STATE CORONER'S COURT OF NEW SOUTH WALES

Inquest:	**Inquest into the death of GB**
Hearing dates:	**21 May 2014**
Date of findings:	**21 May 2014**
Place of findings:	**State Coroner's Court, Glebe**
Findings of:	**Deputy State Coroner Hugh Dillon**
Catchwords:	**CORONIAL LAW – Death in custody** -- Cause and manner of death **–** Suicide -- Remand prisoner -- Not caused by systemic or human error.
File number:	**2011/390718**

Representation:	Sgt S Korneluk (Advocate Assisting coroner) Mr Singh (Justice Health) Ms Binning (Commissioner for Corrective Services)
Findings:	I find that GB died on 26 or 27 September 2011 at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales by asphyxiation due to hanging himself while on remand.
Non-publication orders:	Orders have been made under s 74 of the Coroners Act (see coronial file). Pursuant to s 75(5) I permit a report of these proceedings on condition that Mr GB not be identified except by the initials "GB".

IN THE STATE CORONER'S COURT
GLEBE
SECTION 81 CORONERS ACT 2009

REASONS FOR DECISION

Introduction

This is an inquest into the death of GB, a remand prisoner who died on the evening of 26-27 September 2011 at the Metropolitan Remand and Reception Centre after hanging himself in his cell. He had been refused bail in respect of a number of alleged offences.

Jurisdiction

His death was reported because it occurred in custody. An inquest is therefore mandatory under the provisions of s 23 of the Coroners Act.

Mr GB was a 38 year old man who had an extensive history of drug dependency and related criminal offences. At the time of his arrest he was using "ice" and behaving in erratic fashion. It seems that he had been using and dependant on drugs from the time he was about 18 years old. He came from a loving and caring family who made genuine and regular attempts to help him rehabilitate himself.

Role of the coroner

The coroner's role is that of investigator and fact-finder. The coroner's function is to follow the evidence in an attempt to identify a deceased person, when and where that person died, the physical cause of death and how that death came about. A coroner may also make recommendations relating to a particular death especially in relation issues of public health and safety.

Coroners have particular responsibilities under the Coroners Act to investigate deaths in custody. Prisoners are vulnerable, not only because they are deprived of their liberty and are under the power of the State, but because very many of them are mentally ill or drug-dependent or sick, sometimes all three of those things.

They have few advocates or protectors and are never likely to become popular in the wider community. The State owes them a duty of care and it is therefore necessary that Corrective Services and Justice Health be held accountable for their management of prisoners. In most cases, there will be little or no criticism but the scrutiny of an independent coronial system is a safeguard and an incentive to maintain appropriate and reasonable standards of care of those in custody.

The issues

In this case the primary issues are:

- the identity of the deceased person
- the date and place of Mr GB's death
- the cause of his death and
- the manner or circumstances of his death.

The case has been thoroughly investigated by officers of the NSW Police Force and the Department of Corrective Services. The facts have been clearly brought out and are uncontentious. There do not appear to be any systemic issues of significance that must be addressed by the Department.

The background

Mr GB was arrested on 12 September 2011 in Wollongong. He appeared in the Wollongong Local Court but was unable to meet bail conditions. He was then transferred to the MRRC.

He was assessed on his reception there by Justice Health staff. At that stage he was not assessed as being at risk. On 18 September he told another inmate that he wanted to kill himself. As a result, he was reassessed and placed in a 'safe cell' and was then managed for about a week by the Risk Intervention Team. He was also treated with diazepam to help calm him down as he was withdrawing from "ice". And he was prescribed methadone.

On 20 September he became involved in a violent altercation with prison staff. He was then placed on segregation as a disciplinary measure but this was postponed while he was still assessed as being 'at risk'. He was assessed again on 22 and 24 September and, as a result, remained under the management of the RIT. On 22 September he was served with a Court Attendance Notice in respect of a charge of Assault Occasioning Actual Bodily Harm in respect of the injury he had inflicted on the correctional officer on 20 September.

On 26 September Mr GB was once again assessed by the RIT. This time he appeared co-operative and was willing to engage with the team. He appeared more settled and was remorseful for his actions when under the influence of 'ice'. He denied suicidal ideation and guaranteed his own safety. The 'RIT' order was then lifted and he was placed on segregation as he no longer appeared to be at high risk of self-harm.

He was not administered diazepam on 26 September due to an oversight by a nurse but was given his methadone dose that afternoon. He was placed in a one-out cell.

At a little after 5am the following morning he was discovered hanging in his cell.

The officer who responded immediately, Senior Correctional Officer Kaiteli, did not follow the required protocol for dealing with attempted hangings and was not carrying the '911' tool was supposed to have on his person for the purpose of cutting ligatures. Nevertheless, whether or not SCO Kaiteli had followed protocol would have made no difference. Mr GB was beyond resuscitation by that time.

I note that internal disciplinary investigation has taken place and the Professional Standards Branch of the Department of Correctional Services is considering what action to take in respect of SCO Kaiteli. A recommendation from me is unnecessary in the circumstances.

Conclusion

It is not clear why Mr GB took his own life. He gave no obvious indication that he was planning to and appeared to regaining his mental equilibrium the day before he died.

Suicide is unpredictable. A number of studies of psychiatric patients have shown that there is a low statistical correlation of 'high risk' assessment and suicidal behaviour. Suicidal ideation, of itself, is not predictive of self-harm. Some suicides are planned well in advance; others are spontaneous. Mr GB left no notes or messages that reveal his thinking or plans to us or how he came to make his fatal decision.

The Department of Corrective Services has good protocols for managing prisoners at risk of self-harm and executed them appropriately in Mr GB's case. So too did Justice Health. The assessments appear to have been carried out conscientiously and cautiously and, based on the evidence available to the team, were reasonable and appropriate.

As well as being tragedy of life wasted and prematurely ended, Mr GB's death was also an agonising event for his family who continued to hope until his death that he may be able to change his life. The frustration and distress of a family who lose a young man in this way is difficult to imagine. I hope that they will accept my sincere and respectful condolences.

Findings s 81 Coroners Act 2009

I find that GB died on 26 or 27 September 2011 at the Metropolitan Remand and Reception Centre, Silverwater, New South Wales by asphyxiation due to hanging himself while on remand.

Magistrate Hugh Dillon
Deputy State Coroner for NSW