following:

- that a minimum of three officers were to respond to a knock up call after lock down, due to the fact that inmates in open wing accommodation are not secured in their cells.

- that in response to a knock up call, officers were not to consider calling a nurse or ambulance until *after* they had attended the inmate and assessed the situation themselves.

As will be seen, these practices created significant delays in the response to Nathan's health crisis. The flow on effect was that it took too long for emergency medical care to reach him. Whether or not CSNSW policies mandated these specific practices is unclear on the evidence. Certainly, the involved officers believed that night they were bound to comply with them.

Jeffrey Preo, Aaron Robinson and Brandon Tan

Three other people are important to the events of that night: Jeffrey Preo, Aaron Robinson and Brandon Tan. These three men were Nathan's fellow inmates in H wing. In the weeks leading up to Nathan's death Mr Robinson had become friendly with him, as they were both shortly due for release. Mr Preo knew Nathan as well. For his part, after Nathan's death Mr Tan wrote to the NSW Ombudsman expressing deep concern at the delayed response to his health crisis. All three men witnessed Nathan's crisis that night and gave evidence of what they saw and did. Their memories of Nathan's last minutes were visibly painful to them, as was their frustration and distress that he could not be saved. However, they knew that Nathan's family had a strong need to know what happened. At the close of the inquest Nathan's family expressed their gratitude for the support and comfort these men had given to Nathan, and for bearing witness at his inquest.

The day and evening of 31 August 2018

On the morning of 31 August 2018 Nathan attended chapel devotions. This was a regular practice for him, and he was said to be an active participant in its discussions.

For the previous two days Nathan had been complaining of flu-like symptoms. A fellow inmate and a cousin both recalled Nathan taking Panadol or Ibufrofen on 31 August for throat ulcers. During his time in custody Nathan maintained frequent phone contact with his family members. On 31 August he had a number of phone conversations which indicate his respiratory condition was steadily worsening. At about 1.54pm Nathan rang his sister Taleah and they discussed plans for him to live at her place when he was released. Just before this, Nathan had spoken on the phone with Ms Pochodyla and told her he felt '*horrible*' and had the flu. Ms Pochodyla asked if he had gone to see the doctor, but he replied, '*you don't see doctors around here, nobody gives a shit about you*'. He told her he'd get some cold and flu tablets.

After lock down at 3.30pm Nathan borrowed a blue puffer from another inmate, who described him as wheezing '*quite a bit*'. There is some evidence that on the supervised medication round at about 6.30pm Nathan was issued a new blue puffer, but the evidence is unclear. After that Nathan had dinner and watched football on television. At around 9.30pm Nathan's mother Jodie rang him and asked if he was ok, to which he replied that he was. Jodie believes he said this because he didn't want to worry her. Nathan spoke again with Ms Pochodyla, who said he sounded '*a hundred times worse*' than he had earlier. In fact, she couldn't understand a lot of what he was saying. His words were slurring, and she had to ask him to repeat them. She urged him to go to the doctors and he replied that he would call them up now. Nathan then spoke to Summer, saying '*I love you baby, I will talk to you tomorrow*'.

At 10.30pm and again at 10.45pm Nathan spoke by phone with his brother Shannon. He told Shannon he had ulcers at the back of his throat, that he'd already '*buzzed up*' but that he was ok. He also said he'd seen the nurse all week because of his breathing issues but they had just kept sending him back. He further said he'd seen the nurse today, but she'd sent him back without a puffer. In the opinion of Dr King Nathan's severe asthma condition was worsening that night, and had in fact been deteriorating for many days, based on the above evidence and that of other inmates that he was borrowing their blue reliever puffers. Dr King also noted that Nathan's hospital admissions for severe asthma attack in 2016 and 2017 had been preceded by cold and flu- like symptoms. He thought it probable that Nathan's deterioration had been triggered by a similar infection.

The knock up calls

At 11.27pm that night Nathan used his cell alarm to call for medical help. He spoke to Mr Fawzy, who was stationed in the duty room with Mr Singh. The duty room was located across a yard from H wing.

Nathan said: '*Chief, I'm finding it hard to breathe and I need you to get a nurse down here*'. Mr Fawzy replied: '*Hold on tight, we'll be down shortly*'.

Mr Fawzy then contacted the night senior Mr Phali and told him that an inmate in H Wing had knocked up, was having breathing difficulties, and needed a nurse. Mr Fawzy and Mr Singh did not immediately head to H wing. Nor did they ask for the night nurse or an ambulance. They were insistent that when responding to a knock up call, medical or otherwise, they were first required to attend and verify the gravity of the situation. In addition, as noted they believed that three officers were required when entering an open wing after lockdown. Thus, the two officers had to wait until a third officer Mr Fifita could join them.

At about 11.29pm a second knock up call came through to the duty office. The caller, who was probably Mr Aaron Robinson, told Mr Fawzy: *'Chief you better get down here quick, he needs a nebuliser'.* Still the officers did not head to H wing. Mr Fifita had not yet arrived at the duty room, as he was using the bathroom in the adjoining reception area. He joined the other two officers at approximately 11.37pm. In the ten minutes that had elapsed since Nathan's knock up call the officers did not take any steps to speed up the arrival of Mr Fifita. Nor did Mr Phali himself monitor their progress or make enquiry as to why they had not yet notified arrival at H wing.

Once Mr Fifita arrived at the duty room the three officers commenced walking to H wing. CCTV footage showed their progress as they made their way across the yard. They were not moving at speed. Mr Fifita can be seen walking about 10 metres behind the other two. He explained that he had injuries to his knees which limited his mobility, and the other two officers were not permitted to get ahead of him. Each was certain they were not permitted to run to the location. They arrived at H wing at 11.38.25pm, more than eleven minutes after Nathan's first call for help.

The call for the night nurse

Meanwhile Mr Phali made a call to RN Wright asking her to attend. Although in his evidence Mr Phali said he rang RN Wright when Mr Fawzy first called him, this is contradicted by his statement, and by RN Wright's evidence that she was not contacted until 11.40pm. For the reasons given at paragraph 69 below, I prefer her evidence on this point. Mr Phali told RN Wright that an inmate had knocked up, was '*breathing funny*', and needed a nebuliser. RN Wright told the court that Mr Phali did not communicate to her any sense of urgency about the inmate's situation. To attend Nathan, RN Wright needed to exit through a number of locked doors to the Dillwynnia car park. She then drove to the OMMPCC front gates, arriving at 11.45pm to be met by Mr Phali. At that moment Mr Phali was receiving an urgent radio report from Mr Singh at H wing. Mr Singh told him that Nathan was now '*unresponsive'*. Realising for the first time that Nathan's situation was urgent, RN Wright told Mr Phali to call an ambulance. It was now 18 minutes after Nathan's call.

I note for completeness that in evidence, Mr Phali said he had already directed the front gate to call an ambulance. But this is contradicted by the evidence of RN Wright, of the front gate officer Mr Sham Dhanju, and of NSW Ambulance records showing that they received the call at 11.48pm. At the inquest Mr Phali conceded that the stress of the night's events may have impaired his recollection of their timing and sequence. Mr Phali and RN Wright then set out on foot for H wing, detouring to collect a first aid trolley from the OMMPCC Health Centre. They arrived at H wing at 11.49pm. Twenty-two minutes had now elapsed since Nathan's call for help.

Nathan's collapse

By this time the three officers Fawzy, Singh and Fifita had been at H wing for eleven minutes. They described approaching the building just after 11.38pm and hearing inmates at the windows, yelling at them to '*hurry up, he can't breathe'.* This did not appear to prompt them to move any more quickly. Inside the communal room they found Nathan lying on the lounge, '*gasping for air'* and repeatedly trying to use a puffer. He was unable to speak. Gathered in the room were most of the wing's inmates.

The mood was highly agitated, with some voicing anger and frustration at the officers for the time they had taken to get there.

Aaron Robinson and Jeremy Preo were among those gathered there. Both knew Nathan suffered from asthma and that he had been unwell in the previous few days. Mr Robinson said he had realised immediately that Nathan was suffering an asthma attack – he was gasping and appeared unable to exhale, with his chest '*barrelling*' with each breath. Mr Robinson sat next to Nathan on the lounge, trying to bring his panic levels down. He told Nathan to look at him and to try to breathe. Hunched over and gasping, Nathan was unable to speak. Mr Robinson was close to tears as he described Nathan's desperate state:

'*He was in a panic, couldn't exhale. He was a man begging for help with his eyes and he couldn't say a word …What little breath he had was just gasping for help'.*

Since Nathan was in no condition to walk to the Health Centre Mr Fawzy left to collect a wheelchair, returning with one just before 11.43pm. Mr Fifita, Mr Robinson and Mr Preo then tried to lift Nathan into it. It was at this point that Nathan collapsed. All witnesses described his body as suddenly stiffening. Some said he appeared to suffer a short fit. As one witness described it:
'At that moment the life went out of his body, he had no life'.

Mr Robinson and Mr Preo placed Nathan on the floor, on his side in the recovery position, while Mr Fifita put a jumper under his head as a pillow. Mr Singh immediately radioed to Mr Phali: '*We need an ambulance'*. Thereafter Mr Robinson and Mr Preo remained on the floor with Nathan, their attention focused upon him. They talked to him and tried to help him breathe. Mr Fifita stood close by, while the other two officers attempted to manage the increasingly agitated group of inmates.

The attempts to revive Nathan

RN Wright told the court that when she arrived at H wing with Mr Phali at 11.49pm, it was immediately clear to her that Nathan's condition was very serious. She moved him onto his back to assess him. She was unable to locate a pulse or any signs of breathing. Nathan's pupils were fixed and did not respond to light. She and Mr Phali commenced first aid, with Mr Phali performing chest compressions and RN Wright providing oxygen via a mask and cylinder.

It was then that RN Wright realised the first aid trolley was missing its defibrillator. In accordance with usual practice, it had been taken from the trolley at the commencement of the night shift and placed in the officers' duty room. When the defibrillator was retrieved RN Wright applied its pads, only to find that Nathan had no shockable rhythm. It could provide no assistance in restoring his heartbeat. RN Wright tearfully told the inquest that when she found there was no shockable rhythm she felt sure Nathan was no longer alive. Nevertheless, she and Mr Phali continued to deliver chest compressions and oxygen until the arrival of two ambulance crews. NSW Ambulance had dispatched an ambulance to the OMMCC at 11.56pm, within eight minutes of receiving a call.

At the inquest there was no issue concerning the timeliness of this response. Paramedics arrived at the prison main gate at about 12.14am, to find another ambulance crew from Penrith already there.

At H wing they found Nathan lying on his back on the ground, with RN Wright performing CPR with a defibrillator attached. The ambulance paramedics confirmed that Nathan was in cardiac arrest. He had no pulse, no spontaneous respirations and there was no rise or fall of his chest. They maintained resuscitation efforts for a further 30 minutes, including CPR and intravenous adrenaline, but to no avail. At 12.44am Nathan was pronounced deceased.

During her first aid efforts RN Wright injected a dose of the opioid-blocker Naloxone into Nathan's right thigh muscle. This action was a source of great distress for Nathan's family. It appeared to them that on arrival she had erroneously assumed he had collapsed due to an illicit drug overdose. On his behalf they were deeply hurt by this suggestion. They were also deeply upset at the possibility that administering Naloxone had taken precious time away from the effort to save his life. At the inquest RN Wright explained that although she had asthma '*on her mind*' as the cause of Nathan's collapse, she had hoped there was a reversible cause, such as a drug overdose. She told the court she had not wanted to harm Nathan or insult his family by injecting him with Naloxone.

Dr King did not consider RN Wright's administration of Naloxone to have been inappropriate. In addition, he thought it had little or no bearing on the outcome and would have neither enhanced nor impaired Nathan's prospects for survival. The profound distress felt by Nathan's family is very understandable. There is of course no evidence that Nathan had ingested opioid drugs. His tragic death was entirely due to an acute asthma attack. I note Dr King's evidence that at the very least, the administration of Naloxone did not harm Nathan's chances for survival, and I hope that this evidence ameliorates at least to some extent his family's pain.

Expert evidence regarding the emergency response

One of the matters upon which Dr King's opinion was sought, was whether a more effective emergency response could have saved Nathan's life that night. In Dr King's opinion, Nathan's asthma attack was impending from the time he began to experience cold and flu-like symptoms, most likely in the preceding two days. His condition clearly worsened throughout the hours of 31 August. By 11.27pm when he called for help, a life-threatening attack was imminent, and he was in immediate danger of respiratory arrest.

Dr King told the court that thereafter every passing minute reduced Nathan's chances for survival. His airways progressively shut down and he urgently needed treatment to open them. As we know, twenty-two minutes passed before the only form of onsite medical help arrived, with the arrival of RN Wright at 11.49pm. Dr King commented that by then Nathan was many minutes into respiratory arrest, and his brain was suffering acute lack of oxygen. He had probably ceased breathing from the moment the attempts were made to move him into the wheelchair, about four minutes earlier. To have any chance of survival, he needed aid that only paramedics with advanced life support training and equipment can deliver namely tracheal intubation andventilation.

In Dr King's opinion, even if RN Wright been able to arrive *before* Nathan became unconscious, the chances were small that she could have averted his death, given the limited equipment she had and her lack of advanced life support training. By this time Nathan's lungs needed mechanical ventilation. Dr King agreed that Nathan's chances of survival would have been greater if an ambulance crew had been able to arrive prior to his respiratory collapse at 11.45pm.

This would only have been possible if an ambulance had been called *immediately* when he first sought help at 11.27pm. This evidence must have been very distressing for Nathan's family to hear. I accept Dr King's opinion that from the time of Nathan's first knock up at 11.27pm, there was a very limited window of opportunity to save his life. Thereafter his prospects of surviving without immediate paramedic treatment were poor.

Conclusion regarding the emergency response

The above conclusion does not in any way diminish the adverse findings that must be made about the response to Nathan's acute attack that night. Nathan's situation at 11.27pm required an *urgent* response. The response he received fell well short of this. The resulting delays in the request for a nurse and ambulance removed what little chance Nathan had ofsurviving.

When Nathan's severe asthma attack struck, he notified Mr Fawzy that he was having difficulties breathing. CSNSW policy dictates that breathing difficulties constitute '*a medical emergency or serious health problem'*: Custodial Operations Policy and Procedures 5.5: *Cell security and alarm cells*. In such a situation the correctional officer is mandated to *'immediately go to the cell'*. Thus, CSNSW policy makes clear that an inmate reporting breathing difficulty is to receive an urgent response.

Despite this, and taking Nathan's knock up call at 11.27pm as the starting point for each of the following events, it took:

- over eleven minutes for correctional officers to reach his side
- thirteen minutes for a nurse to be summoned
- twenty-two minutes before a nurse arrived at his side
- forty-seven minutes before ambulance paramedics attended him.

These time frames cannot be accepted as adequate or appropriate to a medical emergency. The lack of urgency which characterised the response of the involved officers, in particular the ten minutes' time which elapsed before they set out for H wing, is in my view inconsistent with the above CSNSW policy. For the most part, the four involved officers did not give the impression of being personally uncaring people. They were emotionally affected by Nathan's traumatic death.

Yet the earlier stages of his medical crisis were treated with a lack of urgency which was painful for those in court to witness, let alone the acute distress it must have caused his family. The delayed response was in addition characterised by a lack of coordination and planning. On the walk to H wing the three officers did not discuss a plan and on arrival, no officer took charge or had direct responsibility for Nathan's welfare. Mr Singh said he had assumed that Mr Phali had called for the night nurse some minutes previously. That he was mistaken underlines the absence of communication which also impaired the response.

The unreasonable length of time it took for correctional officers to reach Nathan's side had the flow on effect of delaying the nursing and paramedic response to his emergency, to the point where neither RN Wright nor the ambulance paramedics had any real hope of saving his life. Nathan's last minutes of consciousness as he waited for medical help must have been agonising for him and those around him.

Mr Robinson's memory of Nathan's desperate attempts to breathe will not be forgotten by those who heard his evidence.

The contribution of CSNSW policy

But the delayed response of the officers should not be solely attributed to errors of judgement on their part. It is clear that their adherence to CSNSW practices and instructions played a significant role in retarding their response. This is a systemic issue and in my view those practices now require speedy review. I have outlined at paragraph 45 above certain practices which officers Fawzy, Singh and Fifita believed they were bound to adhere to that night. That is, that a minimum of three officers was required to respond, and that a nurse or ambulance could not be called until they had assessed the situation themselves.

The source of the first belief is an Operating Procedure, current at that time and referred to as 'LF4', which appears on its face to require that when there is an emergency at OMMPCC in an open wing environment, three officers must attend. I refer here to Standard Operating Procedure *Posts/Staff Identified for an Emergency Response*. At the inquest Ms Linda Ferrett, Acting Director of CSNSW Northern Region, cited LF4 as the applicable procedure to implement what was referred to as 'COPP 13.2'. This is CSNSW's *Custodial Operations Policy and Procedure for Medical Emergencies*. Ms Ferrett's coronial statement made clear that all officers were required to adhere to this policy. I note that COPP 13.2 is stated to apply to situations where an inmate is discovered hanging or '*is found unconscious or seriously injured'*. There is nothing in the document to suggest application to a situation of seriousillness.

Secondly, and despite Ms Ferrett's statement that compliance with the Operating Procedure was mandatory, some of her responses at the inquest indicated that this need not always be the case. For example, in the event that one of the required three officers was delayed in joining the others, she considered two officers could proceed to the scene after notifying their night senior. The inquest did not hear any evidence of instruction to correctional officers that LF4 could be modified in certain circumstances. This was certainly not the impression held by any of the four officers involved in Nathan's case.

I note all four had been employed for many years as correctional officers. As for the source of the second belief, Standard Operating Procedure *Room Call Systems (Room Alarms)* directs officers to '*proceed directly to the cell/room'*, and '*where appropriate Justice Health staff must be notified of the incident*.' It would appear that the three responding officers interpreted this to mean (or were instructed to this effect) that before they called for nursing or paramedic assistance, they had first to attend the incident.

Adherence to these practices significantly delayed the response of the correctional officers to Nathan's medical emergency. Adherence to these practices is incompatible with the urgent response that he required, and which is mandated in COPP 5.5. There is a pressing need for review of these policies. Before moving on to examine Nathan's medical care while he was in custody, I will consider a particular submission made on behalf of the family. This is that on their arrival at H wing, the three officers made their priority the security of the situation rather than Nathan's welfare. The evidence largely supports this submission, although as noted the officers took some steps directed at Nathan's care, such as requesting an ambulance and retrieving a wheelchair.

However, given the circumstances I do not consider it would be fair to criticise the officers for this aspect of their conduct. The situation in H wing was a challenging one and they were outnumbered. They focused on trying to de- escalate the mood, and this largely remained their focus until the inmates were later transferred to an adjoining wing. I do however strongly endorse the further submission made on behalf of the family, that the response exposed a lack of guidance to correctional officers on how to manage an emergency medical situation in an open wing. After all, it will not always be the case that fellow inmates are on hand to provide the assistance that Mr Robinson and Mr Preo gave. Recommendations for improvement in this area will be considered later in these findings.

Nathan's ongoing medical care while in custody

I will now address the evidence regarding Nathan's medical care for asthma while he was an inmate at the OMMPCC. The JH Network describes its provision of custodial health care as:

'.. a staged health assessment process that commences with a reception screening assessment.

…Further assessments are undertaken in a planned and coordinated manner with follow up appointments arranged for those patients identified …with a diagnosed acute and/or chronic condition'.
[NSW Health Policy *Health Assessments in Male and Female Adult Correctional Centres and Police Cells*] As will be seen however, an examination of the actual care provided to Nathan reveals that a structured plan for evaluating and managing his asthma was missing. While Nathan was in custody his severe asthma was not properly managed.

The health service provided to him was inadequate, and significantly contributed to his risk for the fatal attack which took his life on the night of 31 August.

I have reached this conclusion on the basis of:

- evidence that the asthma treatment provided to Nathan fell short of what is required under JH Network policy; and

- the opinion of specialist Dr Greg King, addressed below, that while in custody Nathan's severe asthma was not diagnosed, properly monitored, or managed.

Nathan's initial screening assessment

When Nathan was received into custody on 10 May 2018 he underwent a routine health screening, known as a Reception Screening Assessment. The purpose is to identify and document an inmate's health risks and medications and if need be, to place them on a Wait List for nursing and/or medical appointments. Nathan's Reception Screening Assessment was performed by Registered Nurse Mohini Kumar. Nathan told RN Kumar that he used Salbutamol (Ventolin) for his asthma condition. He also advised her that he had been hospitalised for asthma about two months previously. RN Kumar made an entry on Nathan's Health Problem Notification Form that he suffered asthma and may *'complain of difficulty breathing or chest tightness'*. She then made a written request to Nathan's GP for details of his current medications.

As a result of her initial screening RN Kumar placed Nathan on the Wait List for four appointments.

These were:

- an asthma review with a Primary Health nurse
- an asthma medication review with a GP, with a '*semi-urgent'* priority
- an appointment with the Aboriginal Health nurse
- an appointment with a Mental Health nurse.

RN Kumar explained that she made the first three of these appointments because she recognised Nathan needed a comprehensive assessment of his chronic asthma. She told the court that she expected the appointments would take place promptly. She did not have any further involvement with Nathan. Most unfortunately, and for reasons which remain unknown, RN Kumar's referral of Nathan for an asthma review was electronically discontinued on the Wait List the following day.

The requirement for a Chronic Disease Screen

At the time she assessed Nathan, RN Kumar was not aware that according to JH Network policy she was required to refer him for a Chronic Disease Screen. She was one of several JH Network clinicians involved in Nathan's care, who were either unaware of the necessity for a Chronic Disease Screen or had only limited understanding of its importance. A Chronic Disease Screen [CDS] is mandated for inmates like Nathan who have a confirmed chronic condition. Nathan also met criteria for a CDS on the basis that he was an Aboriginal patient aged 35 years or older.

Had Nathan been referred for a CDS, then according to NSW Health Policy this would have been performed within 30 days. It would have involved:

- a review of the frequency with which Nathan used his blue puffer - an important marker for how well or otherwise his asthma was controlled
- a test of his lung function with a Peak Flow meter
- preparation of an Asthma Action Plan
- information to help Nathan identify his asthma attack triggers
- placement on a Wait List for review by a medical officer.

The court heard that an Asthma Action Plan is critical to good asthma care. This is, as Dr King described it in his first report, '*a clear and simple plan to implement, to prevent deterioration and death'.* Importantly, as a result of the CDS Nathan would have been placed on the JH Network's Clinical Pathway for Asthma. This is a tool designed to guide an inmate's ongoing asthma treatment while he or she is in prison. As the evidence below describes, while Nathan was in custody he did not receive a Chronic Disease Screen.

An Asthma Action Plan was never developed, and his asthma treatment was not coordinated or managed under such a plan.

Nathan's asthma attack on 3 June 2018

On 22 May 2018 Nathan attended the OMMPCC Health Centre with symptoms of wheezing and was given a replacement Ventolin puffer. Earlier that morning he had a scheduled appointment for a doctor review. An entry was made at 9.00am '*DNA Did not attend*'. It is not known if Nathan knew of this appointment or was prevented for other reasons from attending. Then on 3 June 2018 Nathan had an asthma attack. He came to the Health Centre with shortness of breath and was attended by Registered Nurse Parveen Samant. She measured his oxygen saturation as at 94%, which indicated he was suffering a severe asthma episode. He was treated with Ventolin via a nebuliser and was given oxygen. In addition, he was required to take oral Prednisone for two days. This episode presented an opportunity for staff at the Health Centre to check whether Nathan had received his CDS and importantly, whether there was an Asthma Action Plan in place for him. This did not happen. At the inquest RN Samant acknowledged that she ought to have made this check but did not. As a result of his asthma attack Nathan was given an appointment with the visiting GP for 5 June. This was the only occasion Nathan saw a doctor while he was in the OMMPCC.

The GP consultation on 5 June

Dr Kenneth Landers is a staff specialist and Visiting Medical Officer with the JH Network. In 2018 he was attending five correctional centres on a weekly basis, one of these being the OMMPCC. At the consultation on 5 June Dr Landers concluded that Nathan had not fully recovered from his asthma attack. He left directions for Nathan's lung function to be tested with a Peak Flow Meter. In addition, he prescribed a further five days of Prednisone, as well as a Symbicort inhaler which was to be used at least daily. Like RN Samant, he did not check Nathan's records to see if he had undertaken a CDS and had an Asthma Action Plan. Had he done so he would have seen that neither was in place. Dr Landers did not have any further involvement in Nathan'streatment.

Dr Landers told the court that his focus on 5 June was to treat Nathan for his recent acute asthma attack. Certainly, he did not see his task as extending beyond that, so as to satisfy himself that Nathan's chronic asthma was being effectively managed. It is fair to note that on 5 June there would have been little opportunity for Dr Landers to undertake the comprehensive asthma assessment that Nathan was still waiting to receive. His consultation with Nathan was probably one of the 12-15 consultations that, he said, typically take place on the visiting GP day. Nevertheless, it would not have been an arduous task for Dr Landers to confirm whether or not Nathan had received a CDS and had an Asthma Action Plan. At the inquest it was evident that at the time, Dr Landers had a limited understanding of the CDS process and did not see for himself any role in its operation, or indeed in the ongoing management of Nathan's severe asthma.

It is striking that in common with Dr Landers, almost every JH Network clinician with whom Nathan had contact lacked an adequate understanding of the CDS, and its key role in ensuring that chronically ill patients did not deteriorate. During his sixteen weeks at the OMMPCC Nathan had many contacts with JH Network staff. These included attendances for replacement Ventolin and for doses of Prednisone. Not one picked up that he had not received a CDS and did not have an Asthma Action Plan.

No one was alert to the number of times he had been issued with a fresh Ventolin inhaler, a red flag for uncontrolled asthma. In particular his attendance with an acute asthma attack on 3 June might have been expected to prompt enquiry as to these matters, but it did not.

Dr King's evidence regarding Nathan's ongoing care

Dr King was asked for his expert opinion as to whether the management of Nathan's asthma condition while he was custody was adequate. Dr King's opinion regarding the emergency medical response on 31 August has been described above at paragraphs 89 following. There was in fact a high degree of overlap between the two issues. This is because in Dr King's opinion, the prospects for surviving a severe asthma attack are low except in rare cases where medical expertise and equipment are readily available. Consequently, for patients like Nathan with severe asthma, the '*death prevention focus*' must be on the ongoing management of their condition.

Dr King told the court that ongoing management of severe asthma requires the following elements:

- diagnosis by a specialist respiratory physician
- regular clinical assessment
- formation of a written Asthma Action Plan
- regular monitoring of lung function using a peak flow meter
- regular use of preventor medication
- an action plan for periods when asthma symptoms worsened.

Having examined the evidence Dr King had no hesitation in classifying Nathan as a person at high risk of severe asthmatic attack, based on:

- his history of hospital presentations for asthma, in particular in the preceding 12 months
- his frequent use of Ventolin
- his use of Prednisone over the course of a year
- his smoking.

Furthermore, at inquest Dr King commented that the number of times Nathan had been issued with a Ventolin puffer from the OMMPCC Health Centre (at least seven times) ought in itself to have been a major red flag. Nathan's asthma was clearly severe and poorly controlled. Proper attention to his condition would have identified other red flags: his likely underuse of preventer medication and the onset of cold and flu symptoms two days prior to his death. To the question whether the management of Nathan's condition was adequate, Dr King's answer was a qualified 'no'. His primary criticism was the failure of JH clinicians to identify Nathan as a person at risk of severe asthmatic attack. In his view the medical evidence available to the clinicians ought to have compelled this conclusion.

Dr King acknowledged that managing asthma well is not easy in the community and was likely more difficult in the physical environment of a prison. Nevertheless, he thought it ought to be possible for custodial health services to identify high risk patients such as Nathan when they entered custody.

Dr King described the following as the features which had to be included in a plan for Nathan:

- referral to a respiratory disease's specialist

- assessment at four-weekly intervals to monitor how frequently he was using his preventor and reliever medication regular lung function monitoring

- a clear plan of action for when his asthma symptoms worsened (increased dosage of preventor medication, commence Prednisone, hospital referral, etc.)

- a discussion with him about how to monitor his asthma and recognise when he was at risk of an attack.

Regarding the referral of severe asthmatics to a *specialist* clinic, Dr King explained that that many doctors and nurses underestimate the severity of the risks posed by severe asthma. Specialist doctors and nurses on the other hand are expert at identifying it, are more alert to signs of uncontrolled asthma, and have more success in persuading patients to make necessary changes to their behaviour.

Conclusion regarding the adequacy of Nathan's asthma care while in custody

Nathan's actual care and treatment fell well short of what Dr King considered adequate for a person suffering severe asthma.

The health treatment which Nathan received also stands in strong contrast with the JH Network's statement of its service for chronically ill inmates (paragraph 117 above). Health care was not provided to Nathan in a '*planned and coordinated manner'.* In particular the failure to screen him for chronic disease and to have in place an Asthma Action Plan are serious deficiencies, given their importance in preventing fatal asthma attacks.

Based on that evidence, and the expert evidence of Dr King, I have to conclude that while he was in custody Nathan did not receive the health care that he deserved. At the inquest evidence was given by Ms Therese Sheehan, who is the Deputy Director of Nursing within the JH Network. She agreed there were significant gaps in the care Nathan had received while in custody, and readily acknowledged that his case had exposed a disconnect between the JH Network's policies regarding the CDS, and what the actual state of knowledge and practice was on the ground. At the close of evidence, a submission was made on behalf of the JH Network, that it was '*unlikely*' that a CDS or an Asthma Action Plan would have averted Nathan's death. The evidence does not support this submission.

According to Dr King, a properly implemented Action Plan for a person with severe asthma would have included regular reviews to assess whether asthma was under control. It would also include an intervention plan of action should the patient's condition deteriorate.

Both measures would have reduced Nathan's risk for the fatal attack which took his life. At the inquest Ms Sheehan described system changes which have taken place since Nathan's death. These include a prompt at the Reception Screening Assessment to ensure the clinician places an inmate with asthma on the CDS wait list. The CDS must take place within 30 days. Staff at the OMMPCC have also received refresher training in asthma management and the CDS requirements. These responses are welcome. However, the evidence establishes that there is ample scope to build on these improvements with further changes, which will be considered now.

The question of recommendations

The evidence at the inquest established that systemic deficiencies contributed to Nathan's inadequate care, both on the night of 31 August and in his preceding months in custody. At the close of the evidence Counsel Assisting proposed recommendations which are future-focused and designed to build on the lessons learnt from Nathan's tragic death. The recommendations were directed to the Commissioner of CSNSW and to the CEO of the JH Network. Nathan's family supported these recommendations and made further ones. I will now consider whether it is necessary or desirable to make these recommendations.

Recommendations to the Commissioner, CSNSW.

I have found that the response made by CSNSW to Nathan's medical crisis on the night of 31 August was unreasonably delayed, uncoordinated and inadequate. It deprived Nathan of the small chance he had of surviving his acute asthma attack. The four recommendations to the Commissioner proposed by Counsel Assisting are supported by the Reynolds family and by the four involved officers.

The first two recommendations propose that CSNSW review its practices and procedures in relation to a '*serious health event',* including:

- the way in which COs identify and respond to these events, in particular the importance of assuming that reports of breathing difficulties are a life-threatening event
- the role to be undertaken by the senior CO, in particular the circumstances in which he or she ought immediately to request nursing or paramedic assistance.
- Importantly, Counsel Assisting proposed that the review include instruction to correctional officers about what happened on the night of 31 August, andwhat can be learnt from it.
- Regarding the first recommendation, Dr King was in no doubt that where an inmate with asthma had breathing difficulties, this needed to receive the response of a medical emergency.

In his report dated 11 May 2020 Dr King explained this was because:

'…it is very hard to tell the very few instances [of asthma attacks] that are ***immediately*** *life-threatening. Therefore, either all 'breathing attacks' in inmates with asthma have to be treated as potentially immediately life- threatening, or there is a reliable risk stratification at start of incarceration. I would anticipate it would be more feasible to take the former approach, i.e. that all cases are potentially life-threatening and that the inmates are attended rapidly, with the appropriate equipment and medications, and with the nurse alerted immediately*.'

Relatedly, in her evidence Ms Ferrett agreed that in cases of breathing difficulties, and where there would be delay in the gathering of three correctional officers, the policy needed to be that a nurse would be called immediately.

I strongly endorse Dr King's statement that reports of breathing difficulties need to be treated as life-threatening events. Nathan's tragic death graphically illustrates this imperative. And this indeed is the intent of COPP 5.5, which effectively mandates that inmates with breathing difficulties receive an urgent response.

So why has Counsel Assisting proposed this review? The rationale lies in the practical incompatibility on the one hand of COPP 5.5, and on the other, the obligation of officers to comply with 'LF4' which requires attendance of three officers in open wing environments. To this may be added the belief held by the three responding officers, that before requesting nursing or paramedic assistance they must first attend the scene and assess its gravity. In cases of medical emergency, it is simply not acceptable to delay nursing or medical assistance due to a requirement that correctional officers first attend the incident. Nor is it acceptable that in such cases they cannot do so until at least three officers are present. Nathan's tragic death demonstrates the practical difficulty for officers of reconciling the obligations within COPP 5.5, with policies and instructions which carry a real risk of delaying both their response and that of medical assistance.

CSNSW opposed these two recommendations. It was stated in submissions that there was 'flexibility' in the policy which required the attendance of three officers (at paragraph 18) and in the instruction that officers are not to run to a medical emergency (at paragraph 20). That there is flexibility in the application of these practices may be a perception within CSNSW management, but this was not apparent to the officers on the ground. This further underscores the need for clarity and clear instruction to officers about how the applicable procedures are to be implemented in cases of serious medical events.

Overall, the submissions advanced on behalf of CSNSW did not provide a basis to reject these recommendations. The evidence at inquest did not support the submission made that '*Instructions on responding to incidents within all correctional facilities … are clear'.* Nor can it be accepted that the practices and procedures which the evidence has established as problematical are already '*covered in the COPP 13.2 Medical Eme*rgencies'. As noted, COPP 13.2 is stated to apply to an inmate discovered hanging or found unconscious or seriously injured. Furthermore, COPP 13.2 does not provide guidance as to when a health event might permit departure from the practices which, as this inquest has identified, unreasonably delayed the correctional officers' response.

It was proposed by CSNSW that the '*three'* officers could receive retraining. This is not an acceptable response to what happened that night. There is no reason to suppose that the need for retraining is confined to the involved officers in this case. Nor is it clear from the CSNSW submissions what the retraining would cover, as the submissions do not acknowledge that the involved officers departed from any of the policies or practices the subject of the recommendations.

The need for review of policies, procedures and instructions in the areas enumerated in recommendations 1 and 2 is strongly indicated. The third recommendation to the Commissioner concerns training of correctional officers about the risks and potential dangers of asthma.

CSNSW opposes this recommendation on the basis that 'specific medical training' is outside the scope of correctional officers' expertise and duties. This is acknowledged. However, the intent of the recommendation is not to make correctional officers responsible for the medical treatment of inmates. It is to improve their understanding of this potentially fatal condition and assist them to determine when escalation to nurse and paramedic care is needed. In their evidence officers Fawzy, Singh and Fifita acknowledged they had very limited knowledge or experience of asthma, one of the principal chronic illnesses within the prison population.

This point was well illustrated in the evidence of Mr Singh. When asked why on his arrival at H wing he did not immediately request an ambulance, he replied that he had thought Nathan's puffer would fix the problem. The final recommendation to the Commissioner is that the Commissioner review night staffing arrangements for minimum security centres, and ensure correctional officers are sufficiently fit to respond to urgent events. This recommendation is only partially supported by CSNSW. In their submissions it is stated that Mr Fifita '*ought to have made [his knee problems] known to his employer, CSNSW'* (at paragraph 19). Yet as the submissions elsewhere acknowledge, Mr Fifita had no obligation to do so, and officers have no mandated ongoing fitness requirements. The physical fitness of correctional officers to respond to medical emergencies should not be a matter for self-report. The evidence establishes the need for CSNSW to examine its policies in this area to arrive at an acceptable solution.

For the above reasons, I am satisfied it is necessary and desirable to make the four recommendations to the Commissioner, CSNSW.

Recommendations to the CEO, JH Network

I have found that the ongoing management of Nathan's severe asthma while he was at OMMPCC was inadequate, did not comply with the JH Network's own policies for asthma management, and fell well short of what was recommended by Dr King for proper asthma management. For these reasons Counsel Assisting proposed six recommendations to the CEO of the JH Network. It is encouraging that the recommendations are supported by the JH Network, and also by the Reynolds family and the nurses who were involved in Nathan's care. I also acknowledge the steps the JH Network has taken since Nathan's death to improve staff knowledge of and compliance with CDS requirements.

The third and fifth of the proposed recommendations relate to the JH Network's practices for managing inmates who suffer or may suffer *severe* asthma. Dr King's evidence at inquest made a strong case that patients who suffer severe asthma are not easily diagnosed and need the input of a specialist service. Of course, specialist diagnosis and management would involve resourcing and logistical challenges, but as submitted by Counsel Assisting, the JH Network should investigate whether telehealth appointments could assist. Telehealth appointments would also reduce problems of continuity that are created with changes to an inmate's placement. Regarding recommendation 4, the response on behalf of the JH Network was that all night first aid trolleys now contain a defibrillator. This is welcome news. The JH Network will however reiterate the need for compliance with this requirement. Underlying recommendation 6 is the evidence at inquest that when she attended Nathan RN Wright did not feel confident about administering an intramuscular injection of adrenaline. The evidence was unclear as to whether doing so was within the capacity of a JH registered nurse.

The purpose of the recommendation is to provide clarity on this issue.

Recommendation regarding the Winnunga model of health care

Included in the recommendations to the JH Network is one which proposes that it investigate the model of care provided to First Nations prisoners by Winnunga Nimmityjah Aboriginal Health and Community Services ['Winnunga']. Winnunga is a First Nations health organisation which since 2019 has provided health care and support to First Nations people who are incarcerated in the Australian Capital Territory. Winnunga's aim is to address the complex social and medical needs of First Nations prisoners more appropriately. It provides medical and nursing care, as well as social and emotional support for detainees and their families. At the inquest material about Winnunga was provided to the court by Nathan's family. The court also heard evidence from Mr Matthew Trindall, a descendant of the Gomeroi people, and Director of Aboriginal Health for the JH Network. Mr Trindall is aware of the work of Winnunga. On behalf of the JH Network he expressed willingness to explore its model of care and consider if any of its features could benefit the way in which care is delivered to First Nations prisoners in NSW.Mr Trindall acknowledged that NSW had a much greater prison population than that of the ACT, and further that its First Nation inmates had a more diverse range of needs, due to their diverse environments and backgrounds. Nevertheless, he endorsed the advantages to First Nation prisoners when their health care was delivered with the involvement of First Nation clinicians and workers.

Dr King agreed that the quality of asthma health care was enhanced when delivered by a clinician who is familiar with the patient's social and cultural background. This was especially important in helping patients to understand the risks of their condition and persuading them to make necessary changes to their behaviour. The 1991 Royal Commission of Inquiry into Aboriginal Deaths in Custody sent a clear message that the particular health needs of First Nations prisoners need to be recognised and addressed. Models of care which improve health outcomes for First Nations people in custody must be seriously considered. For this reason, I make this recommendation.

Joint recommendations to CSNSW and the JH Network

Counsel Assisting made two recommendations *jointly* to CSNSW and the JH Network.

The first was that the two agencies review the existing communication arrangements between senior COs and JH registered nurses. This recommendation arose from evidence that the officers at H wing did not have a direct line of communication to either RN Wright or the ambulance while they were on route to Nathan's location. As correctional officers are generally prohibited from carrying phones, they had to use their portable radios to relay information to Mr Phali, who as senior CO had the capacity to pass this on via mobile phone.

At the inquest Mr Singh expressed frustration that he had been unable to directly relay to RN Wright or to the oncoming ambulance crew any information or updates about Nathan's condition. Nor was he able to directly receive from them any instructions for first aid. For her part, it is clear that until she arrived at Nathan's side RN Wright had not been properly informed by Mr Phali of the gravity of Nathan's situation. She needed real time information about his condition from a correctional officer at the scene.

This capacity is of obvious significance in cases where nursing or paramedic assistance is delayed. This recommendation was supported by Nathan's family, and by the JH Network. It did not appear to be supported by CSNSW.

The second joint recommendation was that COs and registered nurses receive training in how to respond to and provide aid, where the medical emergency has occurred in an *open* minimum-security environment. The unsecured environment of H wing presented undeniable challenges for the responding officers and for RN Wright. This factor (among others) hampered the ability of the officers to provide aid to Nathan, a fact acknowledged by Mr Singh when he expressed his thanks to Mr Robinson and Mr Preo for their care of Nathan.

I was not made aware of any evidence that CSNSW provides specific training for officers to manage an emergency situation in an open wing environment. This recommendation was supported by Nathan's family and the JH Network. Submissions on behalf of CSNSW indicated they would consider scenario training for responding to medical emergencies '*within dormitory style accommodation'*, which I assume equates to open wing accommodation. Consideration would be given to conducting this training alongside JH staff and emergency services. I welcome their support of this recommendation.

The evidence strongly supports the need for review and training as outlined in all the recommendations proposed by Counsel Assisting. I am satisfied that they are necessary and desirable.

Additional recommendations made on behalf of Nathan's family

Nathan's family supported all the recommendations proposed by Counsel Assisting. In addition, they made 16 further recommendations which I will now consider. Nine of the recommendations are directed to the CEO of the JH Network.

There is clear merit in Family Recommendation 7, that the JH Network develop prison-specific templates for Asthma Action Plans. The template currently in use is not specific to the custodial environment. The JH Network supports this recommendation, and I will incorporate it within Recommendation 1 directed to the JH Network. The JH Network also supports Family Recommendation 1, that the Adult Emergency Response Guidelines for Acute Asthma be updated, to better guide referral of inmates to the CDS and development of Asthma Action Plans. There is merit in this proposal, which is designed to reinforce JH's existing systems for placing patients onto these pathways. This proposal appears as Recommendation 7 to the CEO of the JH Network.

Family Recommendation 3 proposes the development of electronic medication charts, which raise alarms where dispensing signals exacerbation of asthma. The JH Network does not support this, submitting that it would be both costly and unworkable due to the variability of patient use and baselines. I accept this argument, and also the further submission that improved clinician education (contemplated within Recommendation 1 to the JH Network) should help achieve the purpose of the recommendation.

Family Recommendation 4 is also opposed by the JH Network. This is that the JH Network develop a protocol for clinicians dispensing asthma medication, to assess correctness of patient use and indications of exacerbation.

The education aims of this proposal will be met by Recommendation 1(ii) to the JH Network.

Family Recommendation 5 is that an audit be conducted to compare numbers of referrals to the CDS, with numbers of likely qualifiers. I accept the submission of JH Network that this proposal would be very costly and of doubtful benefit, noting that there are currently 13,000 NSW inmates who have chronic diseases.

Family Recommendation 6 proposes that the Reception Screening handbook be revised to include a specific heading addressing the significance of the CDS. I note however that the current screening handbook has a specific marker drawing attention to the CDS.

Family Recommendations 14 and 15 regarding specific training to JH Network staff is already addressed in Joint Recommendation 2.

Family Recommendation 2, the family proposes that evidence relevant to Dr Landers' treatment of Nathan be forwarded to the NSW Medical Council, for consideration of whether his professional conduct on 5 June 2018 should be reviewed.

This proposal is not supported by Dr Landers, by the JH Network, or in the submissions of Counsel Assisting in reply. In support of this proposal the family submitted that Dr Landers did not meet his professional obligation to satisfy himself that Nathan's severe asthma was being properly managed. Referral was said to be justified on the following grounds:

- his evidence exposed a lack of sufficient awareness of the requirements of the CDS and its clinical pathways.
- he did not undertake any enquiry as to Nathan's compliance with medication, frequency of puffer use, or placement on the CDS asthma pathway.
- he did not initiate any long-term response plan for Nathan's asthma.

The evidence establishes that at the time he was treating Nathan, Dr Landers had but a limited understanding of the CDS process and the manner in which a patient entered its treatment pathways.

In addition, his evidence gave the impression that he had seen little or no role for himself in ensuring that Nathan had received a CDS screen and had an Asthma Action Plan in place for the ongoing management of his condition. In these respects, it must be acknowledged that his treatment of Nathan on 5 June was deficient. Submissions on behalf of Dr Landers acknowledged that '*alternative management should have been considered*' in Nathan's medical treatment. However, the acknowledgement was said to be available '*in hindsight*' only [refer paragraph 77]. In addition, Dr Landers' submissions and also those on behalf of the JH Network were that it was necessary to take into account Dr Landers' role as a primary care GP in the custodial setting; and that the standards expected of an asthma specialist like Dr King ought not to be applied to him (paragraph 19 of the JH Network submissions; paragraph 16 of Dr Landers). I do not accept this submission. As a staff specialist and visiting medical officer, Dr Landers was obliged to make himself aware of the JH policies that applied to his patients.

These included the policies in place for clinical management of asthma. Accepting that the GP clinic on 5 June provided limited scope for a comprehensive assessment, it would be expected that Dr Landers was sufficiently aware of the centrality of the CDS process and its clinical pathways, to check that these were in place for Nathan and to arrange a follow up appointment to ensure that he was being managed in accordance with them. Nevertheless, and having carefully considered the matter, I am not of the view that it would be appropriate to refer Dr Landers to the Medical Council for consideration of review of his conduct. In reaching this conclusion I have taken into account Dr Landers' evidence that he is now familiar with the CDS procedure and the making of Asthma Action Plans, as this awareness had been reinforced by the JH Network since Nathan's death. A further matter I have taken into account is that Dr Landers' deficiencies in treatment of Nathan were not isolated. The evidence established that there was an overall systemic failure to manage Nathan's asthma in accordance with JH Network policies and the established principles of good asthma management. Given this context, I am not satisfied that it would be appropriate to refer Dr Landers' conduct to the Medical Council for its consideration.

Family Recommendations to the Commissioner, CSNSW.

CSNSW has indicated support for Family Recommendation 8, that asthma be included as a significant health condition in COPP 6.3 *Inmate Health Needs*. The need for this recommendation is strongly indicated and I will make it as part of Recommendation 3 to the Commissioner, CSNSW.

Family Recommendations 9, 11, 12 and 13 have merit, but their content has been substantially addressed in the recommendations which I will be making: respectively Recommendation 1 to the CSNSW/Joint Recommendation 2.

Recommendation 4 to the Commissioner; Recommendation 1 to the Commissioner proposing instruction to officers of the lessons learnt from Nathan's death; and Joint Recommendation 2.

Regarding Family Recommendation 16 that defibrillators be made available within each standalone unit, CSNSW has advised in its submissions that this is now the case.

In Family Recommendation 10 it is proposed that CSNSW consider updating its medical emergency policies, to recommend that staff access OIMS for any health alerts. This is not supported by CSNSW. The proposal is said not to be practical, and further that the Health Problem Notification Form is *'used to identify immediate health needs and issues and is the appropriate way for [CSNSW] staff to understand medical conditions of inmates'*.

While this recommendation has merit, I am mindful of the need not to overburden staff with additional requirements when they are responding to an emergency. In my view, the purpose of the recommendation would be achieved with proper adherence of officers to the provisions of COPP 5.5.

Findings required by section 81(1) of the Act

Identity

The person who died is Nathan Reynolds.

Date of death:
Nathan Reynolds died on 1 September 2018.
Place of death:
Nathan Reynolds died at the Outer Metropolitan Multi-Purpose Correctional Centre, Berkshire Park NSW 2765.
Cause of death:
Nathan Reynolds died as a result of bronchial asthma.
Manner of death:
Nathan's death from natural causes was contributed to by deficiencies in the management of his severe asthma by the Justice Health and Forensic Mental Health Network, and deficiencies in the immediate response to his medical emergency by Corrective Services NSW.

ANNEXURE 1: RECOMMENDATIONS

Recommendations to the Commissioner, CSNSW

Recommendation 1: Responding to a serious health event

CSNSW review its practice, procedures and the instructions given to Correctional Officers [COs] regarding CO response to reports of an inmate experiencing a *'serious health event'*. The review is to include:

(i) training about how to identify a '*serious health event'* (which includes asthma attacks or serious breathing difficulties)
(ii) how the responding COs are expected to make their way to the inmate (e.g. walking, jogging, or running)
(iii) ensuring COs assume the event may be life threatening until proven tothe contrary.
(iv) instruction to COs on the events of 31 August 2018 and the lessons learnt from the death of Nathan Reynolds

Recommendation 2: Role of the senior CO

CSNSW review its practice and procedures concerning the role of the senior CO in responding when an inmate is suspected of suffering a serious health event. This includes the senior CO:

(i) ensuring attending COs are aware of the health emergency involved
(ii) immediately deciding whether to request a nurse or paramedic to attend, before a CO sights the inmate, such as when:
- COs cannot immediately attend on the inmate
- a nurse may be delayed in reaching the inmate
- there is incomplete information as to the inmate's condition

(iii) the senior CO attending on the inmate as soon as practicable to manage the response
(iv) if a nurse or paramedics are called, ensuring accurate information is conveyed to them about the inmate's condition and updates are reasonably provided.

Recommendation 3: Training about asthma

CSNSW provide COs with training or education on asthma including but not limited to:

(i) the risks posed by asthma to an inmate

(ii) the difficulties identifying when a known asthmatic inmate is at elevated risk of a life-threatening asthma event

(iii) identifying flags for severe asthma when known asthmatic inmates may be at greater risk of a life-threatening asthma event (e.g. regular or excessive puffer use; cold/flu symptoms)

(iv) bringing this to the attention of the Health Clinic

(v) including asthma as a significant health condition to be included in the Custodial Operations Policy and Procedures 6.3 *Inmate Health Needs*.

Recommendation 4: Adequacy of rostering arrangements

CSNSW review its staffing arrangements including but not limited to:

(i) ensuring there are sufficient COs on duty to enable an immediate response to an inmate who suffers or is suspected of suffering a serious health event

(ii) ensuring rostered COs are sufficiently fit to enable them to respond urgently to a serious health event.

<u>Recommendations to the CEO, JH Network</u>

Recommendation 1: Review of practices for asthma management

The JH Network review, where appropriate in consultation with a respiratory specialist with experience equivalent to that of Dr Gregory King:

(i) its asthma awareness education for patients

(ii) its training for nurses and doctors about severe asthma (including how to identify a possible case, its risks, the need for specialist review, maintaining curiosity about a patient's medication use and when to recommend change in placement or transfer to hospital owing to severity of condition)

(iii) its templates for Asthma Action Plans so that they are specific to the custodial environment

(iv) its training for nursing staff in asthma management or capacity within correctional centres (including developing rapport, learning of inmates' circumstances, and enhancing efficacy) and

(v) its arrangements for patients with suspected severe asthma being reviewed in a specialist respiratory clinic, of the kind overseen by Dr Gregory King, including possible use of telehealth.

Recommendation 2: Review of Winnunga Nimmityjah Aboriginal Health and Community Services

The JH Network investigate the Winnunga Nimmityjah Aboriginal Health and Community Service's model of care and consider if any features of that model are relevant and beneficial to the way in which the JH Network provides medical care to First Nations inmates.

Recommendation 3: Review of rostering arrangements for nurses at night

The JH Network review the adequacy of nursing rostering arrangements at correctional centres in circumstances where a nurse is not based/assigned to a correctional centre overnight (or is required to attend there from offsite).

Recommendation 4: Review of the first aid trolley

The JH Network examine introducing a requirement for all first aid trolleys to be used in responding to a serious health event at night, have a defibrillator om it at all times.

Recommendation 5: Review practices and procedures for management of asthma patients

The JH Network review Chronic Disease screening and asthma management plan protocols/procedures to ensure:

(i) patients suspected of suffering severe asthma have that diagnosis confirmed by a specialist with expertise in asthma management

- for patients diagnosed with severe asthma, their management plans provide for: regular lung function monitoring and clinical assessment
- regular reviews of the patient's symptoms and medication usage
- regular reviews of the recorded amounts of reliever and preventer medication being issued to the patient in a given period
- when symptoms worsen, a plan to increase preventer medication and start prednisone treatment.

Recommendation 6: Review of training requirements for nurses on night shift

The JH Network review whether registered nurses are able to administer intramuscular adrenaline when responding to emergency situations.

Recommendation 7: Update of '*Adult Emergency Response Guidelines*'

The JH Network consider updating the '*Adult Emergency Response Guidelines*' for acute asthma to provide more specific guidance on the referral of inmates to the Chronic Disease Screening and for the development of an Asthma Action Plan.

Joint recommendations to CSNSW and the JH Network

Recommendation 1: Review of communication arrangements between senior COs and registered nurses

CSNSW and the JH Network review the arrangements for senior COs and registered nurses having the means of immediate, continuous, and real time communication whether through use of portable radios or mobile phones, particularly in circumstances where a registered nurse may be required to attend a medical emergency from offsite.

Recommendation 2: Scenario training for COs and registered nurses in providing emergency first aid to an inmate within an open minimum-security environment

CSNSW and the JH Network examine the provision of joint scenario training to COs and registered nurses in managing a situation, and providing emergency first aid treatment to an inmate, within a minimum-security wing/environment where inmates may not be secured within cells.

16. 291962 of 2018

Inquest into the death of LC. Findings handed down by Deputy State Coroner Truscott at Lidcombe on 11 June 2021.

This is an inquest into the death of LC (a pseudonym). LC died on 23 September 2018 aged 51 years as the result of a shot gun wound to his head. LCs' death was deliberately self-inflicted. The identity of LC's and place, time and cause of LC's death is uncontroversial, as is the manner of his death.

LC was, until a short time before his death, in a de facto relationship for over 30 years with LK (a pseudonym). They had two adult children. LCs' family did not attend the inquest as they had earlier advised the officer in charge Detective Inspector Grant that they did not wish for an inquest to be held. However, the inquest is required under sections 23 and 27 of the *Coroners Act 2009* ("the Act"). Efforts have been made to contact LC's family in recent times, to no avail.

The Commissioner of NSW Police, having a sufficient interest, was granted leaveto appear in the inquest.

As s. 23 of the Act is applicable to LC death, the coronial findings will be published. Due to LC's death being self-inflicted, the provisions of s. 75 of the Act apply and accordingly an order has been made that there be no publication of the name of, or any matter (including the publication of any photograph or other pictorial representation) that would reveal LC's true identity. It is for this reason that pseudonyms are used for both the deceased and his former partner.

Likewise, some of the evidence is sensitive and it is appropriate that it not be published and that no access is granted to this material. Accordingly, orders are made pursuant to ss. 74 and 65 of the Act.

<u>This inquest is required to be held by a Senior Coroner</u>

Section 27(1) (b) of the Act requires an inquest to be held when the Court's jurisdiction to hold an inquest arises under s. 23 of the Act.

Section 23(1) (c) confers jurisdiction to hold an inquest upon a Senior Coroner where a death is "as a result of" a "police operation".

At approximately 1:50pm on 23 September 2018, police received an urgent broadcast that LC's had, in breach of an Apprehended Domestic Violence Order ("ADVO") approached and committed violence against LK and had decamped from the scene in his vehicle. The police located and followed LC. When the police signalled for LC to stop his vehicle on the Newell Highway less than 10 km north of Dubbo, he did so. However, when a police officer opened the door of LC vehicle she saw that he had a shortened rifle by his legs and had shot himself under the chin. He died shortly thereafter.

Those circumstances are such that LC's death is regarded as being aresult of police operations. However, that is not to suggest that any police officer by act or omission caused or was responsible for LC's death.

<u>The role of an inquest</u>

The Coroner is required to make the following findings, pursuant to s. 81 of the Act:

- the person's identity;

- the date and place of the person's death; and
- the manner and cause of the person's death.

The "manner" of LC's death requires some inquiry into the police operation that resulted in LC' death.

Following LC death, Detective Inspector Rodney Grant was assigned as the Critical Incident Investigator. He travelled from Bourke to the scene.

Four police officers in three marked police vehicles were involved in LC vehicle stop. This was captured on the In Car Video ("ICV") of the lead police vehicle. Each of the officers was identified as a "directly involved officer", and on the day following the incident each directly involved police officer engaged in an interview as part of the critical incident investigation. The transcripts of those interviews form part of the evidence in the inquest. Those four police officers were not required to give further evidence in the inquest.

Brief of evidence and witnesses

The matters of fact are established in the evidence collected during the critical incident investigation, led by Detective Inspector Grant. They are collected in a brief of evidence, which also contains further material gathered during the coronial investigation.

That brief of evidence is tendered as Exhibit 1. It includes a Body Worn Camera ("BWC") video of a statement taken from Ms Kim at between 2:10pm and 2:23pmon 23 September 2018. It also includes ICV footage commencing at 2:23:13pm, shortly prior to LC stopping his vehicle at 2:25:17pm. Further, LC's criminal history, which was limited, as well as intelligence records from the police WebCOPS and COPS computer system form part of the brief. Transcripts ofVKG police radio communications between the directly involved police officers and the VKG despatcher are contained in the brief.

Detective Inspector Grant gave evidence in the inquest, as did a VKG police radio operator, Mr Kerr. There were no other witnesses called at the inquest.

LC's relevant criminal history

LC was charged with an assault upon a man in 2009. As part of that incident, police located two rifles in LC's vehicle that were unsecured. LC was convicted and fined for the firearms offence and he lost his firearms licence (which was a category "AB"). His firearms were seized and forfeited. In 2014, he unsuccessfully applied for his firearms licence to be restored. In 2015, a police intelligence report indicated that LC was known to sometimes borowand use firearms belonging to friends.

In July 2018, LC was charged with a number of assaults of LK. The allegations were serious including that LC pulled LK by her hair, hit her to the right side of her face, kicked her to her leg and body causing bruising and placed a hot saucepan to the back of her neck, burning her. After being charged by way of Court Attendance Notice, LC was released on bail and served with an ADVO for LK's protection. He appeared in court and the proceedings were adjourned to a date in January 2019. The conditions of the ADVO, amongst others, included prohibiting LK from contacting or attempting to locate LK.

LK moved to a new address some two and a half hours drive from where she had lived with LC. She told the police that she did not want LC to find her.

In August 2018, LC indicated to police that he wanted the ADVO varied so that he could resume his relationship with LK. It appears police told LC that LK did not want any contact with him. On 20 August 2018, LK made a complaint that she had heard through family that LC was asking about her location. The NSW Police COPS entry identified that police intended to speak to LC in relation to breaching a condition of the ADVO. However, for unknown reasons this did not occur.

LC acquires a firearm

In the morning of 23 September 2018, LC borrowed a .22 calibre rifle and 80 to 100 rounds of ammunition from a friend, claiming he needed to shoot rabbits. Upon receiving the firearm, LC took it to a caravan and with the use of a saw he shortened it by cutting off the barrel and half of the stock. It is not difficult to infer that when LC received the firearm he had no intention to return it to his friend. After shortening the firearm, LC drove the two and a half hours to LK's residence in his vehicle.

Violent incident at LK's address

At approximately 1pm, LK was sitting on her couch watching television. Shehad her front door open but the front screen door was closed and locked. She heard a scratching sound at the back door and thought it was the dog. She then heard the same sound at the front door shortly after which she saw LC standing at the entrance of the room looking at her. He approached her with a boning or butchers' knife in his hand. He had used that knife to cut the wire screen near the latch and placed his hand in to unlock the door. LCs placed a knee on the couch and used one arm to push LK down. She was clutching her phone to her chest. LC said words such as "Why are you doing this to me" and "I can't live without you". He held the knife up and stabbed at her three to four times. LK raised her hand to defend herself, thinking that he was going to plunge the knife into her. The knife struck her finger, causing a long wound and bleeding.

LC moved off LK. LK was able to de-escalate the situation, although she thought he wanted to kill her. LC remained in the house for about 40 minutes during which time LK made him a drink. They each had a cup of tea and cigarette and LC told her he wanted her to return to their home with him that day. LK told the police that she didn't want to get in his vehicle because she knew she would never get out of it. She assured LC she would return to live with him, as she hoped that saying so would keep him from hurting her. LC told LK that a family member had told him of her address, andthatthe previous day he drove to the town and saw her vehicle at another family member's address and then drove home. He told her that when he returned he had parked his car near a church and walked to her house.

At some stage, LC cleaned up the blood from the lounge-room floor and, after having the knife in the back of his pants, he placed it on a small table. LK, wanting LC to leave, told him that she was expecting her sister to visit and that he should go. He told her that if he went to prison he would kill himself. They heard the neighbours' truck arrive and LK told LC that he should go, because if someone saw him he would be reported to the police. As soon as LC left, LK locked the front door and whilst standing in a corner next to it telephoned emergency services on '000'. A police radio broadcast regarding the incident was transmitted at approximately 1:48pm. LK remained on the telephone with the emergency telephone operator until the police arrived at her address at about 2pm. Highway patrol police interviewed LK from 2:10pm to 2:23pm and obtained the above version of events.

The response by the directly involved officers

Constable Flemming, at Dubbo Police station, responded to the broadcast. He drove Dubbo 15 (a police van) in the direction of the town where LK lived and he saw a car matching the description of the registration of L C ' s vehicle (a white utility) driving southbound on the Newell Highway towards Dubbo. The car was driving in a normal manner at a speed of 100 kilometres per hour. The posted speed at that section of Newell Highway was 110 kilometres per hour.

Constable Flemming followed LC's vehicle. Initially, a car was between him and LC's vehicle. Constable Flemming remained about 200 metres behind LC's vehicle whilst he was following it, until such time as other police were in a position to assist in a vehicle stop procedure. Constable Flemming was not wearing BWC. He says that was because a quick or (at least as it was suggested to him by the interviewing officer) an emergency response was necessary.

Senior Constable Wheelhouse was driving highway patrol vehicle Western 220. Her vehicle's ICV footage has been tendered in the brief of evidence. Senior Constable Wheelhouse was wearing a BWC but it was not activated. She states that she did not think to do so and agreed with a suggestion made to her by the interviewing police officer that her BWC was fairly new to her. Senior Constable Wheelhouse said she had only been trained in its use a couple of days beforehand. Constables Sutton and Worthington were in Dubbo 35 which directly followed Dubbo 15 and shortly before the vehicle stop, Dubbo 220. Those officers did not activate the ICV and did not activate the BWC that they were wearing. Constable Sutton says that she had inadvertently put the BWC onto standby mode, and Constable Worthington says that his camera had failed to turn on.

From the VKG records, it is evident that the directly involved officers had been communicating with each other on a different radio channel about performing a co-ordinated stop of LC's vehicle at a location known as the "truck stop" south of Brocklehurst on the Newell Highway. There is no evidence in the brief about these communications or under whose supervision they were conducted. Detective Inspector Grant suggested that the supervisor was Sergeant Jason Russell who provided a statement. In any event, their plan was conveyed to MrKerr via VKG. The ICV records Western 220 turning left onto the Newell Highway to take up a position directly behind Dubbo 15, at which stage Dubbo 15 was a couple of seconds behind LC vehicle. LC's vehicle was still travelling at approximately 100 km per hour. The ICV recording starts at a time when Western 220 was about to enter the Newell Highway. The recording shows LC's vehicle (at 2:23:37pm) followed by Dubbo 15 (at 2:23:39pm) going past. At this point in time, there is no car between those vehicles and the lights and possibly the sirens of Dubbo 15 are activated. Constable Flemming indicated in his interview that he had formed an intention to stop LC at the truck stop. He says that he did not engage warning devicesat all until he intended to stop him. Senior Constable Wheelhouse briefly flashed the sirens of Western 220, however switched them off because at that stage she was behind Dubbo 15. The truck stop is shown in the ICV recording at 2:23:59pm, at which point LC does not respond to Dubbo 15's lights and sirens.

Once past the truck stop, at about 2:24:43pm Dubbo 15 moved to the left of the road, allowing vehicles Western 220 followed by Dubbo 35 to go past so that Senior Constable Wheelhouse in Western 220 took lead position with lights and sirens activated. It is unclear why LC did not stop at the truck stop as he appeared to have the opportunity to do so. Although Constable Flemming suggested this may havebeen because there were other vehicles in the truck stop, there was in fact only one vehicle which had apparently pulled over in response to the lights and sirens.

LC was travelling at a speed of between 80 to 90 kilometres per hour as he was passing the stop. It appears that the speed limit was still 110 kilometres per hour on this section of the Newell Highway.

LC activated his left-hand indicator within 15 seconds of Western 220 taking the lead position behind him. The ICV records LC vehicle pulling over to the side of the road at 2:25:03pm. Each of the police officers say that they did not consider themselves at any stageto be in a pursuit. Given that L C stopped when he did, the policeofficers' view appears to be correct, as they had no cause to consider that a pursuit was required at that time. Senior Constable Wheelhouse agreed with the suggestion put to her by the interviewing police that she had formed the view, based on the broadcast of the allegation against LK, that she had reasonable cause to stop and arrest LC. After LC's vehicle pulled over, Senior Constable Wheelhouse exited Western 220 and approached the passenger side door of LC's vehicle. As the radio communications had indicated knives were used in the earlier incident, Senior Constable Wheelhouse had her OC spray in hand. Although Senior Constable Wheelhouse did not conduct the operation as a dangerous vehicle stop, she agreed with the interviewing officer's suggestion that she was cautious when she approached the car. That is borne out by the ICV footage.

Senior Constable Wheelhouse opened the door of LC's vehicle and saw blood running from LC's nose and mouth and a firearm between his legs. Constables Sutton and Flemming went to the driver's side of the vehicle where they also saw the firearm between LC's. Constable Flemming checked for a pulse and called for an ambulance. Senior Constable Wheelhouse and Constable Worthington administered first aid to LC. Police later assisted in transferring him to the ambulance. The P79A form records that LC was pronounced deceased enroute to Dubbo Base Hospital. His time of death is recorded as being at approximately 2:20pm, which is slightly earlier than the times recorded on the ICV. The attending paramedic, Mr Cumming, however, states that he pronounced LC deceased at the scene. However, nothing turns on these slight discrepancies.

Issues at the inquest

1. The issues list distributed prior to the inquest comprised the following:

    a. The appropriateness of the actions of NSW Police Force officers on 23 September 2018.

    b. The appropriateness of the communication to attending police officers of information and intelligence in relation to LC having a firearm on 23 September 2018.

    c. Whether there were difficulties with communication via police radio (VKG) on 23 September 2018, and the cause of any difficulties.

    d. Whether any recommendations are necessary or desirable in relation to any matter connected with LC's death.

The firearm

The friend from whom LC acquired the firearm was interviewed by police and fully co-operated with their inquiry. He was charged with the appropriate offence and those matters were finalised in the Local Court.

Although it is deeply concerning that someone with a firearms licence would provide a firearm to someone without a licence, there was no utility in revisiting that issue in the inquest.

The circumstances by which LC came to be in possession of a firearm do not disclose any systemic failing or opportunity for improvement regarding the scheme for licensing firearms. The evidence reveals that the Firearms Registry had no information available to it that the owner of the firearm was likely to commit the offence he did and there was no way of predicting that it would occur.

LC's' bail

As noted above, in July 2018 after charging LC with serious violent offences against LK, police released LC on bail. Detective Inspector Grant gave evidence that conditions of bail encompassed LC complying with the ADVO. Detective Inspector Grant considered that bail was appropriate in light of LC's criminal history and the conditions of the ADVO. In addition, the evidence indicates that appropriate actions were taken by police to ensure LK's safety (by applying for the ADVO and keeping her new address secret from LC). LC was not spoken to by the police in late August as suggested in the COPS material. Detective Inspector Grant expressed the view that this should have been followed up, although the reason it was not was not identified in evidence (other than as it was a junior officer who sought advice regarding what to do). The inquest did not inquire into this as it is outside the scope of the manner of LC's death.

Actions of police

Detective Inspector Grant commended the way the police officers approached LC's vehicle whilst on foot. Those officers were aware via VKG that although LC's used a knife against LK, that knife had been left at her house. However, they were also clearly made aware by VKG that it was not known whether LC had any other weapons in his vehicle. Detective Inspector Grant gave evidence that the protocol for a dangerous vehicle stop depends on the police having confirmed knowledge that there is a weapon or firearm in the vehicle. The ICV clearly shows that the police approached LC vehicle in a co- ordinated fashion. The police on the driver's side approached widely in an "inverted V" shape so that they could protect themselves if needed. They sought to make eye contact with the driver. The officers on the passenger side approached cautiously but quickly and Senior Constable Wheelhouse had thecan of OC spray in her hand in case that was needed.

None of the police officers had their firearms drawn; however it appears they were in a position todo so if required. Detective Inspector Grant described the police stop and approach as "text book" and gave evidence that the police officers acted exactly as they are trained to do. The police officers' evidence is that they did not hear or see LC dischargethe firearm, which is consistent with the ICV footage. Police did not have any opportunity to prevent LC from taking his own life. They did all they could to provide first aid but his injuries were non-survivable.

Interviews with directly involved officers

An issue arising during the inquest concerned the investigative strategy adopted as part of the initial critical incident investigation. The records of interview and evidence of the officer in charge evidenced that the directly involved police officers were shown the ICV prior to being interviewed and were asked a number of leading questions during the course of their interviews. Detective Inspector Grant gave evidence that he was advised by the then Director of the Professional Standards Command of the NSW Police Force to show the ICV to the directly involved officers prior to interview.

He said that the NSW Police Force Standard Operating Procedures ("SOP") governing the use of ICV required that the ICV be shown to the police officers prior to interview.

The relevant extracts of the SOPs were tendered as Exhibit 3. Paragraphs [64] and [65] of the SOPs create, in effect, a presumption that ICV media files are to be made available to an officer who was an occupant of the police vehicle at the time of the incident, prior to him or her being interviewed, and that the actions of an officer captured on another ICV system may be made available to that officer if it is not captured on their own ICV system.

I find that Detective Inspector Grant acted as he was required to by those paragraphs of the SOPs. However, on its face and without the benefit of evidence as to the rationale for why those paragraphs have been included in the SOPS, the effect of the SOPs is concerning. On one view, they seem to require police investigating other police officers (in the context of a critical incident) to take a different investigative approach to that which might be adopted in other investigations. In situations involving an investigation of fellow police officers, transparency is of great importance. Further, as Detective Inspector Grant said, such a practice could create a real possibility of witness memory displacement. I note that in his evidence, Detective Inspector Grant stated that he disagreed with the approach and had initially opposed it. I agree with Detective Inspector Grant in this regard and find that a practice of showing the ICV to officers being investigated prior to being interviewed is capable of prejudicing the integrity of those investigations.

However, in the absence of any evidence as to the rationale for these paragraphs of the SOPs, I do not intend to make a formal recommendation regarding these issues. However, as suggested by counsel assisting, I intend to raise this issue with the NSW State Coroner for possible consultation with a suitable representative on behalf of the Commissioner of NSW Police.

Further, Detective Inspector Grant's accepted that when interviewing the directly involved officers, he used leading questions. He explained that he do so because he was adopting what he described as a "cognitive interview" technique rather than a "conversation management" approach. He gave evidence that, as a matter of investigative theory, both approaches may be justified depending on the circumstances. It is not necessary for me to make findings on questions of abstract investigative theory. I accept that there are situations where the use of leading questions as part of an investigation are appropriate.

Though such questions should be avoided in a Critical Incident Investigation interview the fact that the ICV indicated that the directly involved officers had done nothing wrong may well have justified the greater use by Detective Inspector Grant of leading questions. I make no criticism of the officer in charge or Commissioner of Police in this regard.

Police Radio Communications

I find that there was some evidence in the brief that the communications on police radio were sometimes challenging. However, the VKG transcript and recording indicate it was adequate and there is no suggestion that any communication was lost or failed due to any systems failures on 23 September 2018. It is apparent that the communications between the directly involved officers and any officer who was acting as their supervisor are not included in the brief. However, the plan that had been devised to stop LC's vehicle was appropriately communicated to VKG and those communications continued throughout the operation, including when the ambulance arrived. Clearly, the facts reveal that LC did in fact have a loaded firearm and plenty of ammunition in his vehicle.

This posed a real risk to the officers tasked with affecting the vehicle stop. The inquest considered whether more could have been done to prepare the officers for that risk. Senior Constable Wheelhouse's evidence was that she did not regard this as a high risk stop. The adequacy of the content of what was communicated to the police was examined in the inquest, with particular regardto the intelligence that LC had been known to borrow firearms. In addition, the inquest examined whether it was effectively conveyed to the directlyinvolved officers that LC had a firearms licence which was no longer current and had no firearms registered to him.

Mr Kerr broadcast over the radio:

"*And just so you know the POI is known, nil outstanding but he does havenon-current firearms. He's got a category AB licence but no firearms and he's also got bail as well all wrapped around an Enforceable AVO that he has with the POI …sorry the victim..*"

That information was responded to by Constable Flemming. Detective Inspector Grant was quite certain that the words "no firearms" meant that LC had "no firearms licence", despite the next sentence affirming the category of licence. Mr Kerr gave evidence that he was referring to firearms, rather than a licence.Mr Kerr said he was meaning to convey that LC previously had a firearms licence but no longer did. Mr Kerr agreed he could have better communicated those facts.

This information may have affirmatively conveyed to the police that LC didnot have firearms with him and accordingly that Senior Constable Wheelhouse's approach to LC's vehicle did not need to comply with a dangerous vehicle stop protocol.

When Constable Flemming was about 20 kilometres north of Dubbo (half way to the planned stop location) Mr Kerr conveyed the following information to him and Dubbo 35 and Western 220: "*The POI was with a butcher's knife when he attacked his partner… He did leave that knife there but* ***it's unknown if he does have anything else***." (my emphasis)

All of the police officers were aware that LC had left the knife at LK's house. Detective Inspector Grant asked Senior Constable Wheelhouse these questions (Questions 163 to 169):

"Q163. ….Did you hear something mentioned about weapons or anythingover the radio?

A163. I only when I've heard the replay was when we listened to it, um, before this interview, I did hear radio broadcast that he, I think had a class AB firearms licence.

Q164. Yes.

A164. But due to the fact that out on the Golden Highway our radio comms aren't as good.

Q165. Yeah.

A165. Or I possibly wasn't listening to all that information. I think I possibly acknowledged it but whether I actually, it's actually sunk in that he did have, he did have firearms.

Q166. Yeah.

A166. Or did have a, or did have a licence yeah.

Q167. Is it correct that they said that he had a licence but do youremember hearing that in fact it said that he has no firearms?

A167. Firearms. Yeah, no, I couldn't.Q168. Yeah. O.K.

A168. Well I, I just, I assume I, coming in, driving in - - -Q169. Yeah, yeah, how long.

A169. - - - I, um, I was just under the assumption that he's just had aknife."

Senior Constable Wheelhouse then said that "I think radio turned around and said they're unsure whether he had more" and she agreed with the interviewer's proposition that you should expect that if someone had a knife at some stage they may have another one.

Constable Flemming said at Question 182 of the relevant record of interview that "…at no point did I know he had a firearm in the car".

There was an issue during the inquest as to whether Mr Kerr could have provided more information about LC's firearms or criminal history, and in particular about LC being known to borrow firearms from friends. Detective Inspector Grant's evidence was that at the time there weremultilayered information sources that the VKG despatcher would have been required to access separately, and that the communications system is currently under renewal so that platforms are more easily accessible. It is apparent from reading the material in tab 17 of Exhibit 1 that the relevant intelligence was not readily accessible. Having heard from Mr Kerr, I am of the view that he did not have the time to trawl through that material, nor was it his job todo so.

Mr Kerr gave evidence that if he had been directed by a police officer to make a particular inquiry he would have done so, however that did not occur on this occasion. Ideally, there would be a system whereby, for any person who previously had firearms and who is subject to an AVO, intelligence (no matter how old) such information is automatically placed as a warning on the front page.This would result in police officers and despatch operators not having to search through pages of material to see whether there is any relevant information. As Detective Inspector Grant said, such a situation would be ideal. I find that the evidence reveals that the police officers acted in a justified and wellexecuted and co-ordinated vehicle stop to arrest LC for violent offences and breaching an ADVO. They acted professionally and bravely. The task they carried out shows how a task routinely carried out has the potential to put their own personal safety at great jeopardy. That LC took his own life is deeply regrettable, but that he did not seek to take the lives of others is something that the community and the police officers should be deeply grateful for.

Findings

Identity	LC (a pseudonym)
Date of death	23 September 2018
Place of death	Newell Highway, near Brocklehurst
Cause of death	Gunshot wound to the head
Manner of death	Suicide

17. 305251 of 2018

Inquest into the death of Nathan Macri. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 5th March 2021.

Nathan Macri, aged 37, died on 5 October 2018 at Sydenham railway station when shortly after 11 pm he accidentally collided with the side of carriage of an incoming train. He was intoxicated after having spent a night out with friends watching a band.

Mr Macri was the loved son of Albert and Janice. He had an elder brother Matthew and younger twin sisters Julia and Jessica. Mr Macri was married to Sheetal and together they had a son, who was eight months old at the time of Mr Macri's death. Like his father, Mr Macri was a solicitor. He loved music and played guitar in a band, he had close and loving relationships with his family and numerous friends. Matthew said that Mr Macri had an infectious enthusiasm for life and was passionate about so many things. He lived every day as though it was a grand adventure. At the inquest, Mr Macri's family generously shared a video which captured the essence of who Mr Macri was. His fun night out ended in a very tragic accident. He will be forever missed.

Outline of Circumstances of Incident and Cause of Death

Mr Macri had been with friends watching a band at the Marrickville Bowling Club. After leaving Marrickville Bowling Club, he and his close friend, Daniel walked to Sydenham Station in order to travel home. His other friends were going to follow and meet them on the platform before travelling together on the train. Whilst on the station platform, Mr Macri accidentally collided with the side of an incoming train. It was 23:06:28. The collision caused his legs to fall down the gap between the train and the platform with his upper body becoming "caught" by the train. Mr Macri was turned several times as the train continued moving, finally stopping at 23:06;40, Mr Macri lay against the end doors of the next carriage, his legs dangling down, his lower torso between the carriage and platform. He was bent at the abdomen with his chest and head downwards. He remained in that positionfor a littleover 10 minutes untilemergency personnel extricated him, at which time he was declared deceased at 23:22.

A post mortem examination concluded that Mr Macri died of the combined effects of positional asphyxia and multiple injuries. Mr Macri's injuries were remarkably relatively minor. He had numerous abrasions and bruises to his upper body and limbs, but of note. his neck, cervical spine and adjacent tissue were described as normal - showing no obvious abnormalities. There was a contusion of skeletal muscle adjacent to thoracic vertebrae 1 and 2, but the post mortem examination was consistent with the CT scans, which showed no intracranial pathology, no fractures or dislocations (including those involving the cervical spine and thoracic vertebrae). There was no abdominal injury. The only fracture identified was that of his right symphysis pubis. A toxicology report indicated that Mr Macri's blood alcohol reading was **0.229g/100ml** and his urine alcohol reading was **0.314** g/100ml.

This level of alcohol was noted in the post mortem repo1 as very high and relevantly, that it may have caused, among others, symptoms such as staggering, slurring of speech and sleepiness. This was consistent with the culmination of Mr Macri having consumed alcohol over the course of the afternoon until shortly before he left Marrickville Bowling Club. The CCTV footage at Sydenham railway station shows Mr Macri highly intoxicated, having difficulties with balance, mobility and co-ordination and drowsy when seated.

Nature of Inquest - Mandatory

Sections 23 and 27 of the Coroners Act 2009 (the Act) require that where deaths occur as a result of police operations, an inquest be held and that it be held by a senior coroner. Such inquests are usually referred to as ''mandatory" inquests. Section 23(2) provides that "a police operation means any activity by a police officer while exercising the functions of a police officer other than an activity for the purpose of a search and rescue operation". Mr Coffey who appeared for the Commissioner of NSW Police Force (NSWPF) submits that the attending NSWPF officers were engaged in a "search and rescue operation" and as such I should not find that this inquest is mandated under the legislation. Mr Coffey does not cavil with the inquest being held (he made his submission in closing in any event); however, he seeks to a finding that excludes Mr Macri's death being as a result of police operations. Such a finding can only be made if this inquest was excluded under s. 23(2) of the Act.

There is no definition of the term "a search and rescue operation" in the Act nor is there any reference to the introduction of s23 (2)1. which commenced on 21 September 2016. Though "search and rescue" is a conjunctive term, it may be that the term applies regardless of whether the rescuer knows the location of the person. For example, an adventurer who sends a mayday message from the wilderness may be the subject of a ''search and rescue operation" even though their location isknown due to having activated their personal location beacon.

The activity of the NSWPF officers in attending upon Mr Macri on platform 6 did not involve any activity to locate him, as his whereabouts was known and reasonably immediate.

The term need not involve a rescue that is successful but there should be some activity that one can point to that involves at least an attempt to remove a person from danger to a place of safety to fall within that definition. Whilst NSWPF officers did attend to Mr Macri, with the aimof rescuing him (in the sense he be removed from danger and if possible returned to safety), the activities they engaged in did not involve any act to remove him from that danger or peril, so as to restore him to safety. The NSWPF officers' activity falls within their police function of "saving lives" and it goes without saying that if the officers thought they could have saved Mr Macri's life they would have, but a decision was made not to remove Mr Macri from his position of danger of death, preferring to wait for the arrival of paramedics and Fire and Rescue to do so.

NSWPF officers attend all nature of emergencies involving fatalities and injury such as motor vehicle accidents, fires and train accidents. I do not understand such attendances are classified as ''search and rescue" even if in a rural or remote setting as opposed to an urban or populated environment.

The NSWPF officers engaged in the following activities upon their attendance at the scene: discussions with Sydney Trains staff, engaging in crowd control, liaising with other emergency agencies, making a decision not to move Mr Macri and speaking with Dr Tong.

Those functions are inmy view outside activities of "search and rescue", particularly in light of the evidence that the attending NSWPF officers intended to wait for Fire and Rescue and paramedics to arrive to affect a rescue. Whether this inquest is 'mandatory' does not require a determination that Mr Macri's death was caused by NSWPF officers nor that he died at the hands of NSWPF officers. In any event, given the cause of death and the timing of it, an understanding of the circumstances or the manner of Mr Macri's death cannot exclude the decision by NSWPF officers not to move him or at least attempt to move him when it was apparent his life was imperilled if he remained in the position he was in.

Accordingly, I find that the NSWPF officers' attendance at platform 6 was not an activity for the purpose of a search and rescue operation and accordingly, this inquest is a required or mandatory inquest. The coroner is to make findings pursuant to s. 81 of the Act as to the identity, date and place and the manner and cause of death. There is no controversy in this case as to identity, place of death or manner and cause of death. A coroner is also empowered by s. 82 to make any recommendation considered necessary or desirable arising from the inquest.

Evidence and Witnesses

The brief of evidence is mainly contained in Exhibit 1 - a three volume compilation of statements from persons and numerous Information logs such as Ambulance electronic medical records (eMRs) and Incident Detail Reports (IDRs), transcripts of triple O calls, policies and procedures. Persons who provided statements included Mr Macri's friends, Dr Tong and his wife, bystanders, NSWPF officers, Sydney Trains staff, attending paramedics and representatives from Ambulance NSW, Fire and Rescue NSW and Marrickville Bowling Club.

Footage from CCTV cameras at Sydenham railway station was obtained. Sensitive footage taken from platform 6, and which depicts Mr Macri's final moments, was tendered separately as Exhibit 2. Footage from a NSWPF Body Worn Video (BWV) Camera, which is also sensitive in nature, was tendered as Exhibit 3. Non-publication orders pursuant to s. 74(1) (b) and restricted access orders pursuant to s. 65 of the Act have been made regarding these exhibits. Those assisting me obtained two expert reports: one from Associate Professor Anna Holdgate, an emergency medicine physician and another from Mr Sean Mutchmor, the National General Manager, Quality and Safety, for the Australian College of Rural and Remote Medicine – both of whom gave evidence in the inquest.

The officer in charge, Constable Melissa Windass, gave evidence further to her statements and the very helpful documents she prepared which set out timelines of events. Dr Tong and three of the attending NSWPF officers gave evidence. They were Sergeant Chapman, who was in charge and Senior Constables Reid and Pezzullo, who assisted in holding Mr Macri's head shortly before the arrival of the paramedics. Ms Jeffries and Ms Fazlic, the attending paramedics also gave evidence.

Issues

An issues list was distributed to parties prior to the inquest:

- Whether the actions of police officers were in accordance with relevant policies and were otherwise appropriate in the circumstances (in particular, the decision not to remove Mr. Macri from his position between the train and the platform).

- Whether the actions of staff at Marrickville Bowling Club in continuing to serve Mr. Macri alcohol on the evening of 5 October 2018 were appropriate and, relatedly, whether there were appropriate systems/railing in place at Marrickville Bowling Club with respect to the responsible service of alcohol.

- Whether the multiple injuries suffered by Mr. Macri, absent the positional asphyxia, were fatal.

- Whether the level of care and skill provided by NSW Ambulance paramedics to Mr. Macri at the scene was appropriate.

- Whether there are any passenger safety systems which could be installed to the Sydney train network to enhance passenger safety.

- Whether it is necessary or desirable to make any recommendations.

Events of 5 October 2018 leading up to the accident

Mr Macri had spent the morning of Friday 5 October 2018 attending client conferences at the Downing Centre District Court. He then "signed off for the day" and at about 1.30 pm, he met a group of friends at the Club York for lunch. The group of six shared four bottles of wine and Mr Macri had a couple of glasses of full-strength beer and later a liqueur. He also consumed a shared pizza and a main meal.

From Club York, Mr Macri travelled to Sydenham railway station where, at about 4:45pm he met his friend, Daniel. They walked to the Batch Brewery Company in Marrickville where they met other friends, and Mr Macri had a paddle of five standard drinks. The group left the Batch Brewery at about 7:00pm had travelled to Marrickville Bowling Club. The band Rose Tattoo was playin9 and there were about 250 people in attendance. Over the following four hours Mr Macri continued to drink alcohol including about 3 schooners of beer and about 7 glasses of Jack Daniels and coke. None of his friends or staff thought he was particularly intoxicated.

Constable Windass provides a conservative estimate that Mr Macri had consumed at least 21 standard drinks during the course of the afternoon and evening. Mr Macri's friend Daniel said Mr Macri's level of intoxication was nothing out of the ordinary and he had seen him like this many times before. Another friend Ritesh, who was with him that night, also gave a statement to police and said he didn't think Mr Macri was drunk during his time at Marrickville Bowling Club. In fact, he described the night as a *relatively quiet night* with not many drinks consumed. A third friend describes Mr Macri as being only moderately affected by alcohol.

The Marrickville Bowling Club CCTV footage shows that on occasion Mr Macri may have displayed some outward signs of intoxication as the night progressed.

He tripped on a chair and stumbled a bit when in the poker machine room, and he miss-stepped when exiting the premises, and as he walked away from the venue he veered a bit on the footpath. CCTV footage of him whilst ordering and collecting drinks at the bar did not show any particular signs of poor co-ordination or overt intoxication. Daniel told the police that itwas only after leaving the Marrickville Bowling Club that he realised Mr Macri was drunk. CCTV footage from various cameras at Sydenham railway station shows that when Mr Macri and Daniel arrived at the station it was about 23:00. Mr Macri does appear to be heavily intoxicated. At one point in time he walked up a set of stairs tripping at the midway landing. He dropped a water bottle and fell over onto his back when he bent down to pick it up. Daniel assisted him to move to the edge of the step before helping him sit up. Mr Macri use the handrail to standing position and walked and swerved a little along Platform 6 until stopping to take his jacket off (it had become wet from the rain on the steps) - he struggled with the co-ordination required to do so.

Mr Macri sat down on one of the bench seats on platform 6 and drank some of his bottled water, spilling some onto the ground. With his jacket over his arm, his head to the side he sat as if he was dozing for less than a couple of minutes.

The Incident and Response

Daniel stepped closer to Mr Macri and indicated that the train was arriving. He then tapped his leg as if to waken him as the train was pulling into the station. Mr Macri rose from his seat, jacket still over his left arm and instantly launched off the seat taking 4-6 steps running in a straight path without stopping at the safety line - perhaps it was due to his momentum and lack of orientation and co- ordination. Mr Macri collided with the side of the train, his left foot falling down the gap between the platform and the train carriage. His body is then ''caught'' by the train carriage and he is turned so that his right leg falls down the gap, his stomach and arms are on the platform until he is again turned so he is now facing upwards. His head collides again and he is turned again so that when the train stops, he is between the platform and the end doors of the train carriage, his left shoulder against the train door and his right shoulder against the platform, both legs dangling in the gap and his head, face and body facing downwards, in a horizontal position in the direction from where the train had come.

Next to the doors was the train guards' cabin. The train guard exited her cabin saw Mr Macri and the closed carriage doors. She immediately returned to her cabin and called Sydney Trains Central Control advising of the accident. Daniel called Triple Zero. Other people also made calls. The collision occurred at 23:06:28 and the train stopped at 23:06:40. Daniel spoke with the ambulance emergency operator at 23:07:36. According to the IDR, the first ambulance unit containing paramedics Jeffries and Fazlic was dispatched at 23:09:05; a dispatch to NSWPF and NSW Fire Rescue at 23:09:11 Indicated Mr Macri was *unconscious and not breathing.* At 23:09:07, the IDR update noted that *chemicals and other hazards not involved, there* is *someone trapped, everyone* is *not completely awake (alert) the type and nature of injuries are not known. There* is *no bleeding now.* Dr Tong, a general surgeon at St George Public Hospital, and his wife who had been travelling on the train had both heard a thud when Mr Macri collided with the train.

Dr Tong exited the train and went to Mr Macri. Dr Tong stayed to assist if required for the duration of the incident. Dr Tong attended Mr Macri momentarily touching his back but generally stood back until he went to him and assessed him for the **first** time between 23:08:55- 23:09:12 at which point he then spoke with Daniel (who had given his phone to a train guard to speak with the emergency operator). The CCTV shows Daniel gesticulating while talking to Dr Tong, consistent with telling Dr Tong about how the incident happened. The train guard who was speaking to the emergency operator gave the phone to Dr Tong at 23:09:49.

Dr Tong spoke with the operator on Daniel's phone whilst he assessed Mr Macri at 23:10:39. This was his **second assessment**. At 23:11:00 at the end of his call, the transcript records that Dr Tong said, *"he is breathing"* and the operator asked is *it effective?"* to which Dr Tong replied, *"He is breathing but he also looks like his neck is starting to, he looks a little bit cyanosed".* He was still on the phone to the operator when NSWPF officers arrived at Mr Macri's location at 23: 11:05. Four NSWPF officers who had been in the meal room at the railway station heard the police radio broadcast and arrived at the scene at 23:11:05. Dr Tong returned the phone to Daniel at 23:11:14. The NSWPF officers moved bystanders away.

Between 23:11:35-23:11:50, the CCTV footage shows Dr Tong speaking with Senior Constable Pezzullo during which he holds his two fingers to the side of the neck consistent with him advising that he could feel Mr Macri's carotid pulse, at which point NSWPF officers ask passengers who are on the platform to return to the train carriages behind where Mr Macri was. Dr Tong stands back. The IDR indicates that at 23:12:13 the NSWPF officers asked for an arrival time for ambulance - they were advised they were 2-3 minutes away. At 23:12:03-23:12:26 the IDR entry (from another triple O call) indicates: *the patient was stuck between train and platform; the patient was* a *male of unknown age whose consciousness and breathing is unknown.* The broadcast also identified that *it is not known when this happened. It* is *not known if there is serious bleeding, it is not known if he* is *completely alert, the extent of injuries unknown.*

At 23: 12:35 Dr Tong is gesticulating to the NSWPF officers consistent with informing them of his concern about needing to move Mr Macri into a position whereby his torso is up and his mouth and airways open so he can breathe. The CCTV footage shows no response by NSWPF officers at this time. An incident log received at 23:12:38 from Joanne from Sydney Trains Security, provided information that *"Passenger has fallen between* a *train and the platform and is wedged in place – rail staff unable to get person out."* Whilst on this call Joanne was advised that NSWPF officers were on scene and ambulance on the way.

The emergency operator called Daniel's phone and he handed it to Senior Constable Pezzullo at 23:12:50. At 23:13:05 Dr Tong reapproaches Senior Constable Pezzullo but he is on the phone with the emergency operator until 23:13:29 The operator asked *"is someone maintaining his airway"* and when he answered *"no"* she asked *"is there anyone there that can maintain his airway'.* The phone cut out and Senior Pezzullo returned the phone to Daniel. During this time {23:12:23-23:13:30) Dr Tong speaks to the train guard, his gesticulations are consistent with him conveying to her the need for Mr Macri to breathe (at whichtime he says he asked her for gloves).

Dr Tong then steps back again and only approaches the NSWPF officers when Senior Constables Pezzullo and Reid look to him. The time is 23:13:38. Dr Tong attended Mr Macri and assessed him for a third time, his hand going to the left side of Mr Macri's neck at 23:13:45. At 23:13:48 the IDR was updated with information that the "*Patient is still breathing. Becoming cyanosed. Police on scene.*" It is unclear whether this information was conveyed to the operator at 23:11 by Dr Tong during his second assessment or during Dr Tang's third assessment.

At 23:13:57 Senior Constable Pezzullo raises his arm. Dr Tong again steps back. At 23:14:15 the IDR records *"Doctor here. Still got pulse.* It is unclear where this information comes from as the timing of it occurs prior to Dr Tang's third assessment of Mr Macri.

The train guard returns and provides Dr Tong with a pair of gloves at 23:14:14.

Dr Tong returns to check Mr Macri for a fourth time at 23:14:41-23:14:45 while Senior Constable Pezzullo speaks with Daniel whose gesticulations are again consistent with explaining how the: incident happened. By this stage there are seven NSWPF officers on platform 6 including the designated mobile supervisor Sergeant Chapman who was in charge.

Dr Tong stands back again at 23:15:07 and police direct rail staff to evacuate passengers from the train. Dr Tong approaches Mr Macri for the fifth **time** at 23: 15:34 as passengers start leaving the train carriages onto platform 6. At 23:15:45 many passengers are on the platform walking past Mr Macri while Dr Tong is leaning over Mr Macri. The CCTV footage shows the ambulance arriving alongside the boundary fence at 23:16:10. At this time Senior Constables Pezzullo and Reid assist Dr Tong by holding Mr Macri's head and keeping the train carriage doors from opening. Senior Constable Pezzullo said in his statement that when he knelt down and held Mr Macri's head, he noticed that his face was purple especially his lips, but that Dr Tong againchecked for a pulse and told himthat he could feel the pulse. Dr Tong said in his statement that they had tried to lift him up from under his arms but were unable to do so. All he could do was provide a jaw-thrust in an attempt to keep Mr Macri's mouth and upper airway open.

Paramedic Jeffries said that whilst she was en route she had seen the IDR that Mr Macri was not breathing and had no pulse, so she ordered a specialist medical team. The earlier IDR entries of 23:08:39 and 23:09:11 indicated that Mr Macri was unconscious and not breathing but does not mention pulse. The 23:10:31 report identified that a doctor was on site and Mr Macri had a carotid pulse. The 23:13:48 report stated he was still breathing but becoming cyanosed, followed by a 23:14:15 report that identified that he still had a pulse. The IDR indicates that the specialist medical team acknowledged the incident at 23:15:51. By 23:17:1O the platform is completely full of passengers and other police start directing the crowd consistent with the paramedics arriving at the emergency entrance to access platform 6. At 23:18:00 the passengers near Mr Macri are directed to exit in the opposite direction at which point the first of the paramedics arrives at Mr Macri.

Two NSWPF rescue officers arrived at Mr Macri at 23:18:00 simultaneously with the three paramedics. The police can be seen on CCTV footage at 23:17:45 making their way against the exiting crowd, along the edge of the platform from the entrance opposite to the end the paramedics entered.

The paramedics report that when they arrived on platform 6 the scene was chaotic with passengers. That is consistent with what is seen on the CCTV due to the unfortunately timed decision to evacuate the train just as the ambulance was arriving. At 23:18:20 paramedic Jeffries bends down to assess Mr Macri. Her case description records that Dr Tong had told her that Mr Macri was pulseless and not breathing but she carried out her own assessment. Paramedic Jeffries described that Mr Macri was cyanosed, not breathing and had nil pulse. The paramedics attempted to place ECG electrodes on Mr Macri to identify if he had any cardiac activity but were unable to apply the electrodes due to his position.

Sergeant Chapman turned his BWV on at 23:19 because he was concerned about Mr. Marci's colour. When Paramedic Jeffries commenced her assessment of Mr. Macri, the rescue personnel leave the platform by climbing over the boundary fence at the road. A fire engine arrives at 23:18:45 and the passengers who were diverted from platform 6 crowd the path between the fire engine and the footpath until 23:19:40 with the fire truck departing at 23:20:14. The IDR records at 23:20:33 that the crew were attempting to gain access to assess Mr. Macri. At 23:21:00 three Fire and Rescue personnel arrive on platform 6 and at 23:21:29 the NSWPF rescue personnel return to platform 6 and pass equipment over the fence onto the platform completing this task at 23:22:00.

At 23:22:24 Fire and Rescue push or hold against the train carriage while NSWPF officers lift Mr Macri's legs onto the platform and Mr Macri is rolled onto the platform by 23:22:36. The paramedics placed ECG electrodes on Mr Macri but did not provide any resuscitation. Paramedic Jeffries declared Mr Macri deceased. At 23:23:50 Fire and Rescue return their equipment over the fence to thetruck.

Dr Tong's Evidence

Dr Tong said that during his **first** assessment he spoke to Mr Macri, but he only heard him grunt. he smelt alcohol and could see that Mr Macri was breathing. He was unable to assess any injuries Mr Macri may have had due to the position of Mr Macri's body. Dr Tong was concerned about any attempts to move Mr Macri could exacerbate any injuries he might have, and he was most concerned about any penetrating injuries. Daniel's information about what had happened was useful as it explained that a medical episode did not cause Mr Macri to fall. Dr Tong said that when he was handed the phone to speak with the emergency operator at about 23: 1O he noted that Mr Macri's lips were a little bit blue, but he had a pulse and he was breathing. Dr Tong said he was concerned to protect Mr Macri's airway but that that he did not feel that he had the skill set to move Mr Macri from the position he was in both interms of an ability to physically move him onto the platform and noting the absence of any medical apparatus to treat him once he had been removed.

Dr Tong said that he did not think he was the best or safest person to place Mr Macri in a better position. Dr Tong said he conveyed his concerns about moving Mr Macri but denied having instructed the police not to move him. Dr Tong said he stood back from Mr Macri because his role was as a bystander with medical experience, to do what he could to assist.

He said the police were moving the crowd and telling the station master to call triple 0 . He said he became more concerned when he noticed Mr Macri becoming drowsier, having difficulty breathing and his skin becoming more mottled. As a result, Dr Tong felt that there was now a need to move Mr Macri into a better position to assist his breathing. He spoke with the train guard and asked if they had any breathing apparatus and he asked for gloves but did not make any other requests.

Dr Tong assessed Mr Macri again had though Mr Macri was still breathing and had a pulse he looked worse and Dr Tong was worried. By this stage eight minutes had elapsed, since the collision and Dr Tong said that the need to move Mr Macri to keep him breathing outweighed any concerns that moving him would exacerbate any existing injuries.

At 23:16:00, Dr Tong cleared Mr Macri's mouth which had vomitus in it. Assisted by Senior Constables Reid and Pezzullo and Sergeant Chapman they tried to move him out, but they couldn't because Mr Macri was stuck. In his statement (which he made that night), Dr Tong said *"The police officers and I began to move the man in* a *better position. We opened the door of the carriage partially. Once we moved the door to the correct position we asked the train workers to keep the door there. The man was still stuck but in* a *better position ... that the man's neck and airway could be supported ".*

In his evidence, Dr Tong said that despite the support they were giving to Mr Macri he continued to deteriorate. When the paramedics arrived, he recalled telling them Mr Macri had fallen, he was intoxicated, he was wedged, and they had tried to move him but were unable to. It was pointed out to him that Senior Constable Pezzullo said in his statement that when he helped hold Mr Macri's head, Dr Tong said that he could still feel Mr Macri's pulse. Dr Tong said he could not recall if Mr Macri still had a pulse at that time. In his statement Dr Tong said that at that time he was holding Mr Macri in the jaw-thrust he was unable to feel a carotidpulse. Dr Tong said that he could not recall telling the paramedics that Mr Macri was pulseless or breathless and he could not recall the paramedics inquiring how long Mr Macri had been pulseless or breathless for.

At 23: 19 Senior Constable Chapman activated his BWV, because he was concerned that Mr. Macri's face and lips were blue. Officer Chapman's said in his evidence that at the time he activated the BWV he believed that Mr. Macri should be extricated from his position and placed on the platform. Officer Chapman said that he did not have any discussion about this with any other NSWPF officer and said in his evidence that he made no attempts to carry out an extrication because he did not think itwas possible due to the lack of "manpower".

Within 9 minutes of their dispatch the general paramedics were with Mr Macri, which was 11 minutes after the collision. The last information contained in the IDR had been logged 4 minutes earlier *"Doctor here-still got* a *pulse ".* Paramedic Jeffries said that when she assessed Mr Macri he was pulseless and unconscious. She attempted to place ECG electrodes on him, but she was unable to do so because of his position relative to the platform and the train. At 23:20 Sergeant Chapman's BWC records Dr Tong stating "there's no response, he's no longer breathing, and he's clearly cyanosed."

At approximately 23:22 Fire & Rescue assist police in extricating Mr Macri, by what appears to be an application of force by 'pushing' the train and swiftly extricating Mr Macri, placing him on the platform. Officer Chapman said that he did not know that it took such little effort to push the train to enable this extrication and with the benefit of hindsight he would have done so earlier. Mr Coates, the Director of Sydney Trains Safety and Security has reviewed the CCTV footage and suggests that the train was not moved at all when pushed by the three or four Fire and Rescue officers. Mr Coates suggested that it was unlikely that 400 kg of manpower would have any effect shifting a 50-ton train carriage. I think he is correct.

I suspect that Mr Macri's extrication was possible partly due to his death and the number of people available to lift him to the platform. It is regrettable that this extrication was not attempted immediately at 23:18 when both the Rescue personnel and the Paramedics arrived on the platform, given the retrieval equipment was not needed and the electrodes could not be placed on Mr Macri. Once Mr Macri was placed on the platform the paramedics attached ECG electrodes which indicated that there was no activity. Paramedic Jeffries declared Mr Macri deceased at the scene at 23:22.

Whether the multiple injuries suffered by Mr Macri, absent the positional asphyxia, were Fatal

Associate Professor Holdgate addressed this issue in her report setting out that she agreed Sergeant Chapman said that he deferred to Dr Tong and additionally held a belief that more manpower was required for removal, but he did not discuss removing Mr Macri with any other NSWPF officers who were there. It was only with the benefit of hindsight that he learned that it was possible. If Dr Tong had not been there, he would have tried to protect Mr Macri's airway and wait for paramedics to attend. He was taken to the First Aid Handbook provided to NSWPF officers for training and updates. He said he had never seen the Handbook before and was uncertain if he held an up to date First Aid Certificate. When asked questions by Mr Coffey he said that he attends weapons training on an annual basis during which time the police do CPR training.

Having seen the CCTV footage which shows Dr Tang's actions towards Mr Macri, his engagement with the police, his standing back, his concerns to the emergency operator and from having heard Dr Tong in the witness box I accept his evidence that he did not at any time direct nor did he advise the police that they should or should not remove Mr Macri from the gap. At the time he had grave concerns about Mr Macri's ability to effectively breathe. He tried to communicate that to the police.

Simultaneously, the emergency operator was on the telephone raising the same concerns with Senior Constable P e z z u l l o . After that telephone call, the police directed the evacuation of the train and then sought Dr Tong to assist in airway management. The evacuation process unnecessarily created a chaotic environment for both that airway management and the arrival of the paramedics; however, it is unlikely that situation had any adverse outcome other than causing stress to those attempting to assist Mr Macri.

Whilst Dr Tong did not direct police nor express himself in any commanding or authoritive manner, I accept that the police deferred to Dr Tong's well-founded concern about moving Mr Macri. The mechanism of how Mr Macri came to be in that position had been explained to both Dr Tong and the police by Daniel. They had every reason to suspect that Mr Macri likely had very serious injuries which could include penetrating injuries had he any broken bones. Given Mr Macri's position, it was not possible to assess whether he had any of those potentially life-threatening injuries.

Dr Tong said that when he saw Mr Macri's colouring turn blue, that any concern for exacerbating Mr Macri's unknown injuries was outbalanced by the need to move him to protect his airways. This was when he pointed out to the police that Mr Macri needed to have his head held for him to help him breathe.

Associate Professor Holdgate set out in her report that *"entrapped patients should be extricated as* a *matter of urgency to allow management of airway breathing and circulation and to avoid the development of crush syndrome. Extrication can be very challenging, as in this case, and there* is *always* a *risk of inadvertently exacerbating* a *spinal injury or worsening blood loss by moving broken bones or releasing compressive forces which are containing blood* loss. *In all* cases *the risks and benefits need to be assessed before attempting extrication and the decision will also depend on the skills and experience of the treating team While in retrospect early extrication may have been life-saving for Mr Macri, in my opinion Dr Tong made his best decisions based on the scene in front of him and his own clinical experience".* In her evidence, Associate Professor Holdgate recommended immediate extrication, except for persons who had been injured by impalement.

Although I accept that Dr Tang's role was to assist and he was not directing the NSWPF officers in any way, I do not think it was unreasonable for the NSWPF officers to have deferred to Dr Tang'sconcerns about moving Mr Macri especially in light of the fact that they thought Mr Macri was stuck or wedged in position. It may have been that his extrication was uneventful due to both the number of people then available and perhaps regrettably, the fact of his demise. Regarding the NSWPF standard operating procedures and policies about lifesaving extrication of entrapped persons - there are none. In her closing address Counsel Assisting fairly set out what,if any, guidance was provided to NSWPF officers in the NSWPF policy and procedure documents, which were in evidence. I agree with Counsel Assisting's submission that thetenor ofthe NSWPFpolicies tend to be focussed on the responsibilities involved in co-ordinating other first responders, namely, emergency services and liaisingwith personnel of varying rankandstation.

NSWPF officers who are first responders should have some guidance to take life saving measures and attempt to extricate a person who would otherwise die while awaiting the arrival of paramedics. Inthat regard Icommendthe contents of Associate Professor Holdgate's report.

Whether there are any passenger safety systems which could be installed to the Sydney train network to enhance passenger safety.

Whilst the issue of the installation of passenger safety systems was investigated it was not the subject of particular questioning during the inquest. The Sydenham railway station, like many throughout NSW, was constructed many years ago. Platform 6 is a curved platform and the gap between the train carriage and the platform in 236mm. Sydney Trains provided documentation and addressed the Issue of whether safety barriers would ensure passenger safety and has determined that such are not possible due to the curvature of the platform. During the inquest Mr Coates provided an additional statement setting out that pushing a train to secure the release of a person trapped in the platform- to-carriage-gap raised a number of issues including the number of different models of train carriages with different specifications which could cause more injury to the trapped person. Having read that statement it would be unwise to presume that the method to extricate a person from that gap would be as simple a procedure as itturned out to be in this case. Mr Macri did not fall into the train-to-platform-gap because he was exiting or entering a train carriage, or he was behaving recklessly on the platform. His reaction to Daniel's information that the train was arriving appears to have been distorted due to his intoxication and dozing.

Though Mr Coates gave evidence that there are hundreds of incidents a year of "near misses" with the train-to-platform-gap, the way Mr Macri entered the gap is far different to those cases. The evidence in this inquest does not give rise to consider any recommendations to Sydney Trains to install any passenger safety systems to prevent such an incident from occurring again. The rail staff at the scene did not have any relevant equipment, nor are they trained, to extricate persons. Sydney Trains' policy requires the train guard to immediately notify their Central Control operator, who then organises emergency services and deals with logistics. Mr Coates said he reviewed the actions of train staff and was satisfied that they complied with the relevant policies and made the necessary notifications.

I note that Fire and Rescue NSW have a training manual in which Chapter 16, which deals with railway incidents. It is apparent that there is an apparatus called a hydraulic airbag which can be utilised in combination with step blocks. This induces sideways movement of the train carriage so as to release a trapped person. That apparatus is best used by trained personnel. Thus, the fate of a person trapped in the gap may well depend on the arrival time of relevantly trained rescuers.

Whilst I accept Mr Coates' analysis that the train guards carried out their required duties, I do so with one exception and that is: no train guard fetched an emergency first aid kit. Mr Coates agreed but stated there would be nothing in the kit which would have assisted. With respect, that isnot the point, and certainly there is no evidence that any rail staff engaged inany decision-making process where it was determined that the kit was not required. Rather, it just didn't happen. Dr Tong said that he had asked for gloves on at least two occasions. Had a first aid kit been provided at least he would have had those without having to repeat his request.

Whether the level of care and skill provided by NSW Ambulance paramedics to Mr Macri at the scene was appropriate.

In a statement dated June 2019 Paramedic Jeffries said that when her ambulance was dispatched at 23:09, the information on the Mobile Data Terminal (MDT) stated that the patient was trapped, pulseless and unconscious and when she arrived, Mr Macri was cyanosed, not breathing and did not have a pulse. She said that Dr Tong told her that he was pulseless and unconscious but that she didn't pay much attention preferring to carry out her own assessment.

She appears not to have noted the IDR report of 23:14 that Mr Macri was at that time reported to be breathing and as having a pulse. It has not been possible to ascertain from where Ms Jeffries obtained the information that when she was dispatched, Mr Macri was pulseless and not breathing, because at the time of dispatch the IDR did not mention a pulse. Further, the last IDR at 23:14 reported that Mr Macri was breathing and had a pulse. Ms Jeffries said ,in her statement that when Dr Tong told her Mr Macri was pulseless she did not ask him how long he had been without a pulse. It would seem that when she arrived, Ms Jeffries was under the misapprehension that Mr Macri had been in cardiac arrest for nine minutes. It is more likely that he went into cardiac arrest after the time Dr Tong and the NSWPF officers held his head up and placed him ina jaw-thrust.

Ms Jeffries was concerned that the power to the train was still on and asked that it be turned off. She considered that Mr Macri was well stuck, and she unsuccessfully tried to place ECG electrodes on him. The CCTV footage indicates that that attempt was complete by 23:20. A police officer suggested they could extricate Mr Macri and asked Ms Jeffries if she wanted them to try. She reconsidered how wedged Mr Macri was and replied "yes". She held Mr Macri's head while three or four officers removed him. She then successfully applied the ECG and Mr Macri was asystole. She said she believed Mr Macri had central cyanosis, that is, he was blue around the face. She noted blood on her gloves and thought his head was deformed consistent with injuries.

In a second statement made in November 2020, Ms Jeffries reiterated that she had read on the MDT that Mr Macri was trapped, not breathing, unconscious and pulseless. She described that Mr Macri's legs were above the platform and his head was below it, and that although she was able to see that his eyes were fixed and dilated, she was unable to use a torch to assess his pupils due to his position. I think Ms Jeffries has incorrectly recalled Mr Macri's positioning because his legs were dangling down, and his head was still being held by Dr Tong and the NSWPF officers. But in any event she did correctly recall that she thought he was incardiac arrest and hewas trapped.

She said in her second statement that after the police officer said to her "I think we can move him" she says she considered that Mr Macri's condition was critical and extricating him was a priority in order to assess his injuries, and consistent with the Ambulance NSW Protocol T15, *Trapped Patient,* asked that he be extricated.

It is difficult to reconcile Ms Jeffries evidence because if she thought Mr Macri had been breathless and pulseless since 23:09 it is more likely that she would have formed the view upon her arrival rather than at 23:22 that Mr Macri's condition was critical requiring priority extrication. If it had been a priority it should ha.ve been considered when she arrived and when the Rescue police were standing next to her at 23:18. It is unclear why she referred to the policy in any event as it applied to patients at risk of crush injury syndrome which, given the shortness of time involved, was not a risk to Mr Macri. I accept Ms Jeffries evidence that due to the chaos on the platform due to the number of passengers being evacuated she was not even aware that the rescue personnel had arrived at the same time as herself. This may have led to her delayed consideration of extricating Mr Macri. Ms Jeffries explained that she did not perform cardiopulmonary resuscitation (CPR) after the ECG electrodes confirmed that Mr Macri was in asystole.

She deemed his injuries incompatible with life . She had regard to the history of the mechanism of injury and trauma; that he had been trapped and crushed between the train and the platform; that prior to her arrival there was no pulse and no breathing; she noted central cyanosis; Mr Macri had fixed and dilated pupils, a likely significant head injury and, as mentioned above, the ECG confirmed he was inasystole. Ms Jeffries attached to her statement Ambulance NSW protocol C2 *Cardiac Arrest Decision Algorithm,* which sets out that a patient with suspected reversible causes of cardiac arrest require minimal scene time and urgent transport to hospital, such causes relevantly including hypoxia and hypovolaemia.

Associate Professor Holdgate was asked questions about Mr Macri's condition once he was placed on the platform and she, like Mr Mutchmor, agreed with Ms Jeffries assessment that Mr Macri had, by then, injuries incompatible with life. Associate Professor Holdgate explained that Mr Macri's cardiac arrest came at the end of Mr Macri's deterioration marked by his inability to breathe rather than it being a cardiac injury. She explained that a successful resuscitation was extremely unlikely and even if it did occur, Mr Macri's would have had profound systemic hypoxicinjury.

Mr Mutchmor reviewed Ms Jeffries actions and decision to declare Mr Macri deceased without attempting CPR. He said that in addition to hypoxia and hypovolemia being causes of Mr Macri's cardiac arrest, the scenario suggested it could also have been due to tension pneumothorax or a cardiac tamponade or all four. He noted that Ms Jeffries carried out all of the appropriate tests, including the ECG, to confirm Mr Macri's death before declaring it.

The only criticism he made was in relation to Ms Jeffries notesafter the incident which make up the eMR, stating that it would have been appropriate for Ms Jeffries to more specifically document her clinical interpretations, physiological assessments and her rationale for clinical decisions, thereby disclosing her clinical thinking at the time.

I note that it would also have made a better source of information to include in any later statements about the incident. As earlier stated, there is no question about the timeliness of arrival of the paramedics. Given the subsequent expert reviews and evidence provided regarding the medical care Mr Macri received, I find that the paramedics applied an appropriate level of skill and care at the scene.

Whether the actions of staff at Marrickville Bowling Club in continuing to serve Mr Macri alcohol on the evening of 5 October 2018 were appropriate and, relatedly, whether there were appropriate systems/training in place at Marrickville Bowling Club with respect to the responsible service of alcohol.

Constable Windass provided comments in her statement regarding Mr Macri's state of intoxication at Marrickville Bowling Club upon viewing the relevant CCTV footage from the club when Mr Macri left the premises and when he was at Sydenham railway station.

Mr Valentin, on behalf of Marrickville Bowling Club, conceded that insome of the club footage Mr Macri is seen to trip, but notes that is as he is leaving the club. Earlier footage of Mr Macri shows no obvious signs of intoxication, which was consistent with other interactions with staff during that night. Mr Valent in points out that after NSWPF undertook a review of the incident involving Mr Macri, they took no action against the club inrelation to Mr Macri's intoxication.

The inquest had numerous statements from Marrickville Bowling Club and heard evidence from the then bar manager Tom Jones. Mr Jones confirmed he was familiar with the Prevention of Intoxication on Unlicenced Premises and Intoxication Guidelines published by Liquor and Gaming NSW and that adherence to these Guidelines was implemented at the club. Between September and October 2018, he was liaising with licencing police to ensure the club complied, given it had been pointed out to the club by NSWPF that the alcohol service management plan required updating and that NSWPF were concerned with some recent incidents involving assaults and intoxicated persons on or from their premises.

Mr Jones said that on 5 October 2018 staffing and patron numbers were compliant with the club "Dance Party" policy. A statement made by a friend of Mr Macri indicates that he was on the dance floor and exuberant and would give hugs. There is no suggestion that his behaviour was untoward or would have caused staff to become concerned about his behaviour or to question his level of intoxication. Even his friends did not think he was overly intoxicated, although Daniel made that realisation when they left the club. Mr Valentin submitted that I would find that the continued services of alcohol to Mr Macri was appropriate.

Whether it is necessary or desirable to make any recommendations

The final issue relates to whether I consider it desirable or necessary that recommendations arising out of this inquest be made. Counsel assisting put forward the following two matters for consideration: That NSWPF consider using the facts of this case in its officer training as it relates to first aid and publictransport incidents.This incident should act as a reminder to all NSWPF officers about how critical effective airway support and removal of any constrictions to the airway is.

For all first responders, including train employees, to be reminded of what Associate Professor Holdgate said were the four critical factors to remember their ownsafety is paramount: ii. Call for expert assistance; focus on airway breathing and circulation; and if a person is trapped and their airway and circulation cannot be assessed or effectively maintained, get the person extricated so as to facilitate both.

There are situations where it could be dangerous to remove someone (e.g. when impaled). But otherwise airway and circulation are critical.

a. To the Commissioner of the NSWPF – that the First Aid Handbook, and relevant policies, be amended to include the instruction for first responding NSWPF officers to remove a trapped person where their requirement to maintain breathing and circulation outweighs any risk of further injury, when time is of the essence and prior to the arrival of paramedics and other rescue personnel.

Identity Nathan Macri

Date of Death 5 October 2018

Place of Death Sydenham Railway Station

Cause of death the combined effects of positional asphyxiation and multiple injuries

Manner of death Whilst intoxicated Mr Macri accidentally collided with the side of a carriage of an incoming train which resulted in him becoming injured and unconscious When the train stopped, he was wedged between the train and the station platform and remained there until extricated by emergency responders by which time he had died due to his injuries and an inability to breath effectively due to his position.

18. 314209 of 2018

Inquest into the death of James Sampson Doran. Findings handed down by Deputy State Coroner Grahame at Lidcombe on the 18th November 2021

James Sampson Doran was 85 years of age at the time of his death on 13 October 2018. He was serving a custodial sentence and had most recently been living at the Metropolitan Special Programs Centre (MSPC), within the Long Bay Correctional Complex before being transferred to hospital for palliative care.

In the early hours of 13 October 2018, he was discovered by nursing staff, unconscious. He was cold and had no signs of life. A post mortem examination was conducted on 16 October 2021. The forensic pathologist conducting the examination recorded the cause of death as "metastatic prostate cancer."

Whilst in custody, it is reported that Mr Doran kept in touch with some members of his family. They did not wish to be involved in the inquest.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations, arising from the evidence, in relation to matters that may have the capacity to improve public health and safety in the future. In this case there is no dispute in relation to Mr Doran's identity, or to the date, place or medical cause of his death.

Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of James Doran.

Scope of the inquest

The inquest took place on 18 November 2021. A comprehensive police brief was tendered including police statements and photographs, as well as prison and medical records. The officer in charge of the investigation, Senior Constable Timothy Bujeia gave brief oral evidence by video link

Background

Mr Doran was born was born on 25 April 1933, to parents C and L, in Manly NSW. Mr Doran was the second eldest child and had three brothers. Mr Doran grew up in Campsie NSW and attended De La Salle College in Marrickville for the entirety his Schooling. At the age of 18, Mr Doran was enrolled in National Service and travelled to Korea for an unknown amount of time to assist in the activities following the end of the Korean War.

Upon returning to Australia, Mr Doran taught as an English teacher at St Patricks School in Fairfield NSW and became a Patrician Brother. However, he did not make his final vows and decided to leave the Patrician Brotherhood community. After leaving the Patrician Brothers, Mr Doran married P and had three children, M, C and J. During this time, Mr Doran lived in Campsie with his family whilst running a general store with his wife.

Around 1980, Mr Doran and his family moved to Inverell NSW, where he was a teacher at Holy Trinity Catholic School.

Around 1983, Mr Doran moved with his family to Lismore NSW where he was a teacher at St Johns College, Woodlawn, an all-male boarding school operated by the Marist Brother's Organisation.

Around 1988, Mr Doran moved his family to far North Queensland where he was a teacher at St Teresa's Catholic College, Abergowrie QLD. Mr Doran retired as a teacher.

Around 1994, Mr Doran moved to Brisbane and then to Kingscliff NSW, where he and his wife lived together until they separated soon before he was sentenced.

Custodial History

Initially Mr Doran had minimal recorded criminal history. In 1950, he was charged with wilful and obscene exposure.

On 16 September 2014, Mr Doran was charged with 81 Sequences of historical child sex offences. A vast number of these charges related to incidents that occurred at St Johns College, Woodlawn between 1980 and 1988. During this time, Mr Doran was appointed the dormitory master on various occasions. He was also charged with an offence relating to his time at St Patricks and one during his time at Holy Trinity College.

On 29 May 2015, Mr Doran was charged with a further 11 sequences relating to sexual offences against children. Mr Doran was also charge with multiple sexual offences against a male student whilst employed at St Patricks Patrician Brothers School, in Fairfield, NSW. The offences for which he was charged related to children between the ages of 15-17 years of age. Ultimately, on 6 April 2017, Mr Doran was sentenced by Judge R Toner, in the District Court of NSW, for a total of 30 offences. He received a term of 13 years imprisonment with a non-parole period of 6 years, due to expire on 5 April 2023. Mr Doran was 83 years old at the time of his sentence.

Medical History prior to Custody

As a part of his sentencing submissions, Mr Doran was examined by Dr John Obeid. Dr Obeid prepared an extensive report and detailed Mr Doran as suffering from the following medical conditions, including but not limited to - Ischaemic Heart Disease, Hypertension

Hyperlipidaemia, Non-insulin dependent diabetes mellitus, Peripheral neuropathy, Muscular degeneration, Depression, Chronic Obstructive Pulmonary disease, Obstructive sleep apnoea, Carcinoma of the left kidney, Carcinoma of the thyroid, Chronic lower back pain

Chronic vasomotor rhinitis, Prostatism, Possible gastrointestinal bleeding, suspected benign essential tremor, Gout and abdominal aortic aneurysm. It is clear that prior to entering custody Mr Doran was already infirm and unwell.

Time in Custody

On 6 April 2017 Mr Doran entered custody. He was always active in requesting assistance in relation to his care and treatment. He was assessed by Justice Health & Forensic Mental Health Network (JH) at various times in relation to his ongoing risks in custody. A risk of falls and depression was noted. He was described as a frail, elderly and hearing-impaired man who had mobility issues and used a CPAP machine at night.

He was initially housed at the Metropolitan Remand and Reception Centre.

On 7 April 2017, Mr Doran was reviewed by a doctor and referred to a number of specialists. He was then referred to the Aged Care Unit at Long Bay Hospital.

Mr Doran remained in the Age Care Unit until 15 April 2017, when he was discharged and transferred to the Metropolitan Special Programs Centre (MSPC) within Long Bay Correctional Centre. Mr Doran remained here until he was transferred to the Prince of Wales Hospital on 2 October 2018, where he remained until he died.

Medical History whilst in custody

During Mr Doran's time in custody, he was transferred between the Metropolitan Special Programs Centre, Long Bay Hospital and the Correctional Health Unit, Secure Annexe at the Prince of Wales Hospital on multiple occasions for treatment and specialist appointments.

On entry into custody he was reviewed by a doctor and referred to specialists in cardiology, ear nose and throat medicine, ophthalmology, gastroenterology, physiotherapy and respiratory medicine. There was a request for pathology and an abdominal ultrasound was completed. On 14 June 2017, Mr Doran was reviewed by Doctor Weerakoon at the Prince of Wales Urology outpatient clinic. Dr Weerakoon recorded that a renal tract ultrasound was performed revealing an enlarged prostate.

Extensive discussion between Dr Weerakoon and Mr Doran took place, regarding investigations for prostate cancer and recorded "James himself does not want any investigation or treatment for a possible prostate cancer."

On 6 February 2018, Mr Doran was diagnosed with Metastatic Prostate Cancer following a biopsy. Upon discovery the cancer rated a 9 on the Gleeson scale. As a result of this, Mr Doran was referred to palliative care and treated on prostate cancer drug zoludex and bicalutamide. To assist with pain, Mr Doran was administered Fentanyl and Endone.

Mr Doran was discharged from the Prince of Wales Hospital, back to the care of Long Bay Hospital. During his time at Long Bay Hospital, Mr Doran suffered from two falls. One in April 2018, which resulted in a fracture of the neck of the left femur, requiring surgery. The records reflect that the surgery went well, and he was discharged back into the care of Long Bay Hospital 7 days later.

The second fall occurred on 1 October 2018, as a result of this fall, he was again transferred to the Prince of Wales Hospital. The fall resulted in a fractured hip. Due to his ill health, Mr Doran remained at the Prince of Wales Hospital.

Upon his admission, Dr Welkee Sim, a Geriatrician, noted that Mr Doran was delirious and in pain. His prostate cancer was confirmed to be progressing aggressively, with the cancer marker rising from 691 in July 2018, to 8642 on 5 October 2018, despite treatment.

Events leading to his death

While at the Prince of Wales Hospital, Mr Doran's health deteriorated. The Justice Health medical notes reflect that while his condition was stable, he was noted as being disoriented and confused. Given his deteriorating health, Mr Doran remained at the Prince of Wales Hospital for Palliative care only.

On 12 October 2018, Mr Doran was seen by Geriatrician, Dr McGregor-Wood, who noted that Mr Doran had slightly rapid and shallow breathing and ordered 1.5mg of Hydromorphone.

About 9:00am on 12 October 2018, palliative care doctor, Dr Clark-Dickson attended and noted laboured breathing.

About 11:10am on 12 October 2018, nurses provided comfort measures, sedating Mr Doran. His family was informed.

About 10:00pm on 12 October 2018 nursing staff were turning Mr Doran, in order to prevent pressure sores and noted that he was non-responsive with rapid breathing. About 10:45pm that night, the night staff were advised that Mr Doran was expected to pass away during the night.

About 11:50pm on 12 October 2018, nursing staff moved Mr Doran, again noting that he was non-responsive with rapid breathing.

About 1:30am on 13 October 2018, Registered Nurse Medina Beremo attended to Mr Doran and discovered he was unconscious, cold, and with no signs of life. Dr Hannah Corbett entered the room and pronounced life extinct.

What was the cause and manner of Mr Doran's death?

On 16 October 2021, a post mortem was conducted by Dr Istvan F Szentmariay. He stated that Mr Doran's death was caused by metastatic prostate cancer, in accordance with the medical records he had reviewed.

I am satisfied that Mr Doran's death was due to natural causes and that he was provided with appropriate care for his pre-existing conditions whilst in custody. I did not identify any issues with the attempts made at resuscitation by correctional or medical staff.

Formal findings

Identity: The person who died was James Sampson Doran

Date of death: He died on 13 October 2018.

Place of death: He died at Prince of Wales Hospital, Randwick NSW.

Cause of death: He died of metastatic prostate cancer

Manner of death: He died of natural causes, in custody.

19. 392964 of 2018

Inquest into the death of A. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 22 October 2021.

On 20 December 2018 A died in Long Bay Correctional Centre, Sydney. He was 34 years old. A's friend and cell mate R found him unresponsive, hanging from the ceiling of their shared cell. R immediately called for help, but emergency services were unable to revive A and he was pronounced deceased. At autopsy the cause of A's death was identified as hanging.

When a person is in custody at the time of their death, an inquest is mandatory pursuant to sections 23 and 27 of the Act. The Coroner must make findings as to the date and place of the person's death, and the cause and manner of death. The Coroner must also examine whether the State has discharged its obligation to provide the person with appropriate care for their physical and mental health.

In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

A's death raised questions about the adequacy of the care he received for his mental health issues while he was in custody. The main areas for examination were the following:

- why did A not see a mental health nurse, despite being placed on the relevant waitlist?
- was the treatment and management of A's mental health consistent with relevant policies, procedures, and guidelines?
- where did A get access to the rope which he used?
- are there appropriate procedures for Corrective Services NSW [CSNSW] and the Justice Health and Forensic Mental Health Network [the JH Network] to share health information about inmates?
- are there appropriate means for families to communicate their concerns about an inmate's mental health?

A's life

A was born in the Republic of the Philippines on 17 November 1984, the first of three children born to his parents. When A was in his late teens his mother moved to Australia. A's father died in 2002, and his mother married C later that year. She then sponsored A, his sister, and his brother to join her in Australia. A arrived in Australia in 2006. By this time, he had two children in the Philippines, one of whom has since died. In Australia he lived with his mother, stepfather C and his two siblings.

He worked as a process worker, and then commenced a diesel mechanic apprenticeship in his stepfather's business. He was a permanent resident of Australia but did not take steps to become an Australian citizen. He continued to be a citizen of the Philippines. A formed a de facto relationship in 2010 which ended the following year. His de facto partner was the victim of offences committed by A in January 2012, of sexual intercourse without consent and intimidation. On 17 October 2014 A was convicted of these offences and sentenced to a term of imprisonment. He would not be eligible for parole until January 2018.

Prior to be being sentenced A had commenced a new de facto relationship with D, and their relationship continued while A was in custody. D visited A weekly and spoke with him most days by phone. A's mother, stepfather, brother, and sister were also very regular visitors. At the close of evidence in the inquest, A's mother and his sister spoke movingly of A on behalf of their family. A's mother spoke of his happy personality, his easy nature with people, and his respect for her. She is heart-broken by his death. A's sister described how she had been looking forward to visiting him on the weekend after his death, and her sadness at never seeing her big brother again. It was evident that A was much loved by his family. It grieves them deeply to know that he became overwhelmed with despair at his situation and died alone.

A's health while in custody

A did not have any significant physical health issues. Nor prior to entering custody did he have any reported history of mental health problems. While he was in prison he had various primary health appointments for routine physical health matters. When he was received into custody in October 2014 A had a Reception Screening Assessment. This noted that he had 'denied suicidal, self-harm or harm other thoughts. The following year A began to experience sleep problems. In November 2015 he referred himself to the prison health centre due to 'feeling stressed' and having sleep difficulties.

The first documented reference to A suffering depression was on 20 June 2018. He had been transferred to the Special Programs Centre at Long Bay Correctional Centre so he could participate in a program for convicted sex offenders, which will be further described below. On arrival at Long Bay Correctional Centre A received a primary health care assessment in which he disclosed that he had been experiencing depression.

While assessing A, Registered Nurse Mary O'Gorman noted that he 'can guarantee safety of self and others when asked'. She referred him for assessment by a mental health nurse, placing him on the waitlist as 'Category 3'. This refers to patients who are considered stable but require attention within 14 days to three months. Two days later, in another attendance at the health clinic A again complained of a lack of sleep due to stress. His place was maintained on the mental health nurse waitlist, and he was advised to speak to a psychologist employed by CSNSW.

When A died six months later he had still not been seen by a mental health nurse, despite RN O'Gorman's classification of his clinical need. This failure and its possible impact on A's risk for suicide will be considered later in the findings.

The Moderate Intensity Sex Offender Program

While he was in custody A completed various programs including first aid, working safely at heights, and use of calculators. However, in January 2018 he was refused parole because he had not undertaken a specific program to address his sex offending behaviour. This was the Moderate Intensity Sex Offender Program [the MISOP program], a custody-based residential therapy program for men who have committed sex offences. The six to eight-month program aims to help men change the thinking, feelings and attitudes which led to their offending behaviour.

A decided to undertake the MISOP program and he commenced it on 5 July 2018, choosing not to seek parole in November 2018 so he could complete it. At the time of his death on 20 December 2018 he was very close to completing the program. He would next be eligible for parole on 29 January 2019.

The MISOP program and similar ones are conducted in a wing of Long Bay Correctional Centre called the Custody Based Intensive Treatment wing, or CUBIT wing. This is a stand-alone unit housing a small number of offenders, which aims to create a therapeutic community. All inmates in the CUBIT wing are engaged in sex offender therapeutic programs and are expected to work on treatment goals and practice their new skills together. They have a high degree of access to psychologists, mainly through the program's frequent group sessions. They also have certain freedoms not available to other inmates, in order to assist their transition from custody to the community.

Ms. Meagan Donaldson facilitated the MISOP group in which A was enrolled. Ms. Donaldson is a registered psychologist with endorsement in forensic psychology. She was employed by CSNSW from 2002 until her resignation in 2020. From September 2012 onwards she was a senior psychologist, responsible for managing the teams which provided programs for sexual offenders. Ms. Donaldson came to know A well in the course of their group sessions, which were conducted twice weekly and sometimes thrice weekly. At the inquest she described him as 'an active and vocal member from the beginning'. He attended all group sessions and treatment work, and 'was open to feedback from the therapist and group members.

At the inquest Ms. Donaldson told the court that throughout the course A appeared motivated to address the factors which had led to his offending and appeared keen to move on with his life. In her statement she described him as 'energetic, good humoured, and appeared to form genuine friendships with others'. Two such friendships were with fellow inmates R and S. At the inquest R and S gave evidence about A and his state of mind in his last days, which will be described further below.

A's immigration status

A significant factor in A's life during his last year was his immigration status. On 27 June 2017 A's permanent resident visa was cancelled due to his criminal convictions. This meant that when his sentence concluded he would be deported to the Philippines. This was a source of distress for him, as he wanted to remain in Australia. A wrote to the Minister for Home Affairs on 14 December 2017, asking that his visa not be cancelled as he had no close family in the Philippines and nowhere to live there.

He was not successful: on 13 November 2018 he was notified that the original decision to cancel his visa would not be revoked. According to R and S, A was noticeably stressed and worried by this news. With help from Ms. Donaldson, A lodged papers for a merit review of the decision, and a hearing was listed in the Administrative Appeals Tribunal on 21 and 23 January 2019. A's mother thought that he was fairly optimistic of success.

A was aware that completion of the MISOP program would be helpful in getting parole. He also believed it would boost his chances of remaining in Australia after his sentence expired. This belief appears to be based on advice provided to A by CSNSW Psychologist Owen Warner in August 2017, and a discussion A had with his mother. In the second of his three statements, A's step father said A had been told that if he completed the course 'he could stay in Australia when he finished it and was released'. Against this background therefore, the news on 13 November 2018 that his visa would nevertheless be canceled must have left A with strong feelings of disappointment and dismay. A's mother believed that he 'got inconsistent advice and information ...and that gave him a false sense of hope and made the disappointment and frustration much worse for him'.

Additional stresses in A's final week

In the nine days prior to A's death two things happened which greatly added to his distress. A's partner D was a frequent visitor and they spoke on the phone several times each week. During her visit on 8 December 2018 they talked about his upcoming tribunal hearing and A told her that on her next visit he would give her some documents to deliver to his lawyer.

However, in a phone conversation on 11 December 2018 D told A that she no longer loved him and was ending their relationship. A was very upset and said words similar to: 'If we don't end up together, I better end my life'. D did not consider he was serious about taking his own life. She assured him that she would continue to help him, and indeed they had further phone conversations throughout the week.

In one of these conversations A became angry that D had forgotten to book a prison visit to collect the documents for his lawyer. She agreed to visit him again on 22 December 2018 for this purpose. Then on 17 December 2018 the family received sad news from the Philippines: A's uncle had died. A had been very close to his uncle, who had helped his mother to bring him up. On 18 December 2018 D broke the news to A on the phone, describing him as 'speechless' when she told him.

A's emotional condition in his last weeks

Corresponding with these sad events, in A's final couple of weeks a number of people grew concerned about his state of mind. One of these was A's stepfather C. C spoke with A on the phone fairly regularly, and around this time he noted a significant shift in A's mood. In their telephone calls A was crying and seemed to be 'scared of something or mentally broken … his attitude was 'I don't care anymore', he'd say that sometimes'.

C was deeply concerned about A. In his second and third statements and in his evidence to the court, C said that he had rung the correctional centre on two occasions to convey how worried he was that A might hurt himself. C does not believe that any action was taken after his calls. I will discuss this evidence later in the findings.

Fellow inmates also noticed A's deteriorating mood. A number of them provided statements to the inquest, describing A as a generally happy and energetic person who got on well with everyone. This changed in his last couple of weeks. R, who was sharing a cell with A at the time, said that in his last days A seemed 'mentally and emotionally drained and was giving up on everything'. S thought he had become isolated and 'withdrawn, depressed, sluggish and definitely not his happy self'. R and S did their best to support A when he received the news of his immigration status and the break-up with D.

In his final week A made a number of allusions to taking his own life. On 14 December 2018 he was seen to be crying in a phone conversation with D. The next day he said to her:

'I feel my life is nothing …If I lose you, I would rather die …I want to finish my suffering.'
Three days later he told her:

'You might not see me this Saturday, as what I've said before, my life is nothing if I don't have you'.

That day in his group session A told Ms. Donaldson and the group members that his relationship with D had ended. He informed his cell mate R that he wasn't going to the gym anymore and 'did not have faith in God anymore'.

The next day A learnt of the death of his uncle. The following evening, 19 December, he told R that he was worn out, saying 'I'm so tired, I can't get out of it'. It was on the next morning that he took his life.

20 December 2018

On the morning of 20 December 2018, A was observed during a routine head check at 6.15am. Soon afterwards R left their cell to go to the gym, returning at 7.20am. On the door of their cell he saw a sign indicating 'do not disturb'. Knowing A had been feeling low and thinking that he might want to have some time to himself, R left to have breakfast. R came back at 8.00am and saw that a green towel had been placed across the inside of the cell door window. The cell door had been locked from the inside, but R had a key and used it to enter. He immediately saw A hanging from the cell ceiling. R rushed outside and shouted for help, then returned and tried to hold A up from the waist.

Other inmates ran to help him, while a correctional officer cut the noose that was suspending A from a conduit pipe in the ceiling. A was carried outside his cell and correctional officers commenced CPR, while an inmate conducted mouth to mouth breathing. A medical team arrived and attempted to use a defibrillator, but A could not be revived. He was declared deceased at 8.11am. The issues at the inquest

The adequacy of A's mental health care and treatment

The inquest examined two key aspects of A's mental health care and treatment while he was in custody. The first was why, six months after being placed on the waitlist, A had not been reviewed by a mental health nurse. The second issue was the question whether, in light of her interactions with A in his last few days, psychologist Ms. Donaldson should have made a formal notification that he was at risk of suicide or self-harm.
In addition to giving evidence Dr Kerri Eagle provided a report providing her opinion first, as to whether the overall care and treatment A received while he was in custody was adequate; and secondly, whether Ms. Donaldson ought to have notified that he was at risk.

The failure to be seen by a mental health nurse

It was common ground that at the time of his death on 20 December 2018 A had still not been seen by a mental health nurse, despite a referral having been made on 20 June 2018.

At the inquest Dr Ma was asked about this failure. He explained that at the time of A's death, the Long Bay inmate population of approximately 1,000 was being assisted by the equivalent of a 1.5 fulltime mental nurse position. Official waitlist times could not be met, as appointments had to be postponed due to the need to interpose emergency cases. Dr Ma advised there is now the equivalent of two fulltime mental health nurse positions. This has been achieved not because of additional funding, but by reallocating existing state-wide resources. Dr Ma pointed out that unfortunately this had not led to an improvement in the wait time for inmates to see a mental health nurse. In fact, the proportion of inmates who had not been seen within the required waiting times had increased. The reason was that the same period had seen an increase in the inmate population, and resources for mental health care had not kept pace with this increase.

Dr Ma and Dr Eagle were both asked what treatment a mental health nurse might have provided to A, had he been able to be assessed prior to his death. They concurred that if on presentation he appeared to be suffering an underlying mental disorder or illness, he would likely have been referred to a psychiatrist for treatment options such as medication. This could have reduced A's risk for suicide. Both cautioned however that it was not clear on the material if A was in fact suffering an underlying disorder. Nor was it possible to say that any such treatment would have prevented his death. On the evidence therefore, it cannot be said that had A been assessed by a mental health nurse this would have prevented his very sad death.

However, I accept the submission made on behalf of A's family, that seeing a mental health nurse would have offered an additional support for A and may have reduced his risk for taking his own life. The failure to ensure that A was seen by a mental health nurse ought not to go without comment. The submissions on behalf the JH Network pointed to recent steps taken to improve its custodial health services. These appear to consist mainly of enhancements to its information management systems. The improvements will allow the JH Network to better identify those patients whose waitlist times have been exceeded.

Without wishing to minimise these steps, I observe that of themselves they are unlikely to ensure that inmates receive the care they need in a timely way. Dr Ma's evidence in his first statement and at the inquest was that A's referral to see a mental health nurse did not take place because 'the demand placed on the mental health waitlist outweighed the available staffing resources in the period'. The neglect of funding for custodial mental health services has long been a matter for coronial concern. Recent examples include the Findings of inquest into the death of F, 11 June 2021, Ryan DSC; and Findings of inquest into the death of MH, 15 July 2021, State Coroner Magistrate O'Sullivan. As a society we cannot find it acceptable that men and women who need help are forced to wait so long to receive it. Inmates are not at liberty to arrange their own medical and psychological help and neither are their families. They depend on the State to do so. For this reason, I will request those assisting me to forward a copy of the findings in this inquest to the Ministry of Health, for consideration of the issue of funding for mental health services in Long Bay Correctional Centre, with emphasis on funding for mental health nurse positions.

I will now consider the second aspect of A's mental health care and treatment. This is Ms. Donaldson's interactions with A, and whether these ought to have led her to take a different course of action in relation to his risk of suicide.

Ms. Donaldson's interactions with A

Senior psychologist Ms. Donaldson facilitated the group sessions for A's group. In this role she had additional interactions with A, first in helping him with documentation for his immigration review, and secondly during his last week, discussing with him the breakup of his relationship with D and the death of his uncle.

By the time of these events, the participants in A's group sessions numbered three or four. In the group session on 17 December 2018, A told the group that D had ended their relationship. He had not yet become aware of his uncle's death. According to Ms. Donaldson's case notes, A was emotional and told the group he felt 'hurt, lost and rejected'. Part of the 2.5-hour session then focused on helping A to identify his feelings and to develop strategies to cope with them. These included keeping a journal, maintaining a routine, and talking to others.

After the group session Ms. Donaldson attended a staff meeting in which she informed her colleagues about A's relationship breakdown. The attending staff included both therapeutic and custodial staff. After this Ms. Donaldson had a one-on-one meeting with A. She told the court that having an individual session with a program participant was uncommon, as the program primarily used a group-based learning model. Nevertheless, she thought it was important on this occasion. A was deeply distressed about his relationship breakup, on top of his longstanding concerns about his immigration status.

She wanted to see how he was coping and to consider whether any risk of suicide or self-harm was present. During the individual meeting Ms. Donaldson found A to be calmer and less tearful than in the group session. They talked again about coping strategies, and about accommodation options on his release. She reminded him that she needed to be sure that he was safe. To this he replied: 'I wouldn't do that'.

Overall Ms. Donaldson felt reassured that A was 'processing' the relationship breakup and had some protective factors in place. These included that he had post release plans, he had friends who were fellow participants in the program, and he had access to a treating psychologist. In her notes Ms. Donaldson concluded: 'I did not consider [A] to be at risk of self-harm or suicide at this time'.

The next day was 18 December. Ms. Donaldson again facilitated the group session. A had just received the sad news of his uncle's death, and he was again emotional and tearful. Ms. Donaldson asked if she should be concerned about his safety. A's reply was 'I've thought about it, but it's not worth it, I know how to cope'. He said further he was 'okay'. A had mentioned to Ms. Donaldson that he would like to have the support of a chaplain, so after the group session she emailed Chaplain Colin Sheehan suggesting that A would benefit from pastoral support. After that she attended a staff and inmate social event. She observed A keeping company with S and then preparing and eating a meal. She thought these were positive signs that he was coping. In her statement she said: 'I had certainly not formed a view that [A] was at risk of hurting himself'.

The following day, 19 December 2018, Ms. Donaldson spoke briefly with A to let him know she had contacted the Chaplain. Nothing about his presentation caused her any particular concern. This was the last time she saw him.

The CSNSW policy for mandatory notification

Ms. Donaldson did not make a mandatory notification that A was at risk of suicide or self-harm. Given the above interactions, ought she to have done so? Notably, in his statement and oral evidence Mr. Terry Murrell said that in his opinion Ms. Donaldson was required to have made a notification, once A had disclosed on 18 December 2018 that he had 'thought about it'.

The process of raising a mandatory notification is an element within CSNSW policies directed at managing inmates who are at risk of suicide and self-harm. The primary policy is Custodial Operations Policy and Procedures 3.7 [COPP 3.7]. Prevention of suicide and self-harm is stated to be a team responsibility to be shared between staff of CSNSW and the JH Network 'at all staffing levels':

COPP 3.7 mandates that staff make a notification of risk of self-harm or suicide, in circumstances where they have identified that such a risk is present. A mandatory notification leads to the formation of an Immediate Support Plan for the inmate's health and safety. The plan must be appropriate to the level of risk and be consistent with the principle of least restrictive care. Within 24 hours of the mandatory notification being made, a Risk Intervention Team must convene to review the inmate's risk and if need be, develop additional strategies to manage it.

To guide staff in identifying if an inmate is at risk of suicide or self-harm, COPP 3.7 attaches two key documents:

- Suicide and Self-Harm: Risk Factors for Consideration - Reference Guide
- Suicide and Self-Harm: Inmate Interview Questions to Further Evaluate Risk.

Part 2 of the Policy mandates that both documents 'must be read in conjunction with [COPP 3.7]'.

The first document, which I will call the 'Risk Factors document', directs staff to raise a mandatory notification where an inmate has current or recent suicide or self-harm thoughts or behaviour. In dot point form, five types of such thoughts or behaviour are listed. Relevant to A, the third one is 'Thoughts of suicide, self-harm or dying in the last 72 hours.

The Risk Factors document also directs staff to 'investigate further' when they become aware that an inmate has, among other things:

- a current mental health impairment (including 'threat of suicide or self-harm as 'throw-away line'')
- current or recent situational factors.

Mr. Murrell told the court that expert advice had guided the content of the Risk Factors document and the Inmate Interview Questions. Their purpose was to give staff as much guidance as possible in identifying and responding to the risk of suicide or self-harm. Mr. Murrell explained that the policy and attached documents were intended to provide a low threshold for mandatory notification. This was because all staff members, irrespective of job description or level of training, were responsible for helping to prevent suicide and self-harm. Many staff members would have no training or experience in assessing an inmate's mental health. They may also lack familiarity with the inmate. Nevertheless, they had an obligation to apply the policy if they identified that a risk may be present.

Ms. Donaldson's evidence concerning mandatory notification

In her evidence Ms. Donaldson said she was familiar with the content of the above two forms, but she had not had cause to use them while working with the CUBIT programs. In her experience it was uncommon for CUBIT participants to experience acute suicidality. They lived in a minimum-security therapeutic environment and were usually at a stage in their sentence where their release date was approaching. Ms. Donaldson told the court that on 18 December 2018 she had concluded that A did not reach the threshold where she needed to make further enquiries, or to undertake a comprehensive risk assessment. She explained that the latter would have involved exploring with A what the 'thought' was, in response to his comment that he had 'thought about it'. At the time she had concluded that although A had had a 'thought' it appeared to have been fleeting, and he had discounted it with his follow up comments that 'it' wasn't worth it and that he knew how to cope.

He had then discussed with her his plans to manage his distress. She had concluded from this, that his expression that he had 'thought about it' did not amount to a thought of suicide or self-harm, such that she needed to make a mandatory notification. Because of these features, Ms. Donaldson had formed the view that A was not at risk of suicide or self-harm. However, she said that with hindsight, it would have been of benefit to have explored with him what the nature of the thought was, and whether an intent lay behind it.

The submissions on behalf of A's family

On behalf of A's family, Ms. McLaughlin submitted that Ms. Donaldson was obliged to make a mandatory notification following A's comment to her that he had 'thought about it'. It was submitted that Ms. Donaldson's failure to do so was inconsistent with applicable policies, reflecting:

> *'… a fundamental misunderstanding of either or both the content of those policies and procedures – or the level of risk required before a mandatory notification is to be made'.*

This submission is based on the argument that pursuant to COPP 3.7, notification is not optional once an event has occurred that falls within any of the three circumstances on the front page of the mandatory notification form. The three circumstances are:

> *a a deliberate act of self-harm/attempted suicide has occurred*
> *b a threat of self-harm/attempted suicide has occurred*
> *c an inmate is assessed as at risk of self-harm/suicide.*

The evidence of Mr. Murrell, referred to above, provides support to this submission. Mr. Murrell said that he interpreted COPP 3.7 strictly; and that Ms. Donaldson ought to have made the notification '… in the strictest sense of the [Policy]'.

Does the policy permit an element of discretion?

I accept the submission that COPP 3.7 and its attached documents remove any discretion to make a mandatory notification, once a staff member identifies the presence of any of the features listed under the heading 'Raise mandatory notification if..'. In A's case, the factor is said to be the presence of 'Thoughts of suicide, self-harm or dying in last 72 hours. However, I do not accept that Ms. Donaldson's decision not to make a mandatory notification in A's case evidenced any misunderstanding on her part, either of the content of the policy or the applicable level of risk.

Acceptance that a staff member must raise a mandatory notification once they have identified the presence of a listed risk factor does not mean that there is no room for individual discretion in deciding whether that risk factor is actually present. The Policy, as well as the application of commonsense, dictate that a staff member is to exercise judgement in identifying whether the inmate's thought actually amounted to one of suicide or self-harm. This was the opinion held by Dr Eagle, who commented that an element of clinical judgement was required in ascertaining whether a person presented with any of the listed risk factors. In her view A's remark that he had 'thought about it' was 'very ambivalent and very vague', and there existed a wide range of such expressions. There had to remain room for clinical judgment in interpreting whether a person's expression was in fact a threat of self-harm or suicide. Dr Eagle's evidence on this point is in my view supported by the documentation. The Risk Factors document itself recognises there may be ambiguity in the nature of the inmate's expression.

While thoughts of suicide or self-harm require the staff member to raise a mandatory notification, in circumstances where the threat is a 'throw-away line' the staff member is instructed to 'investigate further'. The term 'throw-away line' appears to acknowledge that in some circumstances, an inmate's expression of a thought may require the staff member to consider whether it does in fact represent a thought of self-harm or suicide, so as to mandate notification.

This interpretation is reinforced by 2.1 of COPP 3.7, wherein it is stated that

> *'Any staff member who suspects an inmate might be at risk of suicide or self-harm must make further inquiries to determine if a mandatory notification is required …' [underscore added].*

I conclude therefore that it is mistaken to interpret the Risk Factors document as removing clinical discretion from the decision to make a mandatory notification. Room must be left for further inquiry as to whether the inmate's expression does in fact amount to a thought of self-harm or suicide. This may particularly be the case where the staff member is, like Ms. Donaldson, an experienced psychologist who has worked extensively with the inmate. So much was implicitly acknowledged by Mr. Murrell in his evidence, when he conceded that certain factors could bear upon whether the staff member determined that a mandatory notification was required. Two factors which he identified were the mental health expertise of the staff member, and his or her degree of familiarity with the inmate.

Having carefully reviewed the evidence, I do not consider it was unjustified for Ms. Donaldson to have regarded A's comment that he had 'thought about it' as an expression in the nature of a throwaway line. A had no history of suicidal behaviour or mental illness. He had followed his comment with further remarks that 'it' was 'not worth it' and that he knew how to cope. Furthermore, despite the distressing events of his last week, he had continued to actively participate in the MISOP program. At times he showed that he was applying his skills to cope with the impact of these events. The conclusion I reach is that in deciding that she did not need to make a mandatory notification, Ms. Donaldson exercised clinical judgement and further, that COPP 3.7 permits her to do so. On the basis of what she knew about A and his situation, it was not unreasonable for her to have concluded that his implicit reference to suicide was in the nature of a throwaway line. That being so however, the appropriate response from Ms. Donaldson would have been to 'investigate further' with A what his thought was and what he meant by it. This response would have been consistent with COPP 3.7 and in particular the Risk Factors document.

In this respect I accept Dr Eagle's opinion that while A's statement that he had 'thought about it' may not have amounted to an expression of self-harm or suicide, it did require further questioning as to what he meant by it. In her view Ms. Donaldson ought to have further explored A's remark, ideally in another one-on-one meeting with A after the group meeting on 18 December 2018. I note that in her evidence Ms. Donaldson recognised and acknowledged that it would have been appropriate for her to make further enquiry with A on 18 December 2018.

Was Ms. Donaldson's management of A consistent with her professional training and expertise?

The submissions on behalf of A's family fairly conceded that there is no basis to make an adverse finding against Ms. Donaldson on this ground. The submissions acknowledged Dr Eagle's opinion, that the major risk factor which A presented at the time of his death was overwhelming distress caused by the recent events in his life. Ms. Donaldson's psychological treatment had been properly focused on helping A to cope with that. It was 'appropriate evidence-based psychological support'.

There is a further reason why it would not be appropriate to be critical of Ms. Donaldson in relation to her decisions about A's risk for suicide. This is her lack of awareness of two events which she said would have had a bearing on her approach. The first of these was that A's stepfather had contacted the correctional centre expressing concerns about A's state of mind. Ms. Donaldson agreed that concerns held by an inmate's family were important information, and that 'at the least' she would have raised these concerns with A had she known of them. The second was the fact that in June that year A had been referred for review to a mental health nurse. This may have indicated to Ms. Donaldson that A's state of distress was of a more longstanding nature and had not just developed in response to the events of the past couple of weeks. Relevantly, I note that the Risk Factors document instructs staff to raise a mandatory notification when 'external sources of information suggest threats, thoughts of or an actual suicide or self-harm attempt in the last 72 hours.

How did A get access to the rope?

A second issue for examination at the inquest was how A got access to the rope, or more properly speaking the cord, which he had used to make the noose. This was a matter of significant concern for A's family. In her autopsy report, forensic pathologist Dr Rianie Janse Van Vuuren described the ligature as consisting of 'two strings tied together and folded into a small loop, extending into two loose ends.'

On the ceiling of A's cell was an electrical conduit pipe leading to the ceiling light. It was around this pipe that A had tied the cord which he used that morning. The inquest heard evidence as to where A may have obtained the cord. The correctional officer who first responded to the emergency was Khalil Mesann. He said that he recognised the cord around A's neck as the same type which inmates in the CUBIT wing sometimes used to hang their washing. According to Officer Mesann, correctional officers were aware that the cords were potentially harmful and would remove them; however, the inmates seemed to have little difficulty replacing them. When Officer in Charge of the coronial investigation Senior Constable Kimberley Flaskas attended the scene, she noticed cords of similar appearance in different places around the CUBIT unit. She saw a 'white coloured rope' being used as a clothesline at the entrance to A's wing. In a garden bed outside the cell area she also saw 'a clear/white coloured string'. She formed the opinion that the cord used by A had been woven using a combination of both types of string.

Scene photographs of A's cell were taken immediately after his death. These show an improvised cloth curtain stretching from the end of the double bunk bed to the opposite wall. It was intended to give users some privacy when using the toilet.

A's friend and cell mate R told the court that the curtain was attached to a handmade white cord. He was unsure who had first put the curtain up. He added that inmates used the same type of cord to hang washing in the garden. A's friend S had previously shared the same cell with him. S told the court that he and A had put up the toilet curtain, attaching it to a nylon cord which A had made. To make the cord A had woven together pieces of nylon twine which were used to bind the inmates' bed linen when it was delivered to them from the prison laundry each week. S said that in his experience, the correctional officers did not confiscate the handmade lines. Like R and Senior Constable Flaskas, S had also seen similar twine used in the garden. The court heard evidence as to whether any changes had been made since A's death, regarding the inmates' access to rope or cord products.

In response to A's death, on 10 March 2021 a Security Direction was issued in relation to laundry bundles at the Metropolitan Special Programs Centre. The Direction prohibits the use of 'plastic rope' for tying linen products from the prison laundry. Short plastic cable ties are now used. This response is welcomed and obviates the need for me to make a recommendation in relation to this issue.

Hanging points in prisons

The manner of A's death also raised issues about the accessibility of hanging points in Long Bay Correctional Centre. Every year inmates in NSW prisons take their own lives in tragic circumstances, often by hanging themselves. Repeatedly, expert evidence in inquests has emphasised the importance of suicide mitigation strategies, in particular reducing inmates' access to hanging points. Recent examples include the Findings of Inquest into the death of Tane Chatfield, 26 August 2020, Grahame DSC; and Findings of Inquest into the death of L, 20 April 2019, Ryan DSC.

The existence of hanging points within NSW prisons has also been the focus of parliamentary interest, most recently in the following:

- the NSW Legislative Council's Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody conducted in 2020 and 2021
- the NSW Legislative Council's Legal Affairs Committee Budget Estimates sessions of March 2021.

In this inquest, psychiatrist's Dr Ma and Dr Eagle concurred that it is not possible to predict with reliability if and when a person will complete suicide. Both stated that given this uncertainty, the most effective way to reduce the risk was to minimise access to hanging points.

In older correctional centres like Long Bay Correctional Centre where A was incarcerated, the risk posed by hanging points is heightened, as the older design of its fittings and furniture presents greater opportunities for suicide by hanging. For this reason, those assisting the inquest sought information from CSNSW as to what steps had been taken since A's death to reduce the prevalence of hanging points in cells at Long Bay Correctional Centre. Assistant Commissioner Leon Taylor provided a statement in response. He is responsible among other things for NSW prison infrastructure planning. Assistant Commissioner Taylor advised that funds of $6 million had recently been made available for projects to improve cell safety in NSW prisons. Cell safety projects focus on:

- building new cells which incorporate anti-ligature design principles
- removing obsolete cells
- refurbishing old cells to remove hanging points.

The new funding will be used to reduce hanging points in Long Bay, Parklea and Junee Correctional Centres. At Long Bay Correctional Centre, cells containing a total of 249 beds are in the process of being refurbished to remove obvious hanging points. The work focuses on removing unsafe plumbing fixtures, bed frames and light fittings, and replacing these with safer alternatives. It is encouraging to hear of these efforts to reduce suicide risk in NSW correctional centres. The new funding evidences a recognition by CSNSW authorities of the seriousness of this problem, and a commitment to reduce its magnitude.

However, the Long Bay refurbishment program will not include cells in the CUBIT wing. In his statement Assistant Commissioner Taylor said that priority for refurbishment funds is given to maximum security prisons which house inmates on remand, and mentally ill inmates. These inmates are considered to be most vulnerable to self-harm or suicide. Assistant Commissioner Taylor explained further that as a minimum-security wing, the CUBIT unit is intended to 'recreate a more homely environment encouraging behavioural reform'. Thus, the unit's features and fittings are less austere in design than those in more secure parts of the prison.

I accept that it is proper for the Assistant Commissioner to take a risk-based approach to the allocation of resources for suicide mitigation. I also accept that in places like the CUBIT wing a balance needs to be found between safety considerations on the one hand, and on the other, creating an environment to support inmates on their path of adjustment into community life. This is likely to result in a reduced focus on suicide mitigation in the design of furniture and fittings.

For this reason, it would not be appropriate in this inquest to make a recommendation that has repeatedly been made in previous ones. I will simply make the observation that a large proportion of NSW inmates continue to be housed in environments which present significant self-harm risks. There is a compelling need for NSW authorities to continue the work of reducing this risk by providing accommodation which conforms to safety standards. The remaining areas for examination involved communication issues between custodial agencies and the families of inmates.

Ccommunication between staff of CSNSW and JH Network

I have noted that in December 2018 Ms Donaldson was unaware A had been referred for review by a mental health nurse. This was not a failure on her part: there is no evidence that this information was recorded in any documentation available to her. In her evidence Ms Donaldson said this information would have been of benefit to her in understanding the level of A's risk for suicide.
For this reason, Counsel for A's family proposed that CSNSW and the JH Network:

' …develop the necessary procedures and policies to ensure that referrals for mental health services for inmates are communicated between both agencies, and the fact of that referral and its outcome is recorded on [the Offender Integrated Management System]'.

On behalf of CSNSW it was submitted that the issue of information sharing between CSNSW and JH Network staff is not straightforward. I acknowledge this is the case. There are important privacy reasons why it would not be appropriate for CSNSW staff to have access to certain JH Network records regarding inmates and their health disclosures. Nevertheless, based on the evidence given at inquest by Ms Donaldson and Dr Eagle, there is a case for CSNSW psychologists at least, to have access to key information about an inmate with whom they are working. An example would be the fact of a referral for an inmate to see a mental health nurse.

In his evidence, Dr Ma said that work was underway within the JH Network to allow CSNSW psychologists access to relevant JH Network records. Discussions and planning had commenced in April 2020. For this reason, it was submitted on behalf of the JH Network that there was no need for the recommendation sought by A's family. However, I have decided to make a recommendation along the lines sought by A's family. I intend no criticism of Dr Ma, when I say that his evidence on this project lacked the detail I would require in order to be satisfied that this issue had been addressed. I will therefore make a recommendation as follows:

'That CSNSW and the JH Network develop the necessary procedures and policies to ensure that referrals made by the JH Network for mental health services for inmates and the outcome of those referrals be communicated to CSNSW psychologists'.

Communication between families and correctional centres

Adding to their grief at the loss of their son, A's mother and stepfather are distressed that CSNSW authorities appear to have taken no action in response to calls which C said he had made during A's final weeks. C's evidence is that he rang the correctional centre twice in the weeks leading up to A's death. In both calls he expressed his deep concern that A was '*at rock bottom'* and would harm himself. He said that someone needed to '*keep an eye on A'.* C says that on both occasions the person to whom he spoke said they would pass the information on. As noted, Ms Donaldson was unaware that A's family were deeply worried about his emotional state during his final two weeks. She and Dr Eagle concurred that serious concerns held by A's family would have been important information for Ms Donaldson to know when considering his risk level.

According to submissions made on behalf of CSNSW, I ought not to accept C's evidence that he made the calls. It was submitted that C was, at the least, mistaken about having done so. In her submissions, Special Counsel for CSNSW pointed to discrepancies in C's evidence about the calls, including when exactly they were made. I accept there were areas of confusion in C's evidence about this. The further submission is made that accepting C's evidence that he made the calls would be contrary to '*compelling inferences available'* from police and CSNSW evidence that the calls were not made at all. The evidence relied upon is that NSW Police officers recently searched phone records but were not able to locate any calls made by C to the correctional centre. However, the court heard that the searches were unable to encompass a second landline number which C had at the time, but whose number he could no longer recall. In my view this evidence does not support a *compelling* inference that the calls were never made.

The further submission is made that C's evidence about having made the calls was of little probative value because accepting it would be *'tantamount to deciding [the issue] on [C's] demeanour'.* I do not know why the conclusion is drawn that if C's evidence is accepted by the court, it could only be on the basis of C's demeanour. As submitted by Counsel Assisting, it has not been suggested there was any motive for C to fabricate the evidence of his calls, and it is '*entirely believable'* that he would be deeply worried about A and want to tell prison authorities about it.

I do accept the submission on behalf of CSNSW, that it would be a serious matter to conclude that CSNSW employees had received C's calls but failed to act in response to his deep concern about A. Consistent with the principles of *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361, a court would require cogent proof in support of such a serious allegation.

Bearing the above considerations in mind, I have concluded that the state of evidence is such that I am not in a position to find whether or not C's calls were received by CSNSW employees. For the purposes of this inquest, it may be argued that such a finding is not strictly necessary. This is because based on the submissions on behalf of CSNSW, the Acting Commissioner does not oppose the recommendation proposed by A's family directed at this issue. This is that CSNSW and the JH Network:

'.. develop compatible policies and procedures to ensure that family members of inmates are able to effectively communicate their concerns about the mental health or risk of self-harm/suicide of that inmate'.

The evidence at inquest provides a basis for a recommendation for review in this area. The court heard evidence that when inmates enter custody, they and their families receive a handbook providing information about how to contact authorities with concerns about the inmate. Yet in their evidence A's stepfather, and A's cell mate and friend R, did not recall receiving this. Nor did they appear to be aware of the 1800 hotline operated by mental health nurses on a 24-hour basis, which inmates and families may contact mental health concerns.

Additional recommendations

As noted above, I intend to make recommendations directed at the sharing of certain health information between staff of CSNSW and the JH Network; and that CSNSW and the JH Network review their policies regarding communication with families of inmates. On behalf of A's family, it was further submitted that a recommendation should be made *mandating* training in the provisions of COPP 3.7 for all CSNSW employees who come into contact with inmates. In response the Acting Commissioner has advised that he intends to amend 2.1 of COPP 3.7 in accordance with this recommendation. This obviates the need for me to make this recommendation.

One further area remains for consideration. This is the question whether COPP 3.7 and its attached Risk Factors document and Inmate Interview Questions require review. In her evidence Dr Eagle said that in her opinion the 'mandatory notification' approach taken in COPP 3.7 was not an effective one for managing risk, and that an individualised assessment was to be preferred.

I am confident that the latter approach makes sense in circumstances where the staff member holding concerns about an inmate is a professional mental health practitioner like Ms Donaldson.

However, where the staff member has no such expertise and experience, there is force in Mr Murrell's evidence that a simple approach is required, imposing a low threshold for notification. Relatedly, Counsel for A's family has submitted that the Risk Factors document ought to include the further risk factor, as to whether the inmate is housed in an area of the prison where the removal of hanging points has not yet taken place. In her evidence Dr Eagle agreed that the inmate's environment and access to lethal means of suicide should be included in the risk assessment. She cautioned however that responding by placing an inmate in a safe cell has associated harms, which may heighten their sense of isolation and remove their access to usual coping mechanisms.

In response to the above evidence, Counsel Assisting proposes a recommendation that CSNSW consider reviewing COPP 3.7 and its attachments, in order to:

- determine whether the Policy should apply to psychologists and other professional mental health practitioners employed by CSNSW; and
- determine whether the matters referred to in the Risk Factors document and Inmate Interview Questions documents currently meet the criteria for best practice to prevent suicide or self-harm of inmates.

Counsel for CSNSW has advised that the Acting Commissioner does not oppose the above recommendations and does not oppose a further one to the effect that an additional risk factor be listed, namely the potential risk for self-harm posed by the inmate's current accommodation.

Findings required by s81 (1)

Identity
The person who died is A.

Date of death:
A died on 20 December 2018.

Place of death:
A died at Long Bay Correctional Centre, Matraville NSW 2036.

Cause of death:
The cause of A's death is hanging.

Manner of death:
A died when he hanged himself while in lawful custody, with the intention of ending his life.

Recommendations pursuant to section 82

To the Acting Commissioner of Corrective Services (NSW):

That consideration be given to reviewing Custodial Operations Policy and Procedures 3.7, including annexures 'Risk Factors for Consideration - Reference Guide' and 'Inmate Interview Questions' to:

Determine whether the Policy should apply to psychologists and other professional mental health practitioners employed by CSNSW; and determine whether the matters referred to in the Risk Factors and Inmate Interview Questions documents currently meet the criteria for best practice to prevent suicide or self-harm of inmates. This review should also consider whether an additional risk factor be listed, namely the potential risk for self-harm posed by the inmate's current accommodation.

To the Acting Commissioner of Corrective Services (NSW), and to the CEO, Justice Health and Custodial Mental Health Network:

That CSNSW and the JH Network develop the necessary procedures and policies, to ensure that referrals made by the JH Network for mental health services for inmates and the outcome of those referrals be communicated to CSNSW psychologists.

That CSNSW and the JH Network develop compatible policies and procedures, to ensure that family members of inmates are able to effectively communicate their concerns about the mental health or risk of self-harm/suicide of that inmate.

I request those assisting me to forward a copy of these findings to the Ministry of Health, for consideration of the issue of funding for mental health services in Long Bay Correctional Centre, with emphasis on funding for mental health nurse positions.

20. 4700 of 2019

Inquest into the death of AF. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 18th August 2021.

This is an inquest into the death of AF who died on 4 January 2019. He was only 24 years of age. At about 2.30pm that day, he rammed a police vehicle at Bass Hill which had been attempting a traffic stop. He then drove away from the scene, left his vehicle, and stole a delivery truck. He then stopped and had an altercation with members of the public which ended in one man being seriously stabbed. He then stole a taxi at knifepoint. He was travelling in the taxi and being pursued by police when he collided with a kerb at Arncliffe. He exited the vehicle shortly after and began to stab himself in the chest. Police approached AF and rendered first aid, but AF was pronounced dead at the scene. Sections 23 and 27 of the *Coroner's Act 2009* ("the Act") require a Senior Coroner to conduct an inquest where a death has occurred in these circumstances.

"The purposes of a s.23 Inquest are to fully examine the circumstances of any death in which Police …… have been involved, in order that the public, the relatives and the relevant agency can become aware of the circumstances. In the majority of cases there will be no grounds for criticism, but in all cases the conduct of involved officers and/or the relevant department will be thoroughly reviewed, including the quality of the post-death investigation. If appropriate and warranted in a particular case, the State or Deputy State Coroner will make recommendations pursuant to s.82."

A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves identifying any lessons that can be learned from the death, and whether anything should or could be done differently in the future, to prevent a death in similar circumstances. This inquest is not a criminal investigation, nor is it a civil liability proceeding intended to determine fault or lay blame on persons involved in the incident. This inquest has been a close examination of the police actions on the day of AF's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Non-publication Order

Because AF's death was self-inflicted, an order was made on 12 September 2019 preventing the publication of the identification of AF. Pursuant to s. 75(4) of the Act the order is to continue.

Background

November 2016 - damage to AFP vehicle AF was charged with an offence on one prior occasion. At about 8.25pm on 26 November 2016, AF went to Nithsdale Street in Sydney, which is adjacent to the Australian Federal Police (AFP) building in Goulburn Street. He approached a marked AFP vehicle, which had two officers inside, and started hitting the rear windscreen with a metal bar, causing scratches. He was confronted by the officers and arrested for damaging Commonwealth property. Police searched his car and found his phone, showing directions to the AFP building, and a Koran which had a passage marked relating to judgment day.

Police also noted that AF had a tattoo on his right hand, depicting "313". AF refused to speak to police, and he was taken to Surry Hills Police Station and identified by fingerprints. He told police that as a result of someone shouting at him while he was jogging, he searched on his phone for the AFP and followed the directions to Nithsdale Street. When he arrived, he thought he had seen the collar of an animal inside the AFP vehicle, and had hit the window because he was trying to release it.

On 30 November 2016, police conducted a search of his address and seized his two firearms. Weapons and firearms prohibition orders were put in place and his security license was suspended. AF was initially refused bail on this charge. On 20 January 2017, an order was made dismissing the charge pursuant to s. 32 of the *Mental Health (Forensic Provisions) Act 1990*. AF was referred to psychiatrist Dr Olav Nielssen for treatment. Subsequent to this incident, on 5 March 2017, AF was stopped by police in the Westpac Lifesaving Helicopter Base car park. He said he was going for a jog. No charges were laid.

Referral to Dr Nielssen

Dr Nielssen initially reviewed AF in December 2016. AF reported symptoms including hearing voices of people he could not see, believing that television programs were related to his own situation and the ability to communicate by thoughts. He gave a history of prior use of cannabis and MDMA. Dr Nielssen diagnosed AF with first episode psychosis and commenced an antipsychotic, lurasidone (Dr Nielssen provided AF with a pack of that medication that day). He also referred AF to a local early psychosis service, although that was not taken up.

When Dr Nielssen reviewed AF again on 30 January 2017, AF reported improved feelings. Dr Nielssen later formed the view that AF had developed schizophrenia. AF returned to see Dr Nielssen on five further occasions during 2017. AF also had a referral to a neuropsychologist, Dr Donald Rowe, who saw AF in late 2016 and early 2017. Dr Rowe considered AF to be slightly depressed, and also identified some difficulties he had understanding and following instructions.

This cognitive decline was of concern to Dr Rowe, who recommended treatment with an antipsychotic and monitoring. He also recommended a brain scan and full blood work up, although this was not obtained. AF commenced taking an antipsychotic, lurasidone, and filled a prescription on 23 February and 7 March 2017. When Dr Nielssen reviewed AF on 6 March 2017, he appeared evasive but denied any symptoms of psychosis. Following this, AF went on holiday for a couple of months to Lebanon, from 9 March to 12 May 2017.

When AF next attended Dr Nielssen, on 19 June 2017, he told him he had stopped taking the medication while he was on holiday. Dr Nielssen advised him to recommence the medication and return in three months or sooner if symptoms emerged. AF next attended Dr Nielssen on 18 September 2017. He had not taken the medication, but he reported feeling well. Dr Nielssen asked him to return to him if symptoms re-emerged or if his family was concerned.

On 21 November 2017, AF attended a GP asking about using "*small pieces of magnetic metal inside the ear like earphone speakers*". He was advised not to put any foreign bodies in his ear. On 2 January 2018, he attended a different GP at Greenacre, complaining of swollen lymph glands. He attended that surgery several more times, complaining of tiredness.

He also attended at Chullora Medical Practice in early February 2018, but his behaviour was disruptive, and he was banned from that practice on 9 February 2018.

On 13 March 2018, AF reported an assault at work to police. He declined to give a statement.

On 16 March 2018, he emailed Dr Nielssen, reporting possibly persecutory beliefs about work.

On 19 March 2018, AF attended the Greenacre GP surgery, stating he was feeling anxious; he was given a referral back to Dr Nielssen. AF was offered appointments on 23 and 26 March but failed to attend either.

On 5 November 2018, AF's brother and father took him to Dr Nielssen as AF had reported having "*revelations from God*". Dr Nielssen diagnosed a relapse of schizophrenia. He recommended lurasidone at a higher dose. AF filled a script for that drug on 7 November 2018.

24 November 2018 – speeding and possession of a knife

On 24 November 2018, AF was stopped by police who had detected him traveling at 120kmph along General Holmes Drive, near the airport. He provided a breath sample of 0.034.

There is footage available from a body worn video of that interaction. It shows AF moving very slowly and at times being unresponsive, standing very still.

AF's car was searched, and a black "Jarvis Walker" fishing knife was located in the glove box. The knife was identical to the one used by AF on the day of his death. It was seized by police, who issued a penalty notice.

He was also drug tested by police, with a negative result.

Return to Dr Nielssen

AF returned to Dr Nielssen with his father on 26 November 2018. There is no mention in the notes of the police stop. AF's father was unsure whether AF was taking his medication, although AF said he was. AF said he was sleeping well and denied symptoms of psychosis. AF provided some incongruent answers (for example, saying he had "*come around to accept the surgery*" although he had not been asked about this). He reported he was looking for work. He also told Dr Nielssen he was restoring a 2004 Range Rover, which was not yet registered.

On 10 December 2018, Dr Nielssen reviewed AF. AF reported that he was taking his medication every day, as advised. He appeared talkative. Dr Nielssen thought he had improved. A review was scheduled for 21 January 2019.

On 14 December 2018, AF registered ownership of the Range Rover. At about 6.30pm on 17 December 2018, AF went to Big W at Chullora. He purchased the same Jarvis Walker knife that had been confiscated by police on 24 November 2018. It seems that he kept this knife in his car, the receipt and wrapping were found there after his death. On 29 December 2019, AF attended Coles express at Greenacre at about 10.10pm. He filled up his car with petrol and then drove off without paying.

That offence was still under investigation at the time of his death.

The events of 4 January 2019

Attempted traffic stop at Bass Hill

At about 2.35pm on 4 January 2019, Sergeant Harper, and Senior Constable Stewart, from Bass Hill Regional Enforcement Squad (RES) observed AF's Range Rover. It was not displaying number plates, driving at speed, and had performed a sharp U-turn in Marks Street, Bass Hill, where Bass Hill police station is located. It then passed Sergeant Harper's vehicle on the wrong side of the road and headed south on Hector Street towards the Hume Highway.

Senior Constable Stewart observed AF in the vehicle as appearing expressionless almost in a trance like state. Sergeant Harper followed AF's vehicle, observing it to undertake other traffic and drive aggressively. Both officers were concerned the public were in danger. They decided to stop AF's vehicle. Sergeant Harper broadcast a request over police radio, asking for a highway patrol vehicle to attend, in case AF attempted to evade police. He also informed other RES officers about their intentions via a "back channel" radio. A second RES vehicle, driven by Senior Constable Mohri, was slightly further back in traffic. At this point the Range Rover came to a southbound queue of traffic in Hector Street at the intersection with the Hume Highway. This incident is partially captured on CCTV. Sergeant Harper decided to attempt to stop AF's vehicle at this point, because the other traffic would limit AF's options. He activated his warning lights and drove along a grass verge and cut in front of AF's car from the left. Both officers then exited and approach AF, telling him to get out of the car. At this point, AF accelerated hard towards the police vehicle, colliding with the driver's door. Sergeant Harper managed to get back inside and was not injured, although the driver door was bent backwards in the collision. AF continued forwards, colliding with another car, and then turned left onto the Hume Highway and drove off at speed.

First police pursuit

Sergeant Harper activated his lights and followed AF onto the Hume Highway. However, he was unable to continue, due to the damage to his vehicle, and stopped about a kilometre along the highway. Senior Constable Mohri, in the other RES vehicle, also followed AF. However, after a short distance, he returned to Sergeant Harper and Senior Constable Stewart to check they were okay. At 2.39pm, Sergeant Harper alerted police radio about the collision and police units began looking for AF's vehicle. Those units included SWM512, a vehicle driven by Constable Medulla. Police searched around Yagoona and Bankstown but could not locate AF. At 2.47pm, police helicopter PolAir 4 was also mobilised and began to join thesearch.

Theft of a Woolworth's truck at Chullora

It was later discovered that AF had driven from Bass Hill to Chullora marketplace. At 2.44pm, CCTV captured his Range Rover entering the loading dock. He parked his car and then got into a Woolworths truck nearby, which had its engine running, and drove off.

The driver of that truck was retrieving something from his car and did not observe the theft. When he discovered the truck missing, he phoned 000. Police broadcast an incident about the theft of the truck at 3.01pm.

Collisions at King George's Road, Wiley Park

Meanwhile, AF drove the Woolworths truck from Chullora south along King George's Road, to Wiley Park, where he collided with three vehicles. They signalled for him to stop, but he accelerated away, passing onto the wrong side of the road, and heading south towards Rockdale. There were a number of calls to 000 regarding these collisions. At about 3pm, there was a broadcast via police radio regarding the theft of the truck and these collisions. Constable Medulla heard this broadcast and suspected that the theft of the truck was related to the fail to stop incident at Bass Hill.

Collisions at West Botany Street, Rockdale

At about 3.05pm, AF entered West Botany Street, Rockdale. He collided with three vehicles and then slowed down to a stop. He exited the truck, without engaging the handbrake. A member of the public observed the collisions and parked his Ute in front of the truck, in an attempt to stop it from leaving. CCTV footage is available at this point, which appears to show AF holding a cigarette lighter near to the fuel tank of the truck. The member of the public exited his vehicle, and AF approached him, producing a knife, and demanding his car which he refused, and AF then walked along the road, into traffic, attempting to open other car doors.

Stabbing at Rockdale

Two men who were at Exodus Youth Club in West Botany Street heard a collision and came out to see AF in the street. They approached him and told him they were going to call police. They filmed him on a mobile phone. AF then ran at one of them and slashed towards him with the knife. He was able to fend AF off. Following this, another man, who had been at a Fitness First gym nearby, approached AF. He later told police that he knew AF, having met him a couple of years previously but lost contact.

He said that he saw that AF had the same "313" tattoo as him. He said "*look, we are brothers"* pointing to his own neck to show AF his tattoo. He also said, *"stop stabbing innocent people, drop the knife, calm down…".* AF began walking away and this man followed him. AF then turned and stabbed him in the stomach. This caused a serious injury, lacerating his liver and eviscerating a part of his intestines. He spent a substantial period of time in hospital due to his injuries. Again, numerous calls were made to 000 regarding the collisions and the stabbing, the earliest being made at 3.09pm.

Theft of a taxi at Rockdale

After the stabbing AF walked in front of a maroon taxi, he opened the taxi door, pointed a knife at the driver and told him to get out, which he did. AF then performed a U-turn and drove off southwards. The taxi theft was reported to 000 at 3.13pm. The taxi was equipped with GPS tracking, and this was later analysed to show the route AF took.

He drove south towards Sandringham and then turned north again to Brighton-Le-Sands, entering Grand Parade. The taxi also had CCTV fitted, which shows AF inside the vehicle between thispoint and Arncliffe.

Police car rammed at Brighton-Le-Sands

At 3.22pm, PolAir located the taxi AF was driving on Grand Parade at Sans Souci. There is video footage from the helicopter which shows the following events, culminating in AF's death. Constable Frencham was driving a highway patrol vehicle at President Avenue, accompanied by and Senior Constable Vrondas. He observed AF driving past. He followed AF left onto Grand Parade and activated his warning lights and sirens. As Constable Frencham approached AF in the police vehicle from behind, AF stopped abruptly, and then reversed and rammed the police vehicle. AF then accelerated heavily, away. Constable Frencham was unable to follow immediately due to the damage. He informed police radio about what had occurred.

Second police pursuit

Constable Haylings and Constable Bird were also nearby in police van SG21 at this point. Constable Haylings activated warning devices and drew alongside AF's vehicle. He then veered into AF's lane, causing him to cross onto the wrong side of the road. AF continued up the wrong side of the road. Constable Haylings crossed onto the wrong side of the road and followed.

Third police pursuit

One of the officers who had attended the scene of the stabbing at Rockdale was Senior Constable Mitchell Gage, a Highway patrol officer (CM275). He heard the broadcasts from PolAir about the taxi being located, and he responded, heading towards Grand Parade. Meanwhile, AF continued north on Grand Parade and General Holmes Drive towards the airport. However, as AF approached the tunnel under the airport, he performed a U-turn. A number of police cars then became involved in a pursuit.

First, Constable Haylings observed AF heading south on General Holmes Drive. He activated warning devices, performed a U-turn, and commenced following. He informed police radio that he had sighted the car and provided some updates about the location. Second, Constable Medulla in a RES vehicle SMW512 saw AF approaching towards him. He steered onto the wrong side of the road in an attempt to block AF, but this did not succeed. He then performed a U-Turn. Third, another RES vehicle, SWM517, driven by Senior Constable Pershouse and with Senior Constable Little on board, joined the pursuit. Fourth, Senior Constable Gage caught up with the RES vehicles at the corner of Bestic Street and West Botany Street. He asked via police radio that they move aside, so that he could lead the pursuit, which they did. Fifth, Constable Frencham (CM272) was then able to join behind these vehicles. The course of this pursuit proceeded from General Holmes Drive right onto Beehag Street, left onto Jacob Senior Avenue, right into Bestic Street, and then right again (north) into West Botany Street. At Arncliffe, AF turned left into Wickham Street. The traffic was moderate to heavy. The manner of AF's driving was dangerous. At times he drove on the incorrect side of the road, drove along the footpath, and also went through red traffic lights and major junctions.

As AF travelled along Wickham Street approaching the Princes Highway, he moved onto the incorrect side of the road to pass stationary traffic. A semi-trailer was approaching from the other direction, and so he moved onto the footpath. He then crossed over the six lanes of the Princes Highway, across flowing traffic, and into Forest Road. He then mounted the kerb and blew the front offside tyre. He continued along the footpath, colliding with rubbish bins and then turned his vehicle to the left at Wardell Street and brought his vehicle to a stop. The time was 3.28pm, 49 minutes after the incident in Bass Hill when AF had first come to the attention of police.

AF's death

The events leading to AF's death are captured by PolAir footage, and also on footage from an In-Car Video in Senior Constable Gage's highway patrol car. There is also incidental footage from other vehicles, the taxi, and a Taser camera. A brief description of the sequence of events is as follows. As AF exited his vehicle, he produced a knife and held it in both hands in front of him. He started to stab himself repeatedly in the chest. As that was occurring, Senior Constable Gage arrived and exited his vehicle. He saw AF holding the knife, drew his firearm, and began to approach AF.

Senior Constables Pershouse and Little (SWM517) arrived and stopped immediately behind AF to his right, in order to block his exit. Senior Constable Little got out of the passenger door. However, he was in Senior Constable Gage's line of fire, and so he immediately backed away to his right. He stood with his back against the taxi. As AF continued to stab himself, Senior Constable Gage realised that AF was harming himself. He removed his OC Spray with his left hand, and sprayed AF in the face. AF turned away to his right and continued stabbing himself.

Senior Constable Medulla arrived (SWM512) and approached from behind Senior Constable Gage to the left. He deployed a Taser. It is unclear whether one of the probes made contact with AF's body. However, the officers who observed the Taser deploying believe it was effective in incapacitating AF. Simultaneously, AF fell forwards, away from Senior Constable Gage, and twisted to his left, landing on his right shoulder and side. Police officers approached AF immediately. Senior Constable Little can be seen in the video suffering the effects of OC spray, which was still in the air. Other officers arrived and provided first aid.

It took approximately 17 seconds from the time AF stopped his taxi to when he fell to the ground. AF commenced stabbing himself about five seconds after stopping the taxi, and Senior Constable Gage deployed OC spray about 10 seconds after that. By that time, AF had stabbed himself 17 times. He stabbed himself a total of 24 times before he fell to the ground. Police called an ambulance at 3.32pm, which arrived promptly at 3.37pm. However, it quickly became obvious that AF has sustained non-survivable injuries. He was declared deceased at the scene.

Issues

Police pursuits are governed by the policies and procedures of the NSW Police Force. In certain circumstances, police officers are permitted to disregard the road rules, but they must do so within the boundaries of the policies that guides them. Where a pursuit of a vehicle occurs, there are strict rules governing what police must do and who they must notify.

In this case there were obvious and serious risks to the safety of the public, and it was necessary for police to take action, including the pursuits to stop AF. Acting Sergeant Hrymak of the Traffic and Highway Command identified some possible breaches of the Safe Driving Policy on the day. There is evidence that those matters have been reviewed and finalised through internal police processes. Accordingly, I do not propose to make any recommendations in that regard. I have carefully considered whether anything should have been done differently by the police in their attempts to prevent AF from further endangering the public on this day.

I am satisfied that this matter was appropriately assessed as a high-risk situation due to AF's dangerous driving, the fact that AF had a knife and that a member of the public had been stabbed. I note the opinion given by Senior Constable Henley, an Operational Safety Instructor of the Weapons and Tactics Policy and Review, who conducted a review of the events of this day that the actions of the officers were appropriate. Senior Constable Gage was on his own when he was the first to attend the scene where AF had finally stopped his car. He was in the process of containing and negotiating with AF when Senior Constable Little arrived shortly after and assisted. Senior Constable Medulla arrived next and appropriately attempted to stop AF from continuing to self-harm. All of this happened within seconds. I commend each of these officers. They all assessed the situation appropriately and responded in accordance with their training.

I offer my sincere condolences to AF's family. The evidence supports a finding that he was suffering from his diagnosed schizophrenia at the time of this tragedy.

Findings:

I find that AF on 4 January 2019 at Forest Road, Arncliffe NSW as a result of multiple stab wounds to the chest that he inflicted upon himself

21. 83697 of 2019

Inquest into the death of Tafari Walton. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 30 April 2021.

These are the findings of inquests into the deaths of Gabriella (Gabby) Thompson and Tafari Walton.

On 13 March 2019, Tafari stabbed Gabby multiple times at her home in Glendale. She died from her injuries soon after at the John Hunter Hospital, in Newcastle, NSW. She was 27.

Following the stabbing, Tafari left the scene in Gabby's car and police were called. Tafari was not located until the next morning, despite an extensive police search, various incidents involving the public and a brief policepursuit.

On 14 March 2019, police confronted Tafari at his home, in Glendale, NSW. He ran towards officers, holding a knife. Two of the officers fired shots, causing fatal head and abdominal wounds. He died at the scene. He was 22.

The nature of an inquest

An inquest was required to be held into each of these deaths because, in Gabby's case, it appeared she had died as a result of homicide, and in Tafari's case, it appeared he had died as a result of police operations (ss. 27(1)(a), and 27(1)(b) and 23(1)(c) of the *Coroners Act 2009*). As the circumstances of the two deaths were closely connected, these inquests were held concurrently, and evidence in one inquest was admitted in the other. The primary function of an inquest is to identify the circumstances in which the death occurred. At the conclusion of an inquest, the role of a coroner, as set out in s. 81 of the *Coroners Act 2009*, is to make findings where possible as to:

- The identity of the deceased person.
- The date and place of the person's death; and
- The manner and cause of death.

A secondary purpose of an inquest is to consider whether it is necessary or desirable to make recommendations in relation to any matter connected with the death. This involves considering whether any lessons can be learned from the death, and whether anything should or could be done to prevent a death in similar circumstances in the future.

The facts

Gabby's background

Gabby was the youngest of three children to Pamela Cashman and George Thompson, with two older sisters, Georgina, and Rebecca.

Mr. Thompson died in 1998. Ms. Cashman re-partnered with Kevin Cashman, who died in 2004, and, at the time of these events, Jimmy Yilich. Gabby was generally healthy. She may have suffered depression in the year or so before her death. She attended a psychologist on one occasion in July 2018 and was prescribed an antidepressant, Efexor. However, her friends and family do not think she suffered from depression or other mental health issues, and there is no evidence of any significant mental health treatment.

Gabby also had limited involvement with police. She had a High Range PCA and a Drive while suspended recorded against her in 2014. She was the victim or witness in other incidents. Although there is evidence of Gabby drinking and using drugs, her friends and family did not know her to be an abuser of substances. There was methamphetamine in her system at the time of her death, and the possible reasons for that are described below.

Possibly in consequence of his early life trauma, Tafari developed significant behavioural issues. Concerns were noted by Dr Anthony Nicholas, a clinical psychologist, who reviewed Tafari in 1999 when he was 2, and considered him to be a "very damaged child" at high risk who needed ongoing specialist support.

Tafari attended mainstream schools, but his behaviour deteriorated. He was reviewed by a number of other mental health professionals during his childhood, who suggested different diagnoses. In 2009, he was he was diagnosed with Major Depressive Disorder, Conduct Disorder, Oppositional Defiant Disorder and Post Traumatic Stress Disorder. He was at one stage believed to have a learning difficulty, although this was doubted. Tafari was treated for a period with an anti- depressant, fluoxetine (Lovan).

In 2010, when aged 13, Tafari started drinking to excess and also used Ice for the first time. He later stated he was using up to 7 points of Ice daily from the age of 15. His substance use probably compounded his mental health issues and his conduct deteriorated further. Tafari left mainstream schooling and attended behaviour schools. His mother thinks Tafari's experience in education, and later in custody, led to further sadness and disconnection from society. Tafari did have a positive influence in his life, from Chris Teale, the Director of Pipeline Youth Project, who acted as a mentor and with whom Tafari learned to fly aeroplanes.

Tafari had a substantial juvenile and adult criminal record, including acquisitive offending and violence. He also had a large number of bail breaches, though he was later involved in a class action regarding these. Significantly, his record also included knife-related crime. In 2007, when aged 10, he allegedly threatened to stab a neighbour. In 2012, aged 15, he was convicted of possession of a knife twice, and also of reckless wounding, when he stabbed another child.

He entered detention for this, for the first time, in November 2012, just prior to his 16th birthday, and was released in May 2013. He returned to detention from July 2013 to January 2014, for an aggravated break, enter and steal using an offensive weapon. He returned to custody in February 2015 for two months, for an assault. The following year, then aged 19, he received a 2-year sentence for Assault with intent to rob, relating to robbery of a hotel; he was in custody from 6 May 2015 to 5 May 2016. A month after his release, on 7 June 2016, he returned to custody in circumstances I will shortly describe. He was convicted of firearms offences and received a total effective sentence of 3 years and 9 months.

He remained in custody from 7 June 2016 to 23 January 2019, when he was released on parole. In summary, in the six years spanning to his death at 22, Tafari spent more than four years in gaol. Tafari threatened or attempted self-harm a number of times. In July 2011, when he was 14, he attempted to hang himself. In September 2011, he took his mother' car and then tried to hang himself again and was admitted to John Hunter Hospital. The context of that incident was the end of a romantic relationship. In June 2012, following an adverse court outcome, he deliberately walked into traffic. However, while in custody at the end of 2012, he was reviewed by a psychiatric registrar and found to be coping well. There were further acts of threatened self-harm during his relationship with Gabby, which I will describe shortly.

Gabby and Tafari's relationship

Gabby met Tafari through a mutual friend in 2013. They formed a relationship in early 2014, when Tafari was 17 and Gabby was 22. The relationship was a violent one from the start, although violent incidents were not often reported to police. Friends and family of both Gabby and Tafari describe their relationship as “toxic” and they give evidence about incidents they can recall. Some witnesses suggest Gabby instigated incidents with Tafari. A holds the opinion that Gabby was psychologically abusive to Tafari, that she belittled and demeaned him, and that he was physically abusive to her. Friends of Gabby, in contrast, identify Tafari's intense jealously and controlling behaviour towards Gabby. Tafari’s paranoia, and problems with relating to people and controlling his emotions were features of his personality disorder. These personality traits are likely to have contributed to the problems in the relationship.

It is not possible, or necessary, to itemise and evaluate each incident. However, it is useful to form an impression of the nature of their relationship, drawn from the evidence in the brief and the oral testimony, to provide context for the events that led to Gabby's death.

Having considered all of that evidence, on balance I find that it establishes the following facts: that there was significant, ongoing domestic violence, including physical violence and other forms of controlling behaviour; that Tafari was the primary perpetrator of that violence; and that Gabby was the primary victim of his violence. It is a feature of this case that few of the violent incidents were ever reported to police or other authorities, by Gabby or others. Gabby did not want to report them, probably because she was afraid of retaliation from Tafari if she did. Some of Gabby’s friends and family were aware of the violence, but were also afraid of Tafari, and perhaps they did not see it as their place to make a report. The exception was Emma Russell, whose report to police on 13 March 2019 will be described below.

Counsel assisting submitted that I should not be critical of Gabby’s or Tafari’s friends and family for not doing more. I agree they were in a difficult position, in particular as Gabby was generally reluctant to involve police. However, the circumstances of Gabby’s death underline the risk that domestic violence posed to Gabby, and the tragic consequences of not taking more action to protect her. Only a few of the incidents of violence were considered in detail during the evidence. The brief also contains further material relating to other incidents. The salient incidents are described below. The violence commenced just a few months into the relationship, in about April 2014, when Tafari assaulted Gabby, causing bruises, splitting her lip, and pulling out hair.

Nonetheless, the relationship continued. Gabby fell pregnant and had a termination. A month later, she fell pregnant again and had a further termination. Tafari believed Gabby had cheated on him. Tafari's pre-occupation that Gabby was cheating on him was a consistent theme in later incidents, including the circumstances which led to her death. Some witnesses say they were both jealous of each other and of possible infidelity. There is material which suggests that Gabby had sex with one person in 2014 and had a brief relationship with another person in early 2017, while Tafari was in custody. Tafari's concerns about this issue appear disproportionate and are probably a function of his personality traits.

On 7 July 2014, Tafari became enraged about Gabby cheating on him, drank excess alcohol and deliberately drove a car into a tree. He also obtained a knife and told his mother he was going to kill Gabby. He was scheduled at John Hunter hospital but released on leave overnight. He was commenced on quetiapine (Seroquel) an anti-psychotic. On 18 July 2014 police were called for the first time to an argument between Gabby and Tafari in the front garden of A's home. A woman was calling for help. No offence was reported, and it was recorded as a verbal argument. Following this, Tafari left and went to a park to hang himself. He was taken to the Nexus Unit at John Hunter hospital, but not admitted. In September 2014, an Apprehended Violence Order (AVO) was obtained against Tafari, protecting A and her family, following an incident where Tafari threatened B with a knife. He breached that AVO soon after.

On 18 April 2015, police were called for a second time because Gabby was heard screaming. They told police the argument was about a "jealousy matter". Gabby said she had no fears, and it was again recorded as a verbalargument.

On 2 May 2015, when Gabby was pregnant with C Tafari again accused her of "hooking up" with someone in a nightclub, and he assaulted her, wrapping his shirt around his fist, and punching her and stomping on her face. This incident was not reported to police and she did not attend hospital. Tafari entered custody.

In July 2015, Gabby approached Nova Women's Association and saw a caseworker, Rebecca Prestwidge. Gabby was primarily looking for help with housing. She reported domestic violence from Tafari. She said she did not have current concerns as he was in custody. She obtained some support for housing and also stayed at a refuge for a period.

In April 2016, while still in custody, Tafari made threats towards Gabby inphone calls made from gaol. These calls were recorded, and the transcripts were in evidence. They provide some insight into the dynamic in this relationship. In a subsequent call, Gabby told Tafari she had been out with two girlfriends. In response, he told her she was a slut, and that he was going to punch her face when he saw her. He then called his mother to complain to her that she had looked after C when Gabby went out but had not told him. He made repeated threats to kill or harm Gabby, her family, and friends. His mother counselled him about the relationship and suggested it might not be worth it and told him what he was saying was not appropriate. After this, Gabby sought assistance from Ms. Prestwidge again. Gabby reported the threats from Tafari in the phone calls. She was very anxious about Tafari's release from custody and wanted to flee the area. She wanted to change the locks, as A had a key and she was concerned Tafari would gain access.

Ms. Prestwidge suggested an AVO, although Gabby thought this would probably make Tafari angrier. Tafari was released from custody on 5 May 2016. He told his probation officer that Gabby was "playing games" and he found herfrustrating.

On 9 May 2016, he provided urinalysis which was positive for 'Ice' (crystal methamphetamine).

On 10 May 2016, Tafari was taken to hospital for assessment, because he was planning to kill himself. He was assessed and released with a referral for community follow up.

That evening, he attended Gabby's home, reportedly asking for money to gamble and drink. She refused and he assaulted her, taking C from her, and telling her if she made a noise he would kill all of them before anyone came. He then took a knife and demanded Gabby kneel on the ground, saying "you are going to sell your soul to the devil". He calmed down after this, although she remained, and left the home the following day.

On 14 May 2016, Tafari took a large overdose of Seroquel, in the context of further Ice and alcohol use, and he was admitted to hospital again. He was reportedly found by his brother with a photo of Gabby and C on his chest.

On 25 May 2016, Tafari contacted Gabby while he was having contact with C asking for a phone ledger book. He threatened to take C in his mother's car and run it off the road. When Gabby attended the home, he accused her of infidelity, and checked through her phone. He then obtained a knife and again threatened to kill Gabby before the police arrived.

On 26 May 2016, Gabby reported this incident, and the one from 10 May, to police, and gave a statement.

On 27 May 2016, Tafari was arrested and charged, and a provisional AVO was imposed. The charges were later withdrawn. He was taken to the Materhospital for a court-ordered mental health review. However, while there he attacked a nurse, grabbing her by the throat and threatening to kill her if she did not give him the keys. He then escaped and was not located for the following 10 days. He was later charged for that incident, also.

At some stage during this period, there may have been a further incident, where Tafari imprisoned Gabby in her home for 3 days, armed with a gun. Gabby disclosed this incident to Ms. Prestwidge from NOVA, at some point between April and July that year, but asked her not to make any record about it. It was not reported to police, child protection services or mentioned by Gabby to anyone else at any stage.

Although the incident as described is highly concerning, the lack of any recorded account from Gabby has the result that no finding can be made that it occurred. Ms. Prestwidge was not asked to appear as a witness and no adverse finding will be made regarding her contact with Gabby.

On 6 June 2016, Tafari attended his mother's home with a loaded .22 pistol. He later said he had obtained the gun from a drug dealer, intending to kill himself. It was loaded with a single round. He held it to his own throat, as well as a knife, threatening to kill himself. A 90-minute police siege followed, which ended when A's partner B disarmed Tafari and he surrendered to police.

On arrest, he was found to have five bags containing a total of about a gram of Ice. As a result of these matters, Tafari was arrested, his parole was revoked, and he returned to custody. He was later convicted of firearms offences arising from the siege. He remained in custody until 23 January 2019.

Tafari in custody 2016 to 2019

Tafari's access to mental health treatment during his time in custody was an identified issue for the inquest. At the early part of his sentence, a history of auditory hallucinations was noted. His mother also contacted the prison in order to advocate for Tafari to get treatment. He was taking Seroquel (an antipsychotic) and Escitalopram (an anti-depressant).

On 2 August 2016, he reported possible auditory hallucinations, and was talking about the devil, although it was doubted these were true hallucinations. He was assessed by Dr Gordon Elliott for a court report, who considered that Tafari's diagnosis was in keeping with a personality disorder. Later in August 2016, Tafari stated that his medication was not working, and he refused to take it anymore. A recommendation was made for correctional officers to monitor him, and a referral to psychology would remain open if he needed it. He was not reviewed by a mental health professional again until September 2018, two years later. He was offered a referral to psychology in July 2017, but he declined this. Nonetheless, Tafari appeared relatively stable over this time. He engaged in prison programs and remained, for the most part, in mainstream prison discipline.

On 20 May 2018, an incident occurred where Tafari and 2 others were accused of stabbing an inmate with a gaol-made weapon. The victim did not suffer life- threatening injuries. Tafari was charged with Wounding with intent to cause grievous bodily harm and refused bail.

On 18 September 2018, Tafari was observed looking dazed and confused and was behaving bizarrely, talking to an apple. He seemed distressed, talking about a family issue, and was taken to a nurse for assessment, but he refused to talk. He was taken back to his POD to talk with another inmate. He was placed in an assessment cell on a Risk Intervention Team protocol and remained there for about 10 days. He admitted he had taken Ice. On 20 September, he tied his prison greens around his neck in a possible attempt at self-harm and staff had to negotiate with him to remove it. However, he later said he was merely tying his greens in a bow tie "to look like a Freemason". On 18 October 2018, Tafari was reviewed by psychology staff. He was cooperative, although fidgety and tangential. He wanted advice on how to stay out of gaol. He was seen by psychology staff again on 27 November 2018. Although he was stressed about a court appearance, he wanted education about conflict resolution and assertiveness.

Tafari's bail and parole conditions

Tafari's earliest release date to parole was in December 2018. However, he was still bail-refused for the May 2018 wounding offence at this time.

In January 2019, a release application was made. The transcript of the hearing and the subsequent determination is within the brief. In light of the strength of the case, including a letter from the victim stating Tafari was not involved, delays in preparation of a prosecution brief and anticipated delays in a trial at Port Macquarie, the Magistrate granted Tafari strict conditional bail.

Tafari's bail conditions included daily reporting to police, that he reside at his mother's address, and a curfew from midnight to midday, when he could only leave in the company of defined people, including his mother and Gabby. He was also to comply with mental health treatment and abstain from drugs. His next Court appearance would have been on 20 March 2019.

Tafari did report to police as required. However, the evidence shows he wasnot always residing at his mother's home and spent at least part of his nights at Gabby's home. Although there was an enforcement provision, there are no records showing that his residence was ever checked by police. That said, as he was permitted to be away from his mother's home in Gabby's company, it is unlikely a breach would have been detected, or would have resulted in a breach.

Tafari was also subject to a statutory parole order. The terms of parole are also significant. At the time his sentence was imposed, in October 2017, standard parole conditions included a requirement not to use prohibited drugs. However, an amendment made to the *Crimes (Administration of Sentences) Regulation 2014* in February 2018, with the effect that a parolee was required to comply with "all reasonable directions of a community corrections officer", including (if the officer so directed) to cease drug use and undertake drug testing. It was these new conditions which applied to Tafari at the time he was released from custody. Accordingly, and somewhat remarkably, when Tafari was released from gaol, his parole conditions did not require him to cease taking drugs.

Tafari on parole

Tafari reported to his parole officer, Geoffrey Brady, on the day following his release. Mr. Brady saw Tafari a total of seven times prior to his death. He assessed Tafari according to a structured risk assessment tool, the Level of Service Inventory, and determined that Tafari had Medium/High needs. That assessment determined the frequency of reporting, among other things. He also prepared a case plan. Given Tafari's history, he identified risks of aggressive behaviour, arising from substance abuse and mental health issues. These issues were to be given priority. The evidence shows that efforts were made to engage Tafari in mental health treatment. On 5 February, Tafari attended GP Dr Paul Karen and obtained a mental health care plan. The same day, he attended psychologist Janelle Pritchard. This was not a useful interview, because he was 50 minutes late for a one-hour appointment. Gabby and C also attended, and Gabby reportedly answered questions on Tafari's behalf. The following day, on 6 February 2019, Tafari reported for parole. When asked to do a drug swipe test, he admitted using ecstasy and smoking Ice two days prior, after a friend offered it to him. This was about 10 days into his parole. Mr. Brady gave Tafari a verbal direction not to use drugs and also obtained Tafari's consent for a referral to psychoeducation and drug counselling. However, Mr. Brady did not take any other action regarding a possible breach of bail and parole, including, for example directing for Tafari to undertake further drug testing.

That issue is considered further, below.

There is evidence that Tafari continued to take drugs after this point. On 9 March 2019, Gabby's sister Rebecca saw Gabby and Tafari snorting cocaine. There is also evidence he took drugs for an extended period in the days leading to Gabby's death.

On 11 February 2019, Mr. Brady made the first of two home visits. No concerns were noted, with Tafari saying his relationship with his partner was going well.

On 12 February, Tafari missed an appointment with Ms. Pritchard, because he was in Sydney with Gabby. He told Mr. Brady the next day, and also said he planned to arrange a different counsellor. He then attended a different GP on 15 February 2019 and was referred to Hunter Primary Care for counselling, although that referral did not proceed.

A few days later, on 19 February 2019, Tafari cancelled an appointment with a mental health and substance use service. He attended on 22 February, but declined the service, saying he preferred to attend SMART Recovery sessions. There is no evidence that he did so.

On 26 February, he attended a third GP, and was referred to Headspace in Newcastle. That referral did not proceed.

Finally, on 27 February, Tafari was referred to a private psychological service, ProCare. He was seen promptly by a clinical psychologist Ms. Radojevic on 28 February. She considered he suffered from anxiety and possibly ADHD and proposed a psychiatric review. A further appointment was booked for April. He reported this to Mr. Brady on 5 March, and Mr. Brady verified this and made enquiries about whether drug counselling could also be provided.

Despite these positive steps, there is other evidence which suggests that things were not going well, at least in relation to Tafari and Gabby.

Gabby had recently moved into a new home in Glendale. She told her friends this was because she did not want Tafari checking her phone history. She was reportedly apprehensive about his release. However, she also seems to have been keen to continue the relationship, probably also for C to have her father in her life. The day Tafari's release, Gabby's mother noticed bruising on her arms. A says she also noticed Gabby had after bruising after Tafari was released from custody. On 25 February 2019, Gabby told a colleague she could not go to work because Tafari had "trashed" her house.

Either then or in early March, Tafari put a hole in a wall in Gabby's house, a matter to which I will return. Around this time, Gabby attended her friend Claudine Gordon-Meki's home with a black eye. According to Ms. Gordon-Meki, a fight had occurred at A's home, with Tafari trying to strangle Gabby. Neighbours also later told police that they heard shouting in the street, from a man and a woman. On 11 March 2019, Gabby told her mother that she was scared Tafari was going to kill her. She said she was going to have to quit work, as she couldn't keep turning up with bruises on her. She said her mother could not say anything, as Tafari would hurt her, too. These matters support a finding that Tafari continued to be physically violent to Gabby, on a number of occasions, after his release to parole. Nobody reported these matters to police or other authorities.

Events of 12 March 2019

In the morning of 12 March 2019, Gabby texted her friend Zac White and then called him, saying that Tafari was "scitzing out". She was concerned Tafari would monitor her calls. She also called her work, saying she was not going to attend that day and would probably have to quit. She appeared hushed and cautious. Later that morning, Mr. Brady conducted a second home visit at Tafari's home.

Tafari told Mr. Brady Gabby had cheated on him while he was in custody, but said he while he felt jealous, he didn't consider it that serious. Mr. Brady did not think Gabby was at immediate risk of harm.

Gabby was present at the home that day, although Mr. Brady only saw her briefly, and did not observe anything untoward. Around lunchtime, Gabby's friends Emma Hoy and Leroy Meki visited. Gabby told Ms. Hoy that Tafari had been awake for six days, had been taking Ice and he had been forcing her to take it, putting it in her drinks. He had been accusing her of cheating on him and talking about something that happened in 2014. She also had bruises on her face, leg, and arms, which she covered with makeup. According to Mr. Meki, Tafari smoked Ice that afternoon.

Gabby's sister Rebecca also saw her that afternoon. She told Rebecca that Tafari was on "day 4" which Rebecca took to mean he had been on drugs for four days. At 6.40pm, Mr. White texted Gabby, saying "Dad is down could I grab those coins?" He later explained he was referring to some coins his dad collected.

Tafari saw the message from Mr. White, because at about 11pm he called him, on Gabby's phone, asking him what was going on with Gabby and saying she was "texting heaps of blokes". Mr. White denied there was anything going on. Tafari then sent a further text to Mr. White, who called him back and suggested they meet and talk about it the next day.

Tafari began to accuse Gabby of infidelity. Tafari showed Gabby's mother a list of men's names, accusing Gabby of being unfaithful. He then assaulted Gabby and threatened Mrs. Cashman. Mrs. Cashman called A for assistance, who attended and took C away from the home. At a little after midnight, Gabby told her mother that there was a knife on the floor of her car. When Mrs. Cashman went to locate it, Tafari dragged Gabby out of the house by the hair and they left in the car. They drove to Tafari's brother D's House Gabby then returned to her mother's house for the night. At 2am, Tafari went out to a hotel to play pokie machines with his brother. At about 3.20am, he went to his mother's house, complaining again that Gabby was sleeping with everyone in Newcastle.

A and Tafari both went to Mrs. Cashman's house, to return the phone and car keys to Gabby. At this point, Tafari told Gabby the relationship was over. Tafari then returned to his brother's house for the remainder of thenight.

Concern for welfare report

Earlier in the evening, Tafari had contacted some of Gabby's other friends, including Emma Russell and Cody Patrick, asking about who Gabby had been sleeping with. Ms. Russell was concerned, and she spoke to Ms. Gordon-Meki, who had been in touch with Gabby about not going to work. They agreed that they should ask police to do a welfare check.

At 12.40am on 13 March 2019, Ms. Russell called Sen Cst Parsons who was undertaking station duties at Belmont police station. She said she had received a strange call from Tafari and was concerned. According to Ms. Russell, she also stated she was worried that Tafari would stab and kill Gabby.

At 12.41am, Sen Cst Parsons created a Computer Aided Dispatch ("CAD") message. It was recorded as a "concern for welfare" rather than a domestic violence incident. It did not mention a concern about Gabby being killed. It stated as follows:

INFT'S FIREND "GABRIELLA THOMPSON" DIDN'T ATTEND WORK TODAY. INFT RECEIVED STRANGE PHONE CALL FROM HER FRIEND'S PARTNER "TAFARI WALTON". INFT IS C4W AS HER PARTNER HAS BEEN VIOLENT IN PAST & RECENTLY RELEASED.

At 1.58am, Prob Cst Hancock and Sen Cst Walker acknowledged the incident. They checked information about Tafari that was known to police. It is likely this would have included his criminal history and bail conditions. They then attended at Gabby's home at about 2.43am. At this time, it appears Gabby was at her mother's. They knocked, but got no response, and left about 8 minutes later. Sen Cst Walker then phoned Gabby's phone and also left a message for the informant, Ms. Russell.

Ms. Russell returned this call at 3.34am. She repeated how worried she was for Gabby, saying she was concerned Tafari was going to kill her. Sen Cst Walker therefore raised another CAD message, at 4.04am, for the oncoming shift. This message, like the earlier one, was a "concern for welfare". It does not mention concern about Gabby being killed, although it does provide much more detail. It stated as follows:

Infts friend "Gabriella Thompson" didn't attend work on 12/03/2019 without explanation which is out of character. Inf then received aphone call Thompsons partner Tafari WALTON around midnight in which he was interrogating her about who Thompson had been hanging around with while he was in gaol. Inf spoke to other friends who had received similar phone calls through the night with one male friend receiving threats from WALTON for being a friend of Thompsons. WALTON has been violent in the past to Thompson and inf is concerned for her safety. Contact inf with result.

****** Info only***** Night shift attended the address early morning of 13/03/2019 and processed the job after being unable to raise anyone at the address. Inf returned a phone call to police 4am this date and elaborated on the concerns for her friend. Due to new information a duplicate job has been created for day shift to attend and attempt to locate Thompson.*

This second CAD message was acknowledged at 6.55am by Sen Csts Grime and Sandford. They attended Gabby's home at 8.39am, but still no one was home. Lights inside the property were on. They also attended Tafari's mother's address and spoke to B who told them Tafari was out with Gabby or D. Sen Cst Grime then phoned Gabby and left a message, which she returned at 8.54am. The officer said her friend had contacted police and was worried about her. Gabby stated she was fine; she had only just woken up and saw the missed calls. She appeared chirpy and happy. Those officers took no further action. This will be explored further below.

Ms. Russell also made contact with Gabby, who replied at about 9.13am saying, "we're all good" and "will see yas soon".

Gabby's death

On the morning of 13 March 2019, Tafari began the day at his brother's house, and Gabby at her mother's home. At about 9.30am, Tafari called Gabby and asked her to come and pick him up. Gabby phoned A and told her she was going to do this. According to A she warned Gabby not to. She arranged to meet Gabby at a McDonalds and repeated this advice.

She suggested it was not in her best interests to remain in the relationship. Nonetheless, Gabby went to D's house to collect Tafari, arriving after 10,30am. Tafari was with a friend, K with whom he had been talking on the doorstep. According to K, Tafari told him at this point he was never going back to gaol, and that he would kill himself before he went back.

Tafari told A he was going to Gabby's house to collect his things, saying that he was going to move in with D for a while. He appeared calm. He then left with Gabby in her car. Gabby and Tafari arrived at 11.02am. Aa call was made from Gabby's phone; which police suspect may have been drug- related; it is unknown who made the call. A and B decided they would go to Gabbi's. A arrived at XX and parked in the driveway.

When B went to the door, Tafari refused to open it, claiming they were in the shower. Gabby then called out for help, and B entered. He saw Gabby on the floor with blood on her face and a rope around her legs. Tafari told B there was someone in the house with a gun, but Gabby said this was untrue. Tafari broke free and started choking Gabby. B said Tafari had a vacant look. Fearing he might have a weapon, B then left, and went to get A whom he thought would be able to talk to Tafari. Gabby call for help, to return the two children to D partner, M & B therefore called her and asked where she was. She told him to call the police. B then returned towards the house, as Tafari was exiting. Tafari said to him, "she thinks she's dying."

Tafari then left the scene in Gabby's White Mitsubishi Outlander. B Gabby at the top of the steps, holding her neck. He rendered first aid, finding a towel to put around her neck, and after this he called 000. He ended that call and called A again, to inform her that Tafari had left, and asking where the children were. A took the children to a safe place, and she travelled back to Gabby's house, arriving while B was on the phone to the ambulance for a second time.

An ambulance attended within about 10 minutes at 11.47am. Police were also informed of the incident, arriving at 11.49am. Gabby was conveyed to John Hunter Hospital, but she was pronounced deceased at 12.39pm.

Autopsy - Gabby

An autopsy was carried out by Dr Hannah Elstub on 18 and 19 March 2019. The cause of death was given as multiple stab wounds. Gabby suffered a total of 16 stab wounds including a laceration to her throat which severed her internal jugular vein. She also suffered a penetrating injury to her right lung and a fractured nose, as well as multiple other injuries. Toxicology showed that Gabby had methylamphetamine (Ice) in her system at the time of her death. Forensic Pharmacologist Dr Shuang Fu states that this was at the lower end of the reported toxic range. This is consistent with Gabby consuming drinks to which Ice had been added, as she had reported to Ms. Hoy.

The search for Tafari

The police search for Tafari was extensive. It was initially coordinated by A/Insp Phillip Cosgriff, and then by Ch Insp David Matthews, who gave evidence to the inquest. A/Insp Paul Laksa coordinated the criminal investigation. Local police from Lake Macquarie and Target Action Group (TAG) officers from Newcastle were also involved, as well as local officers from the Operations SupportGroup.

The first police to arrive, Sen Csts Austin and Tull, obtained information about Tafari, as well as Gabby's vehicle details and their phone numbers. It was quickly realised that Gabby's phone was still within the house. A phone triangulation was commenced on Tafari's phone to see if he could be located. That appeared to show Tafari was still relatively close by, in an area to the west. There were extensive searches, but Tafari was not located. Police canvassed local houses for information and attended addresses of known associates. A police helicopter, PolAir, was also dispatched from 3pm to assist.

Cardiff

It was later discovered that Tafari had in fact driven Gabby's Mitsubishi straight from to XX Street, Cardiff, just a few hundred metres to the east. This was a home previously owned by a person known to him who had moved out in about 2012. He broke into the property and remained there all day, with the Mitsubishi parked in the driveway. The occupier was at work.

At about 5pm, the occupier returned to Lovell St, where she found Tafari in her driveway, claiming he had run out of fuel. She told him to leave, and he drove off in the Mitsubishi. She entered her home and found it had been ransacked. Fingerprints later confirmed Tafari had been inside, and CCTV from the street shows he entered at about 11.38am and left at about 4.54pm. Ms. Holt phoned 000.

A large number of police officers responded to this incident, arriving at 5.16pm, and searched the surrounding area. By this time, PolAir had returned to refuel at Bankstown. These searches were negative.

Elemore Vale

E later told police that Tafari arrived at about 9pm, but there is some evidence that he arrived prior to that time. In particular, he made a call to E sister, F at about 8.45pm, probably using E's phone.

E later told police that Tafari came to her door and told her that Gabby had been cheating on him. He appeared stressed. He came inside, changed clothes and shoes, and asked to borrow her car, to which she agreed. He drove off in her Ford Falcon, leaving the Mitsubishi behind. She says she was unaware of Gabby's murder. She did not contact police.

The search of Tafari's home

The phone triangulation of Tafari's phone appeared to include the area where his mother's home was located. At about 8.50pm, police attended the address and conducted an extensive search. Tafari was not present. Police advised the family to leave, out of concern that Tafari would return. The family agreed to stay with G & B's mother, who had moved to a new address. The fact that the family had left the property was significant, as the address was one where Tafari might have been expected to attend. A/Insp Laksa asked for other police to be informed that the family had left the home, and a CAD message to that effect was issued at 6.17am the following morning. That information does not appear to have been made known to the police officers who encountered Tafari at the address. That issue will be considered further, below. Police had also been conducting surveillance on the address, in the event that Tafari returned. However, following the search, and the family relocating, that surveillance ended.

Tafari would attempt "death by police". She says she was assured that Tafari's safety would be a priority. At about 10pm she told them about the earlier call from Tafari. A/Insp Laksa attempted to get authority from the Duty Operations Inspector to trace the phone that had been used to make the call. This was denied by the Duty Operations Inspector because he determined that relevant test was not met. Reverse call-charge records were sought instead. If the phone call had been traced, police might have discovered Tafari's contact with E earlier, and also the fact that Tafari was now using the Ford Falcon. They ultimately attended E's home at about 4.30am, having by then located the Ford Falcon, and found Gabby's Mitsubishi parked in her driveway. Following this, H went to see friends, J and K and at about 3am J called police. No attempt appears to have been made to alert police to Tafari's presence prior to this point.

Police pursuit

According to l, after they left H's home, Tafari threatened him with a knife and said he wanted to drive. Tafari thendrove to L's home in Wallsend, where they had some cocaine. All three then returned towards h's address, with l driving. By this time, about 3am, police were responding to the call about H's home. Sgt Lee Cousins saw the Commodore approach Dudley Road, performed a U-turn, and commenced a pursuit. According to I Tafari held a knife to l's throat and told him to drive off, which he did at high speed. About 8 minutes later, the Commodore entered Warners Bay Road and Sgt Cousins ended the pursuit. He patrolled the area but could not locate Tafari.

At 3.41am, Sgt Cousins spotted the Commodore again, and conducted a second pursuit, which again ended after a few minutes. According to l, he slowed down at one point and he and l decamped, leaving Tafari behind in the vehicle. They later reported the events to police. Tafari remained in the Commodore, but his whereabouts after these events are not known. It is possible he attended his mother's home and attempted to enter, as the flyscreen in one window had been removed when police attended the following day. He may have spent the night elsewhere. At 6.51am, CCTV captures the Commodore driving into a reserve to the south of Karen Ave, in Glendale. Local residents saw a male, who was probably Tafari, looking over fences, and an hour later a male was seen walking through the backyard of a property on Bell Street. This sighting was reported to police, who attended.

Bell Street

Shortly after, at about 8.30am, Roslyn Harrison returned from doing some shopping to her home in Bell St, Glendale. She saw Tafari inside her garage holding a folded knife. He demanded her keys and told her "I just want to see my mum." She declined. While Tafari was fiddling with the knife, Ms. Harrison ran off and alerted a neighbour. The neighbour then called police at about 8.35am. Police units attended and conducted a search, including dog units. Police spoke with Ms. Harrison at Bell Street, where she told them about Tafari wanting to see his mother. This was relayed via police radio at 8.47am, with a request to attend the address.

Police briefings

At about 8.30am that morning, police involved in the search for Tafari had planned to hold a substantial briefing about the investigation at Belmont Police Station. It would have been expected to provide police information about the status of the search and the events that had occurred overnight, including the fact that Tafari's family had not spent the night at their home. However, when the Bell Street attempted carjacking was reported, police left the station and proceeded to Glendale. The briefing did not take place. As a consequence, information which had been obtained during the search for Tafari overnight was not disseminated to all police units who responded to the Bell Street incident.

Separate to this briefing, there was an informal briefing held at Newcastle Police Station for TAG officers. The TAG officers expected they would become involved in the search for Tafari that day, although they were not yet formally tasked to do so. Those officers included Sgt Piddington, and Sen Csts Fullick, Scotsman and Barnett. Sgt Piddington did not recall all the details of the briefing, although expects he would have reviewed the timeline of criminal activity, locations Tafari had been at and the details of the Commodore he was driving.

He had reviewed COPS events relating to Gabby's death and intelligence material. He does not recall if he was aware of the information about having spent the night at a different address. None of the other officer's present recall thatinformation.

Tafari's death

After leaving Bell Street, Tafari returned to the reserve to get the Commodore, and drove the short distance from there too, acting on the information that Tafari might try to see his mother; the three officers from TAG (Sen Csts Fullick, Scotman and Barnett) had already att en de d stopping about 60m away from the house. They saw a vehicle parked outside, and Sen Cst Scotman made enquiries and discovered it belonged to B. The officers had a discussion at this point and formed a view that A and her family might be inside. There was concern that Tafari may harm the occupants. As a result, Sen Cst Fullick asked police radio to contact A to see if she was okay, and if Tafari was present. At 8.57am, Tafari drove into the driveway of his mother's home. He then exited and appeared to have seen police. Sen Cst Fullick broadcast "He's waving at us. Radio we have the POI." As a result, several police units began converging on

After Tafari's arrival, he jumped the gate motioning to officers to follow him. At 8.58am, the TAG officers broadcast that Tafari had "just run into the house". Sen Cst Barnett broadcast, "we have two officers out the front, we need more cars here, we're going to try to contain the mother's house." Following this broadcast, another police unit (Sen Csts Smith, Robinson and Willemsen), was directed to attend the rear of the premises, in case Tafari absconded through the rear of the property. The property has a driveway to the right and a passageway to the left, which both lead to an area at the rear. At the rear of the property, there is a pool and a raised, chest-height deck which is bounded by a glass barrier. A set of stairs positioned opposite the rear door, leading down to ground level towards the pool gate. A narrow passageway separates the deck from the pool fence.

Sen Cst Fullick and Det Sen Cst Scotman climbed over the gate and entered the driveway to the right. It appears that Det Sen Cst Scotman asked the three Detectives to go to the left of the property. Sen Cst Barnett remained outside, intending to enter via, or remain at the front door. At 8.59am, a neighbour, Paris Burton began filming events on her mobile phone. It shows Det Sen Cst Scotman jumping the gate and going down the side of the house out of view. While it does not show Tafari, there is some audio, including police commands and the gunshots. As Sen Cst Fullick advanced down the driveway, he yelled out, "Tafari, show us your hands, brother." This can be heard on the mobile phone footage.

The Detectives needed to climb a fence in order to get down the left-hand side passage. Det Sen Cst Webb climbed first, followed by Det Sen Cst Newton. As Det Sen Cst Webb moved along the passage, he dropped his handcuffs, although his colleague Det Sen Cst Newton told him to continue, as he would pick them up. Det Sen Cst Webb was the first to arrive at the rear of the property.

He had his firearm drawn. Det Sen Cst Newton also drew his firearm, but had it in the “sul” position, namely held at chest level with the barrel pointed downwards. Det Sen Cst Webb continued moving around the side of the deck. He was initially unable to see Tafari. When he arrived near the foot of the stairs, he saw Tafari standing on the deck trying to open the door to the home. The space where all the officers were standing was cramped. Det Sen Cst Webb was in a vulnerable position, standing close to and beneath Tafari, and with his back to a pool barrier. His colleague Det Sen Cst Newton was approaching behind him, and Det Sen Cst Symington arriving beyond that. Sen Csts Fullick and Scotman were approaching from the opposite side (the right).

Tafari raised his hands, holding a 10-15cm bladed knife in his right hand. According to the officers, he said, words to the effect “come on fucking shoot me.” Det Sen Cst Webb told Tafari to put the knife down repeatedly. He then drew his OC spray and discharged it, although this had no apparent effect on Tafari. Tafari took a step back and then moved quickly towards Den Sen Cst Webb, with the knife raised.

At the point when Tafari passed the top step, Det Sen Cst Webb and Sen Cst Fullick each discharged two shots, with two shots hitting Tafari and the others hitting a bike and a chair on the deck. Tafari fell to the ground, landing at the point where Det Sen Cst Webb had been standing. It is estimated that Tafari was less than 2m away from Det Sen Cst Webb when the shots were fired. None of the other officer’s present were in a position to shoot, as others were standing in their line of fire. On the mobile phone footage, the time from police starting to shout commands to the shots being fired is approximately 13 seconds.

A radio broadcast about the shooting was made at 8.59am. Following this, many other officers arrived. Police commenced first aid. An ambulance arrived at 9.08am, but Tafari was declared deceased soon after, at 9.17am. Tafari was found to be carrying 4 plastic bags containing cocaine at the time of his death.

Autopsy - Tafari

A full autopsy was conducted on 19 March 2019. It recorded the cause of death to be gunshot injuries to the head and abdomen. Tafari was struck in the right temple, with the bullet exiting near his left ear. A second shot entered at the right side of his back, damaging Tafari's liver and kidney.

Both shots were inevitably fatal.

Toxicology shows that Tafari consumed a large quantity of cocaine and Ice in the period prior to his death. Dr Fu opined that the level of cocaine indicated that Tafari was likely to have consumed more cocaine after about 2.30am when he shared a “last line” with l and L.

Expert evidence

A review of the action of the offers present at Tafaris' death was performed by Sgt Paul Scott, an Operational Safety Instructor. He gave evidence to the inquest. Det Sen Cst Apthorpe provided evidence on testing Det Sen Cst Webb's MK-6 OC spray. This was a small version of the standard issue OC spray, and was intended to be used in plain clothes work. He concludes that the spray used by Sen Cst Webb did not function adequately, only travelling a total horizontal distance of about 1 to 1.5m. He also found that other canisters were deficient. This issue is considered, below.

Ballistics evidence from Matthew Bolton was unable to confirm which officer fired which shot, although the trajectory of the rounds which missed Tafari could be described. He also gives an opinion that the shot that struck Tafari in the chest was fired from a range of between 1m and 2m.

The issues

A list of issues was circulated prior to the inquest, to identify the broad areas of interest which were expected to be the focus of evidence.

In Gabby's case, as well as the formal findings required by s. 81 of the *Coroners Act 2009*, the issues were as follows:

- Whether the nature and adequacy of supervision provided to Tafari by Community Corrections had any impact on the risk presented to Gabriella at the time of her death.
- Whether appropriate action was taken by NSW Police Force in response to the concern for welfare reports made by Emma Russell on 13 March 2019, and in particular:
- What information was obtained from Ms. Russell and recordedby police?
- What information was known to the responding police?
- What action was taken by responding police, and was other action available?
- Was any further action appropriate after Gabriella contacted police at 8.54am on 13 March 2019?

In Tafari's case, the issues were as follows:

- The nature of Tafari's mental health issues and the treatment he received, in custody and on parole.
- Whether adequate supervision was provided to Tafari by Community Corrections, including:

- Steps taken to monitor his adherence with mental health treatment.
- Illicit substance use, including drug testing.
- Whether adequate action was taken by NSW Police Force to locate Tafari, following the death of Gabriella Thompson on 13 March 2019.
- Whether adequate steps were taken by NSW Police Force to disseminate information about the investigation to police officers who were searching for Tafari.
- Whether appropriate action was taken by the involved officers, in light of information known to them, including:
- The extent to which a plan was discussed prior to approaching
- The decision to engage Tafari, and other optionsavailable.
- The use of appointments.

The salient issues arising from the evidence are addressed in turn, below.

Tafari's mental health and treatment

Dr Danny Sullivan, a consultant forensic psychiatrist, prepared a report for the inquest about Tafari's mental health. He gave the followingopinions:

While Tafari was a child, several diagnoses were suggested, including oppositional defiant disorder, conduct disorder, attention deficit hyperactivity disorder, obsessive-compulsive disorder, and major depression. It is likely that most of these were met at various times. Emotional trauma contributed to the development of these conditions. By the time of his death, Tafari's primary diagnosis was mixed personality disorder with antisocial and borderline traits. Dr Sullivan described this as a severe personality disorder. This diagnosis is consistent with the view of Dr Gordon Elliott, who assessed Tafari for a Court report in August 2016. Borderline personality disorder generally comprises four clusters of symptoms: cognitive and perceptual symptoms, including brief hallucinatory experiences and delusions; interpersonal problems, where some relationships are idealised while others are devalued; emotional lability and volubility; and impulsive behaviours, including deliberate self-harm.

These symptoms all contributed to Tafari's behaviour. Tafari also had a severe substance abuse disorder, including stimulants, cannabis, and alcohol. Tafari did at times display psychotic symptoms, and he expressed some unusual beliefs that might be considered delusional. However, these were probably induced or exacerbated by substance use. Some paranoid and delusional thoughts could also be explained by his personality disorder. There was, in Dr Sullivan's view, no evidence of sustained symptoms, and Tafari was repeatedly assessed as not having a serious mental illness. Additionally, Tafari did not display psychotic symptoms during periods of imprisonment where he did not have access to substances. Accordingly, Dr Sullivan did not consider Tafari had a psychotic illness. At the time of his death, Tafari met the criteria for stimulant intoxication. It was also likely that he had a methamphetamine-induced psychotic disorder at the time of the events which led to his death.

Dr Sullivan opined that Tafari received adequate and appropriate treatment while in custody. Tafari had been ambivalent about receiving mental health treatment and did not seek further treatment after assessment in August 2016. He came to the attention of mental health services again in the context of substanceuse.

It may have been the case, as Tafari's family suggested, that he would have benefitted from further planning, prior to his release from custody, to ensure he received appropriate through-care. However, because Tafari was facing serious new charges, his discharge from custody was uncertain. He was also not consistently involved with mental health professionals in custody, although he did see a psychologist on two occasions to prior to release. In these circumstances, it may have been difficult to organise appropriate assessment and treatment until Tafari was in fact released.

Once in the community, significant efforts were made, by Tafari and his mother, to obtain appropriate mental health care for him. He was connected with psychologists and was also scheduled to commence drug and alcohol counselling. However, treatment did not commence prior to hisdeath.

Unfortunately, Tafari's condition was going to need long-term treatment, more than that which could be provided on a GP mental health care plan. Nonetheless, the referrals made to GPs were appropriate. Dr Sullivan described in evidence the nature of such treatment, involving possibly biological, psychological, and environmental elements, and which would have required voluntary engagement with Tafari. Critically, Tafari appears to have commenced using substances on his release from custody. In these circumstances, it is unlikely that any treatment would have been of benefit in any event. Overall, I find that the mental health treatment Tafari received, both in custody and in the community, was appropriate.

Supervision of Tafari by Community Corrections

The supervision Tafari received from Community Corrections was generally good. Mr. Brady met Tafari and assessed his needs, correctly identifying areas of high risk as aggressive behaviour, drug use and mental health. Mr. Brady met Tafari on seven occasions over the seven-week period of parole, including two home visits. Mr. Brady also confirmed Tafari's progress by making contact with third parties. This was an appropriately high level of supervision. Although Tafari did not commence mental health treatment prior to his death, Mr. Brady explained in evidence that he thought Tafari was doing quite a good job of obtaining referrals himself. Mr. Brady did not seek to intervene, because he believed it would be more meaningful if Tafari organised such treatment, as it signalled that he was engaged in the process. Given the complexities to Tafari's presentation, it was going to take time to organise appropriate treatment.

The action taken after Tafari's admitted drug use on 6 February 2019 is more significant. As noted, following this admission, Mr. Brady did not require a drug test, but gave Tafari a direction to cease drug use, and also obtained his consent for a referral for drug counselling. Corrective Services policy provides that where a parolee is required to undertake drug testing, this must be included in a case plan. The policy identifies situations where drug testing should not be required, including where it is not related to an offender's risk, and where the test results would not change the supervision response.

Dr Sullivan opined that there would have been benefits in conducting a rigorous program of urine drug screens, because it may have detected drug use and would also have provided some deterrence against Tafari using drugs. However, he acknowledged that it was speculative to consider the outcome of those tests. Further, he acknowledged that drug testing is resource-intensive, and can create a "world of headaches" where parolees do not attend or provide inadequate samples. Mr. Brady did not update Tafari's case plan to require drug testing. He accepted in evidence that he had intended to do so, and that this was an oversight. It is possible that, had it been included in the case plan, and had Tafari been thereby notified that he would be required to undertake further drug testing, this might have had a deterrent effect and curbed his drug use. However, Mr. Brady stated that, even if he had included drug testing in Tafari's case plan, this would not have changed his approach. He did not consider drug testing to be appropriate or necessary during the following weeks. Tafari appeared to be engaging well.

This is to some extent supported by the fact that Tafari was engaging with a number of health professionals, and that none of them recorded any concerns about drug use. Mr. Brady also noted that in his role, he was expected to work with clients regarding drug use, which required the client to be comfortable describing their drug use in order to identify ways to reduce the risk of relapse. Some actions, such as reporting to police, would be counterproductive. There needed to be a balance between managing risk and working with the client.

While Mr. Brady believed there was training provided on this issue, he could not recall specific guidance. The policy material provided to the inquest does not give any detailed guidance on how to address this balance, and in particular what circumstances ought to require drug testing in the case of admitted drug use. It would appear desirable that the policy identify circumstances where drug testing will be required. This is so, even though Community Corrections will have what Dr Sullivan described as a "fascinating tightrope to walk between coercion and compliance", balancing the need to build rapport with a parolee against the need to manage their risk.

Tafari's admitted drug use was potentially a breach of his parole conditions,and an offence, and also a breach of his bail conditions. Guidance issued by Corrective Service provides in effect that an officer must only submit a breach of parole report for drug use where there is a specific direction not to use drugs on the person's parole. Until 6 February, Tafari did not have such a condition on his parole, and accordingly Mr. Brady did not take breach action. Policy also provides guidance on what action to take where a parolee has committed a further minor offence, in effect giving discretion to the supervising officer.

Tafari was also under a specific bail condition not to use drugs. Tafari was subject to strict bail conditions, reflecting his serious charges and the risk he presented. However, Mr. Brady did not address his mind to what action, if any, to take in relation to the breach of bail. I am not critical of that, because Community Corrections policy does not currently provide any guidance on this issue.

Policy should be amended to provide Community Corrections officers guidance on the circumstances where an officer should report a breach of bail to police, in particular where the breach reflects an identified risk to the community. A recommendation to this effect is made, below. The evidence clearly establishes that Gabby was at increased risk from Tafari, partly in consequence of his undetected drug use.

While I am not critical of Mr. Brady, this in an area where policy should be amended to provide further guidance.

Police response to the concern for welfare report

The concern for welfare report made by Emma Russell represented an opportunity take action to protect Gabby. Ms. Russell was concerned about Gabby and hoped police would check on Gabby to see if she was safe. There were some differences between what Ms. Russell believes she reported, and what Sen Cst Parson's recalls her saying. Ms. Russell accepted that her recollection at the time of her statement in August 2019 was likely to have been better than it was during evidence. In her statement she recalled telling Sen Cst Parsons that she was concerned about Tafari's phone call, as he sounded erratic, describing previous violence and that Tafari was "knife-happy". She recalled saying she was afraid Tafari would stab and potentially kill Gabby. It is clear that, regardless of what details Ms. Russell gave to police, she was conveying a concern that Gabby had been or would be the victim of domestic violence. Tragically, she was correct; Gabby died within a few hours of hercall.

Sen Cst Parsons did not have a recollection of the call, and took no notes,other than the CAD message. The message was brief, and he accepted in hindsight that he could have provided more detail. I agree that it would have been appropriate to record more detail in the CAD message. The CAD message was important because police attending the incident relied on the information. Sen Cst Parsons also accepted that he understood Ms. Russell was concerned about Tafari having physically hurt Gabby again, and that he understood this to be a concern about domestic violence. However, he stated that if there had been significant things said to him, he would have recorded these; he specifically denied being told of a concern that Tafari might kill Gabby.

Sen Cst Walker, who responded to Sen Cst Parson's CAD message and attended Gabby's home, also spoke to Ms. Russell later in the early hours of 13 March 2019. He similarly denied much of the detail provided by Ms. Russell about that call. He accepted that Ms. Russell gave more details about her concerns than were recorded in the original CAD message, as is reflected in the more detailed CAD message he created. However, he stated that if something else pertinent had been said, he would have put it in the CAD message.

Sen Cst Walker also understood Ms. Russell's concern to be about domestic violence. However, he did not consider that the fact that it was described as a domestic violence incident would have affected his approach to the incident. Sen Cst Grime was the officer who eventually spoke with Gabby on the morning of 13 March 2019. He was reluctant to accept the characterisation of the incident as being one involving domestic violence. In contrast to Sen Cst Walker, he believed the description of the CAD message did affect his approach to the incident. He understood that an incident described as a domestic violence incident would have engaged the relevant policy, including a requirement that police attend to see the alleged victim. He did not do so in Gabby's case, because when he spoke to her by phone she appeared "chirpy" and answered his questions frankly.

There are sound reasons why all incidents relating to suspected domestic violence should be recorded as such. In addition to ensuring appropriate oversight of all domestic violence incidents, it would be an appropriate way to ensure that police attending domestic violence incidents are aware of their nature. I make a recommendation to this effect, below.

There are also sound reasons why police should, in most cases, attend victims where there is a concern about domestic violence. Seeing a victim may reveal information not available over the phone, including a victim's physical appearance, location and the other people who are present. There may of course be reasons in particular cases why attending a victim would be unsafe or inappropriate, but absent these exceptional circumstances, police should attend. In my view, the failure of police to see Gabby following the concern for welfare report represents a missed opportunity to take action to protect her. However, I am not critical of Sen Cst Grime for not seeing Gabby, in circumstances where he did make contact with her by phone, and where Gabby herself indicated that she did not require police assistance.

The NSW Police Force domestic violence policy that was in force at the time of these events was available to the inquest. The policy requires officers to thoroughly investigate domestic violence incidents, and notes that the reluctance of a victim to provide information is not a reason to cease investigating. It also requires police to attend an incident, even where a second call is made indicating police are not required. However, the policy does not appear to explicitly require police to physically attend all domestic violence incidents. In my view, the policy should be amended to reflect this requirement, other than in exceptional circumstances. A recommendation to this effect is made, below.

Manner of Gabby's death

Only one witness could give any detail about the circumstances of Gabby's death, namely B and A who also attended Gabby's home prior to her death, did not approach the property and did not see Tafari or Gabby. She was not asked to give evidence. When Gabby called for help, A realised that something was amiss, and she drove away. It is likely that she heard the remarks between B and Tafari at the door, rather than what Gabby said, as Gabby was located at the back of the house and some distance from where A was waiting in the car. The available evidence suggests that a period of about 5 minutes elapsed between the arrival of B and A and the firstcall B made to A after leaving the home. It is difficult to understand how the actions described by B could have taken that long.

Only about a minute elapsed between the call to A and the call to triple- zero. During that time, B says the following things occurred. First, he saw Tafari leaving the home. B approached the home and saw Gabby in the doorway, who was bleeding heavily. He tried to find something to stem the bleeding, looking in the bathroom and bedroom before returning to Gabby. He tried to apply pressure to the wound, and then went to wash his hands, before calling triple-zero. Again, it is difficult to match those actions with the timing of the calls.

Cause he … Cause they ... they were fighting, and he's taken her inside, dragged her inside as far as I can tell um and that was when I was in and he didn't want to let me in.

If B saw these events, that is inconsistent with the account he gave in his statement and in evidence. However, in evidence B suggested that he might have been speculating when he said this to police. He also said he was "very cranky" at that point with Tafari, possibly suggesting he intended to make things worse for Tafari, although how that could be the case is not clear. He was firm in his evidence that he had not observed Gabby and Tafari outside the house.

The events of 13 March 2019 would have been traumatic. B was not prepared or trained to respond to the highly volatile situation which confronted him. As a result, B may have acted in ways which are now difficult to understand. However, he maintained his account, despite close questioning during the inquest. The matters to which I refer above would leave some doubt as to the circumstances of Gabby's death. However, on balance, I find that it is likely that those events occurred substantially as B described them. I find that Tafari assaulted Gabby at her home. He tied her up with a rope, and then fatally stabbed her, after B had left the home to call A and the police. Gabby's death was a homicide that occurred in the context of domestic violence.

Dissemination of information by police

The efforts made by police to locate Tafari were extensive. While in retrospect other steps might have been taken, I accept that adequate resources were allocated to the search, and that police efforts were appropriate.

One issue during the search which had consequences was the information about Tafari's family relocating to another address. As I have noted above, following police search of the home on the evening of 13 March, the family decided to spend the night at a different address. The fact that they had relocated was significant, as Tafari might have been expected to attend the home.

A/Insp Laksa directed that this information be disseminated to other officers, and this appears to have been done at the latest by the CAD message sent at 6.17am on 14 March 2019. However, that message was only available to officers who had access to the Lake Macquarie CAD system.

Ch Insp Matthews became aware of the information and relayed it to Det Sen Cst Newton when they spoke about the investigation, in the morning of 14 March 2019. He confirms this in an email sent at 7.23am. Accordingly, Det Sen Cst Newton was aware of the family's relocation. He could not recall if he told either of his colleagues, Det Sen Cst Symington or Det Sen Cst Webb; neither of those officers recalled this information.

It is likely that the police officers attending the briefing scheduled later that morning would have been told about the family's relocation. However, as mentioned, that briefing did not take place, because police received information that Tafari had attended Bell Street. The Target Action Group officers from Newcastle were not aware that the family had relocated. They were not intended to be part of the briefing, which was for local units only. The CAD message regarding the family relocating had not been sent to them, although it would have been possible for them to obtain it.

Although not formally assigned to the search for Tafari, the TAG officers understood that they would probably be asked to assist. There was an informal briefing between Sgt Piddington and the other officers, during which information relevant to the search for Tafari was discussed. However, the information about the family relocating was not known to Sgt Piddington or the other officers. As a result, none of the TAG officers knew about the family relocating. Sen Cst Barnet said he believed the family was inside the home. Sen Cst Fullick was also concerned that someone was in the house, although he did not know either way. As I have mentioned, Sgt Barnett asked Sen Cst Fullick to contact radio to check A location, but this could not occur prior to Tafari's arrival. In contrast, Det Sen Cst Newton was aware that the family had relocated.

Det Sen Cst Webb also had some basis to believe that A at least was n o t at the home. This was because, while at Glendale, he had received a call from A/Insp Laksa, asking him to return to the station in order to take a statement from A as a result, he believed A was probably on her way to the police station. Surprisingly, neither Det Sen Cst Newton nor Det Sen Cst Webb responded t o the broadcast from Sen Cst Fullick, which was asking about A whereabouts, to reveal the information they each knew. They accepted they could have done so. However, the time between Sen Cst Fullick's broadcast and Tafari's arrival was only about a minute, during which time the radio was busy. Also, neither officer was in a position to confirm for certain that A and her family were not inside the home. The evidence shows there was a disconnect between the information known by some police officers about the family's location, and the officers who attended Tafari's home in order to apprehend him. This had a possible consequence for the events as they unfolded, as I shall describe below.

Action taken by police at Glendale

While overall I find that police acted appropriately in this incident, there are some aspects of their police conduct which should be highlighted. *Firstly*, Tafari clearly presented a high risk to the public, as evidenced by the incidents he had caused following Gabby's death, including the police pursuit, threats against members of the public and most recently the attempted carjacking in Bell Street. There was an urgent need to locate and apprehend Tafari, both to answer for his actions against Gabby and others, and to protect the public from further harm.

Second, as I have noted above, information about the family relocating was not known to the TAG officers. They believed the family could be inside the home and feared that Tafari was going to cause them harm. They had tried to confirm A's whereabouts by radio, but there was insufficient time to confirm this information. Their belief that the family could be inside the home increased the urgency of their response. Conversely, Det Sen Csts Newton and Webb each had an understanding that Tafari's family were not at the home, although they did not know whether this fact was for certain.

Third, the six police officers who attended the property had limited knowledge about its layout. Sen Cst Fullick had in fact attended the property at about 2.30pm on 13 March 2019, when the search for Tafari was in its early stages. On that occasion, Sen Cst Fullick walked down the driveway and looked into the back yard, saw the deck and the pool, and also tried to open the garage door, which was locked. However, he was not aware that there was a passage on the opposite side of the house which also entered the back yard.

None of the other officers knew the layout of the property, and in particular none knew the cramped nature of the back yard. Their lack of knowledge might have suggested a need to proceed with caution, although this was to be balanced against the competing need for urgency. Had they known the layout of the rear of the property, this might have affected the manner in which they approached it.

Fourth, although police believed Tafari was going to his home, because he had told Ms. Harrison in Bell Street that he wanted to see his mother, Tafari's arrival by car was sudden and unexpected. Police thought he was going to travel on foot, and the TAG officers locked their car doors in in case Tafari approached their vehicle from behind. The suddenness of his arrival contributed to the urgency of the police response to some degree, and also reduced the opportunity for any discussion or planning.

Fifth, when Sen Cst Fullick saw Tafari enter the driveway, he broadcast to police radio that Tafari had "run into the house". He intended to convey that Tafari had run onto the property, rather than into the house itself. However, on hearing this broadcast, the Detectives Newton, Webb, and Symington understood that Tafari had actually entered the house. This is despite the fact that Det Sen Cst Webb was also told that Tafari had "gone over the fence". Their belief that Tafari was inside the house affected their approach to the incident because they believed they were trying to contain Tafari in the house. They did not expect to confront Tafari at the rear.

Sixth, there was limited discussion or planning between the six officers about what they were going to do. That said, each team had discussed in broad terms the nature of their task prior to Tafari's arrival. Sen Cst Barnett had reminded the TAG officers that their aim was to contain and negotiate Tafari at the property. He had prior experience as a tactical officer, and he anticipated that tactical police would be involved. Similarly, the Detectives also had a discussion in their vehicle about the situation. They recognised that Tafari being at the home would be a "good opportunity to contain him".

However, once Tafari had been seen and police approached the property, the only discussion was to the effect that Sen Cst Fullick asked Detectives to go to the left of the property, while the TAG officers went to the right.

In light of the urgency of the situation, I am not critical of the fact that there was not more discussion or planning. As Sgt Scott observed, the situation was "very fluid and emerged quickly" and the officers did not have an opportunity for open discussion. It was necessary for the officers to locate Tafari, as he was not visible from the street. It was possible, for example, that he had either entered inside the property, but alternatively he might have absconded over the back fence. It was also necessary to confine Tafari to a known area, in keeping with the guiding principle of "contain and negotiate".

However, the lack of discussion meant that the information mentioned above was not shared between the officers. There was no discussion about what was known about the family's whereabouts, or the fact that Tafari had not been seen to enter the house or what was known about the layout of the property. All these matters conceivably had an impact on the manner in which the officers approached the rear of the property.

In evidence, Sen Cst Fullick denied that, had he known for sure that the family was not present; this would have lessened the immediate risk that Tafari presented. Nonetheless, it would appear logical that such information would have lessened the risk.

While there may have been people in neighbouring properties, they would have been physically further away, and less at risk. Sgt Scott ultimately agreed with this proposition. However, this issue is hypothetical, as none of the officers did know for sure where the family was.

The inquest received evidence about training for planning in such situations, namely NSW Police Force's STOPAR training. That acronym stands for Stop, Think, Observe, Plan, Act, Review. It is intended to provide a framework for situational awareness and critical thinking, supporting the need for police officers to plan appropriate responses. It has more limited application in high-risk situations, where the "plan" is already pre-determined, namely, that officers should contain and negotiate.

Of the six officers involved in Tafari's death, only Sen Cst Scotman had any recollection of STOPAR training. However, some elements of the STOPAR model were used by police, at least in the period prior to Tafari's arrival, in particular by observing and discussing the broad nature of the plan.

Seventh, the officers proceeded quickly into the rear of the property. The Commissioner submits that I should not find the officers moved "too quickly" but that they proceeded appropriately in the circumstances and had no other option but to locate Tafari as quickly as possible. I agree that they acted with the urgency they perceived necessary at the time. Had there been an opportunity for a discussion about the plan and had the TAG officers been made aware of the information about the family relocating, this might have affected the speed at which the officers approached the rear of the property.

While Sen Cst Fullick moved quickly towards the rear of the property, I also accept that he did so deliberately and that he was exercising some caution. He considered there was urgency because he believed there were people inside the house. He thought Tafari was there to kill his parents. On seeing Tafari, he exited his vehicle and ran towards the property, and used a bin to climb over the gate while Sen Cst Scotman covered him. Sen Cst Barnett called out after him, saying, "hold up" or "wait up". While he did not stop, it appears Sen Cst Fullick did slow down, with his firearm drawn and facing partly towards the house, because he was concerned about the possibility that Tafari may "pop out" from under the house.

Eighth, the fact that the officers moved quickly into the rear of the property had an impact on the way the events unfolded. Det Sen Cst Webb did not see Tafari until he was near the bottom of the stairs that led to the deck. He believes this was because Tafari was partially obscured by the doorway.

Det Sen Cst Webb's position at that point was, as I have already noted, very vulnerable. He was located beneath Tafari and close to him, with no physical barrier between them. He could not use the balustrade, because there was insufficient room for him to hold his firearm in that position. The space around Det Sen Cst Webb was cramped, and he was aware that the other officers were approaching from both the left and the right. This in effect meant that he had no exit route. Had he proceeded less quickly into that area; he might have stopped at a point which was less vulnerable. However, given his evidence that he was unable to see Tafari prior to the point when he was at the foot of the stairs, it is not possible to conclude that a slower approach would have changed the outcome.

Ninth, Det Sen Cst Webb gave evidence of his attempts to persuade Tafari to drop the knife. He stated that Tafari was holding the knife at chest height, and beckoning with his other hand, repeatedly saying "just shoot me". Tafari was moving towards him on the deck at this point.

In response, Det Sen Cst Webb announced himself as a police officer, and told Tafari to drop the knife. He said he called Tafari by name and was using a tone which was "more of a plea". Tafari did not comply. It is therefore clear that Det Sen Cst Webb made efforts to communicate with Tafari and de-escalate the situation before he used his appointments.

Tenth, Det Sen Cst Webb appropriately attempted to discharge his OC spray, transitioning from his firearm to discharge the OC spray with his left hand. The OC spray discharged at an insufficient pressure and did not reach Tafari. A subsequent investigation by police revealed a problem with the particular type of OC spray canister used.

The inquest was told that these have been withdrawn from service, and a replacement is being considered. In those circumstances it is unnecessary to take the issue further. It is not possible to conclude that, if the OC spray had functioned adequately, it would have changed the outcome. OC spray is not always effective in stopping an assailant. However, it is highly regrettable that a less lethal tactical option could not be used.

It was through no fault of Det Sen Cst Webb, who acted entirely appropriately. Tragically, when the OC spray failed, all tactical options other than a firearm had been exhausted.

Eleventh, I find that Det Sen Cst Webb and Sen Cst Fullick were justified in discharging their firearms. NSW Police Force policy provides that firearms are only to be discharged when there is no other reasonable course of action available. This occurs when there is an immediate risk to the officer's life or the life of someone else, or there is an immediate risk of serious injury to the officer or someone else and there is no other way of preventing that risk. The lawfulness of a decision to discharge a firearm would be determined by the general law, including by operation of s. 230 of the *Law Enforcement (Powers and Responsibilities) Act 2002*, which permits police officers to use such force as is reasonably necessary to exercise a function under the Act.

Det Sen Cst Webb gave compelling evidence about the moments prior to the shooting. He observed Tafari to take a step back after he had discharged the OC spray, and Tafari then moved quickly towards him.

He came straight toward Det Sen Cst Webb, with the knife raised above his head and the blade pointing forwards. He recalls thinking the "point of no return" was the top stair and that if Tafari passed that point he would be "either hurt real bad or I'm dead". When Tafari reached that point, Det Sen Cst Webb transitioned back to his firearm, and discharged two rounds. Det Sen Cst Webb is unable to recall what happened next. This was due to memory loss, one of the consequences of significant psychological issues that he has suffered following this incident. The next thing he recalled was jumping back and coming into contact with Det Sen Cst Newton. This demonstrates how close they were and how limited the space was.

Sen Cst Fullick, who was standing to the other side of the deck, observed Tafari lunging towards Det Sen Cst Webb. He believed Det Sen Cst Webb was in immediate risk of his life. He did not consider the use of OC spray, because he did not think it would be effective. He therefore also discharged his firearm twice. By the time these events occurred, there were no other options reasonably available to police. The discharge of firearms was justified in thecircumstances.

Manner of Tafari's death

In Dr Sullivan's opinion, it is likely that Tafari was aware of the consequences of his actions when he lunged towards Det Sen Cst Newton with a knife. Dr Sullivan noted that Tafari had previously made statements about suicidal ideation, which made it more statistically likely that he would die from self-harm. Dr Sullivan also noted that Tafari's actions indicated an awareness that he could die, and a potential willingness to die, in that he invited police to shoot him. I note that it was not Tafari's request to shoot him that caused Det Sen Csts Newton and Webb to discharge their firearms, but their concern that Tafari was going to stab and kill Det Sen Cst Newton.

Dr Sullivan noted that Tafari is likely to have realised that he was facing a long prison sentence. Tafari had made comments to B to the effect that he would not be returning to gaol. This suggests he was resolved not to be apprehended by police. Tafari would have had an appreciation of the general impact of his behaviour, even though he was intoxicated and possibly psychotic at the time. Dr Sullivan's impression was that Tafari had affected a "suicide by police." I agree that the evidence taken as a whole demonstrates that Tafari intended the consequences of his actions. While a finding might be recorded that Tafari's death was "self-inflicted", this term does not sit easily with a situation where a person provokes a response in others. Instead, I will make a finding which reflects Tafari's intentions.

Accordingly, I find that Tafari had sufficient awareness of the consequences of his actions, and that he intended to provoke police to shoot him. I will record a formal finding to that effect.

To the extent that s. 75(5) of the *Coroners Act 2009* is engaged by that finding, I will order that these findings may be published, subject to separate non- publication orders that were made in the course of the inquest.

Sgt Scott helpfully provided some academic research related to the issue of provoked police shootings, which he preferred to describe as "use police to commit self-harm." He noted that police in Victoria have policy or training material specific to this situation, which he had reviewed. NSW Police Forceare giving consideration to adopting some of that training in a module of STOPAR training, although that project was "in its infancy".

Sgt Scott did not consider it likely that knowledge that a person was intending to provoke police to shoot them would vary the current tactics used by police. The Commissioner also opposed a recommendation that police consider discrete policy on the issue. Nonetheless, in my view it is desirable that police officers are given specific guidance on how, if at all, tactics should be varied where a suspect is believed to intend to provoke a police shooting. I make a recommendation to this effect, below.

Findings required by s. 81(1)

Gabby

As a result of considering all of the documentary and oral evidence given at the inquest, I confirm that the death occurred and make the followingfindings.

The identity of the deceased

The person who died was Gabriella Pamela Thompson.

Date of death

Gabriella died on 13 March 2019.

Place of death

Gabriella died at the John Hunter Hospital, NSW.

Cause of death

Multiple stab wounds.

Manner of death

Homicide by a known person, in the context of domestic violence.

Tafari

As a result of considering all of the documentary and oral evidence given at the inquest, I confirm that the death occurred and make the followingfindings.

The identity of the deceased

The person who died was Tafari Walton.

Date of death

Tafari died on 14 March 2019.

Place of death

Tafari died at Glendale, NSW.

Cause of death

Gunshot injuries to the head and abdomen.

Manner of death

Tafari was shot as he moved towards a police officer while armed with a knife, intending to provoke the officer to shoot him. The death was a result of police operations.

Recommendations

A number of recommendations have been identified in the course of these reasons.

Tafari's family proposed a further recommendation, to the effect that the Commissioner should audit compliance with STOPAR training. As I have observed, the involved officers were not generally aware of that training, although they nonetheless demonstrated elements of the process in their approach. However, as the inquest did not receive evidence generally about the take up of this training, I do not consider a recommendation necessary ordesirable.

I make the following recommendations.

To the NSW Commissioner of Police:

- *Consider amending NSW Police Force policy, including if appropriate the Domestic and Family Violence Standard Operating Procedures and the Code of Practice for the NSW Police Force Response to Domestic and Family, in order to:*
- *Clarify the requirement to record a CAD message as "Domestic Violence" where the circumstances reported by the informant relate to suspected domestic violence, even where no offence is reported.*
- *Clarify that, where a report relates to domestic violence, responding police officers should attend and talk to the alleged victim personally, unless there are exceptional reasons not to do so.*
- *Consider developing further training and guidance for police officers about the risks of, and appropriate responses to, people who are likely to attempt to use police officers to commit self-harm.*

To the Commissioner of Corrective Services NSW

Consider amending the Community Corrections Policy and Procedures Manual - Section B1 - Legal Issues at [1.7], to identify the circumstances when a Community Corrections officer should report a suspected breach of bail to police, in particular where the breach relates to an identified risk to the community.

Consider amending the Community Corrections Policy and Procedures Manual - Section E2 - Drug testing, to provide further guidance on the circumstances where drug testing ought to be required of an offender who has admitted drug use.

22. 117552 of 2019

Inquest into the death of Walter Clough. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 8th November 2021

Walter Clough was aged 66 years when he died at Junee Correctional Centre on 14 April 2019. On 5 April 2017 Mr Clough was sentenced to a term of imprisonment. He received a further term of imprisonment on 6 September 2019 and would not be eligible for release until 12 February 2021. At the time of his death therefore he was in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009.*

The role of the Coroner

The Coroner must makefindings as to the date and place of a person's death, and the cause and manner of death. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Background

Walter Clough was born in Narrandera on 3 March 1953, the fifth of twelve children born to his parents. As an adult he was employed as a truck driver. He married and had four children. He suffered two serious traffic accidents which caused significant injuries to his chest, lungs and back. These resulted in a condition known as right hemidiaphragm paralysis, involving a loss of lung function causing shortness of breath, headaches, fatigue and breathing difficulties. After the second accident Mr Clough was no longer able to work. Mr Clough also had a medical history of hypertension, sleep apnoea and depression. He used prescribed medication for some of these conditions, including opioid medications for chronic back pain. He had also been a heavy smoker but had ceased smoking someyears previously.

Mr. Clough's health care in prison

Junee Correctional Centre is operated by the company GEO Group Australia [GEO]. During his time in custody Mr Clough received regular treatment for his medical issues from nursing staff, general practitioners and psychiatrists. On a number of occasions Mr Clough attended the Health Clinic at Junee Correctional Centre complaining of shortness of breath. This was a longstanding problem due to his loss of lung function following his traffic accidents. For this he was prescribed Spriva, a long acting bronchodilator used for chronic obstructive pulmonary disease. On other occasions Mr Clough complained of dizziness and chest pain, but despite medical investigations no cause could be found for these.

On a number of occasions Mr Clough was seen by Dr Darren Corbett, a General Practitioner employed by Junee Correctional Centre. On 25 March 2019 Mr Clough was again examined by Dr Corbett, who concluded that Mr Clough's breathing difficulties were worsening, and that his paralysed diaphragm was creating further breathing difficulties. Dr Corbett added the inhaler Seretide to Mr Clough's medication regime.

Mr. Clough's admission to Wagga Wagga Rural Referral Hospital

On 8 April 2019 Mr Clough was again short of breath, with low oxygen saturations. He was transferred to Wagga Wagga Rural Referral Hospital, where he remained for three days. There he was found to have type 2 respiratory failure due to respiratory acidosis. He was also diagnosed with a lower respiratory tract infection for which he was treated with antibiotics. When he was discharged back to Junee Correctional Centre on 11 April 2019, the plan was for him to continue antibiotics and to use a different inhaler in addition to his usual m e d i c a t i o n s .

Mr. Clough's return to Junee Correctional Centre

When Mr Clough returned to prison he did not have a formal health review. However, he briefly saw Dr Corbett in the Health Centre and told him he was feeling better. Dr Corbett prescribed the antibiotics advised by the hospital and changed Mr Clough's inhaler to the recommended one. His other medications were continued. Mr Clough received his prescribed medications that day and on 12, 13 and 14 April 2019, in accordance with his discharge instructions from hospital. A member of the nursing staff, Endorsed Enrolled Nurse Tracie Cudmore, dispensed Mr Clough's medication on 13 April. She noted that he was short of breath, although no more than was usual for him. EEN Cudmore gave Mr Clough his medication the following day as well. This time she did think he was more out of breath than usual. She asked him if he was okay and he replied that he was. She advised him to buzz for help if he needed assistance.

When EEN Cudmore checked Mr Clough's health record, she could find no entry that Mr Clough had received a health care assessment on his return from hospital. For this reason, she made an appointment for him to be seen for a check-up by a Primary Health Nurse later that day. At about 1.31pm that day a correctional officer came to Mr Clough's cell to collect him for his appointment. As Mr Clough and the officer approached the exit to his wing, Mr Clough collapsed face forward onto the ground. CPR was immediately commenced, and Mr Clough was carried to the Health Centre. Despite these efforts and those of ambulance paramedics, Mr Clough could not be revived. He was pronounced deceased at about 2.30pm.

The cause of Mr. Clough's death

Forensic Pathologist Dr Alison Ward performed an autopsy. She found that the cause of Mr Clough's death was complications of chronic obstructive pulmonary disease. A significant contributing condition was cardiomegaly, which is an enlarged heart. This is usually due to an increased workload on the heart, likely caused in Mr Clough's case by his underlying hypertension and chronic obstructive pulmonary disease.

Since Mr. Clough's death

Following Mr Clough's death, GEO has issued a directive to all Junee Correctional Centre health staff that when an inmate returns from a hospital admission he is to receive a review, during which the inmate's hospital discharge papers are to be reviewed and the discharge plan implemented. This may involve prescribing new medications and making recommended appointments for the inmate.

In Mr Clough's case it appears this did not happen. However, I note that on his return from hospital Mr Clough had an informal attendance on Dr Corbett, who proceeded to prescribe the antibiotics advised by the hospital, and to change Mr Clough's inhaler as recommended. Mr Clough received these medications and treatments that day and the following days. In Mr Clough's case the evidence at inquest established that the medical and psychiatric care and treatment which he received while he was an inmate was appropriate. The evidence did not disclose any basis for making recommendations.

Findings required by s81 (1)

Identity

The person who died is Walter Clough.

Date of death:

Walter Clough died on 14 April 2019.

Place of death:

Walter Clough died at Junee Correctional Centre, NSW.

Cause of death:

Walter Clough died as a result of complications of chronic obstructive pulmonary disease. A significant contributing condition was cardiomegaly.

Manner of death:

Walter Clough died as a result of natural causes, while he was in lawful custody.

23. 154687 of 2019

Inquest into the death of Milo Wild. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 3rd November 2021

A Coroner is required to confirm that a particular death occurred and make findings as to the identity of the person who died the date and place of death, and the cause and manner of the death. In addition, under section 82 of the Act a Coroner may make recommendations that are necessary or desirable in relation to any matter connected with the death, including health and safety.

Background

Milo Wild was only 28 years old when he died in Prince of Wales Hospital on 16 May 2019. Just nine weeks previously he had been diagnosed with a rare and aggressive form of lymphoma, a cancer which develops in the body's lymphatic system. Despite chemotherapy treatment Milo's condition rapidly deteriorated. Milo's mother Catherine Archer and her sister Jacqueline Archer were by Milo's side when he died in the early hours of 16 May 2019.

Due to COVID restrictions it was not possible for Milo's family to be physically present at this inquest. However, Milo's parents and his aunt Jacqueline Archer attended each day by means of AVL link. In addition, Jacqueline and Catherine Archer gave evidence at the inquest.

At the close of the evidence, Jacqueline Archer spoke to the court on behalf of Milo's family. Milo was their much-loved son, nephew and brother, a person who was smart, energetic, engaging and funny. Milo's family was proud of him and of all he achieved and experienced in his short life. They are shattered by his loss, and they love him and miss him deeply.

Issues at the inquest

The key issues at inquestwere:

- whether the symptoms experienced by Milo in custody ought to have led to an earlier diagnosis of lymphoma.
- whether an earlier diagnosis of lymphoma would have resulted in a better outcome for Milo; and
- whether Milo's status as a prisoner reduced his chance for survival.

In examining these issues, the court was assisted with expert evidence from the following specialists:

- Professor Richard Fox, oncologist, Department of Clinical Haematology and Medical Oncology, The Royal Melbourne Hospital.

- Associate Professor Vincent Roche, rural procedural GP and clinical lecturer, Community Medicine, Sydney University. Milo's treating haematologist Dr Carol Cheung and neurosurgeon Professor. Marcus Stoodley also provided relevant evidence.

The inquest also examined concerns raised by Milo's family about his treatment at those times when he was a patient in Prince of Wales Hospital and under guard. A key concern was that he remained shackled with hand and ankle cuffs up until 10 May 2019, only six days before his death. He was by then extremely weak and ill.

Additionally, Catherine and Jacqueline Archer were distressed by what they describe as insensitive conduct on the part of Milo's guards. While these concerns do not strictly relate to the cause and manner of Milo's death, they were a source of distress for his family. They will be discussed later in the findings.

Milo's life

Milo was born in London on 16 March 1991, to parents Catherine Archer and Sergio Daniele. The following year he and his mother moved to Australia where they settled in Sydney. During his short life Milo had a range of medical conditions. His childhood illnesses included pneumococcal meningitis and respiratory infections. In 1995 itwas found that he had hearing loss on his right side, probably as a result of the meningitis.

When Milo was eight years old he and his mother moved to Maningrida in the Northern Territory. A few years later they moved to Darwin, where Milo completed his schooling. He started an electrical apprenticeship, then moved into sales work. As a young adult Milo lived for a few years in Melbourne, then moved to Sydney in 2016. On a trip to the Philippines in January 2018 he suffered a violent assault. He needed hospitalisation and treatment for significant bruising, lacerations and a broken tooth.

On his return to Australia Milo continued to suffer headaches and dizzy spells. He was often unwell with symptoms of left-sided paraesthesia, blurred vision, and loss of grip strength. His mother Catherine Archer noted that his face looked *'lopsided'* and *'puffy'* and that he seemed to have memory loss. He also suffered from anxiety, and from short, stroke-like episodes known as transient ischaemic attacks. These caused him to suffer body numbness, speech problems and movement deficits. In mid-2018 a transient ischaemic attack took Milo to the Emergency Department at Prince of Wales Hospital [POWH], where he suffered a further attack. Milo was referred to see neurologist Dr Christian Skulina at Macquarie Neurology. Scans of his brain and cervical spine revealed a severe occlusion (blockage) of a segment of the middle cerebral artery in Milo's brain. I will refer to this condition as an *'occluded MCA'.* Dr Skulina arranged for Milo to be reviewed by neurosurgeon Dr Marcus Stoodley.

Milo had consultations with Dr Stoodley on 25 July 2018 and 14 August 2018. Dr Stoodley confirmed that Milo had an occluded MCA, and that this was the cause of his dizziness, light headedness, and occasional cognitive disturbance. He thought the occlusion might have been caused by Milo's recent trauma, or his childhood viral infections. In his view Milo needed brain surgery, being an artery bypass graft. Milo's surgery was booked for 2 November 2018 at POWH.

Unfortunately, as described below, the surgery did not proceed as planned.

Milo's arrest and incarceration

At around this time Milo was sharing an apartment in North Bondi with a flat mate. On 26 August 2018 a fight broke out between visitors to the apartment. Milo became involved and exchanged blows with one of the visitors, Jordan Byrne. During this fight, it is alleged that Milo took a knife from the kitchen and stabbed Jordan Byrne in the stomach. Jordan Byrne died in hospital soon afterwards.

Milo was arrested and taken to Waverley Police Station, where he was charged with the murder of Jordan Byrne. The following day he was refused bail at Central Local Court and was taken to Parklea Correctional Centre. When Milo went into custody, he was assessed by nurses employed by the Justice Health and Forensic Mental Health Network [the JH Network]. Milo disclosed his diagnoses of anxiety and occluded MCA, and that he had surgery booked for November that year. Because of his history of confusion, loss of consciousness and headaches, JH Network staff recommended that he be placed in a two-out cell until *'cleared by* a *GP'.*

In the meantime, POWH had cancelled Milo's 2 November operation. This was probably because a letter asking Milo to confirm the booking was not seen by him before he went into custody on 26 August 2018. Milo's mother Catherine made enquiries with Dr Stoodley's rooms. She was able to establish that the surgery could still proceed at POWH even though Milo was in custody, but that a new date would need to be scheduled. Milo's surgery eventually proceeded at POWH on 22 February 2019. It was as a result of this surgery that Milo's fatal lymphoma was discovered.

I turn now to consider the issues examined at the inquest.

Whether the symptoms experienced by Milo in custody ought to have led to an earlier diagnosis of lymphoma

Milo's lymphoma was formally diagnosed on 7 March 2019, while he was recovering in hospital. A CT scan revealed swollen lymph nodes above and below Milo's diaphragm. These were strongly suspicious for lymphoma, a diagnosis which was confirmed soon afterwards with a biopsy. In Milo's preceding six months in custody, he had experienced a range of physical symptoms and had many interactions with JH Network staff. Catherine and Jacqueline Archer believe that Milo's concerns for his health were not taken seriously by prison health staff. They are distressed by the possibility that with better attention to his health, his lymphoma might have been diagnosed and treated at an earlier stage. They ask if this might have prevented his death at such an early age.

Related to this concern, it is the family's contention that while he was in custody Milo *'received absolutely no case management support in relation to his cerebrovascular condition or anxiety, contrary to Justice Health policy*'. In addressing these issues, I will first examine the adequacy of health care which Milo received for his known conditions of anxiety and occluded MCA. I will then turn to the question of whether, as a result of their interactions with Milo, JH Network staff ought to have ordered further investigations into the possibility of lymphoma.

Was the treatment Milo received for anxiety adequate?

When Milo entered custody, he underwent a Reception Screening Assessment. This included an assessment performed by a mental health nurse on 30 August 2018.

The mental health assessment identified that Milo had suffered anxiety for some time and was using prescribed medication for it. According to JH Network records, his score for depression was relatively mild and he stated that he had no thoughts of self-harm or suicide. Following this assessment Milo's prescribed medication of metropolol was continued. On 1 November 2018, during a medical review with visiting GP Dr Chew, this was changed to propranolol, as itwas considered that metropolol was contributing to a low heart rate. Milo received a psychological welfare check on 7 September 2018, in which he denied thoughts of self-harm and said that he was getting on with other inmates. The author noted that he appeared to be *'coping well'.* In a medical review on 8 November 2018, visiting General Practitioner Dr Tony Chew noted that Milo was experiencing anxiety, and he referred him for counselling to a mental health nurse.

Psychologist Theis Dencker reviewed Milo on 18 December 2018. According to Mr Dencker's notes Milo's mood was angry and frustrated, but he reported no thoughts of harming himself or others. Mr Dencker noted that Milo's diagnosis of anxiety was *'to be explored further in next session'.* There is no record of further mental health reviews before Milo's admission to POWH for his surgery, and the subsequent discovery of lymphoma.

Milo's family has submitted that at the commencement of his incarceration Milo ought to have been placed on a waitlist to see a doctor, psychologist and/or psychiatrist for his condition of anxiety. They submit further that he ought to have received *'an ongoing course of treatment'* for his anxiety. I note that the relevant JH Network policy, Policy 1.225, mandates a waitlist entry only when further management of an inmate's condition is required. Based on Milo's initial mental health assessment, there is no evidence that further management was warranted at that time, other than those actions which were taken: namely, continuation of appropriate medication and placement in a 'two out' cell. I accept as correct the submission on behalf of the JH Network, that prior to entering custody there is no evidence Milo had engaged in psychological therapy or other forms of counselling for the management of his anxiety.

Further as regards the submission that Milo ought to have received ongoing treatment, there is no evidence that Milo reported symptoms of anxiety again until his consultation with Dr Tony Chew on 8 November 2018. This led to Milo's review with psychologist Mr Daneker on 18 December 2018. Based on Mr Dencker's notation, it does appear that further appointments were intended to explore Milo's anxiety. It is reasonable to assume that this plan was disrupted by Milo's admission for surgery in February 2019, and the subsequent discovery of his lymphoma. I have concluded that there is no evidence that Milo's mental health care while in custody was inadequate or inappropriate.

Was the treatment Milo received for his occluded MCA adequate?

A similar criticism is made by the family that Milo did not receive appropriate health care for his condition of occluded MCA.

Two areas of deficiency were identified: that Milo did not receive active ongoing care for this condition; and secondly the length of time which elapsed before he was able to see a specialist neurosurgeon.

The first area of criticism presupposes that Milo's condition of occluded MCA required active investigation and treatment, in addition to the regular monitoring which he received and of course the surgery recommended for him by Dr Stoodley.

Yet on a careful review of the evidence I can find no basis for this claim. As regards *ongoing* management of Milo's condition, Dr Stoodley's evidence was that no particular treatment was required. He stated further that while Milo awaited surgery there would not have been any need for a neurosurgical review unless he developed new symptoms. The question of whether the general medical care and attention which Milo received was adequate is considered later in these findings. Specifically, as regards his condition of occluded MCA however, there is no evidence that JH Network staff failed to manage this condition or failed to provide Milo with any ongoing medical investigation or treatment that was indicated for it.

The delay in obtaining a neurosurgical appointment

The second area for examination was the length of time it took for Milo to receive a neurosurgical review of his condition. There is no doubt that Milo required surgery for his occluded MCA. This was known to JH Network staff from the outset of his incarceration. Yet he was not able to see a neurosurgeon until 18 February 2019, almost six months after his entry into custody.

JH Network records show that on 20 September 2018 a referral was made for Milo to see a neurosurgeon. On that date Milo was reviewed by Dr Eric Hinder, a Senior Career Medical Officer employed by the JH Network. Milo had requested to see a doctor two days previously as he had been feeling dizzy and light-headed. Dr Hinder was aware from Milo's file that he had a condition of occluded MCA, and he wished to assess his symptoms and arrange further care if needed. After carrying out a limited examination, Dr Hinder made a referral for Milo to see a neurosurgeon at POWH. He also made what is called a 'Medical Hold' application, to ensure that Milo remained at a prison which had 24-hour nursing cover.

Dr Hinder gave Milo's specialist referral a priority rating of 'semi urgent'. According to the *PAS Waiting List Priority Level Protocol* current at that time, this meant that Milo's condition *'required attention within 3 to 14 days'.* At the inquest Dr Hinder was asked if he was aware that in fact Milo did not see a neurosurgeon until some five months later.

With some candour, Dr Hinder replied that while 3-14 days might be *'the official version' ,* custodial health care did not work that way. In his experience it was most unlikely that Milo would receive a specialist appointment within 14 days, owing to the limited availability of specialist appointments and CSNSW escort teams. Priority would always have to be given to inmates suffering emergencies or who had fixed appointments such as chemotherapy. In Milo's case Dr Hinder wanted him to be seen within three months 'as *the outer limit',* and preferably sooner.

Milo was reviewed by another visiting GP, Dr Tony Chew, on 23 October 2018. He had again been suffering dizzy spells. Dr Chew conducted a basic neurological examination and recorded that Milo showed *'no significant abnormal findings'.*

However, he noted that Milo had still not seen a Neurosurgeon. Dr Chew wrote a new referral, this time giving it an 'urgent' priority. According to JH Network policy this meant that Milo's condition *'required attention within one to three days',* but Dr Chew said he did not know whether this was likely to eventuate or not.

Throughout October and November 2018 Milo continued to experience dizziness, light headedness and numbness of the hands. Dr Chew saw Milo on two more occasions, on 1 November and 8 November 2018. On both occasions this was because a nurse had asked him to review Milo. On 1 November Dr Chew documented that Milo was *'asymptomatic',* despite Milo having reported *'several episodes of light headedness'* to a nurse only twenty minutes earlier.

On review a week later Dr Chew again recorded that Milo had no specific complaints. JH Network records show that a consultation with a neurosurgeon was booked for Milo on 10 December 2018, but it was cancelled. This was apparently because the specialist was not available that day. Milo's specialist review finally took place on 18 February 2019. This was in order to prepare for his surgery, which had been booked for 22 February 2019.

It can be seen from the above that once Milo entered custody it took several months to obtain a specialist review for his occluded MCA. This was despite referrals having been made on a semi-urgent and an urgent basis. In the opinion of Dr Roche, this delay was not unreasonable. In his first report Dr Roche commented that while the delay in Milo's case was not optimal, nevertheless there were often *'significant delays of many weeks and often some months'* for patients in the community to secure a neurosurgical appointment.

In his submissions on behalf of the family, Mr Bernhaut urged me to discount Dr Roche's opinion on this point. However, the evidence is such that I am unable to do so. A/Professor Roche's expert opinion on this point generally accords with that of Dr Stoodley, who noted in his statement that there is *'often* a *delay of more than* a *year'* for a patient in the community to undergo this kind of neurosurgery. I also accept the submission on behalf of the JH Network that the delay ought not to be attributed to the JH Network, since Milo's referral was for an appointment with an external specialist. The timing or availability of such an appointment was thus outside the control of the JH Network.

Nevertheless, Mr Bernhaut's submission that the court would be *'concerned'* about this situation is correct. In inquests into deaths in custody, this court regularly hears evidence that prison waitlist timeframes are unable to be complied with. Since the timeframes are considered to be those that are clinically appropriate, non-compliance with them carries the clear risk that inmates' health is put at risk. For this reason, and notwithstanding the opposition of the JH Network, there is a case for adopting the recommendation proposed by Milo's family, that the JH Network introduce a mechanism to enable staff to identify those inmate patients who have not received their appointment within the timeframe contemplated under the PAS Waiting List Priority Level Protocol.

As submitted by Counsel Assisting, this could prompt staff to take follow up action if appropriate, such as seeking appointments with an alternative clinic, or at the least scheduling a review of the inmate's condition to monitor for a change in condition.

This recommendation appears as Recommendation 1.1 at the close of these findings.

Was Milo's general medical and nursing attention adequate?

I now address the submission of Milo's family, that JH staff frequently overlooked his requests for medical help and attention and downplayed the symptoms he reported. This is related to the issue which follows, namely whether with proper regard to Milo's symptoms, JH Network staff would have investigated for the possibility of lymphoma at an earlier stage. While he was in custody Milo kept notes about his health and his interactions with JH Network staff. In these he documented symptoms of mental confusion, difficulty with coordination and balance, nausea, light-headedness, blurred vision, headaches, weakness, hand numbness, fatigue, excessive thirst, and chronic back pain. Late in December 2018 he was also hearing a *'ringing sound'* in his ears. However, the evidence at inquest does not support the claim that Milo did not receive medical attention in relation to these symptoms. Following his transfer to Long Bay Correctional Centre Hospital on 21 September 2018, Milo had regularly scheduled reviews by JH Network nurses.

At these attendances his vital signs were measured and recorded. In addition, he was reviewed by Dr Hinder on one occasion and by Dr Chew on three occasions. On any occasion when an appointment was missed, Milo received a replacement one within a few days. According to the records, on some attendances Milo disclosed to JH Network staff some of the symptoms he listed in his notes. On other occasions it is noted that he voiced *'nil concerns'*. Regarding the latter occasions, there is insufficient evidence to infer, as urged in submissions for the family, that Milo did in fact report symptoms, but JH Network staff failed to record them.

I accept that frequency of health care attendance does not of itself amount to quality of care. In addition, as I have noted, it is not satisfactory that Milo had to wait a lengthy period to secure a neurosurgical review. This aside however, the evidence does not support the contention that Milo had significant difficulty obtaining access to ongoing health care while he was in custody. Furthermore, there is no evidence that his symptoms escalated over this period. It was not unreasonable for his treating nurses and doctors to conclude that his condition was fairly stable.

This leads me to the specific concern of Milo's family that the nature of his symptoms ought to have triggered further medical investigations which may have led to an earlier diagnosis of lymphoma.

The discovery of lymphoma and treatment for it

On 22 February 2018 Milo was transported to POWH to undergo surgery for his occluded MCA, which Dr Stoodley performed. In the days following his surgery Milo suffered high fevers. On 24 February 2019 he underwent a chest x-ray which revealed enlarged lymph nodes. A follow up CT scan two days later showed swollen and enlarged lymph nodes above and below Milo's diaphragm. These, together with Milo's fevers and general feeling of weakness, were suspicious for lymphoma. Then followed a series of tests to confirm the diagnosis of lymphoma and to ascertain its spread.

A CT-guided biopsy was performed on 7 March 2019, which confirmed that Milo had anaplastic T-cell large celllymphoma.

The following day, a PET scan showed that the disease had infiltrated Milo's bone marrow and spleen, indicating stage IV disease.

Specialist haematologist Dr Carol Cheung supervised Milo's treatment program. Milo had a consultation with her on 15 March 2019, and four days later he commenced the standard treatment for this type of lymphoma. This was a multi agent form of chemotherapy known as 'CHOP', consisting of the drugs cyclophosphamide, doxorubicin, vincristine and prednisolone.

It was expected that Milo would need eight cycles of CHOP chemotherapy at three weekly intervals, with the possibility of radiotherapy to follow. Dr Cheung considered that even with this course of treatment, Milo's overall prognosis was *'rather guarded'* due to the advanced nature of hisdisease.

Milo's first two cycles took place on 19 March and 8 April 2019. They were delivered at POWH, with Milo returning to Long Bay Hospital after each one. During this period Milo suffered fevers and back pain. By late April 2019 he was in a high degree of pain and was too feverish to have his third cycle of chemotherapy. Milo's treating team suspected that his fevers were probably due to disease progression. A follow up PET scan on 2 May 2019 brought very bad news. Although some affected areas showed a small improvement, Milo had developed new lesions on his brain, with progression of the lymphoma cells into his cerebrospinal fluid. In a report dated 6 May 2019 Dr Cheung stated that:

'[G]enerally speaking, aggressive lymphomas that have secondarily spread into the central nervous system are not curable. The best achievable outcome would be to provide control of the disease such that the patient is *relatively symptom-free for* a *short period of weeks to months.'*

Sadly, Milo's disease did not permit him *even* a short period of respite. On 6 May 2019 he was transferred to POWH's haematology unit where a replacement form of chemotherapy was attempted. By this time however Milo was extremely unwell, and on 11 May 2019 he entered palliative care. He died on the night of 16 May2019.

Milo's family has acknowledged that overall, his treatment for lymphoma proceeded in a timely manner. They expressed their gratitude to the oncology/haematology staff at POWH for their attempts to slow the course of his illness.

Should Milo's symptoms have led to earlier investigations?

Milo's family has submitted that, having regard to his symptoms while he was in custody, a competent doctor would have been expected to order further investigations for the possibilityof lymphoma. However, the consensus of medical opinion at the inquest was that Milo's symptoms would not have given rise to a suspicion of lymphoma, in particular as the lymphoma was unlikely to *have* spread to his central nervous system at that stage.

In his report, oncologist Dr Fox summarised his opinion as follows: *'in retrospect [the lymphoma] could have been diagnosed earlier but there were no specific symptoms relating to lymphoma at the time'* . He stated that the first sign of lymphoma is commonly the discovery of an enlarged lymph node, which in Milo's case occurred in late February 2019.

In his evidence Dr Fox explained that it would have been difficult to attribute any of Milo's symptoms to the lymphoma's development. Dr Cheung and Dr Roche concurred. According to Dr Cheung in her oral evidence, some of Milo's symptoms, such as numbness and excessive thirst, were not at all associated with lymphoma. Others that were associated with lymphoma, namely fatigue, lack of energy and nausea, were non-specific and were associated with other conditions as well.

In Dr Fox's opinion, *even* Milo's back pain was unlikely to *have* been due to developing lymphoma, as the lymph nodes shown on his 26 February 2019 scan would not have been large enough to create pain in this area.

Furthermore, diagnosing Milo's lymphoma would have been complicated by the existence of an unrelated serious condition, being his occluded MCA. According to Dr Stoodley, certain of Milo's symptoms, such as his dizziness, light-headedness and cognitive disturbance would have been readily attributed to this condition. Dr Roche agreed, emphasising that visiting General Practitioners were not specialist oncologists or haematologists. In his opinion, *'most competent doctors'* would have considered that Milo's symptoms of dizziness, light-headedness, forgetfulness and nausea were consistent with his known condition of occluded MCA.

Mr Bernhaut's submissions on behalf of the family took issue with Dr Roche's opinion on this point. Mr Bernhaut noted Dr Stoodley's evidence that he would not normally expect symptoms of excessive thirst, nausea and hypotension to be caused by an occluded MCA. This, Mr Bernhaut maintained, was knowledge which *' would not be beyond the capacity of* a *reasonably well trained and competent GP'.*

Mr. Bernhaut did not rely upon any expert evidence to support his assertion that the average competent GP would have undertaken further investigations if faced with a patient reporting the above symptoms, in circumstances where the patient was known to suffer an occluded MCA. Dr Roche on the other hand is a clinician with many years' experience working as a General Practitioner and teacher. Moreover, his opinion on this point is in general supported by that of Dr Fox, who stated that at the time, Milo was not exhibiting specific symptoms relating to lymphoma, and by Dr Cheung whose opinion was that most of Milo's symptoms were either not associated with lymphoma or were of a non-specific nature.

The weight of the evidence therefore supports the conclusion that there was no failure on the part of JH Network staff in not undertaking further investigations of Milo's symptoms. Unfortunately, his symptoms did not provide a sufficient clinical indication to investigate for the possibility of lymphoma.

Whether an earlier diagnosis of lymphoma would have resulted in a better outcome for Milo

This was a question of great importance for Milo's family. When Milo's lymphoma was diagnosed in late February 2019 it was at an advanced stage. Had earlier investigations taken place would these have detected the lymphoma, thus giving him a longer period to live? Neither Dr Cheung nor Dr Fox was able to give a definitive answer to this question. However, Dr Cheung thought it likely that Milo's lymphoma had developed within a short time frame, probably within weeks rather than months. She based this on the lymphoma's rapid rate of growth during the period she had been involved in his care. Despite the introduction of chemotherapy in March 2019, the lymphoma continued to spread.

This indicated to her that prior to receiving the retarding effect of chemotherapy, the lymphoma was likely to have been growing at an even faster rate.

In his report Dr Fox noted that central nervous system lymphoma is very aggressive and does not respond well to chemotherapy or radiotherapy. Once brain involvement had occurred, patients generally had only a couple of months to live. For this reason: '... *earlier diagnosis and hence earlier treatment of [Milo's] CNS disease would not have made* a *significant difference'.* The expert evidence supports a finding on the balance of probabilities, that earlier diagnosis and treatment would not have made a difference to Milo's prospects for survival, due to the very aggressive nature of his lymphoma.

Whether Milo's status as a prisoner reduced his chance for survival

In Dr Cheung's opinion, once Milo's lymphoma was diagnosed his treatment was delivered in a timely manner. Although there was a delay of seven days between the ordering of his CT-guided biopsy on 28 February 2019 and its performance on 7 March 2019, this was related to *'insufficient hospital resources'* and was not attributable to Milo's status as a prisoner.

Dr Roche concurred, stating in his report that the commencement of Milo's chemotherapy was *'timely, as compared to my experience with non-custodial patients who have* a *new diagnosis of malignancy'.* Dr Fox agreed, commenting in his evidence that the period between Milo's diagnosis and treatment was *'pretty fast',* and that patients in the community not uncommonly had to wait longer. The evidence supports the conclusion that Milo's status as a prisoner did not compromise his chances for survival. While there were constraints and delays in obtaining medical reviews, the evidence is that these were not significantly different to those which affected patients in thecommunity.

Was the use of restraints in hospital appropriate?

It is important to note that Corrective Services policies do make room for compassion in the treatment of very ill inmates. Clause 2.6 of the above Protocol provides that cuffs may be removed from inmates *'who are severely incapacitated'.*

In addition, Custodial Operations Policy and Procedures [COPP] 19.6 applied at the time. It and its current iteration state that a review of an inmate's Escort Assessment must be performed where *'the inmate's condition deteriorates or they become severely incapacitated':* cl 2.5. Relevant to this, at clause 5.2 of the COPP it isrecognised:

- that an inmate's risk level may decrease due to deterioration in the inmate's health, in which case the requirement for restraints *'should be reviewed';* and
- where an inmate is receiving end of life care, security arrangements *'canbe reviewed'.*

It is appropriate that policies of Corrective Services NSW [CSNSW] allow for a compassionate response where inmates are severely ill. However, in Milo's case the evidence revealed two issues in the practical implementation of these policies, which warrant further examination by CSNSW.

The first is that there were clearly periods when Milo's condition significantly deteriorated, for example on 25 February 2019, 13 March 2019 and again on 18 March 2019. Despite this, no revision of his security arrangements resulted in the removal of his restraints. This did not occur until Milo was receiving end of life medical treatment, some two months later.

At the inquest Mr Jason Hodges, who is the Governor of Long Bay Hospital Correctional Centre, described attending Milo in hospital on 10 May 2019, in company with the Manager of Security, Mr Adam Riddell. Following this, Mr Hodges gave a verbal direction that Milo's hand and ankle cuffs were to be removed. In addition, Milo was to be permitted extended visiting hours and phone calls from family members. Ms Jacqueline Archer recalled that after this date Milo was no longershackled to his bed.

Yet it is clear from clauses 2.5 and 5.2 of COPP 19.6 that review of an inmate's security arrangements is not restricted to end of life circumstances. A review is to occur when the inmate's condition deteriorates, or they become severely incapacitated. The intent is surely to address those cases where an inmate, although not at end of life stage, is nevertheless so unwell that their risk level does not warrant restraint.

The second area concerns the question of how a review of an inmate's security arrangements is to be initiated. In Milo's case the evidence indicated that the review took place only after Catherine Archer had made numerous requests for her son's conditions to be eased. There is no evidence that it was initiated by his treating doctors or his correctional escort officers (known as medical escort officers).

The court heard evidence on this issue from Mr Hodges and from two correctional officers who had guarded Milo while he was in hospital, Officers Luke Domenici, and Christine Curtois.

At the inquest Mr Hodges described his understanding of how a review of security arrangements was initiated:

> *'Generally,* a *treating doctor will contact* a *senior officer to advise that the end of life stage has been entered. The officer wi/1 escalate it through their chain of command. It will then be* assessed *by the Governor or delegated person.'*

Officer Domenici's evidence also reflected an understanding that it was the inmate's doctor who took the first step. He told the court that when an inmate was *' terminally ill',* his or her doctor could speak with the medical escort officers, to request that hand and ankle cuffs be removed. The officer should then escalate this request to the prison's Manager of Security, who would perform a security risk review.

It makes sense for an inmate's treating doctors to take the first step in initiating a review of security arrangements. They are best placed to identify that there has been a clinical deterioration justifying the review. However, a difficulty with this model is that COPP 19.6 does not govern the conduct of medical practitioners.

Furthermore, implementing the policy on this basis relies on medical practitioners being aware of the role they are expected to play under the policy. In Milo's case the evidence did not disclose an effective way by which hospital staff were made aware of this. In contrast to Mr Hodges and Officer Domenici, Officer Curtois's experience was that the first step was usually taken by individual medical escort officers, who would themselves identify that an inmate patient's condition was deteriorating, and who would escalate this to the Manager of Security.

But this approach also has potential problems. Unless there is a continuity of officers making up the medical escort, they may not be in a position to identify that an inmate's condition hasworsened.

Thus, the evidence at inquest identified practical issues in the implementation of COPP 19.6 and the Protocol. Counsel Assisting proposed a recommendation, supported by Milo's family, designed to ensure that hospital staff are aware of their role in instigating a review of a patient's security arrangements where appropriate. In my view this awareness is a key element in ensuring that the policy's provisions for compassionate treatment work effectively. The proposal appears below as Recommendation 2.2.

The evidence described above also identified inconsistencies in correctional officers' understanding of the circumstances in which a review of security arrangements is required under the policy.

At the inquest the Manager of Security at Brush Farm Corrective Services Academy, Robert Skimmings, told the court that all new recruits receive face to face training in relation to medical escort functions. Mr Skimmings stated further that supplementary training was available via online modules, but it was not mandatory even for officers who perform this work regularly.

Mr Skimmings also advised that a specialist medical escort unit had been formed, to perform much of the work of escorting metropolitan inmates to and from hospital and performing guard duties at hospital. Mr Skimmings agreed that it would be of benefit for officers within the specialist unit to mandatorily undertake specific training in performing medical escort and hospital guard duties. I accept the submission of Counsel Assisting and Mr Bernhaut, that it would be appropriate for officers who regularly perform medical escort duties to undertake mandatory training in those duties. I note this recommendation is not opposed by CSNSW. It appears as Recommendation 2.1.

The conduct of medical escort officers

Catherine and Jacqueline Archer raised a further issue which, although not contributing to the cause of Milo's death, nevertheless increased the family's emotional distress at this very sad time. This was the treatment they said they had received at times by Milo's medical escort officers at POWH.

Thebehaviour includedofficers:

- talking loudly when Milo was trying to rest; despite him asking them to be quieter
- not providing him with items such as warm clothing and an air mattress (which was ultimately provided)
- not allowing him to have a bedside phone, which required him to walk to the phone in the hallway and to stand while he used it
- generally being discourteous to Milo and Catherine.

Catherine and Jacqueline Archer were not able to identify the individuals who behaved in this manner, due to the medical escort officers not wearing name badges. As a consequence, the officers said to have behaved in this manner have not been identified and have not had the opportunity to address these allegations in court.

Thus, I make no adverse findings against individuals regarding these allegations. However, I consider it is appropriate to adopt the amendment to COPP 19.6 proposed in submissions on behalf of the family and supported by Counsel Assisting. This is that medical escort officers wear departmental name badges when guarding inmates. I note that CSNSW does not oppose this recommendation. It appearsas Recommendation 2.3. I observe that this is not the first time the court has heard evidence from families as to the conduct of medical escort officers. Similar concerns were raised by the family in the *Inquest into the death of John Laurenson* (Findings 31 March 2021, Deputy State Coroner Ryan). At that inquest the court heard evidence from Mr Terence Murrell, General Manager of Corrective Services' Statewide Operations, that the Protocol requires medical escort officers to behave courteously and respectfully towards inmate patients and their families.

Mr Murrell told the court further, that the relevant policies had been referred for review, to include consideration of whether further training of officers in this area was required. I am not aware whether, since the date of those findings, that review has been undertaken. I will make a specific recommendation regarding the training which officers receive as to their conduct, in circumstances where they regularly perform medical escort duties. This recommendation is incorporated within Recommendation 2.1.

Findings required by s81 (1) of the *Coroners Act 2009*

Identity

The person who died is Milo Wild.

Date of death

Milo Wild died on 16 May 2019.

Place of death

Milo Wild died in the Intensive Care Unit at Prince of Wales Hospital, Randwick NSW.

Cause of death

Milo Wild died as a result of complications of anaplastic large cell lymphoma with central nervous system involvement.

Manner of death

Milo Wild died of natural causes while he was an inmate of Long Bay Correctional Centre.

Recommendations pursuant to section 82 of the *Coroners Act 2009*

<u>Recommendations to the CEO. Justice Health and Forensic Mental Health Network</u>

That the Justice Health and Forensic Mental Health Network consider introducing a form of alert or reminder to be built into the JHeHS or PAS system in order to alert the Medical Appointments Unit and clinical staff, where an inmate patient has been referred for specialist review,

But has not seen within the time frame contemplated under the relevant clinical priority category within the PAS Waiting List Priority Level Protocol. That the Justice Health and Forensic Mental Health Network consider amending the 'Health Assessments in male and female adult correctional centre and police cells policy' [Policy 1.225] to provide that a request for release of information [ROI] must be submitted to an inmate's known external healthcare provider(s) within 72 hours of the completion of the Reception Screening Assessment.

Recommendations to the Assistant Commissioner, Corrective Services NSW:

1. That Corrective Services NSW consider introducing, in the case of correctional officers who perform medical escort duties, mandatory training regarding the content of the Custodial Operations Policy and Procedures 19.6 and the 'Protocol for guarding inmate patients' prior to commencing such duties, with particular focus on:

- *the use of restraints for inmatepatients*
- *risk assessments in circumstances where there is a change in the inmate patient's condition*
- *the role of treating medical practitioners in suggesting a review of security arrangements in respect of an inmate patient's Escort Assessment*
- *conduct of escorting officers.*

That Corrective Services NSW consider providing an information sheet to all hospitals to which inmates are admitted as patients, which summarises the circumstances in which an inmate patient's treating medical practitioners may suggest a *review of security arrangements in respect of the inmate patient's Escort Assessment.*

That ***CSNSW*** *consider amending the Custodial Operations Policy and Procedures 19.6 to provide that correctional officers performing medical escort duties must wear* a *departmental name badge at all times while onduty.*

24. 181202 of 2019

Inquest into the death of Robert Maxfield. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 9th March 2021.

On the morning of 10 June 2019 Robert Maxfield aged 45 years was found unresponsive, lying on his bed in the cell which he shared with another inmate at Cooma Correctional Centre. Mr Maxfield had been an inmate there since 24 March 2019. He would have been eligible for release on 27 February 2020. Since Mr Maxfield was in lawful custody at the time of his death, an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

The post mortem report

An autopsy examination was performed by forensic pathologist Dr Johan Duflou. Dr Duflou did not find any significant injuries, but did locate healed scars on Mr Maxfield's arms, suggestive of prior self-harm. Toxicological analysis of Mr Maxfield's blood detected methadone, at a level which in Dr Duflou's opinion might be expected to cause death from respiratory depression. Further testing indicated that Mr Maxfield had likely been ingesting methadone for at least one and a half months prior to his death. Dr Duflou also found the presence of the antidepressant mirtazapine at a level that was capable of causing somnolence as a side effect. Dr Duflou found the cause of Mr Maxfield's death to be multiple drugtoxicity, with methadone likely to have been the drug with the predominant adverse effect.

Mr. Maxfield's life

Robert Maxfield was born on 20 June 1973. He had a long de facto relationship with Veronique Kovacovic which was still current at the time of his death. The couple had three children Nathan, Jason and Jeremy. Mr Maxfield worked casually as a concreter. Mr Maxfield struggled with dependence on illicit drugs. He attempted rehabilitation and had participated in the methadone program.

Mr. Maxfield's medical history

Mr Maxfield had a medical history of gastro-oesophageal reflux disease and he had a single kidney. He had also been diagnosed with schizophrenia and depression for which he used the prescription drugs olanzapine and mirtazapine.

From March 2019 Mr Maxfield was incarcerated at Cooma Correctional Centre where he was classified as minimum security and shared a cell with another inmate. While he was in custody Mr Maxfield received his prescribed medications in a monthly pack for him to self-administer. The last pack he received before his death was on 29 May 2019.

Between January 2019 and May 2019 Mr Maxfield had regular reviews of his blood pressure, pulse, temperature and weight. The results were all within the normal range. He underwent a psychiatric review via telehealth on 8 May 2019. In the opinion of the psychiatrist he did not display suicidal thoughts, and his dosage of olanzapine was reduced. There was a plan to review his mirtazapine dose in the future.

The events of 9 and 10 June 2019

Mr Maxfield's activities on the day and evening of 9 June 2019 were not unusual for him. He took some exercise and played cards with fellow inmates. At about 3.20pm he and his cell mate went into their cell for the afternoon and evening. According to his cell mate, Mr Maxfield lay on his bunk, which was the bottom bunk, and watched TV.

A heavy snorer, Mr Maxfield dozed until 7.30pm when his cell mate asked him if he was awake. Mr Maxfield responded with a moaning sound, then returned to loud snoring. The cell mate went to sleep at about 8.30pm. Although he awoke at times throughout the night he did not hear Mr Maxfield snoring.

A head check was conducted at approximately 8.05am the next morning. Correctional officers found Mr Maxfield lying on his bunk, with his legs over the side of the bed. He was cold to the touch and did not respond to their efforts to rouse him. Correctional officers commenced first aid and CPR, which was continued by ambulance officers when they arrived at 8.16am. However, Mr Maxfield could not be revived, and he was pronounced deceased at 8.26am.

What was the source of the methadone?

I have noted that the cause of Mr Maxfield's death was found to be multidrug toxicity, with methadone detected in his post mortem blood at relatively high concentrations.

In Australia methadone may only be legally sourced through a treatment program. It is usually administered as a treatment substitute for heroin and other opioids. There is such a program for inmates within Cooma Correctional Centre; however, at the time of his death Mr Maxfield was not an authorised participant. It must be assumed that Mr Maxfield ingested the methadone as a result of having obtained it without authorisation. The methadone may have been brought into the Correctional Centre covertly, or he may have obtained it from within the Centre. Mr Maxfield was known by other inmates to ingest illicit drugs when he could obtain them.

Since Mr Maxfield had not received any visitors while he was at Cooma Correctional Centre, he could not have obtained the methadone directly from any visiting members of the public.

It is possible he received it indirectly by these means, for example from an inmate who had obtained it as a result of a visit. It is also possible of course that he obtained it unlawfully from Correctional Centre staff.

The other possibility is that he obtained it from a participant in the Correctional Centre's methadone treatment program. The prison takes measures to reduce the opportunity for participants to divert their authorised dose to other inmates. The participant is directed to swallow his or her liquid dose under the supervision of Justice Health staff. The inmate is then given a drink of water and directed to swallow it, then to speak their MIN number or open their mouth. This process is observed by correctional officers.

Despite this, there is evidence that methadone diversion continues to occur. Inmates may manage to avoid swallowing their dose; alternatively, the dose may be regurgitated and provided to another inmate for payment. The evidence does not allow me to conclude exactly how it was that Mr Maxfield obtained access to the methadone detected in his post mortem blood.

It was encouraging to hear evidence that Justice Health has trialled a new practice for its opioid treatment program. It involves the use of the opioid buprenorphine in place of methadone. Buprenorphine is delivered to the inmate via a monthly subcutaneous injection. It is expected this procedure will reduce the prevalence of opioid diversion. I have noted that the antidepressant mirtazapine was also found in Mr Maxfield's post mortem blood, at a higher than expected level. Mr Maxfield's prescribed doses of mirtazapine were delivered to him in his monthly medication pack. An audit of his medication pack revealed that had he been dosing at the prescribed level, there ought still to have been 16 mirtazapine tablets remaining in his pack at the time he died. These were not located in Mr Maxfield's cell. It is not possible on the evidence to conclude what exactly Mr Maxfield had been doing with his mirtazapine medication. Given the levels in his post mortem blood, it appears likely he was exceeding his prescribed amount.

Conclusion

The time, place and cause of Mr. Maxfield death are able to be established on the evidence. As to the manner of his death, there in insufficient evidence that he ingested the methadone and mirtazapine with the intention of ending his own life. There is no evidence that deficiency or inaction on the part of CSNSW or JH contributed to Mr. Maxfield's death. Steps are taken by both agencies to reduce the harmful practice of medication diversion among inmates. While more stringent measures might be possible, these may have the effect of discouraging participation in important opioid treatment programs, as well as adversely affecting the day to day life of inmates. Similar considerations apply to steps which might be taken to reduce the incidence of visitors to the prison who might attempt to introduce contraband items. For these reasons I do not see any basis for making recommendations in this inquest.

Findings required by s81 (1)

Identity
The person who died is Robert Maxfield.

Date of death:
Robert Maxfield died between the dates of 9 and 10 June 2019.

Place of death:
Robert Maxfield died at Cooma Correctional Centre,

Cause of death:
The cause of Robert Maxfield's death is multiple drug toxicity.

Manner of death:
Robert Maxfield died as a result of an accidental drug overdose, while he was in lawful custody at Cooma Correctional Centre.

25. 308628 of 2019

Inquest into the death of Conway Perrie. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 18th November 2021.

At the time of his death, Conway Perrie was 75 years old and in lawful custody at Long Bay Correctional Complex, serving a sentence of imprisonment. Mr Perrie had a history of chronic kidney disease, which had progressed to an advanced age at the time of his death, together with a number of other significant medical conditions.

After attending a routine medical appointment at hospital on 1 October 2019 Mr Perrie was returned to his usual accommodation at Long Bay, and later went to sleep that night. The following morning, Mr Perrie was found to be unresponsive in bed, with no signs of life. Despite emergency services being contacted and resuscitation efforts being initiated, Mr Perrie sadly could not be revived and was subsequently pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Perrie was not appropriately cared for and treated whilst in custody.

Mr. Perrie's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life.

Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr Perrie's personal history prior to his incarceration. Mr Perrie was born in January 1944 to his parents, James and Eileen, who had previously emigrated from Ireland to Australia. Mr Perrie had three brothers and three sisters and was raised in the Liverpool area in Sydney. Mr Perrie married in 1961 and had two children. For a time, Mr Perrie worked as a truck driver and on the railways. After approximately 12 years Mr Perrie's marriage ended, and he later formed a long-term defacto relationship with Lynette Towers. Mr Perrie and Ms Towers had a child together, and Ms Towers remained in regular contact with Mr Perrie during his time in custody.

There is no doubt that Mr Perrie was, and still is, loved by Ms Towers, who has been greatly affected by Mr Perrie's passing and feels his loss most deeply. There is equally no doubt that Mr Perrie is greatly missed by his loved ones and those who knew him best.

Mr. Perrie's custodial history

On 31 May 2018 Mr Perrie entered the custody of Corrective Services New South Wales (**CSNSW**) after being charged with a number of sexual assault offences alleged to have occurred between 2003 and 2014. After being remanded in custody, Mr Perrie was later convicted of a number of these offences.

On 16 July 2018, Mr Perrie was sentenced to an aggregate sentence of 11 years imprisonment commencing on 29 May 2018 with an overall non-parole period of 7 years and 6months, meaning that the earliest possible date that Mr Perrie could be released from custody was 28 November 2025. Whilst in CSNSW custody, Mr Perrie was housed at Grafton Correctional Centre, Mid North Coast Correctional Centre and the Metropolitan Remand & Reception Centre. On 11 February 2019 Mr Perrie was transferred to the Metropolitan Special Programs Centre (**MSPC**) at Long Bay Correctional Complex, where he remained until his death.

Mr. Perrie's medical history

Mr Perrie had a history of chronic renal disease (stage 4 at the time of death) with congestive cardiac failure, hypertension, bilateral carotid artery stenosis, type 2 diabetes mellitus, previous cerebrovascular accident (in 1986), gout and squamous cell carcinoma of the skin (multiple lesions). According to Justice Health & Forensic Mental Health Network (**Justice Health**) records, Mr Perrie attended a number of consultations with nursing and medical staff between June 2018 and February 2019 where his multiple chronic health conditions were discussed and treatment provided.

Between February 2019 and October 2019, following Mr Perrie's transfer to the MSPC, he also attended a number of scheduled appointments at Prince of Wales Hospital (**POWH**). Relevantly, Mr Perrie attended the POWH Renal Outpatient Clinic on 12 March 2019 for review of his chronic kidney disease. In August 2019 a recommendation was made for Mr Perrie to be placed within the Kevin Waller Unit, an aged care unit at Long Bay Correctional Complex, due to his age and frailty. However, because of a shortage in available accommodation, Mr Perrie was unable to be placed at this time.

On 28 August 2019 Mr Perrie was transferred to the POWH emergency department following a possible syncopal episode. On review, Mr Perrie was found to be tired, but reported no preceding chest pain, shortness of breath or palpitations. An examination was conducted, which was found to be unremarkable, and Mr Perrie was noted to be haemodynamically stable and afebrile. Mr Perrie was subsequently given medication for his blood pressure and discharged, to be followed up by a general practitioner.

What happened on 1 October 2019?

On the morning of 1 October 2019, Mr Perrie was transferred by a CSNSW medical escort unit to the renal department at POWH for management of his chronic kidney disease, arriving at approximately 11:00am. Upon review, no medical concerns were identified. It was noted that recent blood tests indicated stable kidney function, and that potassium bicarbonate, calcium, magnesium and phosphate levels were all within their respective normal reference ranges. Available blood pressure readings also showed optimal blood pressure control. The assessment provided no indication for any urgent repeat blood or urine investigations as no immediate concerns were identified. A number of further tests were arranged with a view to maintaining optimal blood pressure and diabetes control to ensure that the trajectory of Mr Perrie's renal function decline in the coming years was not above greater than what is expected with normal aging. Overall, Mr Perrie's medical health was noted to be stable from a renal perspective, and a subsequent review was to be scheduled in four months' time.

Following his review, Mr Perrie was transferred back to the MSPC. Upon return, at around 12:30pm, the transporting CSNSW medical escort officers discovered that Mr Perrie had vomited in the rear of the escort vehicle. Mr Perrie was offered nursing assistance from available Justice Health staff but declined, indicating that he had vomited due to motion sickness.

The CSNSW medical escort officers placed Mr Perrie in a holding yard and (according to the escort officers) a verbal handover was completed with the reception CSNSW officer, advising that Mr Perrie had vomited in the medical escort vehicle. According to the escort officers, the reception officer made arrangements for two reception sweeper inmates to clean the escort vehicle.

CSNSW inmate telephone service records indicate that Mr Perrie called Ms Towers twice on the afternoon of 1 October 2019, once at 1:00pm and again at 1:54pm. During these phone calls, Mr Perrie advised that he had returned from his scheduled appointment at POWH and reported that he had been told his renal issues and diabetes were "good" and that the cancer behind his ear had "cleared up". Mr Perrie also mentioned that he had vomited during the return journey from POWH, indicating his belief that this had been caused by motion sickness and/or "diesel fumes" from the escort vehicle. Mr Perrie also advised that the escort officers had offered to seek assistance from a Justice Health nurse, but that Mr Perrie had declined this offer. Overall, it is reported that Mr Perrie sounded positive during these phone calls and mentioned his hope of being transferred "up north" (to a different correctional centre) in the near future.

Mr Perrie was later returned to his cell and was accounted for (together with his cellmate) during a muster and head check at around 2:20pm. According to Mr Perrie's cellmate, Mr Perrie recounted his escort to POWH and advised that he had "spewed" in the back of the escort vehicle. Mr Perrie's cellmate also recalls that Mr Perrie had his evening meal and routine medication before going to sleep that evening.

What happened on 2 October 2019?

Mr Perrie's cellmate woke up at around 6:00am on 2 October 2019 and turned on a television in the cell. He noticed that a piece of paper had been removed from the cell door observation hole. Mr Perrie was known to have a practice of placing a piece of paper in the observation hole following lock in and would later remove it at around 4:00am the following morning. Mr Perrie's cellmate observed Mr Perrie to be lying on the bottom bunk of his bunk bed and asked him to get up. However, Mr Perrie did not respond. Mr Perrie's cellmate shook Mr Perrie in an attempt to wake him, without success, and then checked for a pulse. Concerned, Mr Perrie's cellmate informed a "sweeper" who was delivering food to the cell at that time of Mr Perrie's unresponsiveness and was advised to activate the cell call alarm.

At around 6:21am on 2 October 2019 Mr Perrie's cellmate activated the alarm and informed the answering CSNSW officer that Mr Perrie was unresponsive and could not be woken. CSNSW officers attended Mr Perrie's cell at around 6:23am and found Mr Perrie lying on his back on the bottom of his bunk bed, unresponsive. Mr Perrie was carefully removed from the bunk bed and placed on the ground. Cardiopulmonary resuscitation was initiated by the attending CSNSW officers, assistance was sought from Justice Health staff and emergency services were contacted.

Resuscitation efforts continued and NSW Ambulance paramedics later arrived at the scene at around 6:44am. However, despite continued resuscitation efforts, Mr Perrie could not be revived and was pronounced deceased at 6:49am.

What was the cause of Mr. Perrie's death?

Mr Perrie was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 8 October 2019. Post-mortem CT imaging showed three vessel coronary calcification, heavy calcification of the bifurcation of both carotid arteries, old cerebral infarction in the right inferior cerebellar artery territory, with no acute skeletal trauma (other than resuscitation associated rib fractures). Biochemical analysis of serum and vitreous fluid showed a mildly elevated ketone level, elevated urea and creatinine in keeping with chronic renal disease and an elevated C-reactive protein (a protein marker of systemic inflammation, often elevated in individuals with chronic renal disease). Dr Maistry ultimately concluded that the post-mortem examination, available medical records and ancillary investigations indicated the cause of death to be in keeping with the complications of chronic renal disease on a background of hypertension and type 2 diabetes mellitus. It was noted that Mr Perrie's history of cerebrovascular accident, bilateral carotid artery stenosis and atherosclerotic cardiovascular disease were all significant conditions contributing to the death but not relating to the disease or condition causing it.

Conclusions

Having regard to the relevant records from CSNSW and Justice Health regarding Mr Perrie's period in custody, and the findings from the post-mortem examination, it is evident that Mr Perrie had a significant medical history which directly contributed to his death on 1 or 2 October 2019. As to the time of death, it is evident that Mr Perrie went to sleep sometime on the evening of 1 October 2019 and was found unresponsive in the early morning on 2 October 2019. According to Mr Perrie's cellmate, Mr Perrie had a practice of removing the piece of paper which he placed over the cell door observation hole at around 4:00am. Although the piece of paper was found to be removed when Mr Perry's cellmate woke up, there is no direct evidence as to how this occurred. Given that Mr Perry was last confirmed to be alive on the evening of 1 October 2019, and was found unresponsive the following morning, the time of death is best left as being either on 1 or 2 October 2019.

The evidence also indicates some degree of inconsistency between what is reported by the escort officers upon returning to the MSPC on 1 October 2019, and the CSNSW officer who was rostered on reception duties at the MSPC from 6:00am to 6:00pm. In essence, the reception officer has no recollection of receiving a verbal handover from the escort officers, being informed that Mr Perrie had vomited in the escort vehicle, or of arrangements being made for an inmate sweeper, or sweepers, to clean the escort vehicle.

Whilst independent records of the reported verbal handover do not exist, it is most likely that Mr Perry did vomit in the escort vehicle. Further, the evidence also establishes that it is most likely that the escort officers offered Mr Perry nursing assistance from Justice Health staff, but that Mr Perry declined this offer. The accounts provided by the escort officers in this regard are entirely consistent with the account of Mr Perry's cellmate, and the telephone calls that Mr Perry later made to Ms Towers, during which Mr Perry confirmed the vomiting episode and declining the offer of assistance.

Notwithstanding the above, there is no evidence to indicate that the vomiting episode was connected with the cause of Mr Perry's death. Mr Perry himself provided a reasonable explanation of his own of the vomiting being due to motion sickness and/or the diesel fumes from the escort vehicle. As noted above, Mr Perry had chronic renal disease which had progressed to an advanced stage, together with other comorbidities. Relevantly, no correlation was drawn between the vomiting episode and the cause of death by Dr Maistry in the autopsy report. Further, there is also no evidence that even if Mr Perry had accepted the offer of assistance from Justice Health staff that this potential assistance could have materially altered the eventual outcome.

Overall, the available evidence indicates that Mr Perrie was provided with appropriate nursing and medical care, to address and treat his various chronic medical conditions, whilst in custody. Mr Perrie was regularly reviewed by renal specialists at hospital, and appropriate investigations were conducted based upon his clinical presentation. Relevantly, the review conducted on 1 October 2019 identified no issues of medical concern, noting that Mr Perrie's health from a renal perspective was stable, or any issue which could have predicted the subsequent events. There is no evidence to suggest that any aspect of Mr Perrie's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

Findings

Identity: Conway Perrie.

Date of death: Mr Perrie died on 1 or 2 October 2019.

Place of death: Mr Perrie died at the Metropolitan Special Programs Centre, Long Bay Correctional Complex, Matraville NSW 2036.

Cause of death: The cause of Mr Perrie's death was complications of chronic renal disease on a background of hypertension and type II diabetes mellitus, with cerebrovascular accident, bilateral carotid artery stenosis and atherosclerotic cardiovascular disease being significant conditions contributing to the death, but not relating to the disease or condition causing it.

Manner of death: Mr Perrie died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

26. 323357 of 2019

Inquest into the death of Kingsley Eager. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 23 June 2021

This is an inquest into the death of Kingsley Eager. He died on 15 October 2019. At the time of his death he was 80 years of age and he was serving a term of imprisonment at Long Bay Correctional Centre.

The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- the identity of the deceased.
- the date and place of the person's death.
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

Section 23 of the *Coroners Act 2009* makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated to ensure that the care of that person was appropriate and adequate.

Kingsley Eager

Kingsley Eager was born on 14 October 1939 in Geelong, Victoria. He had one sibling, a younger brother. Mr Eager moved to Sydney in 1959 where he began training as a nurse. It was during this time that he met his future wife. They went on to have two daughters and adopted three children.

On 22 December 2016, Mr Eager was arrested and charged with 26 offences. He pleaded guilty to twenty of these offences on 20 April 2018 and he was sentenced at the Newcastle District Court on 6 August 2018. He was sentenced to a term of imprisonment of nine years and three months. His earliest release date was to be 5 February 2023, and his latest release date was to be 5 November 2027.

Mr Eager was received into custody at Newcastle Court Cells on 6 August 2018. The New Inmate Lodgement sheet noted that he had a heart condition and hearing impairment. Mr Eager was transferred to Parklea Correctional Centre and the Justice Health Problem Notification Form (HPNF) requested "two out" cell placement due to Mr Eager's cardiac issues. In his Reception Screening Assessment, he reported an extensive medical history that was confirmed by information received from his General Practitioner. His medical history included hypertension, benign prostatic hyperplasic, preventative treatment of blood clotting with Cartia, hearing impairment and chronic kidney disease. He also reported that he had been undergoing investigations for Hodgkin Lymphoma.

On 25 September 2018, he was transferred to the Metropolitan Special Program Centre before being transferred to the Long Bay Hospital for his health conditions.

Mr Eager was classified as a C1 Minimum Security inmate and was initially placed in Protection Limited Association Area for three months before his status was changed to Special Management Area Placement. He was granted protective custody due to the nature of his offending and because it was his first time in custody. He had no breaches of discipline charges during his time in custody.

Medical Treatment whilst in Custody

Between entering custody and November 2018, Mr Eager attended numerous consultations with nurses and doctors for treatment of his various medical conditions. On 23 November 2018, he attended an outpatient Ear Nose and Throat specialist appointment at the Prince of Wales Hospital for continued investigation for Hodgkin Lymphoma. On the 13 December 2018, a core biopsy of Mr Eager's right-sided cervical lymphadenopathy was performed which led to a diagnosis of an early stage classical Hodgkin lymphoma with good treatment prognosis.

On the 11 February 2019, Mr Eager attended an outpatient haematology appointment at the Prince Of Wales Hospital Haematology Department where he expressed reluctance to undertake any treatment for his lymphoma. Medical staff continued to offer Mr Eager treatment for his Hodgkin lymphoma, but he declined. Mr Eager's daughter told police that her father was against any cancer treatment due to his upbringing as his own father had been an herbalist. Mr Eager had wanted to try a raw diet with juices to combat the cancer, but this was not possible in the custodial setting.

On the 21 August 2019, Mr Eager attended a consultation with a doctor for recent confusion, lethargy and falls. He was subsequently admitted to the Prince Of Wales Hospital Emergency Department where he was assessed and admitted. He was prescribed intravenous Ceftriaxone and Clindamycin and two units of packed blood cells. On the 27 August 2019, he was discharged and transferred back to the Medical Special Programs Centre. Whilst there he attended regular consultations with nurses and doctors for ongoing treatment of health concerns, mainly related to Hodgkin lymphoma.

Mr Eager's health continued to deteriorate and on 28 of August 2019, he was admitted to the Long Bay Hospital Medical Sub -Acute Unit where he discussed a palliative care plan with a doctor. On 30 August, he completed an advanced care directive stating that he did not wish for intensive or resuscitation measures to be applied.

On the 16 September 2019, Mr Eager was taken back to Prince Of Wales Hospital as his condition had deteriorated. A CT scan showed that his Hodgkin lymphoma had progressed and following a discussion between Mr Eager, his next of kin and the Prince Of Wales Hospital specialist doctor, it was agreed to commence palliative care and cease active treatment. An additional advanced care directive was completed on this date. Mr Eager was transferred back to the Medical Sub-acute Unit on 18 September 2019 where he received palliative care and comfort measures. He was administered Sodium Bi-Carbinate Mouthwash, Nilstat and 5ml of Morphine every six hours prior to his death.

About 6pm on the 15 October 2019, Mr Eager was administered his medication. At that time, he appeared comfortable and responded briefly to medical staff, though his interactions were minimal due to his deteriorating condition. Throughout the evening he was checked on hourly by medical staff and complained of pain if they tried to move or adjust him.

About 9.30pm that night, Registered Nurse Maher attended his room and observed Mr Eager to be unresponsive. She requested Corrective Officers Garratt and Pradhan to attend as she assessed Mr Eager for cardiac output, signs of breathing and neurological response. Corrective Officer Garratt commenced a Critical Incident Time Log and Senior McFarlane was informed of Mr Kingsley's death.

Investigation following Mr Eager's death

About 10.35pm on the 15 October 2019, police from the Eastern Beaches Police Area Command attended the Long Bay Hospital. The Officer in Charge, Plain Clothes Senior Constable Steven Cigana, took photographs and completed the P79A notification to the Coroner. There were no suspicious circumstances detected.

A limited autopsy was conducted by pathologist Dr Van Vuuren on 23 October 2019. Dr Van Vuuren concluded that the cause of death was Hodgkin lymphoma and the consequences.

The available evidence establishes that Mr Eager's care and treatment while he was in custody was appropriate. No family member or associate of Mr Eager have raised any care and treatment issues.

Findings required by *s 81 (1) Coroner's Act 2009*

The identity of the deceased

The deceased person was Kingsley Eager

Date of death

Died on 15 October 2019

Place of death

Died at Medical Sub-Acute Unit of Long Bay Hospital, Long Bay Correctional Complex, Malabar, New South Wales.

Cause of death

The death was caused by Hodgkin lymphoma and the consequences.

Manner of death

Natural causes

27. 337389 of 2019

Inquest into the death of Ivan Milat. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 16th February 2021.

At the time of his death, Mr Ivan Milat was 74 years old and was being held in lawful custody at Long Bay Hospital, within Long Bay Correctional Centre. He was serving a custodial sentence of life imprisonment for a number of extremely serious offences which had been imposed on 27 July 1996.

In the early hours of the morning on 27 October 2019 Mr Milat was found unresponsive in his cell with no signs of life. In accordance with standing not for resuscitation orders, no cardiopulmonary resuscitation was initiated, and Mr Milat was later pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Milat was not appropriately cared for and treated whilst in custody.

Mr. Milat's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Mr Milat was one of 14 children to his parents, Steven and Margaret Milat. He was born and raised in Liverpool, New South Wales and later attended high school in the Fairfield area. Mr Milat left high school at the end of Year 8 and commenced casual welding work.

Mr Milat subsequently formed several temporary relationships during his adult years. After travelling to New Zealand, Mr Milat later returned to Australia and worked for different state government agencies. According to his brother, William, Mr Milat enjoyed a number of hobbies including camping, target shooting, motorbike riding and reading. William maintained contact with Mr Milat after he went into custody and describes having a close relationship with him. In this context, William has no doubt been greatly affected by Mr Milat's passing.

Mr. Milat's custodial history

Mr Milat's first interaction with the police occurred in 1962. Between this date and 1974 Mr Milat was charged with a number of property offences and offences of a sexual nature. On 22 May 1994 Mr Milat was arrested and charged with nine offences, including seven offences of murder. He was subsequently refused bail and remanded into the custody of Corrective Services New South Wales (**CSNSW**). On 27 July 1996 Mr Milat was convicted at the Supreme Court of New South Wales and sentenced to life imprisonment. Following his arrest, Mr Milat was housed at a number of correctional centres throughout New South Wales. However, up until 2019 Mr Milat spent most of his time in custody at Goulburn Correctional Centre.

On 13 May 2019 Mr Milat was transferred to Long Bay Hospital following a deterioration in his health.

Mr. Milat's medical history

Upon his reception into custody Mr Milat was noted to have no major medical concerns. Indeed, William reported that his brother had no relevant medical history.

On 5 October 2018 Mr Milat presented with gastrointestinal symptoms including intermittent painful swallowing. He was reviewed by a general practitioner (**GP**) and commenced on medication to help treat upper gastrointestinal symptoms. Mr Milat subsequently tested positive for Helicobacter pylori (a common type of microorganism usually found in the stomach) and was treated with appropriate medications on 30 November 2018. Following this Mr Milat was regularly reviewed by nursing and medical staff at Goulburn Correctional Centre.

Mr Milat's symptoms remained ongoing and he was referred to gastroenterology for further investigations, including a colonoscopy (which Mr Milat refused) and a gastroscopy (which Mr Milat agreed to). However, on 18 January 2019 Mr Milat declined, against medical advice, to go to Sydney for the gastroscopy investigation. Records kept by Justice Health & Forensic Mental Health Network (**Justice Health**) indicate that Mr Milat had previously been known to cancel investigations against medical advice. As a result, Mr Milat remained at Goulburn Correctional Centre where he was monitored and showed progressive symptoms of weight loss and swallowing difficulties. On 1 February 2019 an advanced care directive was discussed, and later completed, with Mr Milat. On 21 August 2019 the directive was updated to indicate that Mr Milat did not wish for any active or surgical intervention, transfer to intensive care, or for cardiopulmonary resuscitation to be initiated.

On 1 February 2019 Mr Milat was also again referred by a GP to Prince of Wales Hospital for a gastroenterology consultation. However, on 25 February 2019 it was documented that Mr Milat refused to go to Sydney for this consultation, against medical advice. Between February and May 2019 Mr Milat had progressive symptoms of weight loss, throat pain, difficulty swallowing and reflux. He was given symptomatic treatment and offered a soft food diet but declined the latter. On 1 May 2019 Mr Milat agreed to a gastroscopy and arrangements were made for further pathology tests in preparation for an appointment with a GP on 8 May 2019. At this appointment Mr Milat's progressive symptoms were noted, and he was referred urgently to Prince of Wales Hospital for further investigations.

Mr Milat was subsequently transferred to Sydney and admitted to Prince of Wales Hospital between 13 and 27 May 2019 for further investigation of his weight loss and progressive swallowing difficulties. Mr Milat underwent a diagnostic gastroscopy on 14 May 2019 and other investigations including computed tomography (**CT**) scans of the neck, chest, abdomen and pelvis, and a positron emission tomography (**PET**) scan. He had a lymph node biopsy on 17 May 2019 that indicated metastatic poorly differentiated adenocarcinoma.

On 21 May 2019 Mr Milat underwent a palliative oesophageal stent in order to ease his swallowing difficulties. Following this, Mr Milat was referred to radiation oncology and underwent palliative radiation treatment which was later completed on 7 June 2019.

On 6 June 2019 Mr Milat was reviewed by the palliative care team at the Long Bay Correctional Centre Medical Subacute Unit (**MSU**). The MSU worked collaboratively with Prince of Wales Hospital to support comfort measures during Mr Milat's oncology treatment.

On 27 June 2019 Mr Milat was seen by the oncology department at Prince of Wales Hospital and offered palliative chemotherapy for the metastatic oesophageal cancer. It was explained to Mr Milat that the metastatic cancer was incurable, and that chemotherapy treatment was offered only with the aim of prolonging life and maintaining quality of life. Mr Milat was advised that the treatment had a response rate of 30 to 40 percent and a life gain measured in months. Between May and October 2019 Mr Milat was admitted to the MSU on six occasions. Between these admissions Mr Milat continued to be treated at Prince of Wales Hospital. Mr Milat's last admission to the MSU was between 22 and 27 October 2019.

The events of 27 October 2019

During the morning of 26 October 2019 Mr Milat was observed hourly by nursing staff in the MSU. The cell in which he was housed was located directly opposite the nurse's station. During the evening medication round Mr Milat indicated that he sought medication to assist with anxiety and pain relief. Mr Milat was administered these medications at about 9:30pm, and he was then left by nursing staff sitting up in bed with the light on. Following this, visual observations of Mr Milat were performed hourly. At 3:00am on 27 October 2019 Mr Milat was checked on by CSNSW and Justice Health staff and appeared to be asleep in bed. However, during a subsequent visual observation performed at around 4:05am Mr Milat was seen to be not breathing. Justice Health nursing staff performed investigations using an oxygen saturation machine which recorded no heartbeat or oxygen level. A palpable carotid pulse could not be found, and Mr Milat showed no heart sounds or breathing.

There was no response to centralised stimuli, and it was noted that Mr Milat's pupils were fixed and dilated. As Mr Milat had a standing not for resuscitation order, cardiopulmonary resuscitation was not commenced, and Mr Milat was subsequently pronounced life extinct at 4:07am.

What was the cause of Mr. Milat's death?

Mr Milat was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Rianie Janse Van Vuuren on 30 October 2019. Post-mortem imaging showed large pericardial and pleural effusions with single vessel coronary artery calcification. Features suggestive of lymphangitis carcinomatosa were present in the sub pleural septal area. Multiple sclerotic bone metastases were also noted. Ultimately, in the autopsy reported dated 8 July 2020, Dr Van Vuuren opined that the cause of Mr Milat's death was metastatic gastro-oesophageal adenocarcinoma.

Other matters considered during the coronial investigation

As part of the coronial investigation a statement was obtained from Mr Milat's brother, William. In his statement William Milat expressed no concerns with the care and treatment provided to his brother whilst in custody. However, William raised a concern that on 27 October 2019 he first learned of his brother's death when representatives from media organisations contacted him at around 5:00am. It was not until around 7:00am that an officer from the New South Wales Police Force (**NSWPF**) attended William's house and formally notify him of his brother's death.

The coronial investigation revealed that on 27 October 2019 NSWPF officers from Eastern Beaches Police Area Command (**PAC**) received a message at around 4:40am advising of Mr Milat's death. NSWPF officers subsequently attended the MSU at around 5:05am. One of the attending officers spoke to the Governor of Long Bay Correctional Centre and enquired whether Mr Milat's next of kin had been notified of the death. It was indicated that notification had not yet occurred, and William's details were provided. At around 5:45am arrangements were made for NSWPF officers at Camden PAC to notify William of his brother's death. At around 7:00am a NSWPF officer attended William's residence and notified him of Mr Milat's death and passed on her condolences.

As the above events were occurring, Jodie Minus, the on-call CSNSW Media Officer was notified of Mr Milat's death at 4:26am. Between 4:49am and 5:32am Ms Minus received a number of phone calls which she believed to be from various media organisations. Whilst Ms Minus was surprised at the number of phone calls so soon after Mr Milat's death, she noted that it was not uncommon for media organisations to quickly obtain information relating to Mr Milat given the high-profile nature of the offences for which he had been imprisoned. At 5:40am on 27 October 2019 an email statement was sent by the CSNSW media unit to a number of media organisations confirming that Mr Milat had died at about 4:07am earlier that morning. It is therefore evident that the CSNSW statement was issued before William had been notified of his brother's death by the NSWPF.

Section 13.3 of the CSNSW *Custodial Operations Policy and Procedures* (**COPP**) provided that a death in custody must be immediately reported by CSNSW to the nearest police station by telephone. Following this, the NSWPF is responsible for notifying the deceased inmate's next of kin or emergency contact person of the inmate's death. As at 27 October 2019 it was not CSNSW policy to confirm that the NSWPF had notified a next of kin of an inmate death prior to a media release being issued.

However, Michael Duffy, the Director of the CSNSW Media and Communications Unit, explained in his statement that to the best of his knowledge, CSNSW had not previously experienced a situation prior to 27 October 2019 where media organisations became aware of the death of an inmate so soon after it occurred. Mr Duffy explained that usual practice normally allowed for sufficient time between the death of an inmate and the media becoming aware of such a death for NSWPF officers to notify a next of kin of the death.

Since Mr Milat's death, CSNSW has amended the COPP to provide that if CSNSW are approached by the media about a death in custody, the death will only be confirmed after obtaining confirmation from the relevant authorities that the inmate's next of kin or emergency contact person has been notified of the death.

Conclusions

Having regard to the relevant Justice Health and CSNSW records regarding Mr Milat's incarceration, and the findings from the post-mortem examination, it is evident that Mr Milat died as a result of natural disease process. From October 2018 appropriate investigations were conducted to investigate Mr Milat's symptoms and presenting complaints. When Mr Milat's condition deteriorated he was appropriately transferred to the MSU. Following investigations performed at Prince of Wales Hospital, which resulted in a terminal diagnosis, appropriate measures were put in place to provide palliative care for Mr Milat.

The evidence establishes that Mr Milat was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Milat's medical care, or the care provided by CSNSW staff, contributed in any way to his death. In addition, there is demonstrated evidence that appropriate changes have been made by CSNSW to ensure that where a death in custody occurs, the next of kin or emergency contact person of the inmate who has died is appropriately notified before confirmation of the death is provided to any media organisation. This will avoid the regrettable consequence of an inmate's next of kin or emergency contact person being informed of the death through the media or a third party.

Findings

Identity: The person who died was Ivan Milat.

Date of death: Mr Milat died on 27 October 2019.

Place of death: At the Long Bay Hospital Medical Subacute Unit, Long Bay Correctional Centre, Malabar NSW 2036.

Cause of death: The cause of Milat's death was metastatic gastro-oesophageal adenocarcinoma.

Manner of death: Mr Milat died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

28. 351386 of 2019

Inquest into the death of Bailey Mackander. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 15th December 2021.

This is an inquest into the death of a young First Nations man, Bailey Mackander, who was 20 years old when he died from catastrophic injuries after falling eight metres when he jumped over a wall at an ambulance bay at Gosford Hospital.

On 5 November 2019, Bailey (who was an inmate on remand at Kariong Correctional Centre ("CC")) was discharged from the Emergency Department ("ED") of the Hospital. While one of the escorting correctional officers was opening the prisoner door of the transport van for the purpose of returning Bailey to Kariong CC, Bailey stepped back. Although shackled at hand and foot, Bailey took three to four fast steps towards the wall, placed his hands on the top of the wall, and sprung his legs over. One correctional officer leapt onto the wall, but upon seeing the distance below he could not proceed so he ran down the ramp to Bailey. Paramedics and police officers who were at the ED immediately attended to Bailey and he was admitted to the Hospital, before being transferred to Royal North Shore Hospital ("RNSH"). Bailey was placed on life support, but his injuries were irrecoverable and on 7 November 2019 Bailey died with his parents and family around him.

Bailey, like his father David, was a Wiradjuri man. He was born on 24 December 1998. Bailey was the son of Tracy and David and although they separated when he was 10 years old, Bailey remained extremely close to both of them and lived with each of them at different times. Bailey was the younger brother of Tracy's older son, Kaine. David remarried and he and his wife Melissa had twins Molly and Max and later sons Angus and Leo. Bailey also had two stepsisters. Bailey was also very close to Melissa and his brothers and sisters. Sadly, when Bailey was 14 years old, Molly died about a month after her second birthday. Bailey was very much affected by Molly's death and his father David believes that this is the time that things started spiralling. Bailey started smoking cannabis and truanting school. He left school in year 9 and started working as an apprentice carpenter in David's building company.

Bailey was raised in the Nelson Bay and Newcastle area. He grew up surfing and skateboarding, loving sport - running, soccer, swimming - but he gave this up when he started smoking cannabis and getting into trouble. He developed anxiety and when he was about 15 years old, Tracy took him to their doctor and Bailey started taking medication for anxiety and attended counselling. Unfortunately, after a few months he stopped and continued using cannabis and truanting from school. Bailey stopped socialising with his sports friends and started mixing with a different group of people.

Bailey started using methamphetamine and when he was just 16 years old he attended the Ted Noffs drug detoxification service at PALMS in Randwick in January 2015. He did not remain there and went to his mother's place.

On 28 January 2015, Tracy took Bailey to the Emergency Department of John Hunter Hospital and the discharge summary indicates his presentation was for "*worsening suicidal ideation … anxiety and distress in the context of cannabis and methamphetamine use disorder*". Later that year, Bailey was arrested and spent a short time in juvenile detention.

David said that life became a cycle of rehabs, restarting drugs and going off the rails. Bailey was working on and off but by early 2018, Bailey was using methamphetamine heavily and was living between friends and Tracy.

In September 2018, Bailey moved to Newcastle, sleeping on friends' couches. On 7 December 2018, he was arrested, and bail refused. Bailey was sentenced and remained in custody until his release on parole in March 2019. He served most of his time in a privately managed CC and his family made sure that he had weekly visits. He would telephone Tracy most days crying as he did not cope with being in prison. David said that Bailey was having a hard time in prison and he wanted to change. Although Bailey was in protective custody, he was assaulted on some occasions and when Tracy visited him she would see his injuries, such as bruises and a cut mouth. Tracy later learned that Bailey had been injecting heroin and methamphetamine while in the privately managed CC.

On 4 April 2019, Bailey was released on parole and lived with Tracy for a short time. She took him to the doctor to address some medical issues and he was diagnosed with Hepatitis C (Hep C). Bailey was also to take his anxiety medication. Bailey met up with a friend and it became apparent that he had started using methamphetamines again. By the end of April 2019, Bailey had left Tracy's home and moved into another person's place in Newcastle. David spoke with Bailey and he told his father that "*he missed his brothers and he wanted to go to rehab but he couldn't kick the drugs*". Tracy and the parole officer's efforts to have Bailey enter a rehabilitation program were unsuccessful and he continued to use methamphetamine.

In July 2019, Bailey was arrested again. He was bail refused and was transferred to Shortland CC then to Lithgow CC, via John Moroney CC. Tracy visited Bailey in Lithgow CC and he seemed settled and not using drugs. A week later he was transferred to Parklea CC and when she visited him there she reported that he looked terrible because he was using drugs again. Bailey told Tracy that using drugs was his way of coping in gaol because he found it so hard in prison. On 30 October 2019, Bailey was transferred to Kariong CC. On 2 November 2019, Bailey telephoned David and said that he had "*rehab lined up and had been going to church*. *He seemed happy. He talked about getting out when he next went to court in December*". On 3 November 2019, Tracy visited Bailey and she reports that he was really positive, he was attending Narcotics Anonymous and he told her he had made an appointment to see the psychologist the next day. Bailey spoke again with Tracy on 4 November 2019. He was very distressed because after seeing the psychologist he was placed on a Risk Intervention Team ("RIT") status and he was not coping in the cell.

Tracy told him that she would call someone at the prison to help settle him. That was Tracy's last phone call with Bailey. The next time she saw him, he lay dying in a hospital bed. The evidence in the inquest about Bailey's last days at Kariong CC on 4 and 5 November 2019 have caused much distress to not only Bailey's family, but also those involved in his hospital escort and the investigation into his time in the RIT cell, such that some people have not been able to return to work. Bailey was a gentle, loving young man who struggled with a relentless methamphetamine addiction. Despite the unconditional support his parents gave him, he was unable to stop using.

Bailey's story is that of so very many young men who, despite the love and support of family and with their whole lives ahead of them, become literally and in every way destroyed by methamphetamine. This inquest is a convincing example of how prisons are no place for people like Bailey. A photo of Bailey was given to the inquest. He is handsome, young, with sweet almond eyes and he smiles big, really big. He looks like his Mum. He looks like his Dad. Though they did not raise him to end up in prison and though they did not raise him for his life to end the way it did, they are left to live with it. To Tracy and David and Melissa and Bailey's brothers Kaine, Max, Angus and Leo and other family members and friends, I extend my sincere condolences for their terrible loss.

Jurisdiction

This inquest is held pursuant to ss. 23 and 27 of the *Coroners Act 2009* ("the Act") which requires an inquest to be held for any person who dies in lawful custody and that such an inquest is held by a senior coroner. Under s. 81 of the Act the coroner is required to make findings as to the identity, date, place, and cause of death (which are not controversial in this inquest), as well as the manner of death which encompasses the circumstances of and surrounding a death. Under s. 82 of the Act, if the coroner considers that it is necessary or desirable to do so, the coroner can make recommendations about matters arising from a person's death.

Evidence

The brief of evidence contains seven volumes of documents, photographs and CCTV recordings. Further material was tendered during the hearing. Evidence was taken over nine days and submissions were made by counsel assisting on 22 October 2021 (day 10) and by parties on 9 November 2021 (day 11). Of the 18 witnesses that were called, three psychiatric experts gave their evidence in conclave (on 20 October 2021). The other witnesses included Ms Erin Hyde (née Minard), a psychologist employed by Corrective Services NSW ("CSNSW") and Ms Lara Georgiou, a registered nurse in the employ of Justice Health and Forensic Mental Health Network ("Justice Health") who gave particularly important evidence over a time in the witness box, for which I wish to extend my appreciation. Bailey's cell mate (known in the inquest as "John Brown"), although not interviewed at the time by either the investigating police or to my knowledge CSNSW officers, gave evidence.

Remarkably, after learning of Bailey's death, Mr Brown had the foresight and common sense to reduce to writing his recollections of events and his 15- p a g e record is included in the brief of evidence. It is a reminder to coronial investigators that when inquests are held in relation to deaths in custody, particularly those of First Nations' peoples, events leading up to these tragedies contain important evidence which should be collected.

Though the initial investigation focussed on the environment and immediate circumstances at the Hospital's ambulance ramp, and evidence was taken in regard to that from escort officers Correctional Officer ("CO") Rick Slingsby and CO Wheturangi Uerata, it was the events in the days leading up to that time which became the focus of the inquest. The inquest was concerned with questions as to the manner of Bailey's death, including whether he intended to harm himself, intended to escape from custody or simply did not want to be returned to the observation cell in which he had been placed the previous day (known as being placed "on a RIT").

Whether Bailey was appropriately placed "on a RIT" and in the observation cell, and whether his review and management whilst on the RIT were appropriate, were issues in the inquest. In that regard, a number of CSNSW staff gave evidence including Senior CO ("SCO") Ricky (Rick) Lloyd, who co-ordinated the RIT review with other members Ms Marian Thompson (a Special Programs and Activities Officer ("SAPO")) and RN Georgiou (employed by Justice Health). CO Mr Terry Dolling gave evidence as to his participation in the RIT review.

Ms Hyde, CO Ms Kelly-May Dolling, and CO Ms Jennisa Grimshaw gave evidence about how Bailey came to be placed on a RIT and how he was managed in the cell on the first day. SCO Mr Peter Cargill gave evidence in relation to Bailey's management in the cell on both 4 and 5 November 2019 and in relation to Bailey's escort transfers to the Hospital on both evenings. The observation cell occupied by Bailey did not have access to a yard as that had been closed off due to possessing "*hanging points*". The cell had television facilities and a toilet and access to a shower. It was subject to constant surveillance by CCTV which could be observed on a monitor in a nearby officers' room as well as in a central control room. There was a cell intercom that allowed, via the pressing of a button, audio communications between the cell's occupant and a CO. This is sometimes known by its vernacular as a "knock up".

I will refer to the use of the cell intercom as a "cell intercom call" ("CIC"). Though a log of observations was not kept, digital records of times of the CICs and a recording of what was said by Bailey and the respective officers was copied and provide to the inquest by CSNSW. Some CICs were made which received no response or dialogue. Some of the witnesses such as Mr Cargill and Ms Grimshaw were officers who communicated with Bailey; other officers who communicated with him were not called to give evidence. A transcript of the calls and dialogue was tendered as evidence in the inquest.

Those assisting the coroner sought an expert report from Dr Kerri Eagle (forensic psychiatrist) who amongst other matters, indicated in her report various concerning features about the CSNSW RIT process being used as a means to address inmates at risk of self-harm. The Central Coast LHD and Justice Health jointly obtained a report from Dr Richard Furst in regard to that and other matters. Professor Matthew Large was also invited to attend the conclave, although his report addressed an issue of narrower compass. Dr Sarah-Jane Spencer (forensic psychiatrist and Co-Director of Justice Health's Services and Programmes and Custodial Mental Health) provided a statement and evidence in response to the experts' evidence.

Evidence was also taken from Mr Michael Hovey (Director of CSNSW Investigations Branch) who was the lead investigator into Bailey's death as well as from Mr Terence Murrell (General Manager of State-Wide Operations, CSNSW). Bailey was in juvenile detention for a short time in late 2015, during which time he seemed to not cope with detention and required psychological support. Perhaps relevantly and tragically ironic to this inquest, Justice Health records of November 2015 contain nursing notes which record Bailey was considering self-harm in order to go to hospital, however he was not suicidal.

On 11 November 2015, Bailey was seen at a Justice Health clinic after an alleged altercation with another inmate and on 27 November 2015, the mental health clinical nurse consultant saw Bailey and determined that he had anxiety (exacerbated by situational stressors) and made a plan for review by a psychiatric registrar on 2 December 2015.

Bailey entered adult custody for a short time from 3 to 6 July 2018. He commenced his first extended period of time in adult custody on 7 December 2018. Bailey was housed in the privately managed CC from 15 December 2018 until his release on parole on 4 April 2019. During his time in custody the records relevantly indicate that on 8 December 2018 his Kessler-10 ("K-10") score was recorded as in the "*severe*" range. On 28 December 2018, Bailey told a psychologist he had fleeting thoughts of self-harm upon entering custody but no plans and agreed to inform staff if his risk of self-harm increased. On 16 January 2019, Bailey was assaulted by another inmate. On 21 January 2019, Tracy telephoned Parklea CC as she was concerned Bailey was not coping. Bailey was seen by a psychologist and was to remain on an open referral line for monitoring purposes.

On 29 January 2019, Bailey was placed on a RIT after he made a CIC saying that he was "*not right in the head*" and needed to go to the main clinic as he had "*thoughts of slashing up*". A Justice Health nurse completed a Health Problem Notification Form ("HPNF") and recommended a modesty gown, safety blanket, nil sharps and CCTV observation every 15 minutes. An alert was generated for a history of self-harm incident. On 30 January 2019, apparently at a RIT review Bailey said he was "*loving life*" and he was cleared from RIT status.

On 12 February 2019, Bailey reported that he had been assaulted by his cell mate. On 16 February 2019, he was taken to the Justice Health clinic after he reportedly had a fight with another inmate, although he denied that occurred and no injuries were identified. On 3 March 2019, Bailey was observed on CCTV to be punched in the face by another inmate during a fight in the yard, resulting in a cut to his lip which was bleeding. He refused police intervention and stated he had no issue with returning to the wing.

On 19 March 2019, Bailey requested to speak to someone as he had been feeling very stressed and down, had not been sleeping and had "*been trying to see someone for the last 3 months and no one has come to see me*". Bailey was released to parole on 4 April 2019. He was on parole for three and a half months until he was arrested for fresh offences on 16 July 2019. Whilst in the police cells he complained of chest pains and was attended to by an ambulance. The following day, on 17 July 2019 at approximately 10:55am, COs saw Bailey in his cell, and he appeared unwell and was unresponsive, although his vital signs and breathing appeared normal (and CSNSW staff considered that he was choosing to be non- responsive). Bailey was conveyed via ambulance to Mater Hospital for assessment and admission with a preliminary diagnosis of exacerbation of hepatitis.

He was returned to court where he was refused bail. On 18 July 2019, Bailey was transferred to Shortland CC. His K-10 score was consistent with mild depression and/or anxiety disorder. The Inmate Identification and Observation ("IIO") form records he was taking Diazepam daily, had used the drug "ice" and marijuana four hours previously, stated he was upset and showed signs of being depressed and anxious with an aching chest.

On 18 July 2019 there are two HPNFs. At 7:34pm, normal cell placement was recommended. At 8:11pm, a HPNF recorded that CSNSW were to watch out for possible detoxification symptoms and house Bailey in the clinic under camera monitoring until cleared by Justice Health. On 19 July 2019, a HPNF recommended a "*green card*", that CSNSW look out for symptoms including anxiety, encourage the drinking of fluid and alert health centre staff promptly if Bailey's condition changed (until 2 August 2019).

On 29 July 2019, Bailey was transferred to Lithgow CC but had a few days in transit at John Morony CC. A HPNF recommended that CSNSW watch out for unusual or isolative behaviour and that he be placed in two-out cell placement until cleared by Mental Health. On 4 August 2018, Bailey was assessed in the Justice Health clinic after a fight with his cellmate, however no injuries were noted.

On 6 August 2019, Bailey attended a consultation with a mental health nurse and reported being anxious and teary, having difficulties sleeping, panic attacks, vomiting and lack of appetite. He was referred to a general practitioner ("GP") and a psychiatrist commenced Bailey on anti-depressant medication, Mirtazapine. Bailey arrived in Lithgow CC on 9 August 2019. On 10 August 2019, he reported fearing from his life from his cell mate and was relocated. On 19 August 2019, Bailey indicated he had last injected "Bupe" in custody the previous week.

On 31 August 2019, Bailey presented to the Justice Health clinic with reported chest pain for two days which was found to be related to anxiety. He was anxious or stressed about being in gaol and was given Rennies and paracetamol. The Justice Health note records "*W/L made for MH. Recommended to CS they make appointment for psychology for patient. Pt. given pamphlets on relaxation techniques*". An ECG was also performed.

On 3 September 2019, Bailey was found to be HCV (Hepatitis C Virus) positive. Bailey consented to seeing a psychologist and he was to be seen by psychology weekly.

On 9 September 2019, Bailey appears to have been moved to a different accommodation unit upon his request, however it is noted he was "*[s]till showing signs that he is not coping with being at Lithgow*".

On 10 September 2019, Bailey was transferred to Parklea CC where he remained for six weeks until his transfer to Kariong CC on 20 October 2019.

On 12 September 2019, Bailey attended a mental health nurse and reported that he was feeling distressed after being advised his court case was adjourned to January 2020 He was "*desperate to be released*", reported being stood over and said he felt fearful and anxious all the time and had nightmares. He reported he cried every day, felt sick, had shortness of breath, could not eat and that sleep was horrible. A comment recorded *"(likely he is giving his mirtazapine [sic] away)??"* The impression was acute stress on the back of anxiety and situational exacerbation. The recorded plan included a threat assessment, mental health review and to speak to his mother regarding bail. It was noted that if he was not released to bail he would need additional mental health follow-up and review of his medications and "*mx*", and that information was to be handed over to the Area 5 supervisor.

On 13 September 2019, Bailey was seen by Justice Health nursing staff in the clinic. He stated he had epigastric and back pain. He was given Panadol, his regular Mirtazapine and booked for a GP review. The impression recorded was that Bailey had GORD (Gastro-Oesophageal Reflux Disease) and he was prescribed a proton- pump inhibitor for epigastric pain.

On 15 September 2019, a "CERT" call was placed, and Bailey was seen by a nurse for chest pain and reported ingesting a small balloon six days prior "*on transit*". A GP was informed, and he was placed in a health clinic camera cell.

On 17 September 2019, Bailey saw an Aboriginal Health worker for social and emotional wellbeing support. He denied being at risk of self-harm. On 18 September 2019, Bailey saw a nurse regarding his complaints of lower abdominal pain. An x-ray was booked as advised by the GP. The imaging request noted "*reports swallowing needles _>? Attempting to transfer out of facility*".[40]

On 19 September 2019, the x-ray findings recoded that *"[t]here is a radio-opaque foreign body projected over the mid abdomen to the left of the midline, compatible with a razor blade or fragment. This most probably lies in the body of the stomach, please arrange follow up x-ray if required…*." The plan prescribed that Bailey should remain in the Justice Health clinic and be reviewed by a doctor, to obtain stool samples, to give Paracetamol, and for a repeat x-ray to be conducted.

On 20 September 2019, RN Glenn Blundy completed a HPNF setting out that Bailey had allegedly swallowed razors and instructing officers to "*[w]atch for reduced conscious state, [b]lood in stool, vomiting*" and recommended that Bailey be housed in a clinic dry cell for monitoring until he was cleared by his GP. On a version of the form signed by the CSNSW officer, the words "*dry cell*" were crossed out by hand. Bailey was medically reviewed and noted to be "*desperate*" for a hospital transfer, stating he had issues with a cellmate and was "*visibly frightened at thought of being cleared*". He was to be re-examined the following day.

On 21 September 2019, a Justice Health nursing welfare check occurred with no issues reported. At 11:38am, RN Brooke Hampson completed a HPNF recommending Bailey be transferred to normal cell placement, noting he guaranteed his own safety. On the same date, a medical officer at the privately managed CC requested that Bailey be reviewed at Blacktown ED, noting his recurrent epigastric pain and that foreign body ingestion was confirmed on x-ray, although there was no evidence of perforation (as at 19 September 2019). The medical officer recorded that "[*h]is history is unreliable but collateral hx indicates has swallowed a syringe, unclear as to when, possibly 5-6 days ago. Given the ongoing pain/time I do not think the object will pass".* Bailey was conveyed to Blacktown Hospital. A progress note records that he swallowed "ice" and buprenorphine wrapped in sticky tape and a needle two weeks prior. It was determined that no intervention was required, and he was to be reviewed in the ED if there were further concerns. On or around 22 September 2019, Bailey was assessed by a mental health nurse upon his request. He said he wanted to be assessed as mentally ill to avoid a gaol term because it was very hard in gaol. He denied thoughts of self-harm, suicidal intent or suicidal ideation.

On 27 September 2019, Bailey was taken to the Justice Health clinic after reportedly being assaulted in the yard. He was visibly upset. A laceration to his lip was glued. On 27 October 2019, Bailey was seen by Justice Health nursing staff in a clinic, due to complaints of vomiting several times after being punched in the stomach during an altercation with another patient. He linked it mostly to anxiety.

He was given Metoclopramide and his usual Mirtazapine dose. He was reported to be happy to return to the wing. On 30 October 2019, Bailey was transferred to Kariong CC. Mr Murrell gave evidence that Bailey's transfers from Lithgow CC and Parklea CC were due to Bailey having some association problems (with other inmates) and he was not coping with being at either centre. Bailey was transferred to Kariong CC not for the purpose of reducing risk of harm but rather that he was "*pre-positioned at Kariong so he could get to Newcastle court*".

Bailey's custody at Kariong CC

The Kariong CC is operated by CSNSW and the medical services for inmates at that centre are provided by Justice Health. At the time of Bailey's transfer, it had capacity for 96 inmates, so it is a small centre. It currently operates as a transit prison.

An inmate known as John Brown in this inquest had befriended Bailey in the privately managed CC when Bailey served his first sentence. At the time of Bailey's transfer to Kariong CC, John Brown was also in Kariong CC, having been transferred there some months previously. When he learned that Bailey had arrived at Kariong CC he invited Bailey to share his cell.

After Bailey moved in, John Brown observed that he was very unsettled and seemed unable to adjust to being back in prison. John Brown spoke with Bailey about practicing mindfulness to ease his ruminating about the past or worrying about the future. John Brown suggested that he would ask the psychologist to obtain information and Bailey said he would like that.

John Brown spoke to the psychologist and after learning who the material was for, she told him that Bailey was on her list to see on Monday. John Brown told Bailey this and Bailey was pleased to be able to speak to someone. John Brown recalled a conversation that night where Bailey relayed a story told to him. The story was of an inmate who been on a hospital escort and had considered taking the keys from an escorting officer who had appeared asleep, but when he went to grab the keys the officer woke up. John Brown said that he commented to Bailey that a life on the run constantly looking over your shoulder would be worse than doing your time and Bailey agreed with that.

The following day was Saturday, 2 November 2019 and John Brown spent the day walking and talking. Bailey's mood appeared to be down. John Brown thought it might be due to withdrawals as Bailey had disclosed to him that he had (illicitly) used Suboxone (buprenorphine, an opiate substitute) prior to arriving at Kariong CC.

On the Sunday morning (3 November 2019), Bailey was visited by his mother Tracy and when he returned to the cell he told John Brown he enjoyed the visit and loved seeing his mum. During the afternoon Bailey was agitated so John Brown stayed with him and talked to him about fishing, surfing and motorbikes to take his mind off his worries and anxiety. Later that day, after lock-in, John Brown reminded Bailey that he was seeing the psychologist the following morning. They spoke about being honest to get the most out of the session. Though Bailey had made no mention of self-harm over the preceding days, John Brown told him not to disclose any self-harm or suicidal thoughts with the psychologist as it would most likely result in Bailey being placed on a RIT.

John Brown explained in his evidence, "*I did say that and the reason that I said that was not because I thought that he was at risk, it was more...there's a question that they always ask when you see a psychologist in prison…they don't ask about the present…they ask "Have you ever had suicidal thoughts or thoughts of self-harm"…my commentary to Bailey was to not disclose anything from the past because I didn't feel that it would be helpful for his present situation*". Bailey indicated to John Brown that he agreed.

On the Monday morning (4 November 2019), John Brown saw that Bailey was pacing in the yard on his own and looked depressed so told him that he had seen that the psychologist was there and that he should go to the fence to speak with her when she came out. The psychologist called out Bailey's name at about 10 to 10:30am and he went with her. He was gone for over 45 minutes, and when he returned, John Brown asked him how his session had been. Bailey told him that it was good, and he seemed relieved to have spoken to someone but that he had told her he had had "*thoughts of self-harm of [sic] suicide*" and that he was now worried about being placed in an observation cell. John Brown, whilst surprised that Bailey said this to the psychologist after their previous discussion, sought to reassure him that if they had real concerns Bailey would not have been placed back with the other inmates. They went back to the unit for lunch and muster. At about 12 noon, Ms Dolling came to the cell and took Bailey's cell card from the door. She called Bailey over and he left the unit with her.

Bailey's meeting with the psychologist

Ms Hyde was the only psychologist working at Kariong CC and at that time was working a nine-day fortnight, about 7am to 3pm, Monday to Friday. On 4 November 2019, she worked from 7:10 am to 4:10 pm. She had no recollection of speaking with John Brown about Bailey, but she explained that Bailey's name was placed on the service line by the previous psychologist who Bailey had seen. According to the Offender Integrated Management System ("OIMS") records, this was psychologist Ms Jennifer Mackie who saw Bailey two months previously at Lithgow on 3 September 2019. Ms Mackie had indicated on OIMS that in her opinion Bailey required weekly sessions with a psychologist. Ms Hyde explained that Ms Mackie had triaged Bailey's referral as a Psych ("P2") service line which meant that he should be seen within 12 weeks. P2 means "*subacute mental health intervention service line*". P1 means that the inmate should be seen again within 72 hours. Each day, Ms Hyde would create a list of names referred to on the service line. Bailey was seen within the ninth week of the 12-week referral window.

Although Ms Hyde made no reference in her notes of that day to doing so, she said that before seeing Bailey she had reviewed his file by reading the OIMS entries of his current period in custody and she said she would have also read the OIMS from his previous period in custody. She had not however sought access to information contained in his Justice Health file (which included numerous HPNFs) and agreed that accordingly on the day she was very limited in how she could discuss Bailey's risk with him. Although Ms Hyde was unable to precisely recall the length of time she spent with Bailey, she thought it might have been about half an hour. She made handwritten notes and an entry in OIMS.

She was unable to recall at what time of the day she made that entry; however, a time stamp was obtained at the end of the inquest which indicates the entry was commenced at 11:55am on 4 November 2019. In her interview with Bailey, Ms Hyde asked Bailey to sign a form called "Psychology Participant Information Statement and Consent", by which he gave his consent to speak with a psychologist knowing that there was limited confidentiality as his information was shared within CSNSW and could be subpoenaed by outside authorities such as the police. That document is distinct from an "Authority to Release Information" form providing inmate authority for CSNSW staff, such as Ms Hyde, to obtain information from a range of people (third parties). The "Authority to Release Information" form is not completed routinely but rather on an "as needed" basis.

As a result of her interview with Bailey, Ms Hyde determined that he was at risk of self- harm and that he should be removed from the accommodation unit and placed in an assessment cell. During her evidence she had little to no recall of 4 November 2019 and relied on her notes and "usual practice" in regard to how decisions and arrangements were made that day. Justice Health employed a registered nurse at Kariong CC. The nurse who worked on both 4 and 5 November 2019 was RN Lara Georgiou. RN Georgiou provided a statement dated 23 April 2021. She made a clinical note in Bailey's Justice Health records relating to a conversation that she had with Ms Hyde at about 11am, which indicates that Ms Hyde discussed her concerns about Bailey as she had not at that time made a decision about raising the Mandatory Notification. RN Georgiou said that Ms Hyde thought that Bailey may be okay to be in the yard during the day as he had friends and enjoyed exercise, but she was concerned about Bailey ruminating at night. According to RN Georgiou, Ms Hyde said that she was unable to make those recommendations on the Mandatory Notification and that it would have to be decided by the RIT.

RN Georgiou's clinical note reads as follows:

"4/11/19 – 11:00

Nursing: Psychologist (Erin Minard) attended clinic to discuss pt [patient] Decided to place pt on a mandatory notification due to numerous concerning factors. - Daily thoughts of suicide, sister died at 2 years old and parents coped well so they will be fine if I passed away. - See notification and psychologist notes."

Ms Hyde was asked questions about the process of placing an inmate on a RIT. She was referred to a document entitled "Mandatory notification for inmates at risk of suicide or self-harm". This is a seven-page document which has three parts: **Part 1 Mandatory Notification** (pp. 1-2), **Part 2 Immediate Support Plan (ISP)** (p. 1 of 1), **Part 3 Risk Intervention Team (RIT) management plan** (pp. 1-2). Ms Hyde referred to Part 1 as the Mandatory Notification Form ("MNF"). She said the form is required to be completed by the person who forms the view that an inmate is at risk of harm, but she said that it is not part of her role to be involved in Part 2 (the Immediate Support Plan ("ISP"). Ms Hyde said that the decisions involved in the ISP are made by the CSNSW officer on whatever information they have received, and that her involvement was just to provide her verbal assessment of Bailey to them. Ms Hyde was unsure as to whom she provided this verbal handover as she had no memory of it, but she did record in her case notes that she spoke with three seniors.

On 4 November 2019, the Functional Manager was Mr Jason Asprey and the Activity Senior was Ms Dolling. The other senior (the compound senior or officer in charge) was Ms Grimshaw. Ms Hyde was taken to a 34-page CSNSW Policy document entitled "3.7 Management of Inmates at Risk of Self-harm or Suicide" ("the policy") with which Ms Hyde said she was familiar. However, she was not familiar with a document attached to that policy entitled "Suicide and Self-harm ISP/RIT Management Plan Reference Guide".

Ms Hyde said her normal practice would be to speak with staff and complete the MNF, although she had no recollection of when she did so that day and she was unable to say whether she completed the OIMS before or after the MNF. However, on this day, Ms Hyde, for unknown reasons, did not herself complete the MNF but rather this was completed by Ms Grimshaw and it was signed by Ms Hyde. It appears that Ms Hyde may have completed the OIMS entry before Ms Grimshaw completed the ISP as information contained in the MNF appears to have been included in the ISP. Ms Hyde said that she did not see the ISP, nor did she consider she had any role in the creation of it (even though, according to policy guidelines, it involved matters such as "*strategies for the ISP and their relevance to both level of risk and principles for least restrictive care*").

Records indicate that Bailey was placed in the assessment cell at 12:05pm. At this time, Ms Hyde was completing her OIMS document and it would therefore appear that both the Part 1 MNF and the Part 2 ISP were yet to be commenced.

Ms Hyde's OIMS entry is as follows:

"Reason for Contact: Pscyh2 SA MHI service line. Previous contact at Lithgow. Anxiety and poor coping.

Confidentiality: Conditions of contact including limits to confidentiality explained and consent form signed.

Presentation: 20 yr. male. Looks young. Anxious and teary. Low in mood. Maintained good eye contact and engaged well. Normal rate and flow of speech. Logical and sequential in thought. Nil perceptual disturbances evident. Did not present as paranoid. Exhibited insight into his situation and poor lifestyle choices.

Summary: Mr Mackander stated that he is "struggling". He described ongoing anxiety and depressed mood. He stated that he cries daily. He expressed personal responsibility for his situation and feelings of failure. He stated that he returned to drugs within 3 days of his release on parole. He reported regular ice use - started smoking but began injecting last time in custody and continued with same on release.
He has also used speed and Heroin but preference for Ice. Mr Mackander reported that he would like to go to rehab and believes his solicitor is considering this as an option in sentencing.

Mr Mackander is PRLA due to drug related issues which followed him from the community. He stated he feels safe at Kariong and feels particularly supported by his cell mate [John Brown] who he knows from the community. His mother and father are both supportive however his main support person is his mother who he speaks to daily and she also visits.

Mr Mackander believes he has learning problems however has never been formally assessed. He stated he was expelled at 15 for his poor attendance and went on to complete a Carpentry apprenticeship. He did not enjoy his work and was frequently bored.

Mr Mackander reported a lengthy history of anxiety. We spent time discussing the nature of anxiety and its management which Mr Mackander expressed interest in. He is aware of a number of strategies which he is to practice. He stated that his low mood is as significant as his anxiety.

Mr Mackander reported that he thinks about suicide every day and is aware it is always an option for him. He denied having a plan although this was unconvincing. He stated that he had little to look forward to and he has little hope. He stated that there is a case conference with his solicitor on Wednesday when he will learn if rehab is an option for him or not however he believes his (drug related) charges may restrict his options.

The outcome of this meeting will be particularly significant for Mr Mackander in terms of his risk of self-harm. We discussed the impact of suicide for his family, to which he stated, "They will get on with things". He then told me about his 2yo half-sisters death 6 years ago to illness and reflected on how his family have got on with their life now and they would also do so if he was to die.

IMP [Impression]: Impulsive young man reporting "constant" daily suicidal ideation. Presents as hopeless and lacking future orientation. Minimising impact on family. Requires RIT.

PLAN: Discuss with F[functional] M[anager], Activities Senior and Compound Senior. RIT activated".

Though the "PLAN" reads as if it is yet to occur, it is likely that Ms Hyde had completed the entry by 12:30pm and prior to commencing it she had already spoken to senior correctional officers, as Bailey was taken to the cell whilst Ms Hyde was making the OIMS entry. It appears that the RIT was activated before the MNF and ISP forms were commenced because Ms Hyde said that recording the words "*RIT activated*" meant that she had spoken to the staff about her concerns around Bailey's risk before the Mandatory Notification was completed. She thought that the ISP form was completed after she had completed her OIMS entry because the ISP includes verbatim from her case note.

In her statement dated 23 April 2021, Ms Grimshaw said that she had a discussion with Ms Hyde at about 11:20am and at about 11:45am she accompanied Ms Dolling to collect Bailey and take him to the assessment cell. She then completed the ISP with the assistance of Ms Dolling and at 1:10pm she completed the incident report with guidance from "SCO" T (Trevor) Clarke. In her evidence before the inquest, Ms Grimshaw said that the Part 1 MNF was completed in front of Ms Hyde. Ms Grimshaw said, "*I asked her the questions and she gave me the answers and I penned them…[s]itting in the senior's office"*. She thought the time this occurred was shortly after 11:20am, but was not sure because she thought that Part 2 (the ISP) was completed after that and Ms Hyde had made suggestions about the protective factors in the MNF.

The MNF signed by Ms Hyde indicated that she observed or discovered Bailey's risk of self-harm/suicide at 11:15am on 4 November 2019. The MNF refers the officer to the **"Risk factors guide interview questions".** The MNF distinguishes between whether an inmate has carried out an act of self-harm/attempted suicide or whether the inmate has threatened self-harm/attempted suicide. However, that part of the form has not been completed, nor had the part inquiring as to whether it was known whether the inmate had a suicide plan and if so, what it was. There is a box for "**[a]n inmate is assessed as at risk of self-harm/suicide (*see annexures)".** That box is ticked but there are no annexures attached such as the OIMS or any handwritten notes or a formal risk assessment document. The form then has a section, **"List any known risk factors",** under which is written:

"Daily thoughts of suicide, denied plan. Was unconvincing. Limited future orientation impulsive, low mood."

The next section is **"what was the inmate's presentation at the time of this notification?"** under which is written:

"*Teary, flat, anxious*".

The next is **"Identify any situational triggers, if known that had led to this notification"** under which is written:

"*Charges, in custody*".

Finally, the last section asks, **"What Immediate action was taken by the First Responding officer**" and this is handwritten: "*advised FM Astbury and Productive Day K. Dolling*." The reference in Ms Hyde's note that she also spoke with "Compound Senior" appears to refer to Ms Grimshaw, who completed the MNF as well as the ISP.

The ISP is a single page document which refers the officer to the **"Suicide and self- harm: ISP/RIT management plan - reference guide"**. It then has a set of options relating to **Cell Placement** (normal, two-out, transition, assessment or other) and states: *"(option chosen should be least restrictive relative to risk) Note: share accommodation should not be considered as an option where a risk of harm to or from others is known to exist)*". The assessment cell box is selected. The form does not require the officer to set out any reasons for the cell selection.

The next item is **Clothing,** with the note *"(should be at least restrictive option relative to risk)"*. There are no set out options, but Ms Grimshaw has recorded "*[n]ormal Gaol Greens*".
The next item is **Restraints** and Ms Grimshaw has recorded "*[n]il*".

The next item is **Observations,** with options of Physical or Electronic, and whether the observations should be constant or periodic and if periodic the frequency (in minutes). Ms Grimshaw selected constant electronic observations.

Then, the next list is "***Diversionary activities/human interaction*** *(any immediate action required e.g. phone call, provision of reading material etc)".* Ms Grimshaw has recorded "*Phone calls, reading materials, inmate mentor meeting with [John Brown]*".
The next item is **How will the inmate be escorted** which is not completed, except that under **Details** it is written by hand "*NIL sharps*".

At the end of the form there is room for the OIC who is authorising the plan to sign and date it, and lastly there is this:
"***Note: The OIC must ensure that:***

- *An initial **OIMS self-harm alert** is created and relevant information is included in the 'comments' e.g details of the mandatory notification and ISP*
- *An **OIMS IRM** is completed*
- *An **OIMS Case Note** is completed".*

The **OIMS IRM** number 245746 is handwritten in the dedicated field at the top of the front page of the ISP. The Incident Report document 245746 indicates it was submitted for review and created at 1:25pm on 4 November 2019. The document reports that threat of self-harm was reported at 1:10pm. The document reports that the "*[p]hysc* [sic]" assessed Bailey and that at 11:30am an observation/camera cell was implemented with regards to accommodation. At the question "*What was implemented with regards to Monitoring*", the field was answered with "*24-hour observation*". At the question "*[w]hat was implemented with regards to Intervention*", the field is answered "*RIT informed*".

Ms Hyde had no recollection of when it was that she signed the Part 1 MNF. She was asked, "*[d]o you actually have a recollection of Ms Grimshaw asking you, for example "We need to list the known risk factors. What are they?" or "What should I write?""* and she replied "*Yeah, I – not that she said exactly that but as I said, I don't have a memory – an actual memory of her filling that out but I believe it was her. So, I can't really comment on exactly what the conversation was*". Though she believed that they had some conversation about filling the form in, she could not recall where that conversation occurred.

Ms Hyde believes that she told a number of officers that she was going to raise the Mandatory Notification and believes that she spoke to Ms Grimshaw after Bailey had been taken to the cell. She said: "*because I discussed with the activities senior [CO Kelly-May Dolling], which is the senior down on the floor where I interviewed, first, in order to place Bailey in that assessment cell and then discuss with the OIC [Ms Grimshaw in the OIC office] around the paperwork and to inform her of that decision*". Bailey was in fact not taken to the assessment cell immediately after their interview as, according to John Brown's evidence, he was returned to the accommodation unit and later collected. This is consistent with RN Georgiou's notes that prior to 11am, Ms Hyde spoke with her about Bailey and it was at about that time that Ms Hyde decided to place Bailey on a Mandatory Notification. Accordingly, Ms Hyde, after speaking with RN Georgiou, would have spoken to the officers to inform them of her decision.

Ms Grimshaw said that the diversionary activities were included in the form in consultation with Ms Hyde and that Ms Grimshaw ran them by Ms Dolling to see if it was possible to facilitate them. Ms Hyde was asked numerous questions about her decision that Bailey should be placed on a RIT and whether she turned her mind to the policy requiring "*least restrictive options*".

She was asked, "*Did you tell any of those other officers that your recommendation was for a placement assessment cell?"* and she replied, "*I don't recall my, my-my experience is that they go into an assessment cell unless we discuss other*

– unless I'm asked or, you know, there's some kind of discussion otherwise". Counsel assisting asked "*there's, what a default position that they go into an assessment cell?*" and Ms Hyde said "*[y]eah. That's my experience*". Ms Hyde was taken to Ms Grimshaw's statement, in which she said it was Ms Hyde who recommended an observation cell and she was asked if that was accurate and Ms Hyde replied, "*[t]hat's, that's a recommendation that I would make, yes*".

Ms Hyde was asked some questions about her assessment of Bailey's risk. She could not recall whether there were any OIMS alerts which she had seen. She had not made a note of them in her case note on OIMS, however she said she would not in any event. She said that she did not look at Bailey's CSNSW case management file in relation to previous HPNFs, although she could have accessed it.

Ms Hyde was not aware of a Justice Health Mental Health Triage form dated 6 August 2019 that indicated Bailey had been diagnosed with generalised anxiety, panic attacks and had been started on anti-depressants. Ms Hyde conceded that in compliance with the CSNSW policy to carry out her risk assessment, she should have accessed that material and failed to do so. She conceded that it would have helped her to understand more about Bailey's situation on the day and she was limited in how she could discuss Bailey's risk with him. Ms Hyde was taken to the point in the policy relating to taking into account information gathered from contact with family or external service providers when carrying out a risk assessment. She agreed it could have been useful to speak to Bailey's mother and it could have been useful in assisting Bailey in dealing with her recommendation that he go into an assessment cell.

Ms Hyde said that she was in position to seek and obtain Bailey's consent to speak to his mother, but she did not do so, and she was not sure why she did not. Even later that afternoon when an "admin" person telephoned Ms Hyde saying that Bailey's mother was on the phone wanting to speak about Bailey, Ms Hyde declined to take the call and told "admin" to pass on the message that "*her loved one is in safe hands*".

She told "admin" that she did not have Bailey's consent to speak to his mother. In response to counsel assisting's questions, Ms Hyde was unable to explain why, knowing that Bailey's mother wanted to speak with her, she did not attend the cell to obtain Bailey's consent to speak with his mother.

Ms Hyde was taken to the policy which states:

"*Placing an inmate into an assessment cell is a measure of last resort and should not be used routinely. The use of assessment cells must be consistent with the approach of least restrictive care. No inmate is to stay in an assessment cell for more than 48 hours (under an ISP or RIT plan) without the written approval of the Governor. When an assessment cell is used the ISP must specify the … length of time the inmate will stay in the cell … frequency of human interaction … diversionary activities … details of items issued …. [And] observation monitoring schedule...".*

Ms Hyde said that she did not give any guidance about those matters to Ms Grimshaw or any other officer and agreed that she should have done so as the psychologist who made the recommendation that Bailey be in the assessment cell. She was unable to explain why she did not. Contrary to Ms Grimshaw's evidence, Ms Hyde said she did not see the ISP and had no role in it. Ms Hyde was asked questions directed at considering least restrictive care options, such as Bailey being in a cell with John Brown during the day. Though she did not speak to Bailey or John Brown to discuss this option with them, she said that she thought that he was such a risk of harm that the only safe place for him was to be in an observation cell.

Ms Hyde was asked if it was her "*normal practice to talk to officers about the implementation of an ISP for an inmate in an assessment cell*" to which she said, "*[s]o as in would I come back later and … Look Kariong's a very small centre. So, you know we're in a – in a good position in that we're, we're in and out of the compound all day so you, you do see, you know, what plans have been put in place*". She was asked, "*[d]id you consider it part of your professional responsibility once this ISP had been completed to engage with any other officers about how it would be implemented?*" to which she replied "*[n]o*".

Shortly after Bailey was placed in the assessment cell, he made numerous requests to speak with the psychologist. Ms Hyde's evidence was that she had no recollection of Bailey making any such request and that she would have expected to be informed about any distress he experienced during the day. Transcripts of the calls at 12:45pm, 12:58pm and 1:01pm were read out to her and she said that information was not passed on to her, but that she expected that information such as that would have been. Ms Hyde said that had she been so aware, she would have gone to speak with Bailey or had him brought to her office to speak with him.

After the inquest resumed in October 2021, Ms Grimshaw gave evidence that she did not ask Ms Hyde to see Bailey because Ms Hyde was in her office at the time when Bailey was speaking over the intercom and Ms Hyde said to her that she was not going to speak to him. Ms Hyde was recalled as a witness so that this evidence could be put to her and she denied ever hearing Bailey over the intercom when she was in Ms Grimshaw's office.

Ms Hyde agreed with counsel assisting that it was reasonable to consider that she was in Ms Grimshaw's office at around midday based on Bailey being interviewed at about 11am for 45 minutes. However, that time may not be accurate, particularly given RN Georgiou's note that it was 11am when she and Ms Hyde discussed Ms Hyde's consideration of raising the Mandatory Notification. Ms Mahony, on behalf of CSNSW, submits that the OIMS case note time of 11:55am establishes that Ms Hyde was in her own office at that time completing the OIMS case notes.

That is correct; however, it would not have taken more than 30 minutes and given other evidence referred to, Ms Hyde could well have been in Ms Grimshaw's office at around 12:45pm.

Ms Hyde gave evidence that she had completed "*hundreds*" of MNFs but was unable to provide a reason that she signed rather than filled out the form on this occasion. In response to questioning from counsel assisting, she replied, "*I can only assume that it would have been to – that we did it, in a sense, together. So, I was with her as she filled that out, and I signed it*".

Ms Grimshaw said in her statement that she thought she had finished the ISP at about 12:45pm but it is unclear if Ms Hyde was with her at that time. Ms Grimshaw said that she asked Ms Hyde why she would not see Bailey and that Ms Hyde replied that she believed it would escalate Bailey too much. Ms Hyde denied that she had heard Bailey yelling from the assessment cell while sitting in Ms Grimshaw's office. She denied telling Ms Grimshaw "*I don't want to see him*". Ms Hyde denied refusing to see Bailey and on numerous occasions throughout her evidence she sought to explain why she would not see an inmate in an assessment cell. That was clarified in this exchange with Ms Lewer:

"*So, the main reason for that is in my experience they do escalate, because I actually have no - as a psychologist, once you've raised a mandatory so that mandatory is related to the assessment that you've just made around risk. You don't change that assessment until - so the next assessment is by the team that will review that risk, as I said, the following day generally, so I actually can't do anything about the assessment cell or the conditions that they're in, unfortunately, so generally I find that they escalate if I engage in that conversation, which is unhelpful, but the staff are able to provide that information around the process*".

The last exchange with Ms Lewer regarding whether it was possible that Ms Hyde refused to see Bailey was this:

"Q. *If the information was conveyed to you that Bailey wanted to talk about why he was in the safe cell, in those circumstances, you might have refused to see him. Is that fair?*

Yeah. I don't like the - I don't like the use of that word "refusing to see him". It's just not appropriate to see him in that - for that reason, at that moment, when he's just been placed in that cell. But I don't have a memory of that, but certainly it's possible." Ms Hyde said that the CICs on 4 November 2019 at 12:45pm, 12:58pm and 1:01pm indicated that Bailey was having a panic attack and that would be a reason (had she known) that Bailey would have been seen. In my view.

Ms Hyde's evidence was given with the benefit of hindsight. It is likely that Ms Hyde heard Bailey during these times, however considered that he wanted to see her only to argue that he should be removed from the observation cell. It may not have been apparent to Ms Hyde at that time that Bailey was genuinely having a panic attack. Ms Grimshaw said that in the afternoon, Ms Hyde came to her office and told her that Bailey's mother had called but that Ms Hyde did not speak to his mother. When this was put to Ms Hyde, she denied doing so, saying "*[t]here would be no reason for me to tell her that*". I accept that Ms Hyde did tell Ms Grimshaw this information.

Ms Hyde could provide no good reason as to why she did not speak to Bailey's mother. If it was because she did not have Bailey's consent, she could easily have gained that by attending his cell. It is unlikely her attendance for such purpose would have escalated Bailey, especially as at that time he had just spoken to his mother. In any event, Ms Hyde did not proffer that as a reason as to why she did not obtain his consent. On balance, the reason seems to be that she had no intention of speaking with Tracy so there would be no purpose in obtaining his consent to do so. Ms Hyde knew that Tracy was Bailey's main support person, that Tracy would have been concerned about Bailey and that she could have obtained useful information from Tracy about Bailey.

Ultimately, it would also have been most appropriate and courteous to take the telephone call and at least listen to what Tracy wanted to speak to her about. Throughout her evidence, it was Ms Hyde's position that although she had identified that Bailey was at risk of self-harm and she technically raised the Mandatory Notification, it was her belief that it was up to the correctional officers to manage Bailey in the cell and this included any engagement with his family. Further, Ms Hyde, despite having previously completed "*hundreds of MNFs*", was unable to explain why she did not complete the form on this day, leaving it up to Ms Grimshaw to do so.

I was unconvinced by Ms Hyde's evidence that she was not aware that Bailey was not coping in the cell (from the time he was put in it, until he became settled upon speaking with his mother and hearing her undertaking to speak with someone about the situation). As Ms Hyde said, Kariong CC was a small centre. Ms Hyde clearly went up to Ms Grimshaw's office, at least to sign the MNF (which was completed after Bailey was placed in the cell and after Ms Hyde had completed her OIMS entry) and later to tell Ms Grimshaw at around 2:30pm that she had declined to speak to Bailey's mother. Ms Mahony's submissions prefer that the MNF was completed before Bailey was placed in the cell, but I think that is incorrect. Ms Hyde's evidence made it clear that she had little to no memory of the events of the day, whereas Ms Grimshaw did. Ms Grimshaw's evidence that Ms Hyde was in front of her as she penned the MNF which she thought she completed at 12:45pm was compelling, as was her apparent honest recollection when giving evidence that Ms Hyde was sitting in front of her when Bailey was yelling and said that she was not going to see him. Ms Grimshaw said that asked Ms Hyde she would not see Bailey to which, according to Ms Grimshaw, Ms Hyde replied that she did not want to escalate him/ this is consistent with Ms Hyde's explanation in evidence as to why she would not see an inmate in an assessment cell.

It would appear that when Bailey was advised he was being placed in the assessment cell and taken to it, he asked to speak with the psychologist because his first CIC was at 12:05pm and he says, "*Miss can I please speak to the counsel lady like you promised me?*" Ms Hyde was in her office in a different building at that time completing the OIMS case note which she commenced at 11:55am. It is likely that it was after that time that she attended Ms Grimshaw's office to sign the MNF which had yet to be started. The IRM was completed at 1:25pm and indicates that the incident regarding self-harm was reported at 1:10pm.

The time of 1:30pm is consistent with it being by that this time that both the MNF and ISP had been completed (on the basis that the MNF was penned while Ms Hyde was in Ms Grimshaw's office, as it was in fact around 11:20am when Ms Hyde verbally reported Bailey as at risk of self-harm).

I note that at 1:05pm, Ms Grimshaw told Bailey that the Functional Manager was coming to see him. This is consistent with it being a correctional officer who would be able to facilitate Bailey engaging in diversionary activities, rather than Ms Hyde attending (despite numerous and frequent requests by Bailey from 12:05pm to see the psychologist). Consistent with Bailey being with John Brown, there are no further CICs until 1:53pm, and in that CIC Ms Grimshaw told Bailey that the psychologist had gone home. It was then that a phone call was facilitated for Bailey to call hismother.

Ms Grimshaw said that it was Ms Hyde who had made suggestions to her as to what diversionary activities Bailey might have, and that they are contained in the ISP. This engagement is denied by Ms Hyde; however, I prefer the recollection of Ms Grimshaw in that regard. She certainly had never completed either a MNF or ISP before and required guidance. Ms Grimshaw said in her statement that she also received guidance from Ms Dolling. However, Ms Grimshaw said in her oral evidence that this was after she and Ms Hyde had completed the ISP, explaining: "*Because I wasn't confident in my abilities I just wanted to check with her after I filled that out with Ms Dolling to make sure that [John Brown] was a suitable replacement for an Aboriginal delegate and if I could give him a phone call and how that phone call had to be done*". I have no doubt that it was Ms Hyde who suggested to Ms Grimshaw that John Brown might assist settling Bailey. On the basis that the MNF and ISP were completed at the same time and likely finished by 1:10pm, Ms Hyde was in Ms Grimshaw's office by at least 12:45pm. I do not accept Ms Hyde's denials that she did not hear Bailey yelling. I do not accept her denials that she was unaware that Bailey was requesting to see her. I do think she told Ms Grimshaw that she did not want to see Bailey for fear of escalating him or at least hoping that he would settle down once the diversions were actioned.

It would appear that Bailey's escalation in the cell on 4 November 2019 was not brought to the attention of RN Georgiou at any time that day. She said that she attended Bailey at about 4pm and gave him his medication and he appeared calm and settled and he did not raise any issues with her. She made a clinical note to this effect in his file. However, given that she was aware that Bailey's cell placement had changed, and that Bailey was on a RIT she should have, in accordance with Justice Health policy, completed a HPNF. She said that although it was a key document that should have accompanied the MNF, she did not complete an HPNF due to (a lack of) resources as it was a very busy day.

There is a concerning lack of time stamps on the documentation kept by CSNSW in relation to inmates who are placed on a RIT and for inmates who are in an assessment cell.

Although their containment is recorded and although there is a digital record of any CICs made, there is no requirement to record any of those matters on any document to inform the RIT review team or to inform decisions about the appropriate management of an inmate in an assessment cell. This lack of documentation and process has demonstrated the need for recommendations to be made in relation to documentation involved in the RIT process, and is discussed further at [196] to [249] in relation to the RIT review process.

Bailey's experience in Cell 41 on 4 November 2019

Though Bailey was in the assessment cell for observation, there were no instructions provided to any correctional officer about the frequency with which observations should be made and what matters should be noted. There is no contemporaneous log of the times of the CICs, there are no notes of the content of the CICs (or even a synopsis of them), there are no records or notes of any of Bailey's distress, behaviour or any of the activities and interventions Bailey was engaged in, and there are no notes of Bailey's health whilst he was in the assessment cell. I note COPP3.7 at Policy 4.6 states: "*All observations conducted are to be recorded on a ISP/RIT Management Plan-Observation record. Observations are useful both for keeping the inmate safe and for gathering information to inform the development of future plans to manage the inmate's risk*".

Other than one OIMS entry made that evening when Bailey was escorted to hospital with chest pains, there are no entries in OIMS about his time in the assessment cell to which any member of the RIT review team could refer when they came to conduct the review on 5 November 2019. CSNSW does have digital records with time stamps for all the CICs and the audio recordings of the CICs as well as the video recordings of the cell. This material was made available to the coronial investigation and tendered in the inquest together with transcripts of the CICs. However, these recordings were not accessed, considered or referred to by the RIT review team on 4 November 2019. A timeline of the events in the cell on 5 November 2019 (before Bailey was transferred to hospital) was prepared by Bailey's family's representative and tendered into evidence. These records show that on 4 November 2019, Bailey made 67 CICs between 12:05pm and 1:54pm. There are 23 incidents of conversations between Bailey and mainly Ms Grimshaw where he is clearly distressed, asking to the see the psychologist and saying he cannot breathe.

Ms Grimshaw in her statement describes that between the time that Bailey was placed in the assessment cell at 11:50am and 3:30pm, "*[his] demeanour alternated, at times appearing to be one of or a combination of crying, angry, anxious, difficult to placate, to other times appearing calm and happy*". She said that she facilitated John Brown to be with Bailey between 1pm and 2pm, that Bailey had a telephone call at about 2pm, "*at [2:20pm] he appeared happy and calm*" and that Bailey and John Brown moved back to the assessment cell. John Brown returned to his unit at 3pm and gave Ms Grimshaw a book and a drink sachet to give to Bailey (which she did). Ms Grimshaw said that at about 3:30pm, Bailey was quietly reading in the cell and she finished her shift. Ms Grimshaw said in her statement that during that time she had various interactions with Bailey, trying to ascertain the reason for his disquiet, explaining her duty of care to Bailey and the reasons and processes for the ISP, reassuring Bailey, discussing possible diversionary activities, coping techniques, "*distraction conversation*", positive goal setting, encouraging positive behaviour and positive reinforcement. In her evidence she was taken to the transcripts of the content of numerous CIC exchanges between herself and Bailey.

At 12:22.55pm, Bailey said that he could not be in the cell any longer and was in fear for his own safety. Ms Grimshaw told him "*you're on a RIT, that RIT can't be undone, you're gonna have to just calm down and figure it out*." At 12:43pm, after Bailey again pleaded that he wanted to get out of the cell, Ms Grimshaw said, "*Bailey. You need to listen. I've already explained this to you. You can't be processed until tomorrow morning. So, you can't be let out until tomorrow morning…it's non-negotiable*".

Ms Grimshaw said in her evidence that she was of the belief that she could escalate a RIT but could not de-escalate or remove it.

This demonstrates a fundamental misunderstanding as to the policy that "*[t]he ISP can be reviewed and updated until such time as a RIT convenes (correctional centre only) and conducts an assessment and formulates a RIT management plan*". Another fundamental misunderstanding was that a RIT necessitated an assessment cell. It was described by Ms Hyde as the "default" position at Kariong CC.

Ms Grimshaw said she relied on Ms Hyde's advice that Bailey be placed in an assessment cell, rather than exercise her mind as to the least restrictive care requirement, as she had not carried out any assessment of Bailey. Bailey asked to see the psychologist at 12:05pm. Officer John Jentsch, who was apparently watching the CCTV monitor, called Bailey and told him to take a seat and calm down.

Bailey called at 12:09pm saying, "*Chief please*" and Ms Grimshaw told him that everything had been explained to him and he needed to take action. At 12:11pm, Bailey called saying, *"there's gotta be something you can do. I cannot be in here. It's fucking making me feel sick. I'm gonna have an anxiety attack. Please!*" He was again told to sit down, take some deep breaths and just relax. At 12:17pm, Bailey called twice and asked for the counsellor to come and see him. He asked to be let go, said he needed to get out and said "*I'm gonna have a … panic attack".*

Two minutes later at 12:19pm, Bailey asked to be let out and said that he was not coping. Ms Grimshaw told him that he was bringing unwarranted attention to himself (because inmates in another accommodation unit would be able to hear him yelling). Bailey next had an exchange via a CIC with Ms Grimshaw between 12:21pm and 12:23pm where he asked for help, saying that he could not be in the cell anymore. She told him that the RIT could not be undone (as per [129] above) and he needed to calm down. Bailey told her he could not, and Ms Grimshaw told him that he was "*proving the reason as to why you were put on the RIT in the first place by behaving like this*". Bailey made nine further CICs, but these were apparently not answered. The next CIC was at 12:43pm was instigated by Ms Grimshaw, asking Bailey how he was going and if he was a little bit calmer. He said that he wanted to get out and that "*I'm not calm at all*". Ms Grimshaw said that she was prepared to talk to him, but he could not keep telling her he wanted to get out of the cell because it could not change anything.

He told her the cell was not good for his mental state; he asked her to understand where he was coming from, that he was having a panic attack and the cell was making him sick.

When Bailey's voice became elevated, Ms Grimshaw told him that she would talk with him but not if he was doing the "*shouty shouty thing",* a term she used twice during the CIC. When Bailey told her, "*I can't cope in here. Please do something. I can't cope*" she replied, "*[w]ell I was going to let you out for a phone call so you could have a discussion with Mum, but I can't while you're doing this*". Bailey then started crying and sobbing and saying, "*I want to get out of this cell*", he said that he was fine to be [in the cell] with John Brown and that he has "*never wanted to self-harm in my life*". He pleaded for her to let him out, saying it was torture. Ms Grimshaw accepted when giving evidence that the way she spoke to Bailey was inappropriate. The ISP was not completed until after this 12:43pm CIC.

Regarding the issues as to whether Ms Hyde was aware of Bailey's distress and his requests to see the psychologist, I note that two of the diversionary activities entered on the ISP were a telephone call and a visit by John Brown. Ms Grimshaw was unable to specify which of the three diversionary activities on the ISP were specifically suggested by Ms Hyde.

As already indicated at [129], Ms Grimshaw then told Bailey that he could not be let out of the cell until he was processed the following day and it was non-negotiable. She told him that it was not torture and if she was in gaol, the assessment cell is where she would want to be.

He told her he was not "*mental*", and he needed to be out of the cell, but Ms Grimshaw told him, "*I'd like you to have a normal conversation with me rather than this shouty, demand let–me-out.*" He told her he was stressed, panicking, feeling sick and could not cope. She told him, "*[y]ou can cope, and you will cope*". At this point, Bailey asked Ms Grimshaw, "*[p]lease. Can't you get the counsellor to come and see me please*"? Ms Grimshaw told Bailey he could do this easily. Bailey told her he was sick and that he could not breathe. Ms Grimshaw told Bailey that he could not breathe because he was winding himself up, that he was smarter and stronger "*than this*" and told him to "*get it together*". Bailey then said "*why … would you do this to someone... this is not right, get me out of here. Please, or get the counsellor so I can speak…"* Ms Grimshaw did not answer. Bailey called again, and again there was no answer.

At 12:58pm, Bailey called and said, *"please you cannot fucking do this to me…. You cannot … put me in this…. Get me outta here. Get me out. Or call the fucken counsellor or the psychologist that put…*" Ms Grimshaw replied, "*I'll put you on a full RIT and take you greens*". This meant that if Bailey continued to make demands he would have his regular clothes taken from him. In her evidence Ms Grimshaw said that she had not intended those words to be a threat. In her evidence, Ms Grimshaw acknowledged the inappropriateness of some of her wording and said that by this stage she was panicking about what to do.

Bailey continued to make CICs from 1pm which were not answered, in which he repeated all that he had previously said, such as that he was not coping, to call the psychologist, that he had never self-harmed in his life ever and never will, to call the ambulance, that he cannot do this, please help, to call the "*psych*". He repeatedly asked "*please", "somebody help*" and he said, "*I can't breathe*".

Ms Grimshaw did answer the 1:05pm CIC and told Bailey that he had to stop, that he was safe and that the FM (Functional Manager) was coming to see him. John Brown wrote in his notes that at about 1:30pm on 4 November 2019, Mr Clarke (the Intel Supervisor) asked him if would be willing to go to the safe cell to sit with Bailey and try to calm him down. Mr Clarke told John Brown that Bailey was beyond distraught and that his behaviour was such that if it continued to spiral downwards he would face further sanctions. The term "*sanctions*" was John Brown's and he agreed with Ms Mahony that he used that term in his notes because moving from a general cell to an observation cell may feel like a sanction. John Brown agreed to visit Bailey.

John Brown wrote:

"*When I entered the safe-cell, Bailey was pacing and was in tears and very clearly emotional. I hugged him and sat on one of the beds. I asked him why he was so distraught, and he told me that he was terrified of being alone in the cell. I asked him why he was terrified, and he said it felt to him like he was in a horror movie like Saw*."

John Brown said that he was in the cell with Bailey for about one and a half hours. He said that for the first hour, Bailey was inconsolable. After being in the cell with Bailey for about 30 minutes, Bailey made a CIC and pleaded to be taken off the RIT. The only CIC set out in the transcripts is at 1:53.48pm. In this call, Bailey spoke with Ms Grimshaw and asked if the psychologist was still there and Ms Grimshaw told him that she had gone home. In her evidence, Ms Grimshaw said that at the time she told Bailey this she believed that Ms Hyde had left the centre; however, she learned that this was incorrect when she saw Ms Hyde at around 2:30pm after Tracy had sought to speak with Ms Hyde on the telephone. John Brown said in his notes that shortly after Bailey had made the CIC, Mr Cargill came to the safe cell and he quietly and calmly spoke with Bailey, explaining to him that "*he would need to show that he could do one night quietly and calmly in the safe- cell and if everything went well, he would be assessed at 8 am next morning and returned to the unit. Bailey continued to state that he was afraid of being alone in the cell*". John Brown asked Mr Cargill if he could stay overnight in the cell with Bailey, but Mr Cargill said that was not possible. Mr Cargill then left the cell.

According to John Brown, when he and Bailey were in cell 41 together, Bailey told him he would fake an illness to go to hospital. John Brown asked him what he thought he would achieve by doing so and Bailey told him that it would get him out of the safe cell. John Brown replied that he would be returned to that cell and it would most likely ruin any chance of being taken off the RIT the next morning and could mean that he stayed on the RIT for a week. According to John Brown, Ms Grimshaw then attended the cell and repeated what Mr Cargill had said, reassuring Bailey that he would be assessed at 8am the next day and that "*things were being done for him that wouldn't normally be done for other inmates in his situation*". Bailey asked if could make a telephone call. Ms Grimshaw agreed, and John Brown and Bailey went to the accommodation unit 2 where Bailey telephoned his mother. Given that this was Tracy Mackander's last time that she spoke with Bailey, she would prefer to keep as much of this this call as private as possible so I will be brief with the matters significantly relevant in the inquest. I note that SCO Clark, who was Intel Supervisor on 6 November 2019, listened to the recording of the telephone call between Bailey and his mum and made a report of the same date.
The call commenced at 2:07pm on 4 November 2019. SCO Clark reported that:

"*During this call inmate Mackander sounds distressed due to his current placement on a Mandatory Notification. He states he cannot deal with it. The receiver of the call was supportive of him, saying he needs to calm down and he would not have been put in observation cell for no reason. He admitted to having thoughts of self-harm but said he would not carry them out. He also stated he was having panic and anxiety attacks. The receiver of the call stated that she would call the centre and find out what was happening*".

The relevant conversation between Bailey and Tracy included Bailey saying, "*I spoke to a counsellor today. And I said a few things and I just said how I was feeling. And they put me in a RIT cell*". Tracy said to Bailey, "*[d]id you tell them that you wanted to kill yourself or something*" and he said, " *I know I said that the thought goes through my head, like every other inmate in here …I said, but doing it is a different story ... and then I open up to her and I get this shit happening to me…they keep me there for the night and assess me tomorrow…I can't even be in there for 2 seconds…they brought [John Brown] down to talk to me but it's still not working*". Tracy said, "*They'll only keep you there for 24 hours. They can't keep you there any longer than that, can they*?" Bailey replied, "*[t]hey can keep me in there for a week if they wanna kick [keep] me for a loop. And do you know what she said in the notes because I was upset. That's why. They're fucked up…I never said I wanted to kill myself, ever, ever. I said it goes through my mind like every other person in the gaol, I said but doing it is another thing. And it's on my record, I've never ever self-harmed in my life, ever*".

Tracy told Bailey that she would ring the centre and that they could not keep him in there, and that it was only an observation thing. He told her "*[t]hey can; I've known people who have been in there for months, weeks…I'm gonna have a panic and anxiety attack. I fucking can't do it. I can't relax...I can hardly breathe…literally - I can hardly breathe*". Tracy suggested that he do exercises like star-jumps and push-ups and be active in the cell and he responded, "*[t]hey'll think I'm even more fucking mental*…"

After the phone call, which was a little over six and a half minutes, Bailey and John Brown returned to Cell 41. Tracy called the centre and when Ms Hyde refused to speak with her she rang a client liaison officer (at Long Bay CC), who said she would send a consent form to Bailey for him to sign. John Brown wrote in his notes that after Bailey's phone call with his mother, Bailey seemed to have calmed down. John Brown reminded Bailey to be compliant and he would only be in the cell for one night. He asked Bailey if he wanted anything and Bailey asked for a book and an Orange Tang drink, which John Brown delivered to Ms Grimshaw (who in turn gave the items to Bailey). Ms Grimshaw notes that at about 3:30pm, Bailey was quietly reading his book. She then left the compound, leaving Mr Cargill in charge. As there had been an overlap in shifts, Mr Cargill was able to see Bailey and no doubt had a handover about the events of the day before Ms Grimshaw left. Mr Cargill said in his evidence that he started his shift at 1:20pm on 4 November 2019, even though his shift was from 2pm to 10pm, and that everyone else who worked through the day left the compound by 4pm.

RN Georgiou left at about the same time. She noted that Bailey was settled and calm.

This is consistent with Bailey having been upset for the first one and a half hours in the cell, and the diversionary activities (of John Brown visiting, speaking with Tracy, knowing that she was going to call the centre and being given the book) having the desired effect. Bailey was in fact calm and settled for this time (for a short time at least). This changed shortly after 4pm when Bailey made a CIC complaining of chest pain. He was shortly thereafter transferred to hospital for investigation. Mr Cargill had no memory of this earlier part of his shift and set out his recollections in his statement dated 18 April 2021, under the heading "*My recollections of my interactions with Mr Mackander … on 4 and 5 November 2019 …*".

The only matters he addressed in relation to 4 November 2019 were that he had commenced his shift at 1:20pm and on the shift he escorted Bailey from Door 13 of the accommodation building to the ambulance to be taken to the Hospital for a pain to his neck and shoulders. He escorted Bailey back towards Door 13 upon Bailey's return. Notes made by Ms Dolling on 5 November 2019 (provided to Mr Cargill on that date) refer to Bailey attending hospital "*yesterday*". Those notes indicate that Bailey went to hospital at 5:15 pm and returned at 6:45 pm and that the probable diagnosis was a panic attack. The CIC was made by Bailey at 4:08pm; however there is no transcript of it. There are no CSNSW witness statements as to the events leading to Bailey attending the Hospital on 4 November 2019. There is an OIMS case note entry written by Mr Cargill:

"*Inmate MACKANDER was taken to Gosford Hospital in the afternoon of Monday 4th November 2019 by ambulance after complaining of chest pain. He was treated and returned to Cell 41. His discharge letter indicates that he is well. According to medical staff it is possible he was suffering from anxiety. I interacted positively with him upon his return. He did use the intercom to request his TV be turned down and he went to sleep shortly after. He had been reassured that his RIT status will be reviewed in the morning*".

Mr Cargill recorded on the OIMS the IRM 245790. He also completed that IRM. He recorded on 4 November 2019 at 6:31pm:

"*16:15hrs … [Bailey] activated Cell intercom and complained of chest pain. Ambulance was called and Ambulance officers McMillan and Hemmings attended at 16:30. Inmate transported to Gosford Hospital 17:15. Inmate is due to return shortly*. "Following that entry, there is a date of 4 November 2019 and a time of 6:42pm and an additional entry: "*[a]t 1845 hours inmate returns from Gosford Hospital*". The document identified that the duty officer was Daniel Birch and the escort officers were Mr Slingsby and Mr Uerata.

At 5:35pm, Bailey was triaged and 10 minutes later he was seen by the ED doctor, Dr Kathryn Porges. Dr Porges examined Bailey and she reported in her statement that Bailey was polite and a bit stressed. A chest x-ray was performed with normal results. Dr Porges explained that anxiety and stress can manifest in physical symptoms such as chest pain. Dr Porges did not consider that Bailey required a mental health assessment because, in her opinion, he was not in distress and that "*the triggers for a mental health assessment are suicidality or significant risk of self-harm*." Dr Porges considered the possibility that the chest pain may have been reported as a rationale for an excursion from goal but to her Bailey did not appear in distress. Mr Cargill recalled Bailey returning from hospital and it appears that Mr Cargill was of the view that Bailey was not genuine about having had chest pain because he had asked Mr Cargill if there was any medication rather than making a complaint about the pain he was in. Mr Cargill said that he had looked at the discharge summary and remarked to Bailey that Bailey was fitter than he was. I do not think that the exchange between Mr Cargill and Bailey was sufficient for Mr Cargill to form the opinion that Bailey did not genuinely suffer from chest pain and that he was feigning it; however, it is highly possible he was correct given Dr Porges' findings and Bailey's earlier conversation with John Brown about his intention to fake an illness so that he would be taken to hospital.

That is not to say Bailey was not feeling those pains earlier during the day when he was reportedly having a panic attack. Although there is no transcript of the CIC prior to Bailey attending hospital, there is a transcript of a 7:20pm CIC after Bailey returned from the Hospital. In his evidence, Mr Cargill said he was not sure whether it was his voice; however, I am of the view he did answer the call. The transcript provides that:

> *"B: yeah chief can you come and turn this TV off for us please? CO: mate did you get dinner tonight?*
> *B: ah I didn't eat it though, if you've got a spare one can I please have it? CO: but you got dinner didn't you.*
> *B: yeah.*
> *CO: Can you guess whose turn it is now mate? B: what?*
> *CO: can you guess whose turn it is now? B: for what?*
> *CO: for dinner. B: whose?*
> *CO: yeah mine. B: Oh right…*
> *CO: You know what chance you've got of getting that TV adjusted don't ya? B: yeah.*
> *CO: good."*

Mr Cargill has said that he did not consider this conversation inappropriate, and that it is dependent on the context. Bailey did not make any further CICs and appeared to sleep throughout the night.

Dr Eagle agreed with Ms Mahony's proposition that Bailey was likely having a panic attack between 12:05pm and 1:05pm on 4 November 2019. Dr Eagle also agreed that the intervention of placing Bailey with John Brown appeared to resolve those issues. Dr Furst thought that the intervention was in a positive way extraordinary (in a prison context). Professor Large also agreed that having someone with Bailey was an appropriate response. He gave this evidence:

> "*Most people having a first panic attack actually end up in an emergency department. They think they're having a heart attack or an asthma attack, or they think something catastrophic is happening. Some patients will go to the ED a few times and a small number will go lots of times. But most people will be, you know, told that it's an episode of panic and won't run the gauntlet of an emergency department too many times. There are a whole lot of different treatments for panic. Being with somebody else is a - most people who have panic attacks have them when they're on their own. So even people who have panic disorder with agoraphobia usually are quite capable of moving around if they're with someone else. So being with somebody else is a very important way that people with panic disorder regulate that; and I suppose these days, in these times, it would be calling someone. I think Lifeline get a lot of calls from people who are panicking*."

Dr Eagle opined that Bailey was likely exhausted from the anxiety and panic attacks he had been experiencing since being placed in the cell. She described the symptoms of a panic attack thus:

"…the person experiences sort of a heightened sense of panic or heightened fear, to use a layman's term, and that's associated with physical symptoms, so sometimes they feel like they can't breathe, they feel like they might have chest pain, they feel overwhelmed, they feel like they're going to die, and it's an irrational feeling and it makes the person feel like the sensation is never going to end, and that would be considered a characteristic panic attack, and a panic disorder often comes on - panic attacks then come on because of the person's fear that they're going to actually have another panic attack, which then triggers further panic attacks and it becomes a self-perpetuating disorder…".

Escort personnel and documentation on 4 November 2019

Mr Cargill did not refer in his statement to having completed the escort documents for the correctional officers to take Bailey to hospital on 4 November 2019. That they were the same officers on 5 November 2019 seemed to have escaped his memory or attention. Those officers also say they have little to no memory of the transport escort on 4 November 2019. During his evidence, Mr Cargill was taken to CCTV clips of the escorts and of Bailey arriving and departing the Hospital via the ambulance bay. When he arrived, Bailey stepped out of the ambulance and Mr Slingsby held him at the handcuffs and walked with him into the ED. When they departed, Mr Slingsby did not hold onto Bailey at any time. Mr Uerata was armed, and he followed them on each occasion at a distance. The CSNSW van was parked rear to kerb in a parking bay at the far end of the ramp on 4 November 2019 and also took that position on 5 November 2019. Gosford Hospital had sent Kariong CC an email indicating where the prison vehicles should park. It appears that CSNSW did not conduct any intelligence relating to the location; however they should have given that it was a recently completed construction.

After watching the footage, Mr Cargill was asked whether (when he prepared the escort documents) he had the expectation that the unarmed officer would have a physical hold of Bailey whilst returning to the van. Mr Cargill said, "*[i]t was usual. I don't know whether – I can't think back to whether I had an expectation at the time, but it, it was – it was usual to me".* The question was again put by counsel assisting and Mr Cargill said, *"I think the footage does not meet my expectation*".

The "Transfer to Hospital or other place specified order" is a two-page document authorising inmate movements pursuant to s. 24 of the Crimes *(Administration of Sentences) Act 1999*. On the first page it has sections 1-7: 1 Inmate Details, 2 Order, 3 Period of Absence, 4 Location of escort, 5 During escort, 6 On discharge and 7 Approval. The second page has sections 8 Additional/special considerations and 9 Assurance. Accompanying the s. 24 order is a single page document entitled "Escort- assessment" which has three sections: 1 Inmate details, 2 Assessment and 3 Summary (which includes an authorisation). A third document is a page which has the photograph of the inmate, their identification and date of birth. The s. 24 order for 4 November 2019 indicates in section 1 that Bailey had no escape history, there were alerts and there was an OIMS printout. Section 8 mandated that Bailey remain in company of the correctional officer at all times, be treated as high risk at all times, be handcuffed and ankle-cuffed (the latter only to be removed after approval) and that one officer must be armed.

Under "*[o]ther*", there is in handwritten words: "*Close monitoring – has suicidal ideation*". Section 9 indicated that all reports and documents were attached as per policy and procedure, and that there had been no contact with security at the local unit, local police command or the Hospital security. The escort assessment for 4 November 2019 at section 1 identified that Bailey was an unsentenced Classification B inmate on protection and that there were alerts. In section 2, it identified that Bailey did not have an "E" classification or escape record on OIMS and there was no known intelligence that may impact on the escort. In section 2 under "[o]ther", it is indicated by a tick of the respective "yes" boxes that there are issues and that there is information recorded in case notes that may impact on the escort. The section 3 summary has this recorded: "*Psychologist says that Mackander has "suicidal ideation". Officers are reminded that he is to be handcuffed and ankle cuffed at all times and closely supervised*".

Mr Cargill explained that the purpose of the escort assessment was to provide information to the escort officers as to the risk and how to manage risk. He said that he creates the assessment from "*information that's available at the time. So, I look at OIMS, I look at his case file if that's available, I talk to people and whatever information that's just available"*. He could not recall much of the afternoon of 4 November 2019, other than that it was extremely busy. He said that he did mention to the escort officers that Bailey was impulsive and so they were to watch him closely. The relevant policy is 19.6 COPP (Medical Escorts) which must be read in conjunction with 19.1 (General Escort Procedures), states:

"*Escorting officers are responsible for the safe and secure transport of inmates. It is the responsibility of the officer approving an escort to ensure that sufficient correctional officers are assigned to the escort to maintain the security, control and supervision of the inmates on escort*."

"*1.1 Authority and responsibility for medical escorts*

"…The primary responsibility of the escorting officers is to provide adequate security and supervision appropriate to the level of identified risk regarding the inmate

At 5.18 the LOP states:

"*At the completion of the medical appointment escorting officers are to return the inmate to the escort vehicle once the inmate has been secured in the escort vehicle escorting officers are to contact KCC and inform them that the appointment has been completed and the escort is returning to the centre*."

November 2019

Though Bailey had been told on 4 November 2019 that the RIT would be reviewed at 8am, Bailey was not taken to the meeting until after 11am. Bailey woke at 7:28am and made his first CIC at 7:35am, asking what time the psychologist was coming to speak with him.

He was told probably in a half an hour to an hour. At 7:40am, two officers attended the cell and spoke to Bailey. It is unclear who they were and what they said. Bailey waited until 8:13am until he again pressed the CIC a couple of times with no response. He pressed the CIC again at 8:15am and asked, "*How much longer, please it's distressing me out*". The officer told him he was coming down to see him in a minute. At 8:22am, Bailey asked "*what is happening…can you come and get me out of the cell please. Or … speak to the psych or the nurse*". Despite the fact that RN Georgiou had commenced work that day by 7:30am, the officer told Bailey that the nurse was not in yet and that she would come and see him. At 8:24am, Bailey asked when he was able to get out of the cell. He was told to calm down and stop using the CIC.

Officers delivered Bailey breakfast at approximately 8:30am. An hour later at 9:25am Bailey made a CIC again, asking if the nurse had arrived and how long she would be. Bailey was told she would come when she was ready, and he had to just sit down and be quiet for a little bit. At 9:33am, Bailey used the CIC and complained of chest pains and asked when the nurse was coming. The officer replied he would let the nurse know. At 9:42am, officers attended the cell and took Bailey to be reviewed by RN Georgiou. RN Georgiou's notes record a time of 8:50am; however, this seems to be an error and should have recorded 9:50am.

RN Georgiou's notes record the following:

> "*Nursing: Pt was brought to clinic by CSNSW c/o chest pain – also advised pt. was sent to Gosford Hospital last evening c/o chest pain – O/E D/C summary-? Musculoskeletal – cardiac cleared and sent back to centre. CSNSW did not advise AHNM [After Hours Nurse Manager] – spoke [author] with FM and requested Senior to call AHNM in future. Pt then stated he was fine but wanted out of the RIT cell. Obs BTF [Between the flags]. Pt advised I was unable to take him off his RIT, but we would convene with team as soon as possible to discuss and review Pt very agitated and was removed by numerous CSNSW officers; to convene RIT* asap."

RN Georgiou explained that procedures had not been properly followed when Bailey had been taken to the Hospital the previous evening. She said that after 4pm, when there was no Justice Health staff on the premises, the procedure required Mr Cargill to call the after-hours nurse so that any health information could have been sent with Bailey to the Hospital. Bailey was returned to the observation cell at 9:57am. Within a minute of being back in the cell Bailey made a CIC asking if John Brown could come to his cell. Mr Lloyd was the officer who spoke with Bailey. He told Bailey that John Brown had already been spoken to and he was not coming up at the moment as he was exercising. John Brown gave evidence as to why he did not visit Bailey in the cell on 5 November 2019. In his notes, he said that he had seen Bailey being taken to the clinic and that Bailey seemed distressed. Bailey caught John Brown's eye and asked him to come up and see him. John Brown had a discussion with CO Danny Field and asked him what he thought and according to John Brown, CO Field suggested that Bailey was acting and expecting to be treated like a juvenile offender.

John Brown said that he agreed with that assessment and decided not to visit Bailey so that Bailey would learn to cope on his own. He said, "*Shortly afterwards, more senior officers made the decision that I was not to go up and see him*".

Bailey made two CICs at around 10am, which were answered. Bailey said, "*You've got to get me out of here, this is fucking making me sick. It is stressing me out, pleas*e". He was told he would be spoken to a bit later and that he had to settle down and if he did not chill out he would be in there for longer. Bailey was told to settle so that things would go his way. A minute later in the next CIC, Bailey complained of bad chest pains and asked to see the nurse. He was told that the nurse had just seen him, there was nothing wrong with him and that it was his attitude. Bailey then said he had been vomiting so how could the nurse say that he was okay. He was told to stop using the CIC.

Ten minutes later at 10:11am, Bailey made another CIC complaining of severe chest pains and asked for someone to come and see him. The officer said he would come down and speak with Bailey, which he did, talking to Bailey through the door for a couple of minutes. Ten minutes later at 10:32am, Bailey made another CIC complaining that, "*I've got vomit everywhere can you get the fucking nurse for me?*" Mr Lloyd said no. Bailey replied that the cell was full of vomit and Mr Lloyd told him if he was going to vomit, it would be better to do so in the toilet. Mr Lloyd then said, "*[i]nstead of making a mess of your cell where you're probably going to be living for probably a while now with the way you are carrying on, I suggest you either spew in the toilet and clean up the mess there now*."

Bailey made another call at 11am, however that does not appear to have been answered. However, an officer attended the cell and took Bailey out of it at 11:04am to attend the meeting with the RIT review team. There has been an issue in the inquest as to how long the RIT team met to consider the review. It would appear that, at least in regard to Bailey's participation, he was likely in the meeting for 15 minutes and that the team had made their decision within about 15 minutes of his departure from the meeting. After Bailey left the meeting, rather than being returned to Cell 41, he was taken to his accommodation unit which he shared with John Brown. CCTV footage showed Bailey entered the unit at about 11:30am. John Brown said in his statement that when he asked Bailey how he was, Bailey told him that he was terrified that they would send him back to the observation cell.

John Brown assured him that if they did take him back it would only be for one night and he had already managed one night so another night would be fine.

Bailey went to the common room and began pacing, which was not unusual for him. John Brown thought that Bailey's "*demeanour and mood did not seem to be out of the ordinary with the exception of maybe slightly heightened anxiety due to the fear of being sent back to the obs cell*". Bailey went into their cell for a couple of minutes alone and returned to the kitchen with bread and margarine and made toast. Shortly after this, Ms Dolling came to the accommodation unit and escorted Bailey out of the accommodation unit. RN Georgiou said Bailey was returned to the meeting room after Mr Dolling left and although she could not say who spoke to him, he was told what decision was made in the meeting. She said he was "*definitely not impressed…I don't know whether he knew it going to happen...but…it wasn't as emotive as it…had been that morning in the clinic*".

In contrast, RN Georgiou's notes written that day recorded that he was very agitated and distressed at having to return to the assessment cell. She said she told Bailey that she would make contact with the mental health nurse and that he would be seen the next day. She said that the review by the mental health nurse would involve a mental health assessment as she was not qualified to carry out such an assessment.

The Risk Intervention Team review

The policy relating to RIT review is contained in sections 5 to 8 of CSNSW COPP 3.7, "Management of Inmates at risk of self-harm or suicide". The policy requires each team to have a co-ordinator who must be a custodial officer of SCO rank or above, a Justice Health member and an Offender Services and Programs staff member (SAPO). The Non-Justice Health members must have completed the **Awareness of Managing at Risk Offenders** (which is an online-e-learning module) and the co-ordinator must additionally have completed the two-day training course called **Managing At-Risk Offenders** (which is a program requiring personal attendance at the Brush Farm Corrective Services Academy). The task for the RIT review team is to assess the inmate's risk of harm or suicide with reference to the **RIT Assessment Interview and Guidelines,** although such a document does not seem to have been used by the team on 5 November 2019. Ms Dolling, who had participated in at least 50 RIT reviews, said that the team does not in fact carry out an actual risk assessment. She said:

> "*I would feel that is part of the - like, they have - they don't do the actual risk assessment, like, the inmate under threat assessment, no. But it's part - what you would conduct, under the powers of least restrictive care, you have to assess what threats the inmate has made, as to what they can have access to, or what diversionary practices are beneficial for that particular inmate. So, a threat assessment is carried out as part of the package, per se*."

There can only be two outcomes of a review: If the inmate is not considered by the team to be at risk and does not require additional management strategies, the team proceeds to Part 4 and completes a **discharge plan**. If the inmate is considered to be at risk, then the team is required to develop a **Management Plan** which should include strategies that directly **target risk factors** while maintaining **principles of least restrictive care**.

The Management Plan must be **based on all available information.** The duration of the Management Plan can be short or long - such duration as determined by the strategies required to manage the inmate's risk of suicide or self-harm. The policy has a hyperlink for the co-ordinator (or the other CSNSW members) to access numerous forms and annexures including: Inmate discipline checklist, Inmate interview questions to further evaluate risk, Inmate undertaking to share accommodation, ISP/RIT management plan observation record form, ISP/RIT management plan reference guide, Risk factors for consideration: reference guide, RIT assessment Interview and documentation guidelines and Suicide and self-harm procedure checklist. The '**Suicide and self-harm: ISP/RIT management plan-reference guide**' is fairly limited in that it provides a general definition of what is considered to be minimum, medium and maximum restrictive options.

Though it refers to diversionary activities, it does not refer to human interaction which is a field in the RIT Management Plan. It does not refer to access to a person other than staff, nor does it refer to telephone calls under any of the options for diversionary activities. The RIT review process was somewhat defective from its inception as the co-ordinator Mr Lloyd had not attended the two-day training **Managing At-Risk Offenders** which was a mandated pre-requisite to be a co-ordinator of a review team. Not only had he not completed the training, he was not aware of any of the policy applicable to a review and although he knew the policy existed he did not attempt to access it. Further, he incorrectly considered that his role on the RIT was nothing other than to provide advice about security issues.

That he was the co-ordinator on that day seems to be a default task which fell upon the senior compound officer (whoever it was who was rostered). The inquest learned that on 5 November 2019 at Kariong CC, Ms Dolling was on duty. She had not only undergone the mandated training to be a co-ordinator, but she had significant experience in convening RIT reviews. She should have been tasked with co-ordinating the RIT review for Bailey. The fact that Mr Lloyd had no interest in looking at the policy, in regard to not only his role but what was required to be considered in carrying out the task, fell well below the standard required of his position that day.

The second reason that the RIT review process was defective is that the team had access to limited and inadequate information because there were no OIMS or records of observations or incidents of Bailey, his distress and means to alleviate it whilst in the cell on 4 November 2019. There was no reference to the numerous CICs, Bailey's distress, vomiting, panic attacks and anxiety arising from his confinement in the assessment cell. There was no record that he had been told what he needed to demonstrate to be discharged from the cell (namely, be settled and calm – which he apparently did from 7:30pm on 4 November 2019 until at least after 8am on 5 November 2019, when it became apparent to him that the review had not occurred at time he had been told it would). Ms Thompson and RN Georgiou were aware of Ms Hyde's OIMS setting out why she raised the Mandatory Notification and they all had Ms Grimshaw's ISP and Mr Cargill's OIMS report of Bailey attending hospital on 4 November 2019 for chest pains.

In addition, RN Georgiou had discussed Bailey with Ms Hyde (when Ms Hyde was considering raising the Mandatory Notification), she had met Bailey briefly when she dispensed his medication and she had reviewed him that morning in the clinic before witnessing his agitation (when he was informed, contrary to his expectations, that he had to return to the observation cell). It was not until RN Georgiou was preparing for the inquest a couple of weeks prior to giving her evidence that she learned of Bailey's use of the CIC and the course of events on 4 November 2019. She confirmed in her evidence that these were not known and not discussed in the RIT review meeting accordingly, the RIT review team really had no understanding of what was happening for Bailey.

It is unclear what Mr Lloyd brought to the RIT meeting; he had had dealings with Bailey before the RIT review meeting - over the CIC about whether Bailey could have contact with John Brown. Mr Lloyd said in his evidence that he tried to contact John Brown to ask, "*him to come up and talk to Bailey, I believe my response is one of those knocks ups there where he said no, he's already spoken to him*".

John Brown's recollection of why he did not see Bailey that day casts a different light on how that came about and indicated that the senior correctional officers determined that he was not to visit Bailey. I prefer John Brown's version and it is consistent with the Part 3 Management Plan. It appears that the review meeting did not have access to or use the document **RIT Assessment Interview and Guidelines**. The documentation relied upon by the team is not apparent as no reference is made to it in the records of the review, and it is not attached to the Management Plan. The lack of documentation (including with respect to what was asked and said in the meeting, how Bailey presented, what decision was made and why) makes it difficult to scrutinise the RIT review decision-making process.

The RIT review process was derailed when the Functional Manager, Mr Dolling took it upon himself to be involved in the review decision without any regard to the fact that he too (like Mr Lloyd) was unaware of the policy relating to RIT management. Further, his belief was that in Kariong CC, if an inmate is on a RIT they are in an assessment cell with no regard to least restrictive options. Mr Dolling gave evidence that he did not involve himself in the meeting and that he did not even enter the room. The evidence of the witnesses who comprised the review team contradicts him completely. Mr Dolling involved himself in the RIT decision when he had no standing, and worse he had no training and clearly no regard to the process involved to safeguard Bailey's wellbeing and safety. As Counsel Assisting submitted, the information that the RIT team used to make their decision needed to have been accurate and informed by policy. In my views, Mr Dolling's participation effectively disrupted and vetoed the RIT decision-making, and his participation was not documented which, as Counsel Assisting submitted, it should have been.

His involvement interfered with the review process so significantly, that taken together with Mr Lloyd's inexperience and indeed lack of standing to be the co-ordinator, I do not consider that the review process was appropriately or adequately conducted. Counsel Assisting submitted that the RIT review team took into account the incorrect assessment by Officer Dolling of the options available. She submitted that it was open to the team to consider and implement a plan whereby Bailey remained in the assessment cell overnight and has some time in the yard or with his cell mate outside during the day. A tailored placement option could be made available at Kariong CC. As Counsel Assisting said, Ms Dolling was an impressive witness who demonstrated that she was familiar with both process and policy. I accept those submissions.

The RIT review documentation does not require times to be recorded. Where the length of the meeting is put forward to indicate the time taken by the team to make its decision, the document should have such a timestamp to record the time commenced and ended. Dr Furst, in his evidence opined that the length of time of the meeting, which he understood was about an hour indicated that the team spent a lot of time considering a difficult decision about what to do with Bailey. Length of time may be some measure, but it may be that a better measure is to assess the training and information brought to the decision. Ms Thompson had engaged in the two-day training course in September 2019. She had very little experience participating in a RIT team, having participated in "*one or two*" prior to 5 November 2019.She said, "*I've done about five RITs in the whole time I have been a SAPO. And probably three of them was prior to training and one - one was after training at Kariong"* and that was just a few weeks before Bailey's RIT review.

Mr Lloyd had no RIT experience and said that the people responsible for making the assessment of Bailey's mental health were Ms Thompson and RN Georgiou. Though RN Georgiou was not a mental health nurse, as a registered nurse of 15 years she was qualified to make that decision. There appears to be no document which the team is required to complete indicating that it had made a finding that Bailey was still presenting as a risk of suicide. It might be assumed that, because the team completed a Management Plan rather than a Discharge Summary, a decision had been made that Bailey was at risk of self-harm.

The policy provides guidance for a review of RIT management plan which lists a number of matters that the team should consider to re-assess the inmate's ongoing risk of suicide.

Ms Thompson made an OIMS case note after the meeting and recorded that:

> "*The inmate was placed on RIT yesterday 04/11/2019 by the psychologist. RIT review today was attended by JH nurse L Georgiou A/SCO R. Lloyd and SAPO Thompson. The inmate presented as happy and stated that he had no intentions of hurting himself or committing suicide. The inmate was questioned as to why he would tell the psychologist yesterday that he had daily thoughts of suicide. The inmate stated that he was having a bad day yesterday. He stated that he had spoken to his friend over the phone and had become upset with the phone call. The inmate did not say what was said in the phone call, only that it upset him. The inmate asked not to be put back in the safe cell and stated that last night being housed in the safe cell was the worst night of his life. Again, he reiterated that he was fine and that he was not going to hurt himself. The inmate was taken from the room and a decision was made that he should stay in the safe cell and will be reviewed again tomorrow*."

Ms Thompson's OIMS case note does not say that there had been a determination that Bailey was considered at risk of suicide or include the reasons that informed that decision. The final sentence suggests that the decision that was made was a conflation of risk and management. However, it was not the decision that the policy required.

RN Georgiou made some short notes after the meeting:
"*5/11/19 – 11.00*

Nursing: RIT with Senior CSNSW and SAPO Marian – lengthy meeting (over) > 1 hour to discuss, FM also in attendance –due to pts inability to detail why he said he would have suicidal thoughts and unable to clearly outline why he wouldn't team not confident in terminating. Author to email MHN (Mental Health Nurse) to organise a review as soon as possible. Pt able to have reading material and greens [clothes] in cell. Pt very distressed about decision." The result "*team not confident in terminating*" does not indicate that the team considered that Bailey was at risk. Rather, at best it is indicative of the team being unable to make a decision on the material that they had. There is no mention in the Part 3 RIT review documents or Ms Thompson's OIMS that Mr Dolling was present, let alone what impact that had on the meeting.

In her evidence, Ms Thompson said that Ms Hyde had told her on 4 November 2019 about what Bailey had said in the interview with Ms Hyde. Ms Thompson said that on 5 November 2019, she was of a mind to keep Bailey on the RIT because at the forefront of her mind was "*the thought he'd put into the impact it would have on his family, if he had - if he did commit suicide*." RN Georgiou gave evidence over a full day. She was a co-operative witness who attempted to assist the inquest and she gave her answers in a considered manner. In relation to her assessment of the risk that Bailey presented on 5 November 2019, she (like the other RIT review members) did not make any notes. However, in her statement RN Georgiou referred to a list of risk factors. She said in her evidence that she identified those risk factors from "*a combination of the information I'd been given the day before with the psychologist, looking at his file, communicating with Bailey, watching like Bailey's presentation as a ...collaborative assessment*". She agreed in her evidence that when she was making her statement she referred to Justice Health policy "Clinical care of people who may be suicidal".

RN Georgiou said in her statement that she was aware of the Justice Health policy entitled "Clinical care of people who may be suicidal" and referred to a list included in section 3.1.2, "Comprehensive Assessment". In her statement, RN Georgiou itemised features of Bailey's history and presentation at the time of the RIT that gave rise to an increased risk of suicide. Though the list in section 3.1.2 might apply to most remand inmates at probably any given time, further examination established that at the time the indicia were not really considered by RN Georgiou (but rather she did so at the time she was preparing her statement).

The policy clearly says that "*[t]his evaluation should include a thorough assessment of the patient's presentation, history … and current mental state. An important element of suicide and DSH risk assessment is the identification of risk and protective factors associated with DSH and suicide"*. I am not persuaded that RN Georgiou engaged in such an assessment within or outside of the RIT review meeting. The RIT review meeting certainly did not.

Ms Thompson said that the team discussed "*maybe stepping [Bailey] down*". She said, *"[i]t was to sort of keep him in the cell of the wing at night time so he could be observed to letting him to [sic] the yard in the day.*"

This would mean that whilst Bailey would remain on the RIT, it would be on a revised placement. She said there was a discussion about buddying Bailey up in the cell with John Brown, but the team never got that far she said that Mr Dolling came into the room and interrupted the discussion, that Mr Lloyd left taking Bailey with him and then Mr Lloyd returned. In relation to the role Mr Dolling took, Ms Thompson said "*I think because he was acting manager of security that he was able to convince the RIT review*". Ms Thompson said of Mr Dolling, "*He just sort of said, "How's things, how's it going" and that and because Bailey was there we didn't really want to discuss it… so Rick took Bailey out of the room and that's when Rick left the room. And we were just talking, and we were just basically discussing what was best for Bailey; and that's when, you know, Terry said: "Keep him on the RIT*." Ms Thompson said that though she had not been aware that Bailey had used the CIC on 4 November 2019, she was of an opinion Bailey was not in a good place (mentally). It is apparent that she did not have much understanding of what that place was or seek elaboration.

Ms Thompson clearly took her task of being on the RIT review seriously and she and RN Georgiou at least took time to discuss some options, and the meeting apparently took longer than most such meetings. However, the length or duration of the meeting does not indicate much other than that a decision was difficult to reach. Perhaps co-ordination of the meeting with reference to the policy and guidelines would have assisted the members in carrying out a task that they probably were not particularly equipped to carry out.

The two-page form which follows the ISP is called the 'Part 3 Risk Intervention Team Management Plan'. The Management Plan's first section is a question, "**What is the current presentation and situation of the inmate?"** which requires an answer and allows for an entry over only three lines. This section in the form for Bailey was left completely blank. The Management Plan requires reference to the **"Suicide and self- harm: ISP/RIT management plan – reference guide",** which presumably would assist the team to consider the appropriate matters to answer that question. If that question is directed at whether the RIT review team has determined that the inmate is at risk of suicide, it should ask that question and provide for substantially more matters to be documented.

Though the next part of the form relating to **Cell Placement, Observations and Diversionary Activities** (similar to those sections in the ISP) reminds the team that the cell placement should be the **least restrictive relative to risk**, there is no provision for the team to record why that decision was made. The **Diversionary activities/human interaction** section on the form for Bailey only included two of the three activities from the previous day's ISP, and there is no recorded explanation as to why Bailey was no longer to have contact with a mentor such as a John Brown.

It would seem that the conditions of Bailey's cell placement were more restrictive under the Management Plan than the previous day's ISP. Though the Management Plan stated that Bailey could have telephones calls, it appears that this did not occur. This strongly suggests, especially without a documented explanation, that narrowing his diversionary activities (particularly the withdrawal of human interaction) was a "stepping up" rather than a "stepping down" of restrictive measures.

Having heard from the witnesses Mr Lloyd, Mr Dolling, Ms Thompson and RN Georgiou, I am of the view that Mr Dolling, despite his evidence to the contrary did participate in the RIT review meeting. This resulted in an outcome contrary to Ms Thompson's intent to commence "*stepping"* Bailey *"down*", this was stepping up the deprivations without any apparent basis for it.

It was not possible to ascertain from Mr Dolling the reasons as to why there was a narrowing of Bailey's diversionary activities because he denied having anything to do with the meeting. In the assessment cell, there was 24/7 lighting, no access to any recreational environment and no access to anyone who cared for Bailey (such as in person with his cellmate). I note under 6.2 of the Policy it says:

> "*The RIT aims to settle the emotional state of the inmate and address any non-coping behaviours. This may require assistance from staff outside the RIT. It there sets out a number of referrals including Justice Health, a CSNSW SAPO or a CSNSW psychologist*."

Bailey's form had a referral to a Justice Health Mental Health nurse, but other than that the management plan seemed not to direct its attention to setting Bailey. I do not for a minute suggest that Ms Thompson or RN Georgiou did not have care and concern for Bailey, they clearly did, but it seems that they were overridden by senior correctional officers. In regard to the RIT review decision, Mr Dolling's interference in the RIT review process meant that the least restrictive options were taken away from the team. I do not think that RN Georgiou or Ms Thompson would otherwise have decided that Bailey be placed in the observation cell, other than perhaps during the night. Mr Dolling had no regard to policy or any understanding of the concept of least restrictive care. Having said that, I do note that per the 5 November 2019 handover sheet which Ms Dolling gave to Mr Cargill, Kariong CC had only one yard available to inmates as the tennis court (which included a basketball court) was closed and the oval was closed due to trucks being parked on it. Whilst that might explain why Bailey could not access the exercise yard, it does not explain why he could not spend time with John Brown. There is no evidence as to why Bailey had no telephone calls on 5 November 2019.

I note that Ms Dolling said in her evidence that it was quite commonplace at Kariong CC in 2019 for a RIT review team to allow inmates on a RIT access to the yard during the day, telephones and exercise as that "*quite often is helpful in managing them*". There is little utility in my attempting to decide whether the RIT team should or should not have determined that Bailey remained at risk of suicide on 5 November 2019, particularly as it does not seem to be a task required for them to really undertake. I agree with Dr Eagle's appraisal:

> *"…I found the reasoning to be really troubling. I thought it really, it was impossible for Mr. Mackander to resolve. I think there's already no evidence that links suicidal ideation with suicidal risk and so then he denied, he was asked to deny the suicidal ideation which he did. He was asked to provide an explanation for why he had suicidal thoughts the day before which he'd already denied. So, you know, he said, but he did say he had a bad day and he may not have been capable of articulating what he'd said or why he'd said to the psychologist whatever he said the day before anyway. I just think there was, like there didn't seem to be anything you could have possibly said that day that would have got him out of that cell from my perspective. It was inherently non-evidence-based assessment and decision."*

During the inquest, RN Georgiou was taken to section 3.1.2 of the Justice Health policy "Clinical care of people who may be suicidal" and agreed that the policy should have been complied with but was not. The policy required her to carry out an assessment of a patient's risk of deliberate self-harm or suicide, upon performing a well-documented comprehensive evaluation of the complete clinical picture. RN Georgiou was asked when she did that and she replied, "*I would say it was, like, a collaborative approach.*

It was on the day before the information had been given, my review in his file, his presentation in the morning, the RIT review. It was all, it was all compiled. I didn't have any real decisions to make for Bailey until that RIT review and it was a team approach also".

The team approach was extremely limited because, even though the team knew Bailey had been to hospital the previous evening, according to RN Georgiou there was no discussion about it or his attendance at the clinic that morning. They did not know about CICs, Bailey's anxiety and panic attacks, his time with John Brown or his telephone call to his mother. There did not discuss it because there was no record made for them to have regard to. The RIT team were apparently not informed by other correctional officers or Bailey himself of these things apparently because questions were not asked of him.

There was inadequate understanding and planning in relation to the Management Plan. RN Georgiou was not aware the Bailey had no access to an outside area for exercise as she did not know that the assessment cell exercise yards were closed due to being unsafe. RN Georgiou said only a Justice Health mental health nurse could do a mental health assessment and refer Bailey to a psychiatrist. As Kariong CC did not have a mental health nurse, there were two options for Bailey to be assessed consistently with the policy – either for him to see a GP who could prescribe medication or, if he needed to see a psychiatrist, RN Georgiou could send an email to place Bailey on a waiting list for a mental health nurse via telehealth.

RN Georgiou was taken to the last section of page 1 of the RIT Management Plan, which has a heading "**Referrals"**. There are three boxes - the first for "**JH&FMHN**" (with room to apparently specify the purpose of the referral), a box for "**OS&P**" and a box for "**Other**". However, RN Georgiou did not refer Bailey to a mental health nurse. The first box is ticked, which suggests that Bailey was referred to Justice Health. The last box was also ticked, and the handwritten words are "*Mental Health Nurse*". RN Georgiou said that was different to the referral by email to a mental health nurse to which she referred to in her evidence. I note that the Part 3 Management Plan did not have an accompanying Incident Report ("IRM") as required, nor did it have Bailey's signature as required. Though Bailey was to be referred to a Justice Health Mental Health nurse RN Georgiou did not make a referral. RN Georgiou referred in her evidence to emailing a mental health nurse with a very detailed handover. An email has been provided to the inquest which RN Georgiou sent at 4:46pm on 5 November 2019 to the AHNM and another person from Justice Health. That email attached the HPNF and said, "*I have just seen him for his supervised medication with nil further issues*". In addition, at 12:34am on 6 November 2019, RN Georgiou emailed two individuals from Justice Health. She said with respect to Bailey:

> "*I spent the majority of Tuesday with one patient, Mackander #609005 he is a young pt. that had a lengthy consult with Erin (Psychologist) on Monday and she placed him on a RIT. He has some challenging behaviours and I have written some extensive notes on him. I hope he doesn't escalate for you; he needs transfer to an appropriate centre. I did not have the chance to complete the transfer out request or email Min about the appointment, could you please follow up today*".

RN Georgiou said in her evidence that had there been a second nurse at Kariong CC with a mental health background (though not employed as a mental health nurse) who could have performed a more detailed mental health assessment for Bailey. RN Georgiou agreed in her evidence that a referral for a mental health assessment could have been expedited and there would have been more scope to make telephone calls, do more and sit down with Bailey.

I note that the experts were not critical of Ms Hyde's decision to raise the Mandatory Notification after having heard what Bailey said in his interview. Dr Eagle, however, was of the view that Bailey was unlikely at "*imminent risk*". Dr Eagle does not think that the decision to place Bailey in the observation cell was consistent with the principle of least restrictive care. The evidence clearly establishes that at that time at Kariong CC, the policy in relation to least restrictive care was not complied with (as an assessment cell was considered the only option for inmates who were deemed at risk of suicide). This was confirmed by Mr Dolling, Mr Cargill, Ms Hyde and others. It is unfortunate then that at the inquest there was an attempt by some witnesses to suggest that there had been an assessment in relation to the cell when Bailey was first placed into it. However, Ms Thompson and RN Georgiou did try to assess options (to no avail) given the attitude of the senior correctional officers.

Dr Furst acknowledged that there were other less restrictive placement options but that those options do not necessarily protect against suicide. He referred to a 10-year NSW study from 1995 to 2005 which found that 22% of deaths occurred in shared cells, and out of 91 deaths, three had occurred in safe cells. Professor Large proffered that placing a suicidal inmate in a shared cell offered a moderate degree of safety, and that there is a threefold increase of risk with single cell placement, but he was not aware of a study comparing a camera cell. Dr Eagle commented that placing a person in an observation cell is really incapacitating someone's suicide risk. She said: "*You're just simply getting rid of access, and you may be making the problem worse, you may be increasing the distress, increasing the hopelessness, preventing them from addressing whatever is driving that motivation to end their life, so I just think it's a short-sighted strategy to address a much more complex problem, just locking someone up, and that's why we have the least restrictive option….in psychiatric settings, but we need to look at the least restrictive option in the circumstances, in the context of being able to provide appropriate psychiatric support*".

Dr Eagle made a very valid point as to why a review team should have at least one member with expertise as to suicide risk and mental illness. She said this: *"I just wanted to make the comment about the RIT process generally, in psychiatric settings or mental health settings we don't isolate or seclude people for suicidal behaviour, so this is an extraordinary response that is unique to correctional settings, to lock a person in seclusion or in isolation based on an assessment of risk, which is already known to be fraught with uncertainty; the assessment of risk, I mean, of suicide. In those circumstances I think it would be a minimum that there should at least be somebody who has the skills and expertise to assess suicide risk and mental illness on the panel that makes the decision as to whether this extraordinary step that is considered to be highly distressing to most inmates, in my experience, and not considered to be therapeutic or indicated in any other psychiatric setting. You would expect that there should be someone with mental health training on that panel to help make that decision... [and further] the purpose of the ISP is to actually determine the appropriate interventions that a person needs to manage their suicide risk. It's not just a ticket to go into an assessment cell, sit there them [sic] until they get better and pull them out, and as part of that process it's anticipated in the policy that a mental health referral may need to be made and the specific psychological or mental health interventions might be needed, and in that case you don't know what you don't know, so I'm not sure how a person without mental health training or understanding would be able to identify those strategies in those circumstances."*

Counsel Assisting asked Dr Furst whether in his view, a RIT team should be required to have either a psychologist, nurse or a person who is trained in mental health and he replied:

"*Yes, that is a good question. I think on both sides, like given that Corrective Services has access to psychologists in their ranks and given that Justice Health had access to mental health nurses and psychiatrists at times, depending on staff levels and availability, it would be I'd say preferable for that composition to be a mental health nurse or a psychologist, if available, that type of wording [in the policy]. But it [the policy] certainly doesn't specify that right now*."

Professor Large and Dr Furst were of the view that once a decision had been made that an inmate was at risk of harm, the RIT review team would need something significant to change that assessment. Professor Large did point out that in the community system where a patient is placed in isolation (for protection of others), the process to place them in such accommodation is significant whereas the process to remove them from such accommodation is far less so. RN Georgiou said in her evidence that Bailey "*couldn't clearly outline that he wasn't at risk, he couldn't clearly deny that he wasn't [sic] suicidal or that he wasn't [sic] going to hurt himself*. She said he could clearly articulate his desperation to get out of the cell. She was asked whether Bailey could not articulate his lack of risk of self-harm because he was pre-occupied with his distress over being in the assessment cell. It appears that RN Georgiou placed weight on the fact that Bailey was calm when she gave him medication at 4pm on 4 November 2019, and that on the morning of 5 November 2019 when Bailey told her he did not have chest pain but wanted to get out the cell, "*he was calm, he was communicating he wasn't completely you know frantic and desperate in his pleas for the entirety [of his 10 minutes in the clinic]*". However, in her statement RN Georgiou said that Bailey's pleas not to be returned to the observation cell were the most intense she had ever observed in a patient. The fact that Bailey was unable to articulate the right answers to convince the RIT review team that he was not at risk was raised by Dr Eagle [see para. 234 above]. I agree with Dr Eagle's opinion that there were other placement options available and as Counsel Assisting submit, Bailey was denied the opportunity of those options that might not otherwise had occurred had there been compliance with CSNSW policy in the conduct of the RIT review team meeting.

The escalation following RIT review

While the RIT review meeting continued in his absence, Bailey spent about 20 minutes in the accommodation unit unsupervised before being taken back to cell 41 by three officers. During the 50 minutes that Bailey was absent from the cell, officers searched it and removed food and plates. At about the time Bailey was collected from the accommodation unit; an officer entered Cell 41 and left food for Bailey on the bench. When Bailey was returned to the cell, he underwent a strip search, during which CCTV footage shows an officer dropped something white on the floor and after the officers left at 11:52am, Bailey put the white object in his mouth. Within three minutes of being left alone in the assessment cell, Bailey started making CICs. At 11:55am, Bailey made a CIC asking to see the nurse saying that he was vomiting (whilst he can be heard gagging and burping). The officer told Bailey to use the toilet to vomit and that someone was coming up to see him. In the next call at 11:57am, Bailey said "*I can't breathe*".

The officer told Bailey to "*relax a bit"* and *"try and breathe properly*". At 11:59am, Bailey was gagging, and the officer told him to slow his breathing and that he was having a panic attack. At 12pm, Bailey says, "*I can't breathe*" and the officer said "*Mate, as, as I said, you're probably having a panic attack mate you need to slow your breathing down and you…this intercom is for emergencies only*". Bailey replied, "*[t]his is an emergency I can't fucking breathe. Help*". Bailey made another CIC which was unanswered, and he lay on the floor in foetal position. Officers attended the cell and stood near Bailey while he lay on the floor a n d then they left. Bailey then got up off the floor and at 12:03pm a female officer called Bailey and told him that "[*t]he nurse is on her way*". RN Georgiou says that within minutes of returning to the clinic after the RIT review meeting, she received a call from correctional officers saying that Bailey was making CICs and asking to see her. At about 12:05pm, correctional officers and RN Georgiou attended (but did not enter) the observation cell. While Bailey knelt on the cell floor, the officers spoke to him through the internal cell door. RN Georgiou said that she also spoke with Bailey. She said she tried to distract Bailey and encourage him to take deep breaths. They left and Bailey got up and continued to make CICs at 12:06pm.

RN Georgiou said that she thought her presence was probably only making things worse, so after a couple of minutes she left and watched Bailey on the monitor for 25 to 30 minutes to make sure he was okay before going back to the clinic. At 12:06pm, during a CIC Bailey said, "*I can't breathe*" and the officer told him "*[m]ate, you've just been seen by the clinic*". Bailey gagged and asked for "*help*". He again made another CIC and said, "*I can't breathe*" and was told to "*take deep breaths*". Bailey says "[*h]help*" and he is told that the nurse had just seen him.

Five more CICs occurred with Bailey saying he could not breathe, and he needed help. The officer kept telling Bailey that the nurse had seen him and there was nothing she could do, and that he just needed to relax and try to calm down and slow down his breathing. The CCTV footage suggests that although Bailey pressed the CIC button numerous additional times, there are no records of such on the CIC log or they were answered without response. Mr Lloyd, who last dealt with Bailey's call at 12:08pm, was asked by Ms Lewer whether he accepted that the manner in which he and some officers dealt with Bailey on the CICs could be described as contemptuous. Mr Lloyd rejected this suggestion completely and said:

"*I don't agree whatsoever. You have to understand this environment we - we're in. From the minute we walk in the door to the minute we leave, on most days you're bombarded with abuse and knock ups, and requests, and lies, and threats of harm, and threats of assault. It's non-stop. If you can understand that after a long period of time of Mr. Mackander knocking up, knocking up, knocking up, knocking up - and we had seen him a number of times. The nurse had seen him, they deemed him to be okay. That it - it - you're - yeah. Your compassion can be bashed around if you know what I mean? It's - you can't always be helpful to someone who doesn't seem to want to help themselves….. I was just trying to tell him how it is. And that's probably what he - what he needed to hear, hear the facts. That if he - if he tries to behave himself and try to look after himself and do the right thing, then he might get out of the observation cell. But by yelling and screaming continually, it's not helping his cause whatsoever, and I was just trying to tell him how it is. And most of the officers in here that I've read are probably trying to do the same thing*".

Ms Lewer asked Mr Lloyd whether it was the case that Bailey had to behave himself to get out of the observation cell and Mr Lloyd replied: "*Well, obviously, yeah. "If he's behaving in an irrational manner, do you really think it's - it's - it's in his best interest to let him out into the main - into the general population where he could hurt himself? No*."

RN Georgiou said that when she left the office, she watched the monitor at a point where Bailey "*was no longer putting his fingers in his mouth and he did appear a bit more settled*". This must have been during the period after the 12:11pm CIC when the officer told Bailey, *"[y]you're fine, the nurse has seen you*". RN Georgiou conceded that the length of time she indicated she viewed Bailey must be incorrect, given CCTV records indicate that she left the observation cell at 12:07pm and returned at 12:26pm. If she thought Bailey had settled, the only time that could have been was between 12:11pm and the 12:17pm CIC, which would suggest that any viewing of the monitor was for a period of about five minutes. She said that she did not have audio when she was looking at the monitor, which seems to be at odds with evidence that the monitor was in the same room where the officer attending to the CICs was located.

The CIC at 12:17pm is five and a half minutes duration. Bailey asked for help, said he was choking, repeatedly pleaded and prayed for help, was retching and said, "*I can't breathe*". The call was unanswered and at 12:24pm, Bailey returned to lying on the floor. RN Georgiou said that when she returned to her office the telephone was ringing. She answered the telephone and was informed by a correctional officer that Bailey was laying unresponsive on the cell floor. RN Georgiou retrieved her emergency bags and attended the observation cell.

RN Georgiou said that she did not recall seeing vomit, there was not vomit everywhere and she did not smell vomit. She said that although she had seen Bailey putting his fingers down his throat, she had not seen him vomiting. RN Georgiou carried out an examination of Bailey. His observations were normal, and she said that when she tried to open his eyes, he squinted them shut. She said Bailey was medically okay. Though there was nothing apparently concerning to her about Bailey, RN Georgiou placed a Guedel airway device in Bailey's mouth and throat as she said it was standard training to put an airway in if someone is presenting as unresponsive. RN Georgiou said that this was a clinical decision she made in case something changed.

In her statement, RN Georgiou indicated that placing the device may potentially have encouraged Bailey to talk with her. She said in her evidence that it was not her intention to place the device to make Bailey respond, but rather it was a by-product that could have occurred. She placed the device without any response or reaction from Bailey. After Bailey was in the recovery position on the mattress on the bench in his cell, RN Georgiou left the cell and telephoned a Remote Off-site and After-Hours Medical Services ("ROAMS") GP. ROAMS is an on-call system so that medical advice is available to Justice Health staff on a 24/7 basis. RN Georgiou and the doctor agreed that RN Georgiou should call an ambulance. Whilst she was on the phone to the ambulance service and was advised that it was a very busy day and there would be a long wait, she received a radio-call from a correctional officer who advised her that Bailey had opened his eyes and was responding. As such, RN Georgiou ceased calling an ambulance and attended the cell.

However, when she arrived Bailey was again unresponsive, so she recalled the ROAMS doctor and after further discussion, called an ambulance again. Bailey had continued to remain apparently unresponsive for two hours. During that time, RN Georgiou mostly remained in the observation cell (other than for periods of a couple of minutes, 20 minutes and 15 minutes when she was speaking with others and making arrangements for paramedics to attend).

The paramedics attended the cell at 2:15pm. According to RN Georgiou, the lead paramedic spoke to Bailey, asking him to open his eyes and speak with him. When Bailey did not do so, he squirted saline up Bailey's nose and into his eyes. Bailey then sat up and complained that he had chest pain and the paramedic said "*[n]o, you're fine*" and the paramedics left. Bailey said that he would like to have a shower and asked for a towel. RN Georgiou then left. A couple of minutes after their departure, Bailey sat up and leant over the toilet. Officers attended, removed a white item and left again. The white item was likely a piece of polystyrene cup which Bailey was from time to time ripping up and swallowing. Bailey made a CIC at 2:30pm which was answered by an officer who told him: "*The nurse has seen you. Two ambulance officers have been called in to see you. There is nothing wrong with you. We will not be doing anything further for you. Stop knocking up*". RN Georgiou did not know that had occurred. The CCTV shows Bailey pressing the CIC button, but there is no response.

At about 2:40pm, Bailey covered the observation cell camera with toilet paper. An officer attended and removed the paper and another officer spoke to Bailey and left. Again, Bailey pressed the CIC button with no response. At 2:50pm, Bailey again covered the camera with toilet paper and again the officers attended and removed the paper but this time they also removed Bailey's blanket. At this time, Bailey was back lying on the floor. Another officer arrived and splashed water on the cameras to remove the paper and stepped over Bailey who remained on the cell floor. At 2:57pm, Bailey got up off the floor and over the next half hour continued to press the CIC button repeatedly with no response. Officers attended twice and left. At about 4pm, RN Georgiou attended the cell and dispensed medication to Bailey. RN Georgiou said she was not told that Bailey had been vomiting between the time the paramedics left and this time, and she said that had she been informed she would have attended to Bailey. She agreed that she could have attended Bailey and if the symptoms were arising from anxiety and distress she could have contacted a psychiatrist or doctor to obtain medication for Bailey to stop the vomiting and alleviate his symptoms. She said that the correctional officers should have called her. RN Georgiou's clinical notes of the day indicate that she spent a substantial amount of time and effort to ensure that Bailey was medically safe whilst he was in the assessment cell. It would appear that after this time, RN Georgiou was not called upon by any correctional officers and it would appear that they did not answer any of the many numerous CICs that Bailey apparently made throughout the next two hours. RN Georgiou's further clinical notes for the day set out a well-documented record of the medical care she provided to Bailey:

"1215 Nursing: Phone call from compound. Pt knocking up asking for nurse – attend pt. observations cell. Pt had fingers down his throat attempting to vomit. Attempted to discourage. Pt stated he couldn't breathe – Pt pink, alert, walking around cell talking in full sentences. Pt refused to sit down and take slow deep breaths – decided to leave cell area as pt. becoming more upset – watched on camera in room near door for lengthy period (25-30/60 [minutes])- decided to go back to clinic immediately received a phone call to say pt. lying on floor unresponsive.

Attended clinic [sic] – pt. breathing, reacting to pupil RV 1232 PEARL BP 131/79, [0xygen sat] 97%, RA; HR 101 reg, T36.1,BSL 7.1 mmol/L – pt. picked up by CSNSW and placed on bed in recovery position. Pt kept eyes closed and resisted eye opening, hemodynamically stable [with] good air entry

1245 Decided to place a guedels airway in to ensure airway remained open. Pt tolerated same – an officer dropped a pan near cell door and pt. reacted – obs BP 128/178, HR 95 reg, [oxygen sats] 98% RA BSL 6.8 mmol/L. Pt talked to at length about opening eyes and sitting up. Nil concerns for pt. as PEARL – pt. spat guedels and moved back a little from his spit that he dribbled from mouth. Contacted MO Dr Lyndon to discuss- [query] need for ambulance decided to contact. Whilst waiting pt. moved, ended call to ambulance - attended cell again – pt. shut eyes again, attempted to engage pt. again

1300 obs temp 35.9 [degrees Celsius], BP 129/81, HR 92 reg PEARL BSL 5.8 mmol/L [oxy sats] 98% RA. Sat with pt. encouraging to open eyes – contacted ambulance after again discussing with ROAMS

1400 GP - obs BP 126/79; T 36.3 [degrees Celsius] - HR 79, BSL 5.8 mmol/L, PEARL. Guedels no longer insitu 1415 Ambulance arrived – saline to eyes with syringe, pt. woke and became teary saying he had chest pain – advised pt. he is fine, and they left centre with nil further [treatment] required – pt. sitting up alert and talking, left cell

1605 Nursing: attended cell to give pt. his supervised meds –same administered. HPNF updated and sent to AHNM with telephone handover of pt. given in detail".

A HPNF written at 3:21 pm requested that CSNSW staff monitor Bailey and report any signs and symptoms to Justice Health. The signs and symptoms were typed in capital letters:

"*SUICIDAL IDEATION _ ACTIVE RIT – OBSERVATION CELL WITH CONSTANT CAMERA. OBSERVE FOR SEIZURE LIKE ACTIVITY AND SELF HARM."*

In the section regarding what CSNSW staff need to do if such observations are made, RN Georgiou wrote: "*CONTACT AHNM– 13000ROAMS AND AMBULANCE. Encourage positive behaviours & Attempt de-escalation*."

At 4:46pm on 5 November 2019, RN Georgiou sent the HPNF to the AHNM and her Nurse Manager and she had telephone calls with both of those people providing a detailed handover to them before leaving the compound for the day. RN Georgiou had intended to make a referral for Bailey to be assessed by a Justice Health Nurse and had commenced transfer documents to have Bailey transferred to a centre with better medical facilities. Though she in fact did not make any referral for Bailey to be assessed by a mental health nurse, she gave evidence that even if she had, any such assessment would not have occurred that or the next day. In relation to the transfer papers she incorrectly thought that an inmate could not be transferred whilst on a RIT so it is unclear whether she intended that on 6 November 2019 Bailey would be removed from the RIT to affect his transfer.

RN Georgiou was not rostered to work on 6 November 2019 and expected that the referrals would be actioned by the next nurse on duty. RN Georgiou said that in her opinion, Bailey should never have been at Kariong CC as he had a very recent history of being on a RIT, had seen a psychiatrist, was starting medication and that Kariong CC is an isolated site with not very good services and with insufficient nursing hours. RN Georgiou said there was no afternoon nursing shift, no mental health nurse and no drug and alcohol services which raised alarm bells in her for Bailey. Previously, RN Georgiou had a local arrangement whereby she would vet intended transferees to the centre and indicate to the CSNSW Kariong CC manager her opinion as to whether Kariong CC was inappropriate given the medical needs of an inmate. She had taken maternity leave and upon her return learned that this practice was no longer in place. The expert witnesses were asked to comment upon the escalation of Bailey's conduct in the observation cell. Dr Furst agreed with Mr de Mars that RN Georgiou could have commenced a referral to a mental health nurse on 4 November 2019 when she learned from Ms Hyde that Bailey was at risk of suicide. Ms Lewer asked whether further training should be provided to correctional officers to equip them to deal with people who are on a RIT and people who are in acute distress. Dr Eagle said:

> *"…this is a difficult question for me to answer because I think the process is inherently flawed, so I'm going to just [say] that right from the outset, and I don't know what level of training you can have to determine what circumstances it might be okay to do something that's counter-therapeutic, but I suppose you could at least provide some mental health training and some risk assessment training, so that officers have knowledge of evidence based risk factors, when might be appropriate to urgently refer someone for mental health assessment, how to identify risks relating to a person's presentation or mental state, how to respond in a supportive way rather than a punitive way when someone is in distress, so I guess those sorts of things might be able to be covered, but I think the issue here is that this practice is not used as a last resort and it's used to protect, basically, Corrective Services from an adverse event rather than for the benefit of the person who's in distress, and I think that's an inherently conflictual role that the person has when they're making that decision…., I think the training could be done in a few days or in a week. If it was targeted and done in the sort of comprehensive way, you know, I think there are other disciplines that have mental health training like police and other sort of services that could at least give sufficient training so that the person can operate in a safe and effective way and refer on to appropriate people who have more exercise where appropriate, and that could be done any time I suppose up to sort of a week's training in those sorts of workshop formats*."

Dr Furst added that the CIC system is not designed for RIT engagement as it is supposed to be used for emergencies. He said:

> "*I do think that the best way forward is to have one on one support or access to people that can come in and counsel someone and support them as a clinical situation, not through a buzz up system across the state*."

Bailey is taken to hospital on 5 November 2019

At about 4pm on 5 November 2019, Bailey made a CIC and asked for something to eat. He was told that he has been quite sick and throwing up, so food was probably not a good idea and to settle down. Bailey said he could hardly breathe, and the officer replied, "*I know mate, but um, you're doing okay there, so just see if you can relax for a while, okay?*" Bailey told him "*I'll try, I'll try my best*". The officer replied, "*[g]ood on you mate, thank you*".

At 4:20pm, Bailey ran at the door, hitting his head. Officers attended and spoke to Bailey for several minutes and then left. At 4:30pm, Bailey made a CIC and spoke with Mr Cargill. He asked if he could have a shower. Mr Cargill wanted Bailey to clean the cell before having a shower and he agreed to do so. A bucket and mop was taken to the cell and Bailey mopped the cell, after which the items were collected, and Bailey was given a towel. He took a shower and then used the towels to dry the floor.

At 4:55pm, Bailey made a CIC and asked to talk to the officer for a second. Bailey was told that the officer was a bit busy but that he would come around and for Bailey to be patient. Mr Cargill attended the cell shortly after 5pm and collected the towels. Bailey told Mr Cargill that he was in severe pain as he had swallowed four batteries and four razor blades when he was in the accommodation unit earlier that day. Officers respond to this information and ascertained that Bailey had been left unsupervised in the accommodation unit for 20 minutes during the RIT review meeting. They attended John Brown and asked him to check their cell to see if any batteries and razor blades are missing and he said that they were not. Arrangements were made for Bailey to be taken to hospital. Bailey again pressed the CIC button without effect, until he returned to lying on the floor of the cell at about 5:15pm. After a couple of minutes, Bailey got up and made another CIC, complaining that his stomach was "*fucking aching*" and that he was in pain. Bailey was told by the officer that he was busy doing other things. There were two more CICs where Bailey complained of an aching stomach and being in pain and asked what was happening. At 6:07pm, Bailey was removed from the cell, handcuffed and shackled, placed in the prison van and escorted from Kariong CC to the ED at the Hospital by Mr Slingsby and Mr Uerata.

Escort assessment

The documents contained in the escort briefing kit were much the same as the previous day, except Mr Cargill had changed section 3 of the summary on the 'Escort Assessment' to read "*Impulsive inmate with suicidal ideation. Has 'cried wolf' several times. Placed on RIT by psychologist*". At section 8 of the s. 24 order, Mr Cargill typed "*[t]o be closely monitored/supervised at all times, on active RIT*". Mr Cargill said he used the term "*cried wolf*" because on Bailey's return from hospital the previous night, Bailey had asked about his medication and had not mentioned the pain so Mr Cargill thought that he was not "*fair dinkum*". This demonstrates a fundamental misunderstanding of what a panic attack feels like and suggests that by asking for medication, he thought Bailey was a malingerer. However, I accept Mr Cargill's appraisal that Bailey's feigned unconsciousness for over two hours that day was another indication that he was not necessarily genuine in his presentation.

Mr Cargill did not believe Bailey's claim that he had swallowed batteries and razorblades but was compelled to err on the side of caution and have Bailey examined at the Hospital. Mr Cargill denied that using the term "*cried wolf*" was suggesting that Bailey was not suicidal; however, he accepted that someone reading what he had written might think he was suggesting that. Mr Cargill said that he was indicating to the escort officers that Bailey was not trustworthy or reliable. Bailey was taken to the Hospital and escorted from the van to the door of the ED again with Mr Slingsby being the closest escort officer and Mr Uerata being at a distance.

Medical examination and discharge from Gosford Hospital ED on 5 November 2019

An issue in the inquest was whether Bailey's examination at the Hospital on 5 November 2019 was appropriate and expert reports were obtained by those assisting the coroner. That issue was resolved by correspondence and receiving statements from the treating doctor Dr Stephen Cameron. When Bailey was triaged a chest x- ray was ordered and he then saw Dr Cameron, who asked Bailey why he was at the Hospital. Bailey told him that he had swallowed the batteries and razor blades. Dr Cameron examined Bailey and adjunct to that examination he used a metal detector wand over Bailey's abdomen and determined that there were no metal objects causing any obstruction and he did not proceed with a chest x-ray. Dr Cameron discharged Bailey with the instruction that he should return to the ED if he developed any signs of obstruction or perforation.

Dr Cameron agreed with the experts' criticism that his clinical notes were insufficient, and he undertook to improve his note making. He explained that he had on occasion used the metal detector wand on children who had attended the ED as the result of swallowing lithium batteries, and it was a useful non-invasive examination tool. However, he accepted that it was inappropriate to use the metal detector wand on an adult as such use had not been validated. In hindsight he conceded that he should have proceeded with the chest x-ray but that had it been performed and shown foreign bodies in the abdomen, his management plan for Bailey would not have altered. Whilst one of the experts was critical that Dr Cameron had not undertaken a mental health assessment, Dr Cameron explained that after speaking with Bailey, even though he reported swallowing objects he did not illicit any issues to warrant such an assessment. Given the conclave evidence taken at the inquest I accept that Dr Cameron's judgement in that regard is not one which should be criticised.

Bailey's fall

After Bailey's discharge, he returned to the CSNSW van, walking in similar fashion as when he arrived. Unlike on 4 November 2019, Mr Uerata did not open the van door but rather Mr Slingsby did with Bailey standing "*shoulder to shoulder*" at the door next to him. It was while Mr Slingsby was distracted opening the door that Bailey instantly stepped to the nearby wall and propelled himself over. Mr Uerata, seeing Bailey step back and move his head to the left to look at the wall, instantly called out to Mr Slingsby. However, Bailey stepped quickly away, and Mr Slingsby could not grab Bailey to prevent his flight. Both Mr Uerata and Mr Slingsby gave evidence that they did not appreciate at the time that there was an eight metre drop below the wall.

Mr Slingsby jumped onto the wall to follow Bailey, but it was only when he was on top of the wall that he saw how high the ambulance ramp was above ground level. Mr Slingsby said that he thought there was a garden on the other side of the wall. He explained that entering the ramp and travelling to the ED entrance was quite deceiving and that there was no sense of how elevated they were. Bailey most likely was under the same misapprehension that beyond the wall was ground level. Neither Mr Slingsby nor Mr Uerata had any sense that Bailey was a flight risk and I accept that Bailey gave them no reason whatsoever to give them cause to suspect he might be. Mr Uerata said that he was told by Mr Cargill to keep an eye on Bailey because he was distraught and he was crying when he was getting into the escort van at Kariong CC. Mr Uerata said that when Bailey was at the Hospital, he was fine.

Mr Slingsby said that when he had arrived at work on 5 November 2019, he went to Bailey's cell and at that time the nurse and the ambulance paramedic were in the cell. His next involvement was being directed by Mr Cargill to look at CCTV footage to ascertain whether Bailey had been left in the accommodation unit that day. After seeing that Bailey had, he and Mr Cargill attended and spoke to John Brown about whether there were any batteries and razor blades missing from the cell. He was next involved when Mr Cargill tasked him to escort Bailey to the Hospital. Though Mr Slingsby did not recall doing so, he said he would have read the s. 24 and escort assessment documents prepared by Mr Cargill.

Counsel assisting asked Mr. Slingsby whether in his view the requirement for an escort officer to provide close monitoring required that officer to have hold of an inmate. Mr. Slingsby said:

> *"From the policies and procedures with escorts I've done in the past, normally you would assess each inmate because they're all different. If Bailey was - if Bailey had come out of the hospital and he was aggressive, I probably would have hold on - I'm not sure I would have held on to the cuffs. But my - my way of thinking, as I said doing escorts before, putting a patient - sorry, an inmate into the back of a vehicle, I didn't want to put any extra stress on Bailey putting him into the van. So that's one of the reasons I didn't hold on to his handcuffs on the way out."*

It is quite claustrophobic and that he has experienced inmates trying to self-harm in it. He said he was concerned about Bailey in that regard. He sought to keep an inmate as calm as possible in order to enter the van. Mr. Slingsby said that as they were walking to the van he did not notice any changes to Bailey that caused him concern and to take hold of him.

The CSNSW investigation

Mr Hovey said that the CSNSW investigation was impacted by one investigator being so traumatised by the circumstances involved in Bailey's death, and the other by listening to the CIC audio to transcribe the calls, that neither had been able to continue working. The CSNSW investigation proceeded on the basis that Bailey had in fact swallowed batteries and razor blades, however this inquest has investigated that issue further. The evidence demonstrates that whilst that was not the case, at some time (and it is unknown whether it was before or after Bailey was placed in the assessment cell), Bailey had ingested a number of small rocks that were located at autopsy. Also retrieved were pieces of plastic and polystyrene that Bailey had apparently consumed, as seen on CCTV, in the assessment cell. Further, pieces of paper were located at autopsy.

The CSNSW investigation had access to the CSNSW computer system and the hard copy of the inmate's management file. On the computer system, there are case notes (known as OIMS) and Incident Reports (known as IRMs); however, there are no psychologist reports and no Justice Health documents. The HPNFs are kept on the hard copy file but not on the CSNSW computer system. Mr Hovey said that although the investigator can see the time that an OIMS report is created, when the document is printed out that detail is not printed. Mr Hovey said that an investigator involved in a CSNSW investigation into a death in custody does not have access to Justice Health records. Rather, the investigator receives a letter summarising the history of the inmate from a senior person in Justice Health.

Mr Hovey said that as the escort policy there had been no breach of policy by officers Mr Slingsby or Mr Uerata on 5 November 2019. Mr Dolling and Mr Cargill's opinion that Bailey should have been under physical restraint was met by Mr Hovey's response:

> "*Whereas Mr. Cargill and Mr. Dolling may well have had an expectation, if that is not communicated appropriately to the escort officers, then it's just a subjective view that that's what should have happened, in my opinion.*

I share that view. If a senior officer who completes an escort assessment considers that the risk warrants the inmate being physically restrained by the escort officer then that officer should write that opinion on the escort documents – both the s. 24 and the escort assessment - and give that instruction at the verbal escort briefing. Mr Hovey's report included recommendations regarding the correctional officers' management of Bailey while he was in the assessment cell. The recommendation was made in November 2020 and reads:

> "*Ultimately, what these matters indicate is a systemic issue within CSNSW regarding the training and services available to CO's to recognise serious issues with inmates and provide an appropriate response. A primary recommendation of this report is that CSNSW review, update and improve the training provided to CO's not just to identify inmates suffering mental health issues, but in how they provide distress tolerance assistance and review inmates' cell placement needs, in order to comply with the CSNSW duty to take reasonable care of the safety of the inmates*".

Mr Hovey said that since February 2021, CSNSW investigations delve further into systemic processes (such as an inmate being placed on a RIT) so that rather than describing the sequence of events, the investigation looks into the appropriateness of the process. For deaths where an inmate is on a RIT, a CSNSW investigator would now interview members of the first and last RIT review teams. Mr Hovey agreed that a CSNSW investigation into a death in custody was concerned with compliance with the *Crimes (Administration of Sentences) Regulation* ("the Regulation"). Mr de Mars asked whether Mr Hovey had regard to the requirement that inmates receive two hours of exercise per day (which applies to inmates other than those confined in a cell under ss. 53 or 56 of the *Crimes (Administration of Sentences) Act 1999,* which relate to inmate discipline and is not applicable to Bailey's situation in an assessment cell). Mr Hovey replied:

> "*In my experience, it's not easy to facilitate and supervise exercise over an inmate who's held either in a safe cell or a secure cell, as in segregation, for example, it would require no contact with other persons, a search of that area would have to be undertaken to ensure that there was nothing that could be used or secreted for self-harm. It's not unusual, in my experience, for an inmate who is being managed under a RIT to not receive the full period of exercise as you describe*."

Though Mr Hovey is not quite right that a RIT inmate would necessarily have no contact with others, the point he makes is that although the Regulation mandates daily exercise, inmates do not always receive it. It seems that if systemic use of assessment cells means that inmates are housed in breach of the Regulation then those systems need to include staffing levels and facilitating access to areas so that the Regulation is complied with. Ms Alderton asked Mr Hovey whether he would revise paragraph 61 of his report having learned that the correctional staff did not refer Bailey to Justice Health when Bailey used the CIC system requesting same. He agreed that it was incumbent upon correctional staff to make that referral, rather than conduct their own assessment as to whether or not medical attention was warranted.

Family members contacting CSNSW

The unsuccessful attempts that were made by Bailey's mother Tracy to speak to a staff member at Kariong CC on 4 November 2019 and 5 November 2019 were addressed by Mr Murrell. On 4 November 2019, the phone call at 2:16pm was handled by a staff member named Sharon, who was advised by Ms Hyde that she could not speak to Tracy. On 5 November 2019, Tracy made three telephone calls. The first was at 2pm, the second at 2:25pm and the third at 2:32pm. The first call no-one answered. The second call was to the governor at Kariong CC, and she was transferred to the Justice Health clinic at Kariong CC but the nurse at the clinic declined to speak to her. The third call was to a liaison officer at Long Bay CC who advised Tracy that a form to secure Bailey's consent for someone to speak to her would be sent to him. She said she would call Tracy back, but she did not. Mr Murrell agreed that Tracy had a legitimate reason to call given that Bailey was on a RIT. As at present, there has never been any CSNSW policy in relation to CSNSW staff speaking with family members. Mr Murrell said that there was information in the Family Handbook and on the CSNSW website. He conceded that the Handbook did not provide sufficient guidance as to how a family member might communicate information about an inmate who was at risk of harm.

Mr Murrell thought that Tracy's call to Kariong CC that was answered by the administrative person known as Sharon could have been escalated to someone in charge. Dr Sarah-Jane Spencer was also asked questions about Tracy's attempts to speak with someone at Justice Health. In particular, she was asked about RN Georgiou's evidence that although she did not receive a call or was not made aware of a call to the clinic on 5 November 2019, she would not have spoken to Tracy in any event because "*it's a referral to a client liaison officer where … they would … have a release of information signed and I would be asked questions that way. There's no … scope or option to speak to family members directly*".

Dr Spencer commented on RN Georgiou's position thus:

> *"I think I'd echo what Professor Large said, which is that there is - and I think we've heard it from the psychologist who gave evidence earlier today; that I think there is general misunderstanding and fear about doing the wrong thing and that I think the general message that staff, both in corrective services and Justice Health, have is that a patient's consent is very, very important to have. And so I think we've heard a lot over the last few days about some areas that there needs to be some more work on to up-skill staff but I think the general, feeling is very much that I think staff don't want to do the wrong thing and they are very worried about speaking to family or lawyers without the patient's - without the patient's consent. But my understanding of the privacy legislation is very much that you're allowed to receive information from a concerned - well, they don't even have to be concerned family, but from family and from carers and often it's invaluable information that we gain particularly with patients have major mental illness and may not have insight into their illness and collateral is often key. So we really rely on the information that family and carers have even in instances where patients may not consent to us disclosing information about their current circumstances to family. So, I guess, we have more experience dealing with that - the nuance of what we're capable of doing than someone like Ms Georgiou or even the psychologist who may not have expertise dealing with those kinds of - the particular parameters of the legislation."*

Dr Spencer said that correctional centre staff is definitely able to receive information from family, carers or lawyers. She said that urgent consent of an inmate to give information to a family member could be obtained. She said that the family member should telephone the "1800" helpline number. The helpline is staffed by senior mental health nurses during the day and they would contact the nursing unit manager in the centre who would be able to speak with the patient. Dr Spencer agreed to the concept of a policy providing for an inmate's consent to cover the 24-hour period when in a RIT cell so that family information could be obtained

Further evidence of Dr Spencer

Ms Alderton asked Dr Spencer about the wait times for an inmate at Kariong CC to be seen for a mental health assessment. Dr Spencer said that in September 2019, there were 23 inmates on the waitlist, of which nine were to see a psychiatrist. She said some of those would have been follow-ups and some would have been triaged based on urgency. It would be unusual for someone to be seen on the day of referral (even if a priority referral). Dr Spencer spoke about the fact that psychological services are provided by CSNSW whereas Justice Health does not have such a service:

> "*I think there's a - it's not necessarily just a split mode of care but I think the corrective services and Justice Health have very different sort of fundamentally - fundamental overarching principles, you know, Health psychologist is –*

Has got a very different remit from a psychologist who's primary employed by corrective services and Health would really love to have a multi-disciplinary team like you would have in a community setting. Unfortunately, we're very limited by resources in custody. But in an ideal world, we would definitely have Health psychologists working alongside corrective services team as the current network team of mental health professionals."

In relation to RIT review teams, Dr Spencer was supportive of Justice Health maintaining a role. She said that CSNSW psychologists used to be involved in review teams, but they are now replaced by SAPOs and could not recall the circumstances of that change.

Conclusions as to issues

At the commencement of the inquest hearing an issues list was distributed to parties. Some issues resolved upon the acquisition of further documents over the course of the hearing. Some issues diminished and others became emphasised.

Issue 1 and 4 - Was the management of Bailey's mental health in custody by CSNSW and Justice Health in the period leading up to his death reasonable and appropriate, including in regard to drug use, anxiety, distress and risk of self-harm, with reference to relevant policy and procedure?

Issue 5 - Was it necessary and appropriate for Bailey to be placed under the supervision of the RIT and in a CCTV monitored safe cell on 4 and 5 November 2019? Were the responses by CSNSW and Justice Health to Bailey's behaviour while in the safe cell appropriate and consistent with relevant policy and procedure?

According to Dr Eagle, Bailey had a generalised anxiety disorder, panic disorder and a severe substance use disorder (in remission in a controlled environment). Professor Large opined that Bailey primarily had a severe substance abuse disorder (that was not necessarily in remission) and that his significant disturbance of conduct and emotions was consistent with a personality disorder of moderate severity, which may have been less disabling had he been able to quit using drugs. Professor Large agreed that Bailey did have anxiety, but he thought it likely that it was due to his very long-standing drug use and increased trauma (including trauma experienced in prison). Dr Furst thought that Bailey likely had an anxiety disorder but agreed with Professor Large that Bailey primarily had a substance abuse disorder.

Without going into the intricacies of Bailey's diagnoses, it is uncontroversial that he needed help and support to deal with his situation of being in custody (bail refused) on charges which, if convicted, would result in a sentence of further imprisonment. Bailey had an inability to adjust to this situation and cope with it. As a result of these difficulties, Bailey had seen a psychologist on 3 September 2019 at Lithgow CC. He reported struggling with new charges, being back in custody and experiencing anxiety.

The psychologist identified that Bailey should attend psychological counselling on a weekly basis, presumably to gain some assistance in emotional regulation and processing his predicament so that he could adjust to his situation and deal with some of the factors giving rise to it.

The psychologist ranked Bailey as a "P2" priority which meant, according to CSNSW policy, that he should be seen within 12 weeks. Bailey was seen nine weeks later, and the result of that attendance was being placed on the RIT status. The fact that Bailey was not seen earlier may be due to him been transferred to a privately managed CC and then to Kariong CC. The delay of up to 12 weeks, to meet a recommendation for weekly counselling for a young inmate to adjust and learn to cope with his environment and situation, is likely too long. However, he was assessed not to be in such crisis that he needed to be seen within three days as the "P1" criteria requires.

On that basis, there was no breach of policy. However, Bailey still did not receive the psychological support he needed after he was placed in the assessment cell on 4 November 2019. He did not receive any mental health support on 5 November 2019 though RN Georgiou attended to his physical wellbeing. I agree with Counsel Assisting's appraisal that RN Georgiou was a dedicated Justice Health Nurse, attempting to fulfil an overwhelming role being the only nurse rostered at Kariong on 5 November 2019. As said by Counsel Assisting, RN Georgiou's evidence demonstrates the tremendous pressure faced by nursing staff providing care in a correctional centre. Dr Phillip Snoyman, Director of Statewide Services CSNSW, provided a statement at the request of those assisting me which addressed the role of psychologists in the CSNSW system. His statement sets out that psychologists work in geographic clusters and the services provided include assessments, consultations, provision of reports about offenders, liaison with offender management and others in both custodial and community corrections.

Mr Snoyman wrote that the psychologist service includes the provision of services to vulnerable inmates, inmates with specific needs and more intensive series for offenders who present with marked difficulties coping with or adjusting to custody. They deliver programs both in the community and custodial settings. Whilst his statement addressed the breadth of the service, it was not required to address the timeliness or resource availability for the provision of those services.

At the time Bailey was in Kariong CC, for her part Ms Hyde made it clear that there was no time or resource availability to provide counselling to an inmate on a weekly basis. There was no evidence about Ms Hyde's waitlist, but Bailey was seen by her within a week of his arrival in Kariong CC. The Justice Health mental health waitlist had nearly a quarter of the Kariong CC population on it and although there was no indication as to the delays involved in such a referral, it appears that it was at least a week. On 12 September 2019 at Parklea CC, Bailey was distressed after an appearance in court and he saw a mental health nurse on 13 September 2019. Dr Eagle said that attendance warranted a medication review and she noted that Bailey never received a comprehensive mental health assessment as anticipated. I also note that on 22 September 2019 Bailey saw a mental health nurse, but it is unclear whether it was for a comprehensive mental health assessment.

It is concerning that there was no mental health nurse on site at Kariong CC and that the telehealth service involved a delay so that an inmate such as Bailey could not be urgently assessed. In the community setting, hospital EDs, acute mental health teams and community mental health teams are available on a 24/7 basis. In the custodial setting, the ROAMS system and the Mental Health Helpline seeks to provide similar access. The reasons that such access does not manifest in adequate on-the-ground services is likely multifactorial, even down to the resources and whether a single nurse on the day literally has sufficient time to make a referral. The resourcing of adequate staff to cater for the needs of a population with probably higher and more intensive needs than the general community was not a matter for this inquest, but it does go without saying that unless a correctional facility is adequately staffed and resourced to provide services, the provision of those services is likely to be inadequate. That Bailey was not given access to the Justice Health Mental Health Helpline on 5 November 2019 was an oversight by RN Georgiou. I accept Dr Eagle's opinion that Ms Hyde appropriately identified that Bailey had an overall increased risk of suicide and his risk factors warranted mental health involvement and further comprehensive clinical review (as well as liaising with his mother). I accept Ms Mahony's submission that there should be no criticism of Ms Hyde for placing Bailey on a RIT. Ms Hyde had consulted with RN Georgiou about Bailey and informed her that she was raising a Mandatory Notification. Ideally, RN Georgiou would have then completed the necessary notifications and commenced a referral to Bailey for a mental health assessment (if not on the day, then certainly on 5 November 2019.

Particularly at the conclusion of the RIT Review Management Plan). However, given that the next two to three hours of her time were absorbed with attending to Bailey, and she then had to provide services to the other inmate population, it is understandable that she did not do so. RN Georgiou sent an email at 12:34am on 6 November 2019 to the next nurse on duty, regarding numerous inmates including Bailey. In relation to Bailey, RN Georgiou wrote, "*he needs transfer to an appropriate centre. I did not have the chance to complete the transfer out request or email…about an appointment, could you please follow up today*".

Mr de Mars referred to RN Georgiou's evidence that Bailey could not be transferred from Kariong CC to another correctional centre if he was on a RIT. RN Georgiou was incorrect about that.

I note Mr de Mars' submission that Bailey should not have been transferred to Kariong CC which is addressed below. Mr de Mars submits that a further basis to find that Kariong CC was inappropriate for Bailey was that according to Mr Cargill, there was a local practice that an observation cell at Kariong CC should not be used for any period longer than 24 hours as the annexed courtyard was closed due to having hanging points. Given the resources at Kariong CC, such an inmate could also not have access to that exercise in the general yard.

Accordingly, it was submitted by Mr de Mars, it was not possible for an inmate housed in a Kariong CC assessment cell to receive their required two hours of exercise pursuant to cl. 53 of the Regulation. This submission overlooks Ms Dolling's evidence that in her experience, 90% of the time if an inmate was placed on a RIT at Kariong CC, it effectively equalled an assessment cell and it was quite a common practice to allow inmates access during the day to the yard. Clause 53(1) of the Regulation mandates that an inmate should receive two hours of exercise in the open air.

However, under cl. 53(3) an inmate's entitlement to exercise is "*subject to the practical limitations that may from time to time arise in connection with the administration of the correctional centre concerned*". The only explanation as to why the RIT review management plan did not include a diversionary activity consistent with Bailey's right to two hours exercise in the open air is that Mr Dolling said it was the assessment cell or nothing. Given the limited open-air facilities available that day at Kariong CC, there may have been practical limitations to enabling Bailey having access to the yard on his own and/or on a supervised basis. However, Mr Dolling's evidence in that regard was somewhat disingenuous when he tried to say that the option was a matter for the RIT review team, and then on the other hand said *"[t]he layout of Kariong, the way it was set up; I would not think that Bailey would have been given access to the exercise yards*".

If an inmate is denied access to exercise due to the way a correctional centre is set up, then it is arguable that no inmate should be in an assessment cell under the RIT procedure at that centre. Obviously, if the risk of harm is so urgent and a cell is required to contain the inmate (so as to prevent access to the means to self-harm), such containment should occur. However, in my view that should only occur if the inmate is either transferred within 24 hours to a more appropriate centre where cl. 53 can be complied with, or placed on a management plan under which access to two hours of exercise is mandated and appropriate resources are provided for the necessary monitoring or supervision required during the continuation of an assessment cell placement. Mr de Mars also submitted that there has been a breach of cl. 164 of the Regulation because:

> *"(1) an inmate must not -be subjected to any other punishment or treatment that may reasonably be expected to adversely affect the inmate's physical or mental health*".

John Brown made it clear in his evidence and Bailey made it extremely clear that experiencing an assessment cell is a highly unpleasant and undesirable experience such that inmates deem it to be a punishment. Whilst segregation and protective order placements are legislated in the *Crimes (Administration of Sentence) Act 1999*, RIT assessment cell placements are not. This seemingly gives more rights to the segregated inmate than the inmate who is placed in an assessment cell and denied diversionary activities such as human contact or exercise under a RIT management plan. At least an inmate who is subject to a segregation order has a process whereby the decision can be reviewed - there is no such process for an inmate involved in a RIT review decision.

As Dr Eagle highlighted in her report and evidence, there is no legislative framework for the use of assessment cells. Further, there is not only a prohibition on secluding a person at risk in the NSW Health setting; there is a legislative framework for the hospitalisation and treatment of those persons under the *Mental Health Act 2007*. Ms Lewer's submissions spoke to the recommendations that have been put forward on behalf of David and Melissa Mackander that CSNSW's continued use of RIT assessment cells should be properly administered, managed and audited so that the correct balance of inmate protection, CSNSW's duty of care and humane treatment is achieved. Those proposed recommendations are addressed below. Bailey's mental health was adversely affected by his assessment cell placement and the continuation of this confinement on 5 November 2019. That is borne out in Dr Eagle's evidence that Bailey's level of distress, anxiety and panic significantly increased (from that identified by Ms Hyde prior to raising the Mandatory Notification).

Though there may have been a part in which Bailey was manipulative and maladaptive, I am confident that he was experiencing distress, anxiety and panic attacks on both 4 and 5 November 2019 as demonstrated audibly over the CICs, visually on the CCTV footage, verbally over the telephone to Tracy on the first day and in person to John Brown on both days. Although Bailey complained of chest pain on 5 November 2019 prior to seeing the nurse, and then told her his chest pain was fine and that he just wanted to get out of the cell that does not mean that he was pretending to have chest pain. Rather, it is likely that he was aware that the chest pain was related to him being in the observation cell.

There were at times some demeaning, and somewhat punitive comments made to Bailey by correctional officers over the two days that he repeatedly used the CIC system while in the assessment cell. The treatment he received fell short of amounting to punishment, although I am sure Bailey experienced it in that way. It was not one singular instance, but rather the general treatment of Bailey, that adversely affected Bailey's mental health. It seemed that for RN Georgiou, any concerns for Bailey being at risk of self-harm were displaced by RN Georgiou's concern to get Bailey medically or physically through the day and transferred out of Kariong CC. As for the senior correctional officers Mr Lloyd and Mr Dolling, if there was any concern for Bailey's safety it was overridden by a correctional attitude and style for Bailey to develop the adult inmate coping skills that he did not possess. He did not possess them due to the issues discussed by the psychiatrists, but he also did not possess them because he was only 20 years old with teenage years marked by a serious substance use disorder. He was the second youngest inmate at Kariong CC.

Ms Mahony submits that "*CSNSW firmly states that it was necessary to place Mr Mackander under supervision of the RIT and in a camera cell on 4 and 5 November 2019*". That CSNSW takes such a position is consistent with Ms Lewer's submission that an assessment cell is a blunt tool used by CSNSW to protect an inmate from self-harm. These findings, particularly in relation to the RIT review process, indicate that I do not share CSNSW's position in that regard. As I note above, however, I do not criticise Ms Hyde's decision to place Bailey on a RIT.

To continue with Ms Lewer's analogy, the CSNSW management of Bailey on 5 November 2019 was akin to forcing a square peg fit into a round hole. Bailey's maladaptive coping strategies to being in a prison generally and in the assessment cell specifically were not understood and appropriately responded to and no-one appeared to look into the tool kit to see what else was at their disposal.

In that regard, Dr Spencer spoke plainly and wisely when she said:

> "*Often it isn't medical treatments that these patients who are very distressed need; they just need someone who's going to listen and who's going to treat them like a human being, or more like a family member. And you don't need really a lot of mental health training to know that some of the things that were said to Bailey were not going to make him feel fantastic; and that he was pretty worried…. This is just about treating people humanely and thinking about how you can individually make a difference to how someone's circumstances are then and there.*

And there were things that could have potentially been done, like giving him access to the yard, and potentially putting him in a camera cell overnight. But I think the team didn't know that it was available to them; but with hindsight was available, and would have perhaps made a difference to his distress…"

I agree with Mr de Mars that I should accept Dr Eagle's view of the use of assessment cells, And in particular her view that:

"… The use of safe cells in managing suicidal behaviour is counter therapeutic, disempowering and distressing for prisoners, and adds no clinical value, but likely heightens the individual 's risk of self-harm or desperate behaviours. The use of a safe cell, or assessment cell in this case, was observed to significantly increase Mr. Mackinder's distress and was associated with an escalation in apparent desperate behaviours to be released from the cell. Persons with suicidal behaviours or in acute distress, should have access to a comprehensive mental health assessment and services, and if at risk should be transferred to and managed in acute mental health facilities, such as in other jurisdictions in Australia. "

Though Dr Furst disagreed that assessment cells should not be used, and he sought to explain that the assessment cell provides an opportunity for an inmate to achieve some equilibrium, he mainly spoke of the facilities in relation to such cells in the Acute Mental Health Management Units. He did agree that Bailey was distressed in the observation cell and that a referral to a mental health nurse should have been expedited. For the reasons already articulated, I find that although it was necessary and appropriate for Bailey to be placed under the supervision of the RIT, it was not necessary and appropriate for him to be placed and kept in the observation cell. I do not consider that the RIT review process was appropriate or adequate.

Issue 2 - Why did CSNSW transfer Bailey between various correctional centres from 16 July 2019 to 5 November 2019? Did this have any adverse impact on his mental health? Are there policies or procedures in place to minimise inmate transfers for vulnerable prisoners?

There is no evidence to suggest that the transfers were inappropriate or had any particular adverse impact on Bailey's mental health the inquest did not inquire into policies relating to minimising inmate transfers of vulnerable prisoners (other than as set out below).

Mr de Mars submits that Bailey should not have been placed in Kariong CC, adopting RN Georgiou's evidence in that regard. Mr Murrell said that Bailey's placement was positional in that he was due to appear in Newcastle Local Court in the near future. On that basis, Bailey must have been required to appear in person rather than AVL, although that has not been inquired into by the inquest. Mr de Mars submits that there should have been a system in place that provided an appropriate check on Bailey's suitability for his transfer to Kariong CC. Mr de Mars' submission relies on the Justice Health Transfer In and Out Form ("TIOF") completed for Bailey's transfer from the privately managed CC to Kariong CC. The Justice Health Policy 1.395, "Transfer and Transport of Patients" ("Policy 1.395"), in particular at section 3.1.9, identifies Kariong CC as an isolated site.

As such, it requires CSNSW to provide a list of transferees to the local Nurse Unit Manager ("NUM") on the **Inmates for Transfer to a Remote/Isolated Site Form**. The NUM must ensure that a review of the patient's health and other relevant records is undertaken, and the **Remote Site Assessment Criteria Checklist** is completed. The NUM is required to interview each patient and detail any reasons for exclusion of transfer to the proposed isolated site. If Justice Health staff located in remote sites are concerned about the appropriateness of a patient transfer to their site, they are to contact their appropriate delegate in regard to the suitability of the destination. I note that this last requirement does not apply to isolated sites.

The TIOF's section "Is the destination suitable?" refers to both remote and isolated sites by name, but it does not include one site - and that site is Kariong CC. If that is a typographical mistake in the form it should be corrected as it may result in, as appears to have occurred in this case, a lack of regard to Policy 1.395. It does not appear that Bailey was included in any **Inmates for Transfer to a Remote/Isolated Site form** and he was apparently not interviewed as required by Policy 1.395. Despite these failings, the TIOF's section asking, "Is the destination suitable?" has been ticked.

I note that the TIOF for Bailey's transfer to Kariong CC did not include any comments, but in the section asking, "Is the patient suitable for transfer?" a history of "*Hep C/ Anxiety*" and "*ATSI*" is written. The three previous TIOFs have comments recorded in that section as follows: 10 September 2019: "*Alerts: … SH [Self-Harm]*"; 9 August 2019: Aboriginal, Hx [history] Self-Harm, current mental illness; and 28/7/19: "*ATSI MH [Mental Health] issues*". All documents except the TIOF dated 9 August 2019 referred to the existence of a "*current HPNF*" in the section asking, "*Is the transport suitable?"*

The evidence is insufficient to establish that, had the Policy 1.395 been adhered to, Bailey would not have been transferred to Kariong CC. The evidence is insufficient to make a finding that Bailey should not have been transferred, although obviously Kariong CC was inappropriate (due to the events that occurred in relation to the RIT, and in particular the lack of mental health support and the mismanagement of the RIT management plan, together with the adoption of a certain management style of correctional officers).

Dr Spencer indicated that at the relevant time, Kariong CC accommodated generally young Aboriginal men and on that basis she thought that Kariong CC was probably a good placement for Bailey. She indicated that his mental health needs could be met even through the telehealth system. Given the number of people to be seen on that list, whether it would have met Bailey's need for a mental health review as identified prior to his transfer to Kariong CC may be arguable. Bailey's family lived in the area and when Bailey spoke to his parents before going on the RIT he seemed quite happy to be at Kariong CC.

Issue 3 - Was the response by CSNSW to Tracy Mackander's attempts to contact CSNSW about Bailey's mental health in the days leading up to his death reasonable and appropriate? I find that Ms Hyde should have accepted Tracy's call on 4 November 2019, and I do not accept that she lacked the skills to negotiate the issue of receiving information from Tracy and not being able to tell her information without Bailey's consent.

There was no impediment to Ms Hyde obtaining Bailey's consent in the afternoon and calling Tracy back. Likewise, with reference to the evidence set out above at [310] to [317], there was no good reason for a telephone call from Tracy not to have been accepted at Kariong CC on 5 November 2019. The fact that the RIT Review Management Plan apparently did not consider that Bailey could make a telephone call to Tracy on 5 November 2019, as had occurred the previous day under the ISP, was a lost opportunity for them to consider the input Tracy could have in Bailey's management.

Issue 6 - Did Bailey ingest razor blades, batteries or any other foreign bodies prior to his death? If so, in what circumstances?

Counsel Assisting referred in her submissions to an expert radiological report from Dr Raleigh. Dr Raleigh at the request of those assisting me reviewed Bailey's medical records and the autopsy report in regard to whether the CT trauma scan performed on 5 November 2019 had shown foreign metallic bodies in Bailey abdomen; and whether there were any differences between that imaging and the subsequent post-mortem scan. Dr Raleigh was also asked to compare the items identified as having been located at autopsy with that imaging.

In his report, he says that there were metallic foreign bodies in Bailey's abdomen. The rocks located in Bailey's abdomen at autopsy are likely those that were considered to be the metallic foreign bodies identified on the CT trauma scan. The plastic bag and polystyrene cup fragments would not be identifiable on such a scan. Accordingly, I accept Counsel Assisting submission, and it is not controversial, that there are no inconsistencies between the CT scans and the autopsy findings. Bailey did not ingest any batteries or razor blades on 5 November 2019. Bailey said that he had done so in order to attend the hospital. At some unknown time, Bailey did ingest small rocks, pieces of plastic, polystyrene and paper. The CCTV footage of the assessment does show Bailey at times, consuming something consistent with a polystyrene cup, however, though he was under observation, there is no evidence that this was noticed.

Issue 7 - Was the medical escort of Bailey by CSNSW escort officers Mr Slingsby and Mr Uerata to Gosford Hospital on 4 and 5 November 2019 and following discharge, conducted appropriately and in compliance with CSNSW policy?

I find that the escort of Bailey on both 4 and 5 November 2019 did comply with CSNSW policy. Though Mr Cargill and Mr Dolling said that Mr Slingsby should have had physical hold of Bailey due to the escort risk assessment, neither the escort assessment nor the s. 24 order suggested that such a hold was required. Mr Slingsby misjudged Bailey's demeanour and failed to understand that concerns for Bailey's impulsivity were not restricted to inside the hospital setting. Given that the ambulance ramp was not a site of public access, there was no need to be concerned about exercising a prisoner hold in public. Mr Slingsby was on notice that Bailey was impulsive, and he knew that he was in an assessment cell for suicidality. Mr Slingsby did not know that there was a drop behind the wall in the ambulance bay, so he would have had no reason to consider that it would be an object or means to self-harm. He was mindful of Bailey inside the hospital grabbing something to hurt himself. The escort assessment did not suggest that Bailey was an escape risk.

Mr Slingsby said he would hold an inmate if they were aggressive and Bailey was absolutely not aggressive. Even though Mr Slingsby was aware that the moment an inmate is about to enter the van is a moment of higher risk of agitation, he did not take hold of Bailey as he did not want to add to that stress. In hindsight, that was an error of judgement. Mr Reitano made numerous submissions in relation to the powers of correctional officers under legislation. I do not accept that the holding of an inmate's handcuffs by an escort officer is an act of force. In any event, Mr Slingsby did not say he did not hold onto Bailey's handcuffs because he did not want to commit an assault, and nor could he, given that he held onto Bailey's handcuffs entering the Hospital. The van should not have been parked so close to the unsecured perimeter wall as it was not the closest parking bay to the ED entrance of the Hospital; however, it was the bay that the Hospital had advised CSNSW to use for parking.

Issue 8 - What information was conveyed and what documentation was provided by CSNSW officers to Gosford Hospital regarding Bailey at his admission on 5 November 2019? Was this sufficient in the circumstances and in compliance with relevant policy and procedure? The appropriate documentation was provided, and this was ultimately not an issue in the inquest. However, Mr de Mars submits that there should be a policy requiring documentation of a patient's history and recent presentation to be provided to clinicians at the hospital. Since this incident, a Memorandum of Understanding between NSW Health and CSNSW agreed in May 2021 has been introduced to address information sharing on arrival at a hospital as a standard practice.

Issue 9 - Was the medical care, treatment, discharge and proposed management of Bailey by Dr Cameron on 5 November 2019 (including the use of a metal detector) reasonable and appropriate, with reference to relevant policy or procedure?

I address Dr Cameron's care of Bailey on 5 November 2019 above at [290] to [291]. I accept Dr Cameron's concession that it was not appropriate to use a metal detector in the manner he did and to not proceed with an x-ray on 5 November 2019; however, I also accept that if he had conducted an x-ray that would not have altered his management plan for Bailey. Mr de Mars submits that there was evidence from expert Professor Holdgate that Dr Cameron should have conducted a mental health assessment when learning that Bailey presented for swallowing objects. There were competing views about this and neither Dr Holdgate nor Dr Cameron was required to give evidence. I accept Professor Large's evidence indicated that neither of Bailey's presentations warranted such an examination in an ED hospital setting.

Issue 10 - What led Bailey to escape custody and jump over the carpark wall at Gosford Hospital? and;

Issue 11 - Was Bailey aware that the other side of the carpark wall was a significant height from the ground?

Ms Mahony submits that it is open to find that Bailey had in his mind an intention to be transported to hospital for the purpose of absconding. I accept that Bailey orchestrated going to hospital as he did not swallow the objects he claimed to have swallowed.

He likely faked feeling pain in his stomach, although he may have had some discomfort given the items including rocks and polystyrene located at autopsy. Bailey had told John Brown he would fake an illness the previous day to get out of the cell, which was likely his motivation to attend hospital.

Any plan for escape was completely futile and unrealistic given that Bailey was shackled at hand and foot. That Bailey attempted to escape points to how impulsive his act was. Bailey knew that he would be shackled, because he had been on his first attendance at hospital on 4 November 2019. Bailey had every reason to think that the lack of opportunity afforded to him by the way the escort was conducted the previous day would be replicated on 5 November 2019. Any notions of escape were likely abandoned when they were replaced with the need to simply get out of the assessment cell or not be returned to it. I have no doubt that Bailey did not realise that there was an eight-metre drop to the ground from the top of the wall. The fact that Mr Slingsby chased Bailey by jumping up onto, rather than over, the wall saved him from also falling to his death. Bailey was vulnerable and had personality frailties as advanced by both Dr Eagle and Professor Large. Bailey experienced anxiety and distress which was seriously exacerbated when he was in the assessment cell - a cell with 24/7 lighting and no access to open air.

Despite demonstrating settled and calm behaviour overnight from 4 to 5 November 2019 so that he might be discharged from the cell, Bailey was not reviewed and discharged at 8am as he had been told would occur. When Bailey did meet with the RIT review team, the decision was made to keep him in the cell with increased restrictions that were unjustifiably imposed under the management plan.

Bailey was told that if he continued being distressed in the cell he would be in there for much longer. He received no psychological or mental health support and was subjected to a correctional management style that resulted in frustration and a lack of understanding as to how to deal with Bailey's escalating deterioration. Bailey was discharged from the Hospital so quickly, to be returned to the cell, that he only had a short period of respite. All of these experiences likely informed an extremely impulsive and utterly tragic move when Bailey saw that Mr Slingsby was distracted opening the van door.

The height of the perimeter wall was such that it could be vaulted so easily by a person even in shackles, and the location gave no sense that the wall was above a deathly drop. Those factors contributed to Bailey's impulsive act.

Issue 12 - Was the CSNSW response to Bailey's death, including the findings of the investigation report dated 6 November 2020, adequate?

The CSNSW investigation is referred to above at [300] to [309]. As I note at [306], Mr Hovey gave evidence that if CSNSW investigators were conducting investigation now, they would now delve further into systemic processes such as the RIT process. I find that the CSNSW investigation identified the central circumstances relating to Bailey's death. The Investigation engaged in a thorough collection and transcribing of the CICs which are relevant to Bailey's manner of death. Due to an investigator experiencing trauma from having done, the investigation became delayed until a replacement investigator was available.

During an earlier stage of the investigation relating to cause of Bailey's death, that investigator was unable to continue due to associated trauma. That incident reports were relied on rather than statements of officers as witnesses has been noted by Mr Hovey who expressed that now an investigation would or should involve the taking of statements from relevant persons. Arising out of the CIC records, the investigation adequately and appropriately addressed the need for correctional officers to have adequate mental health training.

Issue 13 - Are there any recommendations necessary or desirable in relation to any matter connected with Bailey's death? According to submissions made by Mr Rooney, as at 22 June 2020, the Kariong CC became known as Kariong Transit and Intake Centre ("TIC"). The centre sees inmates transiting in and out seven days per week. The expectation now is that inmates do not remain at Kariong TIC for longer than 24 hours. It is unknown whether this expectation means that inmates would not be placed on a RIT and in an assessment cell at Kariong TIC. Counsel assisting put forward eight recommendations (1-8) to CSNSW and six recommendations (9-14) to Justice Health and two recommendations (15-16) to CSNSW and Justice Health jointly. Those recommendations were added to by Bailey's parents. Justice Health and CSNSW then responded to them.

Findings

Identity	Bailey Mackander was a 20-year-old Wiradjuri man.
Date of Death	7 November 2019
Place of Death	Royal North Shore Hospital, St Leonard's, NSW
Cause of death	Multiple injuries from fall from height

Manner of death Bailey was on remand in the lawful custody of CSNSW and died after he impulsively ran from the custody of CSNSW escort officers and vaulted over the Gosford Hospital ambulance bay wall without realising that the wall was not at ground level but was approximately eight metres above. At the time Bailey escaped he was handcuffed, and ankle shackled and was subject to a Risk Intervention Team Management Plan which caused him to be held in an assessment cell. Whilst in the assessment cell that day, he was without any psychological or social support or access to the open air and was deprived of any diversionary activities involving human interaction and telephone calls. Bailey had a substance use disorder in conjunction with or additional to a generalised anxiety disorder. He struggled with being in prison and he especially struggled with being in the assessment cell. He fabricated stomach pains and a story that he had swallowed metallic foreign objects to attend hospital so that he could have time away from the cell. His escape was impulsive in circumstances where he knew he was about to enter the escort vehicle to return to the cell, without any certainty that he would be discharged from that cell the following day.

Conclusion

This inquest has been a tragic and sad learning of the last days of a young gentle man who was really still a boy. Bailey's teenage years of drug use did not turn his family away, but it resulted in him going to prison and it resulted in him not developing as he otherwise would have. To have the emotional skills to deal with the trauma of prison is not easy when you are young. Perhaps it is not easy anytime. It was Bailey's connection to his family that helped him cope with being in prison. He spoke to his mum on the telephone every day. He wrote to his dad and told him how much he loved him and that this time he was going to stop the drugs for sure. No matter how many times they heard Bailey say that, his family did not turn their back on him.

Bailey was not some prisoner who nobody cared about. Yet his mother's desperate calls to the prison were dodged and unanswered. Bailey's connection to his family was severed in the name of protecting him from harming himself. It was careless. Nobody recognised or considered that more harm than good was being done to Bailey by the terms of the RIT management plan. He was expected to tough it out. Suck it up. Bailey was not thinking when he took off over that wall - he was being driven by sudden impulse and emotion. Perhaps they are the things that can't be imprisoned.

As I said after hearing Bailey's parents speak of him, something has to change. These findings and recommendations will not stop the courts sending young Baileys to prison. They will not cause the correctional system to cater for all kinds in better and more ways or cause the government to invest more money in alternatives so that young people with drug problems are not treated like criminals and I suspect they will not even result in better mental health and psychological support in prisons which are full of people who need it. But perhaps they will save one or two from being placed in a RIT cell to battle their demons alone. To the Mackander family, I am so very sorry for your loss.

Recommendations to CSNSW

Recommendation CS 1

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to require a coordinator of a RIT review meeting to seek that a psychologist be a member of the RIT and in the event that the psychologist is unable to participate in the review meeting, provide an opportunity for the SAPO and/or Justice Health member of the team to consult with the centre's psychologist or an off-site mental health service provider, prior to any determination of the RIT review team.

Recommendation CS 2 (a)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to indicate that the RIT coordinator is required to compile and distribute a folder of specified documents to the RIT members prior to the RIT review meeting in sufficient time so that those members are informed of the matters contained therein. The documents are to include:

i. the Part 1 Mandatory Notification.

ii. prior Mandatory Notifications, ISPs, and RITplans.

iii. recent OIMS case notes with regard to the mental health of the inmate.

iv. any observations of the inmate in a cell made while on an ISP or a RIT; and

v. current OIMS alerts in relation to the inmate.

Recommendation CS 2 (b)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide that any ISP and RIT Management Plan must include written reasons as to the following:

i. the decision to place the inmate on the ISP or the RIT.

ii. the cell placement, including reasons why a less restrictive placement option, if available, is not suitable; and

iii. if a less restrictive placement option is unavailable at the time, why that option is unavailable and when, if ever, it will be available.

Recommendation CS 2 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That any ISP and RIT management plan identify in writing the names of the person/s and/or designation of office who will be responsible for the management of the inmate on the relevant shifts until the next RIT review; and

ii. that this information is provided to the inmate.

Recommendation CS 3 (a)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to provide the following:

i. That an inmate placed on an ISP is to be provided the opportunity to have telephone contact with an approved support person (approved by the governor or delegate). Such telephone contact by the inmate is to be facilitated as soon as possible - preferably within two hours - of the inmate being placed on an ISP.

ii. That a phone call from an inmate to an approved support person be facilitated at the establishment of a RIT Management Plan and upon each 24-hour extension of such plan.

iii. That a phone call from an inmate to an approved support person be facilitated at the discharge from an ISP or upon the establishment of a RIT discharge plan.

iv. The policy should clarify that any additional telephone calls to an approved support person are to be at the discretion of the officer managing the inmate.

v. The policy should make it clear that these telephone calls are not a substitute for any telephone calls for the purpose of human contact or interaction as set out in the ISP or RIT management plan or discharge summary.

Recommendation CS 3 (b)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to include that as soon as practicable following a Mandatory Notification, the managing officer is to:

i. Inform the inmate of the decision and the reasons for the MNF and the ISP components.

ii. Inform the inmate that they are entitled to have telephone contact with an approved support person. If the inmate wishes to do so, they are to provide the name and phone number of that person and once approved by the governor or delegate, a phone call by the inmate to that approved support person is to be facilitated as soon as possible (this should occur within hours of being placed on a ISP or RIT Management Plan).

iii. If the inmate does not wish to nominate a person, that should be recorded in writing.

iv. Inform the inmate that their ISP or RIT status will be subject to review within 24 hours and that they will attend the meeting of the review team to discuss their level of risk of harm and any protective factors and safeguards that can be put in place so that they could be discharged from the ISP or RIT.

v. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for CSNSW staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided. Further, they are to inform the inmate that this will be documented appropriately in OIMS and retained with the inmate's RIT documentation in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

vi. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent that will be documented in OIMS and retained with the inmate's ISP or RIT documentation.

vii. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

viii. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the officer should record this fact and any reasons expressed by the inmate as to why they do not wish to sign.

ix. Complete the appropriate OIMS documentation (with respect to the above) and retain the consent documents.

x. Notify Justice Health that an inmate is on an ISP or RIT (see also, Joint Recommendation CS/JH 3).

Recommendation CS 3 (c)

That CSNSW amend the "Management of Inmates at Risk of Self-Harm or Suicide" policy to require the following:

i. each RIT review member is to sign an acknowledgement of completion of the necessary training to undertake the role.

ii. the coordinator is to record the time of the commencement and conclusion of the RIT review meeting.

iii. the coordinator is to record the time at which the inmate was in attendance at the RIT review meeting; and

iv. the completion of all sections of the forms is to be carried out with the use of the assessment guideline documents.

Recommendation CS 4

That CSNSW amend the following forms: Part 1 Mandatory Notification Form, Part 2 Immediate Support Plan, and Part 3 Risk Intervention Team (RIT) Management Plan, to incorporate the following (including to facilitate the changed policy set out in Recommendations CS 2 and CS 3):

i. the time at which the inmate is placed in the RIT assessment cell.

ii. the time at which the ISP is commenced and the time/s at which it is completed and/or amended.

iii. an acknowledgement to be signed by each RIT review member of completion of the necessary training to undertake the role.

iv. the times at which those adopting the contents of the form signed, and the legible names of the signator/s; and

v. the time/s at which the inmate attends and departs a RIT review meeting.

Recommendation CS 5

That CSNSW investigate the implementation of a procedural safeguard enabling an approved third party to accompany and assist an inmate when they attend a RIT review meeting, on the basis that the third party would attend by remote facility such as web- conferencing.

Recommendation CS 6

That CSNSW investigate and, if practicable, establish a resource document setting out the names of First Nations elders and First Nations organisations, being those who can provide mentoring support to First Nations inmates subject to an ISP or RIT management plan. Such culturally appropriate mentorship and support is to occur whilst the inmate is on the plan.

If such a resource is established, rather than restricting access to it to First Nations inmates subject to an ISP or RIT, other First Nations inmates who are struggling to adjust to their environment and situation should have free access so that they receive culturally appropriate support as needed.

Recommendation CS 7

That CSNSW amend policy and procedure to:

i. Ensure that when an inmate in an assessment cell requests to see a nurse, psychologist, or psychiatrist, that such request be communicated to the nurse, psychologist, or psychiatrist.

ii. In the event that such person declines to attend, a written note to that effect should be made in OIMS.

iii. If a nurse, psychologist, or psychiatrist decline to attend, the inmate should be provided the opportunity to make a call to the 1800 Mental Health Helpline and this should be recorded in OIMS.

Recommendation CS 8

That CSNSW amend its policy to require documentation in OIMS of observations by CSNSW staff of an inmate's behaviour, progress or deterioration while placed in an "assessment cell", with such documentation to be recorded on an hourly basis, and that there be an obligation on change of shift for there to be a verbal handover regarding the observations made about the inmate during that shift.

Where competing shift duties do not permit such records to be made each hour, entries are to be made as duties permit, and an end of shift record must be made, noting the observations of the inmate during the shift. Where no verbal handover is possible, the incoming staff member should review the OIMS of any inmate housed in an assessment cell, at their earliest convenience, in relation to their presentation over the period of their placement in the assessment cell.

Recommendation CS 9

That CSNSW amend its policy to require CSNSW staff to contact the on-duty Justice Health staff member if an inmate's physical and/or mental health is observed to deteriorate while housed in an "assessment cell".

Recommendation CS 10

CSNSW is to address the use of assessment cells at Kariong Transit and Intake Centre ("Kariong TIC") to ensure that they are fit for purpose. Until such time that Kariong TIC is able to provide an inmate on a RIT with access to their entitlement per cl. 53 of the Regulation for daily open air exercise, an inmate who would otherwise be housed in an assessment cell at Kariong TIC should be immediately transferred to a correctional centre which can provide for the placement option of least restrictive care whilst they are at risk of self-harm.

Recommendation CS 11

That CSNSW conduct a review into the use of assessment cells to manage inmates at risk of self-harm and whether such use is consistent with adherence to the concept of least restrictive placement options. Such review should also include whether RIT Management Plans appropriately allow for diversionary activities and human interaction as contemplated by the policy, and whether appropriate mental health interventions are being provided to the inmates whilst in the assessment cell.

Recommendation CS 12

That CSNSW develop a document to provide guidance and structure to officers charged with the task of monitoring and managing an inmate on a RIT in an assessment cell,

so that any deterioration in the inmate's condition can be appropriately escalated and managed and further, so that a proper record is kept of the inmate's progress. This document is to be provided to the coordinator of the RIT review meeting and a copy to the manager responsible for the inmate at the time of that review.

Recommendation CS 13 (a)

CSNSW is to develop an appropriate training module and guidelines to assist staff (including but not limited to psychologists, SAPOs and relevant senior officers) to communicate with family members who are making inquiries about an inmate's wellbeing. That training package is to be rolled out across CSNSW correctional centres.

i. That training should include, but not be limited to:

a) that the CSNSW Family Handbook advises family members when they are entitled to contact a correctional centre in order to provide information about an inmate (see Recommendation CS 13(b)).

b) accepting a telephone call, ascertaining what the inquiry is, taking the name and contact details of the caller and prioritising the urgency of attending to the family's request.

c) understanding the difference between gathering information and giving information.

d) defining what information can be given without written consent.

e) defining what information cannot be given without written consent.

f) determining an appropriate time frame within which any required written consent is obtained from the inmate.

g) the process by which such consent is to be sought and obtained, including what should be specified on the consent form.

h) documenting information provided to a family member; and

i) documenting information provided by a family member and to whom it should be given.

ii. That training should include scripts, consent forms, practical role plays and scenarios.

Recommendation CS 13 (b)

That CSNSW amend the 'Families Handbook' to clearly identify that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances.

All contact should be initially made to the Justice Health and Forensic Mental Health Network 24-hour hotline – ph.: 1800 222 472, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.

Recommendation CS 13 (c) .That as soon as practicable CSNSW send an email memorandum to appropriate staff members reminding them that family members are entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances and accordingly those telephone calls should be accepted and actioned.

Joint recommendations to CSNSW and Justice Health

Joint Recommendation CS/JH 1

That Justice Health and CSNSW liaise and ensure that their respective websites and the relevant part of the 'Families Handbook' are consistent with the following information:

i. that a family member or support person is entitled to contact a correctional centre in order to provide information about an inmate's medical health including mental health in urgent or important circumstances; and

ii. that all contact should be initially made to the Justice Health and Forensic Mental Health Network 24-hour hotline – ph.: 1800 222, and then alternatively to the Functional Manager on duty of the correctional centre where the inmate is detained, or a SAPO on duty at that centre.

Joint Recommendation CS/JH 2

That Justice Health and CSNSW convene a joint working group for the purpose of improving the current custodial mental health model of care, with specific focus on the provision of multidisciplinary, integrated, evidence-based healthcare with shared health records.

Joint Recommendation CS/JH 3

That CSNSW and Justice Health liaise and create mutual policy and procedure (to the extent not otherwise contained in the respective organisations' policies) so that when a Mandatory Notification is raised and an ISP is created, a notification is provided by CSNSW to Justice Health. Further, Justice Health is to create a policy whereby, upon receipt of that notification, a Justice Health nurse will attend upon the inmate. That Justice Health nurse will inform the inmate that Justice Health are aware of their ISP or RIT status, discuss consent to sharing health information (as set out in Recommendation JH 1) and obtain information to create the HPNF, as well as ascertaining and administering to the inmate's health needs.

Recommendations to Justice Health

Recommendation JH 1 (a)

Further to Joint Recommendation CS/JH 3, that Justice Health introduce policy and procedure to include that when a Justice Health nurse conducts an initial attendance upon an inmate they have been notified is on a Mandatory Notification, ISP or RIT that the Justice Health nurse:

i. Inform the inmate that they can now, or at any stage whilst on the ISP or RIT, provide written consent for Justice Health staff to communicate with specified third party(ies) for the duration of or any specified part of the ISP or RIT, with that consent to indicate the parameters, if any, of information to be provided.

ii. Inform the inmate that such consent will be documented appropriately in their Justice Health file and retained in the event that it is useful or necessary for the management and support of the inmate on the ISP or the RIT.

iii. Inform the inmate that they may withdraw their consent in writing at any time and, that where there is a withdrawal of consent that will be documented on their file and retained with the inmate's ISP or RITdocumentation.

iv. Provide an opportunity for the inmate to provide such consent for the duration of, or a specified part of, the ISP or RIT.

v. Request the inmate to sign an acknowledgement that the above has been explained to them and that they understand the process. In the event that an inmate does not wish to sign, the Justice Health staff member should record this fact and any reasons expressed by the inmate as to why they do not wish to sign.

vi. Complete the appropriate documentation (with respect to the above) and retain the consent documents.

Recommendation JH 1 (b)

At the time that Justice Health attends a patient placed on an ISP or RIT, the nurse is to provide to the patient with the phone number for the Mental Health Helpline.

Recommendation JH 2

That Justice Health staff who are likely to communicate with the family or approved support person for an inmate, including clinical and administrative staff, are provided with guidance and any necessary training on effective communication, the boundaries of confidentiality and the avenues for obtaining consent when necessary; such training should include the use of scripts, consent forms, practical role plays and scenarios.

Recommendation JH 3 (a)

That Justice Health give consideration to developing a protocol to ensure that when a Justice Health staff member participates in a RIT review meeting that member is, if available, a mental health nurse and if not, that the participating member has access and opportunity to consult with mental health staff either at the centre or via Remote Off-site After-Hours Medical Services ("ROAMS").

Recommendation JH 3 (b)

That Justice Health give consideration to implementing a priority referral system for any mental health referrals contained in a CSNSW RIT Management Plan.

Recommendation JH 4

That Justice Health give consideration to seeking a joint legal authoritative legal advice addressing the limits and risks of a revocable but enduring consent, in the context of improving the sharing of patient information in custodial health.

Recommendation Joint CCLHD/JH 1

That a copy of the "*Who is JHFMHN*" poster developed by Justice Health be circulated to all New South Wales Health Emergency Departments, and for that document to be brought to the attention of hospital staff to ensure they are aware of relevant contact information to assist where necessary with clinical handover.

29. 362566 of 2019

Inquest into the death of George McLeod. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 27 May 2021.

At the time of his death, George McLeod was 80 years old and was being held in lawful custody as a forensic patient within Long Bay Hospital at Long Bay Correctional Complex. Mr McLeod had a lengthy history of physical and mental health conditions. After having been charged with a serious offence of violence, Mr McLeod was subsequently found unfit to stand trial, and a limiting term was later imposed that was to expire on 25 September 2021.

In the early hours of the morning on 18 November 2019, Mr McLeod was found in his bed inside his cell to be unresponsive, and showing no signs of life. In accordance with an advanced care directive that had been instituted some months earlier due to Mr McLeod's deteriorating condition, no resuscitation measures were initiated. Mr McLeod was subsequently pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr McLeod was not appropriately cared for and treated whilst in custody.

Mr. McLeod's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr McLeod's personal circumstances.

Mr McLeod was born in 1939. At the age of two Mr McLeod and his five siblings were removed from their mother's care. Mr McLeod was subsequently placed in foster care, and he reported that his stepfather subsequently visited him whilst he was living in a care placement. In November 1970 Mr McLeod married, and later had two children. Sometime later the marriage ended, and Mr McLeod lost contact with his children, who were later adopted by their stepfather. In his later years of life, Mr McLeod resided at an aged care facility.

Mr. McLeod's custodial history

Between 1954 and 1974 Mr McLeod had a number of interactions with the criminal justice system in relation to relatively minor property and assault offences. However, between 1974 and 2016 Mr McLeod had a number of further interactions with the criminal justice system in relation to more serious personal assault offences. During this period, Mr McLeod was convicted in relation to a number of offences of violence and was sentenced to lengthy terms of imprisonment. On 26 September 2016 Mr McLeod was arrested and charged with an offence of wounding with intent to cause grievous bodily harm. Following his arrest, Mr McLeod was remanded in custody and initially housed at the Metropolitan Remand & Reception Centre at Silverwater. On 6 October 2016 Mr McLeod was transferred to the Metropolitan Special Programs Centre at Long Bay Correctional Complex due to his medical conditions. On 25 July 2017 a Fitness Hearing was held in the District Court to determine Mr McLeod's fitness to stand trial. Medical evidence adduced at the hearing indicated that due to Mr McLeod's history of vascular dementia with impairment of cognition he:

(a) was incapable of fairly participating in a trial; and lacked the ability to make out a defence and answer the charges presented against him by giving necessary instructions to his legal representatives. Ultimately, a determination was made by the District Court that Mr McLeod was unfit to stand trial. Accordingly, an order was made for Mr McLeod to be detained at Long Bay Correctional Complex to receive care and treatment, pursuant to section 14 of the *Mental Health (Forensic Provisions) Act 1990* (the Mental Health Act).

On 7 September 2017 the Mental Health Review Tribunal (the Tribunal) determined that Mr McLeod was unfit to stand trial and would not become fit to be tried within 12 months of the date of his Fitness Hearing. Therefore, pursuant to sections 46 and 47 of the Mental Health Act, the Tribunal determined that Mr McLeod should continue to be detained at Long Bay Correctional Complex for care and treatment. On 22 March 2018 a Special Hearing was held in the District Court. A qualified finding of guilt was made against Mr McLeod for the offence that he had been charged with. The District Court imposed a five-year limiting term pursuant to section 23 of the Mental Health Act, with the limiting term to commence on 26 September 2016 and expire on 25 September 2021. Mr McLeod was referred to the Tribunal for review pursuant to section 24 (1) of the Mental Health Act and was to be kept in custody pending the determination of the Tribunal. On 10 May 2018 the Tribunal determined that Mr McLeod was suffering from a mental illness and a mental condition. Further, the Tribunal formed the opinion that Mr McLeod had not become fit to be tried for the offences in relation to which he had been found unfit, and that he should continue to be detained for care and treatment as a forensic patient at Long Bay Correctional Complex. An order for detention was subsequently made pursuant to section 47(1) of the Mental Health Act.

A further determination was made by the Tribunal on 10 December 2018 that Mr McLeod remained appropriately detained, and that due to the permanent nature of his condition there was no evidence that there had been any change to his fitness to be tried. On 3 May 2019 the Tribunal noted that Mr McLeod was still unfit to stand trial, with more than 12 months having elapsed since being found unfit by the District Court. The Tribunal noted that the medical evidence provided to it indicated that Mr McLeod continued to be unfit to stand trial and that the conditions which made him unfit were permanent and getting worse. The Tribunal therefore determined that Mr McLeod remained properly detained and that there should be no change to his current circumstances. The Tribunal also determined that a subsequent review would be held within six months.

Mr. McLeod's medical history

Mr McLeod had a history of chronic obstructive airways disease, ischaemic heart disease with two coronary bypass grafts, bradycardia, type II diabetes, hypertension, hypercholesterolaemia and right leg amputation. During his time in custody, Mr McLeod was primarily housed in the Kevin Waller Unit at Long Bay Correctional Complex, which provides additional supports for older inmates with physical frailties. In January 2018 Mr McLeod was transferred to the Aged Care and Rehabilitation Unit at Long Bay Hospital due to his deteriorating mental state. On 6 June 2019 an advanced care directive was put in place noting that Mr McLeod was not for resuscitation due to his existing medical conditions and poor prognosis. On 10 November 2019 the advanced care directive was reviewed and continued, noting that even if resuscitation were to be successful it would likely be followed by a significantly reduced quality of life which would not be in Mr McLeod's best interests. On 13 July 2019 a marked deterioration in Mr McLeod's condition was noted. He was found to have little reactivity, no spontaneous behaviours and increased thought disorders. Accordingly, on 8 August 2019 Mr McLeod was transferred to the Garrawarra Centre, an aged care facility for treatment of inmates with dementia.

In October 2019, due to Mr McLeod's deteriorating condition, consideration was given to the institution of palliative care. On 10 November 2019 Mr McLeod was noted to have poor appetite and to be displaying signs of tiredness and lethargy. At this time Mr McLeod was frail, non-verbal and unable to independently mobilise, spending most of his time bed bound. Mr McLeod was monitored for increased confusion, agitation and disorientation.

What happened on 18 November 2019?

On the evening of 17 November 2019 Mr McLeod was noted by Justice Health & Forensic Mental Health Network (**Justice Health**) staff to be asleep in his bed. Between 12:00am and 2:30am on 18 November 2019 Justice Health staff performed routine observations of Mr McLeod and attended to repositioning. During a routine medication round at 4:30am Justice Health staff attend Mr McLeod's cell and found him to be unresponsive, with no signs of life. In accordance with the advanced care directive in place, resuscitation was not initiated. Mr McLeod was subsequently pronounced life extinct.

What was the cause of Mr. McLeod's death?

Mr McLeod was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Istvan Szentmariay, forensic pathologist, on 22 November 2019.

The examination identified severe advanced atherosclerosis involving the larger arteries, with coronary artery disease and a slightly enlarged heart noted. No acute bony pathology and no acute event within the cranium were identified. Ultimately, in the autopsy reported dated 15 April 2020, Dr Szentmariay opined that the cause of Mr McLeod's death was atherosclerotic cardiovascular disease, with dementia, diabetes mellitus and hypertension noted to be significant conditions contributing to the death, but not relating to the disease or condition causing it.

Conclusions

Having regard to the relevant records from Corrective Services NSW (**CSNSW**) and Justice Health regarding Mr McLeod's period in custody, and the findings from the post-mortem examination, it is evident that Mr McLeod died as a result of significant pre-existing natural disease. Mr McLeod had a complex medical history which made him entirely dependent on the care and treatment provided by Justice Health staff during his time in custody. Following a significant decline in Mr McLeod's condition, and given his poor prognosis, an appropriate advanced care directive was instituted in June 2019. Overall, the available evidence establishes that Mr McLeod was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr McLeod's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

Findings

Identity: The person who died was George McLeod.

Date of death: Mr McLeod died on 18 November 2019.

Place of death: Mr McLeod died at Long Bay Hospital, Long Bay Correctional Complex, Malabar NSW 2036.

Cause of death: The cause of Mr McLeod's death was atherosclerotic cardiovascular disease, with dementia, diabetes mellitus and hypertension being significant conditions contributing to the death, but not relating to the disease or condition causing it.

Manner of death: Mr McLeod died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

30. 388175 of 2019

Inquest into the death of Elias Melhem. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 30th November 2021.

At the time of his death, Elias Melhem was 49 years old and in lawful custody at the Outer Metropolitan Multi-Purpose Correctional Centre, serving a sentence of imprisonment. Mr Melhem had a history of hypertension, hyperlipidaemia, type 2 diabetes mellitus and a right renal transplant.

On the morning of 8 December 2019, Mr Melhem complained of feeling chest pains to a fellow inmate. Mr Melhem later reported that he was feeling better, and made no mention of the pains to anyone else. During the evening, Mr Melhem went to sleep in a common lounge room area within the facility where he was housed. The following morning, as preparations were being conducted for the daily morning muster, Mr Melhem was found to be still in the lounge room area, unresponsive and with no signs of life. Resuscitation efforts were immediately initiated, and emergency services were called. However, Mr Melhem tragically could not be revived and was later pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Melhem was not appropriately cared for and treated whilst in custody.

Mr. Melhem's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr Melhem's personal history prior to his incarceration.

Mr Melhem was born in Lebanon, and later emigrated to Australia with his parents when he was six years old. Mr Melhem completed Year 10 in a high school in Burwood, and later worked at a variety of jobs, including in sales and security. Due to a number of health conditions, Mr Melhem was unable to work from 2015 onwards and began receiving social security payments.

Mr Melhem was previously married, and had one daughter from this relationship. Following the end of this relationship, Mr Melhem resided with his mother in Concord. After entering custody, Mr Melhem was reportedly well liked by his fellow inmates. Mr Melhem also had no issues in his interactions with correctional officers during his time in custody. There is no doubt that Mr Melhem's passing has been deeply felt by his family members and loved ones, and that they continue to miss him enormously.

Mr. Melhem's custodial history

On 18 October 2018 Mr Melhem was convicted in the District Court in relation to a number of fraud-related offences. He was subsequently sentenced to a term of imprisonment of 3 years and 10 months, with a non-parole period of 1 year and 9 months, making his earliest eligible release date 17 October 2020.

Following his conviction, Mr Melhem was initially transferred to the Metropolitan Remand and Reception Centre, and later transferred to the Dawn De Loas Correctional Centre (**DDLCC**) on 25 October 2018. After being housed temporarily at South Coast Correctional Centre from November 2018, Mr Melhem returned to DDLCC in March 2019. On 30 May 2019 Mr Melhem was transferred to the Outer Metropolitan Multi-Purpose Correctional Centre (**OMMPC**) at Berkshire Park, where he remained until his death.

Whilst at the OMMPC Mr Melhem was housed within Honour House, and resided in room 200 with another inmate at the time of his death. Honour House is a minimum-security facility attached to the OMMPC which houses inmates who are in the process of being integrated back into the community following completion of terms of imprisonment. Typically, a morning muster is conducted at 7:00am to ensure that all inmates are accounted for, before certain inmates are permitted to leave in order to work within the community or within the John Morony Correctional Complex. Whilst at the OMMPC, Mr Melhem was employed in the kitchen as a leading hand, preparing and supplying meals to other inmates within the facility. In August 2019 Mr Melhem was promoted to kitchen storeman. Mr Melhem had progressed to a C3 classification, which is deemed minimum security and with electronic monitoring when employment is gained outside in the community.

Mr. Melhem's medical history

Mr Melhem had a history of insulin-dependent type 2 diabetes, hypertension, epilepsy, asthma and hyperlipidaemia. In 2015, Mr Melhem underwent a right renal transplant secondary to end stage renal disease. As a result, whilst in custody, Mr Melhem received haemodialysis three times per week, and had regular pathology testing with his blood sugar levels (**BSL**) taken three times per day. Available Justice Health & Forensic Mental Health Network (**Justice Health**) records indicate that Mr Melhem declined referrals to specialists on a number of occasions whilst in custody:

On 22 October 2018, whilst been reviewed by a general practitioner, Mr Melhem indicated that he did not want any referral to a specialist. On 8 November 2018, whilst at South Coast Correctional Centre, it was noted that Mr Melhem's BSL were elevated However, Mr Melhem continued to decline referrals to specialists despite encouragement and education.

On 29 January 2019 Mr Melhem agreed to be transferred to a Sydney correctional centre for treatment, but later declined all medical appointments, indicating that he no longer wish to be transferred. After the risks of not attending appointments were explained to Mr Melhem, he signed a cancellation form.

What happened on 8 and 9 December 2019?

On 8 December 2019 Mr Melhem worked in the kitchen as part of his usual daily routine. Mr Melhem was working with another inmate, putting meals into a box. At around 10:30am or 11:00am Mr Melhem picked up a box, grabbed his chest and complained of chest pains. Mr Melhem's fellow inmate told him to put down the box and to sit down to rest. After sitting for approximately 20 to 30 minutes, Mr Melhem indicated that he was fine. A short time later Mr Melhem went to lunch before returning to Honour House.

At around 5:00pm, Mr Melhem attended a Justice Health clinic, together with the inmate that he had been working with earlier in the day, in order to receive his prescribed insulin injection. The inmate asked Mr Melhem if he was alright, and Mr Melhem indicated that he was. Whilst receiving his insulin injection Mr Melhem made no mention to Justice Health staff of the chest pains that he had experienced earlier in the day, or of any other health concerns.

After receiving his insulin injection Mr Melhem returned to his unit and had a shower. Sometime between around 6:00pm and 7:00pm, Mr Melhem's cellmate returned to the room and found that Mr Melhem had just woken up. Mr Melhem reported that he had left work earlier in the day after experiencing chest pains and then returned to his room, where he had slept for a few hours and then felt better. After waking, it appears that Mr Melhem left his room and went to the common lounge room area within Honour House. During the evening Mr Melhem was seen by other inmates to be playing a card game on the computer, and to be watching television. Nothing amiss was noted during the course of the evening. Sometime before 10:30pm Mr Melhem returned to his room where it is believed he went to sleep. At around 11:00pm, Mr Melhem's cellmate heard Mr Melhem leave the room, believing that Mr Melhem was going to the bathroom. Instead, it appears that Mr Melhem returned to the lounge room where he lay down on a lounge near the television.

The following morning, at around 5:30am on 9 December 2019, an inmate walked to the lounge room and found Mr Melhem lying on his right side on a lounge, apparently asleep. After the inmate turned the television on, there was no response from Mr Melhem, which was considered to be unusual as Mr Melhem was known to be usually awake by this time. The inmate considered that nothing was amiss, and that Mr Melhem had simply had a bad night's sleep. Accordingly, no concern for welfare was raised at this time. Shortly before the daily muster time at 7:00am, the inmate pushed on Mr Melhem's leg and called out Mr Melhem's name in order to wake him.

When Mr Melhem did not respond, the inmate placed his hand on the back of Mr Melhem's neck and felt that it was cold to touch. Realising that something was wrong, the inmate notified Corrective Services New South Wales (**CSNSW**) officers, who by this time were preparing to conduct the morning muster. When CSNSW officers checked on Mr Melhem he was found to be unresponsive and with no pulse.

In response, two CSNSW officers placed Mr Melhem on the floor and immediately commenced cardiopulmonary resuscitation. Assistance was sought from Justice Health staff and emergency services were contacted. Justice Health staff arrived on the scene a short time later. Defibrillator pads were placed on Mr Melhem's chest and he was found to have no shockable rhythm. NSW Ambulance paramedics later arrived on scene at 7:15am. Despite continued resuscitation efforts, Mr Melhem could not be revived and was pronounced life extinct at 7:24 AM.

What was the cause of Mr. Melhem's death?

Mr Melhem was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Sairita Maistry, forensic pathologist, on 13 December 2019. Examination revealed an enlarged heart with left ventricular hypertrophy and significant severe atherosclerosis of the three coronary arteries which supply the heart muscle with blood and oxygen. Sites of critical stenosis were located in the left anterior descending, circumflex and right coronary arteries, with areas of mottling of the myocardium. Histological examination identified evidence of acute ischaemic injury to the myocardium, with sections of the coronary arteries showing stenotic calcified atherosclerotic plaques. In the autopsy report dated 28 October 2020, Dr Maistry opined that the cause of death is atherosclerotic and hypertensive cardiovascular disease, with type 2 diabetes mellitus being a significant condition contributing to the death but not relating to the disease or condition causing it.

Conclusions

Having regard to the relevant records from CSNSW and Justice Health regarding Mr Melhem's period in custody, and the findings from the post-mortem examination, it is evident that Mr Melhem died from progression of a natural disease process, with death being sudden and unexpected. Although the chest pains experienced by Mr Melhem on the morning of 8 December 2019 were most likely of pathological significance, the only person who Mr Melhem made aware of this was a fellow inmate. Relevantly, when Mr Melhem interacted with Justice Health staff later in the afternoon in order to receive his insulin injection, he made no mention of the chest pains or of any other health concerns.

Had information regarding the chest pains been disclosed, it is likely that this would have prompted some action in order to investigate the nature and significance of Mr Melhem's condition. Indeed, evidence gathered by the police officer in charge, Detective Senior Constable Adam Long, from the Justice Health Nursing Unit Manager at the OMMPC indicates that if Mr Melhem had disclosed such information he would have been transferred to hospital, in accordance with established protocols, for investigation and treatment. Overall, the available evidence indicates that Mr Melhem was provided with appropriate medical care, to address and treat his various chronic medical conditions, whilst in custody.

Mr Melhem was regularly reviewed in relation to his renal issues and type 2 diabetes. However, it appears that Mr Melhem was not always inclined to accept recommendations for his medical issues to be reviewed by appropriate specialists. Relevantly, no CSNSW or Justice Health staff member was informed of Mr Melhem's health complaints on the morning of 8 December 2019. Accordingly, there is no evidence to suggest that any action could have been taken by CSNSW or Justice Health staff to potentially alter the eventual outcome. There is also no evidence to suggest that any aspect of Mr Melhem's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

Findings

Identity

The person who died was Elias Melhem.

Date of death

Mr Melhem died on 9 December 2019.

Place of death

Mr Melhem died at the Outer Metropolitan Multi-Purpose Correctional Centre, Berkshire Park NSW 2765.

Cause of death

The cause of Mr Melhem's death was atherosclerotic and hypertensive cardiovascular disease, with type 2 diabetes mellitus being a significant condition contributing to the death but not relating to the disease or condition causing it.

Manner of death

Mr Melhem died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

31. 388183 of 2019

Inquest into the death of Melvyn Lynch. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 24th May 2021

At the time of his death, Melvin Lynch was 72 years old and was being held in lawful custody in a correctional centre, having previously been convicted of a number of offences. Mr Lynch was not eligible for release from custody until 4 April 2028. In November 2019 Mr Lynch was admitted to hospital for elective surgery to treat his pre-existing medical condition. This admission was complicated, Mr Lynch's condition subsequently deteriorated, and Mr Lynch made a request to be provided with comfort and palliative care, which was instituted. On the evening of 9 December 2019, following a routine medication round and regular observations, Mr Lynch was found unresponsive in his hospital bed, with no signs of life. In accordance with standing not for resuscitation orders, no cardiopulmonary resuscitation was initiated, and Mr Lynch was later pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Lynch was not appropriately cared for and treated whilst in custody.

Mr. Lynch's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Mr Lynch was born in Casino in November 1947, the youngest of four children. During his childhood Mr Lynch and his family lived in Evans Head and Lismore, before later relocating to Sydney. Mr Lynch attended Kogarah primary school and Kogarah Boys high school Mr Lynch studied science at university and worked for a number of large companies. He was described by his sister as being highly intelligent, scientifically minded and with a photographic memory. Mr Lynch later married and moved with his wife to the South Coast region.

They had two daughters together. Following the passing of his wife, Mr Lynch moved to Coffs Harbour. Whilst there, Mr Lynch became active at a local church, and later formed a new relationship.

Mr. Lynch's custodial history

In April 2017 Mr Lynch was charged with a number of offences in relation to child sexual assault and child abuse material. He was refused bail and initially remanded at Grafton correctional centre. Mr Lynch was later convicted of a number of the above offences. He was subsequently sentenced in May 2018 to a 15-year term of imprisonment, commencing on 4 April 2017, with a non-parole period of 11 years concluding on 4 April 2028. Following his conviction, Mr Lynch was classified as a maximum-security inmate (due to the nature of the offences for which he had been convicted).

Mr. Lynch's medical history

Mr Lynch had a complex medical history, with a background of end stage chronic kidney disease, a previous invasive squamous cell carcinoma of the neck (resected in 2013), ischaemic heart disease, atrial fibrillation, type II diabetes and epilepsy. Between April 2017 and October 2019, Mr Lynch was transferred to Prince of Wales Hospital (**POWH**) on a number of occasions for investigations and treatment of his pre-existing conditions. On 21 October 2019 Mr Lynch commenced haemodialysis and was referred to POWH for a plastic lecture and large bowel lesion. On 26 November 2019 Mr Lynch was admitted to the Annex Unit at POWH for elective subtotal colectomy. Following this, Mr Lynch experienced increased work of breathing and the saturations. A chest x-ray was performed on 28 November 2019 which demonstrated a large right-sided pleural effusion. Subsequent cytological examination showed no evidence of malignancy. However, Mr Lynch showed features of multi-organ dysfunction and had recurring episodes of hypotension. Due to Mr Lynch's ongoing profound hypotension and frailty, he was unable to receive his usual haemodialysis treatment. Concerns were raised for an anastomotic leak, a known complication of colorectal surgery. On 3 December 2019 a CT scan of the brain, chest, abdomen and pelvis revealed intra-abdominal gas compatible the recent surgery. However, perforation or anastomotic leak could not be excluded.

On 4 December 2019 Mr Lynch made a request for aggressive interventions to cease, and for his medical care to focus on comfort and quality of life. This was discussed with Mr Lynch's family who were in agreement. Accordingly, on 5 December 2019 Mr Lynch was formally transition to palliative care, with daily review by his treating team and a palliative care team. An advanced care directive was put in place noting that Mr Lynch was not for resuscitation. Following this, Mr Lynch's condition continued to deteriorate. At around 5:00pm on 9 December 2019 POWH nursing staff administered routine medication to Mr Lynch, and also attended to routine pressure area care and repositioning. Following this, Mr Lynch was observed at half hourly intervals. At around 6:50pm Mr Lynch was found to be unresponsive, with no signs of life. In accordance with the advance care directive no resuscitation was initiated, and Mr Lynch was subsequently pronounced life extinct.

What was the cause of Mr. Lynch's death?

Mr Lynch was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Jennifer Pokorny on 13 December 2019. Post-mortem imaging showed a large right-sided pleural effusion and extensive cystic changes in the kidneys, with intra-abdominal fluid also noted. Ultimately, in the autopsy reported dated 6 February 2020, Dr Pokorny opined that the cause of Mr Lynch's death was complications of subtotal colectomy for diffuse polyposis and invasive adenocarcinoma, with end-stage renal failure noted to be a significant condition contributing to the death, but not relating to the disease or condition causing it.

Conclusions

Having regard to the relevant Justice Health and CSNSW records regarding Mr Lynch's incarceration, and the findings from the post-mortem examination, it is evident that Mr Lynch died as a result of natural disease process. Given Mr Lynch's complex medical history appropriate investigations were conducted, and treatment provided to Mr Lynch, in the period between April 2017 and December 2019. It is evident that there were a number of complications associated with the surgery performed in November 2019. The evidence indicates that appropriate investigations were conducted in relation to these complications and that, at the request of Mr Lynch (with agreement from his family), it was appropriate to subsequently transition Mr Lynch to a palliative care pathway.

Overall, the available evidence establishes that Mr Lynch was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Lynch's medical care, or the care provided by CSNSW and POWH staff, contributed in any way to his death. It is noted that Mr Lynch's sister, Marea Andrews, described the care that Mr Lynch received whilst in hospital to be "wonderful", and that she was regularly provided with updates as to Mr Lynch's condition.

Findings

Identity: The person who died was Melvin Lynch.

Date of death: Mr Lynch died on 9 December 2019.

Place of death: Mr Lynch died at the Annex Unit of Prince of Wales Hospital, Randwick NSW 2031.

Cause of death: The cause of Lynch's death was complications of subtotal colectomy for diffuse polyposis and invasive adenocarcinoma, with end-stage renal failure a significant condition contributing to the death, but not relating to the disease or condition causing it.

Manner of death: Mr Lynch died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

32. 7308 of 2020

Inquest into the death of Terence Gray. Findings handed down by Deputy State Coroner Truscott on the 22 October 2021.

This is an inquest into the death of Terence Gray who died from injuries from being struck by a vehicle. The circumstances surrounding Mr. Gray's death are such that an inquest is required under s27 and s23 (1) (a) of the *Coroners Act 2009*.

Mr. Gray had been travelling south on the evening XPT train from Casino to his home in Macksville on the NSW North Coast. Mr. Gray had bought a ticket online which included a seat on a bus from Tweed Heads to Casino and a seat on the train. He had received a SMS text message on his phone which advised him of his seat numbers without identifying which seat was for the train and which seat was for the bus. The text did not indicate whether the ticket had been paid for or not. Mr. Gray was on a disability pension so accordingly the fare for the journey was $2.50 which included both the bus from Tweed Heads and the train from Casino. Mr. Gray boarded the bus at 6.30 pm which then connected with the train.

The train stopped at Grafton at about 9 pm and Mr. Gray left the train though he was still 2 hours away from home. He left the train because shortly prior to it stopping, Mr. Gray was advised by a train employee, Mr. Beadman, that when the train arrived in Grafton he was required to leave it. The reason Mr. Beadman purported to direct Mr. Gray to leave the train and whether he had authority to do so were issues in the inquest. The first issue involved Mr. Gray's level of intoxication, whether his behaviour was disruptive and whether he had a valid ticket. It was revealed in the inquest that Mr. Beadman lacked the requisite authority to direct Mr. Gray to leave the train because despite nearly 40 years of experience Mr. Beadman had not completed a required NSW Trains program (incepted in the preceding 2 years) which would have deemed Mr. Beadman as an authorised person to give a passenger such a direction.

When the train arrived at Grafton two police officers were on the rail platform waiting for Mr. Gray. They had attended as a result of NSW Trains staff placing a request to the Grafton police station to have police attend to remove an intoxicated passenger from the XPT. When the police officers arrived, a rail employee apparently told them that someone on the train had been "playing up". The police officers met Mr. Gray as he was stepping off the train and one officer took Mr. Gray's bag from his shoulder. The police directed Mr. Gray to a location away from the platform so they couldtalk.

The police searched Mr. Gray's bag in which he had a couple of bottles of beer and some empty beer bottles. Mr. Gray told them he kept the bottles to obtain refunds for recycling the glass. The police searched Mr. Gray's wallet and did not find a paper ticket. They did see bottle recycling receipts and a $20 note.

Mr. Gray's phone had run out of battery as had been indicated by Mr. Gray when he was on the train. It is unknown whether Mr. Gray told the police that had the ticket on his mobile phone. The police contacted intelligence and were advised that Mr. Gray did not have any warrants but that he did have a history of self-harm. The police did not think that Mr. Gray appeared to be in such a state of mind.

Mr. Gray told the police he did not know anybody in Grafton and did not intend to stay in Grafton preferring to hitch-hike the 2-hour drive to Macksville. Mr. Gray did not reboard the train and the police left him and returned to their car which was parked in the train station carpark. Mr. Gray made his way to leave the train station and as the police were driving out of the carpark, they saw Mr. Gray speaking to a couple of women. The police stopped their vehicle and asked if Mr. Gray was harassing them. The women said that he was not, that he was merely asking for a light for his cigarette. The police then determined to drive Mr. Gray out of Grafton. Mr. Gray was placed in the back of the police vehicle but was allowed to keep smoking his cigarette. They chose a location about 6 km south of Grafton called McPhillips Creek Truck Stop which was adjacent to the Pacific Highway which at that time and area was an 100kph undivided road.

The police dropped Mr. Gray off at the truck stop pointing out to him that there was a toilet block and seating and told him that sufficient vehicles stopped so that he could ask for a lift. At this stage it was about 9.20 pm. The police returned to Grafton and about 40 minutes later heard over the radio that a pedestrian had been struck by a vehicle on the Pacific Highway near the location where they had left Mr. Gray.

The police attended the accident site and learned that the pedestrian was Mr. Gray. They assisted other police and the paramedics and Mr. Gray was conveyed to hospital but sadly succumbed to his injuries a few hours later. The police declared a critical incident and an investigator was appointed from a command other than Grafton which is consistent with their Critical Incident Protocol. The two police officers who had attended the train station and dropped Mr. Gray off at the truck-stop were deemed “directly involved officers” and were separately interviewed. Their interviews were tendered at the inquest.

Though each officer was subpoenaed to attend the inquest for examination one officer was excused from giving evidence because at the time of the inquest he was a voluntary patient in a psychiatric hospital. The other officer was examined as were a number of other witnesses including rail staff and passengers who had been in the same carriage as Mr. Gray between Casino and Grafton.

Background

Mr. Gray was born on 4 October 1965 in Todmorden which is about halfway between Manchester and Leeds in the United Kingdom. He was the eldest son of Wendy and Jim and he had a brother James who is three years younger. The family immigrated to Australia in 1970 and settled in the ocean suburb of Maroubra where Mr. Gray enjoyed beach, sun, surfing, and skateboards. Wendy, died in 2015, and his father, James, suffered from dementia. Mr. Gray lived with his father for two years prior to moving into a unit at 3/12 Durkin Street, Macksville, in late 2019. Mr. Gray had had a long relationship with Sharon Harvey, and they had two children Hope and Ethan. They separated in 2000 but in 2009 Mr. Gray and Ms Harvey and the children moved to northern NSW but separated again the following year. Mr. Gray became involved in permaculture and established the Mullumbimby Community Gardens and then later the Men’s Shed. Mr. Gray’s family attended the inquest and Hope spoke of his love for his family, friends, gardening, sports, and the outdoors. She spoke of his struggle with depression and alcohol but also his passion for the environment, his humor, and his love for his family.

She spoke of the loss that has not only affected their family but also many friends. I extend my sincere condolences to Mr. Gray's family and friends.

Mr. Gray's Mental Health

Mr. Gray left school after Year 9 and took up an apprenticeship as a butcher and then a baker, which he did not complete. He did not have regular work during his adult life. Mr. Gray had a long history of substance abuse. He commenced smoking cannabis aged 13. He began drinking to excess in his late teens. James believes Mr. Gray became an alcoholic from his early 20s and remained one through to the time of his death.

Mr. Gray had poor mental health suffering from depression and possibly bipolar disorder. He made several threats or attempts at self-harm. He had multiple involuntary admissions to hospital in the context of threatened self- harm and alcohol abuse. Despite this history, James, Ms Harvey and Hope all believe Mr. Gray's threats of self-harm were attention-seeking and not serious. He would usually call an ambulance to say he was having thoughts of self-harm. For this reason, they also consider it likely that his death was an accident, rather than intentional.

Some of the significant hospital admissions are as follows.

On 11 November 2017, Mr. Gray called an ambulance with thoughts of self- harm. He said he had attempted hanging the night prior, but the rope broke. He was taken to hospital. There, he told staff that if he left hospital, he would walk out in front of a car and kill himself.

On 27 Dec 2018, Mr. Gray called an ambulance and reported he felt suicidal. He again said he had thoughts of jumping under a car or a train. He was admitted to hospital on a voluntary basis for a week. He appeared to be withdrawing from alcohol but declined treatment. On discharge, he was referred for drug and alcohol counselling, but failed to attend forfollow-up.

On 22 February 2019, he told a drug and alcohol counsellor in a phone call that he was thinking about hanging himself. An ambulance was dispatched, and he was admitted to hospital voluntarily for 4 days.

On 4 March 2019, police were asked to attend a location at Nambucca Heads, where Mr. Gray was found lying in the roadway, saying he had been hit by a car. In fact, he had not been hit by a car. He was threatening to harm himself by running into traffic. He had been drinking. He was taken to hospital and admitted voluntarily for 3 days.

In April 2019, he was admitted to hospital for alcoholwithdrawal.

At the end of July and again in early August 2019, he called an ambulance after having thoughts of self-harm after drinking alcohol. He was taken to hospital on both occasions. On 27 November 2019, Mr. Gray attended a drug and alcohol counsellor. However, he cancelled an appointment on 11 December 2019 and rescheduled it to 8 January 2020.

At the end of 2019, Mr. Gray spent some time with Ms Harvey and Hope at Tweed Heads. He was reportedly well during this visit, but after he left, he sent Ms Harvey abusive texts, as he had done in the past.

Admission to Coffs Harbour Hospital on 30 December 2019

On 30 December 2019, Mr. Gray was back at home in Macksville. He again called an ambulance, saying he was having thoughts of self-harm. He was taken to Coffs Harbour hospital. He was assessed in the emergency department and admitted on an involuntary basis.

The following morning, he was reviewed by psychiatric registrar, Dr Phillip Mariucci. Mr. Gray said he had relapsed and was depressed over Christmas about not seeing his kids. He was feeling suicidal and spoke of going into the bush and hanging himself. Dr Marinucci assessed that Mr. Gray was not at acute risk of suicide, and that his main issue was alcohol misuse. The plan was to admit Mr. Gray as a voluntary patient for 4 to 5 days for alcohol withdrawal and review him on 1 January 2020. Mr. Gray was transferred to a medical ward and given diazepam to manage symptoms of withdrawal.

The next morning, Mr. Gray told nurses he wanted to discharge himself. He said he had a dentist appointment. Dr Marinucci was not on duty, and so the after-hours RMO, Dr Frances Gosewisch, reviewed him. Mr. Gray told her he felt well and did not have any thoughts of self-harm. Dr Gosewisch assessed Mr. Gray and noted that he did not appear confused or thought- disordered, he was clear and concise, and had no overt signs of withdrawal.

Dr Gosewisch discussed the situation with a psychiatric registrar and medical registrar. Mr. Gray was not acutely suicidal and was a voluntary patient so he could discharge himself against medical advice. He was given a script for mirtazapine (his regular antidepressant), diazepam (for withdrawal) and warned about the risks. He was advised to contact his GP or attend the hospital if he had symptoms of withdrawal or thoughts of self- harm. After discharge on 31 December 2019, Mr. Gray travelled to Tweed Heads to attend his dentist appointment. It is not known where he stayed but it is presumed that he did attend the appointment.

Mr. Gray's journey from Tweed Heads to Grafton

Helen Barnier, a witness in the inquest, was a passenger on the same bus and in the same train carriage as Mr. Gray. She saw Mr. Gray as he walked past before he boarded the bus at about 4.40 pm. She thought to herself that he had had a couple of beers as he seemed to be swaying and he wasn't quite steady on his feet, but she did not think he was particularly affected by alcohol.

She did not observe him whilst on the bus which arrived at Grafton at about 6.30 pm. Ms Barrier and Mr. Gray boarded train carriage D at about 7 pm. Mr. Gray sat in seat 57 which was the window seat which had apparently been reserved by Ms Barnier. She told him he was in her seat, he asked if she wanted him to move, but she said he could stay there as she was getting off first, at Grafton. Ms Barnier sat next to Mr. Gray. She thought that Mr. Gray appeared stressed and he told her that his phone battery had died and that his ticket was on the phone.

A NSW Trains passenger attendant, Michelle Bowling, working the Casino to Grafton leg, commenced checking passengers' tickets. She had the passenger manifesto which indicates seats and names of passengers. When Ms Bowling came to Seat D57 it was apparent to her that Mr. Gray was not sitting in the correct seat. She asked Mr. Gray for his ticket and he told her that he had paid for it. Ms Barnier said that Mr. Gray told Ms Bowling that the ticket was on his phone, but his phone had died. Ms Bowling did not include this in her statement but in her evidence she agreed that Mr. Gray had told her that.

Ms Bowling said she asked Mr. Gray for his name, but she could not locate his name in carriage D, she told him he needed to go to the buffet and pay for his ticket and she continued checking carriage D passenger tickets. She then returned to Mr. Gray and asked for his identification and when he provided her with his pension card she located his name relevant to a seat in another carriage, but the passenger manifest indicated that he had yet to pay the fare. Mr. Gray insisted that he had paid for the ticket, but Ms Bowling told him that he needed to attend the buffet car and pay and in response he tried to give her money from his pocket, but she refused. Ms Barnier said that Mr. Gray was talking in a normal voice and he was not aggressive. She said that Mr. Gray kept saying he had paid for his ticket and that he wasn't going to pay for it again.

Ms Bowling thought that Mr. Gray had been drinking; he was speaking slowly but not noticeably slurring. She said that Mr. Gray never raised his voice at all, and he was polite. She saw that his bag was opened at his feet and that he had some bottles of beer in it. She did not see Mr. Gray drinking and she couldn't say if there was anything about his presentation other than his movements were slow and jolty and he spoke slowly to suggest he was intoxicated. She asked Mr. Gray to hand her the bottles and Mr. Gray refused. Ms Barnier said that he politely but adamantly said "I'm not going to give them to you". Ms Bowling continued checking other passengers' tickets and she later returned to Mr. Gray and reminded him he was required to pay for his ticket at the buffet car. He did not respond. In her evidence Ms Bowling agreed that she did not observe any passenger, including Ms Barnier, to be worried about Mr. Gray's behaviour. She said that no passenger complained to her about Mr. Gray.

Mr. Beadman had worked for NSW Trains for 42 years, the last eight as a Passenger Services Supervisor ("PPS"). That night, he, like Ms Bowling, was working the Casino to Grafton leg and he would hand over to the new southbound crew at Grafton. He was walking through D carriage when Ms Bowling told him that Mr. Gray was without a ticket and that she had noticed alcohol in his bag. Ms Bowling said in her evidence that she probably told Mr. Beadman that Mr. Gray had offered to pay her for his ticket but that he had declined to do attend the buffet to do so. Ms Bowling continued her other duties and had no further contact with Mr. Gray. At some stage Mr. Beadman told her that Mr. Gray would be disembarking at Grafton. Mr. Beadman approached Mr. Gray. Ms Barnier left her seat and stood in the aisle so that Mr. Gray and Mr. Beadman did not speak across her. Mr. Beadman stood in the aisle and faced Mr. Gray and told him he needed to buy a ticket and Mr. Gray replied that he had bought a ticket and it was on his phone, but his phone had died. Ms Barnier said that Mr. Gray was again polite and never raised his voice. She said that Mr. Beadman raised his voice and she wondered why he would do that. At some stage Mr. Beadman asked Ms Barnier if she would like to take another seat and her evidence was that there were a couple of empty seats and so she sat down in the one ahead on the other side of the aisle. She said she did so not because she was "frightened or anything". She said that she didn't sit in that seat for long before the train arrived in Grafton.

Ms Barnier said she did not hear or see anything relating to Mr. Gray after that time until she saw him step off the train and the police take his bag. She saw some fluid leak from the bag. She said that from her observations of Mr. Gray his presentation was that of a normal polite man, he was not aggressive to the train staff.

Mr. Beadman said that over the previous eight years he had on many occasions asked passengers to leave a train because of intoxication or bad behaviour. Mr. Beadman accepted that he did not hold a certificate as an authorised officer to direct passengers to leave a train. He had completed online modules but had failed to attend a workshop to become an authorised officer. He said that when he was working in January 2020 he did not understand that he was not an authorised officer. At the time of the inquest he learned of his misunderstanding and appreciated that only a train driver or an authorised officer (which can include a police officer) could direct a passenger to leave a train.

It would appear that Mr. Beadman had some understanding that, though he held no authority to direct a passenger to leave the train, he could tell the passenger that they were leaving the train and that he would arrange for the police to attend to give effect to the direction. His evidence was that as far as he was aware NSW Trains management was aware of the practice of unauthorised PSS staff determining that a passenger leave a train, but arrangements would be made for the police to attend to affect the removal. Mr. Beadman later said that he had completed training modules for a testing officer not an authorised officer. The legislation relating to the powers to be exercised by authorised officers came into effect in March 2017. Despite the passing of nearly three years, Mr. Beadman though occupying the position of Passenger Services Supervisor had not acquired authorisation to make such a determination. The power to direct a person to leave a train is found in cl. 55 of the *Passenger Transport (General) Regulation 2017.* It relevantly states as follows:

A driver of a public passenger vehicle or train or an authorised officer may direct a person to leave, or not to enter, a public passenger vehicle or train if the driver or authorised officer is of the opinion that—[(a)…] the person is otherwise causing, or is likely to cause, inconvenience to other passengers or to the driver of the public passenger vehicle or train (whether because the person is under the influence of alcohol or another drug, or for any other reason), the person is committing an offence under this Regulation in or on the public passenger vehicle or train, or [(d)…] Failing to comply with such a direction is an offence carrying 10 penalty units ($1100) (cl.55(3)) and can result in the passenger being (physically) removed by an authorised officer (cl 55 (5)). The passenger cannot return to or remain on railway premises for 2 hours following such a direction. (cl55(4))

Section 3 of the *Passenger Transport Act 2014* defines an authorised officer as a member of staff of a transport authority appointed or being a person of a class prescribed by the regulations - see s152. Section 3 also defines that a police officer is an authorised officer. Mr. Beadman was not an authorised officer. The police officers who attended did not know they were authorised officers and apparently had no understanding that they had any functions or powers under the Passenger Transport legislation. Mr. Beadman said that asking a passenger to leave the train was to be exercised as a last resort. He was then taken to the NSW Train Link On- board Procedures Manual to which he responded, “I’ve never seen it”. Nevertheless, he agreed that his understanding was consistent with the policy relevant to “3.6.3 Removal of customers from NSW Train Link Services which says:

"Customer issues such as antisocial behaviour must be brought to the attention of the passenger services supervisor immediately. The passenger services supervisor will assess the situation. In all instances the PSS should seek to de-escalate the situation to restore order and control. If this de-escalation ceases to be effective, and/or the situation poses a risk to the health and safety of NSW Train Link staff, customers, or the public, the PDD may decide the passenger is to be removed from the service or moved to another area of the train".

Mr. Beadman said that "no ticket is probably the least reason to remove a passenger. He was then taken to policy 6.15.1 "Ticketing Irregularities":

Under no circumstances should a customer be: Denied travel by on-board staff when the matter is a fare or ticketing, or concession card issue Removed or asked to leave the train by on-board staff short of their booked destination where the matter is a fares, ticketing, or concession card issue. Only police may remove customers from trains. Is denied travel because they cannot produce the appropriate concession card. Under no circumstances should a train be delayed due to a ticket irregularity over a concession card.

Counsel Assisting asked Mr. Beadman if he understood that the policy stipulated that under no circumstances should a passenger be removed short of their destination due to a fares, ticketing, or concession issue. Mr. Beadman then replied: "A lot of it bounds around the person's attitude to the situation. If you confront somebody that hasn't got a ticket, they're not giving you the information that you need that if (he) had a ticket sent to him on his phone that he would have, and then he has to purchase a ticket".

Mr. Beadman then explained that SMS messaging is sent with a reference number that manifests its evidence (of the existence of a paid ticket), has various notations in it with regards to passengers that need to purchase a ticket. Mr. Beadman was then taken to an SMS message downloaded from Mr. Gray's mobile phone during the course of the coronial investigation. He said he had never seen such a message is that format. The SMS advised Mr. Gray that his seat allocation was D38 and E33. Mr. Beadman said that passengers were often confused because the seat allocation doesn't indicate whether it is for the bus or the train.

The train manifest had Mr. Gray in E33 but the fact that he was in carriage D could be explained by his confusion in that regard. Ultimately Mr. Beadman agreed that Mr. Gray would not have been asked to leave the train due to the ticketing issue, rather it was his behaviour that was of concern to Mr. Beadman. Counsel Assisting took him to further policy that stipulates that rail staff are not to physically remove a customer from a train because that is to be carried out by the police to which Mr. Beadman agreed. He also agreed that he was aware of the policy that:

"The police are only to attend in circumstances where a situation poses a risk to the health and safety of the Train Link staff, customers or general public".

Mr. Beadman said that Ms Bowling told him a number of things including: Mr. Gray was sitting in the wrong seat, that she could not ascertain his name, he couldn't produce a ticket so she had advised him to attend the buffet to purchase one, Mr. Gray was in possession of alcohol and that he appeared to be under the influence of alcohol or drugs.

Mr. Beadman said it was quite obvious that there were empty and full stubbies in plain view as Mr. Gray's bag was opened. Mr. Beadman agreed that he may be mistaken that Ms Bowling had told him that Mr. Gray was under the influence or intoxicated and that shemay have just told him that Mr. Gray was in possession of alcohol. He also accepted he was possibly mistaken that Ms Bowling had told him that Mr. Gray had refused to give his name as she said he had given her his pension card. He did recollect being aware that the person whose seat Mr. Gray occupied was only going to Grafton and that she could relocate to the seat opposite. He agreed that he may have learned that because Ms Barnier was standing (rather than being told that by Ms Bowling).

Mr. Beadman said that he told Mr. Gray that he didn't have a ticket and he had been given time to buy one, the buffet was about to close and that he needed to go there to buy a ticket. He said Mr. Gray began mumbling and swearing under his breath. He thought he heard Mr. Gray say in response to being told to buy a ticket words similar to "I dont give a fucking rats arse I'm going to Macksville".

Mr. Beadman left to complete other duties and came back to carriage D and asked Mr. Gray "How did you go with that ticket?" and Mr. Gray gave a response "that was like a bit of a tirade of sort of mumbling and sort of swearing under his breath". Mr. Beadman then attended the buffet and was informed that Mr. Gray had not intended to buy a ticket, so he returned to Mr. Gray and told him "You are under the influence of alcohol. You've got stubbies in your bag and some full ones there. You have made no effort to hand them over (to Ms Bowling) and I see no alternative that you may be asked to leave the train at Grafton" to which he says Mr. Gray "told me to "Get the fucking cops" or something along those lines".

Mr. Beadman agreed with Counsel Assisting the fact that Mr. Gray could not establish he had paid for the seat identified in the Passenger Manifest (or SMS text he was shown in the inquest) and he had refused to attend the buffet cart to do so was not an issue sufficient to require him to leave the train. Rather it was Mr. Gray's behaviour that was of concern to Mr. Beadman.

Mr. Beadman was asked whether he gave a direction to Mr. Gray to leave the train. In his evidence before the inquest he said he did not yet in his statement to the police which he made the day following the incident in which he said that he told Mr. Gray "I am giving you a direction to leave the train at Grafton. If you don't leave the train, you may get a ticket. He (Mr. Gray) then said "I don't care. Get the cops". In his evidence Mr. Beadman denied giving Mr. Gray this direction or indeed telling him that he was getting off the train in Grafton – suggesting that the police officer to whom he made the statement led him into what to say, though he conceded in his evidence that prior to speaking to Mr. Gray he had already told the train driver to arrange for the police to attend Grafton train station.

Mr. Beadman did not resile from his evidence that Mr. Gray spoke with offensive language in spite of having heard Ms Barnier's evidence that she did not hear it. He conceded such words would be a regular occurrence for him to have heard as a passenger supervisor. He agreed that the first step would be to de-escalate the situation. When he was asked what he did to de-escalate he replied "Well, there is really, it was only my presence that created his antisocial behaviour. So by spending as little time as possible, I could already ascertain he was under the influence of alcohol regardless of what Helen Barnier said and it was quite obvious when he stepped off the train that like I said he wasn't moving…he made no effort to hide the empty bottles of alcohol.

You've consumed four stubbies of alcohol and another two full ones. He wasn't complying with any requests that I made, and they were reasonable requests…" When asked by Counsel Assisting whether he agreed he did not takeany steps to warn Mr. Gray about his behaviour or move him to another seat at the back of the carriage Mr. Beadman replied "He was non-coherent to an instruction in any manner…he was settled in he wasn't going anywhere he wasn't concerned about any ticket or alcohol issues. He just wanted me to fuck off…he had flushed red face; he wouldn't look at me…I may as well have been talking to the glass window or curtain beside him. All I was, was an inconvenience to him." He also agreed that he had not asked Mr. Gray to give him any of the bottles.

Mr. Beadman was asked whether he formed a view that Mr. Gray was a risk to health and safety of staff, passengers, or the general public. He said yes that he had been drinking and he had no – he certainly didn't – he became agitated at anything that I tried to explain to him regarding his – I said to him "You've been drinking. You've had a considerable amount of alcohol. Is that all you've got in your bag? How much have you consumed?" and basically they were all questions of reasonable questions to ask a person, so". He agreed that at no stage did he ask Mr. Gray to hand him the bottles and at no stage had he seen him drinking alcohol. He agreed that no staff member or passenger told him that Mr. Gray was drinking alcohol.

He agreed that Mr. Gray was an inconvenience to him because he was not responding to him. Mr. Beadman said that he didn't give regard to the fact there wasn't another train south until the next morning or that because Mr. Gray had a pension card it was apparent that he had no money nor any apparent association with Grafton. Mr. Beadman was unable to suggest anything he could have done to de-escalate the situation. He had no further dealings with Mr. Beadman and was four carriages away when the train stopped, and Mr. Gray exited the train. He did approach the police when he saw them speaking to Mr. Gray away from the platform, but they apparently indicated to him that they did not need to speak with him as it appeared to him to be "just a move on situation".

Counsel Assisting asked Mr. Beadman whether he had considered that Mr. Gray be allowed to get back on the train and he replied no because he had already told the supervisor of the replacement crew and they had seen the police there. He said that it wasn't possible for Mr. Gray to get back on the train because "He wasn't in a fit state to travel". He said that from his observations of Mr. Gray after disembarking the train, Mr. Gray was unsteady on his feet.

Though Mr. Beadman was of the view that Mr. Gray considered him an inconvenience who was getting off at Grafton, he did not give any consideration to let Mr. Gray be and stay on the train. When he was asked why he replied, "Because he was going to cause inconvenience to the other staff joining and other passengers and he's already showed signs of it". That answer suggests that Mr. Beadman had given it consideration and determined against it.

Mr. Beadman was examined by counsel for NSW Trains, Mr. Brash, and contradicted himself as to his knowledge of whether he had authority to direct a passenger to leave a train or whether he purported to direct or request Mr. Gray to leave. Given that upon learning that Mr. Gray had not attended the buffet to pay his $2.50 fare, Mr. Beadman instantly told the train driver to call the police it is difficult to accept Mr. Beadman had determined to evict Mr. Gray from the train for anything other than refusing to comply with his request to purchase the ticket and had refused to do so in an insignificantly recalcitrant manner.

Mr. Beadsman's answers to Mr. Brasch as to why he did not attend the training workshop to become an authorised officer to exercise duties he was previously authorised to do suggested some personal recalcitrance relating to his obligations and preferred to discharge authority he purported to hold rather than actually held. On this occasion he did so too quickly and in an intolerant and arbitrary fashion.

Further, I reject Mr. Beadman's attempt in the inquest to resile from having purported to direct Mr. Gray to leave the train. He had done so by his communication to the train driver which he conveyed to Mr. Gray. Mr. Beadman knew that the police were called despite their having been no basis for Mr. Beadman to conclude that Mr. Gray "was a risk to health and safety of staff, passengers or the general public" thus invoking the NSW Trains policy enabling an authorised officer to direct Mr. Gray to leave the train.

The Police Attendance and their Powers to Direct and Remove Mr. Gray

Constable Simeonidis was excused from attending the inquest but his interview to police was tendered as evidence and Senior Constable Amos did attend and answered questions relating to police decision making and actions.

As at 3 January 2020, Senior Constable William Amos had been a police officer for over seven years and had been serving at Grafton Police Station some 18 months since August 2018. On the 3 January he was on duty at Grafton Police Station carrying out duties as custody manager. He was experienced with detaining intoxicated people who were under arrest for offences as well as detaining people due to the serious level of their intoxication. Under ss 206/205 *Law Enforcement (Powers and Responsibilities) Act 2002* (LEPRA) a police officer can only detain a person due to intoxication if the person is so seriously affected by alcohol that they are behaving in a disorderly manner or likely to cause injury to themselves or someone else or damage to property or that the intoxicated person is in need of physical protection because they intoxicated.

Separate to that power, the police also have a power under s 198 LEPRA to require an intoxicated person to move on. The exercise of the direction to move along requires a police officer to determine that the speech, balance, co-ordination or behaviour is a result of consuming alcohol and that such conduct is disorderly or likely to cause injury to themselves, others, or property. A move along direction, if given, requires that a person not be at a certain location for a period of 6 hours and it requires the police to tell the police that if they fail to comply with such a direction they are committing an offence.

Senior Constable Amos said that during the time he spoke with Mr. Gray at the train station he did not consider that Mr. Gray fell within either of those categories to give the police cause to issue a direction to move along under s 198 or to determine to detain him under ss 206/205. Senior Constable Amos attended the Grafton Train Station at the request of Constable Simeonidis because another constable who was working as car crew with Constable Simeonidis was busy at the police station. The message broadcast to the police about Mr. Gray on what is known as the CAD system said:
"There is a drunk male without a ticket being abusive to staff on the inbound XPT train to Grafton. Staff request police assist to remove the POI [person of interest]. The train is due to arrive at 8.55 pm. The POI is located in car D seat 57".

Senior Constable Amos was aware of this message as he read in in the police vehicle as they drove to the train station. Though Senior Constable Amos had attended other train stations in Sydney, this was the first time he had attended Grafton Train Station to deal with a passenger staff wished removed from a train. Senior Constable Amos said that the usual process he would undertake would be to speak to a NSW Train staff member to give him information and then speak to the passenger to get their side of the story and "make a decision based on that". He said his options depended on the circumstances, whether offences are committed, who is intoxicated or violent or mentally ill, there would be different steps depending on the precise circumstances. He said that prior to the arrival of the train he spoke with a male staff member, whose name he didn't know, who advised him that there was a gentleman on the train who hadn't bought a ticket and he was "carrying on". Senior Constable Amos said he asked the staff member what it was that the passenger had actually done the staff member said, "I don't know, he's just carrying on".

Senior Constable Amos was not aware of the regulations relevant to NSW Train staff in directing people to leave trains nor was he aware of what impact that had on whether people were allowed to reboard trains after they had been directed to leave. When the train arrived the police officers were standing on the platform and passengers disembarked, they saw Mr. Gray in the queue of passengers at the door waiting to get off. One passenger told him "It's the guy in the cowboy hat" and Senior Constable Amos saw Mr. Gray about to step off the train. As he did so, the police officers approached him which is captured by CCTV footage. Senior Constable Amos said he introduced himself to Mr. Gray and asked him to hop off the train which he did and was doing anyway.

Constable Simeonidis took Mr. Gray's bag and they spoke with him momentarily before they walked off the platform. Senior Constable Amos said that Mr. Gray's co-ordination seemed normal. He said that the police did not have any power to search Mr. Gray, so he asked Mr. Gray to give his consent by asking "Do you mind if we look in your bag mate?" which Mr. Gray apparently said, "Yeah no worries". Neither police officer had worn a Body Worn Camera or had taken contemporaneous notes to record their dealings or conversations with Mr. Gray. In his interview with the police, Senior Constable Amos did not indicate that he had sought or obtained Mr. Gray's consent to look in the bag, when he said he had searched it. Senior Constable Amos agreed that Constable Simeonidis had taken the bag from Mr. Gray as he stepped off the train which is seen in the CCTV footage. After Counsel Assisting referred to the Senior Constable's evidence that he heard clinking he asked what it was the police were looking for and Senior Constable Amos replied "Well, I was worried that there was broken glass or something that might – he might have access to that could harm me or you know it was just an officer's safety point of view".

Given that Constable Simeonidis had taken Mr. Gray's bag as he began to take a step down from the train at no stage was Mr. Gray thereafter in possession of the items for the police to consider that it was necessary for officer safety to search his bag. Further, Mr. Gray did not ever display anything other than a co-operative demeanour. Accordingly, I take Senior Constable Amos's explanation as to why the bag was searched as being evidence given in hindsight to justify having done so. In his evidence Senior Officer Amos was clear to identify that he did not have powers under s 21 to search the bag and Mr. Gray was not under arrest.

Having said that, I accept that Mr. Gray did not indicate any opposition to the police searching his bag and he provided his wallet to them when requested. Constable Amos indicated that during the walk from the platform down the ramp he observed Mr. Gray to not to have any problems with balance in that he did not need to hold onto the handrail for support. Senior Constable Amos said "He wasn't – he didn't appear to be – his speech, balance, coordination were affected at all"…He was reminded of the train staff report that Mr. Gray was drunk and Senior Constable Amos replied "Not drunk but yes I did notice a smell of alcohol coming from him and I did notice that his eyes were glazed. That was the only thing I noticed". He said that there was not anything unusual about Mr. Gray's speech. As far as he was aware Mr. Gray was talking normally. In contrast to that evidence in his interview the following day Senior Constable Amos had described that he had formed the opinion that Mr. Gray was moderately intoxicated.

Despite saying in his interview, the following day that he could not recall precisely how many bottles were in Mr. Gray's bag, Senior Constable had agreed that there were about six. He gave evidence that there were 4 empty and 2 unopened bottles. He said in his evidence that he asked Mr. Gray how much he had consumed, and Mr. Gray responded to the effect that he had not consumed the four but that the bottles were for recycling. Senior Constable Amos located recycling refund receipts in Mr. Gray's wallet which corroborated such a practice.

Senior Constable Amos said that Mr. Gray had told him that he had purchased a train ticket but did not mention that the ticket was on his phone or that his phone was uncharged. Senior Constable Amos said he was looking for some kind of proof that Mr. Gray had bought a ticket and that there was no wallet in the bag, so he asked Mr. Gray for his wallet. Mr. Gray took out it of his pocket and gave it to him. Senior Constable Amos said he looked through Mr. Gray's wallet to look for a ticket and some form of identification.

After finding Mr. Gray's identification in his wallet, Senior Constable Amos gave it to Constable Simeonidis who made inquiries over the police radio about Mr. Gray such as whether there were any outstanding warrants because if there had been they would have taken Mr. Gray back to the Grafton Police Station. He said that Constable Simeonidis did not bring anything to his attention though he did not specifically inquire of what the request for information resulted in. Evidence contained in Constable Simeonidis' interview indicated that he had received some information that Mr. Gray had a history of attempted self-harm. According to his interview Constable Simeonidis didn't think Mr. Gray was in that frame of mind. According to Senior Constable Amos, Constable Simeonidis did not tell him about any information he had learned.

Senior Constable Amos said that Mr. Gray told him he was headed for Macksville and Senior Constable Amos told him "Unfortunately mate you're not welcome, the staff are - you know you're not welcome back on the train, however you can wait here and catch the next train but it is not until tomorrow morning. You're welcome to stay inside the train station area". None of this conversation was relayed by Senior Constable Amos in his interview the following day about his contact with Mr. Gray but he said in the inquest that a railway staff member had told him that Mr. Gray could stay at the station. This must have been before Mr. Gray disembarked because there is no evidence suggesting any liaison between the police and the railway staff after that time.

In any event, it seems at odds that NSW Trains having caused Mr. Gray to leave the train would allow him to remain on the premises given the prohibition of 2 hours in cl 55 of the *Passenger Transport (General Regulation) 2017* referred to above.

Senior Constable Amos said that Mr. Gray told him that he had to get back to Macksville that night and he asked if the police could give him a lift. Senior Constable Amos said "I'm sorry mate. Its two hours away, you know, we can't give you a lift that far…. you'll have to get your own way there...you're welcome to stay here and wait for the next train. Obviously so long as you're not harassing people". Given that according to Senior Constable Amos's evidence he considered Mr. Gray 100% polite, not showing any particular signs of intoxication and hadn't learned what "passenger carrying on" had meant, it is unclear why Senior Constable Amos, at that stage of the evening would be concerned that Mr. Gray might harass people. In any event, his evidence is that Mr. Gray laughed and said in jest "The only way you, you guys will give us a lift is if I threaten to kill myself".

Senior Constable Amos said that despite his belief that Mr. Gray was joking he asked him directly if he had thoughts of self-harm and Mr. Gray had replied "No". He then asked Mr. Gray how he would try if he did attempt self-harm and Mr. Gray replied, "I don't know, with a rope". Senior Constable Amos said that he had seen that there was no rope in Mr. Gray's bag. Despite that conversation he did not tell Constable Simeonidis about Mr. Gray's response nor did he ask if there were any warnings on the police information system that Constable Simeonidis was inquiring into, nor could he give an explanation as to why he did not ask though he explained that it was due to the NSW Police Force mental health training that he had undertaken that he had thought to ask Mr. Gray the means by which he might self-harm. Senior Constable Amos explained that based on Mr. Gray's answers and his own observations of Mr. Gray he held no concerns about Mr. Gray's mental health.

Senior Constable Amos said that the train started to leave at the point he had told Mr. Gray that the police could not take him to Macksville. Mr. Gray said that he would hitch-hike so Senior Constable Amos gave him directions on how to get to the Pacific Highway. Senior Constable Amos was asked questions about whether he considered that Mr. Gray could re- board the train before it left. He agreed that his observations of Mr. Gray as being polite, co-operative and not particularly drunk was in contrast to what had been conveyed on the police computer system, but that he did not talk to any train staff about Mr. Gray continuing his journey because he had already been told that Mr. Gray wasn't welcome on the train. Senior Constable Amos thought that the issue with Mr. Gray was "Primarily I thought the main concern was that he didn't have a ticket…he had the money in his wallet to pay for a ticket, he was able to go and buy one, but he wasn't welcome to be on that particular train".

Counsel Assisting asked Senior Constable Amos if, on reflection, the police could have talked to the train staff about Mr. Gray being able to reboard the train. Senior Constable Amos replied "I could have but my understanding was it's their business if they don't want him on the train. There's nothing I can say to prevent that, you know what I mean. They'll make the decision. It's got nothing to do with me". Later he was asked to comment on Mr. Beadman's evidence that Mr. Gray was so intoxicated he was "not fit to travel" and Senior Constable Amos replied "Yeah, it's often my experience the train staff exaggerate circumstances in order to get police to attend and I believed that that's what was occurring. My assessment was that he was at most moderately intoxicated only".

He was then asked "was there any reason why you didn't bring an independent mind to the task and broker his return to the train?" to which he replied "As I said I thought that them being in charge of that particular business in a sense that if they were refusing him entry onto the train there's nothing I could do or say about that. That's their decision and it has nothing to do with me. I certainly have no power to tell them to let him on the train…so I didn't think that was an option".

Though Mr. Gray disembarked the train on his own accord in that the police did not have to physically remove him, he only did so due to the fact that he had been told to do so by Mr. Beadman who also told him the police had been called. Mr. Gray no doubt saw the police standing on the platform as the train came to a stop. That the police officers did not understand that they had authority and were effectively exercising that authority under the Passenger Transport legislation is of concern particularly in light of the fact they did not share Mr. Beadman's opinion that Mr. Gray was not fit to travel. On that assessment it may be due to his intoxication Mr. Gray was not fit to leave his seat and attend the buffet to pay for one.

It is difficult not to think that the only reason Mr. Gray was required to leave the train was due to his recalcitrance in not leaving his seat to buy a $2.50 ticket and an irrelevant clash of personality with Mr. Beadman's. That the police did not understand their role in requiring Mr. Gray to leave the train and station (for 2 hours at least) was unfortunate as if they had it may have been an opportunity to return Mr. Gray to the train given that there was no other train until the next morning.

The Police Decision to Take and Leave Mr. Gray 6 km out of Grafton near the Pacific Highway

After the train had left and the police had determined that there was no basis for their continued engagement with Mr. Gray – he had no warrants and had apparently committed no offences and was not so intoxicated that they would give a direction to "move along" or detain him for his own or others protection – the police walked to their car in the carpark.

Mr. Gray was still near the bus bay sitting on a brick wall near a garden bed. Ms Bella Miller was nearby and smoking a cigarette. Ms Miller had been in the same carriage as Mr. Gray and disembarked in Grafton with her sister and son. They were waiting for transport near the garden bed. Ms Miller had seen the police talking to Mr. Gray and searching his bag. She thought it was for about 10 minutes and noted that Mr. Gray was quiet. Mr. Gray asked Ms Miller if he could buy a cigarette. She asked him where he was going to, and he said Macksville. She said that his bag was on the other side of the low wall in the garden and he leant over to get it and overbalanced but the wall stopped him from falling over completely. After putting his hands out to balance himself he picked up his bag and walked over to her. She noticed that he was swaying a bit. She gave him a cigarette and another for the road. She sympathised with him as she was aware that he had "kind of got in the situation where he was drinking and that's where it got him to be kicked off the train…we were just trying to help him kind of find somewhere to go because he was just in the middle of nowhere ... there's no trains coming until the next morning…". Ms Miller said that she thought he was intoxicated and that he didn't appreciate how far Macksville was. She didn't notice anything from his speech because he didn't speak much. She thought his intoxication was "a little bit over medium… he wasn't functional completely".

She had said in her statement that she thought that he was well effected (one below seriously affected). In her evidence she agreed with that assessment and said he wasn't aggressive, just cruisy and quiet. Ms Miller said that the police drove past them and stopped their car and asked her "Is he bothering you?" to which she replied "No, he's all good boys". The police then told Mr. Gray "move on move on" and Ms Miller gave evidence that "I said "Why? Like he can't move on. Where is he going to go?" and that's when they offered to take him to where they dropped him off".

She said that she had told the police that Mr. Gray was not bothering them that he was fine. She said she was trying to help him because she knew he was stranded. In her statement she had said that Mr. Gray "was drunk, though not wasted" ...and…" I believe he was a risk to himself and the police should have known that too". In her evidence in Court, she said she stood by that comment 100%. She explained her point of view that had Mr. Gray was unstable as evidence when he fell in the garden and that showed he could have fallen anywhere and that people who get kicked off the train for intoxication usually go into the (police) cell to sober up.

She said that had Mr. Gray been aggressive rather than nice and quiet he may have been arrested and sobered up in a police cell. It appears that police in Grafton have from time to time regularly taken passengers removed from trains to other locations.

Sergeant Wiles gave evidence that there used to be a house where a passenger in such a situation could stay as the occupants would accommodate them, but that house no longer existed. Sergeant Wiles said that on occasion he had taken people to McDonalds for a coffee or to the BP Tornik service station which was on the Pacific Highway before the diversion freeway was operational (after January 2020). Sergeant Wiles said that when officers Simeonidis and Amos returned to the Grafton Police Station they told him they had taken Mr. Gray out to McPhillips and he had remarked that BP Tornik would have been better. In his evidence he said that was due to the distance McPhillips was from Grafton and as a supervisor he seeks to mitigate risks to his car crews and prefers them to stay closer to Grafton.

Senior Constable Amos was asked questions about why he and Constable Simeonidis decided to drive Mr. Gray out of town. Senior Constable Amos said that after Ms Miller told her that Mr. Gray was not harassing her she had a look on her face that suggested that or gave him the impression that he was annoying her. Having heard from Ms Miller any expression of being annoyed was probably due to the police interference rather than Mr. Gray. In any event Senior Constable Amos left the police vehicle and said to Mr. Gray "You're not going to be welcome here if you're going to harass people". He then asked Mr. Gray if there was anywhere in Grafton the police could take him to and Mr. Gray said "no". Senior Constable Amos then determined to offer Mr. Gray a lift to get him away from the train station and out of Grafton to give Mr. Gray a head start on his journey. Senior Constable Amos said he did not exercise s 196 LEPRA powers because he assumed that Mr. Gray "would leave shortly but he didn't want him to harass other people that may have been waiting for a lift to try and get them to give him a lift to Macksville."

Mr. Gray agreed and he sat in the cage of the police truck but because he was well-behaved and polite Senior Constable Amos let him continue smoking his cigarette. The vehicle drove south and Senior Constable Amos and Constable Simeonidis talked about where they would drop him off.

A motel was on the way, but Senior Constable Amos determined that was unsuitable because Mr. Gray might harass people coming and going for a lift. Ultimately he decided McPhillips because he thought Mr. Gray could ask a truck driver rather than a car driver for a lift to Macksville. He did not notify police radio that they had taken Mr. Gray from the train station or that they had left him at McPhillips truck stop. Later they told Sergeant Wiles that they had done so, and he had told them that BP Tornik would have been a better place. Senior Constable Amos said that he had told Sergeant Wiles this over a mobile phone whereas Sergeant Wiles thought it was in person at the station because they had a conversation about where BP Tornik was.

McPhillips Creek truck-stop is set back from the Pacific Highway a little. Senior Constable Amos did not consider that though Mr. Gray was moderately intoxicated he would be at risk near a road with 100 km speed zone because he assumed that Mr. Gray would wait at the truck stop rather than go onto the Pacific Highway. The time that that police left Mr. Gray was 9.23 pm.

At about 10 pm, Ms Laura Blacklock was travelling south from Yamba with her daughter and two grandsons. They had stopped in Grafton for dinner and drove past McPhillips which she recalled seeing the signs but remarked that it was dark and there were no street lights there. She was driving at about 80 or 90 km an hour rather than at the speed limit of 100 km because she doesn't like driving fast at night due to the possibility of kangaroos. She was driving up a rise in the left-hand lane with an overtaking lane to the right. Suddenly she said she saw a flash of white coming from the middle of the road on the driver's side. She said he was right in front of her headlight, less than a metre away. It was asif Mr. Gray had come out of nowhere.

He hit the windscreen of her car. Ms Blacklock applied the brakes immediately and pulled over. Other vehicles also stopped, called emergency services and gave assistance to Mr. Gray. When the radio message was heard at Grafton Police Station officers Simeonidis and Amos feared that the pedestrian was Mr. Gray andshortly learned that it was.

Police Superintendent Cameron Lindsay prepared two reports for the Inquest, the first dated 13 May 2021 and the second dated 4 June 2021. Superintendent Lindsay was the senior critical incident investigator assisted by Detective Sergeant Mackie.

In his first report he indicated that Senior Constable Amos and Simeonidis could have dealt with Mr. Gray as an intoxicated person, but he did not say that they should have due to the level of Mr. Gray's intoxication. He said the police officers, in taking Mr. Gray from the train station to McPhillips truck stop, had a duty of care towards him – such duty arising once they had him in the truck as he was in their custody. He thought that with the benefit of hindsight they could have given him a move along direction at the train station or found a place where he could have been cared for. In relation to the police removing Mr. Gray from the train station at Grafton where he might harass other people, Superintendent Lindsay says "That gives rise to consideration where…you would treat Mr. Gray as an intoxicated person. That if he was to the level that he was harassing patrons...and a …danger to himself or other persons". Superintendent Lindsay agreed with Counsel Assisting that there would be benefit in police actually communicating with train staff about what it is that they are attending to and the nature of the incident. He also agreed with the proposition that general duties officers would benefit from some training or information about the sorts of powers that can be exercised by train staff and the circumstances in which a person can be required to leave a train.

Given that the police are being requested by NSW Trains staff to exercise those powers themselves it would be of significant benefit. Superintendent Lindsay agreed that Constable Simeonidis, having ascertained that Mr. Gray was in a positive frame of mind, had little cause to interrogate the police radio operator for more information about Mr. Gray's history of self-harm incidents. However, he also agreed that had Constable Simeonidis done so he would have learned that most of the incidents involved traffic and would have unlikely made the decision to drop Mr. Gray to hitchhike on a freeway.

Superintendent Lindsay said that in regional areas police regularly assist members of the public to get to safe places and in dealing with intoxicated persons to get them to places where they will receive more care. However, he was not of the view that the McPhillips Creek truck stop fell within the category of such a place. However, Mr. Gray had indicated his intent to hitch-hike and the police officers thought he would be in a better position to obtain relief from truck drivers than other people.

The Level of Mr. Gray's Intoxication

Mr. Gray was conveyed to Grafton Base Hospital and blood samples were taken. One sample was later tested which indicated that at about midnight he had a blood alcohol content of 0.187 gm/100 ml. He also had a therapeutic level of diazepam (Valium) and mirtazapine, an anti- depressant. Dr Naren Gunja, a forensic toxicologist, gave evidence in the inquest further to a report which was tendered. He surmised that given Mr. Gray's chronic use of alcohol he likely metabolized alcohol at a higher rate than the average person. He was asked to estimate Mr. Gray's likely alcohol level at the time the police were speaking to him (on the basis that he did not consume any alcohol between that time and the time of the accident). Dr Gunja suggested a level of about 0.22 to 0.24 which even taking into account Mr. Gray's chronic use of alcohol is a significant reading. In his report Dr Gunja describes a reading of 0.18-0.24% thus:

"When blood alcohol content is in this range, the effect on an individual would be significant psychomotor impairment including staggering gait, reduced situational awareness and responsiveness to surroundings, visual impairment and confused mentation".

Dr Gunja said that Mr. Gray would have appeared intoxicated. Dr Gunja said that he sees people in that condition a lot in hospitals and he said that would cause you to say to that person "You are not safe to go home. You should stay overnight". Dr Gunja thought that if Mr. Gray had consumed two more drinks after he spoke with police his behaviour would not have been noticeably different. He thought that to be at about 0.2 when he spoke with police Mr. Gray had likely consumed eight standard drinks. As for when Mr. Gray had taken the diazepam, Dr Gunja was unable to suggest a time other than the last 12 hours.

I note that Ms Barnier commented that when she observed Mr. Gray after he sat in her seat he was noticeably stressed. Dr Gunja said that the diazepam would have added to the sedative effect of alcohol and it would have made him even more drowsy and slurred speech that what the alcohol would have done. Ms Bowling's evidence that she observed that Mr. Gray's speech was noticeably slow. Ms Miller said that she thought that Mr. Gray when quiet when the police were speaking to him.

That Mr. Beadman thought Mr. Gray was not fit to travel is hard to categories given that Mr. Beadman's observations were likely adversely affected by his own reaction to Mr. Gray's apparent recalcitrance refusing to go to the buffet car to get a ticket. If Mr. Beadman exaggerated Mr. Gray's intoxication, Senior Constable Amos and Constable Simeonidis may in hindsight have underestimated it.

Mr. Gray may have been in a fit state to remain sitting on the train, but he was not in fit state to be on a highway at night time to hitch-hike. There is no evidence at all that his collision with Ms Blacklock's vehicle was an act of self-harm. Rather it is likely that he was in the middle of the two lanes heading southbound on the highway because he was disoriented in where he was and at what speed and distance vehicles were from him. That he had left the truck-stop to try his luck on the highway may well have followed a driver refusing to give a drunken man a lift anywhere or that there were insufficient vehicles stopping at that location.

NSW Trains Removal of Passengers Policy and Training of Authorised Officers

Mr. Dale Merrick, the acting chief operating officer for NSW Trains gave evidence in the inquest. NSW Trains has business obligations under Work Health and Safety Act to ensure that as far a reasonably practicable, the health and safety of both staff and passengers is protected. Those obligations underpin most, if not all, of the NSW Trains' policies. Mr. Merrick confirmed that Mr. Beadman did not hold accreditation as an authorised officer empowered to direct a passenger to leave a train. Though he had completed an online session he had not participated in a two-day face to face course which included undertaking role play exercises. The third and final element of the accreditation process involves competence and assurance of the accreditation.

There were also refresher courses. A significant application of the policy involved de- escalation of a situation so that a rail staff member would not be involved in the physical removal of a passenger but that the police would affect such. Mr. Merrick agreed with Counsel Assisting's description of the training regime to skill authorised officers to discharge their function as a quite sophisticated regime. Mr. Merrick said that the train driver and the Passenger Service Supervisor were the two roles targeted for accreditation training. NSW Trains was walking towards having an authorised officer (other than the train driver) working on every service which involved 9,000 regional and 30,000-odd intercity train services a year.

Mr. Merrick agreed that a person who hadn't undergone the accreditation training, such as Mr. Beadman, were at a disadvantage in that they are not adequately trained to actually make the decision to remove someone from a train, for example what subjective factors relevant to the passengers situation should be taken into account including whether it was day or night time and what condition they were in. Mr. Merrick agreed that train staff should bring conduct of a passenger to the Passenger Services Supervisor's attention whose role is to then try to de-escalate the situation. If de-escalation was not possible the next consideration is whether there is a risk to the health and safety of other passengers, public or staff. Removal should be as last resort.

Mr. Merrick appreciated that where only the train driver was an authorised officer any direction to leave a train which is needed to be carried out face to face provides operational difficulties. As far as the procedures ends, it is when the police are notified because it is only the police who are to affect a physical removal of a passenger (which mitigates the risk to the train staff and other passengers).

Mr. Merrick thought that Mr. Gray would not have had seats allocated to him unless he had paid for his ticket and indeed he would not have been able to be on the coach (bus) unless he had established payment. Mr. Merrick thought there would be merit in there being communication between the rail staff member and the attending police about what the incident involved and what the options are for the passenger. This would include whether the passenger should continue on their journey to their destination given the location time of day and incident.

Submissions regarding Findings and Recommendations

Findings in relation to NSW Trains

Mr. Beadman did not comply with NSW Trains training and policy. He was not authorised to direct Mr. Gray to leave the train. He did not attempt to de-escalate the situation with Mr. Gray rather he seemed to escalate it. Mr. Gray likely did use words such as "I don't give a fucken rat's arse" but given the circumstances of those words, they, with Mr. Gray's conduct, were insufficient to determine that he was a potential risk to the health and safety of passenger's staff or public. Mr. Beadman did not give sufficient, if any, proper consideration of whether Mr. Gray presented an unacceptable risk to the health or safety of passenger's staff or public. He did not give any regard to the NSW Train policy of removing Mr. Gray as a last resort nor did he consider any other options in relation to Mr. Gray's travel. Mr. Beadman did not provide any warning to Mr. Gray that he could be removed if he failed to obtain a ticket. Mr. Beadman was aware that removal for a ticketing issue was contrary to NSW Trains policy.

Mr. Gray was not drinking alcohol on the train and was not committing any offence. The issue of his ticketing was insufficient in itself to trigger his removal from the train. Indeed, the evidence is insufficient to show that Mr. Gray either did not have a valid ticket and rather it suggests that he had good reason to believe that he had in fact paid for his $2.50 fare given he had been given seat numbers for both the coach and the train. Mr. Beadman lacked sufficient training to discharge an important function of a Passenger Services Supervisor and due to that lack of training was at a disadvantage to appropriately respond to Mr. Gray's behaviour and circumstances and comply with NSW Train policy. NSW Trains as an organisation was aware that unaccredited staff who had not engaged in the appropriate training programme implement since March 2017 were rostered as Passenger Services Supervisors in January 2020.

Findings in relation to NSW Police

Mr. Madden submitted that I would not be critical of the police conduct as they sought to strike a balance between their role as law enforcement officers and their role to assist a member of the public.

That submission would have more force if the police had determined to provide Mr. Gray with that assistance prior to witnessing his engagement with Ms Miller. It was pretty clear from Senior Constable Amos's evidence that he had determined that it would be an effective police operation to remove Mr. Gray from Grafton. In my view, that it was to be of assistance to Mr. Gray to help him on his way to hitchhiking was secondary.

I do not accept Mr. Madden's submission that Mr. Gray's intoxication fell "well short" from serious intoxication. Given the blood alcohol reading and Mr. Gray's history of excessive alcohol consumption, I am of the view that it was likely "somewhat short" from serious intoxication. The circumstances of a high-risk environment, namely a dark multi lane 100 km highway, was such that the level of Mr. Gray's intoxication warranted the police to consider the risk of harm to him. The fact that the police officers apparently did not consider the prospect that Mr. Gray would leave the truck stop and walk the short distance to the highway to increase his chances of getting a lift to Macksville indicate that they gave insufficient consideration to Mr. Gray's circumstances.

A moderately intoxicated person might not be at risk of harm if they are standing at an empty truck bay but certainly would be if hitchhiking on an unlit highway at night. In taking Mr. Gray to the tuck stop the police, somewhat naively and without great foundation, assumed he would stay there. They placed him in a dangerous situation. There is no suggestion that they did so with any ill intent, but they unfortunately did so without giving sufficient regard to the gravity of Mr. Gray's situation. I reject Mr. Madden's submission that the police could not have anticipated that Mr. Gray would leave the truck-stop and enter the highway. Mr. Madden seeks to rely on Ms Barnier's assessment that Mr. Gray looked like he had had a couple of drinks. She had formed that view when she saw him for a short period of time prior to him embarking on the bus at Tweed Heads. Mr. Madden submitted that Mr. Gray was a high functioning alcoholic giving few signs of the real level of his intoxication. Ms Miller's observation of Mr. Gray included the time that he was being spoken to by the police, her short engagement with him and seeing him stumble and unbalanced. I think she correctly assessed him as well affected. It may be that the lack of levity associated with the apparent minor ticketing infraction and Mr. Gray's affability and quiet demeanour disguised the degree of his intoxication from police assessment. There was also a lack of appreciation that Mr. Gray was dealing with a serious interruption to his travel journey which could have serious implications to his welfare.

Mr. Madden submits that Mr. Gray was not detained by the police because they allowed him to smoke a cigarette in the police wagon. I reject that submission as he was clearly detained the moment police took his bag and directed him off the train platform. He was not under arrest at the time nor was he under arrest when he was placed in the back of the police truck, however he was effectively detained and in any event, and more relevantly, he was in police custody and given that fact alone the police owed to him a duty of care. For the Commissioner of Police, Ms Spies submitted that had the police and train staff communicated there may have been a consideration as to whether Mr. Gray could have reboarded the train but that in the circumstances the police had constrained options, such that it may have been better to have left Mr. Gray at the train station. She appropriately did not advance that the police officers had failed to exercise any powers under LEPRA.

The police officers who attended made an assumption that it was appropriate that Mr. Gray was removed from the train for having no ticket and that he had been "carrying on" without making due inquiry as to what the circumstances were and what the options were available to appropriately resolve the situation. They incorrectly did not consider it necessary to communicate with the appropriate personnel nor did they consider the option of Mr. Gray reboarding the train. There is no evidence as to why Constable Simeonidis did not inquire further of the police radio operator about Mr. Gray's history of self-harm. The police had a lack of communication with rail staff and did not appreciate what their task with Mr. Gray and the train journey was. Accordingly, Mr. Gray's co-operation with the police and the situation's lack of gravity led to an apparent light-hearted approach which may have impacted on the police assessment of Mr. Gray's intoxication and predicament. Mr. Gray was obviously intoxicated as evidenced by the observations of a number of witnesses, the blood alcohol reading, and the explanation of that evidence from Dr Gunja. I do not accept Mr. Gray was unfit to travel but his level of intoxication was such that, had he been on the train station platform or other premises and had his behaviour been disorderly the police would have been entitled to have given Mr. Gray a move on direction. However, his behaviour did not warrant such a direction to be given. The fact that Mr. Gray was not aggressive or causing any problem to himself, other persons or property while detained by the police likely contributed to the police officers determining that Mr. Gray was not so seriously intoxicated to be risk of harm, sufficient to detain him until such time as he was no longer so intoxicated.

Mr. Gray had not harassed any person whilst on the public transport or on or off the premises of the train station. He was unlikely to be a risk of harassing people. Senior Constable Amos's view that if Mr. Gray were to ask a person to drive him to Macksville that would amount to harassing conduct sufficient for police to move him from Grafton was misguided, especially since the police knew he intended to hitchhike at night to Macksville. Mr. Gray was significantly intoxicated but his behaviour in the environment where the police spoke with him was such that they reasonably did not consider that he was at risk of harm to himself or others as a result of the intoxication. However, he was sufficiently intoxicated in thathis judgment, balance and senses were likely significantly impaired and the police, in taking him to an isolated location south of Grafton to hitchhike on or near a fast speed multiple lane highway, at night, whilst under such impairment, placed Mr. Gray at risk of serious harm. That risk involved being struck by a fast-moving vehicle which occurred within a reasonably short period of time.

Recommendations

Counsel Assisting advanced the following recommendation:

That the Commissioner, NSW Police Force and the Chief Executive Officer, NSW Trains consider jointly developing policy, training or guidance material to ensure that both NSW Trains and NSW Police Force have a common understanding about the following matters:

The powers that NSW Trains staff and NSW Police Force officers can exercise to require a person to leave a train.

The effect of NSW Trains policy as to the circumstances in which such powers will be exercised by NSW Trains staff.

The circumstances in which NSW Trains will request police assistance to remove a person from a train.

The desirability of NSW Trains staff and NSW Police Force Officers discussing the circumstances in which a person has been asked to be removed from a train, including any alternatives that are available, including the passenger remaining or reboarding the train.

The preferred train stations at which such passengers should be disembarked, in light of the location, the time of day, the availability of services or amenities and the circumstances of the person.

The Commissioner opposes such a recommendation being made in relation to state-wide operations because there are specialised transport police within the NSW Police Transport Command (PTC).

The PTC command structure has some 600 police officers operating across three sectors including North/Central (Central Sydney-Newcastle), North/West (Parramatta-Penrith) and South/West (Bankstown-Cabramatta) primarily operating within the Metropolitan, Hunter and Illawarra areas. Sometimes the PTC provides support to Regional Commands. The Commissioner's submissions set out that the PTC officers have a thorough knowledge and understanding of the relevant transport legislation and they are available to provide advice and support to general duties police officers. The Commissioner does not oppose the recommendation applying to non-PTC areas but takes issue that the two agencies jointly prepare policy as that is not a practicable course. The Commissioner particularly opposes any engagement of NSW police officers in questioning the power or appropriateness of NSW Trains staff having directed or requested a passenger off a train and requested police to attend to affect such removal.

To the Commissioner, NSW Police Force and To the Chief Executive Officer, NSW Trains

- Consider developing aligned policies, training or guidance material to ensure that in areas not with the Police Transport Command locations, both NSW Trains and NSW Police Force have a common understanding about the following matters:
- The powers that NSW Trains staff and NSW Police Force officers can exercise to require a person to leave a train.
- The effect of NSW Trains policy as to the circumstances in which such powers will be exercised by NSW Trains staff.
- The circumstances in which NSW Trains will request police assistance to remove a person from a train.
- The desirability of NSW Trains staff and NSW Police Force Officers discussing the circumstances in which a person has been asked to be removed from a train, including any alternatives that are available, including the passenger remaining or reboarding the train.
- The preferred train stations at which such passengers should be disembarked, in light of the location, the time of day, the availability of services or amenities and the circumstances of the person.

Identity: Terence Gray

Date of Death: 4 January2020

Place of Death: Grafton Base Hospital

Cause of Death: Multiple Injuries

Manner of Death: Whilst intoxicated Mr. Gray accidentally collided with a motor vehicle on the Princess Highway having been required to leave the southbound _ XPT Train by a Passenger Service Supervisor who was not an authorised officer. Mr. Gray had then been taken by NSW Police Officers from Grafton Train Station to a nearby truck stop at McPhillips Creek to hitch-hike home after 9 pm on 3 January 2020.

33. 38704 of 2020

Inquest into the death of Victor Madeley. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 23rd June 2021

At the time of his death, Mr. Madeley was serving a term of imprisonment at Long Bay Correctional Centre; an inquest is mandatory pursuant to Sections 23 and 27 of the *Coroners Act NSW 2009* (the Act). Section 81 of the Act 2009 provides jurisdiction to a Coroner to hold an inquest into the death, or suspected death of a person, and to make findings as to the date, place, cause and manner or circumstances of death. Section 82 of the Act provides for coronial recommendations.

Background

Victor Madeley was born on the 27 April 1935 to parents Ebenezer and Mary Madeley. He was the youngest of nine children to the couple. Mary died shortly after Mr. Madeley's birth. Mr. Madeley lived with his paternal aunt and uncle until 4 years old, when he returned to his family home to be raised by his father and siblings. He is the father to one son; however, this relationship was estranged following his incarceration. Mr. Madeley met his wife Nancy in 1955; the family lived in West Wyalong, and then Tumut until Nancy's death in 1978.

Mr. Madeley had a lengthy medical history and was a heavy smoker until 1970 when he was hospitalised for treatment for a collapsed lung. He suffered asthma, gastro-oesophageal disease, Type 2 diabetes, Chronic Obstructive pulmonary disease, transurethral resection of the prostate, ischaemic heart disease, myocardial infarction and arthritis. On 25 October 2016, Mr. Madeley was arrested and charged with several historical sexual offences. He was given conditional bail until this was revoked on the 2 December 2016. On 8 March 2018, Mr. Madeley was sentenced to a term of imprisonment of 18 years, with an earliest release date of 1 June 2025.

During his incarceration Mr. Madeley was regularly attended to by Justice Health medical personnel for the management of his health conditions. While housed at the Cessnock Correctional Centre, he was transported to Cessnock District Hospital on several occasions suffering exacerbation of asthma. On the 31 January 2019, Mr. Madeley was transferred from Cessnock Correctional Centre to the Metropolitan Special Programs Centre due to ongoing medical concerns, and Cessnock did not have the capacity to provide for his medical needs.

On the morning of the 4 February 2019 Mr. Madeley was transferred to the Prince of Wales Hospital for treatment of shortness of breath and chest pain. He was discharged that evening to the Kevin Waller Unit – Aged care and Rehabilitation Ward at Long Bay Hospital with a diagnosis of chronic bronchitis and a urinary tract infection. At 11:30pm that evening he was checked by Corrective Services staff and appeared sleeping. At 4.00am on 5 February 2020 when checked by Corrective Services and Justice Health personnel he showed no signs of life. CPR was not administered as Mr. Madeley was clearly deceased.

The investigation into Mr. Madeley's death establishes that he suffered multiple serious complex and chronic illnesses, for which he was provided appropriate care and treatment from Justice Health and was appropriately accommodated by CSNSW.

Findings:

Identity: Victor Madeley

Date: 5 February 2020

Place: Kevin Waller Unit – at Long Bay Correctional Centre, NSW

Cause: Diabetes mellitus and its complications.

Manner: Mr. Madeley died due to natural causes whilst in the lawful custody of Corrective Services NSW

34. 80909 of 2020

Inquest into the death of Timothy Moffatt. Findings handed down by Deputy State Coroner Ryan at Lidcombe on the 5th October 2021.

On 12 March 2020 Timothy Moffatt aged 72 years died in Prince of Wales Hospital, in Sydney. Mr Moffatt had been serving a sentence of imprisonment since 2014. He was therefore in lawful detention, and an inquest into the circumstances of his death is mandatory pursuant to sections 23 and 27 of the *Coroner's Act 2009*.

The role of the Coroner

The Coroner must make findings as to the date and place of a person's death, and the cause and manner of death. In addition, pursuant to section 82 of the Act the Coroner may make recommendations in relation to matters which have the capacity to improve public health and safety in the future, arising out of the death in question.

Mr. Moffatt's life

Mr Moffatt was born in Newcastle, England on 14 January 1948. He was adopted and raised by his maternal uncle and aunt. When he was seventeen years old he migrated to Perth, Australia to reside with his mother who had moved there.

In 1980 Mr Moffatt moved to Bellingen on NSW's mid north coast. Here he developed an interest in health, body building and injury management. This led him to undertake a massage course at Coffs Harbour's School of Natural Medicine. He then entered a partnership in the Coffs Harbour Remedial Massage Centre. Mr Moffatt was diagnosed with prostate cancer in 2008. He declined his doctor's treatment recommendation of surgery and radiotherapy, preferring to undertake natural therapies.

Mr. Moffatt's entry into custody

In February 2012 Mr Moffatt was charged with offences of assault with acts of indecency. When further charges were laid in 2014 he was refused bail and he entered custody on 21 February 2014. In 2016 he pleaded guilty to a number of counts of indecent assault, and was sentenced to 13 years 6 months imprisonment with a non-parole period of 9 years. He would first be eligible for parole on 19 February 2023.

While in custody Mr Moffatt was regularly treated and assessed by medical and nursing staff. At times between 2015 and 2019 he was transferred to the Prince of Wales Hospital for specialist management of acute renal failure and investigation of his existing prostate cancer. He had developed hydronephrosis in both kidneys, which required a stent to be surgically inserted to carry urine from his kidneys to his bladder. This condition was the cause of significant impairment to Mr Moffatt's kidney function. He was regularly assessed by renal physician Dr Jonathon Erlic.

From 2014 until 2018 Mr Moffatt continued to decline treatment for his prostate cancer. However, in May 2018 a scan revealed that his cancer had metastasised into areas of his bones. He agreed to undergo chemotherapy treatment. Despite treatment, Mr Moffatt's prostate cancer and kidney disease continued to progress. In November 2019 a comfort care plan was developed for an end of life pathway. Mr Moffatt underwent surgery in January 2020 to change his ureteric stents, but when the new stents developed problems it was decided that further surgery would not be inhis best interests.

On 9 March 2020 Mr. Moffatt was transferred back to Prince of Wales Hospital with hyperkalaemia due to his kidney failure. It was decided that he would receive palliative care and monitoring. A nurse who checked him at 5.05am on 12 March 2020 found that he was no longer breathing, and he was pronounced deceased. An autopsy performed by pathologist Dr Lene Berger found that Mr Moffatt had died as a result of metastatic prostate carcinoma.

Conclusion

The evidence at inquest established that the medical care and treatment which Mr Moffatt received while he was an inmate was appropriate. With regard to his prostate cancer it is clear that up until May 2018 he declined the medical treatment which he was offered, which was his right.

I express to Mr Moffatt's family my sincere sympathy for their loss.

I thank Coronial Advocate Senior Constable Howard Mullen for his assistance in the preparation and conduct of this inquest. I also thank the Officer in Charge of the coronial investigation, Senior Constable Petrina Price, for her preparation of the brief of evidence.

Findings required by s81 (1)

Identity
The person who died is Timothy Moffatt.

Date of death:
Timothy Moffatt died on 12 March 2020.

Place of death:
Timothy Moffatt died at Prince of Wales Hospital, Sydney.

Cause of death:
Timothy Moffatt died as a result of metastatic prostate carcinoma.

Manner of death:
Timothy Moffatt died from natural causes, while he was in lawful custody.

35. 103425 of 2020

Inquest into the death of David Jones. Findings handed down by Deputy State Coroner Truscott at Lidcombe on the 23 June 2021.

This is an inquest into the death of David Grahame Jones aged 88 years.

At the time of his death, Mr Jones was imprisoned in Long Bay Correctional Centre, Sydney, NSW. An inquest into his death is required pursuant to sections 23 and 27 of the *Coroners Act NSW 2009* (the Act). Section 81 of the Act 2009 provides jurisdiction to a Coroner to hold an inquest into the death, or suspected death of a person, and to make findings as to the date, place, cause and manner or circumstances of death. Section 82 of the Act provides for coronial recommendations.

David Grahame Jones was born on the 24 July 1932. He was the youngest of the children to his parents.

Following his graduation from Newington High School, Mr Jones lived in England for two years working for a Rover Company. Upon his return to Australia he worked with Granville Motors, and in the 1960's developed his own motor repair company, until his retirement in 2002. Mr Jones met his wife in 1962, the couple married and following retirement, the couple settled.

Mr Jones had an extensive medical history; he suffered several complex and serious medical conditions. He'd had several surgeries during his lifetime, including an appendectomy in 1942, a right shoulder surgery in 1978, a mitral valve replacement in in 2003, knee replacements to his right knee in 2010 and left knee in 2014 and a cardiac bifascicular block in 2019.

He suffered several serious health conditions including, atrial fibrillation, type 2 diabetes, heart valve disorder, mitral valve replacement, heart failure, burdle branch block, hypercholesterolemia, renal failure, vitamin D deficiency and gastroesophageal reflux disease.

On the 30 September 2019, Mr Jones was arrested and charged with several child sexual assaults and was subject to strict bail conditions. On the 14 October 2019, his bail was revoked, and he was remanded into Corrective Services custody. Mr Jones was initially housed at the Goulburn Correctional Centre, until being transferred to Parklea Correctional Centre on the 4 November 2019. While housed at Parklea, Mr Jones was transferred to Blacktown Hospital on two occasions, following unwitnessed falls in his cell. On the 6 February 2020, he was admitted to the hospital again and remained there until a placement at the Kevin Waller Aged Care and Rehabilitation Unit Long Bay Hospital.

On the 11 February 2020, he was transferred to Kevin Waller Aged Care and Rehabilitation Unit, Long Bay Hospital with an "Advanced Care Directive".

A "Not for CPR" order was completed on the 13 February 2020.

On 19 February 2020 Mr Jones was transferred to the Prince of Wales Hospital for investigations and treatment into a decline of overall heath and weight loss. He was diagnosed with sigmoid diverticulitis, acute on chronic kidney injury and oesophageal candidiasis.

On the 10 March 2020, he was returned to Kevin Waller Aged Care and Rehabilitation Unit for palliative care.

On the 2 April 2020 Mr Jones Mr Jones died in his bed in his cell. CPR was not administered in accordance with the directive dated 13 February 2020.

The investigation into Mr Jones's death establishes that he suffered multiple serious complex and chronic illnesses, for which he was provided appropriate care and treatment from Justice Health and was appropriately accommodated by CSNSW.

Findings:

Identity: David Grahame Jones

Date: 2 April 2020

Place: Aged Care and Rehabilitation Unit Long Bay Correctional Centre, NSW

Cause: General frailty and Inanition, chronic cardiac and renal failure & diabetes.

Manner: Natural causes whilst in the lawful custody of Corrective Services NSW.

36. 148520 of 2020

Inquest into the death of Jodie St John. Findings handed down by State Coroner O'Sullivan at Lidcombe on the 10th November 2021.

This inquest concerns the tragic death of Jodie St John. Ms St John was 41 years of age when she died as a result of falling off the edge of a cliff at theSkillion, Terrigal.

Ms St John attended the Skillion at approximately 1:30pm on 17 May 2020. Civilians called triple zero at 1:53pm after seeing Ms St John on the ocean-side of the two fences at the Skillion. NSW Police Force ("NSWPF") officers attended from around 2:03pm. Despite a continuous and genuine effort to preserve her life, Ms St John fell from the cliff at around 3:15pm, sustaining injuries which caused her death.

I am grateful for the attendance of Ms St John's daughter Kristy at the hearing and for her generosity in sharing her loss with this court. I offer Kristy and all of Ms St John's family my sincere and heartfelt condolences.

The role of the coroner

The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death: s. 81 of the *Coroners Act 2009* (NSW) ("the Act"). A coroner may also make recommendations arising from the evidence in relation to matters that have the capacity to improve public health and safety in the future: s. 82 of the Act.

In this case there was no dispute in relation to the identity of the deceased, the date and place of death, or the physical cause of death. Accordingly, the focus of this inquest centred around the manner of Ms St John's death, and the circumstances in which she died.

Ms St John's death occurred during the course of a police operation, and accordingly, the holding of an inquest by a senior coroner was considered mandatory pursuant to ss. 23(1) (c) and 27(1) (b) of the Act.

In part, the purpose of an inquest in such circumstances is to examine whether any lessons can be drawn from a particular incident, with a view to improving systems, policies, practice or training, and potentially preventing future deaths ifpossible.

The issues

A list of issues was prepared before the proceedings commenced and circulated to the parties. In addition to determining the statutory findings required by s. 81 of the Act, the issues explored at inquest included:

- Whether Ms St John's fall resulted from an action done by her with the intention of taking her own life.

- Whether the police operation was carried out in accordance with applicable policies and procedures.
- Whether the NSWPF officers in attendance had adequate training in the areas of mental health and negotiations.
- The adequacy of the police operation, including but not limited to:
- The support, guidance and instructions provided to Senior Constable Hyde,
- The timeliness of NSWPF negotiators' arrival in circumstances where the Skillion is a known location for suicide,
- The briefing and utilisation of NSWPF negotiators,
- Whether adequate consideration was given to facilitating contact between Ms St John and Leanne Randall, and
- The co-ordination of the operation, including information gathering and sharing.
- The adequacy of suicide prevention and deterrence measures at the Skillion, including fencing, signage and security/monitoring.
- The secure attachment of NSWPF Body Worn Video ("BWV") cameras.
- The adequacy of the remote operation system governing the CCTV cameras at the Skillion, and training of NSWPF officers in use of the system; and
- Whether it is necessary or desirable to make any recommendations in relation to any matter connected with the death of Ms St John.

The evidence

The court took evidence over two hearing days. The court also received extensive documentary material, compiled in a four-volume brief of evidence. This material included witness statements, medical records, photographs and video records.

While I do not intend to refer to all of the material in detail in these findings, it has been comprehensively reviewed and assessed. In addition to oral evidence from the officer in charge, Detective Chief Inspector Glenn Trayhurn, the following NSWPF officers attended the inquest via audio-visual link to provide evidence:

Senior Constable Nicholas Hyde, Chief Inspector John Zdrilic, Senior Constable Karen Wilesmith and Negotiator Pete, four of the NSWPF officers involved in the NSWPF operation at the Skillion; Negotiator Kirsty, Officer in Charge of the NSWPF Negotiation Unit, Counter Terrorism and Special Tactics Command; and Chief Inspector Matt Hanlon, Manager of the NSWPF Mental Health Intervention Team. I was impressed by the frankness with which a number of the involved NSWPF officers reflected on the events surrounding Ms St John's death at the hearing.

It was clear that Senior Constable Hyde and Negotiator Pete had both reflected on their actions during their involvement with Ms St John on 17 May 2020 and the events that occurred. It was apparent to the court that both NSWPF officers were affected by Ms St John's death. Despite their best efforts, Ms St John could not be safely moved away from the cliff edge. This no doubt is a very difficult part of their jobs and I thank them for their efforts in trying to prevent Ms St John's death. Ms Julie Vaughan, Director of Community and Recreation Services at Central Coast Council (the "Council") also attended the inquest via audio-visual link to provide evidence.

Background

Jodie Maree St John was born in Western Australia on 17 September 1979 and was raised in Kalgoorlie. She was 41 years old at the time of her death. Her father left the family when she was a baby and her mother remarried five further times. Ms St John had three older brothers, including a fraternal twin. One of Ms St John's brothers died by suicide in around 1998. Her twin brother stated that their mother, who had a history of depression, attempted suicide when they were about 14 by taking an overdose of prescription medication. It is apparent that Ms St John had experienced first-hand the tragic loss of family members to suicide, and it is particularly tragic that Ms St John struggled with her own mental health throughout her life.

Ms St John suffered considerable abuse throughout her life in addition to her struggles with her mental health and substance abuse issues. Her teenage years were difficult, and she experienced significant trauma. At the age of 14, Ms St John was declared a ward of the state and fell pregnant to a man ten years her senior. Ms St John went on to have five children.

Since 2009, Ms St John had been in a volatile relationship with Paul McCarthy and their relationship eventually ended in early 2020. At the time of her death, Ms St John was living with Mr McCarthy in order to save money, however they remained separated.

At the time of her death, Ms St John was employed at Hornsby Hospital as an environmental officer in cleaning services. Her employer provided a statement to the court and noted that Ms St John had worked for Hornsby Hospital for approximately 12 years. The length of her employment is commendable in circumstances where she had significant personal struggles to deal with.

Mental Health and Substance Use

Ms St John had a history of drug and alcohol dependence, in addition to mental health issues including depression and anxiety.

In 2014–2016, it appears that Ms St John sought help from a psychiatrist and counsellor and was diagnosed with depression and adjustment disorder. However, according to Mr McCarthy, at some point in 2016–2017, Ms St John ceased taking her prescribed medication and seeing doctors.

In 2018, it appears that Ms St John suffered from particularly poor mental health and suicidal ideation.

On 22 August 2018, Ms St John was admitted to Gosford Hospital under s. 22 of the *Mental Health Act 2007* (NSW) ("the MH Act") after an apparent suicide attempt.

During this admission, Ms St John told the treating psychiatrist that she intended to *"jump off a cliff at Terrigal"*. Ms St John was discharged with a follow up actionplan. On 30 August 2018, Ms St John was admitted voluntarily to the Mental Health Unit at Gosford Hospital due to suicidal ideation, specifically that she wanted to jump off the Skillion. Upon discharge, Ms St John was directed to continue with her medication, namely 20 mg daily of Escitalopram.

On 4 November 2018, Ms St John was admitted to Gosford Hospital under s. 22 of the MH Act after reportedly telling Mr McCarthy she would jump off a cliff. The mental health team assessed Ms St John as having a low acute risk of suicide at that time, but noted that her *"intermediate to long term risk is moderately elevated, considering ongoing stressors, lack of support systems, past attempt, frequent threats, personality style and family hx (sic)"*. Ms St John was discharged, and her medical records refer to follow up appointments and referrals in November 2018.

Ms St John's mental health appeared to stabilise after this point. Mr McCarthy stated that 2019 was a good year, and Ms St John *"seemed in a good place".*

According to the statements provided by Mr McCarthy and Ms Randall, Ms St John's mental health deteriorated again in 2020. None of the documentary evidence the court received indicated that Ms St John was taking any prescribed medication at the time of her death.

The critical incident on 17 May 2020

The morning of and travel to the Skillion

Between 10:00am and 11:00am on 17 May 2020, Ms St John departed her house for around one hour. Upon her return she sat under an orange tree in her front yard with a bag of food and four cans of Double Black Vodka. It appears that Ms St John and Mr McCarthy had an argument before Ms St John walked into the house and called a taxi.

Between 12:30pm and 12:45pm, Ms St John left the house in a taxi. Ms St John appeared happy and talked about being lucky to have work during the Covid-19 pandemic. The taxi driver noted that at one-point Ms St John started worrying about how she was going to get home and so he offered her his number, and suggested she could also catch an Uber or public transport. Ms St John then said not to worry about it, as she would make her own way home. She was dropped off in the vicinity of the Rugby Club near the Skillion at the Haven, Terrigal. The Skillion is a point at the headland south of Terrigal beach. At the top of the headland is a viewing platform. It is a popular lookout for locals and tourists. There are two safety fences installed at the Skillion. The first is approximately 1.3 m high and is similar in appearance to a pool fence. The second is a chicken wire fence, approximately one metre high. Two CCTV surveillance cameras are installed at the Skillion. They are operated by the Council, and are accessible to police stations in the Brisbane Water Police District. CCTV surveillance cameras first captured Ms St John standing on the viewing platform at the Skillion at 1:31pm.

At 1:50pm, civilian witnesses noticed Ms St John at the Skillion. They saw Ms St John climb over the first safety fence and then walk around the second safety fence. Ms St John then approached the cliff edge and sat down with her legs hanging over the edge of the cliff. The CCTV surveillance cameras corroborate this timing and depict Ms St John walking on the other side of both fences at 1:50pm.

At 1:53pm, one of the civilian witnesses called triple zero. Triple zero was also called by other members of the public regarding Ms St John, and a broadcast was made over NSWPF radio. The radio message was responded to by Brisbane Water 36 (BW36), the NSWPF vehicle driven by Senior Constable Nicholas Hyde and Senior Constable Karen Wilesmith, as well as by Brisbane Water 14 (BW14), driven by Sergeant John Rutherford.

Attendance of NSWPF officers

At about 2:03pm, Senior Constables Hyde and Wilesmith attended the Skillion and ran up the hill. Senior Constable Hyde stated that when they arrived, they had no knowledge of Ms St John's name, or of any mental health issues she may have had. Senior Constable Hyde jumped over one of the two safety fences and stood behind the second safety fence, approximately ten metres from Ms St John. As Senior Constable Wilesmith approached, Ms St John was hostile towards her and told her to *"fuck off"*. Senior Constable Wilesmith retreated to the viewing platform and stood in a position behind a tree from which she could see Ms St John. Senior Constable Hyde engaged Ms St John in conversation and Senior Constable Wilesmith took notes from a distance. At 2:06pm, Senior Constable Hyde requested a negotiator urgently via NSWPF radio.

At 2:10pm, Sergeant Rutherford arrived on scene. Sergeant Rutherford was on duty as the external supervisor and took initial command of the situation. While travelling to the scene, Sergeant Rutherford communicated via radio that no NSWPF officers were to go over the second fence. Upon arrival, he directed other attending NSWPF officers to perform crowd control and other duties and began to liaise with NSW Ambulance and Fire and Rescue NSW personnel.

At 2:21pm, Sergeant Rutherford was contacted by Negotiator Sue, a Team Leader within the Negotiation Unit, who had been provided with basic details of the situation by the Northern Region Operations Coordinator. Negotiator Sue advised Sergeant Rutherford to have one NSWPF officer in a safe location to try and keep Ms St John engaged. She suggested that the officer should talk to her in a calm voice and to reassure her that NSWPF and NSW Ambulance officers were there to help her. Sergeant Rutherford was informed that trained negotiators were on the way. She advised that she could be contacted if further advice in relation to negotiation was required.

At 2:25pm, Chief Inspector John Zdrilic arrived at the Skillion and took control of the NSWPF operation. Chief Inspector Zdrilic gave evidence that he did not have contact with anyone from the Negotiation Unit prior to the arrival of the trained negotiators. Chief Inspector Zdrilic stated that, as the District Inspector, he had overall accountability for providing an effective response and controlling the situation, including communication with station staff at Gosford Police Station, ascertaining the location of trained NSWPF negotiators, and other resources including NSW Ambulance, Fire and Rescue NSW and the NSWPF Rescue Unit. Chief Inspector Zdrilic was aware of a NSWPF vessel on scene and requested that the boat remain near the Skillion but out of sight. Officers from Fire and Rescue NSW and NSW Ambulance were also in attendance.

Senior Constable Hyde continued to speak to Ms St John and eventually ascertained her first name. Ms St John made comments about experiencing domestic violence, having lost her kids and not being able to access $10,000 from her superannuation in order to move out of her accommodation.

Ms St John was drinking a pre-mixed alcoholic drink in a can and said she was waiting for high tide. She was described as aggressive and agitated.

At one point, Ms St John stood up and walked along the cliff edge. In doing so, she passed within one or two arm's lengths of Senior Constable Hyde. Senior Constable Hyde gave evidence that he briefly thought he may have been able to grab Ms St John at this point, but decided against it on the basis that he was slightly too far away and if he attempted to grab her and missed, then all trust would be lost.

Attendance of Negotiator Leanne

At around 2:47pm, Negotiator Leanne attended the scene in her capacity as a trained negotiator. Chief Inspector Zdrilic briefed Negotiator Leanne with the basic details of the situation, including Ms St John's name and the fact that Ms St John had taken exception to Senior Constable Wilesmith's presence.

Negotiator Leanne requested that Chief Inspector Zdrilic inform Senior Constable Hyde that she was coming down.

Senior Constable Hyde said to Ms St John *"my friend wants to come down and talk"* but did not explicitly note that it was a woman. Negotiator Leanne approached the second fence at around 2:51pm. Upon seeing her, Ms St John became extremely agitated and said:

"So, they send down a fucking female, I'm not talking to a fucking female."

Negotiator Leanne asked why, and Ms St John replied:

"I'm not talking to a fucking female. Get the fuck away"

At 2:53pm Negotiator Leanne withdrew to the main viewing area with Senior Constable Wilesmith and made no further contact with Ms St John.

Attendance of Negotiator Pete and Negotiator Jerry

At around 3:00pm, two more trained negotiators, Negotiator Pete and Negotiator Jerry arrived at the Skillion in separate cars. A fourth negotiator, Negotiator Andrew was still travelling to the scene.

Negotiator Pete recalled being briefed with background information including Ms St John's name, how long she had been at the Skillion, where she worked, and that she had children in care. Negotiator Pete stated that he did not have any real information about her mental health.

The trained negotiators were assigned their respective roles: Negotiator Pete as the primary negotiator and Negotiator Jerry as the secondary negotiator. Negotiator Jerry stated that *"it was decided that Negotiator Leanne would stay and co-ordinate things at the command post"*. Negotiator Leanne also conveyed information by telephone to the team leader, Negotiator Andrew.

Senior Constable Hyde asked Ms St John if it was okay if another friend came down, noting that it was a man, and Ms St John agreed.

At around 3:12pm, Negotiator Pete and Negotiator Jerry climbed over the first fence and headed towards Ms St John and Senior Constable Hyde. The presence of Negotiator Jerry agitated Ms St John who shouted several times *"tell him to go away"* and *"if he doesn't go, I'm going"*.

Negotiator Jerry withdrew from the cliff edge area but remained in between the two fences. Negotiator Pete gave oral evidence that he asked Negotiator Jerry to move back to the second fence, but to stay on the ocean-side of that fence so that Negotiator Jerry could still take notes and assist.

Negotiator Pete gave evidence that Ms St John calmed after Negotiator Jerry withdrew but remained nervous and turned around occasionally to check Negotiator Jerry was not coming down to the cliff edge.

Senior Constable Hyde recalled that Ms St John remained upset and continued yelling for Negotiator Jerry to goaway.

At 3:15pm, Ms St John rolled from her sitting position onto her stomach, carefully lowering her legs over the edge. Ms St John then said words to the effect of:

"[t]here is a ledge down there, I'm gunna get down there and I'm gunna go".

At approximately 3:15pm, Ms St John appeared to slide off the cliff edge and made a frightened scream before landing on a ledge about 20 metres below the edge of the cliff. Negotiator Pete and Senior Constable Hyde then climbed over the second safety fence and approached the cliff edge. They could no longer see Ms St John. A short time later, a NSW Ambulance officer abseiled down the cliff to where Ms St John had landed. He ascertained that there were no signs of life and she was pronounced life extinct at 3:30pm. At 6:50pm, the NSWPF Rescue Unit recovered Ms St John's body.

Critical Incident Investigation

A critical incident was declared by Assistant Commissioner Max Mitchell at 3:40pm. At 3:48pm, Detective Chief Inspector Glenn Trayhurn was appointed the Senior Critical Incident Investigator.

At 5:35pm, Detective Chief Inspector Trayhurn informed Chief Inspector Zdrilic that the involved officers were Senior Constable Hyde, Negotiator Pete and Negotiator Jerry. Detective Chief Inspector Trayhurn asked that the three officers be separated but not isolated. When Detective Chief Inspector Trayhurn attended the Brisbane, Water Police District building later that afternoon, he observed that the involved officers had been duly separated and each had welfare officers in attendance. On 19 May 2020, directed interviews were conducted with Senior Constable Hyde and Negotiator Pete, which included both officers answering questions prior to and after reviewing footage from the CCTV surveillance cameras. Negotiator Jerry and other witness officers provided statements which are included in the brief ofevidence.

Post-mortem examination

On 21 May 2020, Dr Lorraine Du Toit-Prinsloo conducted a post-mortem examination. She determined the direct cause of death to be multiple injuries, which resulted from the fall, with no antecedent causes identified.

Toxicology results indicated that at the time of her death, Ms St John had a blood alcohol concentration of 0.194g/100mL, and cannabinoids were alsodetected.

Findings

Issue 1: Whether Ms St John's fall resulted from an action done by her with the intention of taking her own life

There is considerable evidence that Ms St John attended the Skillion in contemplation of suicide. She had a long history of mental illness, notwithstanding that her previous periods of suicidal ideation were some years prior to her eventual death. Those periods however suggested that she had previously contemplated suicide at the Skillion.

Further, prior to the attendance of NSWPF, at around 1:00pm, Ms St John sent an email to Mr McCarthy with the subject line *"My life with u causing my suicide"*. During the course of her interaction with Senior Constable Hyde, Ms St John made statements consistent with ongoing suicidal intent, such as telling him she would leave her iPad open so he could have it *"when I'm gone"*, and stating she was waiting for high tide because she wanted to land in the water.

Against this, Ms St John had previously expressed suicidal intention (including plans to end her life at the Skillion) and not acted on those thoughts. Further, she told the taxi driver about her concerns of how she was going to get back home. Finally, shortly before she fell, Ms St John said words to the effect of *"I'm just going on to the next ledge"* before moving onto her front and slowly moving her way back. This may not have been an expression of suicidal intent. The involved NSWPF officers that attended the Skillion gave evidence that they were uncertain regarding Ms St John's mental state during their attendance and whether Ms St John actually intended to end her life on that day.

During his directed interview, Senior Constable Hyde stated that he thought Ms St John was just moving to another location when she said she was moving to the *"next ledge"*. Negotiator Pete declined to give an opinion on what he thought Ms St John was trying to do just before she fell. In oral evidence, both Senior Constable Hyde and Negotiator Pete remained uncertain as to what Ms St John's intention was at the point that she fell from the cliff. Notwithstanding that there was no evidence provided to the court that there was, in fact, a second ledge that Ms St John could have reached by lowering her body over the edge, I am unable to make a finding that Ms St John fell from the cliff edge as a result of an act done with the deliberate intention of ending her life. It is unknown whether Ms St John thought there was a second ledge that she wished to move to or whether she had decided to end her life at that time. It is clear however that as a result of her state of immense distress and suicidal ideation, Ms St John placed herself in a situation that posed an immediate risk to her life and sadly that riskmaterialised.

Issue 2: Whether the police operation was carried out in accordance with applicable policies and procedures

The brief of evidence contained a number of applicable NSWPF policy documents and guidelines. No issues emerged at the inquest as to adherence with applicable policies and procedures during the course of the police operation.

While the trained NSWPF negotiators were not in contact with Ms St John for any significant stretch of time, their actions accorded with the Standard Operating Procedures of the Negotiation Unit.

Negotiator Kirsty, officer in charge of the Negotiation Unit, gave oral evidence that she was satisfied with the conduct of the operation based on her position and experience as a NSWPF negotiator.

Issue 3: Whether the NSWPF officers in attendance had adequate training in the areas of mental health and negotiations

Mental Health Training

Chief Inspector Matthew Hanlon, Manager of the NSWPF Mental Health Intervention Team ("MHIT"), provided a statement and gave oral evidence regarding NSWPF mental health training and the courses facilitated by the MHIT.

The MHIT previously conducted a four-day training course for frontline officers which included lectures on different facets of mental health and suicide awareness. This course had a particular focus on communication and de-escalation techniques and was conducted by subject matter experts drawn from the NSWPF and the civilian population. Chief Inspector Hanlon gave oral evidence that the focus was on *"time, safe distance and communication"* and included a suicide intervention role play. Officers who completed this course became prioritised first responders to mental health incidents. Negotiator Pete completed this course in April 2008 and gave oral evidence that this training included specific content on suicide intervention and inspired him to pursue his training as a negotiator.

The above four-day course has been replaced by a two-day course entitled the Mental Health Enhanced Policing Practice Course, which was piloted in late 2019 and early 2020. This training includes similar content on communication and de-escalation techniques and further addresses decision-making in critical incidents. The two-day course has increased emphasis on experiential learning and role plays. It includes a role play module that addresses dysregulation disorders/self-harm, acute behavioural disturbance with psychosis, substance misuse and suicide. One of the role play scenarios provided to participants regarding suicide intervention involves a female on a cliff edge.

The above two-day course is limited in terms of the number of officers who can attend the program, and consequently the MHIT has rolled out an electronic learning module entitled STOPAR De-escalation. *"STOPAR"* stands for *"stop, think, observe, plan, act and review".* The STOPAR De-escalation module is mandatory training for NSWPF officers and Chief Inspector Hanlon noted that it was developed in response to a coronial recommendation in 2018. Senior Constable Hyde completed the STOPAR De-escalation module on 28 June 2021. Chief Inspector Hanlon gave evidence that the module encourages officers to *"take stock of the situation, make an assessment of the situation and take the correct response"*.

The MHIT also conducts a one-day Mental Health Workshop Program, which is an abridged version of the four-day training course. The course content includes modules on suicide response and risk assessment, a mental health tool kit and techniques in communication, negotiation and de-escalation. Senior Constable Hyde and Senior Constable Wilesmith each completed the one-day course in August and May 2014 respectively.

At the hearing, Senior Constable Hyde was unable to differentiate between skills or techniques he gained specifically during his mental health training and his natural instincts, developed from experience in dealing with people in varying states of agitation and mental crisis.

To establish rapport with Ms St John, he stated that he used the strategies that came naturally to him, rather than any learned techniques. Senior Constable Hyde stated that he could not comment on whether additional training would have been of assistance, as *"you can have all the training in the world and in a split second the situation changes"*.

During oral evidence, Chief Inspector Hanlon stated that the MHIT also has capacity to provide bespoke training to NSWPF officers in certain areas, in accordance with identified needs. Those representing the Commissioner explained that this bespoke training falls outside the courses identified above but is tailored towards identified issues that are best addressed by training, skills advice, guidance and awareness. Typically, such training is one to three hours in length.

Chief Inspector Hanlon gave an example of bespoke training delivered to officers in the Eastern Suburbs Police Area Command, the area which encompasses the Gap, a known suicide hotspot near Watsons Bay in Eastern Sydney. Chief Inspector Hanlon stated that the data currently available supports looking at the training needs of the Brisbane Water Police District, which encompasses the Gosford, Terrigal, and Woy Woy Police Stations. Chief Inspector Hanlon stated that he had recently developed a training package for the Northern Region. Of the 11 Police Districts in the Northern Region, Brisbane Water Police District was identified as having the greatest suicide risk and highest rate of mental healthincidents.

Negotiation training

Negotiator Kirsty stated that mental health training forms a significant part of negotiation training and ongoing professional development provided to active NSWPF negotiators. Negotiator Pete gave oral evidence that he undertook training to become an accredited and active NSWPF negotiator in 2011. He stated that this training included a mental health component which included talks over a number of days from psychiatrists and psychologists and covered specific material on suicide intervention including role plays.

Nothing in the evidence suggests that the NSWPF negotiators who attended the Skillion on the day of Ms St John's death were inadequately trained in negotiations or mental health. Unfortunately, they simply had limited opportunity to deploy their skills in this instance, given Negotiator Leanne was required to retreat, and Negotiators Pete and Jerry were engaged with Ms St John for around only four minutes.

The NSWPF operation largely centred around the engagement of Ms St John by Senior Constable Hyde, whose efforts were commendable. During his directed interview on 19 May 2020, Senior Constable Hyde expressed a degree of uncertainty regarding various matters that arose during his engagement with Ms St John, particularly whether he should have attempted to physically restrain Ms St John, whether or not he should have allowed Ms St John to speak with Ms Randall and whether he introduced the trained negotiators in the correct manner. As was discussed above, this level of reflection is a credit to Senior Constable Hyde and shows that he thought deeply about the events surrounding Ms St John's death and whether he could have done anything differently.

Negotiator Kirsty observed in oral evidence that although not a trained negotiator, Senior Constable Hyde was able to engage with Ms St John, in a manner that she would expect of a first responding NSWPF officer.

She was complimentary of his continued persistence in trying to build rapport with Ms St John and noted that he conducted himself in accordance with his training and the relevant policies. I respectfully agree with the view of Negotiator Kirsty.

Notwithstanding that Senior Constable Hyde was uncertain whether his training or natural instincts guided his response when interacting with Ms St John, I am satisfied that the level of mental health training he had received allowed him to adequately and effectively engage with Ms St John. There can be no criticism of the level of mental health training that he had. However, given the evidence as to the heightened suicide risk and rate of mental health incidents in the Brisbane Water Police District, together with the specific evidence as to the prevalence of suicide and attempted suicide incidents at the Skillion, it is appropriate that I make a recommendation that bespoke training be delivered by the MHIT to all NSWPF officers stationed in the Brisbane Water Police District, tailored to the training needs and suicide risks within that area.

Issue 4: The adequacy of the police operation

The support, guidance and instructions provided to Senior Constable Hyde

The court heard evidence regarding the support that Senior Constable Hyde received during his interaction with Ms St John, in addition to the timeliness with which such support was provided.

Senior Constable Hyde was in communication with Ms St John from his arrival at the top of the Skillion at 2:06pm until her fall from the cliff at around 3:15pm. Senior Constable Hyde was in the line of sight of other NSWPF officers throughout the operation. Senior Constable Wilesmith recalled that she was able to hear what Ms St John was shouting out but could not hear Senior Constable Hyde except on the occasion that he called out a word or two. Negotiator Pete noted that the wind and other factors meant it was difficult to hear the conversation between Senior Constable Hyde and Ms St John.

Senior Constable Hyde had a police radio on him, but in order to not disturb Ms St John, he had turned the volume down. During oral evidence, Senior Constable Hyde stated that he passed information onto other NSWPF officers by radio, but was not provided information, advice or instructions in return, although it was possible that information was given to him via radio and he did not hear it as he had turned the volume down. Accordingly, direct verbal communication between Senior Constable Hyde and other officers was limited. Chief Inspector Zdrilic gave evidence that he made various communications to Senior Constable Hyde either by NSWPF radio or via his mobile phone, but any communication had to be *"intermittent, short and succinct".* This limited the amount of specific support, guidance and instruction that could be provided to Senior Constable Hyde. Some non-verbal communication between officers was utilised. At one-point, Senior Constable Wilesmith approached the fence, and Senior Constable Hyde made a hand motion to indicate *"go back"*.

Senior Constable Hyde gave evidence that he was informed of the arrival of negotiators by seeing them standing on the viewing platform, and Negotiator Pete stated that he made non-verbal cues to indicate to Senior Constable Hyde that he was coming down.

The timeliness of NSWPF negotiators' arrival in circumstances where the Skillion is a known location for suicide

The first call to triple zero was made by civilians at 1:53pm. Chief Inspector Zdrilic gave evidence that after acknowledging the job at 1:57pm, he used his radio to ascertain if there were any trained negotiators in the surrounding areas. At 2:06pm, Senior Constable Hyde urgently requested a negotiator.

The first trained negotiator, Negotiator Leanne arrived at around 2:47pm. Two further trained negotiators, Negotiator Pete and Negotiator Jerry, arrived separately at around 3:00pm.

Trained negotiators are primarily employed part time and work on an on-call basis. Negotiator Kirsty gave evidence that the Negotiation Unit runs on-call permanent teams only in metropolitan areas. This is due to the amount of interventions they are called out on, whereas in regional areas, which include the Central Coast region, there may only be two to three jobs per month, and therefore it would not be sensible to have permanent on-call negotiators.

Further, NSWPF negotiators' attendance at the Skillion must also be seen within the context of a regional setting, where typically greater distances need to be covered to reach attendances within any given Police District. Attendance of trained NSWPF negotiators to incidents within the confines of Sydney, must not be compared to attendances of NSWPF negotiators outside of Sydney.

Accordingly, the response time is impacted by the nature of the rostering system and the spread of negotiator resources across New South Wales. By way of example, on 17 May 2020, Negotiator Pete was not rostered on and was not on-call but was contacted at around 2:10pm as he was the negotiator geographically closest to the Skillion. Based on his experience as a District Inspector in the Brisbane Water Police District, Chief Inspector Zdrilic described the attendance of negotiators in that timeframe as *"timely"*. Negotiator Kirsty echoed that appraisement, noting it was a *"fairly efficient deployment".* I accept the evaluation of the witnesses and find that NSWPF negotiators attended in a timely manner.

The briefing and utilisation of NSWPF negotiators

Chief Inspector Zdrilic gave oral evidence that his role was to provide a briefing to the trained negotiators, but the decision to approach Ms St John, and any strategic decisions, fell to the negotiator team, namely Negotiators Leanne, Pete and Jerry. It can be seen that both attempts to introduce trained negotiators to Ms St John led to a level of increased agitation. With the benefit of hindsight, it is clear that Ms St John held animosity towards female officers, which led to her agitation on the occasions when Senior Constable Wilesmith and Negotiator Leanne approached the cliff edge. However, both Senior Constable Wilesmith and Senior Constable Hyde gave oral evidence that the gendered basis for Ms St John's dislike towards Senior Constable Wilesmith was not clear to them prior to Negotiator Leanne'sarrival.

Senior Constable Hyde re-established a level of rapport with Ms St John prior to the introduction of Negotiator Pete and Negotiator Jerry. Senior Constable Hyde gave evidence that he cleared the approach of one further, male, negotiator, with Ms St John prior to Negotiator Pete and Negotiator Jerry approaching the cliff edge.

Senior Constable Hyde stated that Ms St John was receptive to Negotiator Pete being at the cliff edge but become upset when she saw Negotiator Jerry. Negotiator Pete gave evidence that despite Ms St John's previous negative reaction to Negotiator Leanne, he did not have particular concerns regarding Ms St John's reaction to his approach, as he was a male. Negotiator Pete also noted people in crisis do not always respond positively to the arrival of negotiators. Accordingly, he had a plan in place and strategies to deal with that response and overcome any adverse reaction. The strategies he listed included introducing himself, *"talking up"* Senior Constable Hyde, and letting Ms St John know he was there to support her. Ultimately, Negotiator Pete stated that the plan was to ease Senior Constable Hyde out and bring Negotiator Jerry in once the introductions werecomplete.

With regard to the decision for Negotiator Jerry to retreat from the cliff edge but remain between the two fences, Negotiator Kirsty stated that this was the appropriate approach. She stated that in the circumstances it was appropriate for Negotiator Jerry to remove himself from the cliff edge until Negotiator Pete built up rapport and decided it was an appropriate time to re-introduce Jerry.

Negotiator Kirsty concurred with the evidence of Negotiator Pete and stated that despite the rapport built between Senior Constable Hyde and Ms St John, the trained negotiators are *"adept at building rapport and facilitating a smooth change over"*. Negotiator Kirsty gave evidence that the introduction stage does carry significant risk, but that trained negotiators are trained to manage that risk.

Throughout her time at the cliff side, Ms St John said to Senior Constable Hyde words to the effect of *"you'll finish your shift soon"* and *"you'll leave soon",* in response to which Senior Constable Hyde assured her that he was not leaving. Negotiator Kirsty stated that in her experience many people in Ms St John's position feel isolated and detached and have limited connections and personal relationships with others. Accordingly, it is not unusual for them to make statements to the effect that people will leave them, and no one cares, which reflect more on the person's state of mind rather than demonstrating a particular attachment to a specific person.

The trained negotiators who attended the scene were briefed with Ms St John's basic details including her name, occupation and that she had children in care. They were not briefed with information regarding her mental health or previous detention under s. 22 of the MH Act in 2018. Chief Inspector Zdrilic gave oral evidence that he did not recall finding out any information about Ms St John's mental health history, but there was a *"significant presumption"* of mental illness due to the unfoldingevents.

Negotiator Pete stated that while information about a subject is helpful, where a person in crisis is standing on a cliff edge, the priority is to start a conversation with them, rather than waiting for the information to come in. Negotiator Pete gave evidence that had the interaction progressed, he would have expected that further information would be passed to him by Negotiator Jerry who was acting in the supportive role of the second negotiator.

Negotiator Kirsty concurred with this assessment, stating that the initial strategy is to build rapport, before moving onto problem solving and intelligence gathering.

Whether adequate consideration was given to facilitating contact with Ms St John and Ms Randall

At one point, Ms St John asked Senior Constable Hyde to contact her friends from work, including her friend Leanne Randall. Senior Constable Hyde rang Ms Randall a few times before making successful phone contact at around 2:41pm. During this phone call, Senior Constable Hyde confirmed Ms St John's last name, and asked Ms Randall to stay by the phone. Ms Randall stated that she called back and spoke with Senior Constable Hyde at around 3:10pm. Contact between Ms St John and Ms Randall was not facilitated during either call and Ms St John was told that the first call had gone to message bank.

It is unclear whether the trained negotiators were informed of Ms St John's request to speak to Ms Randall or not. Chief Inspector Zdrilic gave oral evidence that had he been aware of such a request, it would have been part of his briefing, but he did not specifically recall passing on that information. Negotiator Pete stated that he was not aware of Ms St John's request. During his interview on 19 May 2020, Senior Constable Hyde stated he was unsure of the process he should follow with regard to Ms St John's request. Senior Constable Hyde gave oral evidence at the hearing that he was concerned that Ms St John might have wanted to say goodbye to her friend and that in training NSWPF officers are told that facilitating contact of this nature is *"something you don't do"*. The NSWPF officers who gave evidence on this topic each expressed strong views that requests of this nature should not be facilitated, or at best should be treated with utmost caution.

Chief Inspector Zdrilic gave evidence that the training provided generally to officers, and in the area of mental health was clear on this point. He stated that when someone is contemplating self-harm, they should never be introduced to a family member or friend. The rationale for this is that the person in crisis may wish to self-harm in the third party's presence or say goodbye.

Negotiator Pete stated third party interventions of this nature would be *"highly scrutinised"* and it is not something he would recommend, as there is the concern that the person in crisis wants to speak with the third party before completing the intended suicidal action. He pointed to the email Ms St John sent to Mr McCarthy as evidence of the volatility of her relationships and the need for caution. He noted that before contact can be facilitated with a third party there are a number of steps that must be taken in accordance with the Standard Operating Procedures of the Negotiation Unit. These steps include a conversation with the Commander of the Negotiation Unit, a thorough interview with, and history of, the third person and the assessment and management of the risks associated with this intervention.

Negotiator Kirsty affirmed the evidence of Negotiator Pete and Chief Inspector Zdrilic. She stated that it would not have been appropriate for first responding NSWPF officers to have engaged Ms Randall directly in the negotiation at such an early stage. Rather, in her view, Ms Randall was a potential source of intelligence and information as the process of information gathering progressed.

The co-ordination of the operation, including information gathering and sharing

As part of the coronial investigation, the court received some limited evidence about the co-ordination of the NSWPF operation involving Ms St John, in addition to the information that was gathered in relation to her and how that information was shared amongst attending NSWPF officers. The importance of ensuring a co-ordinated NSWPF response to persons in crisis, as well as appropriate gathering and sharing of information that may assist in helping such a person, is obvious.

Negotiator Kirsty gave oral evidence that information gathering generally falls to the fourth negotiator in a team of four negotiators. The responsibilities of that role include contacting a variety of sources to obtain a background regarding the person in crisis including their mental health and NSWPF history. Negotiator Leanne was assigned the role of fourth negotiator and team leader, as Negotiator Andrew had not yet arrived.

The opportunity for information gathering and sharing was limited by the short time the NSWPF officers were in attendance at the Skillion. For example, Ms St John's full name was first ascertained after the phone call between Senior Constable Hyde and Ms Randall at around 2:41pm. In oral evidence, Senior Constable Hyde stated that he communicated this information to the other NSWPF officers by radio.

It cannot be known whether, had the operation continued, avenues for learning more about Ms St John (particularly her history of mental illness) might have been explored and hence might have assisted the negotiation. In circumstances where NSWPF negotiators arrived on scene in a timely manner, however only shortly before Ms St John fell off the cliff, and in circumstances where Senior Constable Hyde had turned down the volume on his radio so as to not upset Ms St John, it is unhelpful to examine whether more information could have been shared, or shared sooner, between the NSWPF officers in attendance. Particularly with the benefit of hindsight. Senior Constable Hyde did the best he could with the situation he faced and worked hard to build rapport with Ms St John. Similarly, he communicated with the negotiation team as best he could, however their attendance was very much in the early stages. Further information was not yet able to be gathered in relation to Ms StJohn.

This view is supported by Negotiator Kirsty, who gave evidence that she was not concerned that Ms St John's history of mental health crises had not been brought to the attention of the trained negotiators, given the negotiation was still in the early stages when they arrived. I find that the coordination of the operation involving Ms St John was adequate, as was the information that was gathered and the dissemination of same amongst the attending NSWPF officers.

Issue 5: The adequacy of suicide prevention and deterrence measures at the Skillion, including fencing, signage and security/ monitoring

It became evident throughout the inquest that the Skillion is a known location that is attended by persons contemplating, or intending to die by suicide. Chief Inspector Zdrilic gave evidence that as District Inspector in the Brisbane Water Police District, he is aware that the Skillion is a location that people contemplating self-harm attend.

He had personally attended the Skillion for suicide interventions approximately six times in the three and a half to four years he had worked in the district. He was aware that other colleagues had also attended the Skillion for the same purpose. Chief Inspector Zdrilic stated that such incidents are handled *"almost exclusively"* by General Duties officers.

In 2019 and 2020, trained negotiators were called to attend suicide interventions at the Skillion on four occasions. Negotiator Pete estimated that he had been called to the Skillion approximately eight times during his ten years as a negotiator. However, he also noted that other cliffs along the Central Coast are also known as locations people attend in contemplation of suicide and that he had similarly attended around six other coastal locations.

Chief Inspector Hanlon noted that the Skillion formed part of a recent 12-month review undertaken of suicide hotspots, in conjunction with Lifeline. The Skillion was identified as a hotspot in this process but did not appear in the top four or five locations. Chief Inspector Hanlon described a disconnect between the low representation of the Skillion in the data and his expectations based on his understanding of policing in the area.

Fencing

As stated above, there are currently two safety fences installed at the Skillion, approximately ten metres apart. The first is approximately 1.3m high and is similar in appearance to a pool fence. The second is a chicken wire fence, approximately one metre high. Senior Constable Hyde and Negotiator Pete both found the fences easy to jump over. Negotiator Pete described the act of crossing the second fence as *"stepping over"*. It is also possible to walk around the side of the fences, although there are thick bushes impeding the path. Overall, Detective Chief Inspector Trayhurn gave evidence that the fences would stop a small child but are *"not a deterrent of any measure for a grown person".*

The infrastructure at the Skillion is the responsibility of the Council. Ms Vaughan gave oral evidence that the facilities at the Skillion, including the fencing and signage, falls within her portfolio as Director of Community and Recreation Services.

In oral evidence, Chief Inspector Hanlon referred to guidelines developed with Lifeline regarding fencing at suicide hotspots. These guidelines were said to specify 1.5m as the minimum height for fencing at suicide hotspots and recommend 1.7m as an optimal height. The guidelines also refer to not having footholds or a clear structure that allows climbing. Although the guidelines do not form part of the evidence in this inquest, it is clear from the oral evidence of Chief Inspector Hanlon that the fences at the Skillion currently do not meet the standards of thoseguidelines.

Ms Vaughan told the court that the fences at the Skillion were installed to protect against accidents. They were not specifically designed to deter or prevent persons reaching the cliff edge for the purpose of committing suicide. As Ms Vaughan told the court *"suicide prevention is not core business of the Council"*. Chief Inspector Hanlon acknowledged that even when fencing meets the standards specified in the guidelines, a person with the intention to be on the ocean-side of a fence will find the means. Negotiator Pete gave evidence that at the other coastal sites to which he has been called for suicide interventions, there are sometimes only one or no fences installed. Chief Inspector Hanlon acknowledged that improving fencing at one location may move the problem to another location.

I acknowledge that there are limits as to what can be achieved to protect the safety of suicidal persons with fencing. It was pleasing to hear in the oral evidence of Ms Vaughan, a general openness on behalf of the Council to review the adequacy of the fencing.

While I do not make any specific recommendations regarding the fencing at the Skillion, it would be prudent for the Council to have regard to available guidelines as to anti-suicide fencing, when considering any future improvements to the safety measures at the Skillion.

Signage and hotspot phones

Chief Inspector Hanlon gave evidence that the three primary measures to address suicide at height, as identified in the guidelines developed with Lifeline, are fencing, signage and hotspot phones. Having discussed the fencing at the Skillion above, it is important to review some of the other suicide prevention measures currently in situ.

There is at least one sign at the Skillion, which reads *"In crisis? Call 13 11 14 now",* followed by the Lifeline logo. This signed is affixed to the fence surrounding the viewing platform. This sign was provided at the instigation and funding of Lifeline. During oral evidence, Ms Vaughan noted that representatives from the Council were attending a further meeting with Lifeline on 29 October 2021 to discuss updating the signage. Ms Vaughan also noted that the Council was open to discussing with Lifeline whether a hotspot phone was appropriate, noting that responsibility for installation and maintenance would lie with Lifeline.

Security and monitoring

The Council has installed two CCTV surveillance cameras at the Skillion, one at the top of the hill, near the viewing platform, and one at the bottom of the hill, near the carpark. The captured CCTV footage is not actively monitored or reviewed by the Council. The CCTV footage is accessible from Gosford, Terrigal and Woy Woy Police Stations.

Issues arising

It is difficult to assess the adequacy of suicide prevention and deterrence measures at the Skillion without precise data in relation to the prevalence of suicides and suicide attempts at that location. Most of the evidence as to the risk posed by the Skillion was anecdotal, provided by NSWPF officers that had attended the Skillion as part of suicide interventions. The Council confirmed that it does not keep or have access to statistics regarding the frequency of suicides, NSWPF attendances or threats of self-harm at the Skillion. This is concerning in circumstances where NSWPF consider the Skillion a known suicide hotspot.

Ms Vaughan stated that the Council, together with the NSWPF and other interagency groups, is a member of the Suicide Prevention Central Coast Alliance which leads the Black Dog Institute's Lifespan program. However, Ms Vaughan gave evidence that the Council's role was limited to participation in one of the nine subcommittees, which was focused on awareness and education campaigns.

Accordingly, the Council is reliant on other professional entities for information regarding suicide. With respect, in circumstances where the Skillion falls within the confines of the Council, it is regrettable that the Council does not take a more proactive approach to assessing the risk that the Skillion presents to persons contemplating suicide. Although suicide prevention may not be the core business of the Council, it is equally something that it should actively be engaged in, especially in circumstances where the Skillion is such a well-known area of risk.

The Council should not be solely reliant on information provided by other professional entities. Chief Inspector Zdrilic gave oral evidence that he believes there is a system of information sharing between the members of a local mental health suicide intervention group, of which the NSWPF, the Council, Lifeline and NSW Health are members.

Ms Vaughan appeared to be unaware of any such system, which underscores the lack of understanding that the Council has of its role in suicide prevention at the Skillion. Given the evidence provided regarding the general awareness of NSWPF officers of the Skillion as a location attended by persons contemplating suicide, the Council should be liaising with local NSWPF command in order to establish, or re-establish, a system for sharing data and information concerning suicides and attempted suicides at the Skillion. Data can then inform the Council's decisions regarding prevention and deterrence measures at the Skillion.

It was pleasing to hear in the Council's closing submissions that they are open to the sharing of data and making further improvements. This was also supported by the Commissioner of the NSWPF. I accordingly recommend that the Council liaise with NSWPF to establish a system for the sharing of data and information concerning suicide and attempted suicide events at the Skillion.

Issue 6: The secure attachment of NSWPF body worn video ("BWV") cameras

BWV footage is a valuable tool for contemporaneously recording a NSWPF officer's actions and is of great assistance to the coronial process. Senior Constable Wilesmith gave oral evidence that she was wearing a BWV camera, but did not turn it on. Senior Constable Hyde stated that the BWV camera attaches with a clip to the epaulet on his left shoulder, but it bounces as he runs, and it fell off as he jumped the first fence.

Senior Constable Hyde gave evidence that threading the camera through the epaulet can be fiddly and it is obvious what you are doing. He was concerned that re-attaching the camera and commencing recording would unnerve Ms St John and lead to a loss of trust. Accordingly, Senior Constable Hyde put the camera in hispocket.

I accept that in this case Senior Constable Hyde was faced with a difficult decision and chose to focus on Ms St John and building rapport and trust. However, the importance of NSWPF officers activating BWV cameras cannot be understated. Had Senior Constable Hyde been able to activate his BWV, it would have further assisted this court in capturing the thoughtful engagement he had with Ms St John.

Issue 7: The adequacy of the remote operation system governing the CCTV cameras at the Skillion, and training of NSWPF officers in use of this system

There are two CCTV surveillance cameras installed at the Skillion which transmit footage to Gosford, Terrigal, and Woy Woy Police Stations.

The footage is not actively monitored by the NSWPF, nor is there a system of alerts or notifications if the CCTV surveillance cameras capture a person on the ocean-side of the fence. Detective Chief Inspector Trayhurn gave evidence that the CCTV footage is always on display and in a prominent area where NSWPF officers can view it. If NSWPF officers become aware of an unfolding incident they can sit down and monitor the footage.

The CCTV surveillance cameras rotate through a series of views according to a fixed pattern. The fixed pattern can be interrupted and controlled remotely by NSWPF officers at Gosford, Terrigal, and Woy Woy Police Stations.

Sergeant Stephen Hassett provided a statement detailing the three levels of training for use of the CCTV system at the Skillion. The Basic Level covers the ability to view, manually control the cameras, and bookmark and save footage. Training in this level of use has been offered to NSWPF officers in the Brisbane Water Police District.

Senior Constable Rebecca Gibson attempted to operate the CCTV surveillance cameras from Terrigal Police Station. Senior Constable Gibson was untrained in the program that operates the CCTV surveillance cameras and she had difficulties navigating the program. Senior Constable Gibson contacted Gosford Police Station and spoke with Constable Gerrard O'Sullivan who was also having difficulties. Senior Constable Gibson contacted Woy Woy Police Station and obtained some advice from an unknown male about operating the CCTV surveillance cameras. At the point where Ms St John fell off the cliff, one of the CCTV cameras had frozen and there was a tree blocking its view.

Detective Chief Inspector Trayhurn gave oral evidence that despite being untrained in the system, he found it simple to operate, albeit with the guidance of an officer at the station. Detective Chief Inspector Trayhurn observed there are instructions next to the monitor regarding its use, and that it is a simple matter of moving the computer mouse on the screen and clicking in order to change the view. He expressed the opinion that the functionality of the CCTV system may have been impacted by internet speeds, as the system takes some time to catch up with the user's clicks. He noted that if the user is clicking repeatedly, the CCTV camera may not capture the intended view.

Given the written evidence of Senior Constable Gibson and the oral evidence of Detective Chief Inspector Trayhurn, it seems prudent to review the use of the CCTV at Brisbane Water Police District stations. It was pleasing to hear from counsel for the Commissioner of NSWPF that this has been taken on board.

Accordingly, I recommend that NSWPF review its training of NSWPF officers stationed at Gosford, Terrigal and Woy Woy Police Stations with regard to the CCTV system and ensure relevant training is provided to all officers. I also recommend that NSWPF investigate whether internet speeds are negatively impacting on the functionality of the CCTV system, and if so, take the appropriate steps to rectify that issue.

Formal Findings

Identity : The person who died was Jodie Maree St John.

Date of death: She died on 17 May 2020.

Place of death: She died at the Skillion, Terrigal NSW.

Cause of death: She died of multiple injuries.

Manner of death: Ms St John sustained multiple injuries as a result of falling off the edge of a cliff at the Skillion, Terrigal. Prior to falling, she had been engaged in communications with NSWPF officers.

Recommendations pursuant to section 82 *Coroners Act 2009*

Section 82 of the Act confers on a coroner the power to make recommendations that they may consider necessary or desirable in relation to any matter connected with the death with which the inquest is concerned. It is essential that a coroner keeps in mind the limited nature of the evidence that is presented and focuses on the specific lessons that may be learnt from the circumstances of each death.

For reasons stated above, I make the following recommendations:

To the Commissioner of Police, New South Wales Police Force

That the Commissioner of the NSWPF give consideration to the delivery of bespoke training by the MHIT with regard to suicide intervention to all NSWPF officers in the Brisbane Water Police District, tailored to the training needs of those officers.

That the Commissioner of the NSWPF give consideration to a review of its training regarding the remote use of the CCTV system installed at the Skillion and investigate whether internet speeds at stations in the Brisbane Water Police District are negatively impacting on the use of that system.

To the Chief Executive Officer, Central Coast Council

That the Council liaise with the Brisbane Water Police District and take steps to establish a system for the sharing of data and information concerning suicides and attempted suicides at the Skillion.

37. 201875 of 2020

Inquest into the death of William Berger. Findings handed down by Deputy State Coroner Lee at Lidcombe on the 24 June 2021.

At the time of his death, William Berger was 74 years old and was being held in lawful custody at Cessnock Correctional Centre. Mr Berger had a lengthy history of physical health conditions, including chronic obstructive pulmonary disease and metastatic prostate cancer. He had been admitted to hospital on a number of occasions in the 18 months preceding his death for treatment of these conditions. During Mr Berger's most recent hospital admission in July 2020 it was found that his condition had deteriorated significantly. On 7 July 2020 Mr Berger was found in his hospital bed to be unresponsive, and showing no signs of life. Mr Berger was subsequently pronounced life extinct.

Why was an inquest held?

Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death. When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated. A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately. It should be noted at the outset that the coronial investigation did not identify any evidence to suggest that Mr Berger was not appropriately cared for and treated whilst in custody.

Mr Berger's life

Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Understanding the impact that the death of a person has had on those closest to that person only comes from knowing something of that person's life. Therefore, it is important to recognise and acknowledge the life of that person in a brief, but hopefully meaningful, way. Regrettably, only limited information is available regarding Mr Berger's personal history prior to his incarceration. Mr Berger was born and raised in the United States. Mr Berger's parents separated when he was approximately two years old. Mr Berger was raised by his aunt and uncle, but remained in regular contact with his mother, although he had little contact with his biological father until he was about 17 years old.

Mr Berger completed high school in the United States before joining the United States Navy where he was stationed in San Francisco for four years. During his service Mr Berger acquired qualifications as an electrician and was deployed to Vietnam and the Marshall Islands. Mr Berger was reportedly honourably discharged at the end of his service and later took on contract work in both the United States and Pacific Islands. In 1969 Mr Berger migrated to Australia and formed a relationship. Mr Berger also commenced work in the electrical trade. In 1972, Mr Berger's son was born. In 1981 Mr Berger gained employment with a construction company involved in the construction of powerlines in the Snowy Mountains region of New South Wales. He also formed a new relationship at this time.

In 1983, Mr Berger was transferred by his company to Orange. In the same year, Mr Berger married his then partner. In 1985 Mr Berger and his wife took over the lease of a tavern near Orange, where they commenced working. Sometime later Mr Berger returned to Sydney and formed a new relationship.

Mr Berger's custodial history

In October 1986 Mr Berger was convicted and sentenced in relation to the manslaughter of his first wife and his stepdaughter. After spending approximately five years in custody, Mr Berger was release to parole on 6 May 1991. In 1993 Mr Berger was charged with an offence of murder involving his then de facto partner. Mr Berger was later found guilty by a jury of this offence and convicted. On 21 March 1995 Mr Berger was sentenced in the Supreme Court to a term of imprisonment of 28 years commencing on 10 November 1993, with a non-parole period of 21 years that was to expire on 9 November 2014. Mr Berger was initially housed at Maitland correctional centre before later being transferred to a number of other correctional centres including Lithgow, Bathurst, Wellington and Grafton. In 2019 Mr Berger was transferred to Cessnock correctional centre where he remained until his death. In 2014 Mr Berger made an application for parole. On 4 September 2014 the State Parole Authority refused parole on the basis that it was considered that Mr Berger was "*unlikely to adapt to normal community life*" and that "*it is not appropriate for [Mr Berger] to be considered for release on parole*". As a result, Mr Berger remained in custody, with his overall sentence due to expire on 9 November 2021. In March 2020 Mr Berger made a further application for parole. However, this application was later withdrawn in April 2020 due to the COVID-19 pandemic.

Mr Berger's medical history

Mr Berger had a history of chronic obstructive pulmonary disease (**COPD**), asthma, acute myocardial infarction, metastatic prostate cancer and urinary system disorder. In 2019 and 2020 Mr Berger was transferred and admitted to hospital on a number of occasions for management of his COPD, after presenting with coughing and shortness of breath.

What happened in June/July 2020?

On the morning of 30 June 2020 Mr Berger presented to the Justice Health & Forensic Mental Health Network (**Justice Health**) health centre at Cessnock correctional centre, complaining of shortness of breath. Mr Berger was found to have a moist sounding cough, chest congestion and reduced oxygen saturation levels (though consistent with his usual levels).

Following consultation with a primary care doctor, arrangements were made to transfer Mr Berger to Cessnock Hospital for further medical review. Following assessment, Mr Berger was deemed suitable for transfer back to Cessnock correctional centre and he was later discharged on the same day. On 4 July 2020 Mr Berger was reviewed by Justice Health nursing staff for a routine COVID-19 quarantine check. He was found to have developed a productive cough and rigors overnight. The on-call medical officer was consulted and Mr Berger was prescribed antibiotic medication.

On the morning of 5 July 2020 Mr Berger was again reviewed by Justice Health nursing staff after complaining of breathing difficulties and difficulty sleeping due to coughing and hot and cold sweats. Mr Berger also reported having to use his salbutamol inhaler frequently during the night, and that he had difficulty walking across his cell to use the toilet. On examination Mr Berger was found to be showing signs of increased work of breathing, together with crackles of his left lower lung and a right-sided wheeze. Arrangements were subsequently made to transfer Mr Berger by ambulance to Cessnock Hospital for assessment, ongoing management and treatment of his condition. Whilst at hospital Mr Berger was diagnosed with pneumonia and commenced on intravenous antibiotic therapy and salbutamol, which appeared to improve his symptoms. During the evening of 6 July 2020 Mr Berger's condition deteriorated overnight, as it was noted that he had been complaining of left-sided chest pain and was diaphoretic. Investigations on 7 July 2020 revealed an elevated troponin level together with blood test derangement. Due to Mr Berger's deteriorating condition arrangements were initiated with a retrieval team at John Hunter Hospital in Newcastle to transfer Mr Berger to an intensive care unit for a higher level of care.

Later that morning Mr Berger was assessed by a retrieval team from John Hunter Hospital. He was found to be slightly drowsy, tachypnoeic, hypoxic and with respiratory cachexia. It was also noted that Mr Berger had worsening respiratory acidosis. Following this assessment, it was determined that Mr Berger was unsafe to transfer due to his current clinical status. It was considered that intubation and invasive ventilation would be required in order to conduct a transfer safely. However, as Mr Berger's baseline lung function was poor, intubation was not considered to be a feasible option, and also considered to carry significant risks. Following consultation with Mr Berger's son, his treating team and the intensive care team at John Hunter Hospital a decision was made to not transfer Mr Berger and to instead provide him with ward-based care at Cessnock Hospital. Mr Berger continued to be provided with care at hospital and was found to be unresponsive at 11:55am. Mr Berger was later formally pronounced life extinct at 12:32pm.

What was the cause of Mr Berger's death?

Mr Berger was later taken to the Department of Forensic Medicine where a post-mortem examination was performed by Dr Allan Cala, forensic pathologist, on 9 July 2020. Dr Cala noted that Mr Berger had a well-documented history of chronic airways disease and prostate cancer. Further, Dr Cala opined that it was clearly apparent that Mr Berger had an acute exacerbation of chronic airways disease resulting in his death at hospital. Ultimately, in the autopsy reported dated 15 April 2020. Dr Cala opined that the cause of Mr Berger's death was acute exacerbation of chronic airways disease, with carcinoma of prostate noted to be a significant condition contributing to the death, but not relating to the disease or condition causing it.

Conclusions

Having regard to the relevant records from Corrective Services NSW (**CSNSW**) and Justice Health regarding Mr Berger's period in custody, and the findings from the post-mortem examination, it is evident that Mr Berger died as a result of a significant pre-existing natural disease process.

The evidence establishes that Mr Berger's presentations in June and July 2020 were appropriately assessed and investigated. When it became evident that Mr Berger's condition had deteriorated significantly, appropriate arrangements were made to transfer Mr Berger to hospital for further assessment and management. Given Mr Berger's clinical status and the need for intubation and invasive ventilation, and associated risks, in order to affect a transfer from Cessnock to Newcastle an appropriate decision was made to keep Mr Berger at Cessnock forward-based care.

Overall, the available evidence establishes that Mr Berger was provided with an adequate and appropriate level of medical care during his period in custody. There is no evidence to suggest that any aspect of Mr Berger's medical care, or the care provided by CSNSW and Justice Health staff, contributed in any way to his death.

Findings

Identity: The person who died was William Berger.

Date of death: Mr Berger died on 7 July 2020.

Place of death: Mr Berger died at Cessnock District Hospital, Cessnock NSW 2325.

Cause of death: The cause of Mr Berger's death was acute exacerbation of chronic airways disease, with carcinoma of prostate being a significant condition contributing to the death, but not relating to the disease or condition causing it.

Manner of death: Mr Berger died from natural causes, whilst in lawful custody serving a sentence of imprisonment.

38. 241740 of 2020

Inquest into the death of Donald Greenaway. Findings handed down by Deputy State Coroner Forbes at Lidcombe on the 12th October 2021.

This is an inquest into the death of Donald Victor Greenaway who died on 17 August 2020 while he was being held in lawful custody at Long Bay Correctional Centre. He was serving a 21-year prison sentence.

The role of a Coroner as set out in s.81 of the *Coroner's Act 2009* ("the Act") is to make findings as to:

- the identity of the deceased.
- the date and place of the person's death.
- the physical or medical cause of death; and
- the manner of death, in other words, the circumstances surrounding the death.

The Act requires a Senior Coroner to conduct an inquest where the death occurred whilst a person is in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

This Inquest has been a close examination of the circumstances surrounding Mr Greenaway's death and pursuant to s.37 of the Act a summary of the details of this case will be reported to Parliament.

Mr Greenaway

Mr Greenaway was born on 21 October 1931. He was 88 years old when he died in cell 9 of the Aged Care Ward at Long Bay Correctional Centre. He was serving a 21-year prison sentence for child sex offences committed over a 30-year period. He had a non-parole period of 15 years and 9 months. Some of the offences were committed when Mr Greenaway was a volunteer teacher at the Woodlands Boys Home at Wallsend, an institution which was the subject of examination by the recent Royal Commission into Institutional Responses to Child Sex Abuse.

Mr Greenaway entered into custody on 3 December 2013. His earliest possible release date was to be in September 2029.

Mr Greenaway appears to have had no known close friends or associates. His closest surviving relative is a first cousin. The cousin has informed this court that Mr Greenaway was an only child and his parents have now both passed away. His father died in 1976 and he continued a close relationship with his mother until her death in 1994.

He was raised in the small town of Craven in New South Wales and attended Newcastle Boys High School. After leaving high school, he worked in various retail positions and at a sawmill, before moving onto an apparently successful career as an accountant and/or auditor.

Mr Greenaway's paternal grandmother was Aboriginal, and Mr Greenaway identified as an Aboriginal man. Mr Greenaway spoke to the prison Chaplain early upon his incarceration about his Aboriginality and cultural tradition. He stated that his father took him to the Aboriginal community in the Newcastle area as a child, but he did not have any further contact with that community.

Mr Greenaway's one surviving cousin stayed in contact with him whilst he was in custody by way of the occasional exchange of letters. The cousin has informed this court that, as far as he was aware, there were no issues with the medical treatment Mr Greenaway received whilst he was in custody.

Medical Background

Mr Greenaway was diagnosed with an enlarged prostate in around 2007, having had urological problems for about 15 years.

Mr Greenaway was diagnosed with prostate cancer in March 2009 when a biopsy showed a stage IV adenocarcinoma. He underwent external beam radiotherapy, under the care of oncologists at the Calvary Mater Hospital in Newcastle, which was completed in July 2009. After that, Mr Greenaway received follow-up assessments by specialists at the hospital and no evidence of recurrence of the cancer was detected over a three-year period.

Prior to going into custody, he was last seen by an oncologist at Calvary Mater Hospital on 7 December 2012, when his PSA was noted to have risen slightly although not so much to suggest a recurrence of the cancer. Mr Greenaway was advised to monitor his PSA score at 6-monthly intervals, and he was to be reviewed in one year

Care and treatment in custody

At the time of his arrest and entry into custody on 3 December 2013 'prostate cancer' was recorded on Mr Greenaway's New South Wales Police Force Custody Management Record as a current medical problem for which he was receiving 'radiation treatment'. In addition, Mr Greenaway's other conditions included peripheral neuropathy, radiation enteritis and proctisis, osteopenia and hypertension

Mr Greenaway's complex medical conditions soon saw him frequently transferred to Prince of Wales Hospital for treatment during the course of his period in custody. For most of the 6 years he was in custody before his death he was housed within the Kevin Waller Unit or the Aged Care and Rehabilitation Unit of Long Bay Hospital. In both those settings the records indicate that he was seen by nursing staff on a daily basis and was also under the care of a geriatrician and general practitioner, among the other clinical staff. A detailed chronology of his medical care in custody is Exhibit 2 in these proceedings.

Mr Greenaway's PSA was tested on various occasions throughout 2014 in 2015 while he was in custody.

From December 2015, he began to receive frequent treatment at the Royal Prince of Wales Hospital for urinary symptoms including haematuria, cystitis, kidney stone removal and cystoscopy.

On 14 February 2016, Mr Greenaway underwent a CT scan at the Prince of Wales Hospital. The CT noted a mild to moderately enlarged prostate and noted that there were no lesions suspicious for metastases.

Diagnostic tests on 4 March 2016 revealed moderately large prostate lateral lobes with no obvious malignant lesions. Abdominal pelvic CT on 8 March 2016 showed no suspicious osteolysis lesions.

There followed a series of further, relatively frequent admissions to Prince of Wales Hospital in 2016 and 2017 for urinary symptoms.

On 13 October 2016 Mr Greenaway underwent a further CT of the upper abdomen and pelvis. That examination noted that there were no suspicious lesions.

In April 2017 a suspicious nodule was detected on Mr Greenaway's bladder, which was suspected to be a transitional cell-carcinoma.

He was reviewed 15 June 2017.

On 9 September 2017, sclerotic lesions were found upon CT scanning on the right proximal femur and right inferior pubis, which suggested bony metastasis from either the bladder lesion that was detected, and/or the prostate. It is noted that those bony lesions had not been present on CT's performed in March and October 2016. Mr Greenaway did not wish for there to be further investigation of the lesions.

The bony lesions appeared unchanged upon examination on 25 October 2017.

A non-resuscitation order was put in place on 30 December 2017 by the treating geriatrician upon Mr Greenaway's wishes.

Mr Greenaway began to receive palliative care from the Nelune Comprehensive Cancer Centre at the Prince of Wales Hospital on 5 April 2018.

On 26 April 2018, a bone scan was arranged, with clinicians noting that there was no hard evidence that prostate cancer had recurred, and that radiotherapy for the bony lesions was not indicated as it did not appear that Mr Greenaway was being caused significant pain or was at risk of fracture.

The results of a further bone scan on 3 May 2018 showed widespread osteoblastic metastases. On 14 May 2018 Mr Greenaway was commenced on androgen deprivation therapy for prostate cancer, and it was thought that palliative radiotherapy to symptomatic bony lesions may be beneficial. That therapy was carried out on 25 June 2018. Regular evaluation of Mr Greenaway's PSA in that time showed that it was kept in low level.

On 24 May 2018, Mr Greenaway was seen by a psychiatrist. He was noted to have accepted his cancer diagnosis and treatment and declined any further psychiatric review. He was noted as having presented as settled.

On 11 July 2018, a further CT scan of the upper abdomen and pelvis showed an increase in the size and density of the bony metastases.

On 7 November 2018, Mr Greenaway saw Dr Ingham at Prince of Wales Hospital Radiation Oncology. A diagnosis of high-risk prostate adenocarcinoma was noted, with progressive disease and widespread bony metastases.

It appears throughout 2019 Mr Greenaway received regular review by Prince of Wales Hospital Radiation Oncology and remained largely symptom-free. A palliative care review was conducted by Dr O'Keefe on 1 April 2019, when it was noted that Mr Greenaway's back pain with being well-controlled, particularly following the palliative radiotherapy to his right pelvis. It was noted that Mr Greenaway was continuing to be treated with androgen deprivation therapy and a plan was made for the community palliative team to continuously monitor Mr Greenaway's progress

On 6 November 2019, a review was conducted by Dr Chen at Prince of Wales Hospital. It noted that Mr Greenaway was reasonably well with no symptoms or signs to suggest prostate cancer progression and no bone pain. Mr Greenaway's PSA is noted to have risen to 3.6, with the suspicion that he developed castrate-resistant prostate cancer.

On 13 March 2020 a CT showed that Mr Greenaway's sclerotic lesions had significantly increased in size, with additional and large lymph nodes and nodules in the lung bases.

By 5 May 2020, Mr Greenaway's PSA had risen to 15.2. He was referred to Professor Goldstein for consideration of enzalutamide for management of castrate resistant prostate cancer.

On 10 May 2020, Mr Greenaway stated to nurses that he no longer wanted to be sent to hospital, but wanted to be kept comfortable at Long Bay.

On 28 May 2020 Mr Greenaway was admitted to Prince of Wales Hospital for removal of skin lesions on his cheeks, back and legs. This was the last time he received treatment in hospital.

From 5 June 2020, and consistent with his apparent wish for no further investigations or treatment, Mr Greenaway remained in custody at Longbow Hospital, receiving palliative care until his death on 17 August 2020.

Conclusion

The cause of Mr Greenaway's death is well documented.

An autopsy performed by Dr Elsie Berger on 26 August 2020 confirmed that the direct cause of Mr Greenaway's death to be the effects of metastatic prostate carcinoma. The post-mortem CT scan revealed widespread metastatic lesions in Mr Greenaway's body.

Having regard to the relevant records from Corrective Services New South Wales and Justice Health regarding Mr Greenaway's period in custody and the findings from the post mortem examination, it is evident that Mr Greenaway died as a result of a significant pre-existing natural disease process Dr Colin Chen, Staff Specialist in the Department of Radiation Oncology at Prince of Wales Hospital was involved in his treatment since 2018 and expressed the opinion that Mr Greenaway was managed with the best supportive care.

The medical records indicate that Mr Greenaway's illness was continually assessed and investigated. The re-emergence of his cancer was detected and though he initially refused further assessment and treatment in late 2017 he reconsidered that view and from early 2018 he received regular treatment in the form of hormone therapy and palliative radiation for his cancer by oncology specialists at Prince of Wales Hospital. His cancer had become castrate resistant by May 2020. It is evident that Mr Greenaway wished to receive only palliative care towards the end of his life and refused further admission to Prince of Wales Hospital, wishing to be made comfortable in Long Bay Hospital.

Dr Chen, radiation oncologists Prince of Wales Hospital provided a letter to this court noting that Mr Greenaway developed castrate resistant metastatic prostate cancer complicated by bladder outlet obstruction, which was a terminal condition. There is no evidence that his level of medical care during his period in custody was not adequate and appropriate. There is no evidence to suggest that any aspect of the care provided by Corrective Services New South Wales and Justice Health staff contributed in any way to his death

Findings: s 81 Coroners Act 2009

Identity
The person who died was Donald Victor Greenaway
Date of death
Mr Greenaway died on 17 August 2020
Place of death
Mr Greenaway died in Cell 9 of the Aged Care Ward at Long Bay Correctional Centre.
Cause of death
The cause of Mr Greenaway's death was metastatic prostate carcinoma
Manner of death
Mr Greenaway died from natural causes, whilst in lawful custody serving a sentence of imprisonment

39. 273670 of 2020

Inquest into the death of Jack King. Findings handed down by Deputy State Coroner Grahame at Lidcombe on the 17th November 2021.

Jack King was 77 years of age at the time of his death on 20 September 2020. He was serving a custodial sentence and was placed at Long Bay Prison Hospital within the Aged Care and Rehabilitation Ward. Mr King had been in NSW custody since he was bail refused on 2 July 2015. He had a long history of offending against children. Mr King was discovered unresponsive on 20 September 2020. He could not be revived. A post mortem examination was conducted on 24 September 2020. The forensic pathologist conducting the examination recorded the cause of death as "complications of metastatic squamous cell carcinoma, likely urothelial origin."

The role of the coroner is to make findings as to the identity of the nominated person, and in relation to the date and place of death. The coroner is also to address issues concerning the manner and cause of the person's death. In addition, the coroner may make recommendations, arising from the evidence, in relation to matters that may have the capacity to improve public health and safety in the future. In this case there is no dispute in relation to Mr King's identity, or to the date, place or medical cause of his death. Nevertheless, where a person dies in custody, it is mandatory that an inquest is held. The inquest must be conducted by a senior coroner. When a person is detained in custody the state is responsible for his or her safety and medical treatment. It is important to review all inmate deaths, including those which appear to have been naturally caused so that the community has confidence that each prisoner has received adequate and appropriate medical care. I note that the court was not notified of any potential issues with his care or treatment. Section 81 (1) of the *Coroners Act* 2009 NSW requires that when an inquest is held, the coroner must record in writing his or her findings in relation to the various aspects of the death. These are my findings in relation to the death of Jack King.

Scope of the inquest

The inquest took place on 17 November 2021. A comprehensive police brief was tendered including police statements, photographs and CCTV footage, as well as prison and medical records.

Background

Mr King was born on the 12 November 1942 in Fulham West in the United Kingdom. On the 24 September 1954, when Mr King was aged 11, he was admitted to care at the request of his father.
Mr King was transported to Sydney as a child migrant under the auspices of Barnados and arrived in Sydney on the 29 September 1955 at the age of twelve. He completed his secondary education at the Dr Barnardos Farm School, Mowbray Park, Picton NSW. After school he commenced working at a service station in Ryde. In 1971 Mr King met and married M and fathered two children with her, a son and daughter. In 1986 Mr King was charged with criminal offences in NSW but failed to appear before Redfern Local Court and a warrant was issued for his arrest.

Mr King left NSW and made his way to Western Australia without this warrant being executed. In Western Australia Mr King met and married J and fathered three children with her.

The court was informed that at the time of his death Mr King was estranged from his family. No family members wished to take part in the inquest process and no care or treatment issues were raised. As a result of further offences previously committed in NSW, he was extradited from Western Australia and on the 2 July 2015, after being bail refused, entered NSW Correctives Services custody. He was sentenced at the Downing Centre District Court on the 3 March 2017 to 15 years imprisonment with a non-parole period of 7 years 6 months, with the sentence commencing on the 2 July 2015.

Medical History

On the 17 July 2020, Mr King was taken from Junee Correctional Centre to Wagga Wagga Base Hospital/Rural Referral Hospital following routine blood tests that identified he had hyponatraemia and hyperkalaemia. At the time of admission, Mr King's medical conditions included dementia, osteoarthritis, gastric reflux and hypercholesterolemia. He denied feeling pain or recent urinary symptoms. Medical records indicate he was feeling well during this admission. Following the discovery of a mass during a renal ultrasound, Mr King underwent a CT IVP examination on the 20 July 2020, which identified numerous lesions around the right kidney and the liver. A further CT scan was conducted on the 21 July 2020. The findings were in keeping with bladder transitional cell carcinoma with upstream extension. The liver lesions were thought to be benign. On the 3 August 2020, an ultrasound guided biopsy was conducted. This biopsy resulted in a diagnosis of squamous cell carcinoma. Mr King was discharged from Wagga Wagga Base Hospital on the 3 August 2020, with the intention of him being transferred back to Junee Correctional Centre and potential transfer to Long Bay Correctional Centre for palliative care. The discharge summary from Wagga Wagga Base Hospital noted that given Mr King's social circumstances and dementia, treatment would likely be of a supportive/palliative nature. On the 13 August 2020, Mr King was transferred from Junee Correctional Centre to Wagga Wagga Base Hospital at the request of medical staff at Long Bay Correctional Centre.

This was to ensure adequate medical care prior to his transfer to Long Bay Hospital. During this admission at Wagga Wagga Base Hospital, he was assessed by both the urology and oncology teams and deemed to be appropriate for conservative palliative care management only. On the 17 August 2020, Mr King was transferred to Long Bay Hospital for palliative care management. On the 21 August 2020, Dr Hovey, a Senior Staff Specialist within the Department of Medical Oncology at Prince of Wales Hospital, saw Mr King. Mr King reported no pain and did not appear to be in distress. She advised that he was not suitable for any form of systemic therapy and recommended supportive palliative care for Mr King. Dr Urban saw Mr King on the 26 August 2020 and 9 September 2020 and concurred with Dr Hovey that Mr King was not suitable for systemic treatment due to his frailty and dementia.

Events leading up to his death

On the 20 September 2020, Mr King was housed within cell 11 of the Aged Care Rehabilitation Unit. He was cared for by nurses Francine Cullen and Pramila Ranjitkar. First Class Correctional Officer Ross Sparkes was assigned to that area.

On the morning of the 20 September 2020, Mr King was incontinent of faeces and Nurse Cullen had to shower and dress him. He was then placed in a recliner chair and moved to the dining area where he refused food but consumed a meal replacement drink. Mr King remained in the dining room until about 11:00 a.m., when he was placed back in his cell and into bed. About 12:30 p.m., Mr King was placed in the recliner chair and moved to the dining area. Mr King again refused to eat but consumed a meal replacement drink. He was placed in front of the television until being returned to his room at 2:30 p.m. He was left in the recliner chair before his television. Nurse Cullen undertook half-hour visual checks and observed movement in Mr King's limbs in these checks.About 4:00 p.m. Nurse Cullen did another round and detected the smell of faeces coming from the hallway where Mr King was housed. She identified the smell as coming from his cell and looking into the cell she saw him fidgeting.

Nurse Cullen requested assistance from Nurse Ranjitkar. Nurse Ranjitkar was about to commence a meal, so they agreed she would eat and then the two of them would change him. Nurse Cullen and Nurse Ranjitkar donned personal protective equipment prior to entering the cell, as Mr King has previously attempted to touch staff after defecating. Nurse Cullen looked into the cell and saw Mr King was not moving. She then collected a trolley of observational medical equipment and checked Mr King's heartbeat, pulse and blood pressure. She confirmed he was deceased. Nurse Cullen completed the life extinct form, recording the time of death as 4:30 p.m. Police reviewed CCTV showing the exterior hallway of Mr King's cell and no suspicious circumstances were identified. The "knock up" button located within the deceased's cell was confirmed to be operational. NSW Police conducted a full investigation including reviewing the available CCTV footage. There were no indications that Mr King's death was suspicious. Mr King's identity was confirmed by a nurse who had been caring for him. A post mortem examination was conducted by Doctor Rebecca Irvine at the Department of Forensic Medicine, Sydney on the 24 September 2020. Her findings were consistent with the medical records which were obtained.

Findings:

Identity: The person who died was Jack King

Date of death: He died on 20 September 2020

Place of death: He died at Long Bay Correctional Centre Hospital, Long Bay NSW - Aged Care Rehabilitation Unit (ACRU)

Cause of death: He died of complications of metastatic squamous cell carcinoma, likely urothelial origin.

Manner of death: He died of natural causes, in custody.

40. 334150 of 2021

Inquest into the death of Kevin Thomas Byrne.

Following advice received from NSW Police that a known person has been charged with an indictable offence in connection with this death, the Coroner suspended the inquest in accordance with *s 78 (1) (a) (i) of the Coroners Act 2009.* In accordance with *s 79 (3) of the Coroners Act 2009* the inquest cannot be resumed until the charge is finalised.

Summary of deaths in custody/police operations reported to the NSW State Coroner for which inquests are not yet completed as at 31 December 2021

No	File No.	Date of Death	Place of Death	Age	Circumstances
1	124745/15	27/04/15	Camden	43	Police Op
2	88742/16	21/03/16	Bradbury	36	Police Op
3	99958/17	02/04/17	Silverwater	32	In Custody
4	142803/17	09/05/17	Blacktown	20	In Custody
5	264782/17	30/08/17	Kelso	47	Police Op
6	371691/17	07/12/17	Parklea	37	In Custody
7	15711/18	15/01/18	Malabar	57	In Custody
8	28682/18	26/01/18	Maroubra	33	Police Op
9	46266/18	09/02/18	Westmead	55	In Custody
10	54603/18	15/02/18	Westmead	44	In Custody
11	60363/18	20/02/18	Goulburn	67	In Custody
12	136203/18	30/04/18	Randwick	44	In Custody
13	209734/18	07/07/18	Silverwater	30	In Custody
14	279370/18	11/09/18	Silverwater	48	In Custody
15	281398/18	12/09/18	Goulburn	43	In Custody
16	297261/18	27/09/18	Tweed Heads	22	Police Op
17	328285/18	25/10/18	Berkshire Park	30	In Custody
18	338690/18	03/11/18	Ryde	26	Police Op
19	400495/18	30/12/20	Tumbarumba	27	In Custody
20	2380/19	02/01/19	Wagga Wagga	60	In Custody
21	10495/19	10/01/19	Silverwater	43	In Custody
22	28070/19	25/01/19	Villawood	33	Detention Centre
23	70710/19	04/03/19	Villawood	26	Detention Centre
24	110322/19	08/04/19	Silverwater	39	In Custody

25	120612/19	13/04/19	Cessnock	57	In Custody
26	126969/19	21/04/19	Aldavilla	24	In Custody
27	146621/19	08/05/19	Silverwater	27	In Custody
28	159733/19	17/05/19	Garran (ACT)	70	In Custody
29	179888/19	09/06/19	Silverwater	55	In Custody
30	200952/19	25/06/19	Lithgow	44	In Custody
31	218076/19	12/07/19	Westmead	26	In Custody
32	221357/19	16/07/19	Randwick	53	In Custody
33	236119/19	29/07/19	Newcastle East	36	Police Op
34	239447/19	31/07/19	Taree	40	Police Op
35	248597/19	09/08/19	Parklea	59	In Custody
36	252231/19	13/08/19	Malabar	76	In Custody
37	256729/19	17/08/19	St Leonards	53	Police Op
38	258876/19	19/08/19	Glen Innes	40	In Custody
39	259359/19	19/08/19	Randwick	33	In Custody
40	269131/19	28/08/19	Malabar	33	In Custody
41	276007/19	03/09/19	Cessnock	37	In Custody
42	278264/19	05/06/19	Silverwater	42	In Custody
43	280398/19	08/09/19	Westmead	73	In Custody
44	281694/19	09/09/19	Randwick	54	In Custody
45	289826/19	16/09/19	Westmead	44	In Custody
46	289835/19	16/09/19	Malabar	42	In Custody
47	302386/19	26/09/19	Silverwater	55	In Custody
48	308934/19	02/10/19	Penrith	33	Police Op
49	324097/19	14/10/19	Wellington	27	In Custody
50	345858/19	01/11/19	Erina	45	Police Op
51	407715/19	28/12/19	Blacktown	60	In Custody
52	3733/20	02/01/20	Liverpool	36	Police Op
53	4795/20	05/01/20	Randwick	59	In Custody

54	7307/20	08/01/20	Newcastle	35	Police Op
55	10127/20	10/01/20	Malabar	52	In Custody
56	22402/20	19/01/20	Cessnock	28	In Custody
57	20808/20	20/01/20	Silverwater	59	In Custody
58	26597/20	26/01/20	Randwick	81	In Custody
59	26654/20	25/01/20	Malabar	70	In Custody
60	48323/20	12/02/20	Vaucluse	44	Police Op
61	80902/20	11/03/20	Malabar	43	In Custody
62	90781/20	20/03/20	Watsons Bay	41	Police Op
63	91972/20	23/03/20	New Lambton Heights	70	In Custody
64	94710/20	22/03/20	Yass	39	Police Op
65	100722/20	01/04/20	Randwick	31	In Custody
66	103021/20	02/04/20	Lithgow	59	In Custody
67	112521/20	13/04/20	Cessnock	67	In Custody
68	118749/20	20/04/20	Kogarah	51	Police Op
69	135219/20	05/05/20	Cesnnock	34	In Custody
70	137690/20	07/05/20	Berrima	51	Police Op
71	139754/20	10/05/20	Randwick	64	In Custody
72	188420/20	22/06/20	Marlee	17	Police Op
73	194015/20	30/06/20	Randwick	73	In Custody
74	225458/20	31/07/20	Darlinghurst	29	In Custody
75	231668/20	07/08/20	Watsons Bay	26	Police Op
76	232908/20	09/08/20	Silverwater	41	In Custody
77	235801/20	12/08/20	Parklea	24	In Custody
78	245234/20	21/08/20	Malabar	32	In Custody
79	257581/20	03/09/20	Silverwater	59	In Custody
80	257665/20	03/09/20	Junee	34	In Custody
81	268433/20	14/09/20	Cessnock	34	In Custody
82	277315/20	23/09/20	Kogarah	33	Police Op

83	277394/20	23/09/20	Silverwater	32	In Custody
84	279909/20	24/09/20	Parklea	32	In Custody
85	304043/20	22/10/20	New Lambton Heights	30	Police Op
86	305849/20	24/10/20	Randwick	50	In Custody
87	308509/20	27/10/20	Malabar	77	In Custody
88	343056/20	02/12/20	Malabar	76	In Custody
89	352738/20	12/12/20	Villawood	29	In Custody/Detention
90	2579/21	31/12/20	Bathurst	57	In Custody
91	4815/21	06/01/21	Nowra	37	In Custody
92	13852/21	17/01/21	Glebe	54	Police Op
93	18103/21	20/01/21	Parklea	88	In Custody
94	18276/21	20/01/21	Malabar	55	In Custody
95	23453/21	22/01/21	Bonnells Bay	50	Police Op
96	24674/21	27/01/21	Silverwater	35	In Custody
97	63278/21	04/03/21	Matraville	87	In Custody
98	60334/21	02/03/21	Chifley	33	In Custody
99	64779/21	05/03/21	Silverwater	44	In Custody
100	77932/21	18/03/21	Broken Hill	38	Police Op
101	81529/21	22/03/21	Dubbo	64	In Custody
102	87081/21	28/03/21	Malabar	57	In Custody
103	94740/21	05/04/21	Parklea	52	In Custody
104	118189/21	27/04/21	Cessnock	37	In Custody
105	144151/21	20/05/21	Gunnedah	27	Police Op
106	170411/21	13/06/21	Silverwater	25	In Custody
107	176671/21	18/06/21	Kogarah	30	Police Op
108	185025/21	25/06/21	Clifton	24	Police Op
109	196736/21	08/07/21	Malabar	43	In Custody
110	205817/21	18/07/21	Westmead	23	In Custody
111	207908/21	20/07/21	Mascot	27	Police Op

112	219730/21	29/07/21	Casino	27	Police Op
113	230432/21	10/08/21	Parklea	29	In Custody
114	248509/21	30/08/21	Malabar	85	In Custody
115	257730/21	08/09/21	Malabar	76	In Custody
116	259055/21	09/09/21	Berkshire Park	71	In Custody
117	261563/21	12/09/21	Malabar	82	In Custody
118	261655/21	11/09/21	Malabar	53	In Custody
119	263382/21	14/09/21	Kariong	48	In Custody
120	269301	17/09/21	Woollahra	35	Police Op
121	268412/21	19/09/21	Silverwater	41	In Custody
122	282930/21	03/10/21	Silverwater	36	In Custody
123	286536/21	07/10/21	Moree	22	Police Op
124	302441/21	23/10/21	Silverwater	35	In Custody
125	302513/21	23/10/21	Liverpool	31	In Custody
126	306257/21	26/10/21	Junee	48	In Custody
127	317032/21	06/11/21	Cessnock	26	In Custody
128	319041/21	09/11/21	Seven Hills	45	Police Op
129	339279/21	26/11/21	Malabar	70	In Custody
130	339043/21	28/11/21	Waterloo	42	In Custody
131	355435/21	14/12/21	Bradbury	48	Police Op
132	369343/21	29/12/21	Wellington	29	Police Op