STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of Mandaswamy SHANKARANARAYANA**
Hearing dates:	**26-28 May 2014**
Date of findings:	**6 June 2014**
Place of findings:	**State Coroner's Court, Glebe**
Findings of:	**Deputy State Coroner HCB Dillon**
Catchwords:	**CORONIAL LAW** – Death in Custody -- Cause and manner of death **–** Suicide while on remand on homicide charge (see Inquest into death of Leoni Felix)
File number:	**2012/259122**

Representation:	Mr C McGorey (Counsel Assisting) instructed by Ms G Lewer (Crown Solicitor's Office) Mr J Downing instructed by Mr L Sara (Hicksons) for Justice Health Ms J Blackwell (Commissioner for Corrective Services) Mr L Grant (solicitor) (Dr Hearps) Ms K Doust (Nurses' Association) for RN Buldygin and RN Ake
Findings:	I find that **Mandaswamy SHANKARANARAYANA** died on 17 or 18 August 2012, taking his own life by hanging himself in his cell at the Metropolitan Special Programs Centre at the Long Bay Correctional Centre complex while on remand in respect of a homicide charge.

Recommendations:	***To the Ministers for Health and for Corrective Services***: 1. I recommend that, given the overlap of the psychological, mental health and medical disciplines (if a patient / inmate is to be treated holistically) these services to be managed by Justice Health. 2. Alternatively, I recommend that the current process of working towards developing guidelines for the sharing of patient information and an efficient system or method of sharing relevant patient information continue with all practical speed. 3. I also recommend that the working party or the two relevant departments consider the longer term issue of merging or transferring Corrective Services psychological staff into Justice Health. 4. I recommend that Justice Health nurses be required to have undergone suitable mental health training before they are permitted to conduct mental health assessments. 5. I recommend that decisions by Justice Health staff concerning Health Problem Notification Forms relating to 'green cards' not be made without access to all relevant patient records. 6. I recommend that where practicable a custodial patient who is being assessed psychologically or psychiatrically at intervals be assessed by the same clinician over that time to both build a therapeutic relationship with the patient but also to better comprehend any subtle (but significant) changes in the patient's mental status.

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

REASONS FOR DECISION

Introduction

This is an inquest into the death of Mandaswamy Shankaranarayana**.** He died on the night of 17 & 18 August 2012 at the Metropolitan Special Programs Centre, part of the Long Bay Correctional Centre complex, by hanging himself in his cell while on remand in respect of a charge of alleged murder of his wife, Leoni Felix. (An inquest into her death has been held concurrently with this one.)

Jurisdiction

Under the Coroners Act 2009, an inquest is required to be held into any death that occurs in custody.

Mandaswamy Shankaranarayana

Mr Shankaranarayana was a 40 year old man who was born in India to a Catholic family and who migrated to Australia in 2004 with his wife Leoni Chandrika Felix and their son Deon. The marriage was arranged in the Indian custom. By January 2012, it appears that the relationship was an unhappy one.

Mr Shankaranarayana was an intelligent man of quiet and modest disposition who worked as a toolmaker. The death of his wife and his arrest for her murder shocked those who knew him because it seemed so out of character for him to act in such a violent fashion. He had, however, during course of his marriage, occasionally used physical violence towards her. On a couple of occasions police were called, although no further action was taken.

Shortly after the alleged murder, Mr Shankaranarayana attempted suicide by lacerating his throat and wrist. For several months before his death in custody, he was assessed and treated as a person at risk of self-harm. By the time of his death, however, the risk of self-harm had apparently dissipated. His suicide occurred just before his son Deon was to be sent to back India to be cared for by the extended Felix family.

Mr Shankaranarayana had no known history of previous mental illness.

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 a special responsibility in relation to deaths in custody. Prisoners not only lose their liberty but are vulnerable to the power of the state. They are often vulnerable as well due to mental illness, physical illness or social disadvantage. Prisoners have few champions or advocates. Yet the state owes them a duty of care. One of the ways that the state ensures that its agents fulfil their responsibilities to people in custody is by having a coroner – an independent judicial officer – investigate deaths that occur in custody and holding a public inquest – an independent judicial inquiry – into those deaths.

Inquests are not criminal trials but independent judicial investigations. In most cases, few criticisms will be made of the agencies charged with managing prisoners. Sometimes, however, systems fail, or are found to be defective or imperfect in some respect. People occasionally make mistakes or behave unprofessionally. If so, coroners will attempt to identify what went wrong and why and recommend changes. In this case, I do not expect to make criticisms of individual staff but I propose to make some recommendations concerning systems that were set up to care for Mr Shankaranarayana and his fellow inmates.

The issues

The Coroners Act requires me to make findings as to:

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

In this case, the question of the manner and circumstances of Mr Shankaranarayana's death raises a number of issues that have been examined during this inquest:

1. Did any of the decisions made by Justice Health contribute to Mr Shankaranarayana's death? In particular:

a) What process did Justice Health undertake to recommend that Mr Shankaranarayana was fit for "normal cell placement"? And was that process a reasonable one?

b) Was Justice Health's decision on 8 August 2012 to recommend that Mr Shankaranarayana was fit for "normal cell placement" a reasonable decision?

c) What did Justice Health understand would result from recommending that Mr Shankaranarayana was fit for "normal cell placement"

d) Was there an appropriate system of communication between Justice Health and NSW Department of Corrective Services?

2. Did any of the conduct of the Justice Health nurses who attended Mr Shankaranarayana when he was discovered contribute to his death? In particular:

a) Did the nurses have the appropriate expertise to render aid to Mr Shankaranarayana (including use of the defibrillator)?

b) Had the nurses received adequate training in resuscitation and attending prisoners after self-harm attempts?

3. Did any decisions made by the NSW Department of Corrective Services contribute to Mr Shankaranarayana's death? In particular:

a) Should Mr Shankaranarayana have been placed in a cell with hanging points?

The background

Mr Shankaranarayana was arrested on 16 January 2012 and bail was refused. He remained in custody on remand from that time until his death in August that year.

His mental state was first assessed by Justice Health when he was taken into Corrective Services custody on 19 January 2012. Due to his self-inflicted injuries and other evidence, he was assessed as being at risk of self-harm and was placed in a 'safe cell' pending further assessment by the Risk Assessment Intervention Team (RAIT) clearing him for 'normal' cell placement.

The RAIT is a multi-disciplinary team made up of a mental health nurse, a psychologist and a Corrective Services officer. They seek to determine whether an inmate is at risk of self-harm and, if he or she is found to be, to make suitable arrangements for accommodation of that person.

In making their assessments, RAIT teams have access to both Corrective Services and Justice Health records. (Justice Health is a branch of the NSW Health Department and, for patient privacy reasons, keeps separate records.)

If the RAIT determines that an inmate has a mental health problem, it typically refers the inmate to a mental health nurse or psychiatrist for ongoing assessment or treatment[1].

The RAIT will formulate a RAIT Management Plan for the Inmate, which is to be counter-signed by all three members. The Justice Health representative at each review might also complete a Health Problem Notification Form ('HPNF').

The ultimate decisions concerning cell placement, however, are the province of Corrective Services, not Justice Health. An inmate's cell placement is determined by Corrective Services having regard to the recommendations made by Justice Health on an

[1] Wood tab 30 [10].

HPNF. Corrective Services is required to act upon HPNF recommendations unless there are overriding security concerns justify otherwise.

Mr Shankaranarayana was regularly assessed by RAIT teams during January 2012. By the end of January, he was assessed as being suitable for normal gaol routine and case management. Although the risk of self-harm was seen to have reduced, he was categorised as an inmate who must be placed 'two-out' until further notice. A 'green card' was issued.

A 'green card' is a card placed in a slot outside an inmate's cell identifying him as a person who must be accommodated 'two-out' for safety – usually medical -- reasons. (A cell-mate can raise the 'knock-up' alarm if the inmate becomes ill or threatens to do something harmful to himself. The cell-mate may also be a companion or 'buddy' for the inmate on the 'green card'.)

Mr Shankaranarayana was reviewed by a psychiatrist, Dr Russell Cook, in February 2012. He exhibited no signs of major depression or other significant mental illness. During February he was further assessed by a psychologist who found that he did not need intense psychological support or treatment.

On 30 March 2012, Mr Shankaranarayana had the misfortune to see his cellmate hanging in their cell. He was moved to another wing, again under 'green card' conditions and was referred to a psychologist. He was seen by a psychologist a number of times in April and June 2012 as a result of this incident.

One of the disadvantages for an inmate on a 'green card' placement is that every time a cellmate is moved, he has to be moved to a cell with another person. For outsiders, this may appear to be a relatively minor annoyance but for prisoners it is assumes considerable significance. It is highly disruptive for the person involved and many prisoners are anxious to be placed in a cell by themselves. In June, Mr Shankaranarayana requested that he be taken off 'green card' conditions for this reason. The request was referred to Justice Health.

During his time in Long Bay, Mr Shankaranarayana came to be regarded by prison staff as a useful member of the wing community because of his fluency in Bahasa Indonesia. Although he was born in India, he had lived in Indonesia for six years. A number of Indonesian prisoners were housed in the wing and he became an informal interpreter. Staff regarded him as quiet, polite and respectful of staff and inmates.

On 8 August, Enrolled Nurse Donald Standring met Mr Shankaranarayana in response to the 'green card' request Mr Shankaranarayana had made.

Although not formally employed as a full-time mental health nurse, EN Standring had spent the last three years working in mental health environments within prisons. In the course of his employment he had undertaken mental health training with Justice Health.

EN Standring completed a HPNF that same day, which recorded "*Hx suicide attempt when first in gaol…Good future orientation mixing well…Coping well in gaol"* and that MS suitable for "*Normal cell placement"*. EN Standring noted in the Justice Health's clinical notes that "*DC state nil management issues and if made NCP* [normal cell placement] *will*

keep him two out". The noted plan included "*NCP states seeing psychology inform DSC of Hx officer* [?] *13 wing encourage psychology follow up + Chaplin R/V by psychiatrist file…"*[2]

Corrective Services did not have access to the Justice Health's clinical notes. The HPNF constituted Justice Health's formal communication to Corrective Services concerning its assessment and recommendation.

Following receipt of the HPNF dated 8 August 2012, Corrective Services proceeded on the basis that Mr Shankaranarayana's green card could be lifted. He was moved from a two-out cell on 15 August 2012. Prior to that date Mr Shankaranarayana had been placed in the cell with Amerudin Hasan, an Indonesian inmate.

Mr Hasan gave evidence at the inquest that Mr Shankaranarayana was unhappy in gaol. At one point, Mr Shankaranarayana said to Mr Hasan that, whereas Mr Hasan would be out of gaol in a few years, he was looking at 25 years in gaol and did not want to live. He also complained that life in gaol was the life of a dog. He also said that after Mr Shankaranarayana went one-out they had remained in cells side by side and had communicated by knocking on the wall. Mr Hasan said that this was just to make sure that Mr Shankaranarayana was all right.

After he was arrested, arrangements were made for Mr Shankaranarayana's son Deon to be sent to India to be cared for by Ms Felix's family. Deon was to leave on 20 August. Mr Shankaranarayana's brother was to bring Deon to the gaol for a visit on Sunday 19 August. In a telephone conversation a few days before the planned visit, Mr Shankaranarayana told Deon to pray for him, to 'be good' and that 'everything will be fine'.

Mr Shankaranarayana and the other inmates were 'locked down' at 2.30pm on 17 August. After this Mr Shankaranarayana was not seen again alive. Mr Hasan gave evidence that shortly after the lock-down, he had tapped on the wall and had received no response from Mr Shankaranarayana. He said that he had again knocked on the wall later that night but again had heard nothing back. He said that he was concerned then about Mr Shankaranarayana but he did not speak English and could not communicate with the prison staff.

The next morning, at approximately 7.20am, during a head count by prison staff, Mr Shankaranarayana was found by Correctional Officer Moore hanging in his cell. He had used a strip of cloth torn from a sheet as a ligature. He immediately raised the alarm. Other officers responded straight away. Mr Shankaranarayana was cut down and placed on the floor of his cell. Senior Correctional Officer Hampton commenced CPR and alternated from time to time with other officers. Justice Health nurses working in the clinic on the ground floor were summoned and brought emergency equipment. An ambulance was called. Officers kept up CPR until the paramedics arrived on the scene and took over.

The nurses who attended were Dmitry Buldygin, who was a recent nursing graduate, and Ms Merelita Ake, an experienced nurse but who was in the gaol only as a casual agency nurse. Neither nurse knew what the emergency was and were shocked that they

[2]JH Clinical Note 8/8/12, clinical correspondence tab 55.

had been called to attend to a man who had hanged himself. Mr Buldygin had not had to attend to an unconscious person before and had not used a defibrillator except on a dummy in training. Ms Ake had not used a defibrillator before either except in training.

Correctional officers gave evidence that both nurses appeared flustered and had had to be given instructions by them. (Officers are all trained in first aid.)

Mr Buldygin administered oxygen and then, apparently at the prompting of officers, used the defibrillator. Mr Buldygin thought he could feel a very faint pulse but no other witness who attempted to feel for one did. The defibrillator detected no heart rhythm.

When the paramedics arrived, they examined Mr Shankaranarayana and found him to be cyanosed and unresponsive supine on the cell floor. No pulse or breathing was detected. They attached a defibrillator and observed him to be asystole (ie, there was no cardiac output – he had 'flatlined'). They pronounced him dead. At 7:50 am all persons exited the cell and it was double-locked to preserve the death scene for police investigators.

A team of police investigators arrived soon afterwards under the supervision of Detective Inspector Natasha Fairfax. They tested the 'knock-up' system in the cell. It was operational. Mr Shankaranarayana had not used it or made any call for assistance from the time he was locked down.

Did any of the decisions made by Justice Health contribute to Mr Shankaranarayana's death?

Suicide is unpredictable and suicide risk assessment is an uncertain 'science' in mental health. Some suicides are impulsive, others are pre-meditated but take place shortly after the plan is first conceived, and still others are carefully planned over time. In my view, there were genuine and reasonable attempts made by both Justice Health and Corrective Services to protect Mr Shankaranarayana from self-harm.

Mr Shankaranarayana did not leave a note or record of his reasons for taking his own life. But it is clear that he was remorseful for killing his wife Leoni Felix, intelligent enough to realise that he had no absolute defence and would, at the very least, spend many years in gaol and, finally, that he would very soon lose his son to his wife's family in India, perhaps never to hear from him again. He must also have realised that his son had learned or would learn that his father had killed his mother. Atonement and reconciliation would be difficult if not impossible in such a relationship. Mr Shankaranarayana had few real friends in gaol and was intelligent enough to foresee a long period of desolation and loneliness in prison. Against that background he took his own life.

Yet Mr Shankaranarayana was able at least on a superficial level to hide disguise his true thinking from those who managed him in gaol. Only to Mr Hasan does he appear to have revealed his mind. But he did not tell even Mr Hasan of any plans he had for terminating his life.

Although, in my view, it would be preferable for decisions such as those taken by Mr Standring to recommend normal cell placement for Mr Shankaranarayana to be taken

by a multi-disciplinary team, such as a RAIT team or a RIT team, Justice Health cannot be criticised for its incapacity to read Mr Shankaranarayana's mind or predict his plan. The risk assessment process may have been correct, and later confounded by an impulsive action on Mr Shankaranarayana's part, or Mr Shankaranarayana may have deliberately set out to confound the process by dissembling about his true intentions concerning self-harm.

Was there an appropriate system of communication between Justice Health and NSW Department of Corrective Services?

The most significant systemic issue this case (and others like it) raises is whether the correctional system (in the broad sense) as currently designed allows for the optimal management of prisoners at risk or who may be at risk. It has a number of very good features, the RAIT process (with all it entails, such as safe cells and multi-disciplinary assessment) being a prime example.

Nevertheless, once an inmate is assessed through the RAIT process as no longer being at high risk of self-harm, the ability of correctional officers and Justice Health clinicians to share information relevant to decisions such as whether a prisoner is at risk or frank in disclosing relevant risk factors is limited.

If a system for managing the mental health of prisoners was to be designed from the ground up, it is doubtful that it would have psychiatry being practised by Justice Health and psychology by Corrective Services in respect of the same inmate. Health records (or records relevant to health assessment, including mental health) ought, it seems to me, be available to the clinicians making the relevant decisions. It is a fundamental principle of medicine that good diagnosis and good treatment starts with a good history. If relevant parts of an inmate's history are not available to, or not easily accessible by, clinicians this creates a risk that diagnosis and treatment will not reach the optimal level.

It is common knowledge that large numbers of prisoners are mentally ill and medically sick or both. The care and management of this vulnerable (and chronically ill) population ought to be made as efficient as possible for those who have responsibility for delivering health care in the prison system.

Did any of the conduct of the Justice Health nurses who attended Mr Shankaranarayana when he was discovered contribute to his death?

Although it cannot be said with absolute certitude that Mr Shankaranarayana was no longer alive when he was attended by the Justice Health nurses, it appears to me that it is highly likely that he was either dead or beyond resuscitation when they arrived. Nothing they did or did not do appears to have contributed to Mr Shankaranarayana's death.

The only witness who thought he had felt a pulse was Mr Buldygin. Mr Buldygin frankly admitted that he had been shocked and became very anxious when he saw the officers administering CPR to Mr Shankaranarayana. Mr Shankaranarayana was assessed as being centrally warm but peripherally cold by those who first attended his

cell. When the paramedics arrived they found him asystole and cyanosed, despite CPR, oxygen and defibrillation being administered. Mr Shankaranarayana's circulatory system was not functioning.

CPR and oxygen were applied almost immediately to Mr Shankaranarayana upon his discovery. He showed no signs of life in the 20 or so minutes before the paramedics arrived.

Although evidence was not given of this fact during the inquest, I am informed by forensic pathologists that a person who hangs him- or herself can lose conscious within seconds and that the circulation can stop in as little as 30 seconds. Only a few minutes are available thereafter before irreparable and ultimately fatal hypoxic brain damage is inflicted.

Did the nurses have the appropriate expertise to render aid to Mr Shankaranarayana (including use of the defibrillator)?

The nurses had the appropriate training but no practical experience in using defibrillators to resuscitate living patients. Although it appears that, due to his inexperience, Mr Buldygin was initially in shock and in some difficulty performing his duties he was able to perform his duties when prompted. Fortunately, the correctional officers were more than capable at first aid and were able to assist him. Mr Buldygin no longer works for Justice Health. Ms Ake is an agency nurse.

Evidence was given that Justice Health nurses are given a relatively intense induction but it is, naturally, very difficult if not impossible to prepare a nurse psychologically to treat a hanged person for the first time. I make no criticism of either Mr Buldygin or Ms Ake for their performance.

Did any decisions made by the NSW Department of Corrective Services contribute to Mr Shankaranarayana's death?

I do not believe that decisions made by Corrective Services contributed to Mr Shankaranarayana's death. I am aware from this and other inquests that an extensive program designed to reduce risk from hanging points have been underway in NSW prisons for some years. It is unnecessary to comment further on that subject.

The real question is whether it was reasonable to place Mr Shankaranarayana in a one-out cell. In the light of the evidence available at the time, the decision seems to me to have been reasonable. Mr Shankaranarayana appeared to have stabilised psychologically in prison. He reported that he was psychologically quite well (although, unsurprisingly, like most prisoners) he had a low level of depression. He was well-regarded by staff and other inmates, he had a son whom he loved and he had been in the gaol for several months without further attempts at self-harm.

A prisoner who is kept 'two-out' is constantly inconvenienced by the need to be moved around cells. He or she rarely enjoys any privacy. Given Mr Shankaranarayana's good behaviour, his helpfulness to the staff and other inmates as an interpreter, and his

mental health assessment, it was appropriate to grant his request for a single-cell placement.

Improvements in the system: recommendations

Although there are arrangements or systems that theoretically enable some sharing of patient information between Corrective Services staff and Justice Health staff, in practice this is not routine.

For obvious privacy reasons, and perhaps for other administrative reasons, information is not easily passed from one organisation to the other. Of course, not all prisoner information held by Corrective Services is relevant to Justice Health and vice versa.

It is often remarked that our prisons are the 'psychiatric hospitals of the 21st century'. So, to an onlooker, it appears strange that information relating to the mental health of prisoners is frequently obtained by Corrective Services staff psychologists but this information does not appear to be routinely shared or passed on to Justice Health.

Indeed, although there may be very good reasons for the psychologists to be employed and managed by Corrective Services, it is not obvious to me what those reasons are. Given the overlap of the psychological, mental health and medical disciplines (if a patient / inmate is to be treated holistically) it would seem be more efficient for all these services to be managed by Justice Health. Both Dr Gerald Chew, Clinical Director of the Custodial Mental Health Service in NSW, and Dr Danny Sullivan, a forensic psychiatrist at the Victorian Institute of Forensic Medicine, commented during the inquest that ideally mental health services ought be managed in a unitary fashion.

During this inquest, I was informed that together Corrective Services and NSW Health are considering this issue and how best to approach the complex mental health issues involved in managing the prison population, many of whom bring with them into custody an array of psychological, psychiatric and physical pathologies and disorders.

I recommend that this process continue with all practical speed to develop guidelines and an efficient system or method of sharing relevant patient information. I also recommend that the working party or the two relevant departments consider the longer term issue of merging or transferring Corrective Services psychological staff into Justice Health.

Second, while I imply no criticism of the nurse involved, it does not appear appropriate to me that an Enrolled Nurse without specialist mental health training should be placed in the position of having to conduct mental health assessments as happened in this case. For such assessments to be conducted without access to all relevant patient records appears to be both poor professional practice and potentially unsafe. I was informed that staff shortages are a chronic problem for Justice Health. This makes adoption of any recommendation I make more difficult no doubt. The problem may be addressed by implementing in-house mental health training for Justice Health nurses or by seconding Justice Health nurses to psychiatric units for a period of training.

Third, Dr Sullivan observed in one of his independent expert reports that it is generally preferable that a patient who is being assessed at intervals be assessed by the same

psychologist [or clinician] over that time. This would enable the clinician to both build a therapeutic relationship with the patient but also to better comprehend any subtle (but significant) changes in the patient's mental status.

Conclusion

The death of Mr Shankaranarayana is in itself a most unfortunate event. We can only speculate about why Mr Shankaranarayana killed Leoni Felix. But he had eight months to contemplate the magnitude of his crime and to consider the damage he had done to her and others, the shame he had brought on himself and his family and the long separation, perhaps for life, he would suffer from his son. It seems that he concluded that the enormity of these things was more than life was worth.

It also compounds the tragedy of the death of his ex-wife Leoni Felix. For both families, these deaths have brought desolation and confusion. Mr Shankaranarayana's death has deprived his son of a father, his parents of a son and Ms Felix's family of a trial according to law.

Findings s 81 Coroners Act 2009

I find that **Mandaswamy SHANKARANARAYANA** died on 17 or 18 August 2012, taking his own life by hanging himself in his cell at the Metropolitan Special Programs Centre at the Long Bay Correctional Centre complex while on remand in respect of a homicide charge.

Recommendations s 82 Coroners Act 2009

To the Ministers for Health and for Corrective Services:

1. I recommend that, given the overlap of the psychological, mental health and medical disciplines (if a patient / inmate is to be treated holistically) these services to be managed by Justice Health.

2. Alternatively, I recommend that the current process of working towards developing guidelines for the sharing of patient information and an efficient system or method of sharing relevant patient information continue with all practical speed.

3. I also recommend that the working party or the two relevant departments consider the longer term issue of merging or transferring Corrective Services psychological staff into Justice Health.

4. I recommend that Justice Health nurses be required to have undergone suitable mental health training before they are permitted to conduct mental health assessments.

5. I recommend that decisions by Justice Health staff concerning Health Problem Notification Forms relating to 'green cards' not be made without access to all relevant patient records.

6. I recommend that where practicable a custodial patient who is being assessed psychologically or psychiatrically at intervals be assessed by the same clinician over that time to both build a therapeutic relationship with the patient but also to better comprehend any subtle (but significant) changes in the patient's mental status.

Magistrate Hugh Dillon
Deputy State Coroner for NSW