CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of George Cameron
Hearing dates:	3 December 2020
Date of findings:	3 December 2020
Place of findings:	Coroner's Court of NSW, Lidcombe
Findings of:	State Coroner, Teresa O'Sullivan
Catchwords:	CORONIAL LAW – death in custody, mandatory inquest, manner of death
File number:	2017/27511
Representation:	Mr D Welsh, Coronial Advocate Assisting the Coroner Ms M Katawazi, Solicitor, Department of Corrective Services NSW Mr H Norris, Legal Advisor, Justice Health & Forensic Mental Health Network
Findings:	The findings I make under section 81(1) of the Act are:

Identity
The person who died was George Cameron

Date of death
George Cameron died on 8 September 2017

Place of death
George Cameron died at Parklea Correctional Centre, New South Wales

Cause of death
The cause of George Cameron's death was plastic bag asphyxia

Manner of death
George Cameron's death was self-inflicted with the intention of ending his life

Non-publication orders:

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 That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009* (NSW):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. Names, addresses, phone numbers and other personal information that might identify:
        i. Any member of George Cameron's family;
        ii. Any person who visited George Cameron while in custody (other than legal representatives or visitors acting in a professional capacity); and
        iii. Any victim of an alleged criminal offence committed by George Cameron.
    b. Names, personal information and Master Index Numbers (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW') other than George Cameron.
    c. Photographs, closed-circuit television and hand-held video camera footage of Area 1, Parklea Correctional Centre and of the deceased George Cameron.
    d. Portions of the Inmate Accommodation Journals and Log Books that describe security checks performed by CSNSW staff.
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 section 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. George Cameron died at 81 years of age on 8 September 2017 at Parklea Correctional Centre. At the time of the death, Parklea Correctional Centre was managed by the GEO Group Pty Ltd on behalf of Corrective Services. On 31 March 2019, GEO handed over management of Parklea Correctional Centre to MTC Broadspectrum. MTC Broadspectrum currently manages Parklea.

2. As Mr Cameron was in lawful custody at the time of his death, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act.

The role of a Coroner and purpose of this inquest

3. The role of a coroner, as set out in s 81 of the Coroners Act, is to make findings as to the following:

   (a) the identity of the deceased;
   (b) the date and place of the 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.

4. Pursuant to s 82 of the Act a coroner also has the power to make recommendations concerning any public health or safety issues arising out of the death in question.

Evidence at Inquest

5. A short inquest was held on 3 December 2020. The brief of evidence compiled by Senior Constable Cambridge was tendered (Ex.1).

Custodial History

6. On 5 September 2017, Mr Cameron was arrested in relation to several serious offences relating to an incident alleged to have occurred at Hornsby Westfield shopping centre on the 5 September 2017. He was refused bail by police and appeared at Hornsby Local Court on 6 September 2017. He was refused bail at Hornsby Local Court and remanded into custody. The next court date was to be 9 November 2017.

7. On 6 September 2017, he was transferred from Hornsby Police cells to Parklea Correctional Centre. Upon arrival at Parklea, he was initially placed within the observation cells in the prison's reception area. At about 11 p.m. on 6 September 2017, Justice Health completed a Reception Screening Assessment. The assessment identified several physical conditions requiring monitoring. Consequently, Mr Cameron was placed in a "2 out" cell, meaning he would be housed with another inmate who could ensure his physical wellbeing and raise the alarm should Mr Cameron have any health issues.

8. The Reception Screening Assessment also canvassed Mr Cameron's mental health. Mr Cameron denied previous attempts at self-harm or suicide. When asked if there was anything causing him concern, Mr Cameron responded, "Yes. Just being here." When asked how he thought he would cope in prison, Mr Cameron said, "As I always do. Well."

9. The Reception Screening Assessment returned a Kessler score of between 10-19. The Kessler scale is a simple measure of psychological distress, with a score in the aforementioned range indicating that the person is likely to be well. The Reception Screening Assessment records that Mr Cameron had guaranteed his own safety to interviewing Justice Health staff, which means that he denied thoughts of self-harm or suicidal ideation and had no intention to self-harm whilst in custody.

10. Mr Cameron was housed in cell 37 within the clinic area. The placement was selected in response to Mr Cameron's health issues and a need for him to be protected from other inmates due to the nature of his charges. Cell 37 is monitored by closed circuit television, but areas of the cell were not visible due to the lighting and the bunkbed.

Circumstances of Death

11. Mr Cameron arrived in the cell at 9:17 p.m. on 7 September 2017. At 8:05 a.m. on 8 September 2017, he used the intercom system to contact correctional staff and request his regular medication as well as some additional medication to assist with constipation. At 8:10 a.m., Mr Cameron contacted correctional staff and requested to speak with his wife. At 8:52 a.m., Mr Cameron again contacted staff and asked to speak with his wife. He was informed that he would not be able to make a phone call until he was cleared by reception screening. Mr Cameron was served a morning meal at 8:57 a.m. At 9:48 a.m., Mr Cameron contacted correctional staff and requested constipation medication.

12. CCTV shows that at 10:59 a.m, Mr Cameron removed bedding from a black plastic bag on the bottom bunk. At 11:04 a.m., he placed the bedding back into the plastic bag. At 11:04 a.m., Mr Cameron stood up and took hold of the plastic bag that contained the bedding and again removed the bedding. He retained hold of the plastic bag. In the CCTV, Mr Cameron is visible on the lower bunk, but the upper bunk obscures his head. At 11:20 a.m., Mr Cameron's legs can be seen to twitch. At 11:21 a.m., his legs twitch again and his left hand slides across his body to fall to his side.

13. Within her statement, Correctional Officer Yonita Nelson states that at about 11:42 a.m. she opened cell 37 and observed George Cameron to have a black plastic bag over his head. She

grabbed the plastic bag off his head and saw that he was pale and not breathing. She requested medical assistance.

14. Staff commenced cardio-pulmonary resuscitation, but Mr Cameron could not be revived. At 11:55 a.m., Dr Grimsdale pronounced Mr Cameron to be life extinct. Body worn camera footage within the brief of evidence depicts this occurring. However, at 12:00 p.m., ambulance officers attended and detected a faint pulse. They recommenced CPR and prepared to transport Mr Cameron to hospital. At 12:36 p.m., while Mr Cameron was being loaded into the ambulance, ambulance officers pronounced him life extinct.

15. Police canvassed prisoners in neighbouring cells but none provided information that they had heard Mr Cameron give any indication of harming himself. The only reasonable hypothesis for Mr Cameron to have the plastic bag over his head is that he wished to commit self-harm. No other persons had access to him during the period that the bag was placed over his head.

Cause and Manner of Death

16. On 12 September 2017, pathologist Dr Pokorny conducted an external examination of Mr Cameron. Dr Pokorny's post-mortem report lists the direct cause of death as unascertained. Dr Pokorny states that while the history and circumstances are strongly suggestive of plastic bag asphyxia, there were no specific injuries or marks around Mr Cameron's neck to indicate the presence of the bag and there were no photographs of the bag in-situ.

Changes made since the death

17. In June 2018, CCTV camera technology was upgraded in six cells in Area 1, including Detox Cell 37, in which Mr Cameron was housed. The upgraded CCTV camera technology has the capacity to provide visibility in low light and darkness. MTC Broadspectrum now provides a mesh bag for linen when inmates are moved to an accommodation wing.

Findings pursuant to section 81 of the *Coroners Act 2009*

1. The findings I make under section 81(1) of the Act are:

Identity
The person who died was George Cameron

Date of death
George Cameron died on 8 September 2017

Place of death
George Cameron died at Parklea Correctional Centre, New South Wales

Cause of death
The cause of George Cameron's death was plastic bag asphyxia

Manner of death

George Cameron's death was self-inflicted with the intention of ending his life.

I close this inquest.

Teresa O'Sullivan

State Coroner

3 December 2020