CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of LP
Hearing dates:	16 December 2019
Date of findings:	13 February 2020
Place of findings:	Coroner's Court of New South Wales at Lidcombe
Findings of:	Magistrate Derek Lee, Deputy State Coroner
Catchwords:	CORONIAL LAW – death in custody, self-inflicted death, Risk Intervention Team review and management plan, review interval, mitigation of risk of self-harm
File number:	2017/297414
Representation:	Mr T O'Donnell, Coronial Advocate Assisting the Coroner Ms A Douglas-Baker for the Commissioner of Corrective Services New South Wales, instructed by Ms M Katawazi (Legal, New South Wales Department of Communities and Justice) Ms B Haider for RN A Munoz Mr M Sterry for Justice Health & Forensic Mental Health Network
Findings:	I find that LP died on 29 September 2017. LP died at the Metropolitan Remand and Reception Centre, Silverwater NSW 2128. The cause of LP's death was foreign body aspiration. LP died as a result of actions taken by him with the intention of ending his life. At the time of his death LP was in lawful custody, on remand, at a correctional centre.

Recommendations: The following recommendations are made pursuant to section 81 of the Coroners Act 2009:

To the Commissioner of Corrective Services New South Wales:

1. I recommend that consideration be given to the implementation or variation of relevant Local Operating Procedures at the Metropolitan Remand and Reception Centre to provide that (a) the interval for review of inmates subject to a Risk Intervention Team Management Plan and/or housed in an assessment cell is to be no longer than 24 hours; and (b) where a review of an inmate cannot be completed such a review is to be deferred to the following day, with priority to be given to review of the inmate on that subsequent day.

2. I recommend that consideration be given to amending section 5.3 of the Custodial Operations Policy and Procedures to provide guidance to Risk Intervention Team (**RIT**) members as to what is to occur if a RIT assessment review is unable to be completed due to an inmate's emotional state, level of aggression, or intoxication due to alcohol or drug use and, as a result, the RIT is unable to determine whether a RIT Discharge Plan is to be completed or a RIT Management Plan is to be developed.

To the Commissioner of Corrective Services New South Wales and *the Chief Executive Officer, Justice Health & Forensic Mental Health Network:*

3. I recommend that consideration be given to the circumstances of the death of LP being used as a case study as part of training and education provided to CSNSW and Justice Health staff to raise awareness regarding the possible risks of self-harm associated with the use of plastic packaging from meal packs (with appropriate anonymization, and conditional upon consent being provided by LP's family and following appropriate consultation with them).

Non-publication orders: Pursuant to section 75(2) of the *Coroners Act 2009* publication of any matter (including the publication of any photograph or other pictorial representation) which identifies any of the following persons is prohibited:

1. LP
2. BD

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1. Introduction

1.1 On 26 September 2017 LP was arrested and charged following an episode of interpersonal violence involving his partner, which ultimately resulted in her death. LP was subsequently taken into lawful custody and transferred to a correctional centre.

1.2 After an intake assessment identified that LP was at risk of self-harm attempts were made to assess LP on 28 September 2017 so that appropriate steps could be taken to mitigate this risk. A day later, on the morning of 29 September 2017, LP was found unresponsive in his cell bed after having apparently intentionally ingested foreign material taken from his cell and from the breakfast that he had been provided with a morning. Resuscitation attempts were initiated but were ultimately unsuccessful and LP was tragically pronounced deceased.

2. Why was an inquest held?

2.1 Under the *Coroners Act 2009* (**the Act**) a Coroner has the responsibility to investigate all reportable deaths. This investigation is conducted primarily so that a Coroner can answer questions that they are required to answer pursuant to the Act, namely: the identity of the person who died, when and where they died, and what was the cause and the manner of that person's death.

2.2 When a person is charged with an alleged criminal offence, or sentenced after being convicted of a criminal offence, they can be detained in lawful custody. By depriving that person of their liberty, the State assumes responsibility for the care of that person. Section 23 of the Act makes an inquest mandatory in cases where a person dies whilst in lawful custody. In such cases the community has an expectation that the death will be properly and independently investigated.

2.3 A coronial investigation and inquest seeks to examine the circumstances surrounding that person's death in order to ensure, via an independent and transparent inquiry, that the State discharges its responsibility appropriately and adequately.

2.4 In this context it should be recognised at the outset that the operation of the Act, and the coronial process in general, represents an intrusion by the State into what is usually one of the most traumatic events in the lives of family members who have lost a loved one. At such times, it is reasonably expected that families will want to grieve and attempt to cope with their enormous loss in private. That grieving and loss does not diminish significantly over time. Therefore, it should be acknowledged that the coronial process and an inquest by their very nature unfortunately compels a family to re-live distressing memories several years after the trauma experienced as a result of a death, and to do so in a public forum.

2.5 Inquests have a forward-thinking, preventative focus. At the end of many inquests Coroners often exercise a power, provided for by section 82 of the Act, to make recommendations. These recommendations are made, usually, to government and non-government organisations, in order to seek to address systemic issues that are highlighted and examined during the course of an inquest. Recommendations in relation to any matter connected with a person's death may be made if a Coroner considers them to be necessary or desirable.

3. LP's life

3.1 Inquests and the coronial process are as much about life as they are about death. A coronial system exists because we, as a community, recognise the fragility of human life and value enormously the preciousness of it. Recognising the impact that a death of a person has, and continues to have, on the family and loved ones of that person can only serve to strengthen the resolve we share as a community to strive to reduce the risk of preventable deaths in the future.

3.2 Understanding the impact that the death of a person has had on their family only comes from knowing something of that person's life and how the loss of that life has affected those who loved that person the most. Therefore it is extremely important to recognise and acknowledge LP's life in a brief, but hopefully meaningful, way.

3.3 LP was born on 24 August 1983 to his parents, Susan and William. LP also had a number of half-siblings from his parents' previous relationships, and by all accounts the extended family was very close knit. LP's mother describes him as a very happy and placid baby.

3.4 As a child LP love to be active and frequently took part in soccer, trail bike riding, water skiing, and skateboarding. LP later attended St Clair High School and obtained his Year 10 School Certificate. After leaving school early, LP took on a traineeship with a motorcycle accessories business and enjoyed the work. Following this LP went to work for his uncle installing kitchens and later, building portable building. Following the closure of this business, LP started up his own business in the construction industry.

3.5 There is no doubt that LP is greatly missed by his many family members. It is distressing to know that the suddenness and unexpected nature of LP's tragic death, in already stressful circumstances following his arrest, has caused his many loved ones immeasurable grief.

4. Background to the events of September 2017

4.1 Sometime in around 2008 LP met and formed a relationship with Donna Welsh. Between 2008 and 2011 LP and Ms Welsh had three children together, including twins. However this relationship subsequently ended. About 18 months following this LP met Blair Dalton on a dating website. At the time LP was living in St Clair in Sydney. Blair and LP formed a relationship soon after meeting online. After about six months Blair decided to move in with LP at St Clair. Whilst living in Sydney Blair worked at a laser clinic in Wetherill Park, whilst LP continued to work in the construction industry.

4.2 After some time LP and Blair began to experience difficulties within the relationship. These difficulties led to Blair leaving the home she shared with LP and periodically staying with LP's mother and sisters.

4.3 Sometime in 2015 Blair, LP, and members of LP's family went to Fiji for a holiday. When they returned, Blair called her mother and told her that she was pregnant. Blair's mother noted that Blair seemed very happy at the time. However, in October 2015 Blair told her mother that she and LP had separated due to LP's illicit drug use. It appears that around this time LP had developed a dependency on methamphetamine, which resulted in a brief admission to hospital for detoxification. Subsequently, LP's family observed that he was behaving erratically due to his drug use. As a result

Blair moved in with her grandmother at Ettalong. Whilst living there she continued to travel to Sydney for work. A month later in November 2015 Blair found a place of her own and to rent in Ettalong and moved in there by herself.

4.4 On 27 February 2016 Blair gave birth to her and LP's son at Gosford Hospital. LP was at the birth and they named their son BD. After Blair and BD were discharged from hospital after a few days LP returned to Sydney. However, LP returned to Ettalong on 10 July 2016 for BD's naming day. At around this time an incident occurred at Blair's home which involved LP yelling and swearing and Blair becoming visibly upset.

4.5 On 24 August 2016 LP was evicted from his home in St Clair and subsequently moved in with his mother and stepfather. On 23 September 2016 LP, whilst apparently under the influence of illicit drugs, became involved in a violent incident with his stepfather. This resulted in LP being charged. A short time later in December 2016 LP was involved in another violent incident, this time concerning his ex-partner. This also resulted in LP being charged, and subsequently refused bail. He was later released from custody on 24 January 2017 and moved in with his aunt in the St Clair.

4.6 According to accounts from LP's family he made some changes in his life after January 2017, by ceasing his illicit drug use and focusing on work. This reportedly led to an overall improvement in his circumstances. During this period of time Blair travelled to Sydney and stayed at LP's sister's house so that LP could have supervised visits with BD. In the same period LP also travelled to the Central Coast so that he could spend the day with BD. There were no reported difficulties arising from this contact between Blair and LP.

4.7 Due to LP's past medical history he was referred by his GP to and outpatient mental health facility in September 2017. On assessment LP reported suicidal ideation but denied any suicidal intent and any self-harming behaviour. The psychiatrist who assessed LP formed the opinion that he had major depressive disorder, ongoing alcohol use disorder and psychosocial stressors. It was noted that LP had several historical risk factors for suicide including depression, alcohol use, and past substance use, even though he denied of suicidal intent or plans.

5. The weekend of 23 and 24 September 2017 and after

5.1 LP's sister, Megan, booked an apartment in the Mantra Hotel in Ettalong over the September school holidays so that she, her children, and her mother could visit Blair and BD. They drove up to the Central Coast on 23 September 2017 and arrived at the hotel in the afternoon, where they met Blair and BD. It appears that Blair subsequently called LP and invited him to join them. LP subsequently caught a train to the Central Coast where he was picked up by his mother. On the way back to the hotel LP's mother asked how he was feeling. LP told her that he had been feeling a bit depressed but that he had been referred to a psychiatrist and, as a result been feeling better. Upon arriving back at the hotel Blair, LP and LP's family had dinner together. At about 8:00pm Blair and LP left the Mantra to go to the nearby Ettalong hotel to watch a football match. After the match finished they returned to the Mantra and were reportedly in good spirits. A short time later Blair, LP and BD left the Mantra and went back to Blair's house.

5.2 The next day, 24 September 2017, Blair, LP and BD returned to the Mantra at about 9:00am. They were again observed to be in good spirits. It appears that they stayed at the Mantra during the morning, and after lunch Blair took LP to a train station so that he could catch a train back to Sydney.

5.3 On 25 September 2017 Blair went to work at Erina. Later that evening she met up with LP's mother and sister for dinner.

6. The critical events of 26 September 2017

6.1 The next morning on 26 September 2017 LP caught a train from St Marys to Woy Woy. He met up with Blair and BD at a supermarket in Woy Woy. It appears that during the day Blair and LP argued about their respective locations: Blair was reluctant to move back to Sydney, whilst LP was equally reluctant to move to the Central Coast as he did not want to move away from his older children who were living in Sydney. At about 2:30pm that afternoon Karen Bell arrived at Blair's house for a beauty treatment. Ms Bell sensed that there was tension between Blair and LP and formed the belief that they had been arguing. She noticed that Blair was not her usual happy self.

6.2 At about 7:00pm Blair and LP put BD to bed. Following this Blair started to wash up the dishes in the kitchen. On LP's version, another argument occurred over Blair's reluctance to move back to Sydney. At some stage Blair told LP that she thought he should leave, but LP told her that he was not going anywhere. According to LP, Blair then walked towards him holding a knife. It should be emphasised that there is no independent evidence to verify LP's version of events, given that he and Blair were the only two people in the kitchen at the time.[1]

6.3 LP asked Blair what she was going to do with the knife. He then used both hands to grab her around the throat and squeezed until Blair became unconscious. It is not known how long LP was holding onto Blair's throat. At 7:10pm LP called Triple Zero from his mobile phone. He told the emergency operator that he needed an ambulance at Blair's address and said, "*I just killed my girlfriend*". When the emergency operator asked what had happened LP replied, "*She pulled a knife on me and I strangled her*".

6.4 The first responding police officers arrived at Blair's house at 7:15pm. They saw that LP was extremely agitated and upset, and described him as "*ranting and waving his arms around*".[2] The police officers entered the kitchen and saw Blair lying on the ground, unconscious with red swelling around her face and neck. LP knelt down next to Blair and said, "*I've killed her, I've killed her*".

6.5 One of the police officers checked Blair and felt a faint pulse. The police officers moved LP away and handcuffed him so that they could attend to Blair. The police officers immediately commenced cardiopulmonary Resuscitation (**CPR**). NSW Ambulance paramedics arrived on the scene at about 7:27pm. On examination Blair was found to be unconscious, not breathing, with nil palpable pulse and in cardiac arrest. Defibrillator pads were applied whilst the police officers continued CPR. The paramedics subsequently established an airway and took over CPR from the police officers. Blair was cannulated and adrenaline was administered resulting in return of spontaneous circulation.

6.6 Following the arrival of another paramedic crew Blair was placed into an ambulance and taken to hospital as installation continued. On arrival at Gosford Hospital emergency department hospital staff took over airway management and maintained ventilation, while stabilising Blair. Once stabilised Blair was transferred to the intensive care unit for further monitoring and assessment,

[1] However, it is noted that police subsequently located a butter knife under Blair's leg. Of course, there is no evidence, apart from LP's version, as to what was done (if anything) with the knife.
[2] Exhibit 1, Tab 23 at [7].

although her prognosis was poor. Subsequent investigations revealed that Blair remained unresponsive to external stimuli and that she had suffered an irreversible hypoxic brain injury. Life support measures were withdrawn on 28 September 2017 and Blair was pronounced life extinct at 5:12pm.

7. Police investigation concerning LP and subsequent events

7.1 LP was later arrested and taken to Gosford police station. He took part in an electronically recorded interview at 1:07am on 27 September 2017. In the interview LP told the police that he and Blair had an argument after BD had been put to bed. LP said that after he told Blair that he was not going to leave she turned around with a knife in her hand. When asked by the interviewing police officers to describe what occurred next, LP became noticeably upset. However he eventually told police, "*I done it and, argh, I done it…*". When asked to explain what he had done LP said, "*I strangled her*"[3], and indicated that he had placed both of his hands around Blair's neck. Due to LP's condition a decision was made to not continue with the interview. LP was charged with attempting to strangle Blair with intent to murder (on the information that was available to police at the time).

7.2 LP appeared at Gosford Local Court later on 27 September 2017. He was remanded into the custody of Corrective Services New South Wales, with his next court appearance on 27 October 2017. LP was subsequently transferred from Gosford to the Metropolitan Remand and Reception Centre (**MRRC**) at Silverwater.

8. Custodial history

8.1 On arrival at the MRRC an intake screening assessment for new inmates could not be completed due to LP being in a distressed state and unable to answer questions posed to him by a Corrective Services New South Wales (**CSNSW**) Services and Programs Officer (**SAPO**). However, it was identified that LP may be at risk of self-harm and, accordingly, he was subject to review by a Risk Intervention Team (**RIT**). LP was subsequently housed in an assessment cell within Darcy Block. The cell consists of a clear Perspex door with a steel security bars, is located near the station for Justice Health & Forensic Mental Health Network (**Justice Health**) staff, and is monitored by two CCTV cameras.

8.2 At about 8:30pm on 27 September 2017 LP was reviewed by a registered nurse from Justice Health. It was noted that LP was tearful and distressed, and that he had previously head-butted the cell doors. However physical observations of LP were normal, and LP denied any health issues. From this assessment, a Health Problem Notification Form was completed recommending that LP be housed on his own in a camera cell (a cell monitored by CCTV cameras), for his own safety and the safety of others, until he could be reviewed by a RIT. Further it was recommended that he only be offered limited possessions, including a safety blanket.

[3] Exhibit 1, Tab 30, Q/A 89.

9. What happened on 28 September 2017?

9.1 On the morning of 28 September 2017 a RIT consisting of Assistant Superintendent (**AS**) (as he then was) Tibo Semetka, SAPO Deborah Moffit and Registered Nurse (**RN**) Astrid Munoz reviewed LP. LP was taken from his cell to a RIT interview room. When asked whether he knew what he had been charged with, LP covered his face with his hands and began to cry inconsolably. After some time the RIT members asked if LP was able to continue with his interview. LP only shook his head and continued crying. Accordingly the interview was terminated and LP was placed back in his cell.

9.2 The RIT members subsequently agreed that LP remained at high risk and was to stay in his assessment cell. It was noted that a further attempt to interview LP would be made on 30 September 2017.

10. What happened on 29 September 2017?

10.1 At about 6:27am on 29 September 2017 LP was escorted from his cell to the shower room, returning at about 6:44am. Upon his return LP collected his breakfast meal pack, and later ate it while sitting at the end of his cell bed. The meal pack contained cereal, milk, and sweetener packets in a clear plastic wrapper. In the course of eating his breakfast, LP discarded the sweetener packets onto the cell floor.

10.2 Between about 9:20am and 9:28am CCTV cameras record LP getting out of his bed, taking toilet paper from his cell toilet and soaking the paper in the toilet bowl. LP also picked up the previously discarded sweetener packets and manipulated them whilst standing in front of the toilet bowl. At about 9:28am LP returned to his bed, holding something in his hand, and lay down covering his head with the blanket. Between about 9:28am and 9:33am the CCTV cameras record LP making minor movements under the blanket. However from about 9:33am onwards no further movement under the blanket is seen.

10.3 At about 10:45am one of the investigating police officers in relation to Blair's death contacted the MRRC in relation to seeking LP's consent to participate in a procedure to obtain a forensic sample from him. At about 10:52am CSNSW officers attended LP's cell with the intention of speaking to him in relation to the enquiry regarding the forensic procedure.

10.4 The CSNSW officers knocked on the cell door in an attempt to gain LP's attention. However LP did not respond causing the CSNSW officers to open the cell door and enter the cell. One of the officers saw that LP's foot was protruding from beneath the blanket and touched it in an attempt to rouse him. However LP was unresponsive. One of the officers immediately notified Justice Health staff at the station near LP's cell, seeking medical assistance.

10.5 Justice Health staff arrived at the cell at about 10:53am and moved LP from his bed to the cell floor. LP was observed to be not breathing, cyanosed, and to have no detectable pulse. Initial examination revealed foreign material in LP's airway. Three pieces of torn plastic bags and a strip of five connected sweetener sachets from LP's breakfast meal packet were removed from LP's airway. Resuscitation attempts were then initiated using a defibrillator and supplemental oxygen which continued for about 20 minutes. However LP could not be resuscitated and was later pronounced life extinct at 11:11am.

11. What was the cause and manner of LP's death?

11.1 LP was subsequently taken to the Department of Forensic Medicine in Sydney where a post-mortem examination was performed by Dr Jennifer Pokorny, forensic pathologist, on 4 October 2017. Postmortem imaging scans revealed foreign material in the oropharynx extending to the epiglottis. Internal examination confirmed the presence of a large foreign body (measuring 110mm x 50mm x 30mm) occluding the larynx and extending to the level of the epiglottis. The foreign body was identified as being composed of a number of pieces of compressed toilet paper. In her subsequent autopsy report dated 23 November 2017, Dr Pokorny opined that the cause of LP's death was foreign body aspiration.

11.2 The evidence relating to LP's past medical history of suicidal ideation, the events of 26 September 2017 and LP's subsequent arrest, and the circumstances in which LP was found all establish that LP died as a result of actions taken by him with the intention of ending his life. The CCTV footage shows that LP used the toilet paper from his cell and the plastic packaging from his breakfast pack to fashion an object which he later ingested. This had the consequence of occluding LP's airway resulting in his subsequent death.

11.3 It should be made clear that although LP's actions were captured by the CCTV cameras in his cell there is no suggestion that any reasonable viewing of the footage should have prompted action prior to the discovery that LP was unresponsive. The footage shows LP returning to his bed, after having soaked the toilet paper in the toilet bowl, and placing the blanket over his head. As a result LP's actions whilst his head was covered were not captured by the CCTV cameras. Even though the CCTV footage shows LP to be motionless a short time later a person viewing the footage might have reasonably believed that LP was simply asleep, rather than unresponsive.

12. Issues relating to the RIT review on 28 September 2017

12.1 During the course of the coronial investigation a number of issues were identified in relation to the circumstances of the RIT review conducted on 28 September 2017. In particular the proximity of the review to LP's death raised questions regarding whether or not an appropriate review was conducted in accordance with relevant policies which applied at the time, and whether appropriate arrangements were made for follow-up review. Further, the unusual circumstances in which LP inflicted his own death raises questions as to whether appropriate measures are in place to mitigate against the risk of another death in similar circumstances. These issues are dealt with individually below.

Timeframe for review of RIT Management Plans

12.2 Section 13.3.2 of the CSNSW Operations Procedures Manual (**OPM**) (which was in force at the time of LP's death) relates to the management of inmates at risk of suicide of self-harm in correctional centres. Relevantly, section 13.3.2.7.5 of the OPM deals with assessment cell placement. It provides:

> "*Placing an inmate into an assessment cell is a measure of last resort and should not be common practice. The use of assessment cells must be consistent with the approach of least restrictive care. No inmate is to stay in an assessment cell for more than 48 hours without the written approval of the General Manager. When an assessment cell is used the [Immediate*

Support Plan] must specify the length of time the inmate will stay in the cell before having the plan reviewed (this should be no more than 24 hours unless in exceptional circumstances)".[4]

12.3 In this context, an Immediate Support Plan (**ISP**) is "*a plan to manage an inmate immediately after they have been identified as being at risk of suicide or self-harm*", and requires consideration of an inmate's cell placement options, risk of harm to or from others, assessment cell apparel, use of restraints, observations and diversionary activities.[5]

12.4 Further, section 13.3.2.15.7 of the OPM relates to RIT Management Plans, which is a plan is designed to consider all options as detailed for an ISP, and include for consideration referrals made for an inmate, transport of an inmate, and an inmate's next RIT review date. Section 13.3.2.15.7 provides the following:

"*RIT Management Plans have a fixed timeframe for review. The review date is determined by the RIT and is dependent on the restrictive nature of the intervention. For inmate placed in an assessment cell, the RIT Management Plan should be reviewed within 24 hours (unless exceptional circumstances exist)*".[6]

12.5 As the OPM has now been superseded, the above provisions have been replicated in the current CSNSW Custodial Operations Policy and Procedures (**COPP**) at section 4.3 (in relation to ISP cell placement options) and at section 6.4 (in relation to next review date for RIT Management Plans).

12.6 Applying these policy considerations to LP's case, it is evident that following conclusion of the incomplete RIT review on 28 September 2017 LP ought to have been the subject of another RIT review within 24 hours. This is because (in accordance with section 13.3.2.7.5 of the OPM) LP was housed within an assessment cell which mandated a review within 24 hours, and also because (in accordance with, section 13.3.2.15.7 of the OPM) LP was subject to a RIT Management Plan. In both cases a review within 24 hours was not required if exceptional circumstances existed.

12.7 However, instead LP was next scheduled to be reviewed by a RIT on 30 September 2017, some 48 hours after his initial attempted review. The progress/clinical notes from the RIT review on 28 September 2017 records that LP attended the interview but was too upset to answer any questions. It was noted that he was particularly distressed. The notes then record the following: "*Due to his presentation [patient] will remain on MNF, [review] 30/8/17*".

12.8 A RIT Management Plan for LP was completed on 28 September 2017. It was signed by all three members of the RIT. Under a heading relating to "*the current presentation and situation of the inmate*", it was recorded that LP was too distressed to talk. The RIT Management Plan was completed identifying that LP was to remain in an assessment cell. Further, the next RIT Management Plan review date was recorded as being 30 September 2017. This is despite a stipulation contained in the RIT Management Plan noting that: "*A review of the RIT plan should be conducted within 24 hours for all inmate is placed in an Assessment cell*".[7]

[4] Exhibit 1, Tab 31.
[5] Exhibit 1, Tab 31.
[6] Exhibit 1, Tab 31.
[7] Exhibit 1, Tab 26.

12.9 In a CSNSW Officer Report form dated 31 October 2017, AS Semetka noted: "*Due to very high volume of inmates assessed to be at risk of self-harm in MRRC and received as fresh custody [sic] RIT is able to review inmates remained [sic] on MNF only once in 48 hours. This is the reason why [LP] was to be deferred to30/09/2017*".[8] However, in his statement AS Semetka acknowledged that there is no CSNSW policy which provides for a RIT Management Plan to be reviewed at 48 hour intervals. Similarly SAPO Moffitt said in her statement that she was also not aware of any such policy. She explained: "*I have enquired with several staff at the MRRC and apparently the policy is (I think) a local order for the MRRC*".[9] Further, RN Munoz said in her statement that she also was not aware of any policy of this kind.

12.10 Instead, AS Semetka agreed that relevant CSNSW policies require that an inmate must be seen within 24 hours while subject to a RIT Management Plan. However AS Semetka noted: "*Ideally [inmates] should be reviewed every day after that but it is logistically impossible in MRRC due to high number of inmates*".[10]

12.11 AS Semetka adhered to this view in his evidence during the inquest. When asked about the operation of section 13.3.2.15.7 of the OPM AS Semetka expressed the view that the 24 hour time frame for review should be complied with "*wherever possible*". He explained that because the MRRC is the busiest correctional centre in New South Wales the volume of new inmates has a direct effect on timeframes for review of RIT Management Plans. In this context AS Semetka explained that because newly admitted inmates are required to be initially reviewed within 24 hours of admission this has an impact on the ability of a RIT to review existing inmates. Notwithstanding these considerations AS Semetka considered that it would be ideal if inmates subject to a RIT Management Plan were reviewed every 24 hours.

12.12 In her evidence SAPO Moffitt said that in her experience, whilst performing duties as part of a RIT for five years, the requirement for a maximum of 24 hours between reviews had never been complied with. Instead SAPO Moffitt explained that a 48-hour interval between reviews had become the norm at the MRRC. Notwithstanding, SAPO Moffitt agreed that it would be beneficial to adhere to the current requirements of the COPP which require a maximum 24 hour interval between reviews. RN Munoz similarly agreed that in her experience the 24 hour interval requirement had never been complied with, although she considered that such compliance would be ideal.

12.13 In his statement AS Semetka said that he could not recall how many inmates were interviewed by the RIT on 28 September 2017, but estimated that on a daily basis the RIT interviews between 7 to 12 inmates. In her statement, SAPO Moffitt said that the RIT saw 9 inmates on 28 September 2017. However none of the RIT members on 28 September 2017 had a precise recollection of how many inmates were reviewed on a particular day. Notwithstanding both SAPO Moffitt and RN Munoz said in evidence that in their experience it was frequently the case that a RIT was unable to review every inmate scheduled to be reviewed on a particular day.

12.14 In evidence, Terry Murrell, the General Manager, State Wide Operations, Custodial Corrections Branch for CSNSW, was asked about the apparent inability of RIT members to comply with the requirements of the former OPM and current COPP in relation to review timeframes. He explained

[8] Exhibit 1, Tab 31.
[9] Exhibit 1, Tab 31A at [23].
[10] Exhibit 1, Tab 31A at [20].

that he was aware that the situation had existed for a number of years. He also explained that he was not aware of the situation existing in any other correctional centre apart from the MRRC. On this basis Mr Murrell considered the issue of review timeframes to be a local management issue. After agreeing that it would be ideal if the 24 hour interval between reviews could be complied with, Mr Murrell indicated that consideration could be given to varying local operating procedures at the MRRC in order to comply with the provisions of the COPP in this regard.

12.15 **Conclusions:** The decision of the RIT members to schedule the next review of LP's RIT Management Plan on 30 September 2017, 48 hours after his initial attempted review on 28 September 2017, was not in accordance with the relevant provisions of the OPM which operated at the time. These provisions required there to be only a 24 hour interval between reviews because LP was housed in an assessment cell and subject to a RIT Management Plan.

12.16 The evidence established that over a period of years it had become accepted practice at the MRRC for the relevant provisions of the OPM in relation to review timeframes to not be complied with. By way of explanation, it appears that the demands placed on a RIT as a result of increasing inmate numbers meant that reviews were occurring every 48 hours, instead of every 24 hours.

12.17 It could not be said that exceptional circumstances existed on 28 September 2017 to allow for non-compliance with the relevant provisions of the OPM in relation to review intervals. This is because the evidence established that the number of inmates to be seen by the RIT on that particular day (and the likely number of inmates that were actually reviewed) was not inordinately high but, rather, consistent with typical workload for a RIT. That is, it was common experience for an RIT to be unable to review all the inmate scheduled for review on a particular day. In this sense, and with respect to LP, 20 September 2017 was no different, meaning that exceptional circumstances did not exist.

12.18 Whilst the evidence established that in the opinion of the 28 September 2017 RIT members it would have been ideal for LP to have been reviewed within 24 hours, it should be noted that LP was still subject to the highest level of restrictive care that was available. In other words, he was housed in an assessment cell with a Perspex door and subject to CCTV monitoring. It should also be noted that it is not possible to say that if a review had been conducted within 24 hours of 28 September 2017 that this would have materially altered the eventual outcome.

12.19 Notwithstanding, having regard to the operation of sections 4.3 and 6.4 of the COPP and that the practice of conducting RIT Management Plan reviews on a 48 hour basis appears to be a practice unique to the MRRC, it would appear desirable for there to be consistent practice adopted across all correctional centres within New South Wales. Therefore, it is necessary to make the following recommendation.

12.20 **Recommendation 1:** I recommend that the Commissioner of Corrective Services New South Wales give consideration to the implementation or variation of relevant Local Operating Procedures at the Metropolitan Remand and Reception Centre to provide that (a) the interval for review of inmates subject to a Risk Intervention Team Management Plan and/or housed in an assessment cell is to be no longer than 24 hours; and (b) where a review of an inmate cannot be completed such a review is to be deferred to the following day, with priority to be given to review of the inmate on that subsequent day.

Outcomes of a RIT assessment interview

12.21 Section 5.3 of the COPP deals with the assessment of risk of suicide or self-harm. It identifies two outcomes of a RIT assessment interview: firstly, if an inmate is not considered by the RIT to be at risk of suicide or self-harm and does not require additional management strategies, then no RIT Management Plan is developed; alternatively, if an inmate is considered by the RIT to be at risk of suicide or self-harm, then a RIT Management Plan should be developed which includes strategies that directly target risk factors while maintaining principles of least restrictive care. Section 13.3.2.15.3 of the OPM is couched in similar terms.

12.22 In LP's case it is plainly evident that a complete and proper assessment could not be conducted by the RIT on 28 September 2017 due to LP's level of emotional distress. This means that the RIT was unable to apply either of the two outcomes referred to above, in accordance with the equivalent provisions of the OPM.

12.23 **Conclusions:** Due to LP's emotional state on 26 September 2017 a complete and proper assessment in accordance with section 13.3.2.15.3 of the OPM could not be completed. As the relevant section provided for only two possible outcomes, a RIT Discharge Plan was not completed and a RIT Management plan was not developed.

12.24 It is conceivable that newly admitted inmates who are subject to a RIT protocol may not be able to be properly interviewed due to their emotional state, level of aggression, or state of intoxication from alcohol or drugs. In such circumstances it would be desirable for a RIT to be provided with guidance as to what ought to occur when a RIT assessment interview cannot be completed for these reasons. In this regard, counsel for CSNSW indicated that CSNSW was open to amending section 5.3 to provide for a third possible outcome to provide for such an eventuality. Therefore, it is necessary to make the following recommendation.

12.25 **Recommendation 2:** I recommend that the Commissioner of Corrective Services New South Wales give consideration to amending section 5.3 of the Custodial Operations Policy and Procedures to provide guidance to Risk Intervention Team (**RIT**) members as to what is to occur if a RIT assessment review is unable to be completed due to an inmate's emotional state, level of aggression, or intoxication due to alcohol or drug use and, as a result, the RIT is unable to determine whether a RIT Discharge Plan is to be completed or a RIT Management Plan is to be developed.

A second Risk Intervention Team

12.26 The COPP provides that for a RIT to operate the following members must be available: a RIT Coordinator, who must be a custodial officer of Senior Correctional Officer (**SCO**) rank or above; a SAPO; and Justice Health mental health nurse.

12.27 In her evidence SAPO Moffitt referred to her awareness of there being a second RIT Coordinator and SAPO being rostered on at the MRRC so that a second RIT could be formed where required. However SAPO Moffitt said that it was her understanding that a second RIT could not be formed due to the unavailability of the required Justice Health staff member.

12.28 In his evidence Mr Murrell said that he was previously unaware of the rostering of CSNSW staff to allow for the potential formation of a second RIT. As this issue was raised unexpectedly for the first time during the course of evidence in the inquest, it was agreed that both CSNSW and Justice Health would provide further information in this regard, following the conclusion of the evidence in the inquest.

12.29 That further information has now been provided by both CSNSW and Justice Health. It establishes that since 28 October 2019 an additional SCO has been rostered at the MRRC to perform the functions of a second RIT. It also establishes that the MRRC is in the process of recruiting an additional SAPO to be rostered on when a second RIT can be formed. If a second RIT cannot be formed then the rostered SCO and SAPO are to perform other duties including the interviewing and screening of new inmates.

12.30 The information provided by Justice Health establishes that the current MRRC nursing staff profile/funding only allows for one mental health nurse to be allocated to the RIT daily. However when the demand for RIT reviews is significantly high Justice Health redeploy a mental health nurse to facilitate formation of a second RIT. However in doing so, this can cause a backlog of work due to the absence of the redeployed staff member. The information provided notes that Justice Health is in the process of reviewing its policies, processes and resourcing in relation to the RIT at the MRRC.

12.31 **Conclusions:** It appears that appropriate consideration is being given by both CSNSW and Justice Health to the issue of staff rostering at the MRRC to provide for the formation and operation of a second RIT when the need arises. Such consideration and discussion between CSNSW and Justice Health is endorsed and encouraged. On this basis, it is neither necessary nor desirable to make any recommendation.

Method of self-harm

12.32 In evidence AS Semetka said that he only became aware for the first time at the inquest of the manner in which LP died. SAPO Moffitt said that she was aware of the way in which LP died, but said that she had not been provided with any specific training by CSNSW about the ways in which inmates could use packaging from their meal packs to potentially cause self-harm. RN Munoz said that she was also aware of the way in which LP died (as she had assisted with the resuscitation attempts on 29 September 2017), but was unaware of such packaging being a concern for the possibility of self-harm by inmates.

12.33 In his evidence Mr Murrell acknowledged that whilst there is no CSNSW policy which identifies plastic packaging from meal packs as being a potential hazard in relation to possible self-harm by inmates, he expressed the view that existing CSNSW polices are sufficiently broad to allow a RIT to put measures in place if it is thought that an inmate is at risk of self-harm. In this regard, Mr Murrell acknowledged that whilst no specific training had been provided to CSNSW staff about the potential risks associated with inmates using plastic packaging from meal packs to self-harm that LP's case might be used as an appropriate case study to warn CSNSW staff members about the potential risks associated with using plastic packaging.

12.34 **Conclusions:** Although some of the 28 September 2017 RIT members were aware of the way in which LP died, none were aware of the potential risks associated with plastic packaging in a self-harm attempt prior to his death. Further, since LP's death it seems that no specific training has been provided to either CSNSW or Justice Health staff members about such risks.

12.35 Given the relatively unusual circumstances surrounding the manner in which LP died it can be accepted that the possibility of such a risk may not be always recognised and considered. Raising awareness amongst CSNSW and Justice Health staff responsible for assessing an inmate's risk of self-harm about this possibility can only serve to assist in the mitigation of such a risk. It is therefore necessary to make the following recommendation.

12.36 **Recommendation 3:** I recommend that the Commissioner of Corrective Services New South Wales (**CSNSW**) and the Chief Executive Officer, Justice Health and Forensic Mental Health Network give consideration to the circumstances of the death of LP being used as a case study as part of training and education provided to CSNSW and Justice Health staff to raise awareness regarding the possible risks of self-harm associated with the use of plastic packaging from meal packs (with appropriate anonymization, and conditional upon consent being provided by LP's family and following appropriate consultation with them).

13. Acknowledgments

13.1 Before turning to the findings that I am required to make, I would like to acknowledge, and express my gratitude to Tim O'Donnell, Coronial Advocate, for his considerable assistance during both the preparation for inquest, and during the inquest itself. I also thank Detective Sergeant Andrew Tesoriero for conducting a thorough investigation and for compiling a comprehensive initial brief of evidence. I thank both of them for the sensitivity and empathy that they have shown in this tragic matter.

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

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

Identity
The person who died was LP.

Date of death
LP died on 29 September 2017.

Place of death

LP died at the Metropolitan Remand and Reception Centre, Silverwater NSW 2128.

Cause of death

The cause of LP's death was foreign body aspiration.

Manner of death

LP died as a result of actions taken by him with the intention of ending his life. At the time of his death LP was in lawful custody, on remand, at a correctional centre.

15. Epilogue

15.1 In the span of only a few days in September 2017 LP's family had to endure significant trauma and grief. There is no doubt that the tragic circumstances surrounding these events has had a lasting effect on them. There is equally no doubt that LP is greatly missed by his large family and those who love him the most, in particular his mother, Susan.

15.2 On behalf of the Coroner's Court of New South Wales, I offer my deepest sympathies, and most sincere and respectful condolences, to LP's family for their most painful and overwhelming loss.

15.3 I close this inquest.

Magistrate Derek Lee
Deputy State Coroner
13 February 2020
Coroner's Court of NSW