CORONERS COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Tane Chatfield
Hearing dates:	13 -17 July 2020 Lidcombe Coroners Court
Date of findings:	26 August 2020
Place of findings:	Armidale Local Court
Findings of:	Magistrate Harriet Grahame, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, manner and cause of death, Tamworth Correctional Centre, Aboriginal health worker, provision of discharge summary to correctional officers, eradication of hanging points in correctional centres
File Number:	2017/288854
Representation:	**Counsel Assisting**: Ms Tracey Stevens instructed by Mr P Armstrong, Crown Solicitors Office **Chatfield Family**: Mr J Blackshield, Levitt Robinson Solicitors **Commissioner Corrective Services**: Mr T Edwards instructed by Mr A Jobe, Legal Department of Communities and Justice **Justice Health Forensic Mental Health Network**: Mr M Lynch instructed by Mr L Sara, Hicksons Lawyers **Hunter and New England Local Health District:** Mr M Lynch instructed by Mr L Sara, Hicksons Lawyers

Findings:	The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are: ***Identity*** The person who died was Tane Chatfield. ***Date of death*** He died on 22 September 2017. ***Place of death*** He died at Tamworth Hospital, Tamworth NSW. ***Cause of death*** He died as a result of hypoxic ischaemic encephalopathy as a result of hanging. ***Manner of death*** Tane was alone when he placed a blanket rope around his neck and attached it to a prominent hanging point in his cell. His death was intentionally self-inflicted.
Non-publication Orders **S 65 & 74 Orders**	**Terms of orders made on 13 July 2020:** 1. That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009 (NSW)*: a. The names, addresses, phone numbers and other personal information that might identify any person who visited Mr Chatfield while in custody (other than legal representatives, visitors acting in a professional capacity or family members including his de facto partner). b. The following details of any persons in the custody of Corrective Services New South Wales ('CSNSW'), other than Mr Chatfield: i. names, aside from the names of any person who is or was in the custody of CSNSW and is called to give evidence as a witness in these proceedings ii. any personal identifying information such as Master Index Numbers (MIN). c. The direct contact details of CSNSW staff not publicly available. d. Wing Diagrams of Tamworth Correctional Centre. e. Tamworth Correctional Centre Employee Daily Schedules for 19 September 2017 to 22 September 2017 inclusive. f. The following sections of the CSNSW Custodial

	Operations Policy and Procedures ('COPP'): i. Section 3.7 – Management of inmates at risk of self-harm or suicide ii. Section 19.1 – General escort procedures g. The following sections of the CSNSW Operations Procedure Manual ('OPM'): i. Section 6 – Escorts; and ii. Section 13.3.2 – Management of inmates at risk of suicide or self-harm in correctional centres. h. The following portions of CSNSW policies not publicly available: i. COPP 13.3 – Deaths in custody • Page 6, sub-section 2.4, third sentence. ii. OPM Section 13.2 – Deaths in custody • Page 9, dot point 6, first 2 sentences. i. Images and footage taken from CCTV. 2. Pursuant to section 65(4) of the *Coroners Act 2009 (NSW)*, a notation be placed on the Court file that if an application is made under s.65(2) of that Act for access to CSNSW documents on the Court file, that material shall not be provided until CSNSW has had an opportunity to make submissions in respect of that application.

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Introduction

1. This inquest concerns the tragic death of Tane Chatfield. Tane died surrounded by members of his loving family at Tamworth Hospital on 22 September 2017. He was 22 years of age.

2. Tane had been brought by ambulance to Tamworth Hospital from Tamworth Correctional Centre ("Tamworth CC") on the morning of 20 September 2017. He was unconscious and in a critical condition on arrival.

3. Tane was alone in his prison cell on the morning of 20 September 2017, having returned from hospital following a cluster of seizures the night before. Around 9.05 am, a fellow inmate peered through the cell peephole and saw Tane hanging from a torn prison blanket tied to an exposed pipe. Tane had been unattended for less than 46 minutes. Correctional staff were immediately notified and resuscitation attempts commenced.

4. Tane was a proud indigenous man of the Gamilaraay, Gumbaynggirr and Wakka Wakka people. He came from a large extended family and grew up in the Armidale area. His mother Nioka, father Colin and family continue to grieve Tane's death and search for answers. The participation by the family in this inquest was directed at seeking the truth of what occurred and prompting change for other indigenous men and women currently incarcerated. I respect and acknowledge the assistance they gave the court.

5. Tane is also survived by his partner, Merinda and their son Jho'Arryn. It is a profound tragedy that Jho'Arryn will grow up without his father. Merinda also attended and participated in the inquest in an attempt to affect change for others. If Jho'Arryn ever reads a transcript of these proceedings, he will know how hard his family fought to seek justice for his father.

6. Tane is missed by all those who loved and cared for him. The court heard a powerful and moving family statement which described Tane's strengths and struggles. Family members spoke of his loving and caring personality. His mother, Nioka said that Tane would "give his shirt off his back for any stranger."[1] One of his sisters told the court "Tane was our strength, he made our childhood bearable…he was our fun and laughter. Tane taught us how to be strong…and made our childhood memorable."[2] His grandmother spoke of Tane's caring nature and his sporting prowess.[3]

7. During the family statements, I also heard of how inter-generational trauma has affected Tane's family. Nioka spoke of Tane's father, Colin and his history of incarceration and prison

[1] Nioka's words, Family statement T 17/7/20, page 11, line 20.
[2] Hazel's words, spoken by Jodie Pitt, Family statement T 17/7/20, page 16.
[3] Lesley's words, Family statement T 17/7/20, page 13.

beatings. Tane's sister spoke eloquently about the harm caused to Tane by his entry into juvenile detention. She explained that instead of being brought up just on his mother's love "he was also brought up by a juvenile system built on punishment, violence and drugs."[4]

8. Beyond the circumstances of this individual tragedy, the investigation into Tane's death raised broader questions about the general standard of medical care and support provided to inmates within our prison system. It also demonstrated that concerns raised during the Royal Commission into Aboriginal Deaths in Custody ("RCIADIC"), thirty years ago, in relation to the placement of vulnerable indigenous prisoners in cells with obvious hanging points remain unresolved today. It shone a powerful light on the inter-generational nature of indigenous incarceration.

9. I am indeed encouraged to learn that Colin and Nioka Chatfield are working on a healing program to address issues that lead to incarceration and intergenerational incarceration of Aboriginal and Torres Strait islander people in this country, and especially within their local community. I sincerely hope that they find the support necessary to make their plans a success.

Background

10. It is necessary to place Tane's incarceration in its wider social context prior to a close examination of the particular facts surrounding his death.

11. According to the Australian Law Reform Commission, Aboriginal and Torres Strait Islander adults make up around 2% of the national population, however they constitute around 27% of the national prison population.[5] In 2016, around 20 in every 1000 Aboriginal and Torres Strait Islander people were incarcerated. Tragically, over-representation appears to have grown, not decreased. Aboriginal and Torres Strait Islander incarceration rates increased 41% between 2006 and 2016 and the gap between Aboriginal and Torres Strait Islander and non-Indigenous rates widened over the decade.[6]

12. Recent figures released by the Bureau of Crime Statistics and Research (BOSCAR) indicate that in NSW the total number of indigenous persons in custody as a percentage of total inmates sits consistently at around 26%, reflecting ongoing over-representation by a factor of 9 - 10. This remains the case even after a significant overall reduction of the number of people in custody during the COVID-19 period.[7] During the inquest, the court was advised

[4] Hazel's words, spoken by Jodie Pitt, Family statement T 17/7/20, page 16.
[5] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.
[6] *Ibid,* pp. 21-22.
[7] NSW Custody Statistics: Quarterly update June 2020.

that the indigenous population at Tamworth Correctional Centre, where Tane was housed, was higher than 50 % both at the time of his death and currently.[8]

13. The over-representation of Aboriginal and Torres Strait Islander people is hardly a recently discovered phenomenon. Its continued existence was accurately described in one submission to the recent Australian Law Reform Commission's Inquiry into the incarceration rate of Aboriginal and Torres Strait Islander people as a "national disgrace".[9]

14. Tragically this is not the first inquest into the death of an Aboriginal man in custody that I have been called upon to preside over this year. During the *Inquest into the death of Jonathon Hogan,*[10] I noted that as far back as 1991, the RCIADIC found that indigenous people were grossly over-represented in custody. Further, the Commissioners noted that this over-representation in both police and prison custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody."[11] In other words, until we do something about over-representation, we will certainly continue to record a disproportionate level of indigenous deaths in custody.

15. During the *Inquest into the death of Jonathon Hogan*, I noted that almost 30 years after the RCIADIC, we have failed to appropriately reduce the grossly disproportionate incarceration of indigenous people or to properly grapple with the underlying factors. The RCIADIC identified indicators of disadvantage that contribute to disproportionate incarceration including: "the economic position of Aboriginal people, the health situation, their housing requirements, their access or non-access to an economic base including land and employment, their situation in relation to education; the part played by alcohol and other drugs - and its effects". The Commission also identified dispossession without the benefit of treaty, agreement or compensation as a factor in over-representation in custody.[12] Decades later, these factors remain at the forefront of our failure to reduce incarceration rates. Despite attempts to "Close the Gap", disadvantage abounds and successive governments have been unable to squarely face the effects of dispossession and move forward with 'truth telling' and with agreement with Aboriginal and Torres Strait Islander peoples.[13]

16. Once again it is incumbent upon me to stress that if we are to reduce the number of Aboriginal deaths in custody we need to grapple with the underlying causes of over-

[8] Statement of Saffron Cartwright, [6]-[7] (Exhibit 1, Tab 76C).
[9] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.
[10] Inquest into the death of Jonathon Hogan, 6 May 2020.
[11] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, pp. 21-22.
[12] *Ibid*, p. 22.
[13] The importance of initiatives such as the *Uluru Statement from the Heart* cannot be underestimated in this context. This statement urges us as a country to do better.

representation. Quite simply, more young Aboriginal men like Tane must be diverted away from the criminal justice system if we are to reduce the number of Aboriginal deaths in custody nationally. Tane entered the system as a juvenile, and was first detained as a child around 14 years of age.[14] At the time of his death he was only 22 years of age. He was on remand and had already spent a significant portion of his adult life in custody.

17. These factors form the relevant background to my specific inquiries. They are worthy of careful consideration and acknowledgement. Tane's death must be understood in its context of real social injustice, ongoing dispossession and his lived experience of inter-generational trauma.

18. This inquest occurred at a time when many Australians are calling for change. It raised issues well beyond my statutory task as a coroner and it may be that Tane's family are ultimately disappointed that some of the recommendations they called for, such as reform of the Bail Act, are beyond my powers in the context of this inquest. I have no doubt they will continue to work for change in other forums.

19. Listening to the family's expression of love and grief for Tane, I was reminded of a passage from the Uluru Statement from the Heart, quoted by State Coroner O'Sullivan in her findings in the *Inquest into the death of Eric Whittaker*[15] earlier this year. It reads:

> "Proportionally, we are the most incarcerated people on the planet. We are not innately criminal people. Our children are aliened from their families at unprecedented rates. This cannot be because we have no love for them. And our youth languish in detention in obscene numbers. They should be our hope for the future.
>
> These dimensions of our crisis tell plainly the structural nature of our problem. *This is the torment of our powerlessness."*

20. Tane's mother echoed this sentiment during the family statements when she told me directly that Tane was killed by the prison system.[16] I acknowledge the truth and pain of her words.

The role of the coroner and the scope of the inquest

21. The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death.[17] A coroner may also make recommendations, arising directly from the evidence, in relation to matters that have the capacity to improve public health and safety in the future.[18]

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[14] Statement of Detective Sergeant Coorey, Exhibit 1, [34].
[15] *Inquest into the death of Eric Whittaker*, 28 February 2020
[16] Nioka's words, Family Statement, 17/7/20 page 11, line 34.
[17] Section 81 *Coroners Act* 2009 (NSW).
[18] Section 82 *Coroners Act* 2009 (NSW).

22. In this case there was no dispute in relation to identity of the deceased or to the date or place of death. However, the manner and circumstances of Tane's death required significant investigation. It is clear that nobody, either within the custodial or medical system or from within Tane's family, foresaw the tragedy that occurred. Trying to understand what happened, even when it seems inexplicable, is a crucial part of preventing future death.

23. When a person dies in custody it is mandatory that an inquest is held.[19] The inquest must be conducted by a senior coroner.[20] When a person is detained in custody in NSW the State is responsible for his or her safety and medical treatment. Given that inmates are not free to seek out and obtain the medical treatment of their choice or have their families directly assist them in this task, it is especially important that the care they are offered is of an appropriate standard and is culturally appropriate. The living conditions of inmates are similarly restricted. Correctional officers and medical staff are called upon to manage a range of inmates, taking into account their often disparate medical needs and other requirements. Considerations relating to medical care and cell placement are important and can have significant impact on an inmate's state of mind and physical well-being.

24. Tane had been in custody since 30 July 2015.[21] He entered custody with a clear risk of self-harm. He was a young indigenous man who had recently been admitted to Armidale Hospital after self-harming with a razor.[22] His initial screening indicated significant levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder. He expressed feeling a lack of family support and was known to have recently experienced suicidal ideation. He informed medical staff that he had "multiple attempts at hanging himself" and "a constant feeling of being lost." He was withdrawing from ice.[23]

25. Over the next two years in custody,[24] Tane did not receive sustained psychological care[25] or support; drug and alcohol treatment; or meaningful assistance to strengthen his troubled relationships in the community, despite his disclosure of past abuse, his fear that his child could be removed and his request to speak with his father who was also incarcerated. Tane continued to return positive drug tests[26] and advised the Justice Health & Forensic Mental Health Network ("JH") that he had been using "dirty fits" for months.[27] His disciplinary record suggests that he remained unsettled on remand.[28] His contact with any Aboriginal Support

[19] Section *27 Coroners Act* 2009 (NSW).
[20] Section *24 Coroners Act* 2009 (NSW).
[21] Exhibit 1, Tab 55 Parole Authority Offender Report, page 5.
[22] Exhibit 1, Tab 60 Armidale Hospital ED triage notes, p21-25.
[23] Exhibit 1, Tab 60 Reception Screening Assessment, p 55-59.
[24] Tane was in the community between 25 August 2015 and 13 October 2015.
[25] It is documented that Tane had one assessment interview with a psychologist, Sarah McCartney on 29 October 2015 and was referred to an aboriginal elder for support.
[26] Exhibit 1, Tab 46.
[27] Exhibit 1, Tab 60 Clinical Notes, p 269.
[28] See Exhibit 1, Tab 46 Misconduct Report and Inmate Discipline Action Form and associated forms, p 211-232.

worker was minimal, the last face to face contact appears to have been in relation to his grandmother's funeral in August 2016.[29]

26. This is the brief background to the despair he appears to have felt in the lead up to the medical emergency that developed in September 2017.

27. The pain, shock and disbelief felt by Tane's family, following his death, is profound and ongoing. His story will affect the lives of his child and his community well into the future. Each successive indigenous death in custody shapes the story younger prisoners learn when they too are incarcerated. Tragically, the utter despair felt by Tane is most likely to have been transitory, but he was alone at this time of great need and for that I am deeply sorry. He too had heard the stories of hangings in custody and he had no reason to trust or reach out to those who were tasked to care for him.

28. It was clear to me that Tane's family loved him greatly and that he is missed every day. I understand that the family's participation in this inquest came with enormous pain. I acknowledge their dignity, strength and generosity in participating in these proceedings.

The evidence

29. The court took evidence over five hearing days. The court also received extensive documentary material, comprising six volumes. This material included witness statements, medical and custodial records, investigation reports, CCTV recordings and photographs. The court heard oral evidence from Tane's treating doctor at Tamworth Hospital, the JH Nurse Unit Manager at Tamworth CC and from involved correctional staff. The court heard from an independent neurologist, Dr Simon, who reviewed Tane's neurological care and from an independent forensic pathologist, Professor Cordner, who was present during the post mortem examination by Dr Cala. The court was also assisted by the expert evidence of Professor Matthew Large, a psychiatrist with extensive expertise in suicide, who undertook an independent review of Tane's mental health care and treatment in custody.

30. While I do not intend to refer specifically to all the available material in detail in these findings, it has been comprehensively reviewed and assessed.

31. A list of issues was prepared before the proceedings commenced.[30] These questions directed the focus of the evidence presented in court. However, as is often the case, a

[29] Exhibit 1, Tab 46, SAPO report p 103.
[30] The issues addressed at the hearing were:
- Whether the management of Mr Chatfield's mental health in custody was reasonable and appropriate;
- Whether the management of Mr Chatfield's general health in custody, particularly the management of any seizures, was reasonable and appropriate;

hearing tends to crystallise the issues which are really at stake. For this reason, after dealing with the chronological facts, I intend to distil my reasons under a small number of broad headings.

32. The focus of the inquest ultimately centred on systemic challenges, rather than judging the conduct of specific individuals involved in the provision of health or custodial services. In final submissions, JH quite properly acknowledged that Tane did not receive the care that he deserved on the morning of 20 September 2020 when he was returned from Tamworth Hospital. Specifically, JH recognised that it should have recommended to CSNSW that Tane be placed in a two-out cell.[31] This acknowledgement was in my view much more profound than any criticism of the individual decisions of particular practitioners.

Chronology

Personal Background

33. Tane was one of a large family and grew up in the Armidale area. He was close to his family who remained in close contact even during his incarceration. Tane had a partner, Merinda and a young son.

34. Tane inspired great loyalty from his friends. The court heard from his co-accused who described him as like a younger brother. A letter from another friend found in Tane's cell after his death expressed great devotion.[32]

35. While Tane had some employment in the community, from his teenage years Tane also struggled with a reliance on illicit drugs, including ice. This is likely to have been the immediate trigger for his entry into the custodial system.

36. From 2012, Tane spent various periods in juvenile detention. Records indicate that he already had a significant drug problem and had experienced symptoms of depression and anxiety.

- Whether the diagnosis and proposed management of Mr Chatfield's seizures by Tamworth Base Hospital was reasonable and appropriate;
- Whether the circumstances of Mr Chatfield's discharge by Tamworth Base Hospital following his seizures was reasonable and appropriate;
- Whether the management of Mr Chatfield in custody following his discharge from Tamworth Base Hospital was reasonable and appropriate (including his cell placement and the availability of a hanging point in his cell);
- Whether the response by CSNSW and Justice Health on 20 September 2017 to Mr Chatfield being found hanging in his cell was timely, reasonable and appropriate;
- The likely cause of Mr Chatfield's death; and
- Whether the CSNSW Investigation Report into Mr Chatfield's death was a sufficient and appropriate response by CSNSW to Mr Chatfield's death.

[31] JH Submissions, T 17/7/20, page 36, line 12 onwards.
[32] Letter from Aaron Collins, Exhibit 1, Tab 74.

37. In 2012 and 2013, Tane had investigations on his brain due to findings of abnormalities in the form of a right basal ganglia cystic structure.[33] These investigations did not result in any relevant diagnosis. Both Dr Simon, neurologist and Dr Cala, forensic pathologist were aware of this finding but expressed the view that it was unlikely to have played a role in Tane's death.

38. On his first entry into adult custody in July 2015 Tane was initially placed in an assessment cell which allowed for frequent observations. He was later allowed to be housed "two out".[34] Tane was released on 20 August 2015.

39. After about six weeks in the community Tane was taken back into custody on 13 October 2015, where he remained until his death. The day after his entry back into custody, he was cleared for 'normal cell placement.'[35] He was subsequently reviewed on 15 November 2016[36] and on 29 August 2017[37] and on each occasion considered suitable for 'normal cell placement.' This meant that although Tane was usually placed in a cell with another inmate, he could also be left alone.

40. Records indicate that Tane had some interactions with JH during 2017 in relation to dental issues. However, there is no record that he had any sustained contact with psychological or cultural support workers during his incarceration[38]. It appears that any support he had was provided by his fellow inmates. Custodial staff described him as a "popular inmate."[39] His cellmate on the night before his death described him as caring and helpful.

41. It is difficult to establish Tane's state of mind during the period leading up to his death. He is reported to have been genuinely excited about the prospect of his impending release. According to his co-accused and others, Tane clearly believed that he would be back in the community very soon. However, the court has also had the opportunity to listen to a number of telephone calls between Tane and his partner which indicate that he found the ongoing separation difficult and experienced feelings of jealousy, frustration and loneliness. An unsent letter addressed to Merinda, found after his death, suggests that the relationship could be volatile and that like many prisoners Tane found it extremely difficult to process his feelings of separation and loss.[40] It is likely he held fears about how his relationship would survive on his release and he mourned the time he had already lost with his son.

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[33] Exhibit 1, Tab 60 CT brain report, p 183.
[34] Exhibit 1, Tab 60, HPNF form – clinical notes, p 270.
[35] Exhibit 1, Tab 60, HPNF form – p 218.
[36] Exhibit 1, Tab 46 HPNF form – p 14.
[37] Exhibit 1, Tab 60 HPNF form – p 217.
[38] Records indicate that he saw a psychologist on one occasion and had limited interaction with the Centre's SAPO. Being on remand it appears he had limited opportunities for training, education or drug and alcohol support.
[39] T 15/7/20, page 12, line 10.
[40] Unsent letter to Merinda Murphy, Exhibit 1, Tab 73.

42. Tane would always have had a place to return to. He was close to a number of his siblings and spoke to at least one of his sisters regularly. A number of family members attended Armidale District Court to support him during his trial. They provided him with new clothes and were excited at the prospect of him coming home.

43. It is clear that when his family saw him at court on 19 September 2017, they could not have foreseen what would soon occur.

Events leading up to Tane's removal from Tamworth CC on the evening of 19 September 2017

44. Over the years Tane spent time at a number of correctional centres. He was moved to Tamworth Correctional Centre at the end of August 2017 so that he could attend his trial at Armidale District Court.

45. On 2 September 2017, Tane was visited by his mother, brother and sisters. On the same day he was also found with drugs and was disciplined for having provided drugs to another inmate.[41]

46. On 4 September 2017, Darren Cutmore, Tane's co-accused was moved into cell 30 with Tane. It is notable that in a number of days that followed, and during Tane's trial, Tane was regularly seen in the JH clinic. This was likely due to his ongoing dental issues. In any case, he did not raise any concerns about his mental health.

47. On 15, 16 and 17 September 2017, Tane made a number of calls to his partner and some friends. He tested positive for drugs on 17 September 2017 and it was on this day he made his last telephone call, which was to his partner. He was agitated and insecure. It is not clear to what extent he was affected by drugs at the time. Some of his calls during this period appear consistent with him trying to arrange drugs in prison.

48. On 19 September 2017, Tane attended Armidale District Court. Darren Cutmore says he gave evidence in support of Tane at the trial. There is evidence from a CSNSW officer present at court that the judge made a brief comment about the two co-accused inmates being housed together. There is no transcript of this, but it is clear that the officer contacted the manager of security who then informed the Centre and immediate arrangements were made for the inmates to be housed separately.[42]

[41] Exhibit 1, Tab 44, Inmate Profile Document, p 2.
[42] Exhibit 1, Tab 35, Officer report form of Clinton Flentjar.

49. In the late afternoon Tane returned from court. Correctional Officer Porter who was involved with his escort reported that Tane was in "good spirits and happy with the progress of his trial."[43] This is confirmed by Darren Cutmore who told the court Tane "was happy, he was as happy as he could be because he was beating his – like his court matter".[44]

50. Tane's mood changed on return to the Tamworth Correctional Centre when he was informed that he and Darren Cutmore were to be separated. Darren Cutmore explained to the court that this distressed Tane and he became "very upset." Mr Cutmore told the court that it had been a stressful time for them both, given that their trial was in progress and this separation was unexpected. Mr Cutmore told the court that when officers informed Tane he would be separated from Mr Cutmore, Tane stated "All we've got is each other and they want to fucking take that away from us too."[45]

51. There is no evidence to suggest that this decision was ever explained clearly to Tane. It is likely to have been experienced as an arbitrary and possibly punitive action. It is likely to have caused him significant distress.

52. Following the separation, Mr Cutmore was moved out of the shared cell and into cell 21. A new inmate, Barry Evans, was placed with Tane. Barry Evans gave evidence before this court. He explained that it was his first ever night in custody and he was extremely frightened and ill at ease. He was struggling with his new surroundings and his head "was all over the place."[46] Nevertheless he remembered Tane tried to "settle him down" and make him feel less uncomfortable and afraid.[47]

53. At 10.12pm Tane 'knocked up' from cell 30. Mr Evans was lying on the top bunk at the time and he remembered Tane explaining the 'knock up' process and then speaking with an officer through the intercom. Mr Evans remembers Tane requesting Panadol. Mr Evans explained that his exact memory of these events was not strong as he was "in another world", only just coping with his first experience of custody. He did remember that Tane was upset and angry at being separated from Darren Cutmore. He appeared anxious, jittery, and worried. Mr Evans also said that Tane told him that he suffered from epilepsy.[48]

54. Officer Meznaric gave evidence that he attended the cell with other officers and spoke with Tane at this time. The officer stated that Tane told them he felt unwell. Officer Meznaric told the court that Tane said "he was feeling unwell, he knew when he got this feeling that he, he

[43] Exhibit 1, Tab 30 Statement of CO Porter [6-7].
[44] T 13/7/20, page 15, line 33.
[45] T 13/7/20 page 10, line 27.
[46] T 13/7/20 page 22, line 50 onwards.
[47] T 13/7/20 page 30, line 10 onwards.
[48] There is no evidence before me that Tane had ever been diagnosed with epilepsy.

was on his way to having a fit. That's pretty much it."[49] The officer stated that Tane was given the opportunity to move to a safe cell. According to Officer Meznaric, Tane told the officers in clear terms that he did not want to go to a safe cell. Officer Meznaric told the court that he felt confident with the decision. He said that as an officer he had come across "a lot of different inmates…a lot them tend to have fits…and most of them will be able to tell you straight away whether they're going to have one or not."[50] He said he had known Tane for quite a while at that time and he felt somewhat reassured by the fact that Mr Evans could knock up if anything happened.

55. Officer Meznaric confirmed the well-known fact that 'safe cells' with their constant bright light and ongoing surveillance are regarded as a place of last resort by inmates. To my mind it is not surprising that Tane was content to stay where he was at that time.

56. According to Mr Evans, Tane remained agitated in his cell. Mr Evans did not see Tane use any drugs that night, however he saw Tane doing something at the peephole in the door of the cell. At the time Mr Evans did not understand exactly what was going on, but later learned that Tane had engaged in 'fishing' from his cell peep hole.

57. Darren Cutmore explained that fishing for drugs or other small items like lighters or food or implements for using drugs is commonplace in custody. It involves throwing a line or string, usually torn from a blanket, out of one cell so that it crosses with a line thrown from another cell. Darren Cutmore explained "we send lines out to each other and catch the line so we can pass stuff between cells…it's kind of a skill you acquire and eventually you get good at it."[51] However, he could not remember having done it that night, and more specifically he could not remember having used drugs that night.[52]

58. The CCTV[53] tendered in these proceedings showed activity in the nature of 'fishing' from Tane's cell, between 10.27 – 10.41pm that night. It is not known what Tane was fishing for or whether he was successful. Mr Evans cannot shed any real light on what was going on in this regard or further explain his fishing attempts. However, it appears Tane was overwhelmed by anxiety and was likely affected, to some extent, by withdrawal from recent drug use.

59. It is possible that Tane used drugs again on the night of 19 September 2017 but it seems unlikely. There were no discernible signs of recent drug use when Tane was admitted to Tamworth Hospital later that night and he told the attending doctor that he had not used for a few days. He had no reason to lie. While some drug paraphernalia was found in Tane's cell

[49] T 13/7/20 page 39, line 10 onwards.
[50] T 13/7/20 page 40, line 19 onwards.
[51] T 13/7/20 page 11, 10 onwards.
[52] T 13/7/20 page 12, line 25 onwards.
[53] Exhibit 1, Tab 66.

the following morning by officers, unfortunately these items were never seized and the opportunity to inspect or test these items was lost.[54] It is not known when they were last used or what traces they may have contained.

60. During the evening of 19 September 2020, Tane's condition worsened. Mr Evans told the court "Tane did mention that he suffered from epilepsy and suffered from fits, and I was like "oh yeah, rightio", and all I could think of was like, like geez man, don't do it now, eh. Don't do it while I'm here, eh. I can't handle this. Like I was, I was a mess myself, you know. And the more it progressed the more agitated he got, the more unsettled he got…and he was just standing there and next minute he hit the floor…you know that's not normal. And then just little, just like in a shake…he was having a fit of some sort."[55]

61. Mr Evans, who had some first aid experience as an auxiliary fire fighter jumped down from his bunk bed and placed Tane in a recovery position. Records show that at 11.04pm Barry Evans knocked up from the cell, calling for help. Officer Meznaric and other officers attended the cell. CCTV footage shows them entering the cell and taking Tane out into the corridor. Officer Meznaric also gave evidence that he saw Tane have another fit. "He was fairly rigid and just convulsing". Officer Meznaric told the court he walked around Tane who was on the floor and tried to make sure he did not hit his head on any of the hard surfaces. Officer Meznaric was in no doubt that Tane was having a genuine seizure.[56] He said that after the seizure Tane took a while to "get his bearings." He described Tane as disorientated as he went down the stairs and that he "still sort of hadn't come fully to himself."[57]

62. Officer Meznaric was involved in taking Tane to the JH Clinic within Tamworth CC to wait for the paramedics. He and another officer witnessed a further seizure while Tane was lying on the bed.[58] He also notified the JH After Hours Nurse Unit Manager, in Sydney about what had occurred.

63. In my view the evidence clearly establishes that Tane had a seizure or series of short seizures of some kind. Dr Simon, an experienced neurologist and Professor Large, a psychiatrist with Emergency Department experience, both viewed the CCTV footage of Tane leaving Tamworth Correctional Centre. Both expert witnesses confirmed that his appearance as dazed and needing assistance to walk was consistent with post-ictal confusion.

64. Tane was taken to the hospital by ambulance. An enrolled nurse recorded that "patient had seizure when NSW Ambulance Officers and myself went to place patient onto ward trolley".[59]

[54] Statement of Peter Thistle.
[55] T 13/7/20, page 26, line 33 onwards.
[56] T 13/7/20, page 43, line 25 onwards.
[57] T 13/7/20, page 51, line 44.
[58] T 13/7/20, page 47, line 39.
[59] Emergence Department Triage Notes, Tab 62.

The ambulance records and Emergency Department records state that Tane informed medical professionals (paramedics, nurses and the doctor) that he had epilepsy and was not compliant with medication. More specifically he told the treating doctor that he had a previous seizure at 17 years of age and another nine months ago.[60] Despite requesting Tane's known medical records both from custody and from community sources, the court has seen no evidence of a past record of epilepsy or the prescription of epilepsy medication and no family member appeared aware of any formal diagnosis.

65. The Court heard from Dr Raj who was the resident medical officer who examined and assessed Tane after his initial triage at Tamworth Hospital.[61] He told the court that Tane was initially monitored in the usual way and that his heart rate, blood pressure and oxygen saturation levels were all normal. The doctor then conducted a specific neurological examination. His records document a systematic approach of assessing Tane's cranial nerves, limbs, reflexes, sensation and coordination as well as observing his mobility.[62] Dr Raj came to the conclusion that it was "unlikely" Tane had suffered epileptic seizures but further investigation was required.[63] He later recorded on the discharge summary that an EEG should be obtained. He explained his impression to the court: "Essentially on the episodes described to us it was unclear whether they were epileptic seizures. There are lots of different types of seizures that can be caused from various different things, one of which is epilepsy. But to actually diagnose epilepsy there are particular criteria. They need to be mapped and often the diagnosis is made by a neurologist."[64]

66. The records show that Tane was kept overnight and observed. It is likely that in addition to suffering from a cluster of seizures, Tane also used the opportunity to seek calming drugs while at Tamworth Hospital. It seems medical staff had suspicions that Tane engaged in "drug seeking behaviour". Tane reported that he suffered unexplained "10 out of 10 pain all over his body" but was described as clutching at his body and complaining of pain only when medical staff were present. Officer Gebadi noticed that Tane was agitated and requested "stronger medication", but that medical staff could see no clinical reason for it.[65] Records indicate that Tane had two doses of paracetamol, two doses of ibuprofen and one dose of oxycodone during his admission.

67. Hospital Emergency Departments can be uncomfortable surroundings and Tane is likely to have felt tired and anxious. In my view, it is possible that Tane, who was known to have substance use issues, may have used the opportunity to attempt to access opiates.

[60] This information is recorded in the Discharge Summary, Exhibit 1, Tab 62, page 10.
[61] Emergence Department Triage Notes, Tab 62.
[62] See discussion of the examination at T 13/7/20, page 73, line 20 onwards.
[63] Discharge Summary, Exhibit 1, Tab 62, page 10.
[64] T 13/7/20 page 57, line 8 onwards.
[65] T 13/7/20 page 63, line 30 onwards.

However, whether or not he engaged in drug seeking behavior while at the Emergency Department does not change my firm view that he had experienced troubling seizures that evening.

68. The evidence given by Dr Raj was considered and clear. Both Dr Simon and Dr Large regarded his assessment as appropriate in the context of a regional Emergency Department. Dr Simon explained that it would be most unusual to prescribe anti-epileptic medication in the circumstances described and that Dr Raj was correct to advise specialist advice was warranted and an EEG should be obtained[66]. I accept his view.

69. Unfortunately, a discharge summary was not provided to the correctional officers on discharge. Dr Raj explained that an Emergency Department in a regional hospital can be very busy and there will be times where a discharge summary is not readily available at the time a patient is discharged. In this case it was completed shortly after discharge. The time stamp on the discharge summary is 8.19am.[67] The information it contained was important and if it had been available it is likely to have affected later decisions about cell placement. The provision of a discharge summary takes on particular significance when the patient is a prisoner who has little or no control over his movements or ongoing access to supervision or medical treatment.

70. Tane was discharged and escorted back to Tamworth CC between 7.45am and 8am. The officers involved in his escort stated that he did not display any major signs of emotional distress.[68] Officer Gebadi thought he was "still a bit agitated", but he was certainly cooperative. Officer Fittler explained that he was not agitated, but he was not entirely happy and was still complaining of body aches and pains. Officer Fittler told the court that while at hospital Tane mentioned that he was due to attend court that day and "was actually quite keen and enthusiastic to get back out and spend time with his partner and son."[69]

71. On return to Tamworth Correctional Centre it is evident from the CCTV footage that Tane could walk unaided and was no longer obviously confused. It is difficult to assess the extent to which Tane remained in any post-ictal state. The expert evidence is that this is possible. Professor Large gave evidence that any signs of such disturbance at this time would be subtle, and likely not readily apparent to others.

72. Before Officer Fittler escorted Tane back to his cell, he was taken to the JH clinic and seen for a brief period by the Nurse Unit Manager Janeen Adams. The CCTV footage demonstrates that this consultation must have only taken a matter of minutes.

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[66] T 16/7/20 page 15, line 45 onwards.
[67] This time is approximate as the fax record indicates it was sent at 8.15am.
[68] T 14/7/20 Page 11, line 11.
[69] T 14/7/20, page 8, line 1 onwards.

73. Ms Adams explained to the court that the JH clinic provides primary health care, mental health, drug and alcohol and sexual health services. The clinic is staffed between 8am and 8.30pm on weekdays and on weekends from 9.30am to 6pm. At other hours, Corrective Services Staff can contact an after-hours Nurse Manager for advice or call Triple 000 in an emergency.[70]

74. Ms Adams arrived at prison at around 7.30am on the morning of 20 September 2017 to attend to an insulin dependent diabetic inmate who required medication. She stated that it was around 8am that she first became aware of Tane. She said that Officer Fittler advised her that he was returning the patient, post discharge, from the Tamworth Hospital. She requested the discharge summary and Officer Fittler advised her that he did not have it. She said that she asked the inmate his name and went into the medical records room to retrieve his file. She told the court she looked at his current Health Problem Notification Form (HPNF). She states that she saw the HPNF dated 29 August 2020 and it was "normal cell placement." She claimed to have "flipped over to the progress notes…to see if there was a nurse entry in regard to the transfer across to hospital, which there was none."[71]

75. It should be noted that according to JH policy a new HPNF form should be completed by the relevant Nurse Unit Manager whenever an inmate's clinical situation changes.[72]

76. Ms Adams outlined the conversation she had with Officer Fittler and with Tane himself. She told the court that Officer Fittler informed her that Tane "had some Endone which calmed him down and he was okay and he needed one of those tests on his – not his heart but his head which I added an EEG and he said, "Yes that's it"". She did not recall Officer Fittler mentioning that Tane had suffered seizures the previous night.[73]

77. She considered that the fact that Tane had been given Endone and that he required an EEG was "conflicting clinical information." Despite this apparently conflicting clinical information, Ms Adams did not make any further inquiries of Tane.

78. Ms Adams recounted the conversation between herself and her patient. She "asked Mr Chatfield how he felt now and he said "okay" and then I asked him did he have any other issues and he said "No Miss".[74] She told him to "knock up" if he felt unwell.[75] This appears to have been the extent of her interaction with Tane himself. In my view this was inadequate.

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[70] T 14/7/20, page 2, line 3 onwards.
[71] T 14/7/20, page 7, line 43 onwards.
[72] Exhibit 1, Tab 85 – Justice Health Policy: 1.231, at [2.2] reads as follows;
"The Nursing Unit Manager (NUM) or delegate is responsible for (inter alia):
- *Ensuring a new HPNF is completed at reception or whenever a patient's clinical situation changes, this may include changes that occur during transfer or differing clinical needs at the receiving centre."*

[73] T 14/7/20, page 8, line 15 onwards.
[74] T 14/7/20, page 8, line 30 onwards.
[75] Statement of Ms Adams Exhibit 1, Tab 39 A, [12].

The failure to make inquiries about the reason for Tane's admission to hospital demonstrates a lack of clinical care and a failure to establish a rapport with the patient.

79. Correctional officers rely on JH to obtain the necessary information and make clinical judgments in order to inform cell placement decisions.[76] More was required of Ms Adams in the circumstances.

80. Ms Adams told the court that she advised Tane that she would need a discharge summary. She stated that "based on the visual observations of Mr Chatfield at the time, he was alert, he answered questions appropriately, and he appeared well, and based on the fact that the patient was been medically cleared for discharge from the hospital back to the community setting, I recommended that the patient be 'sick in cell' to rest until such time as we could get him back over to the clinic to review him."[77]

81. I have considered Ms Adams's evidence carefully and find it difficult to accept. While Officer Fittler initially gave evidence that he gave Ms Adams a handover which included a reference to seizures,[78] he was later unable be "100% certain".[79] Officer Fittler's almost contemporaneous record notes Tane's condition as "multiple seizures" and there was an exchange in the conversation about the need for an EEG. In my view it seems most unlikely that Officer Fittler would have failed to convey the fact that Tane had suffered from seizures to the Nurse Unit Manager, especially in the absence of a discharge summary. The interaction she describes is in my view inherently implausible.

82. I am not in a position to make a definitive finding as to whether or not Ms Adams was aware of the seizures at the relevant time. However, it is clear that whether or not she actually knew, she *should* have known. Ms Adams had a number of options available to her at the time. She could have called the Hospital while Tane was in the clinic. She could have made inquiries with the JH After hours service to find out what had happened the previous evening. She could have questioned the custodial officer who had been at the Hospital for further information or she could simply have asked Tane himself.

83. Ms Adams was also taken to a document entitled "State-wide After Hours report of 19 September 2017."[80] This document was emailed to the clinic on the morning of 20 September 2017, in accordance with the regular daily routine. It is not known when the document was created but the final entry on the list is reported to be at 8am. The CCTV

[76] Exhibit 1, Tab 79 – Justice Health Policy: 1.340 at [2.1] reads as follows;
"JH&FMHN staff must make clinically based recommendations for patient accommodation to CSNSW where the health needs of patients require special consideration."
[77] T 14/7/20, page 9, line 12 onwards.
[78] T 14/720, page 13, line 25.
[79] T 14/7/20, page 23, line 3.
[80] Exhibit 2.

footage shows us that by 8.01am Tane had already been taken to his cell.[81]

84. This document contains a brief summary of various interventions or notifications made to the JH After Hours Nurse Manager overnight. On 20 September 2017, it reports that a patient was transferred overnight to Tamworth Hospital by CC staff. The patient is recorded to have had a history of seizures. Ms Adams stated that she did not see the document until after Tane was taken back to Hospital later that morning in a critical condition. Nevertheless, she could have checked or called for if she had wanted further information.

85. Ms Adams told the court that she handed over responsibility for Tane's care to the other nurse, Ms Veech at around 8am.[82] She informed Ms Veech that Tane should be the first patient to be seen that day.[83] Ms Adams told the court that Ms Veech contacted Tamworth Hospital Emergency Department and requested a copy of the discharge summary. Unfortunately the court could not hear from this nurse, who no longer works for JH. The discharge summary arrived at 8.20.[84] It is not known whether Ms Veech read it, but Ms Adams said she did not see the document or discuss it with Ms Veech.[85]

86. Officer Fittler was informed by Nurse Adams that Tane was to be 'sick in cell' and remain in the cell until receipt of the discharge summary. At this point he understood the plan by Ms Adams was to have Tane returned to the clinic for a compete assessment at that later point.

87. Ms Adams did not complete a nursing certificate for her recommendation for 'sick in cell'. It appears that the policy at the time did not require it.[86] Fortunately this policy has been reviewed since Tane's death and CSNSW now require a medical or nursing certificate for someone to be placed "sick in cell."[87]

88. The completion of a nursing certificate, or a revised recommendation to CSNSW on cell placement and inmate care, was necessary. It was necessary in order for Tane to be clearly made aware of his placement situation (other than him simply being told once that he was

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[81] Exhibit 1, Tab 66.
[82] T 14/7/20, page 14, line 9.
[83] T 15/7/20, page 18, line 30 onwards.
[84] T 14/7/20, page 14, line 15 onwards.
[85] T 14/7/20, page 14, line 22 onwards.
[86] Exhibit 1, Tab 93, Section 7.3 OPM - Miscellaneous Health Issues, 7.3.3.5 reads as follows:
"*The Medical or Nursing Certificate may result in a recommendation to CSNSW that the patient be considered:*
- *for placement on light duties (re-assessed at regular intervals)*
- *unfit for work*
- *fit for work*
- *for the removal of handcuffs during transport or a medical procedure where medically indicated."*

[87] Exhibit 1, Tab 92, Custodial Operations Policy and Procedures - 6.1 JH&FMHN notifications, 3.1 (p.79) reads in part as follows:
"When an inmate informs custodial accommodation staff that they are unwell and wish to remain in their cell they must be assessed by a nurse or medical officer. For the inmate to remain 'sick in cell' a nursing certificate must be provided to the OIC accommodation."

'sick in cell') and even more important that the officers were aware of his situation. CSNSW rely on the medical expertise of JH in order to properly make decisions about cell placement.

89. The court heard from Officer McPherson, who was rostered as the manager of security at Tamworth Correctional Centre on 20 September 2017. Officer McPherson spoke briefly to Ms Adams about Tane. He told the court that Ms Adams did not inform him that Tane was "sick in cell", but just that he should stay locked in his cell until she had seen the discharge summary.[88] Nurse Adams says that Officer McPherson asked whether Tane was "ok to be by himself'. Officer McPherson indicated that he thought it would be "like a period of an hour at the most for him to remain in cell, maybe two."[89] He was not concerned about Tane being left alone as he knew that he had been examined by the Nurse Unit Manager.[90] Officer McPherson was not informed, and did not ask, about the reasons Tane should remain in his cell, other than waiting for the discharge certificate.

90. At around 8.16am when various officers arrived on the landing for morning "Let Go" Tane was back in his cell. Darren Cutmore told the court that he saw Tane very briefly at this time and that Tane looked "upset" but they did not have the opportunity to talk.[91]

91. At 8.17am Officer McPherson attended cell 30 and opened the door. Tane was visible from the CCTV and there was no one else in the cell. Tane was told he would remain in the cell until the discharge summary was obtained. Barry Evans was allowed into the cell to retrieve his belongings. He said that he did not have much opportunity to speak with Tane. He said there was no one else in the cell.

92. Tane was angry about remaining in his cell. Darren Cutmore told the court he heard Tane say words to the effect of "Why the fuck ain't I getting out?" and that his question was ignored by the officers present.[92] According to Darren Cutmore, Officer McPherson just ignored Tane's calls. He characterised the behavior as "outright rude", but typical of the way officers dealt with Aboriginal prisoners at Tamworth.[93] Officer McPherson told the court that he explained to Tane that he would have to stay in his cell until the discharge paperwork arrived from the hospital. He reported that Tane "tried on multiple occasions to change my mind, but he could not remember the exact words."[94] He described Tane's demeanor as "mildly elevated" or "upset." Officer McPherson told the court that Tane wanted a shower. This was refused because "the nurse had asked me to leave him locked in until she had the discharge

[88] T 15/7/20, page 4, line 40 onwards.
[89] T 15/7/20, page 5, line 19.
[90] T 15/7/20, page 7, line 39 onwards.
[91] T 13/7/20, page 13, line 3 onwards.
[92] T 13/7/20, page 14, line.
[93] T 13/7/20, page 18, line 31 onwards.
[94] T 15/7/20, page 9, line 6.

paperwork."[95]

93. Barry Evans was with other inmates down in the yard when he heard Tane yelling. He gave evidence that he heard Tane swearing and angrily yelling to be let out.[96]

94. It is certainly clear that Tane wanted to have a shower. He expressed this to Officer McPherson. It is likely that he continued to yell out the cell window towards the exercise yard shortly afterwards.

95. On reflection, it would have been both preferable and possible to allow an inmate such as Tane to have a shower, in circumstances where he had just returned from hospital.

Tane is discovered by the sweeper in his cell on 20 September 2017

96. Tane was in the cell by himself from 8.17 until 9.05am. There was continual CCTV footage of the cell door during this period and no person entered or exited the cell. During this time one can see an inmate, Brendan O'Leary, who had the job of prison sweeper, cleaning in the corridor between the rows of cells.

97. Brendan O'Leary told the court that he was asked by Darren Cutmore to speak to Tane through the peephole and ask him to pack Darren's stuff, given that they had now been separated. Mr O'Leary looked into the cell. He saw Tane hanging at the back of the cell, and immediately ran for help.

98. A number of officers attended the cell very quickly. The first was Officer Russell Smith. Officer Smith gave lengthy and considered evidence. His account was unchallenged. He said that he saw Tane hanging from the plumbing pipe. He was hanging by a torn prison blanket. Tane was not moving and he cut him down. An ambulance was called and there were extended attempts at resuscitation by correctional officers and JH staff until the paramedics arrived. There is nothing to suggest that the attempts to revive Tane were inappropriate or inefficient.

99. It is not clear from the photographs or oral evidence exactly how Tane's blanket was tied. However, this lack of clarity does not negate the overwhelming evidence that Tane was responsible himself for the act. The CCTV footage makes it clear that no one else entered the cell at the relevant time.

100. Following these events, Tane was taken to Tamworth Hospital and admitted to ICU. Members of his family attended. Tragically he could not be revived. At 4.33pm on 22 September 2017, Tane was pronounced brain dead.

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[95] T 15/7/20, page 10, line 3.
[96] T 13/7/20, page 33, line 17 onwards.

Findings at Autopsy

101. An autopsy was conducted by Dr Allan Cala on 28 September 2017 at the Department of Forensic Medicine, Newcastle. Also in attendance was Professor Cordner, an eminent forensic pathologist from Victoria who had been briefed to make an independent observation on behalf of the family.

102. Dr Cala recorded the direct cause of death as hypoxic ischaemic encephalopathy, caused by hanging. He noted that there was a ligature mark around the front and sides of Tane's neck. He identified a fracture of the left side of the hyoid bone which was associated with a very small amount of haemorrhage. He noted that this injury is commonly seen in self-suspension cases.[97] Dr Cala indicated that he found no evidence of facial assault or head injury. He detected a small 8 mm pineal cyst, but thought it had no significance to the cause of death.[98] There were no findings which indicated a focus for seizure disorder and toxicological testing showed only paracetamol and ibuporofen at low levels. Dr Cala wrote "it is my view that the death of this man did not occur as a result of foul play."[99]

103. Professor Cordner was in agreement with Dr Cala in relation to the cause of death. However he noted that the existence pineal cysts can be associated with neurological problems, including seizures.[100] He agreed that there was nothing to suggest the involvement of any other person in the immediate circumstances surrounding Tane's death. In particular there was nothing to specifically suggest that he had been assaulted around the time he was found in his cell[101]. Professor Cordner had the opportunity to view photographs of Tane taken by family members at Tamworth Hospital and this did not change his view.[102] He was aware of various small abrasions, some of which he thought referable to the processes of resuscitation and intubation.

104. Given the specific concerns raised by Tane's family prior to the hearing, Professor Cordner carefully and thoughtfully considered the possibility that Tane could have been assaulted or even murdered. He found no evidence at the autopsy to support this hypothesis. I accept his view.

Neurological Review after death

105. The evidence at autopsy revealed that Tane's death was caused by neck compression

[97] Autopsy Report for the Coroner, Exhibit 1, Tab 5.
[98] This view was shared by Dr Simon T 16/7/20 page 10 line 1 onwards.
[99] Autopsy Report for the Coroner, Exhibit 1, Tab 5, page 4.
[100] Report of Professor Cordner, Exhibit 1, Tab 76B.
[101] Report of Professor Cordner, Exhibit 1, Tab 76B.
[102] The photos taken by the family were tendered into evidence as Exhibit 3.

subsequent to hanging. The court was concerned to discover whether the seizures Tane suffered in the evening before could have affected his cognitive function or altered his mood. This was particularly important given that Tane had recently expressed excitement about his likely impending release.

106. Advice was sought from an independent consultant neurologist, Dr Neil Simon. He explained that after a neurological event or *ictus*, it is not uncommon to see a collection of symptoms which may include disorientation, agitation, confusion, and some physical symptoms including gait or speech disturbance which are jointly described as indicating a "post ictal state." He viewed the CCTV footage of Tane leaving Tamworth CC on the evening of 19 September 2017 to go to Tamworth Hospital and he recognised physical symptoms which were consistent with a post ictal state.

107. On all the evidence available to him, Dr Simon expressed the view that Tane had experienced genuine seizure activity and the events of that evening were not feigned or manufactured. He explained that there were several possible causes of the events, including an epileptic seizure (either spontaneous or caused by drug intoxication or withdrawal) or alternatively some kind of *non*-epileptic seizure, which *could* also be related to drug intoxication or withdrawal.[103] He explained that drug withdrawal can also sometimes include symptoms of agitation which might mimic a seizure or that stress can bring about a non-epileptic seizure by a mechanism which is incompletely understood.[104] He doubted the relevance of the pineal cyst which was subsequently identified.[105]

108. Dr Simon also specifically considered the way in which seizures can potentially contribute to suicidality. He noted that there was no evidence that Tane had developed symptoms of overt psychosis after the seizure.[106] The most relevant possibility was related to the fact that "people with epilepsy may experience prolonged neurological disturbance following a seizure, which may include fatigue, cognitive dysfunction, psychiatric symptoms and focal neurological deficits."[107] In his view it was "a reasonable analysis [in Tane's case] to suggest that post-ictal suicidal thoughts or altered thought processes interacted with significant existing psychological stressors with or without effects from buprenorphine or buprenorphine withdrawal." He was of the view "that this combination may have contributed to Mr Chatfield's suicide."[108]

[103] Report of Dr Simon, Exhibit 1, Tab 76, page 8.
[104] T 16/7/20 page 5, line 40 onwards.
[105] Report of Dr Simon, Exhibit 1, Tab 76, page 9.
[106] T 16/7/20 page 30, line 28 onwards.
[107] Supplementary Report of Dr Simon, Exhibit 1, Tab 76A, page 1.
[108] Supplementary Report of Dr Simon, Exhibit 1, Tab 76A, page 2.

Psychiatric Review after death

109. The court was also greatly assisted by the expertise of Professor Matthew Large, a psychiatrist with extensive experience in both emergency departments and acute psychiatric settings. He has particular expertise in the study of suicide.

110. Professor Large had the opportunity to review Tane's health records and other documents. He observed that Tane's clearest mental health diagnosis appeared to be substance use disorder. He suggested that it is likely that Tane was "craving drugs and possibly that he was experiencing some withdrawal symptoms at the time of his death". He observed that buprenorphine withdrawal can be mild but can also have significant psychological effects.[109]

111. Professor Large also indicated that Tane's state of mind at the time of his death was almost certainly influenced by his long standing personality structure. There is evidence from his telephone calls and his unsent letter to his partner that indicates he was experiencing feelings of loss and separation. He had also been separated from his co-accused. He was frustrated by being detained in his cell. All of these factors are likely to have combined and affected Tane's mental state.

112. Professor Large was aware that Tane had expressed suicidal thoughts and had self-harmed in the past. He explained that the association between past thoughts and attempts and completed suicide is "weaker than is generally imagined."[110] He explained in evidence that predicting who will commit suicide is extremely difficult and using past behaviour as an indicator of future suicide can be unreliable. Professor Large was aware that Tane had numerous risk factors, but cautioned against believing these operate in a straight forward or cumulative way. He reminded the Court that "the vast majority of people who can be considered to be at high risk of suicide by virtue of having multiple risk factors do not die by suicide, and that lower risk people with fewer risk factors commit about 50% of all suicides.[111]

113. Professor Large told the court that *mental state*, *availability of lethal methods* and *suggestion* are sometimes considered the three main drivers of suicide. Tane had many significant factors affecting his mental state including "his substance use, interpersonal functioning, reaction to incarceration, separation from family and concerns about his legal situation."[112] The obvious hanging point in his small cell made a lethal method immediately and obviously available. Professor Large stated that "suggestion" may also have played a role, "because the deceased was aware of the circumstances of an earlier death in custody and had been

[109] Report of Professor Large, page 19.
[110] Report of Professor Large, page 20.
[111] Report of Professor Large, page 22.
[112] Report of Professor Large, page 23.

placed in a two out cell on 28 May 2014 in the context of this bereavement."[113] Death from hanging in a prison cell was something that formed part of his life history.

114. While some suicides are carefully planned, Professor Large also explained that impulsivity can play a critical role in suicidal behaviour. He referred the court to a study where more than half the subjects had considered suicide behaviours for less than 10 minutes before enacting them.[114] Professor Large's own experience of assessing suicidal people over three decades in emergency departments was consistent with many having had surprisingly short periods of contemplation. This may also have been the case for Tane, whose family and friends were completely blindsided by his actions.

A finding of "intentionally self-inflicted death"

115. A finding that a death is intentionally self-inflicted should not be made lightly. The evidence must be extremely clear and cogent in relation to intention.[115] Records indicate that Tane had a prior serious self harm attempt for which he had been treated in Hospital. There is also evidence that he informed CSNSW that he had "multiple attempts at hanging". Nevertheless, given the shock his death caused everyone that knew him, it was necessary to consider very carefully whether any other person could have been involved in his death. Early suspicions raised by the family were seriously considered.

116. I am satisfied on the basis of the full autopsy conducted by Dr Cala, reviewed by an eminent independent forensic pathologist, Professor Cordner, that Tane's death was not caused by any traumatic injury from a third person.

117. This finding is consistent with the available CCTV footage. I have had the opportunity to thoroughly review the footage and it shows no person entered Tane's cell at the critical time. I have watched the footage of his arrival back to the Centre and he has no obvious injuries.

118. I have also reviewed the conduct of the first responding correctional officers, some of whom gave evidence before me. I accept that the correctional officers acted reasonably in the circumstances they faced on 20 September 2017, once they were alerted to the fact that Tane was hanging. No criticism is made of their response, which was administered within the guidelines in place. I am satisfied that Tane's death was not caused by any failure in attempts at resuscitation.

[113] Report of Professor Large, page 23.
[114] Report of Professor Large, page 23.
[115] The proper evidentiary standard to be applied to a coronial finding of intentional taking of one's own life is the *Briginshaw* standard (*Briginshaw* v *Briginshaw* 60 CLR 336).

119. Based on the evidence before me, it is established that Tane crafted a rope from his prison blanket and hanged himself. It appears likely that this was an impulsive act which occurred at a time of great despair. He was alone and faced with an obvious hanging point.

120. As I stated at the outset, this is not the first impulsive indigenous suicide I have been called upon to investigate this year. I remain enormously troubled by the occurrence of these events. Further consultation with Aboriginal health workers is needed to develop culturally appropriate suicide prevention strategies in custody.

The adequacy of CSNSW response to Tane's call for help on 19 September 2017

121. In my view, the evidence suggests that officers acted appropriately when Tane knocked up on the first occasion. I accept that although he was feeling unwell, he refused to go into an observation cell. In my view, given his classification and his physical state at that point, there was nothing to indicate to the officers that Tane needed to be removed at this time and against his will.

122. When Barry Evans knocked up about 50 minutes later, correctional officers acted swiftly. Tane was removed from the cell and taken by ambulance to Hospital. This was the appropriate action to take following a witnessed seizure.

The adequacy of Tane's treatment at Tamworth Hospital

123. I have had the opportunity of reviewing the medical records made by Dr Raj on 19 - 20 September 2017 at Tamworth Hospital. They are appropriately comprehensive and indicate that he undertook the appropriate physical checks.

124. Dr Raj gave evidence before me and impressed as a thoughtful practitioner who conducted a comprehensive examination of Tane, in an emergency setting. As set out above, his records have been reviewed by an independent neurologist, Dr Simon, who concurred with his approach. I have no criticism of Dr Raj or of the clinical treatment Tane received on the evening and early hours of 19-20 September 2017.

125. It is extremely unfortunate that Tane was taken back to custody without a discharge summary. While I accept that resources at regional hospitals can sometimes be stretched, a patient should not leave without a record of the care they have just received. This is even more important when the patient is a prison inmate who has no control over his ongoing health care. It is essential that the information travel with the patient, so that it can be reviewed on his arrival back in custody.

126. In my view it is appropriate to make a recommendation in this regard.

The adequacy of JH's response on Tane's return from Tamworth Hospital on 20 September 2017

127. At the conclusion of the proceedings, JH made a proper concession that the Tane did not receive the care that he deserved on the morning of 20 September 2017 when he was returned from Tamworth Hospital. Specifically, JH recognised that it should have recommended to CS NSW that Tane be placed in a two-out cell.[116]

128. Ms Adams gave evidence that *had* she known of the seizures she would have taken a different approach and likely would have recommended Tane be given a two out placement.[117] I note that she would have placed him two out because of the potential danger of having an unobserved seizure and injuring himself (and not because of any possible post-ictal risk of mood disturbance of which she was completely unaware).[118] Nevertheless, it would have offered him some protection.

129. In my view Tane should have been placed 'two out' at least until a proper clinical assessment could have occurred. I note that the policy in place at the time of Tane's death listed a number of criteria that may result in an inmate requiring two out placement including: inmates at risk of self harm; Aboriginal inmates under stress or experiencing distress; and inmates with special needs (including health issues). The current policy is even more specific and lists these three criteria only.[119]

130. I accept that Dr Simon was of the view that in a community setting it would be appropriate to have discharged Tane, without the need for 24 hour supervision. He told the court that patients are routinely sent home after seizures and do not necessarily require constant supervision.[120] The situation in my view is completely different in a custodial setting where a cell is locked, and there is little chance a seizure would be detected.

131. As set out in my reasons above, in my view the care Ms Adams provided to Tane was cursory and inadequate. She did not properly turn her mind to his potential risks returning from hospital. It is significant that JH has acknowledged that Tane did not receive the medical care that he should have received in the circumstances.

132. The family have submitted through their legal representative that Ms Adams should be referred pursuant to s 151A (2) of the *Health Practitioner Regulation National Law* (NSW). I

[116] JH Submissions, T 17/7/20, page 36, line 12 onwards.
[117] T 14/7/20 page 13, line 24.
[118] T 14/7/20 page 13, line 35.
[119] Exhibit 1, Tab 92, p. 60, - Extracts from COPP Manual - 5.2 Inmate accommodation – version 1.1, [2.3].
[120] T 16/7/20, page 13, line 44 onwards.

note that counsel assisting did not urge this course. I have given the matter considerable thought and careful consideration since the conclusion of evidence, paying particular attention to the interests of Ms Adams, who had the benefit of legal advice but was not represented in these proceedings. However, I remain troubled that a nurse of her experience appeared to consider the interaction she had with her patient to be sufficient in the circumstances. While she stated that *had* she known of the seizures she may have taken a different course, she did not appear to understand that she *should* have known. Had this lack of insight been present in a junior nurse, I might take a different view. However, she was the Nurse Unit Manager. She informed the court that she had "many, many years of experience" as an ED nurse. [121]I have come to the conclusion that her conduct should be reviewed by her professional body.

The adequacy of specific support offered to Indigenous inmates

133. At the time of Tane's death, there were 88 inmates in custody at Tamworth CC, of which 45 were Aboriginal.[122]

134. The court was informed that the Aboriginal Services and Programs Officer (SAPO) position was in existence at 20 September 2017, however it was vacant. The gaol also had the assistance of a Regional Aboriginal Programs Officer (RAPO), but that person serviced a number of centres, as did a regional Deputy Manager Inmate Classification & Placement, Aboriginal Programs. Given the proportion of Aboriginal inmates this is of concern.

135. The Nurse Unit Manager gave evidence that JH had no targeted Aboriginal position at Tamworth CC. However, given the Aboriginal gaol population is more than 50% she agreed that employing an Aboriginal health worker would be beneficial.[123]

136. I am confident that input and involvement from an Aboriginal Mental Health Worker could have been an important component of improved care and support for Tane and his mental state. The provision of culturally appropriate treatment and suicide prevention work must be pursued.

The adequacy of cell architecture at Tamworth CC

137. The evidence of Professor Large makes it clear how difficult it is to predict who, within a prison population, will attempt suicide. Past behaviour is a less accurate indicator than one might expect. It was Professor Large's view that there was no pressing reason to place Tane

[121] T 15/7/20, page 20, line 47.
[122] Statement of Saffron Cartwright, Exhibit 1, Tab 76C.
[123] T 15/7/20 page 20, line 25.

in a two-out placement when he returned from Hospital, notwithstanding his past behaviour and recent seizure. However, the cell he was placed in should have been safe, because access to lethal methods can be a driver of suicide.

138. It follows that if one accepts the difficulties involved in predicting suicide, we must make more effort to make each cell safer by removing obvious hanging points instead of relying on correctional staff to manage risk by placing inmates in safe cells or "two out" placements.

139. The court was informed that although the cell in which Tane was place has been rectified to some degree, no formal audit of Tamworth Correctional Centre had taken place to provide an overall picture of the outstanding risk.[124] Further, there is no CSNSW current proposal for an overall audit of Tamworth CC because it is an older style facility. Ms Cartright, Acting Manager of Security at Tamworth Correctional Centre, stated that *"it's very challenging for all correctional services to remove all hanging points…we have to prioritise our resources….Tamworth CC is a very old facility, heritage listed built in the 1700s (sic) and there are limitations to what you can do with changing infrastructure in some."*[125] Leaving aside the fact that the centre cannot have been built in the 1700s, this response is in my view entirely inadequate.

140. The limitation of lethal means is one of the most reliable methods of reducing suicide. Professor Large referred the court to evidence which demonstrates the success of removing hanging points as a method of reducing suicide in inpatient psychiatric settings.[126]

141. Coroners have been recommending the removal of hanging points for many years. The issue must be taken seriously. Thirty years on from the RCIADC it is unacceptable to suggest it would be expensive or difficult to achieve the elimination of hanging points in a "heritage listed" facility. I intend to have a copy of these findings sent to the NSW Minister with responsibility for Aboriginal Affairs for his information and review.

Outstanding concerns and the need for recommendations

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

[124] Statement of Saffron Cartwright, Exhibit 1 Tab 76 C, [15].
[125] T 16/7/20 page 67 line 18. It appears that Tamworth Gaol was actually built around 1880.
[126] Exhibit 1, Tab 76Ba, Report of Professor Large, p. 26.

143. The evidence arising during this inquest demonstrated a strong need to consider specific recommendations, particularly in relation to the management of Tane's health treatment in custody. The following recommendations I make arise directly out of the evidence before me. I acknowledge the extensive material provided to me by supporters of the Chatfield family much of which also dealt with ideas and recommendations aimed at reducing the rate of incarceration of aboriginal people. The fact that some of those suggestions have not been adopted as recommendations does not mean they have no merit.

144. It is also necessary to comment, in closing, that by the time I became involved in this investigation, Tane's family remained unaware of many of the important facts about his death. I understand that this lack of information, together with the delay in hearing the inquest has resulted in suspicion and has compounded their grief over Tane's death. The NSW State Coroner is currently consulting with stakeholders in relation to a practice note which will reduce delay and encourage early disclosure in cases of this nature. I am confident that this practice note will improve the coronial process for families like the Chatfields in this court.

Findings

145. The findings I make under section 81(1) of the *Coroners Act 2009* (NSW) are:

Identity

The person who died was Tane Chatfield.

Date of death

He died on 22 September 2017.

Place of death

He died at Tamworth Hospital, Tamworth NSW.

Cause of death

He died as a result of hypoxic ischaemic encephalopathy as a result of hanging.

Manner of death

Tane was alone when he placed a blanket rope around his neck and attached it to a prominent hanging point in his cell. His death was intentionally self-inflicted.

Recommendations pursuant to section 82 *Coroners Act 2009*

146. For the reasons stated above, I make the following recommendations:

To the Commissioner of Corrective Services

That CSNSW conduct a comprehensive audit of all cell hanging points at the Tamworth Correctional Centre and undertake urgent removal of any hanging points identified.

That CSNSW amend policy to notify the next of kin if an inmate is taken to a hospital in a medical emergency, even if that inmate is not ultimately admitted.

That CSNSW implement a policy whereby prisoners who have been taken to hospital are not returned to prison without a discharge summary.

To the Commissioner of Corrective Services NSW and Justice Health

That CSNSW, in consultation with Justice Health, adopt a policy whereby any inmate who has been taken to Hospital is placed either two out or in an assessment cell until a comprehensive JH review can take place. In the event that this is not considered suitable or appropriate, any other placement must be documented with reasons recorded.

That CSNSW and JH actively recruit Aboriginal health workers at Tamworth Correctional Centre. The provision of Aboriginal health workers must include consideration of expanded culturally appropriate Drug and Alcohol and Mental Health Services and workers with expertise in suicide prevention strategies.

To Hunter New England Local Health District (HNELHD)

That HNELHD provide a copy of a discharge summary to officer escort when a custodial patient is discharged from a HNE health service (including from the Emergency Department).

To the Chief Executive, Nursing and Midwifery Board of Australia

I recommend that, pursuant to section 151A(2) of the *Health Practitioner Regulation National Law* (NSW) no 86a, the transcript of the evidence of Ms Adams be forwarded to the Chief Executive, Nursing and Midwifery Board of Australia for consideration of whether the professional conduct of Ms Adams on 20 September 2017 should be the subject of review.

Conclusion

147. Finally, I offer my sincere thanks to counsel assisting, Tracey Stevens and her instructing solicitor Paul Armstrong for their hard work and enormous commitment in the preparation and conduct of this inquest.

148. Once again, I offer my sincere condolences to Tane's friends and family. I acknowledge that the pain of losing a loved one in these circumstances is profound and that their grief is ongoing. I am so sorry that Tane experienced such despair in circumstances which were unsafe for him. Given his history and lack of support in custody, I understand why he could not ask for help when he experienced despair that morning.

149. I greatly respect the Chatfield family's decision to participate in these difficult proceedings to achieve change and I thank them again for courage and grace in such circumstances. Their participation protects the integrity of the proceedings. I wish them well in their ongoing work.

150. I close this inquest.

Magistrate Harriet Grahame
Deputy State Coroner
26 August 2020
NSW State Coroner's Court, Lidcombe