CORONERS COURT

OF NEW SOUTH WALES

Inquest:	MW
File number:	2017 /136779
Hearing dates:	8 November 2019
Date of findings:	24 January 2020
Place of findings:	Coroners Court, Lidcombe
Findings of:	Deputy State Coroner E. Truscott
Catchwords:	Coronial Law-Cause and manner of death-
Representation:	Coronial Advocate: Ms A. Chytra Department of Corrective Services NSW: Ms Azzopardi, Office General Counsel Justice Health & Forensic Mental Health Network: Mr M Sterry, Barrister-at-law GEO Group Australia Pty Ltd: Mr J Raftery instructed by Mr R Casmir.

S74 and s65 Orders	That the following information contained in the brief of evidence tendered in the proceedings not be published under section 74(1)(b) of the *Coroners Act 2009 (NSW)*: The name, image, MIN, personal address and phone number of MW. The names, addresses, phone numbers and other personal information that might identify: Any member of MW's family; and Any person who visited MW while in custody (other than legal representatives or visitors acting in a professional capacity). The names, personal information and Master Index Number (MIN) of any persons in the custody of Corrective Services New South Wales ('CSNSW'). GEO Group Australia policy material contained at Attachment 29 to the CSNSW Investigation report. The Parklea Correctional Centre Daily Roster dated 5 May 2017 at Attachment 22 to the CSNSW Investigation report. Images of MW at Attachment 31 to the CSNSW Investigation report. Images from CCTV footage at Attachment 36 to the CSNSW Investigation report. CSNSW Policy and Procedures for Reception, Screening, Induction and Orientation of Inmates in NSW, dated 16 February 2017. CSNSW Operations Procedures Manual, Section 3.2 Use of Telephones, version 1.4 December 2015. Attachments to the Statement of [redacted] dated 5 November 2019 include: - GEO Action Plan dated 1 September 2017 - GEO Parklea Correctional Centre Operating Manual Attachments to the Statement of Detective Sergeant (OIC) dated 28 October 2019 which include 9x photographs of Parklea Correctional Centre cell 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. **Note that the provisions of s75 (5) Coroners Act 2009 apply to this matter.**
Findings:	**Identity** known as MW **Date of Death** 5 May 2017 **Place of Death** Parklea Correctional Centre **Cause of death** Hanging **Manner of death** Suicide

IN THE CORONERS COURT

LIDCOMBE

NSW

Section 81 Coroners Act 2009

REASONS FOR DECISION

Introduction

1. This is an inquest into the death of a man known in these proceedings as MW, who was 52 years old when he died on the 5th of May 2017 at Parklea Correctional Centre ("PCC").

2. Mr MW was born in 1965. At the time of his death he was in custody awaiting extradition to the United States of America pursuant to an arrest warrant issued on 6 January 2017 under subsection 12(1) of the Extradition Act 1988 (Cth).

3. MW was in the lawful custody of Corrective Services NSW ("CSNSW") at the time of his death. Accordingly, an inquest is required to be held pursuant to sections 23 and 27 of the Coroners Act 2009 ("the Act").

The role of a Coroner and purpose of this inquest

4. Under s81 of the Act a Coroner, is to make findings as to:

   (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.

5. Pursuant to s 82 of the Act a Coroner is empowered to make recommendations concerning matters such as public health or safety issues arising out of the death in question.

6. There is no controversy in this case as to MW's identity, the date or place of his death, nor the cause of death. The investigation into the death of MW focused on the manner of his death.

Evidence and Issues of Inquest

7. The only witness called in the inquest was Detective Sergeant Joseph Coorey who is the Officer in Charge of the investigation. The brief of evidence compiled by Detective Sergeant Coorey was tendered (Ex.1).

8. Mr McAuley who is instructed to represent the interest of MW's teenage children joined the proceedings a few days prior to the commencement of the inquest. He raised a number of matters which, rather than adjourning the hearing date, were resolved by an agreement that following the tender of the brief and Detective Sergeant Coorey's evidence the proceedings would be adjourned and a statement from two persons would be respectively obtained to answer concerns raised by Mr McAuley. Following receipt of those statements Mr McAuley indicated through Ms Chytra that he did not wish to make any further submissions.

9. Dr Balzer provided a statement dated 29 November 2019 about which Mr McAuley drafted a number of questions dated 10 December 2019. In answer to those questions Dr Balzer wrote a response statement dated 14 January 2020. Dr Balzer's 2 statements together with Mr McAuley's questions are tendered as Exhibit 2.

10. The second witness statement was taken from a registered nurse Ms A Hanson dated 21 November 2019. This statement is Exhibit 3.

MW's Personal History

11. MW was previously married and had two children from this union. MW's marriage dissolved around 2014 when he was charged by Australian Federal Police for offences under the Commonwealth Criminal Code Act. MW's wife had custody of their two children. MW had two brothers and a sister. MW moved out of the family home to live with his brother for about eighteen months until he found his own unit. He had held a job for several years up until his incarceration in January 2017. At the time of the inquest his children were teenagers at school.

MW's Criminal History

12. MW experienced his first arrest and charge in January 2014 after which he was on conditional police bail until June 2014. During that time the NSW Police had received information from police in the United States that a warrant for MW's arrest had issued on 6 February 2014 and that they wished to extradite MW to prosecute him for offences including and relating to those he had been charged with in NSW. As a result, the NSW charges were withdrawn, and authorities from the United States commenced their extradition process.

13. On 24 January 2017 MW was arrested by the Australian Federal Police and transported to the Surry Hills Police Station where the warrant was executed. Thereupon, MW appeared before the Local Court, Central via Audio Visual Link ("AVL"). He was refused bail and remanded to 29 March 2017. By the time of his death he had appeared before the court numerous times and had eventually come to learn he would be extradited to the United States.

Reception and Intake Screening

14. Following his first court appearance, MW who had not previously been in custody was transferred on 25 January 2017 from the NSW Corrective Services Cells at Surry Hills Police Station to the PCC. At that time, PCC was operated by GEO Group Australia Pty Ltd ("GEO") through a contractual agreement with the NSW Commissioner of Corrective Services. Health and psychiatric services were provided by the Justice Health and Forensic Mental Health Network ("The Network"); except for psychology services which were provided by GEO. Since April 2019 GEO and The Network are no longer involved in the operation of PCC. MTC-Broadspectrum and St Vincent's Correctional Health Services now operate PCC.

15. Upon his arrival at PCC, MW underwent a reception process which involved both a Correctional Intake Screening undertaken by a Corrections Officer employed by GEO and a Health Assessment Screening undertaken by a registered nurse employed by The Network. MW told the nurse that he had no medical history and no mental health history. He denied any thoughts of self-harm and guaranteed his own safety.

16. MW requested protective custody due to the nature of his charges. He was subsequently housed in cell 21 Wing 2A, a wing reserved for protected inmates. From the 6th of February 2017, MW shared his cell with fellow inmate JB. MW had a future Court date scheduled for the 15th of May 2017. At the time of his death MW was classified as an unsentenced inmate.

17. MW's Health Assessment on 25 January 2017 did not indicate that he had any health issues. The nurse conducting the screening assessment recorded that MW appeared alert and orientated. She noted that MW's speech was clear and coherent and that he looked settled and that he denied any thoughts of self-harm. MW said that he had no medical, drug or alcohol issues. However, he indicated that two years prior he had been treated for depression and anxiety but was not currently taking any medications.

18. A mental health assessment test to measure whether MW was experiencing any non-specific psychological distress called "Kessler 10" was conducted. MW scored 21/50 which falls within criteria (20-24) which describes that a person may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.

19. On 26 January 2017 MW's intake documents (ISQ) underwent further screening where it was noted that he had a history of anxiety and depression but that he did not have thoughts or plans to self-harm. The GEO corrections officer referred MW to psychological services for coping strategies. The ISQ records that MW "Declined any other referrals-states will self-refer if required".

Psychological Services and Medical Treatment and Inmate Management

20. The following day 27 January 2017, psychologist Mary Girgis attended upon MW. He commented to her that he had been unaware that an appointment had been made. Ms Girgis noted that MW presented as calm, polite, co-operative and coherent during the interview. He presented as stable in his mental state with no perceptual disturbances or psychotic phenomena evident. MW reported a history of depression and anxiety. MW denied any suicidal ideations or thoughts of self-harm or plans to do so. He guaranteed his own safety and the safety of others. His insight and judgement appeared to be intact. MW denied experiencing any anxious or depressive symptoms and stated he had managed symptoms for years and was actively using coping strategies he had learned from his previous psychologist. He stated that he did not need to speak to a counsellor and that he had been coping well, denying any difficulties with his sleep and appetite. Ms Girgis advised MW that he could receive psychological assistance and advised him how he could make a referral to obtain an appointment.

21. On 3 February 2017, MW saw Ms Girgis again. MW had not arranged an appointment but had approached Ms Girgis at the gate. Ms Girgis agreed to see him and during interview she noted that MW appeared calm, polite, co-operative and coherent and rapport was easily established. It was noted however that MW appeared agitated and that his mood could be described as sullen.

22. Ms Girgis noted that MW said that he was becoming increasingly agitated and anxious and that he had yet to receive his initial phone call. He said that he had been unable to make any phone calls because he had no money in his account and could not access his property.

23. MW told Ms Girgis that he had been trying to employ his usual techniques to calm his anxiety but they were ineffective. Ms Girgis gave MW some grounding techniques and provided him with supportive counselling.

24. Ms Girgis also amended his referral to welfare stating he is yet to be seen. Ms Girgis also provided MW with a "brain gym" as MW thought that having this kind of distraction would be helpful. Again MW denied any suicidal ideation or thoughts or plans of self-harm. He guaranteed his own safety and the safety of others.

25. As a result of his attendance on Ms Girgis, steps were put in place to address the issues raised by MW and on the 8 February 2017 a phone call between MW and his brother was facilitated.

26. On 10 February 2017 MW attended the medical clinic where he was assessed by Dr Balzer. Dr Balzer was a General Practitioner who worked for The Network from October 2016 to March 2017. MW told the doctor he had two issues. One was an infected toe ("Paronychia") which was drained and he was provided with oral antibiotics. The second was that his sleep had been poor since his incarceration. Dr Balzer prescribed Avanza 30mg (mirtazapine) for assistance with sleeping.

27. In his first statement Dr Balzer remarks that in the RSA clinical summary of 25 January 2017 he noted that MW had denied any thoughts of self-harm and that MW did not express any thoughts of self-harm. In his second statement, Dr Balzer said that his mental state examination of MW involved reviewing the "Health Problem Notification Form" ("HPNF") and RSA Clinical Summary completed on 25 January 2017. Dr Balzer noted that The HPNF notified that it was MW's first time in custody and that he had no thoughts of self-harm. Dr Balzer sets out that the RSA Clinical Summary, which he noted included the Kessler 10 test results, MW had indicated that 2 years previously he had been treated at a medical centre in Hurstville for anxiety and depression and that MW had been asked whether he had ever tried to hurt himself or end his life, or whether there was a family history of self-harm or suicide. Dr Balzer noted that MW replied in the negative to those questions.

28. Dr Belzar said that he did not have access to Ms Girgis's notes from her 2 meetings with MW. Given that Ms Girgis was a psychologist employed by GEO rather than the Network such files would not normally comprise a medical file kept by The Network. Given the matters discussed with Ms Girgis one would not expect that she would have had occasion to refer MW to The Network for any medical or mental health treatment. She did facilitate arrangements for MW to contact his brother as he had sought.

29. On 29 March 2017 MW appeared in the Central Court Local Court via AVL from PCC. Corrections Officer Jason Singh noted in the NSW Corrective Services case notes report that MW advised him that his Court matters were adjourned for 2 weeks and that he denied any thoughts of self-harm and was satisfied with the outcome.

30. On 12 April 2017, MW again appeared in the Central Local Court via AVL from PCC. Following his appearance, Corrections Officer Francine Bakopoulos interviewed MW after his court appearance and noted that he confirmed that he was feeling okay and did not have any thoughts of self-harm or suicide or any other immediate concerns.

31. Those checks were made in conformity with Policy No. PCC/OP205. Clause 6.6-6.8 sets out AVL Checklist screening "to ascertain any changes to an inmate's circumstances likely to affect their current placement and assess if they (sic) are any immediate concerns or self-harm or suicide". In the event of a change, it is noted for The Network Staff to create a form whereby a change of the inmate's (cell) placement is recommended.

32. There was no indication by MW which would have triggered such a notification and indeed his placement with JB was stable for the duration of his time in PCC.

33. On the 17th of April 2017 MW was given nurse-initiated medicines of paracetamol and Sudafed (phenylephrine) a nasal decongestant.

34. On the 23rd of April 2017 RN Hanson attended MW to provide him with the Avanza prescribed by Dr Balzer. MW told RN Hanson that he felt he no longer needed the medication and had not taken it for 7 days. RN Hanson accordingly told him that he would be placed on the Mental Health list for review.

35. MW was last visited by his brother GW on the 27th of April 2017. GW has provided a statement in which he says that MW was excited to see him and they had spent an hour together. MW told GW that he feared for his life in gaol and that because he did not want to be around other inmates using the phones he had been unable to contact his GW.

36. GW said that he sensed that MW was uneasy about his situation. MW told his brother that he was concerned about not being able to get Legal Aid and that he was not being told anything. GW said that MW's mental state appeared stable just concerned about his situation.

37. Prior to this meeting, and about 3 weeks before he died MW had sent a letter to GW in which he disclosed that he had a life insurance policy through his superannuation fund. In the letter MW explained to GW how he wanted things divided up between his ex-wife and children. GW did not mention in his statement whether MW's comment that he was in fear for his life was related to him sending the letter to GW about his life insurance. There was no mention in GW's statement at all about whether they had had any conversation about the letter.

38. Whilst in custody, MW was attended by legal representatives on 5 occasions and he had 5 Local Court appearances via AVL, with his last appearance being on 3 May 2017. He only had one family member, his brother, visit him. He was next due to appear in court on 15 May 2017.

Events leading up to the death of MW

39. On 5 May 2017, MW's cell mate, JB, was due to appear in Court. At about 4.30 a.m. JB was preparing to be collected from his cell. He spoke briefly with MW who wished his cell mate good luck for his bail application. JB was later interviewed by investigating police and he said that he saw no indication that MW had been in a low mood or that he was contemplating suicide. Prison staff did not find anything adverse upon removing JB from the cell that morning. This was the last time MW was seen alive.

40. About 8.20 a.m. Corrections Officers Watene, Fiso and Brooks were conducting rounds in wing 2A. As Ms Watene opened cell 21 she observed MW hanging by a bed sheet. The bed sheet was attached to a grill above the cell doorway. Assistance was summoned and Corrections Officers Fiso, Watene and Brooks assisted in cutting MW down. MW was placed on the floor where the Officers commenced Cardiopulmonary Resuscitation ("CPR"). The Network Health staff attended shortly after and took over resuscitation attempts. Oxygen and a defibrillator were used without success. MW's pupils were observed to be fixed and dilated with no response to light. He had no signs of cardiac or respiratory activity; his lower extremities were cold to the touch. Life was pronounced extinct at 8.30 a.m. Paramedics arrived at 8.40 a.m. as required by protocol.

Investigation following MW's death

41. On 5 May 2017 at about 9.23 a.m. police attended MW's cell. A Crime Scene was established and maintained.

42. Photographs were taken, and MW's body was transferred to the Department of Forensic Medicine, Glebe Morgue. An external Post Mortem examination was ordered and carried out including the taking of a blood sample for toxicological testing. Specialist police from the NSW Police Corrective Services Investigation Unit took carriage of the matter and Detective Coorey prepared the Brief of Evidence to the Coroner.

43. During a search of MW's cell, an envelope was located on a shelf. A letter inside the envelope was addressed to 'W Family C/O GW *telephone number*'. In this letter MW acknowledged that his action would upset everyone and apologised.

44. The police obtained and reviewed CCTV footage which shows MW entering cell 21 at approximately 2.54pm on 4 May 2017 when he and JB were locked in for the night; at 4.32 a.m. On 5 May Correctional Officers approaches cell 21 and a minute later MW's cellmate JB leaves the cell. This is in accordance with the account provided by JB and Correctional Officers.

45. The police canvassed neighbouring inmates. Two of the prisoners said that they had played cards with MW the previous day and they had not noticed anything out of the ordinary. Another prisoner said that he had an AVL Court appearance on 3 May - the same day as MW's last court appearance. He said that following their respective appearances MW did not seem upset.

46. Dr Sairita Maistry, Forensic Pathologist carried out the Post Mortem examination on 10 May 2017. Doctor Maistry noted that there was a visible ligature mark which encircled MW's neck sloping upwards into the occiput. She reported that the pattern and dimension of the ligature mark on MW's neck generally matched the dimensions of the sheet ligature. She noted conjunctival petechial haemorrhages. No other traumatic

injuries were present externally. Doctor Maistry concluded that the direct cause of death was in keeping with hanging.

Modifications to Prisoner Cells

47. The issue of hanging points in PCC has been raised by the evidence in this case (and previous inquests including that of "L"). The brief of evidence includes a statement prepared by Tony Mannweiler who is currently employed as GEO's Contract Compliance and Risk Manager at Ravenhall Correctional Centre in Victoria. At the time of MW's death Mr Mannweiler was the Contract Compliance Manager at PCC. In September 2017 modifications were made to a number of cells, including the one occupied by MW to remove numerous hanging points. Accordingly, there is no need to further address that issue by any recommendations in this matter.

Submissions on behalf of the Family

48. In his submissions Mr McAuley suggested that it was clear that MW had an anxiety depressive disorder. Whilst MW may have been diagnosed with such 2 years prior to his incarceration there was no evidence to conclude that he was suffering such a disorder during his incarceration at PCC or specifically at the time of his death.

49. Mr McAuley suggests that when MW advised RN Hanson that he no longer required the Avanza and had not been taking it for 7 days there should have been an alert about MW's mental health placed on the prisoner information centre which would have resulted in a medical review and a review of his cell placement so that he would not be permitted to be alone in a cell at any time thus minimising his opportunity to self-harm.

50. With respect, given that the prescribed medication was to assist MW's sleep, having not taken the medication for a period of 7 days without any apparent adverse outcome or change in his behaviour, would not necessarily suggest that he was suffering from a mental health condition or experiencing self-harm ideation. In any event, RN Hanson did place him on a Mental Health Review List and indicated to MW that as a result of what he had told her she would organise a medical review.

51. There is no record that MW was reviewed in the following 2 weeks prior to his death. There is no evidence that since 23 April 2017 MW was displaying any signs which should have caused a concern about his mental wellbeing. MW's brother did not suggest that he was concerned by the letter or his meeting with MW and if he was he did not raise any concerns with any personnel employed by GEO or The Network. The screening and referral process during intake was appropriate and compliant with policy OP205 which was attached to Mr Mannweiler's statement.

Conclusion

52. There is no evidence relating to MW's state of mind but his legal situation and pending extradition placed him in a parlous if not, for him, an insurmountable situation. I am

satisfied that those who were managing his custody had no reason to suspect that he might take the absence of his cell mate as an opportunity to end his own life.

53. Given the cell modifications that have occurred in that wing of PCC and the adherence of the applicable policies in relation to the screening and management of MW this inquest is not one where recommendations of any kind need be made.

54. The findings are entered as follows:

The deceased known as MW died at Parklea Correctional Centre on 5 May 2017. The manner and cause of MW's death was suicide by hanging whilst in lawful custody.

Magistrate Truscott

Deputy State Coroner

24 January 2020