STATE CORONER'S COURT

OF NEW SOUTH WALES

Inquest:	**Inquest into the death of W**
Hearing dates:	4 December 2014, 19-21 August 2015, 29-30 October 2015
Date of findings:	11 November 2015
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Sharon Freund, Deputy State Coroner
File numbers:	2011/389486
Findings:	I Find that W Junior died on 15 May 2011 in Cell 247 in the Ebenezer Unit of the John Morony Correctional Centre by hanging whilst suffering an acute mental illness most likely a first episode delusionary psychosis, after taking steps to take his own life.
Recommendations:	To: The Chief Executive Justice Health & Forensic Mental Health Network: I recommend that: 1. When there is a handover of patient care, a note of that handover should be recorded in the patient's case file; 2. In the event that there is no opportunity for direct handover from clinician to clinician (e.g. a gap of a day or more), the patient should be recorded on the incoming clinician's Patient Administration System (PAS) waiting list as an appointment, as part of the handover; 3. The current Policy 1.360, Continuum of Care, Segregated Custody, be amended to make it clear and unambiguous that it also applies to directions for protective custody; and 4. There be education of nurses in their obligations under the Justice Health segregated custody policy (applying the current Crimes (Administration of Sentencing) Regulation 2014 clause 289) as to the scope of the duty required, including making a record of the observations, when seeing protective custody inmates. 5. That consideration be given to the use of telehealth as an emergency measure for psychiatric review in situations where a psychiatric review is urgently required and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU waitlist before the patient is transferred and admitted To: The Commissioner Corrective Services NSW, Department of Justice: I recommend that based on the fact that the regulations require Justice Health to monitor inmates subject to protected custody and segregated custody directions, a revision be made of current Corrective Services NSW, Section 14, Segregated and Protective Custody policy (Exhibit 1, Volume 6 Tab 73, attachment 7) at clauses

	14.7.4 and 14.7.7 to ensure that the requirement to notify Justice Health of a direction is included. To: Both The Commissioner of Corrective Services NSW, Department of Justice and The Chief Executive ofJustice Health and Forensic Medicine Health Service: I recommend consideration be given to whether a revision should be made to the OIMS system to include notification to Justice Health in the form of an alert (via the Justice Health PAS system) of a protective custody or segregated custody or confinement direction, when it is made.
Order:	Non-publication order made pursuant to section 75 of the *Coroners Act 2009* in relation to the name of W.
Catchwords:	CORONIAL LAW – Death in Custody, Hanging death, Adequacy of mental health services; Segregation order; Order for Protective Custody.
Representation:	Mr P Aitken instructed by Ms J Geddes Crown Solicitor's Office as Counsel Assisting; Mr J Brock, solicitor Legal Aid Commission for Mr W senior; Mr P Griffin SC instructed by Ms J Blackwell for the Commissioner of Corrective Services; Mr P Rooney instructed by Mr L Sara for Justice Health and Forensic Mental Health Network; Ms K Bourke instructed by Ms K Donnelly for Dr A Martin; Ms P Kava, solicitor for Christine Muller; Ms P Robertson, solicitor for Nurse Kathryn Austin and Nurse Alan Curtin; Dr P Dwyer instructed by Ms N Evans for Ms F Houshmand;

FINDINGS

Introduction

1. This is an inquest into the death of W, who was 23 years old when he passed away in the late evening of 15 May 2011, after he was found hanging whilst in custody in his cell at the Ebenezer unit of the John Morony Correctional Centre, Berkshire Park, in outer Sydney.
2. As W's death occurred whilst he was in custody, this is a mandatory inquest pursuant to section 23 and 27(1)(b) of the *Coroners Act 2009*.
3. W is survived by his parents W senior and J and older sisters H and S. His unexpected death has left a massive hole in their lives and it is clear from the five days of this inquest that his parents loved him dearly. He was on all accounts an exceptional young man, who had a promising future and who at the time of his death was trying to turn his life around.

The function of the Coroner and the purpose of this inquest

4. The role of a Coroner as set out in s. 81 of the Coroners Act 2009 ("**the Act**") is to make findings as to:
    a) the identity of the deceased;
    b) the date and place of a person's death;
    c) the physical or medical cause of death; and
    d) the manner of death, in other words, the circumstances surrounding the death.
5. A coroner, pursuant to s.82 of the Act, also has the power to make recommendations, including concerning any public health or safety issues arising out of the death in question.
6. It is convenient to note at this juncture the comments of the then State Coroner, Derek Hand, in the *Inquest into the Thredbo Landslide* at p.10[1]:

    "The inquest plays an important function as a fact finding exercise, essential to investigate and answer the relatives' and public's need to know the cause of death

[1] 19 June 2000, unreported

free from the constraints of inter partes litigation. It does not apportion guilt. Although not expressly prohibited by the Act, it is not the function of the inquest to determine any question of civil, let alone, criminal liability."

7. Similar observations were made by his Honour Justice Hedigan in *Chief Commissioner of Police v Hallenstein*[2]*.*

8. In relation to Ws death his identity, place, date and direct cause of his death are not in issue. This inquest has principally focused on the manner and the surrounding circumstances of his death in particular examining the events which occurred in the weeks and days leading up to 15 May 2011. These issues evolved and had to be expanded upon, as the inquest proceeded and included:

   a) Was W presenting with acute symptoms of a mental illness as at 20 April 2011?

   b) Should W have been placed in a "one out" cell on 27 April 2011, after he clearly expressed suicidal ideation at the RIT review on 20 April 2011?

   c) Was W appropriately supervised once he was placed in protection in a one-out cell?

   d) Should more have been done once W had been waitlisted for the Mental Health Screening Unit ("**MHSU**") on 2 May 2011?

   e) Should W have been prescribed an anti-psychotic drug such as Olanzapine on 2 May 2011?

   f) Was there a proper clinical handover between clinical staff in April-May 2011 (and in particular on 9 May 2011)?

   g) Was W advised of the fact that he had been refused parole?

   h) Were there any deficiencies in the investigation of W's death?

   i) Are there any recommendations arising from W's death?

   I shall deal with each of these issues in turn.

Background

9. W Junior was born 22 October 1987. He was the youngest child and only son of W Snr and J.

[2] [1996] 2 VR 1 at [15];

10. The evidence indicates that W, an average student, completed fifth form at Papaakura High School in New Zealand, however he excelled at the arts, including singing and was an extremely talented sportsman, having played at a junior representative level in both Rugby League and Rugby Union.

11. W was over 6 foot 7 inches tall and as a result of his size and physical stature was the target of local gangs who sought his support. From about the age of 18 he was regularly using cannabis and amphetamines. Accordingly in September 2008, when he was 21 years old, his parents moved W to Sydney to stay with family, in an attempt to get him away from these bad influences. W's childhood sweetheart, VL, remained in New Zealand to finish her university studies but intended to move to Australia to be with him once her studies were completed.

12. On Friday 26 September 2008, W and his cousin Hayden Tewao attended the Greystanes Inn in Merrylands. During the course of that night they were involved in an altercation with another patron whom they assaulted and then stole $300 from him. They were both charged with aggravated robbery and related offences and made full admissions.

13. Initially W was denied bail by police however, on 26 November 2008, W was granted conditional bail.

14. Thereafter W committed a number of offences while on bail including:

    a) shoplifting;

    b) special category driver drive with special range PCA; and

    c) malicious damage;

    all the above offences were committed on different days but notably occurred when W was intoxicated.

15. On 13 May 2010, W appeared in the District Court in Campbelltown and was sentenced to a term of imprisonment of 3 years and 6 months commencing on 5 November 2009 and concluding on 4 May 2013, with a non-parole period of 18 months. Accordingly, his earliest possible release date was 4 May 2011.

16. On 19 November 2010, as a result of his conviction for the aggravated robbery offence, the Department of Immigration and Citizenship advised W that he was liable for visa cancellation.

17. On 21 February 2011, W's visa was cancelled. As a result of the cancellation of his visa, W was advised that upon his release from custody, he would be taken to immigration detention and deported. W appealed this decision with the support of his parents.

18. The evidence indicates that up until April 2011, W did not exhibit any signs of self-harm or mental illness. These records included a psychological assessment conducted in November 2009 and further similar assessments in May 2010 and February 2011.

19. In March 2011, W was transferred from the Oberon Correctional Centre to John Morony Correctional Centre. Three weeks later, on 23 March 2011, his interstate transfer request (to be closer to his family in Victoria) was refused due to uncertainty over his immigration status.

20. On 3 May 2011, W successfully argued his appeal regarding the cancellation of his Visa. His father attended this appeal hearing in support.

21. On 14 April 2011, the State Parole Authority refused W's parole due to issues with post-release accommodation. A review was scheduled for 12 May 2011.

22. On 20 April 2011, W told drug and alcohol counsellor Rita Vella that:

> "I need a phone call to my mother. I need to talk to her about something personal and if I get sent back to the yard or my cell I'm going to hang myself"[3]

23. As a result of his expression of self-harm, staff placed him in a safe cell and arranged for the Risk Intervention Team ("**RIT Team**") to assess him. The RIT team comprised of Senior Assistant Superintendent, Cheryl Waters, acting Nurse Unit Manager Robyn Lloyd and psychologist Farrah Houshmand. It was the evidence of Ms Houshmand that:

> "W during interview presented as tearful and emotional and initially was uncooperative and occasionally was reluctant to respond to some of the questions regarding his mental status at the time, however, as the RIT proceeded he become more honest and open regarding his self-harm/ suicidal thought. For example he repeatedly stated: "I am stressed out because I don't know how to handle and deal with my father upon

[3] Exhibit 1, Volume 1, Tab 7 - Statement of Rita Vella dated 7 February 2013 at paragraph 6;

release". He also stated that "my father had an affair with my ex-girlfriend, my father has a very negative attitude and he is very difficult man to deal with, I cannot trust my father anymore and I feel hopeless and helpless about his uncaring attitude".[4]

24. The RIT team on 20 April 2011 recommended that W:

a) remain on RIT for review on 21 April 2011;

b) be accommodated in a safe cell for 24 hours; and

c) be referred to the Clinic NUM and to the psychologists on Wednesday..[5]

25. On 21 April 2011, the following day, W again met with the RIT Team for review. On this occasion the RIT was constituted by Welfare Officer Chris Luckman, Mental Health Registered Nurse Chris Piipari and Case Manager Ferdinand Ricotta. The evidence was that W advised them that:

a) "he had got caught up in a lot of emotions - family stressors. Parents live in Melbourne- had phone contact yesterday";[6]

b) he denied any further thoughts of self-harm; and

c) he agreed to share a cell stating that "he does not like to be by himself."

26. The conclusion of the RIT team was that he be taken off the RIT alert but he was to remain “two-out” in a cell. He was also to be further reviewed by a Corrective Services psychologist.

27. As a result of the RIT assessment on 21 April 2011, W was placed ”two out” in a cell. To affect this, in accordance with policy, a Health Problem Notification Form ("**HPNF**") was completed by Chris Piipari, the Justice Health mental health nurse, and placed on W’s Case Management File, as required.[7]

28. I note that the RIT assessment of 20 April 2011 and the review of 21 April 2011 were noted on W's electronic record, called the Inmate Profile Document, in the Justice Health file and in Corrective Services case notes (or what are sometimes called ‘E notes’).

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[4] Exhibit 1, Volume 1, Tab 9 - Statement of Farrah Houshmand dated 28 May 2014 at paragraph 6;

[5] Ibid at paragraph 7; Exhibit 1, Volume 3, Tab 59- Risk Intervention Team record of 20/04/2011 at pages 434-437;

[6] Exhibit 1, Volume 3, Tab 59- Risk Intervention Team record of 21/04/2011 at page 433;

[7] Exhibit 1, Volume 3, Tab 59- New Health Problem Notification Form of 21/04/2011 at pages 416-417;

29. On 25 April 2011, Anzac Day, W was found to have two black eyes and bruises to his body and neck. He was interviewed by a Justice Health registered nurse, Julie Omoronke Edagbami, and advised that he had "fallen in the shower" but said that he wished to remain in the Main block as he was going home soon. However, on 26 April 2011 he complained of stomach pains, and was taken to the clinic where he confided in staff that he wished to stay away from the cell block where he was housed and that he had no intention of harming himself. He was placed in a safe cell for observation overnight, with a note to the supervising Corrective Services officer to the effect that he was on a two out cell placement from the recent RIT.

30. On 27 April 2011, W was interviewed by a Corrective Services officer, Senior Assistant Superintendent Mark Peteru. It was the evidence of Mr Peteru that:

a) he summoned W from the safe cell to his office for the purpose of interviewing him in regard to his request for protection[8];

b) W indicated during the course of the interview that he feared for his safety from other inmates and that fear stemmed from "inmates having knowledge that he has inherited a considerable amount of money from New Zealand, and they would try to extort money from him"[9];

c) that at the time he carried out the interview he was unaware that W was on a "red card" or "two out placement"[10] or that he had recently been the subject of a RIT assessment[11]; and

d) he did not check W's Case File[12] or OIMS file.[13]

31. Following the interview Mr Peteru recommended and approved W's placement in Special Management Area Placement ("**SMAP**") until 4 May 2011.[14] Accordingly, W was placed in a one out cell (namely a cell on his own) in the Ebenezer Wing ("**E unit**").

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[8] Exhibit 1, Volume 5, Tab GG - Statement of Mark Peteru dated 21/09/2011 at paragraph 4;
[9] Ibid;
[10] Ibid at paragraph 5;
[11] Oral evidence of Mark Peteru on 19/08/2015;
[12] Exhibit 1, Volume 5, Tab GG - Statement of Mark Peteru dated 21 September 2011 at paragraph 5;
[13] Oral evidence of Mark Peteru on 19/08/2015;

32. That same day, Alan Curtin a Justice Health registered nurse, received a phone call from a Corrective Services officer who said that he had placed W in segregation on protection. Mr Curtin prepared a Health Problem Notification form for W'S single cell placement on protection.[15]

33. W also consulted with Ms Houshmand, psychologist on 27 April 2011.

34. On 1 May 2011, Corrective Services Officer Joern Goetze spoke with W and he denied thoughts of self-harm.**[16]** By now W was on protection, in a single cell and had been so for at least 4 days.

35. On 2 May 2011, W was seen by the Justice Health Mental Health Nurse Christine Muller for the first time and Ms Muller conducted an extensive mental health assessment taking an hour.[17] Ms Muller's evidence[18] can be summarised as follows:

a) W had been escorted to the clinic by Senior Assistant Superintendent Cheryl Waters who had advised her that:

"she had been involved in the recent RIT reviews....that W's family had told her that the things W was saying were not true and she thought he was making up stories for attention";[19]

b) W told Ms Muller that:

"he had come into a significant inheritance from the mother of an ex-girlfriend, that his current girlfriend was having an affair with his father and that his ex-girlfriend had arranged for a gang in New Zealand to kill him";[20]

c) she noted that W had lost 6.6kgs in weight in one week;[21]

d) that his presentation was consistent with systematised delusions and he offered no insight;[22]

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[14] Exhibit 1, Volume 5, Tab JJ - memo dated 27 April 2011;
[15] Exhibit 1, Volume 3, Tab 59- Health Problem Notification Form dated 27/04/2011 at page 415;
[16] Exhibit 1, Volume 4, Tab D - Case Note dated 1 May 2011 at page 915;
[17] Transcript 19/8/2015- Evidence of Christine Muller at page 63 lines 25-28;
[18] Exhibit 1, Volume 1, Tab 16 - Statement of Christine Muller dated 20 May 2013;
[19] Ibid at paragraph 23;
[20] Ibid at paragraph 24;
[21] Ibid;
[22] Ibid;

e) she noted that the things W was saying about his family members appeared unusual, and with W's permission she spoke to his mother via telephone who advised her that there was a family history or schizophrenia and that W "was always talking in riddles";[23]

f) she noted that this was W's "first presentation of psychosis";[24]

g) by telephone, she spoke with her clinical supervisor Dr Adam Martin, a senior psychiatrist and then Clinical Director, Community Correction Mental Health at Justice Health. She discussed her assessment of W and Dr Martin advised her "not to commence psychotropic medication due to the potential side effects and risks associated with prescribing medication for a patient that has never had this type of drug and where there is not capacity to have him medically reviewed";[25] she completed a referral to the wait list for the MHSU at the MRRC, Silverwater, and forwarded it to the Nurse Unit Manager;[26]

a) she also spoke to Cathryn Gibson, the manager of Offender Services and Programmes, about need for urgent mental health intervention in custody or in community and need for Justice Health staff to be advised if W was returned to custody.[27]

36. I note that is common ground that at that time a psychiatrist was not available to visit John Morony to conduct reviews of patients with mental health issues.

37. On 3 May 2011, W attended the AAT for his immigration hearing. He represented himself. His parents travelled from Melbourne to attend to provide support. The result was deferred.

38. The following day, namely 4 May 2011, a number of things occurred:

a) a report to the Parole Authority was prepared recommending that parole not be granted due to his uncertain immigration status;

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[23] Ibid at paragraph 26;

[24] Ibid at paragraph 27;

[25] Ibid;

[26] Ibid at paragraph 33; Exhibit 1, Volume 1, Tab 17A - Statement of Christine Muller dated 20 January 2015 at Annexure "A";

[27] Exhibit 1, Volume 5, Tab D - e-Casenote dated 2 May 2011 at page 915;

b) W spoke to his mother my telephone. That conversation was recorded and transcribed.[28] In essence, W indicates he thinks his parole decision will be made by 14 May 2011 and that he was confident he would get parole;

c) a MHSU bed meeting was convened and assigned W a B rating, with a priority of four. As a consequence he remained on the waiting list for transfer to the MHSU and remained in protective custody in E wing.

39. On 5 May 2011, Malcolm Clark, a Senior Community Corrections officer made a file notation noting a parole review date on 12 May 2011.[29] W's protection status was upgraded to limited association that day due to his fears of other inmates. Although the General Manager of John Morony at the time, Mr Aboud, believes that a Protected Custody Direction would have been prepared as required for this change (and the change is noted on the system electronically), no such direction was found on W's Case Management File.

40. On 6 May 2011, W saw Ms Houshmand, the Corrective Services psychologist again. Her evidence was that he presented as "emotionally stable" and denied any current self-harm/suicidal ideation and he "expressed future orientation".[30]

41. On 7 May 2011, W spoke to his mother by telephone and told her his parole review was on 12 May 2011.[31]

42. On 9 May 2011, Nurse Muller returned to the John Morony Correctional Centre and was surprised to see that W was still there. It was her evidence that she spoke to Lisa Hogan, the Nurse Unit Manager to remind her that W was on the MHSU wait list and that he needed to be reviewed (as part of a follow up plan she had devised when reviewing him on 2 May 2011 and which is documented in the clinical notes in his Justice Health file)[32]. I note that Ms Hogan has no recollection of this conversation having taken place.

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[28] Exhibit 1, Volume 2, Tab 27 at pages 122 to 125;

[29] Exhibit 1, Volume 1, Tab 25 - Statement of Malcolm Clark dated 21 October 2014 at paragraph 7 and Annexure A;

[30] Exhibit 1, Volume 1, Tab 9 - Statement of Farrah Houshmand dated 28 May 2013 at paragraph 8;

[31] Exhibit 1, Volume 2, Tab 27 at pages 126 to 129;

[32] Exhibit 1, Volume 1, Tab 16 - Statement of Christine Muller dated 20 May 2013 at paragraph 38;

43. On 11 May 2011, W's visa was reinstated by the AAT and he was informed of this on 12 May 2011.

44. On 12 May 2011, the State Parole Authority affirmed its decision of 14 April 2011 to deny W parole.

15 May 2011 - Date of death

45. On 15 May 2011, the day of his death, W went into the yard around 8.40am.

48. At 8.57am W rang his mother. The phone call was recorded and the transcript records him as saying "they are fucking me around with my parole". His mother asked if he got told about his parole and he said "no' but that he "want" his immigration, which is probably a mistranscription of he "won" his immigration. He told his mum the call was going to cut out and that he was alright.[33]

49. After he was returned to his cell, W used his medical call system in his cell and made a request to speak to Corrective Officer Rourke, privately. Mr Rourke attended W's cell together with Assistant Superintendent Danny Loloa. W stated that "he was scared and feared for his life from other inmates who were after him". Mr Rourke advised W that he was safe in "E Unit" as he was in separate accommodation and these words seemed to reassure W.[34]

50. Mr Rourke was concerned about W's presentation and ordered a psychologist's review.[35]

51. At 12.30pm, Mr Rourke undertook a physical head check and asked W if he wanted his yard open to which W replied "no chief".[36]

52. At just before 3pm on 15 May 2011, W was locked in his cell for the evening. On the evidence, that was the last time he was seen alive. At 9.10pm W was found deceased hanging by his bed sheets attached to the fire sprinkler in his cell, after water flooding from a broken sprinkler head was seen to be flooding the corridor of the cell complex.

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[33] Exhibit 1, Volume 2, Tab 27 at page 131;
[34] Exhibit 1, Volume 1, Tab 10 - Statement of Jeffrey Rourke dated 7 July 2011 at paragraph 8;
[35] Exhibit 1, Volume 5, Tab 63D at page 913;
[36] Supra note 31 at paragraph 10;

Was W presenting with acute symptoms of a mental illness from 20 April 2011?

53. The first real indication that clinicians had observed that W's mental health may be declining was when he expressed suicidal thinking to Corrective Services welfare officer, Ms Vella, on 20 April 2011. Ms Vella immediately arranged for a RIT team to review him. Ms Houshmand, psychologist was a member of that team, along with the then acting NUM, Robin Lloyd and Cheryl Waters from Corrective Services. Ms Waters acted as scribe. After deciding that W was a risk to himself based on his suicidal ideation, the obvious decision was made to house him in a safe cell and recommend further RIT review, referral to the Clinic Nurse Unit Manager and to see a psychologist.

54. W was reviewed the following day by a different RIT assessment team who decided, after interviewing W, to accept his assurances that he was no longer suicidal and had had an opportunity to speak to his mother. They took him off the safe cell placement but recommended a "two out" placement to ensure some degree of company and oversight for him.

55. Ms Houshmand gave evidence on 19 August 2015 and on 29 October 2015. She initially told this inquest in August this year that she thought W may be displaying signs of a first time psychosis, but she wasn't sure and he seemed genuine, if tearful. It was surprising that she had made no note of her tentative thoughts or provisional diagnosis.

56. When Ms Houshmand was recalled on 29 October 2015, she clarified that whilst she thought what W was saying *might* possibly be delusional, ultimately she concluded that she could not be certain as she had no evidence to test the hypothesis against or support it and what he was saying was not obviously delusional and could well have a basis in fact. Accordingly, she decided there was no real evidence that he was delusional and chose not to record either on the RIT form or make an entry on the E case notes about her provisional diagnosis.

57. It was the evidence of Christine Muller that when assessing W on 2 May 2011, "His thoughts were to some extent disjointed and there was evidence of paranoid delusions."

She also states, “I noted that this was W’s first presentation of psychosis”.[37] Indeed in Ms Muller’s email that day to refer W to the MHSU wait list, she wrote, “This patient presents as having a paranoid delusional disorder and was recently on a RIT after expressing thoughts of suicide by hanging in response to some delusional ideas…”.[38]

58. Expert Evidence was obtained from Dr Michael Guiffrida, Forensic Psychiatrist[39] who stated:

> "In my opinion there can be no reasonable doubt that W was suffering from a serious mental illness namely an onset of a first episode psychotic illness with paranoid persecutory delusions...and... revealed some evidence of thought disorder or at least disjointed thoughts. The diagnosis was probably of an emerging paranoid schizophrenic illness first episode. It was in the context of the development of those paranoid persecutory beliefs and the fear that he was going to be killed that W contemplated suicide which was likely to have been a continuing feature of his illness and given his paranoid psychosis remained untreated and that he was left in a single cell protection area he deteriorated to the point where he was overwhelmed by his delusion and his fear and chose to suicide as a relief from his torment".[40]

59. I note that Dr Yvonne Skinner, Psychiatrist agreed.[41]

60. Accordingly, I am satisfied on the balance of probabilities that Wwas suffering acute symptoms of a mental illness from 20 April 2011.

[37] Exhibit 1, Volume 1, Tab 16- Statement of Christine Muller dated 20/05/2013 at paragraph 25;

[38] Exhibit 1, Volume 1, Tab 17A- Second Supplementary Statement of Christine Muller dated 20 January 2015, annexure A at page 12.

[39] Exhibit 1, Volume 6, Tab 78 - report of Dr Guiffrida dated 20 April 2015;

[40] Ibid at page 13;

[41] Exhibit 1, Volume 6, Tab 80 - report of Dr Skinner dated 11 August 2015 at page 80/15;

Should W have been placed in a "one out" cell on 27 April 2011, after he clearly expressed suicidal ideation at the RIT review on 20 April 2011?

61. There is no doubt that W requested a SMAP placement on 27 April 2011 and it is likely that his real fears about his physical safety, from the incident of 25 April 2011, coupled with his delusions drove this request. His SMAP placement was approved by Justice Health Nurse, Mr Alan Curtin, whose evidence was that "it is my usual practice to review the patient's medical record before completing a HPNF form".[42]

62. Mr Curtin gave evidence on the penultimate day of the inquest.[43] He was called primarily so he could offer an explanation as to the inherent contradiction in his statement evidence namely his evidence that he checked W's medical file before he completed the HPNF form and his later evidence that he was not aware that W had previously been placed two out due to suicidal ideation.[44] Mr Curtin gave the following oral evidence in relation to the discrepancy inter-alia that:

a) he was not aware until he read the file that W was "two out" as a result of suicidal ideation; and

b) the fact that W had previously expressed suicidal ideation was not an impediment to the change, as ideation can change daily and on his assessment it wasn't currently present.

63. It is also important to note that being placed "one out" is the inevitable result of being placed in SMAP. There were no "two out" cells in John Morony's E unit.

64. Moreover on 2 May 2011, Nurse Muller made a clinical determination that W should be "one out" for his own protection and the protection of others, which in my view superseded the events of 27 April 2011. This determination was not criticised by either Dr Guiffrida, Dr Skinner or Dr Chew, who added that in his view instability from psychosis was not something he thought the RIT would recognise as requiring a safe cell.

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[42] Exhibit 1, Volume 1, Tab 18 - Statement of Alan Curtin dated 9 May 2013 at paragraph 9;
[43] 29 October 2015;
[44] Exhibit 1, Volume 1, Tab 19 - Statement of Alan Curtin dated 5 June 2015 at page 2/77;

65. Accordingly, I am satisfied on the balance of probabilities that it was NOT inappropriate that W was accommodated in a "one out" cell from 27 April 2011 when he requested protection and segregation.

Was W appropriately supervised once he was placed in isolation?

66. As indicated, on 27 April 2011 W was transferred into SMAP and on 5 May 2011 he was transferred into protective custody. The evidence from Mr Patrick Aboud, the then General Manager of John Morony, was to the effect that there is no material physical difference between these arrangements and a segregation order, as an inmate is kept isolated in a "one out cell" .

67. I note that there are legislative safeguards relating to segregation and protective custody directions, which are set out in sections 8-22 of the Crimes (Administration of Sentences) Act 1999 (as at May 2011), which states:

> **"8 Release from custody**
>
> (1) Unless sooner released on parole, an inmate who is serving a sentence by way of full-time detention (the ***current sentence***) is to be released from custody on the day the sentence expires (the ***release date***), as determined in accordance with Division 1 of Part 4 of the *Crimes (Sentencing Procedure) Act 1999* but subject to any variation of the term of that sentence under this or any other Act.
>
> (2) An inmate may be released from custody:
>
> (a) at any time on the release date for the current sentence, or
>
> (b) if the release date for the current sentence is a Saturday, Sunday or public holiday and the inmate so requests, at any time during the next day that is not a Saturday, Sunday or public holiday.
>
> (3) This section does not apply to an inmate who, as at the release date for the current sentence, is subject to another sentence that is being served by way of full-time detention:
>
> (a) where the other sentence commenced before, but will not end until after, the release date for the current sentence, or
>
> (b) where the other sentence commences immediately after the release date for the current sentence.
>
> **9 Definitions**
>
> In this Division:
>
> ***protective custody direction*** means a direction referred to in section 11.

segregated custody direction means a direction referred to in section 10.

suspension direction means a direction referred to in section 20 (1) (a).

10 Segregated custody of inmates

(1) The Commissioner may direct that an inmate be held in segregated custody if of the opinion that the association of the inmate with other inmates constitutes or is likely to constitute a threat to:

(a) the personal safety of any other person, or

(b) the security of a correctional centre, or

(c) good order and discipline within a correctional centre.

(2) The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre and, on each occasion he or she does so, must notify the Commissioner of that fact and of the grounds on which the segregated custody direction was given.

(3) A segregated custody direction given by the general manager of a correctional centre does not apply in relation to any other correctional centre.

(4) Subsection (3) is subject to section 15.

11 Protective custody of inmates

(1) The Commissioner may direct that an inmate be held in protective custody if of the opinion that the association of the inmate with other inmates constitutes or is likely to constitute a threat to the personal safety of the inmate.

(2) The Commissioner may also direct that an inmate be held in protective custody if the inmate requests the Commissioner in writing to do so.

(3) The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre and, on each occasion he or she does so, must notify the Commissioner of that fact and of the grounds on which the protective custody direction was given.

(4) A protective custody direction given by the general manager of a correctional centre does not apply in relation to any other correctional centre.

(5) Subsection (4) is subject to section 15.

12 Effect of segregated or protective custody direction

(1) An inmate subject to a segregated or protective custody direction is to be detained:

(a) in isolation from all other inmates, or

(b) in association only with such other inmates as the Commissioner (or the general manager of the correctional centre in the exercise of the Commissioner's functions under section 10 or 11) may determine.

(2) An inmate who is held in segregated or protective custody:

(a) is not to suffer any reduction of diet, and

(b) is not to be deprived of any rights or privileges other than those determined by the Commissioner (or the general manager in the exercise of the Commissioner's functions under section 10 or 11), either generally or in a particular case, and other than those the deprivation of which is necessarily incidental to the holding of the inmate in segregated or protective custody.

13 Form of direction

A segregated or protective custody direction must be in writing and must include the grounds on which it is given.

14 Information concerning review of segregated or protective custody direction

As soon as practicable after an inmate is directed:

(a) to be held in segregated custody under section 10, or

(b) to be held in protective custody under section 11 (other than at the inmate's request),

the general manager of the correctional centre is to provide the inmate with information concerning the inmate's rights to a review of the segregated or protective custody direction.

15 Transfer of inmate held in segregated or protective custody

(1) If an inmate held in segregated or protective custody under a segregated or protective custody direction given by the general manager of a correctional centre is transferred to another correctional centre, the segregated or protective custody direction applies:

(a) in relation to the correctional centre to which the inmate is transferred (***the receiving correctional centre***), and

(b) in relation to the conveyance of the inmate to the receiving correctional centre, including custody of the inmate in any correctional centre in which the inmate is held during the course of being conveyed to the receiving correctional centre.

(2) Within 72 hours after the arrival of the inmate at the receiving correctional centre, the general manager of the receiving correctional centre must review the segregated or protective custody direction, having regard to the grounds referred to in section 10 or 11, and give one of the following directions:

(a) a direction revoking the segregated or protective custody direction,

(b) a direction confirming the segregated or protective custody direction,

(c) a direction confirming the segregated or protective custody direction but amending its terms.

(3) A direction given under subsection (2) has effect according to its terms.

(4) A segregated or protective custody direction that is subject to a direction under subsection (2) (b) or (c) is, on and after the giving of that direction, taken to be a segregated or protective custody direction given by the general manager of the receiving correctional centre.

(5) A direction by the general manager of a receiving correctional centre revoking, confirming or amending a segregated or protective custody direction has effect even though it is given outside the period during which it is required to be given under this section.

16 Review of segregated or protective custody direction by Commissioner

(1) The general manager of a correctional centre where an inmate is held in segregated or protective custody must submit a report about the segregated or protective custody direction to the Commissioner within 14 days after the date on which the direction is given (***the relevant date***), regardless of whether the segregated or protective custody direction was given by the Commissioner or by the general manager of a correctional centre.

(2) Within 7 days after receiving the report, the Commissioner must review the segregated or protective custody direction and give one of the following directions:

(a) a direction revoking the segregated or protective custody direction,

(b) a direction confirming the segregated or protective custody direction,

(c) a direction confirming the segregated or protective custody direction but amending its terms.

(3) If the direction is confirmed, the general manager of the correctional centre where the inmate is held in segregated or protective custody must submit a further report about the direction to the Commissioner within 3 months after the relevant date, and within each subsequent period of 3 months after that period.

(4) Within 7 days after each occasion on which the Commissioner receives any such further report, the Commissioner must review the segregated or protective custody direction and give one of the directions referred to in subsection (2) (a)–(c).

(5) The confirmation of a segregated or protective custody direction by the general manager of a correctional centre under section 15, or by the Review Council under section 22, does not affect the requirements for reporting about and reviewing a segregated or protective custody direction under this section.

(6) A direction by the Commissioner revoking, confirming or amending a segregated or protective custody direction has effect even though it is given outside the period during which it is required to be given under this section.

(7) In this section:

report, in relation to a segregated or protective custody direction, means a report recommending whether or not the segregated or protective custody direction should be revoked, confirmed or amended.

17 Revocation of segregated or protective custody direction

(1) A segregated or protective custody direction remains in force until it is revoked.

(2) The Commissioner may, at any time, revoke a segregated or protective custody direction or amend its terms.

(3) The Commissioner must revoke a protective custody direction given at the request of an inmate if the inmate requests the Commissioner in writing to revoke it.

(4) The general manager of a correctional centre may exercise the Commissioner's functions under this section in relation to the correctional centre.

18 Report to Minister on segregated or protective custody direction

(1) As soon as practicable after confirming a segregated or protective custody direction, the Commissioner must give written notice of that fact to the Minister, giving reasons for the confirmation direction, if:

(a) the confirmation direction will result in the inmate being subject to a total continuous period of segregated or protective custody exceeding 6 months, or

(b) the inmate has already been subject to a total continuous period of segregated or protective custody exceeding 6 months.

(2) This section does not apply to a direction confirming a protective custody direction that was given at the request of an inmate.

19 Review of segregated or protective custody direction by Review Council

(1) An inmate whose total continuous period of segregated or protective custody exceeds 14 days may apply to the Review Council for a review of the segregated or protective custody direction under which the inmate is held in segregated or protective custody.

(2) The application is to be in writing and is to include the inmate's reasons for making the application.

(3) The Review Council must review the direction unless subsection (4) applies.

(4) The Review Council may refuse to review the direction if:

(a) the application does not, in the opinion of the Review Council, disclose substantial grounds for a review, or

(b) the Review Council has previously determined a review of the same direction under this Division and the application does not, in the opinion of the Review Council, disclose substantially different grounds for review.

(5) The Review Council may not refuse to review a direction under subsection (4) if a period of more than 3 months has elapsed since the Review Council determined a review of the segregated or protective custody direction.

(6) This section applies regardless of whether the relevant segregated or protective custody direction was given by the Commissioner or by the general manager of a correctional centre.

20 Suspension directions by Review Council

(1) The Chairperson of the Review Council may give a direction for:

(a) the suspension of an inmate's segregated or protective custody direction, or

(b) the transfer of an inmate to a different correctional centre.

(2) A suspension direction may be given at any time after an application for a review is made and before it is determined.

(3) While a suspension direction is in force, the inmate is not to be held in segregated or protective custody unless a new segregated or protective custody direction is given.

(4) The Chairperson may at any time vary or revoke a suspension direction.

(5) A suspension direction does not revoke a segregated or protective custody direction.

(6) A direction for the transfer of an inmate to a different correctional centre may be given:

(a) if the Chairperson considers that the inmate's removal would facilitate the review of the segregated or protective custody direction, or

(b) for any other reason that the Chairperson thinks fit.

(7) The determination of a review of a segregated or protective custody direction by the Review Council under section 22 revokes any suspension direction applying to the segregated or protective custody direction.

21 Procedure for review of segregated or protective custody direction by Review Council

(1) In determining any matter relating to the segregated or protective custody of an inmate, the Review Council is not bound by the rules of evidence but may inform itself of any matter in such manner as it thinks appropriate.

(2) The Review Council must cause notice of any hearing in relation to a review to be given to the inmate who applied for the review.

(3) If the inmate so wishes, the Review Council must allow the inmate to be present, and to be heard, at the hearing.

(4) The inmate may be represented by an Australian legal practitioner chosen by the inmate or, if the Review Council so approves, by some other person chosen by the inmate.

(5) The Commissioner or the general manager of a correctional centre (or both) may be represented by an Australian legal practitioner or by some other person.

(6) Division 2 of Part 9 applies to the conduct of a review by the Review Council under this Division.

22 Determination of review by Review Council

(1) In reviewing a segregated or protective custody direction, the Review Council must take the following matters into account:

(a) whether the direction was given or reviewed in accordance with this Division,

(b) whether the direction was reasonable in the circumstances,

(c) whether the direction was necessary to secure the personal safety of the inmate or any other person,

(d) the security of, and the preservation of good order and discipline within, the relevant correctional centre,

(e) the interests of the public.

(2) In determining an application for review, the Review Council may revoke, confirm or amend the segregated or protective custody direction to which the application relates." These laws recognise the extreme nature of such orders and the potential harm to individual inmates."

68. Moreover regulation 289 of the *Crimes (Administration of Sentences) Regulation 2014* states:

"An inmate who is confined to cell for the purposes of punishment, or under a segregated or protective custody direction, must be kept under daily observation by a prescribed Justice Health officer and have access to essential medical care." (formerly clause 298 of the *Crimes (Administration of Sentences) Regulation 2008* (repealed)).

69. W was in a one out cell from 27 April 2011 and in protective custody from 5 May 2011.

70. It was the evidence of Trevor Perry, the Service Director of Custodial Mental Health for Justice Health that:

"The then Justice Health policy 1.360 Segregated Custody set out directions to staff for the mandatory observation of inmates in segregated or protective custody or confined to a cell for punishment. The version of the policy that was in force in May 2011 was published in May 2009. Specifically, the duties of nurses in relation to inmates in segregated custody in correctional centres other than Long Bay Hospital are set out in section 5.1 of policy 1.360 which states:

> 'All inmates/patients subject to a Segregated Custody Direction must be seen at least daily by nursing staff and at least weekly in the Clinic. A notation related to the review must be made in the patient medical file. The patient should be offered an appointment once a week with the Medical Officer (MO). If the nurse has any concern the MO must see the patient with the next 24 hours.'"

71. In regard to the nature of the observations of an inmate that a nurse must make, the policy states in the same section:

"While a physical examination will not usually be necessary, the minimum contact should include a discussion with the patient, which should be aimed at assessing his or her current physical and mental health state and any potential risks."

72. The policy required the nurse to make a record of the patient's "wellbeing" in the patient's clinical notes".[45]

73. No record could be found of any other visits by a Justice Health employee to W recorded between 2 May and 15 May 2011. It was submitted by Mr Brock, for Senior that the only reasonable inference is Justice Health was in breach of its obligations from 5 May 2011 when W was placed under a protective custody direction in that:

    a) Justice Health did not comply with clause 298 of the *Crimes (Administration of Sentences) Regulation* 2008;

    b) none of the objectives under 1.360.2 were met; and

    c) the daily assessments and clinical notes were not completed as required by 1.360.51.[46]

74. I agree. W should have been subject to daily checks by a nurse. Those checks should have been a discussion about how he was doing so if in the event he was to further decompensate there would be a greater chance of this vulnerability or risk being picked up and managed prior to a catastrophic end.

75. The safeguards put in place to manage and protect a vulnerable inmate such as W were not adhered to and it is only reasonable to conclude that if they had been applied W's chance of surviving his mental illness would have increased enormously.

Should more or could more have been done once W had been waitlisted for the Mental Health Screening Unit ("MHSU") to manage his risk of self-harm?

76. The evidence indicates that W was referred to the MHSU on 2 May 2011 by Mental Health Nurse Christine Muller[47]. The following day, namely 3 May 2011 a MHSU bed meeting was

[45] Exhibit 1, Volume 1, Tab 22C – Letter from Trevor Perry dated 27 October 2015;

[46] I accept Mr Brock's submission that any suggestion from Mr Perry's letter that W would have been checked due to the use of that area for segregated inmates is unsustainable for the following reasons: 1) there is no suggestion that W was awaiting 'transfer' to PRLA accommodation at another prison, 2) there were no other prisoners in his section (segregated or otherwise) and W was not prescribed any medication that would require the attendance of Justice Health staff and 3) there are no clinical notes that support the suggestion.

convened and assigned W a B rating, with a priority of four. As a consequence he remained on the waiting list for transfer to the MHSU and remained in protective custody in E wing until he died on 15 May 2011.

77. As previously indicated I am satisfied that W was suffering from an acute mental illness as of 27 April 2011 which was diagnosed by Nurse Muller on 2 May 2011. The issues that flow from this are whether his risk of self-harm was firstly higher and secondly if so, was his risk so high that steps should have been taken to mitigate that risk other than placing him on the MHSU waitlist.

78. The best person to assess W's risk of self-harm was in my view Nurse Muller. As an experienced mental health nurse practitioner, she conducted a detailed assessment of W on 2 May 2011 and took contemporaneous notes of that meeting. She gave oral evidence on 20 August 2015 and presented as both honest and forthright. Her evidence was that she initially assessed W's risk of self-harm as "moderate" and explained in evidence that:

    a) “my concern was more that he may kill someone else”;[48]

    b) he did not express suicidal ideation;[49]

    c) however he had increased suicide risk factors as he had been diagnosed with "a first presentation psychosis".[50]

79. As a consequence, Nurse Muller discarded the idea of having W put on a RIT and placed in a safe cell while on the waitlist, on the basis that a safe cell was a punitive environment and he would be less likely to tell her if he was feeling like he wanted to harm himself if he was in that environment.[51]

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[47] Exhibit 1, Volume 1, Tab 17A - statement of Christine Muller dated 20 January 2015 at paragraph 5 and Annexure "A";

[48] Transcript 20/08/2015 at page 16;

[49] Transcript 20/08/2015 at page 43

[50] see also Exhibit 1, Volume 1, Tab 17A at paragraph 9;

[51] Transcript 20/08/2015 at page 17; Exhibit 1, Volume 1, Tab 17 at paragraph 4;

80. Nurse Muller was also firmly of the view that W was safer by himself in a "one out" cell because that meant he was less able to harm others, and it meant that his paranoid delusions about his own safety would not be fuelled and he would feel safer.[52]

81. It was also the evidence of Nurse Muller that her concern about W and his risk factors was such that she raised it with more senior people in Justice Health, namely Dr Martin, Catherine Hancock and Mr Perry, after her initial assessment of him on 2 May 2011, and produced a number of emails and diary entries to support this assertion.[53] The documents produced by Nurse Muller however do not specifically refer to W or his specific circumstances. Accordingly, they can be better described as her advocating for better clinical pathways for mentally ill inmates to obtain better clinical assistance.

82. Nurse Muller clearly did have meetings and discussions with Dr Martin, Catherine Hancock and Lisa Hogan after 2 May 2015. Moreover, both Catherine Hancock[54] and Dr Martin (in referring to his meeting with Ms Muller on 5 May) conceded that W was raised as an example of the lack of pathways whilst Lisa Hogan said that it was possible he could have been mentioned as an example, but she didn't specifically recall the conversation.

83. It is important to note however, that all these witnesses deny that Nurse Muller raised W as a patient who was at high risk.

84. Nurse Muller was and is clearly an experienced, caring and competent mental health nurse practitioner. At the relevant time she was clearly frustrated at the lack of resourcing and pathways available to mentally ill inmates to get better care within the Custodial System. She advocated for her patients. W was one of those patients. No doubt looking back through the prism of hindsight Nurse Muller has overrated the risk she evaluated as moderate when she initially assessed W on 2 May 2011.

85. In relation to what clinical pathways were available to the critically mentally ill patient as at 2011, the evidence was as follows:

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[52] Transcript 20/08/2015 at page 18 and 28;

[53] Exhibit 1, Volume 1, Tab 17A at paragraphs 7 - 31 and Annexures "B" to "H" inclusive;

[54] Transcript 20/08/2015 at page 76;

a) Refer, then transfer the patient to the MHSU at Silverwater Correctional Centre: the evidence from Dr Martin and Mr Perry was that this was and is the only practical pathway available;

b) Transfer the patient to the Metropolitan Remand and Reception Centre ("**MRRC**"): this could possibly be carried out by filling out the appropriate HPNF form however the evidence from Dr Martin, Mr Perry and Mr Aboud was that, because of the numbers of inmates coming through the MRRC daily, this pathway would only be used in extremely urgent cases and used very rarely;[55]; and

c) Involuntary transfer to Long Bay Hospital under section 55 of the *Mental Health (Forensic Provisions) Act 1990*: this pathway was not available in 2011 at John Morony Correctional Centre as it required both a doctor and a psychiatrist to sign the schedule and there was no psychiatrist attending John Morony Correctional Centre at this time.

86. Accordingly, the only pathway available to a patient such as W who had been assessed as a "moderate" risk of self-harm was the referral and transfer to the MHSU.

87. I note that since W's tragic death, further resources have been provided to the John Morony Correctional Centre. These include:

a) A psychiatrist attends John Morony Correctional Centre one day per fortnight and is available weekly if urgent matters arise; and

b) A Mental Health Clinical Nurse Consultant attends John Morony Correctional Centre one day each week.[56]

88. I note that Dr Guiffrida also encouraged the use of teleconferencing (or telehealth as it was referred to) for psychiatric review as an emergency measure, although noting the obvious advantages of face to face review. Dr Chew noted that telehealth is used for outlying centres such as Broken Hill. In my opinion, Justice Health should consider the use of telehealth for psychiatric review in appropriate situations where review is urgently required

[55] Mr Aboud oral evidence 21/08/2015; Dr Martin oral evidence 20/08/2015; Mr Perry oral evidence 21/08/2015.

[56] Exhibit 1, Volume 6 Tab 75A- Statement of Dr Gerald Chew dated 17 August 2015, paragraphs 9-10;

and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU waitlist before the patient is transferred and admitted.

Should W have been prescribed an anti-psychotic drug such as Olanzapine?

89. It was the evidence of Dr Guiffrida that:

> "I could see no reason why W could not have been commenced on one of the safer antipsychotic medications initially in a low dose with a gradual increase during with time he could be reviewed by Ms Muller, being a very senior nurse practitioner who would be I think perfectly capable of managing by commencing a delusional patient on an antipsychotic medication..."[58]

90. Dr Skinner did not agree. Her evidence was:

> "W had not previously taken anti-psychotic medications. In considering the prescription of anti-psychotic medication, a number of factors must be taken into account. Individuals react differently to medications, particularly with respect to side effects. Common side effects of anti-psychotic medications include:
> stiffness (dystonia) and shakiness
> Feeling drowsy and sluggish
> Uncomfortable restlessness, agitation
> Dizziness(due to reduced blood pressure)
> ...
> Some side effects of medication are serious and potentially lethal....
> Occasionally persons who have suicidal thoughts are more inclined to act on those thoughts in the early stages of treatment with medication, and should be closely monitored during the early stages of treatment"[59].

91. It is clear that the supervision proffered to W who was being housed in a "one out" cell in protective custody was less than adequate (despite legislative requirements that he be checked daily).

92. There were obvious risks to commencing W on anti-psychotic medication without adequate supervision and accordingly I am not critical of either Dr Martin or Nurse Muller for taking the more conservative approach and deferring the option of medication until he was in an environment like the MHSU where he would be better supervised.

Was there a proper clinical handover between clinical staff?

[58] Exhibit 1, Volume 6, Tab 78- Expert Report of Dr Guiffrida dated 20 April 2015 at page 6;

[59] Exhibit 1, Volume 6, Tab 80 - Expert Report of Dr Skinner dated 11 August 2015 at page 15-16;

93. NSW Health defines a clinical handover as "the transfer of information, accountability and responsibility for a patient or a group of patients".

94. It was the evidence of Nurse Muller that on 9 May 2011, when she was unable to gain access to W as he was already locked in for the afternoon, and prior to leaving for the day, she spoke to the Nurse Unit Manager Lisa Hogan and "handed over the information regarding my immediate patient who was due to attend court that week. I also informed the NUM Ms Hogan that W had remained in custody after his AAT hearing and was on the wait list for the MHSU and needed to be seen".[60]

95. It was the evidence of Nurse Hogan, the NUM, that firstly, she did not recall this conversation or handover occurring but "it could have happened"[61] and secondly she did not have the clinical expertise to make a mental health assessment of someone who was acutely ill.[62]

96. It appears that W fell through the cracks at this point in time. From the evidence there may have been an expectation on the part of Nurse Muller that another mental health nurse would see him after 9 May 2011. Without both a note in the progress notes to record the handover and/or an alert on Patient Administration System ("**PAS**") in the incoming nurse's diary that W should be seen, there was every risk that the follow-up would not occur, particularly in circumstances where there was a gap of some days in between one nurse finishing their mental health duties at John Morony and another one starting theirs. Clearly this occurred.

97. Communication and standardising the recording of that communication is the key to any busy health management system. No one person can be expected to remember the details of one or more patient from one day to the next. I note that since W's death, improvements have been made by Justice Health in relation to standardising handover procedures.[63] However in my view they do not go far enough, particularly in cases where direct handover

[60] Exhibit 1, Volume 1. Tab 16 - statement of C. Muller dated 20 May 2013 at paragraph 49;
[61] Transcript 20/08/2015 at page 88;
[62] Transcript 20/08/2015 at page 89;
[63] Exhibit 3;

(that is a handover from practitioner to practitioner) is not possible and delay of a day or more is possible. In such cases not only should a note of the handover be made firstly in the case file but an actual appointment should also be made for the patient/inmate in the incoming practitioner's PAS appointment diary. Furthermore, education is the key to ensure those procedures are followed and adhered to by all staff.

Was W advised of the fact that he had been refused parole?

98. On 12 May 2011, the State Parole Authority met and issued a "Notification of Determination by the State Parole Authority in respect of review of decision not to make a parole order"[64] ("**the Parole Refusal**") in relation to W, copies of which were forwarded to:

a) the Manager, Offender Records, John Morony Correctional Centre;

b) Benjamin Gillies/Joaanne Stapleton, Bathurst District Office, Probation and Parole Service; and

c) the Officer in Charge of Windsor District Office/ Parole Unit, Probation and Parole.

99. The Parole Refusal stated:

> "TAKE NOTICE that the State Parole Authority, at its meeting on 12 May 2011 considered the case of the abovenamed offender and determined that the decision of 14 April 2011 is to stand and that the offender not be released from a correctional centre at this time. The Parole Authority is not satisfied, on the balance of probabilities, that the release of the offender is appropriate in the public interest, the Parole Authority has regard to the following matters:-
> Needs for post release accommodation [unconfirmed post release accommodation].
> The offender can apply to be reconsidered for possible release on the anniversary of the parole eligibility date 4 May 2012. If the offender applies to be considered for parole the Authority will require a probation and parole officer's report and correctional centre report not later than ...
> PLEASE ENSURE THAT A COPY OF THIS NOTIFICATION IS HANDED TO THE INMATE, READ TO THEM, ITS EFFECT EXPLAINED TO THEM, AND THEIR RIGHTS IN RESPECT OF THE AUTHORITY'S DETERMINATION EXPLAINED TO THEM".[65]

100. There is no evidence that W was ever informed of the Parole Refusal.

101. I note however that in his conversation with his mother on 15 May 2011 he indicates that he is still not aware of the parole decision.[66]

[64] Exhibit 1, Volume 5, Tab CC;
[65] Ibid;

102. I accept Mr Brock's submission that whether W was informed or ignorant of the outcome of the Parole Authority, the situation was deplorable. He was acutely mentally unwell and in isolation. There is evidence that his release date was prominent in his mind and it is reasonable to infer the unsatisfactory management of this information contributed to his ill health.

103. It was the evidence of Christine Moellmer, Community Corrections Officer for Corrective Services that there is, "no specific written policy or procedures relating to the communication of parole refusal to inmates".[67] This is surprising considering that the consequences of receiving such information may be potentially devastating. The dissemination of such information in my view should be regulated.

Were there any deficiencies in the investigation of W's death?

104. There were clearly a number of deficiencies that came to light in relation to the investigation into W's death that was carried out by Corrective Services. These include:

a) one of the time logs from the scene was not kept; and

b) the CCTV footage from the cell corridor area was not downloaded as requested by Mr Aboud.

105. As indicated at the outset of this inquest, as W died in Custody this is a mandatory inquest pursuant to section 23 of the Act. W died in a single cell. There were no witnesses to his death. The CCTV footage would have no doubt provided the best evidence and valuable comfort to his family yet it was not available as it was not downloaded. This should never have occurred.

106. Accordingly, I recommend that training be conducted at the John Morony Correctional Centre on the specific issue of maintaining and preserving a crime scene and crime scene management generally.

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[66] Exhibit 1, Volume 2, Tab 27- Transcript of telephone calls at page 131;

[67] Exhibit 1, Volume 6, Tab 71 - Statement of Christine Moellmer dated 26 November 2014 at paragraph 6;

Conclusion

107. W's death is a tragedy. He was a young man who had the love and support of his family, and enormous potential for a positive future once he was released from custody. However the demons of his mental illness got the better of him, and he took his own life, while alone in his cell on 15 May 2011.

108. I have identified a number of deficiencies in the care and treatment W received for his mental illness.

109. I understand that resourcing within the NSW prison system is stretched and that no doubt will be under a greater burden with the reported growth in the prison population. However, an inflexible under-resourced mental health system will have long term ramifications on both the individual and society as a whole when the poorly or inadequately treated inmate is ultimately released.

Accordingly, I now turn to the findings I am required to make pursuant to s. 81 of the *Coroners Act 2009:*

I Find that W Junior died on 15 May 2011 in Cell 247 in the Ebenezer Unit of the John Morony Correctional Centre by hanging whilst suffering an acute mental illness most likely a first episode delusionary psychosis, after taking steps to take his own life.

For the reasons set out in these findings I make the following recommendations pursuant to s. 82 of the *Coroners Act 2009*:

To:

The Chief Executive

Justice Health & Forensic Mental Health Network:

I recommend that:

1. When there is a handover of patient care, a note of that handover should be recorded in the patient's case file;
2. In the event that there is no opportunity for direct handover from clinician to clinician (e.g. a gap of a day or more), the patient should be recorded on the incoming clinician's Patient Administration System (PAS) waiting list as an appointment, as part of the handover;
3. The current Policy 1.360, Continuum of Care, Segregated Custody, be amended to make it clear and unambiguous that it also applies to directions for protective custody; and
4. There be education of nurses in their obligations under the Justice Health segregated custody policy (applying the current *Crimes (Administration of Sentencing) Regulation 2014* clause 289) as to the scope of the duty required, including making a record of the observations, when seeing protective custody inmates.
5. That consideration be given to the use of telehealth as an emergency measure for psychiatric review in situations where a psychiatric review is urgently required and a patient cannot be seen face to face, or where staff envisage a prolonged period on the MHSU waitlist before the patient is transferred and admitted

To:

The Commissioner

Corrective Services NSW, Department of Justice:

1. I recommend that based on the fact that the regulations require Justice Health to monitor inmates subject to protected custody and segregated custody directions, a revision be made of current Corrective Services NSW, Section 14, Segregated and Protective Custody policy (Exhibit 1, Volume 6 Tab 73, attachment 7) at clauses 14.7.4 and 14.7.7 to ensure that the requirement to notify Justice Health of a direction is included.

To:

Both

The Commissioner of Corrective Services NSW, Department of Justice

and

The Chief Executive ofJustice Health and Forensic Medicine Health Service:

1. I recommend consideration be given to whether a revision should be made to the OIMS system to include notification to Justice Health in the form of an alert (via the Justice Health PAS system) of a protective custody or segregated custody or confinement direction, when it is made.

I close this inquest.

11 November 2015

Magistrate Sharon Freund

Deputy State Coroner